REPRODUCTIVE HEALTH *at a* GLANCE
MADAGASCAR

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Country Context

Madagascar's social, economic and governance indicators showed important improvements in recent years with an average growth rate of 5 percent between 2002 and 2008. Despite those improvements, the macroeconomic situation remains fragile and Madagascar's geographical location makes it vulnerable to tropical cyclones and destructive rains and floods. Poverty remains high, with 68 percent of the population subsisting on less than US $1.25 per day, and 80 percent of the population working as subsistence farmers.[1, 2]

Madagascar's large share of youth population (43 percent of the country population is younger than 15 years old) provides a window of opportunity for high growth and poverty reduction—the demographic dividend. For this opportunity to result in accelerated growth, the government needs to invest more in the human capital formation of its youth. The high population growth rate of 2.7 percent coupled with young population structure could lead to a doubling of the population in the next few decades.

It is important to highlight the rapid population growth. Given the fertility trend and the fact that the population is very young, the population is expected to double by 2050 reaching 42.3 million (Population Reference Bureau).

Gender equality and women's empowerment are important for improving reproductive health. Higher levels of women's autonomy, education, wages, and labor market participation are associated with improved reproductive health outcomes.[3] In Madagascar, the literacy rate among females ages 15 and above is 65 percent.[2] Fewer girls are enrolled in secondary schools compared to boys with a 95 percent ratio of female to male secondary enrollment.[2] Eighty-six percent of adult women participate in the labor force that mostly involves work in agriculture. Gender inequalities are reflected in the country's human development ranking; Madagascar ranks 122 of 157 countries in the Gender-related Development Index.[4]

Greater human capital for women will not translate into greater reproductive choice if women lack access to reproductive health services. It is thus important to ensure that health systems provide a basic package of reproductive health services, including family planning.[3]

Madagascar: MDG 5 status

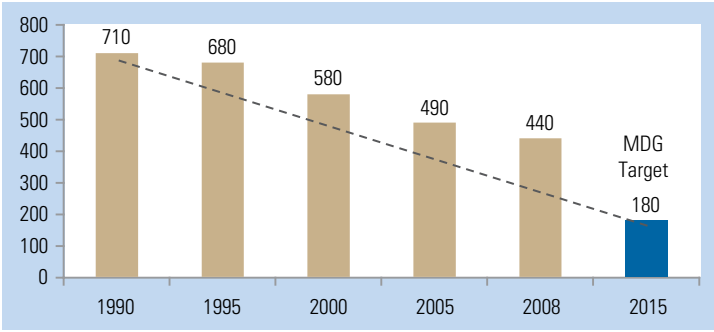
MDG 5A indicators	
Maternal Mortality Ratio (maternal deaths per 100,000 live births) *UN estimate*[a]	440
Births attended by skilled health personnel (percent)	43.9
MDG 5B indicators	
Contraceptive Prevalence Rate (percent)	39.9
Adolescent Fertility Rate (births per 1,000 women ages 15–19)	148
Antenatal care with health personnel (percent)	86.3
Unmet need for family planning (percent)	18.9

Source: Table compiled from multiple sources.
[a] The 2008–2009 DRC DHS estimated maternal mortality rate at 498.

MDG Target 5A: Reduce by Three-quarters, between 1990 and 2015, the Maternal Mortality Ratio

Madagascar has been making progress over the past two decades on maternal health but it is not yet on track to achieve its 2015 targets.[5]

Figure 1 ▪ Maternal mortality ratio 1990–2008 and 2015 target



Source: 2010 WHO/UNICEF/UNFPA/World Bank MMR report.

World Bank Support for Health in Madagascar

The Bank's current ***Country Assistance Strategy*** is for fiscal years 2007 to 2011. The Bank's new ***Country Assistance Strategy Progress Report*** under preparation (P114430) is scheduled to be approved by the Bank's Executive Board on May 26, 2011.

Current Projects:
P100966 MG-Comm.Nutrition II – Add Fin (FY07) ($6m)

Pipeline Project:
P106675 MG-Joint Health Sector Support (FY10) Approval date 7/1/2011

Previous health project:
P072987 MG-Multi Sec STI/HIV/AIDS Prev I (FY02)
P090615 MG-Multi Sec STI/HIV/AIDS Prev II (FY06)
P103606 MG-Sust. Health System Dev. (FY07)

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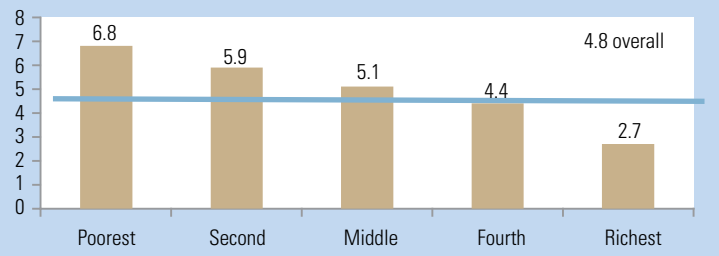
Key challenges

