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Helpdesk Report: Adolescent Reproductive Health in Ethiopia
Date: 1st August 2011

Query: A review of international evidence on approaches and models to improve the reproductive health of adolescent girls, primarily focusing on Ethiopia.

Enquirer: DFID Ethiopia

Content

1. Overview

Situation in Ethiopia
Ethiopia's population of 80 million is increasing rapidly at an annual rate of 2.5% according to 2009 figures. Contraceptive prevalence is only 15%. The estimated adult HIV prevalence rate is 2.1%, with more than 1.1 million people infected. The number of voluntary counselling and testing (VCT) facilities increased from 23 in 2001 to more than 1000 in 2007, and the number of HIV tests taken doubled from 1.7 million tests in 2007 to 3.5 million in 2008.

According to the 2005 Demographic and Health Survey (DHS) the total fertility rate (TFR) for Ethiopia was 5.4 births per woman. As expected, fertility is considerably higher in the rural areas than urban areas. The TFR in the rural areas is 6.0, two and half times higher than the TFR in the urban areas. Fertility has fallen substantially among all age groups over the past two decades. This decline is most obvious in the 15 years preceding the survey, with the largest decline observed between the two most recent five-year periods. Fertility decline is steepest among the youngest cohort, with a 35% decline between the period 15-19 years before the survey and the period 0-4 years before the survey. The decline in fertility observed in Ethiopia can be attributed in part to increasing use of contraception. Use of contraceptive methods tripled in the 15 year period between the 1990 and 2005 from 5% to 15%. The increase is especially marked for modern methods in the five years between 2000 and 2005. This increase is attributed primarily to the rapid rise in the use of injectables from 3 percent in 2000 to 10 percent in 2005.

The key components of reproductive health care include:

- Family planning information and services;
- Safe pregnancy and delivery services;
- Prenatal and postnatal care;
- Prevention of placental malaria, through usage of insecticide treated bed-nets;
- Post-abortion care, in the event of abortion;
- Prevention and treatment of sexually transmitted infections, including HIV/AIDS;
- Information and counselling on sexuality;
- Nutrient supplements during pregnancy;
- Behaviours during pregnancy that are pro-fetal growth;
- Antenatal and neonatal immunization services;
- Elimination of harmful practices against women such as genital mutilation and forced marriage.

Needs of Adolescents

Ethiopia is unusual within the region in having very low levels of sex before marriage. According to the 2005 DHS well over 90% of single women are virgins. Ensuring the health of adolescent girls is vital to the nation. Ethiopia has made progress in improving youth's health; yet, young women still suffer high rates of maternal injury and death due to childbirth without skilled assistance and unsafe abortion. Persistent gender inequalities and traditional harmful practices, including female genital mutilation (FGM) and child marriage, contribute to these significant health challenges.

Global perspectives on the sexual and reproductive health of adolescents: patterns, prevention, and potential
Prof Linda H Bearinger, Prof Renee E Sieving, Jane Ferguson, Vinit Sharma, *The Lancet*, Volume 369, Issue 9568, Pages 1220 - 1231, 7 April 2007
http://download.thelancet.com/pdfs/journals/lancet/PIIS0140673607603675.pdf?id=3d35b1b5aa0ec416:-6777c524:131709b76bd:3d1c1311857599740

Promoting healthy practices during adolescence to better protect this age group from risks will ensure longer, more productive lives for many. Adolescents (aged 10 to 19 years) have specific health and development needs, and many face challenges that hinder their well being, including poverty, a lack of access to health information and services, and unsafe environments. Strategies must be tailored to the developmental needs of this age group and their social contexts, effective approaches are multifaceted.

A reproductive health approach recognises that the foundations of women's health are laid in childhood and adolescence, and are influenced by factors such as nutrition, education, sexual roles and social status, cultural practices, and the socioeconomic environment. Reproductive health care strategies to meet women's multiple needs include education for responsible and healthy sexuality, safe and appropriate contraception, and services for sexually transmitted diseases, pregnancy, delivery, and abortion.

Many factors contribute to their risk for STIs, HIV, or negative health outcomes of early pregnancy, with even greater vulnerability for some subgroups. Biologically, the immature reproductive and immune systems of adolescent girls translate to increased susceptibility to STIs and HIV transmission; pregnancy and delivery for those with incomplete body growth exposes them to problems that are less common in adult women. Many societal issues also contribute to risks for adolescents. Age differences between partners, gender differences in norms for sexual behaviour, and early marriage for girls could all heighten the possibility of sexual coercion.

For unmarried adolescent boys and girls, services are offered as part of child health care and do not encompass sexual and reproductive health. If married, services for adolescent girls are part of reproductive care for adult women. However, several changes have rendered this approach outdated. First, acknowledging wide cultural variation, adolescents are increasingly delaying marriage. Urbanisation has an important role in this societal shift. Second, historically, societies expected childbearing to follow shortly after marriage; now norms are shifting towards delayed childbearing. These changes, which affect all societies to varying degrees, have expanded the gap between puberty and marriage, and between marriage and childbearing. Thus, assumptions about the adequacy and effectiveness of health-service delivery through paediatric or adult reproductive services are no longer appropriate in developing or developed countries. Adolescents, for many reasons, have urgent need for accessible, quality health care.

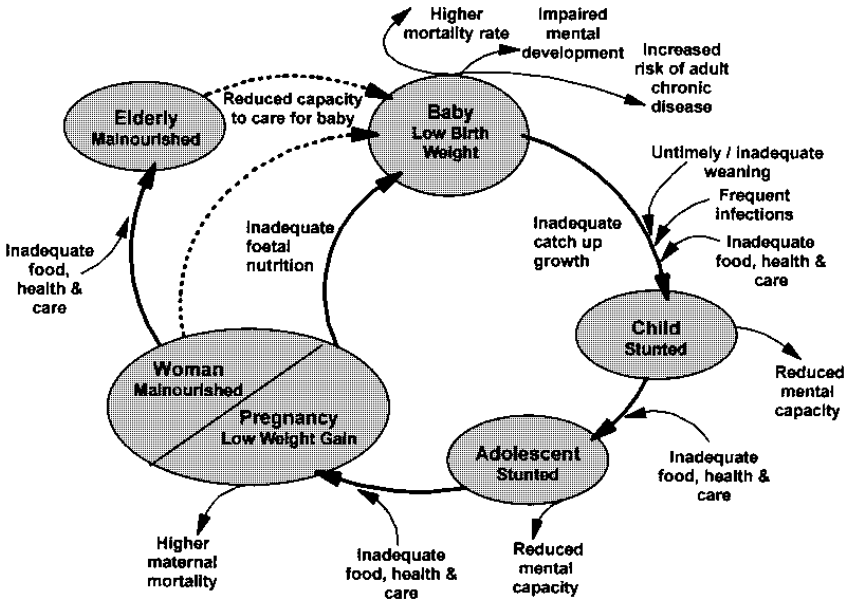
Reproductive Health Issues and Examples of Programmes to Reduce Their Impact

This report will now go on to discuss important reproductive health issues and give examples of programmes to reduce their impact.

2. Nutrition

Nutrition of Women and Adolescent Girls: Why It Matters
by Elizabeth I. Ransom and Leslie K. Elder, Population Reference Bureau, 2011
http://www.prb.org/Articles/2003/NutritionofWomenandAdolescentGirlsWhyItMatters.aspx?p=1

Lifecycle Approach: Poor Nutrition Throughout the Lifecycle



Women are more likely to suffer from nutritional deficiencies than men are, for reasons including women's reproductive biology, low social status, poverty, and lack of education. Sociocultural traditions and disparities in household work patterns can also increase women's chances of being malnourished. Globally, 50 percent of all pregnant women are anaemic, and at least 120 million women in less developed countries are underweight. Research shows that being underweight hinders women's productivity and can lead to increased rates of illness and mortality.

Many women who are underweight are also stunted, or below the median height for their age. Stunting is a known risk factor for obstetric complications such as obstructed labour and the need for skilled intervention during delivery, leading to injury or death for mothers and their newborns. Adolescent girls are particularly vulnerable to malnutrition because they are growing faster than at any time after their first year of life. They need protein, iron, and other micronutrients to support the adolescent growth spurt and meet the body's increased demand for iron during menstruation. Adolescents who become pregnant are at greater risk of various complications since they may not yet have finished growing. Pregnant adolescents who are underweight or stunted are especially likely to experience obstructed labour and other obstetric complications. There is evidence that the bodies of the still-growing adolescent mother and her baby may compete for nutrients, raising the infant's risk of low birth weight and early death.

Possible Solutions

Adolescent girls need access to information and services related to nutrition, reproductive health, family planning, and general health. In communities where many adolescent girls are underweight, supplements may improve girls' overall health and their pregnancy outcomes, including reducing their risk of bearing low birth-weight babies. Because even women who have not used health care services in the past often make contact with health systems when pregnant, it is vital that nutrition interventions be integrated into antenatal care programs. Women should consume daily iron and folate supplements when they are pregnant and for at least three months after childbirth and should receive other micronutrients as needed. In areas where many women suffer chronic energy deficiency and there is a high incidence of low birth weight, pregnant and lactating women may need high-energy food supplements. Educational programmes and public information campaigns can also help address cultural norms that prevent women from eating enough.

Women's energy requirements remain high after delivery, especially when women are breastfeeding, so it is important that they continue to receive enough food. Women require approximately 50 percent more calories while breastfeeding than they need during pregnancy. Maintaining adequate levels of vitamin A is particularly important for nursing mothers.

Improve Women's Status

Policymakers can help improve women and children's nutrition by addressing women's low status in society. Research indicates that women who have greater control over household resources tend to be healthier and better nourished — as do their families — because women tend to spend more on the nutrition, health, and well-being of their households.

There is also increasing concern about the possibility that maternal malnutrition may contribute to the growing burden of cardiovascular and other non communicable diseases of adults in less developed countries. Finally, maternal malnutrition's toll on maternal and infant survival stands in the way of countries' work toward key global development goals.

3. Early Marriage and Early Pregnancy

Harmful Traditional Practices

http://www.etharc.org/resources/organizations?sobi2Task=sobi2Details&catid=3&sobi2Id=134

The National Committee for Traditional Practices in Ethiopia (Mission: The promotion of beneficial traditional practices and eradication of harmful traditional practices) identified 120 Harmful Traditional Practices (HTPs), including Female Genital Cutting (FGC), early and forced marriage, rape, and wife inheritance.

Early Marriage
Many development professionals consider early marriage to be the most significant harmful traditional practice for women in Ethiopia, as it harms women's physical and psychological well-being and curtails their education and future income-earning potential. Not only do women married young bear more children over time, but an adolescent mother is less prepared to care for her children and to manage a household. Many young wives are subject to sexual violence and exposure to sexually-transmitted infections.

Early Childbearing
Early age at initiation of childbearing has a detrimental effect on the health of both mother and child. Pregnancy is an obvious risk and dangerous for young wives: when not fully mature, a young girl's body may be unable to support a pregnancy or a successful delivery. At least one percent of Ethiopian women have experienced obstetric fistula (please see section 5).

Early childbearing also lengthens the reproductive period, thereby increasing the level of fertility. Childbearing begins early in Ethiopia. Among women who were in the age cohort 25-29 in 2005 the median age at first birth was 19.2 years. This represents a small, recent rise in the median age at first birth.

Child Marriage: Ethiopia
Population Council Briefing Paper, July 2004
http://www.popcouncil.org/pdfs/briefingsheets/ETHIOPIA.pdf

Ethiopia has one of highest levels of child marriage. The legal age of marriage is 18 for both males and females, but it is widely ignored. First births have elevated risks and the youngest first-time mothers and their children are especially vulnerable to poor health outcomes. Among married girls aged 15–19 in Ethiopia, almost half have already given birth. The vast majority of births occurring to girls before age 18 are first births (77 percent), and nearly all of these first births occur within marriage (96 percent).

Prolonged and obstructed labour can result in obstetric fistulas (see section 5). First births also have elevated risks of preeclampsia, malaria, and infant mortality. Girls who give birth during adolescence require special attention because they are less mature and are simultaneously coping with their own and their baby's physiological, emotional, and economic needs.

Globally, adolescent mothers tend to be poorer, less educated, and less adequately nourished than older mothers; they also face greater social disadvantage. Married girls receive little or no schooling Eighty percent of married girls have received no education, and 81 percent cannot read at all. Three percent of married girls aged 15–19 are in school, compared to 34 percent of unmarried girls. Lack of education is a reproductive health risk factor.

In Ethiopia, where the HIV epidemic is selective of young females, child marriage may be a significant risk factor for adolescent girls. Among young people aged 15–24, girls are more likely than boys to be infected with HIV (10.0 percent vs. 5.6 percent). Unmarried sexual activity is relatively rare; 94 percent of sexually active girls in Ethiopia are married. Married girls have limited ability to negotiate condom use. Among girls who do not want to get pregnant, 68 percent of married girls are having unprotected sex, compared to only 1 percent of unmarried sexually active girls. The Amhara region reports the highest rates of HIV among pregnant women in the entire country. This region also has the lowest average age of marriage in Ethiopia.