High Fertility

Fertility has been declining over time but is still high among the poorest. Total fertility rate (TFR) has been declining steadily from an estimated 5.2 births per woman in 2004 to 4.8 births per woman in 2009.[6]

Figure 2 ▪ Total fertility rate by wealth quintile



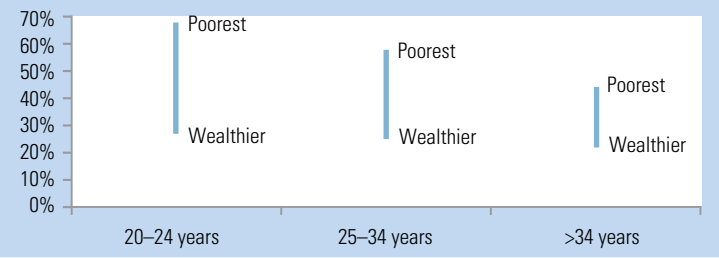
Source: DHS Final Report, Madagascar 2008–2009.

However, wide disparities exist across wealth quintiles with the TFR of women in the lowest wealth quintile being two and half times the TFR of women in the highest wealth quintile (Figure 2).[6] Similarly, TFR is lowest among women in urban areas (2.9) compared to those in rural areas (5.2).

Adolescent fertility rate is high (148 births per 1,000 women aged 15–19 years) affecting not only young women and their children's health (including nutritional status) but also their long-term education and employment prospects. Births to women aged 15–19 years old have the highest risk of infant and child mortality as well as a higher risk of morbidity and mortality for the young mother.[3, 7]

Early childbearing remains prevalent among the poorest. 66 percent of the poorest 20–24 years old women have had a child before reaching 18, while 26 percent of their richer counterparts did (Figure 3). Furthermore, across cohorts the prevalence of early childbearing has remained constant among the richest and seems to have increased among the poorest.

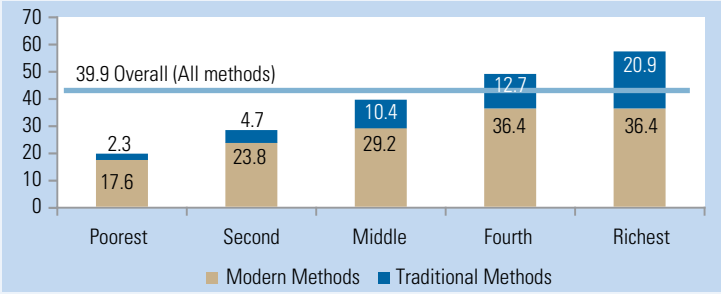
Figure 3 ▪ Percent women who have had a child before age 18 years by age group and wealth quintile



Source: DHS Final Report, Madagascar 2008–2009 (author's calculation).

Two fifths of married women are using contraception. More married women use modern contraceptive methods (29 percent) in contrast to traditional methods (11 percent).[6] There are disparities in the use of modern contraception among women across socio-economic groups: it is 18 percent in the lowest wealth quintile and 36 percent in the highest quintile; it is 17 percent for married women with no education and 34 percent for those with secondary education or higher; and 28 percent for rural women and 36 percent for urban women. Injectables are the most commonly used modern method among married women (18 percent), followed by the pill (6 percent). Use of long-term methods such as the IUD and implants are negligible.

Figure 4 ▪ Use of contraceptives among married women by wealth quintile



Source: DHS Final Report, Madagascar 2008–2009.

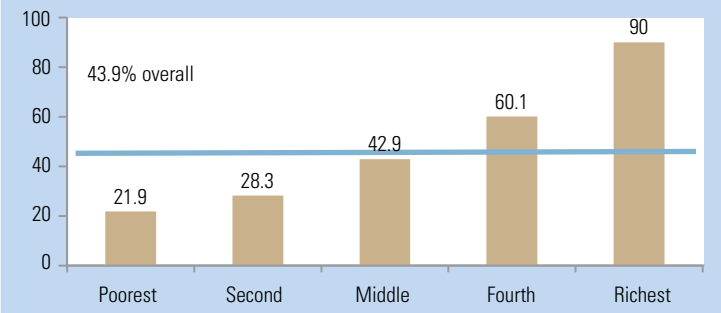
Unmet need for contraception is high at 19 percent but unlike the use of modern contraceptives there is minimal variation among women different socio-economic groups.[6] The high unmet need suggests that some women may not be achieving their desired family size.[8]

Health concerns or side effects of modern contraceptive methods (30 percent) and opposition to use (16 percent) are the predominant reasons women do not intend to use them in future.[6]

Poor Pregnancy Outcomes

While use of antenatal care is widespread, institutional deliveries are less common. About 86 percent of pregnant women receive antenatal care from skilled health personnel; 49 percent have 4 or more antenatal visits.[6] The services provided at antenatal care might not be optimum as half of all pregnant women are anaemic (defined as haemoglobin < 110g/L) increasing their risk of preterm delivery, low birth weight babies, stillbirth and newborn death.[9] A much smaller proportion, 44 percent deliver with the assistance of skilled health personnel a decrease from 51 percent in 2004.[6] While 90 percent of women in the wealthiest quintile delivered with skilled health personnel, only 22 percent of women in the poorest quintile obtained such assistance (Figure 5). Over a third of women did not receive postnatal care within 6 weeks of giving birth.