Recommendations to promote later, chosen, legal marriage

- Raise awareness of the extent of early marriage and the human rights abuse it constitutes.
- Publicise and enforce the national law that establishes 18 as the legal age of marriage.
- Engage communities through public campaigns, pledges, or incentive schemes.
- Raise the awareness of parents, community leaders, and policymakers about the health and rights implications of young girls marrying much older men.
- Develop special social and health support structures for young, first-time mothers.
- Encourage governments and communities to commit to getting girls to school on time and to keeping them in school through the secondary level. Being in school during adolescence has important health and development benefits for girls.
- Develop social and economic programmes for out-of-school girls, including non-formal education programmes.

Possible Actions – Education

There is a positive relationship between educational attainment and median age at first birth, but the impact seems more significant at secondary and higher levels of education. Women with at least secondary education begin their childbearing more than four years (22.9 years) later than women with no education (18.7 years). Seventeen percent of women age 15-19 have already become mothers or are currently pregnant with their first child, which is similar to the pattern seen from data collected in the 2000 EDHS (16 percent). The percentage of women who have begun childbearing increases rapidly with age, from 2 percent among women age 15, to 41 percent among women age 19. Nearly three times as many teenagers residing in rural areas as in urban areas have begun childbearing. Childbearing among teenagers is lowest in Addis Ababa (4 percent) and highest in the Gambela Region (31 percent). The level of teenage parenthood among teenagers with no education is nearly three times that among teenagers with primary education, while it is nearly ten times that of teenagers with secondary and higher education. The percentage of teenagers who have begun childbearing is three times higher among those in the poorest households (24 percent) compared with those in the wealthiest households (8 percent).

International Center for Research on Women

http://www.icrw.org/where-we-work/improving-well-being-married-adolescent-girls-ethiopia

In Ethiopia's Amhara region, almost half of all girls are married by the age of 15. By the time they turn 18, nearly three out of four girls are married. Early marriage presents many health risks for these girls that are compounded by their lack of economic autonomy. To address this vulnerability, ICRW is working with CARE Ethiopia to improve the sexual and reproductive health and economic well-being of adolescent girls by combining health programmes with economic empowerment interventions to reach 5,000 married girls in Amhara. The goal is to better understand how health and economic outcomes interact. ICRW also will track changes in girls' sexual and reproductive health, such as their use of contraceptives, as well as changes in their economic independence, for instance whether they use savings accounts. This project will result in tested best practices to apply in future programmes for girls.

4. Maternal Mortality

Information from:

Demographic and Health Survey 2005

http://www.measuredhs.com/pubs/pdf/FR179/FR179[23June2011].pdf

Maternity Worldwide Website

http://www.maternityworldwide.org/pages/causes-of-maternal-mortality.html

The 3 delays model
This model identifies individual decision making, access to affordable services, and the provision of skilled personnel as the main factors which can delay access to effective interventions to prevent maternal mortality

Phase 1 delay. Delay in decision to seek care

- Failure to recognise complications
- Acceptance of maternal death
- Low status of women
- Socio-cultural barriers to seeking care: women's mobility, ability to command resources, decision-making abilities, beliefs and practices surrounding childbirth and delivery, nutrition and education

Phase 2 delay. Delay in reaching care

- Poor roads, mountains, islands, rivers - poor organisation

Phase 3 delay. Delay in receiving care

- Inadequate facilities, supplies, personnel
- Poor training and demotivation of personnel
- Lack of finances

Maternal deaths accounted for 21% of all deaths to women age 15-49; in other words, more than one in five Ethiopian women who died in the seven years preceding the survey died from pregnancy or pregnancy-related causes. The maternal mortality ratio for Ethiopia for the period 1998-2004 is 673 deaths per 100,000 live births (or alternatively 7 deaths per 1,000 live births). Similarly collected data from the 2000 EDHS show the maternal mortality ratio for Ethiopia for the period 1994-2000 to be 871 deaths per 100,000 live births or 9 deaths per 1,000 live births. Although it appears that maternal mortality may be declining in Ethiopia, the rates are both subject to a high degree of sampling error. Because 95% confidence intervals around the two estimates overlap, it is not possible to conclude that there has been a decline (DHS 2005).

Factors that contribute to a higher risk of maternal mortality for all women can include biomedical factors, reproductive factors, health service factors, and socioeconomic and cultural factors (these factors are discussed in more detail on the Maternity Worldwide website and in the DHS). Adolescents have additional risk factors including not being biologically developed enough to give birth, not being psychologically prepared and having less power in the household in order to negotiate to receive health care. Adolescents are also more likely to be giving birth to their first baby which holds further risks.

Causes of Maternal Mortality

Cause	**Percentage of Maternal Deaths**
Haemorrhage	24%
Infection	15%
Unsafe Abortion	13%
Hypertensive disorders of pregnancy	12%
Obstructed Labour	8%
Other direct causes*	8%

Other indirect causes**	20%

*Other direct causes include: ectopic pregnancy, embolism, anaesthesia-related causes
** Indirect causes include: anaemia, malaria, heart disease

Appropriate and timely intervention from a trained professional could prevent the majority of maternal mortalities.

Time to death for most common obstetric emergencies

Cause of Death	Time to Death
Postpartum haemorrhage	2 hrs
Antepartum haemorrhage	12 hrs
Ruptured Uterus	1 days
Eclampsia (severe hypertensive disorder of pregnancy)	2 days
Obstructed Labour	3 days
Infection	6 days

The risk of a woman dying in pregnancy and childbirth depends on the number of pregnancies she has in her lifetime. The higher the number of pregnancies the greater the lifetime risk of pregnancy related death. Maternal mortality rates are also higher among very young women, those aged 35 years and older and those with four or more children.

Ethiopia: Safe delivery, safe mothers and safe babies
Save the Children, Friday 4 February 2011
http://www.savethechildren.org.uk/blogs/2011/02/ethiopiasafe-delivery-safe-mothers-and-safe-babies/

Ideally, pregnant women should go to a health centre to give birth. It's a sterile environment where they can be educated about exclusive breastfeeding and the importance of hygiene and sanitation for their newborn baby. If a health centre is too far away (as is so often the case) then maybe the lifeline for so many villages in Ethiopia (where 85% of the population lives in rural areas) is their Health Extension Worker, who could be trained in carrying out safe deliveries?

Some basic hygiene training is being rolled out by the Ethiopian government. But health workers will need more extensive training to diagnose antenatal problems and assist in helping mothers deliver their babies safely – as they'll reach many more mothers than health centres and vastly more than hospitals. There are just three hospitals in the entire South Wollo district and they're all in larger towns like Akista (Legambo district) and Dessie – so almost all the population of South Wollo will not be able to access them.

The ratio for giving birth in a health centre vs at home is 1:15 (national average – so the reality in rural areas like South Wollo, will be higher). This suggests that interventions are so far only reaching a tiny proportion of mothers due to give birth – and this is why the health workers and community health volunteers are so vital.

At an ambulance handover ceremony in Sayint, the South Wollo Deputy Head of Health, Luelsegede, said he felt the key for reducing maternal and newborn mortality in South Wollo was training health workers more extensively in antenatal care and safe delivery, and this

seems to be the government's plan. Long term, the government wants to train more midwives, but this will take time.

Demographic and Health Survey 2005
http://www.measuredhs.com/pubs/pdf/FR179/FR179[23June2011].pdf

Birth Intervals
The median number of months since a preceding birth increases significantly with age, from a low of 26.1 months among mothers age 15-19 to a high of 38.8 months among mothers age 40-49.

5. Fistula

Obstetric fistula, a condition that develops when the blood supply to the tissues of the vagina, bladder, and/or rectum is cut off during prolonged obstructed labour, resulting in the formation of an opening through which urine and/or faeces pass uncontrollably. Women who develop fistulas are often socially rejected due to the ensuing dreadful odour. A woman with obstetric fistula is usually thrown out of her home by her husband and typically again rejected by her parents, forcing her to live on her own and not go outside, sometimes for many years if she cannot gain access to treatment.

This condition disproportionately afflicts very young (age 15-19) and first-time mothers. It is estimated that 9,000 new fistulas occur annually in Ethiopia. 2% of 15-19 year olds surveyed had an obstetric fistula (over 4% said a household member had the condition) and only 0.5% of these women reported ever being treated.

Examples of Projects

Fistula
Fistula Project
http://www.hamlinfistula.org.au/index.html

The Addis Ababa Fistula Hospital and its regional Hamlin Fistula Centres offer comprehensive care for women who suffer from incontinence, physical impairment, shame and marginalisation as a result of obstetric fistula. Patients undergo surgical repair by highly skilled Ethiopian and expatriate surgeons who have had extensive training in fistula surgery at the Hospital's main facility in Addis Ababa. Around 93% of these patients are repaired successfully. The average stay of patients whose injuries are not too severe and who arrive for treatment in reasonably good health is around three weeks.

Prevention: Midwife Training- Hamlin College of Midwives
http://www.hamlinfistula.org.au/hospital/midwifery.html

To ensure that there is a skilled birth attendant available to provide maternal health care (pre–natal, intro–natal and post–natal) for every woman in every rural community in Ethiopia.
Facts

- 85% of the population lives in the countryside without ready access to midwifery or other health related services.
- There are about 8,000 – 9,000 new cases of obstetric fistula occurring each year in Ethiopia.
- Training midwives is a key prevention strategy.

Qualified Midwives

- The first 11 students will graduate in 2010 and be deployed to their rural home regions.
- They have all committed to working for at least 5 years during which they will be given regular support, supervision and ongoing training.

- The midwives will be deployed in pairs so that they will have each other's support and can share the work load.
- They will be located in a specially provided health centre with access to a doctor or health officer who can perform Caesarean Sections when needed.
- They will be provided with all necessary means of communication and transportation to ensure that they are fully equipped to establish a safe birth environment in their community.

Strategy

The Hospital's strategy in establishing the Hamlin Fistula Regional Centres is to:

- provide rural women suffering from obstetric fistula with access to medical help
- treat more women suffering from obstetric fistula
- educate the local population about safe birthing practices and the causes of obstetric fistula
- locate women who are hidden away and ostracised because of obstetric fistula
- reduce maternal morbidity and mortality
- reduce the incidence of obstetric fistula and still births in rural Ethiopia

6. Sexual Health

Radio as a Communication Tool

http://www.bbc.co.uk/worldservice/trust/whatwedo/where/africa/ethiopia/2011/03/110304_az_abugida.shtml

A lack of knowledge about sexual health issues, coupled with traditional attitudes towards gender can lead to major problems for young women in Ethiopia. Embarrassment in talking about sensitive topics such as these can be a major barrier to changing behaviour. A youth radio show is helping to break a culture of silence for women and men alike. *Abugida,* a radio show broadcast weekly on Radio Ethiopia. *Abugida* means "A to Z", and the programme covers a subject that remains taboo for many people in Ethiopia: sex.

A major issue

Sexual health is a major issue for young people in Ethiopia – despite decades of health campaigns. Rates of new HIV infections are starting to fall, but still as many as 8% of people are living with the disease in urban areas. Teenage pregnancy is widespread: more than half of girls have had two babies by the age of 18. "There's so many misconceptions about sex in Ethiopia," says Elsabet Samuel, producer of the *Abugida* show. "I recently met a girl who was beaten by her parents because she started menstruating. They thought it meant that she had started having sex."

Let's talk about it

"Conversations just don't happen ... mothers are too embarrassed to talk to their daughters, girls are shy, even friends don't talk about it." The problem isn't a lack of information - there are scores of sexual health campaigns aimed at young people in Ethiopia. The problem, according to Elsabet, is that people don't talk about it. "Conversations just don't happen" she says. "Mothers are too embarrassed to talk to their daughters, girls are shy, even friends don't talk about it."

As a result, an enormous amount of confusion and misinformation surrounds the subject. "People sometimes think that condoms are only for people who have HIV and AIDS," says Elsabet, "or that taking the contraceptive pill makes you skinny." Bombarding young people with more information isn't the answer. "What they really need is communications skills," says Frehiwot Guangul, another producer on Abugida. "They need to learn how to talk about sex, how to talk to their parents, negotiate with their partners, talk about contraception".

Breaking the silence
"It has managed to break the silence on these subjects" Desta is a 17 year old boy who has been coming to the listening groups for almost a year. "Even in our family we are beginning to talk more, to have the courage to talk about condoms and the opposite sex that we didn't have before." Aisha agrees.

Reproductive and Sexual Health among Ethiopia's Youth, Advocates for Youth
http://www.advocatesforyouth.org/storage/advfy/documents/fsethiopia.pdf

As part of the International Youth Speak Out Project, Advocates for Youth and Ethiopia's Talent Youth Association (TaYA) are building a youth activist leadership council that advocates for programmes and policies to improve youth's reproductive and sexual health in Ethiopia as well as internationally

Final Report on the First National Youth Consultation on HIV/AIDS, Sexual, and Reproductive Health in Ethiopia, Family Health International, 2002
http://www.fhi.org/NR/rdonlyres/exykquu3pjtu7qlsqhx7cvpiy2yaafilrhe7zxj5bjgl4nro65pg64ne6wf27mo7f4ddaw572cjlog/ethiopianationalyouthprogram2enhv.pdf

The charter identified the following list of needs and areas for improvement around the nation:

- Creating an environment conducive to sexual and reproductive health for Ethiopian youth.
- Involving young men and women in the design and implementation of programs.
- Decreasing risk-taking behaviour through education and communication activities.
- Promoting the prevention of unwanted pregnancies, STIs, and HIV infections.
- Enacting policies, programs, and enforcing laws that address the harmful social norms that negatively affect girls and young women.
- Creating youth-friendly services at the local level.
- Developing programmes for youth with special needs.

Three-year action plan developed to enact charter
To turn the plans developed in the National Youth Charter into reality, Ethiopian young men and women developed a three-year action plan. The plan served as a practical map for government, donor agencies, religious leaders, and others.

To be effective, the plan suggested:

- Increasing self-risk perception and decreasing risky sexual behaviours among in and out-of-school youths.
- Enhancing communication between youth and their parents.
- Promoting new partnerships among youth and between youth and their communities.
- Expanding access to youth friendly reproductive and sexual health products and services.

Khat and alcohol use and risky sex behaviour among in-school and out-of-school youth in Ethiopia
Kebede D, Alem A, Mitike G, Enquselassie F, Berhane F, Abebe Y, Ayele R, Lemma W, Assefa T, Gebremichael T, *BMC Public Health*. 2005 Oct 14;5:109.
http://www.ncbi.nlm.nih.gov/pubmed/16225665

Over 20% of out-of-school youth had unprotected sex during the 12-month period prior to interview compared to 1.4% of in-school youth. Daily Khat intake was also associated with unprotected sex: adjusted OR (95% CI) = 2.26 (1.92, 2.67). There was a significant and linear association between alcohol intake and unprotected sex, with those using alcohol daily having a three fold increased odds compared to those not using it: adj. OR (95% CI) = 3.05

(2.38, 3.91). Use of substances other than Khat was not associated with unprotected sex, but was associated with initiation of sexual activity: adj. OR (95% CI) = 2.54 (1.84, 3.51). A substantial proportion of out-of-school youth engage in risky sex. The use of Khat and alcohol and other substances is significantly and independently associated with risky sexual behaviour among Ethiopian youths.

7. Family Planning/Contraceptive Use

Among currently married women only 16% of those age 15-19 have ever used a method of contraception. Family planning may be used to either limit family size or delay the next birth. Couples using family planning to limit family size adopt contraception when they have already had the number of children they want. When contraception is used to space births, couples may start using family planning earlier, with the intention of delaying a possible pregnancy. This may be done even before a couple has had their desired number of children.

Reproductive health knowledge, attitude and practice among high school students in Bahir Dar, Ethiopia
Kibret M, *African Journal of Reproductive Health*, 2003 Aug;7(2):39-45.
http://www.ncbi.nlm.nih.gov/pubmed/14677299

This study was carried out to investigate the reproductive health knowledge, attitude and practice of high school students in Bahir Dar, Ethiopia. Data were collected using self-administered questionnaire and focus group discussions. The study revealed that the students had high level knowledge of contraceptives and where to obtain contraceptive services; however, level of use was low. Some of the reasons given for not using contraceptives include lack of access to services, carelessness, unplanned sexual intercourse and pressure from sexual partner. The study indicates that young people engage in sexual relationships at an early age without protection or with unsafe non-conventional methods. There was no significant difference between the demographic variables and contraceptive use at first intercourse. Educational level of the respondents was the only demographic variable that had significant association with sexual experience ($p < 0.05$). The report recommends improved access to family planning information and services and family life education programmes based on the needs and experience of these young people as a potential solution to alleviate their reproductive health problems.

In most sub-Saharan African countries, Azerbaijan, the Republic of Georgia, and the Philippines, less than a third of sexually experienced adolescent girls report using a condom at most recent sex; the proportion is half or more in Uganda, Romania, the Ukraine, Latin America, and the developed world. In most sub-Saharan African countries, Latin America, and the developed world, condom use at most recent sex is greater in adolescent boys than girls. Adolescent girls commonly face obstacles when seeking medical contraceptive methods, including insufficient knowledge about modern methods, limited access to services, and even health-care providers who actively discourage use of such methods by teenagers.

Women's knowledge, preferences, and practices of modern contraceptive methods in Woreta, Ethiopia
Weldegerima B, Denekew A. *Research in Social and Administrative Pharmacy*. 2008 Sep;4(3):302-7. Epub 2008 Aug 8.
http://www.sciencedirect.com/science/article/pii/S1551741107000939

Inadequate family planning services are problematic in Ethiopia. Understanding determinants in contraceptive methods use may be instructive in the design of interventions to improve family planning outcomes. This article assesses determinants of preferences, knowledge, attitudes, and practices of modern contraception among women of reproductive age in Woreta town. It is a community-based, cross-sectional study was conducted in Woreta town,

South Gondar zone, Ethiopia in April 2007. A multistage sampling procedure was carried out to interview 400 women in the study area. A pretested structured questionnaire was used for data collection.

Results
Eighty-nine percent of respondents were aware of modern contraceptives. Among respondents, 88% knew of at least 2 methods, and 12% knew only 1 method. More than 90% of respondents reported positive attitudes toward modern contraceptive use. The major reasons for non use of modern contraceptive methods (MCMs) were being single and a desire for more children. Injectables were the most commonly preferred modern contraceptive (63.2%) followed by oral contraceptive pill (21.2%). Few women reported a preference for the use of condoms (9.5%) or implants (6.1%).

Conclusions
Respondents reported at least modest knowledge of MCMs; however, the results suggest a need for improving accessibility and education among women in this section of Ethiopia.

8. HIV/AIDS

UNAIDS Country Situation Analysis- Ethiopia, 2009
http://www.unaids.org/ctrysa/AFRETH_en.pdf

The single point estimated for 2009 indicates Ethiopia has an adult HIV prevalence rate of 2.3%, an estimated total number of 1.3 million people living with HIV (PLHIV), and a total of 356,682 people requiring treatment. A multisectoral Plan of Action for the national response to HIV/AIDS prevention, treatment, care and support, with the ambition of achieving Universal Access to basic HIV services and intensifying prevention activities, was formulated to guide the response to the epidemic in a holistic manner.

Social mobilisation efforts were successful in reaching millions of people at community level and creating awareness about HIV and available services. In the last Ethiopian fiscal year (July 2008 – June 2009) 153,741 people were on treatment and a total of 5.8 million people received HIV counselling and testing.

With regards to prevention of mother-to-child-transmission (PMTCT) improvements were seen, though much lower than targeted. Coverage among HIV-positive pregnant women was only 6% at the end of 2008. The reasons for low coverage need to be improved and PMTCT uptake needs to be closely linked with efforts to expand maternal and child health service coverage.

Global perspectives on the sexual and reproductive health of adolescents: patterns, prevention, and potential
Prof Linda H Bearinger, Prof Renee E Sieving, Jane Ferguson, Vinit Sharma, *The Lancet*, Volume 369, Issue 9568, Pages 1220 - 1231, 7 April 2007
http://download.thelancet.com/pdfs/journals/lancet/PIIS0140673607603675.pdf?id=3d35b1b5aa0ec416:-6777c524:131709b76bd:3d1c1311857599740

Biologically, the immature reproductive and immune systems of adolescent girls translate to increased susceptibility to STIs and HIV transmission; pregnancy and delivery for those with incomplete body growth exposes them to problems that are less common in adult women. Many societal issues also contribute to risks for adolescents. Age differences between heterosexual partners (younger girl and older male partner), gender differences in norms for sexual behaviour (e.g., sexual involvement expected for boys and men while negatively sanctioned for girls and women), and early marriage for girls could all heighten the possibility of sexual coercion. This can also increase HIV rates as forced sex is more likely to result in

an infection sue to the internal damage (cuts, tears) done to the woman during the rape/forced sex.

The practice of marrying one's sister-in-law (without her consent) upon the death of her husband is widespread and particularly pervasive in certain areas in the south of the country. Today, this practice is feeding the HIV/AIDS epidemic, when widows lose their husbands to the virus and carry it to the next marriage.

Thirteen percent of marriages end in divorce or separation. Many divorced girls return to their families but, if turned away, they often migrate to a city to seek employment as housemaids. Too often, they have to resort to commercial or transactional sex work. With no income-generating skills and little knowledge of how to make positive reproductive health decisions, they are at high risk of contracting HIV/AIDS and other sexually-transmitted infections.

Female Genital Cutting can also increase HIV rates as often the same razor/knife is used to cut several girls potentially passing the infection from one to the other through the blood on the dirty instrument used.

9. Female Genital Cutting (FGC)

DHS, 2005
http://www.measuredhs.com/pubs/pdf/FR179/FR179[23June2011].pdf

Three in four Ethiopian women have experienced female genital cutting. Six percent of circumcised women reported that their vagina was sewn closed (infibulation). Female circumcision has declined over the past five years from 80 percent in 2000 to 74 percent in 2005. Support for the practice has also declined from 60 percent to 31 percent over the same period. In addition, circumcising daughters has declined. Fifty-two percent of mothers with at least one daughter had a daughter circumcised in 2000 compared with 38 percent in 2005.
Talk of reproductive consequences.

According to the United Nations, circumcised women are up to 70 percent more vulnerable to potentially fatal bleeding after delivery. According to a World Health Organisation study published in *The Lancet*, women who have undergone the procedure are also more likely to need Caesareans and the infant mortality rate among their babies is as much as 50 percent higher. Yet, even though circumcised women face a lifetime of pain and suffering, the practice is difficult to eradicate.

Orchid Project
http://www.orchidproject.org/more-about-fgc/health-impacts-of-fgc/

When they start their periods, menstrual blood may struggle to escape from the small hole. Some girls may get internal infections from this and die. Infibulated women have a plug of hard, keloid scar tissue where the soft opening to their vagina should be. When it comes to a wedding night, a girl's husband may have to force his way inside with his penis, but more often, a woman is cut open in advance, sometimes with a knife. The scar tissue is opened only wide enough for penetrative sex to occur. Before or during labour, a pregnant girl or woman will be cut open even more. However, many women who have gone through FGC experience fistula or other birth complications because of the impact of infibulation on their elasticity. It can contribute to maternal mortality, as well as death of the baby during or immediately following birth. For example, because the vagina had no elasticity, the baby cannot pass through the mess of poorly-healed scarring between the woman's legs and this can lead to the death of mother and baby.

Female genital mutilation and obstetric outcome: WHO collaborative prospective study in six African countries
WHO study group on female genital mutilation and obstetric outcome, *The Lancet* 2006; 367: 1835–41
http://download.thelancet.com/pdfs/journals/lancet/PIIS0140673606688053.pdf?id=3d35b1b5aa0ec416:-6777c524:13170e1b838:66981311862949816

Infant mortality can be up to 50% higher. The report showed that women who had experienced FGC had a 31% higher chance of having to give birth by c-section. A newborn whose mother was mutilated was 66% more likely to need resuscitation. Mutilated mothers have a 55% higher chance of giving birth to either a stillborn baby or a baby that soon dies.

10. Rape and Forced Marriage

Adolescents are most at risk of rape and forced marriage. Nearly 8% of currently married women were abducted and forced into marriage—a custom, prohibited by law but not enforced until recently, that vividly illustrates the enormity of male dominance in Ethiopian tradition. Rape is common, and too often its threat drives parents to keep their girls home, out of harm's way, but also out of school. Domestic violence is so accepted that 81 percent of women interviewed believed there are justifiable reasons for a husband to beat his wife.

Kidnapped. Raped. Married. The extraordinary rebellion of Ethiopia's abducted wives
Johann Hari on Ethiopia's forced marriages, The Independent, Wednesday, 17 March 2010
http://www.independent.co.uk/news/world/africa/kidnapped-raped-married-the-extraordinary-rebellion-of-ethiopias-abducted-wives-1922263.html

In 2003 – the last year for which statistics are available – the National Committee on Traditional Practices of Ethiopia found that 69 per cent of marriages begin like this, with abduction, rape, and a forced signature. In a country with a mixture of Protestant, Catholic and Muslim, all religions practise it equally.

"If it hadn't happened to me ... I would have been educated and got my own work and lived my own life. I wish to God that had happened." Her laugh erupts again, like a muffled scream. "Maybe I could have been happy. Now I am old. I have to be happy – at least I have children; I love them."

"My mother's life was a nightmare. I don't know how she survived," she adds, looking down. "She was a very intelligent, very wise woman – but all her life she was abused and beaten – for nothing. She had her back stooped, her legs broken, her jaw broken, even though she did everything right. It was a nightmare, but for her it was a life.

"I had been angry for a long time. I went with him because I had no choice. He raped me. I was crying so I couldn't shout for help. I wanted to run back to my family but he threatened to shoot me. Then I could say some of this."

Ethiopian women are most abused
BBC, Wednesday, 11 October 2006, 12:39 GMT 13:39 UK
http://news.bbc.co.uk/1/hi/world/africa/6040180.stm

Women in Ethiopia are most likely to suffer violence at the hands of their partners in the world, says the United Nations. Nearly 60% of Ethiopian women were subjected to sexual violence, including marital rape, according to the Ending Violence Against Women report.

Case Study

The laws in Ethiopia are not always upheld for these girls as in the case of a 13 year old who was very violently raped, there were many witnesses and clinical evidence but the judge offered the girl marriage to the man who had done this: http://www.washingtonpost.com/wp-dyn/articles/A20835-2004Jun6.html. There are risks of long term physical and psychological damage to the girl as well as social stigma.

Sexual violence among female high school students in Debark, northwest Ethiopia
A. Worku, M. Addisie, East African Medical Journal, Vol 79, No 2 (2002) , Worku
http://www.ajol.info/index.php/eamj/article/viewFile/8911/1777

Sexual violence is a major public health problem with high rates of underreporting. Sex education should be given on a regular basis and policy making bodies and the police be well aware of this high magnitude and take strong measures to reduce it. There are reproductive health consequences of rape including unwanted pregnancy, suicide attempt, vaginal discharge and abortion which happen in 21%, 15.8%, 10.5% and 5.3% of cases, respectively. Between 10 and 19% of teenage girls reported to researchers they had been raped or rape had been attempted, nearly half of these rapes were by a boy friend.

The report makes several recommendations including having sex education in schools, improvements to the way police handle cases and the founding of a special body to follow court cases and look after the well being of victims of sexual violence. Additionally, policy makers should be made aware about the prevalence and outcomes of sexual violence so that assailants are appropriately punished.

WHO Family and Reproductive Health Cluster
http://www.afro.who.int/en/clusters-a-programmes/frh/cluster.html

The Family & Reproductive Health Cluster supports Member States to attain universal coverage of and access to cost effective interventions to reduce morbidity and mortality and promote the Family and Reproductive Health outcomes during the key stages of life including pregnancy, child birth, neonatal period, childhood, adolescence and ageing.

11. Abortion

Unsafe abortion is one of the leading causes of maternal morbidity and mortality in Ethiopia. Nearly one third of pregnancy related deaths are caused by the complications of unsafe abortion. Studies have shown that unsafe illegal abortion is most prevalent among single women, teenagers, students, and factory workers. This trend clearly demonstrates that the country still lags behind in delivering family planning services due to infrastructural and policy constraints that impede effective service delivery.

Safe Abortion Services in Ethiopia, Pathfinder
This project came at a time when the Ethiopian National Legal Code on abortion was revised to accommodate improved reproductive health rights of adolescent and adult women. Pathfinder worked directly with the Government of Ethiopia to establish services in 6 public hospitals and 28 public health centres in four major regions. Pathfinder conducted facility assessment with local counterparts to avoid duplication of efforts with other organisations supporting similar services. The objectives were to determine if trained comprehensive abortion care providers, equipment, supplies, and a referral system were active and in place. They also monitored client friendliness (cleanliness, privacy, light, water flow, etc), supportive supervision, and follow up care. They created a group of core resource personnel who were trained to teach others to provide services. Pathfinder then rolled-out this training, provided supplies and equipment, and conducted post-training follow ups in new facilities.

Marie Stopes International in Ethiopia
More than 90% of all clients who received an abortion at an MSI clinic in Ethiopia last year left with a modern family planning method, according to MSI's 2007 management report.

Only 10 percent of Ethiopian births are attended by skilled birth attendants. Maternal mortality is 673/100,000, and infant mortality is 77/1,000 live births. Most of these deaths are preventable with knowledge that precipitates changes in personal and health-seeking behaviour, as well as access to medical services.

Youth friendly post abortion care:
http://www.pathfind.org/site/PageServer?pagename=Major_Projects_YF_PAC

This project grew out of Pathfinder's pioneering efforts to address the unique needs of adolescents who suffered complications of unsafe abortion and was based on the Post Abortion Care Consortium's *Technical Guidance on Youth-Friendly Post-abortion Care*. The goal of the YF PAC initiative was to increase access to post-abortion care services that are responsive to adolescent needs, thereby decreasing abortion-related morbidity and mortality and decreasing future unintended pregnancies and repeat abortions among adolescent women. Specifically, the project was focused on:

- Mobilising community support for services and activities that prevent unintended pregnancy and address the issue of unsafe abortion among adolescent women;
- Increasing the availability of youth-friendly post-abortion care services in the eight project countries;
- Improving the capacity of providers to deliver youth-friendly post-abortion care services; and
- Increasing the number of adolescent post-abortion care clients who adopt a contraceptive method to prevent future unintended pregnancies.

The estimated incidence of induced abortion in Ethiopia, 2008.
Singh S, Fetters T, Gebreselassie H, Abdella A, Gebrehiwot Y, Kumbi S, Audam S.
International Perspectives on Sexual and Reproductive Health. 2010 Mar;36(1):16-25.
http://www.ncbi.nlm.nih.gov/pubmed/20403802

Unsafe abortion is an important health problem in Ethiopia; however, no national quantitative study of abortion incidence exists. In 2005, the penal code was revised to broaden the indications under which induced abortion is legal. It is important to measure the incidence of legal and illegal induced abortion after the change in the law. In 2008, an estimated 382,000 induced abortions were performed in Ethiopia, and 52,600 women were treated for complications of such abortions. There were an estimated 103,000 legal procedures in health facilities nationwide--27% of all abortions. Nationally, the annual abortion rate was 23 per 1,000 women aged 15-44, and the abortion ratio was 13 per 100 live births. The abortion rate in Addis Ababa (49 per 1,000 women) was twice the national level. Overall, about 42% of pregnancies were unintended, and the unintended pregnancy rate was 101 per 1,000 women.

Conclusions
Unsafe abortion is still common and exacts a heavy toll on women in Ethiopia. To reduce rates of unplanned pregnancy and unsafe abortion, increased access to high-quality contraceptive care and safe abortion services is needed.

12. Approaches and Models to Improve Reproductive Health

Integrating family planning into Ethiopian voluntary testing and counselling programmes.

Gillespie D, Bradley H, Woldegiorgis M, Kidanu A, Karklins S., *Bulletin of the World Health Organization*. 2009 Nov;87(11):866-70.
http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2770289/?tool=pubmed

Integration of family planning into voluntary testing and counselling (VCT) services. Clients interviewed after the introduction of family planning services received significantly more family planning counselling and accepted significantly more contraceptives than those clients served before the intervention. However, three-quarters of the clients were not sexually active. Of those clients who were sexually active, 70% were using contraceptives.

Lessons learned: The study demonstrated that family planning can be integrated into VCT clinics. However, policy-makers and programme managers should carefully consider the characteristics and reproductive health needs of target populations when making decisions about service integration.

Women's Empowerment in Ethiopia: New Solutions to Ancient Problems
Bogalech Alemu, M.Sc., Gender Technical Advisor, Pathfinder International/Ethiopia
Mengistu Asnake, M.D., M.P.H., Deputy Country Representative, Pathfinder International/Ethiopia, September 2007
Developed and written by Jennifer Wilder, Senior Technical Communications Advisor
http://www.preventgbvafrica.org/content/women%E2%80%99s-empowerment-ethiopia

Improving the empowerment of adolescent girls will improve their reproductive health. In Ethiopia, women traditionally enjoy little independent decision making on most individual and family issues, including the option to choose whether to give birth in a health facility or seek the assistance of a trained provider. Harmful traditional practices, including female genital cutting, early marriage and childbearing, gender-based violence, forced marriage, wife inheritance, and a high value for large families, all impose huge negative impacts on women's reproductive health. Improving the social, religious, and economic climate for females to be able to shake off damaging Harmful Traditional Practices (HTPs) and begin assuming responsibility for and control of their reproductive lives.

Pathfinder programme
Focusing in the regions of Tigray, Amhara, Oromia, and SNNRP, where Pathfinder has worked for many years, the organsiation has challenged traditions through trainings, workshops, public meetings, dramas, and collaboration with national, regional, and community leaders, as well as financial contributions in the form of scholarships to keep girls in school. The beliefs and behaviours of community and religious leaders, husbands and wives, adolescent girls and boys have been examined and challenged in a spirit of understanding and respect for people's traditions, as well as a comparable respect for the power of knowledge to bring about changes in ideas and behaviour.

Pathfinder has trained a broad network of nearly 10,000 Community-Based Reproductive Health Agents (CBRHAs) in more than 6,000 kebeles (villages) to provide women with family planning counselling and methods (or referrals) and maternal and child health care. Women and men learn of the true harm that comes from female genital cutting, early child bearing, and many other HTPs. Hundreds of religious leaders and former circumcisers have become ardent advocates for reproductive health care and family planning. The Women Lawyers Association and legal advocates, with help from Pathfinder, were able to push through major changes in the law affirming 18 as the legal age of marriage; and explicitly outlawing female circumcision, rape, forced marriage, and other damaging practices. CBRHAs talk with parents, convincing them to keep their girls in school, delay girls' marriage until they are educated, and stop the custom of circumcision.

Pathfinder scholarships keep girls in school, while a network of successful Ethiopian women visit rural schools as mentors and become inspiring role models of another possible way of

life. Thousands of women have received microcredit loans and training in small-scale business management, paving the way for their economic contributions to family and community that will transform their status forever.

Impact
The impact of the Women and Girls Empowering Projects has been staggering. Pathfinder works closely with partners, key leaders, and medical providers, so there are many contributors to the progress that has taken place in recent years, including a significant drop in the numbers of young women being circumcised, as well as drops in forced marriages. The impact of these many activities is cumulative, with a heightened level of awareness of the importance of improving women's status and well-being throughout society. By integrating women's reproductive health needs with economic, educational, social, and legal concerns, people are adopting gender sensitivity across society. By sensitising all levels of society, from national, to regional, to local leaders and throughout local communities, in conjunction with the different interventions, the transformation of beliefs and behaviour takes on a momentum of its own.

***Empowerment of Ethiopian Women* project**
Focused on removing obstacles to women's basic rights—both social and economic—the project has promoted access to RH/FP services and freedom from sexual exploitation, violence, forced marriage, and other HTPs. The project was carried out in the Amhara and Oromia Regions as well as the capital city of Addis Ababa. In 2005, the Packard Foundation awarded Pathfinder a second related grant for the *Women and Girls Empowerment Project*, designed to continue the effort, but expanding the focus to adolescent girls in recognition of a need for early intervention. This second project works to increase awareness and education among girls and women about RH/FP and personal rights, as well as to emphasize education, life skills, and leadership development. It also provides educational support to poor girls and promotes female education through role models and mentoring.

Other Useful Articles

Global perspectives on the sexual and reproductive health of adolescents: patterns, prevention, and potential
Prof Linda H Bearinger, Prof Renee E Sieving, Jane Ferguson, Vinit Sharma, *The Lancet*, Volume 369, Issue 9568, Pages 1220 - 1231, 7 April 2007
http://download.thelancet.com/pdfs/journals/lancet/PIIS0140673607603675.pdf?id=3d35b1b5aa0ec416:-6777c524:131709b76bd:3d1c1311857599740

This article gives an overview of adolescent reproductive health.

Women's Empowerment in Ethiopia
Pathfinder International Ethiopia, 2007
http://www.preventgbvafrica.org/content/women%E2%80%99s-empowerment-ethiopia

This article has examples of reproductive health programmes in Ethiopia. It provides details about projects that have focused on the empowerment of women and girls in Ethiopia to shake off harmful traditional practices.

Caring for women with abortion complications in Ethiopia: national estimates and future implications
Gebreselassie H, Fetters T, Singh S, Abdella A, Gebrehiwot Y, Tesfaye S, Geressu T, Kumbi S. *International Perspectives on Sexual and Reproductive Health*. 2010 Mar;36(1):6-15.
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Differential use of adolescent reproductive health programmes in Addis Ababa, Ethiopia

Annabel S. Erulkar, Tekle-Ab Mekbib, Negussie Simie and Tsehai Gulema, *Journal of Adolescent Health*, Volume 38, Issue 3, March 2006, Pages 253-260
http://www.sciencedirect.com/science/article/pii/S1054139X05002077

Attitude of teachers to school based adolescent reproductive health interventions
C. A. Iyaniwura, *Journal of Community Medicine & Primary Health Care*. 16 (1) 4-9
Department of Community Health and Primary Health Care, Olabisi Onabanjo University Teaching Hospital, Sagamu.
http://www.ajol.info/index.php/jcmphc/article/viewFile/32399/6067

Women's knowledge, preferences, and practices of modern contraceptive methods in Woreta, Ethiopia
Weldegerima B, Denekew A. *Research in Social and Administrative Pharmacy*, 2008 Sep;4(3):302-7. Epub 2008 Aug 8.
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Gaym A., *Ethiopian Medical Journal*. 2009 Jan;47(2):95-108.
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Sexual violence and use of contraception among women with unwanted pregnancy in an Ngo Clinic, Addis Ababa
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Sexual violence among female high school students in Debark, north west Ethiopia
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Tailoring IEC to CBD needs. IEC in Africa
JOICFP News. 1997 Nov;(281):4.

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IEC- Information, Education and Communication

Sexuality and contraception among never married high school students in Butajira, Ethiopia
Versnel M, Berhane Y, Wendte JF., Ethiopian Medical Journal. 2002 Jan;40(1):41-51.
http://www.ncbi.nlm.nih.gov/pubmed/12240566

13. Additional information

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