Figure 5 ▪ Birth assisted by health personnel (percentage) by wealth quintile



Source: DHS Final Report, Madagascar 2008–2009.

Over half of women who indicated problems in accessing health care cited concerns regarding inability to afford the services while two-fifths indicated unavailability of drugs and service providers at the health facility (Table 1).[6]

Table 1 ▪ Reasons for not delivery in a health facility (women age 15–49)

Reason	%
At least one problem accessing health care	75.6
Getting money for treatment	55.0
Concern no drugs available	43.2
Concerned no provider available	42.3
Distance to health facility	41.8
Having to take transport	31.4
Not wanting to go alone	28.4
Concerned no female provider available	16.8
Getting permission to go for treatment	15.0

Source: DHS Final Report, Madagascar 2008–2009.

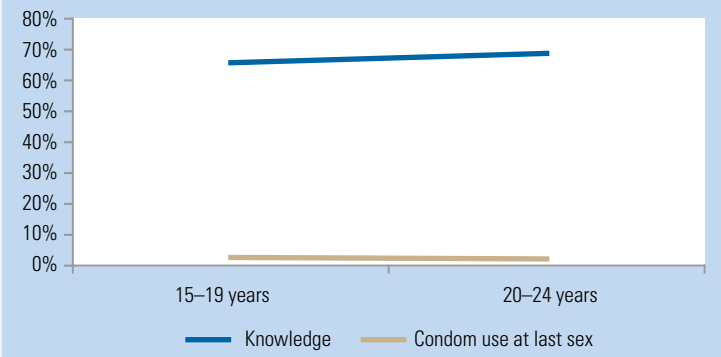
Human resources for maternal health are limited (2) and **referral and emergency services are generally difficult for women to access, particularly in rural areas**.

STIs/HIV/AIDS prevalence is low but a growing public health concern

Madagascar has one of the lowest HIV/AIDS prevalence in sub-Saharan Africa, at 0.1 percent for the population ages 15–49 years.[2]

There is a large knowledge-behavior gap regarding condom use for HIV prevention. While most young women are aware that using a condom in every intercourse prevents HIV, only 2 percent of them report having used condom at last intercourse (Figure 6). This gap widens among older aged women likely due to the fact that the chances of using condoms as a form of contraception diminishes with marriage.

Figure 6 ▪ Knowledge behavior gap in HIV prevention among young women



Source: DHS Final Report, Madagascar 2008–2009 (author's calculation).

Technical Notes:

Improving Reproductive Health (RH) outcomes, as outlined in the RHAP, includes addressing high fertility, reducing unmet demand for contraception, improving pregnancy outcomes, and reducing STIs.

The RHAP has identified 57 focus countries based on poor reproductive health outcomes, high maternal mortality, high fertility and weak health systems. Specifically, the RHAP identifies high priority countries as those where the MMR is higher than 220/100,000 live births and TFR is greater than 3. These countries are also a subgroup of the Countdown to 2015 countries. Details of the RHAP are available at *www.worldbank.org/population*.

The Gender-related Development Index is a composite index developed by the UNDP that measures human development in the same dimensions as the HDI while adjusting for gender inequality. Its coverage is limited to 157 countries and areas for which the HDI rank was recalculated.

National Policies and Strategies that have Influenced Reproductive Health

2003 The Ministry of Health changed its name to Ministry of Health and Family Planning to signal the importance of reproductive health to the health agenda in Madagascar.

2003 The Government took the lead in organizing a series of stakeholder meetings and a national conference to develop a new family planning strategy. Subsequently, the Family Planning program gained recognition at the same level as the fight against HIV/AIDS and Roll Back Malaria.

2006 For the first time, Malagasy government allocated funds to purchase contraceptives. Previously, family planning efforts have depended solely on donor financing.

2008 Safe delivery kits for both normal and cesarean deliveries were introduced by the Ministry of Health at the health center/ hospital level. Deliveries thus became free-of-charge for the patient.

Key Actions to Improve RH Outcomes

Strengthen gender equality

- Support women and girls' economic and social empowerment. Increase school enrollment of girls. Strengthen employment prospects for girls and women. Educate and raise awareness on the impact of early marriage and child-bearing.
- Educate and empower women and girls to make reproductive health choices. Build on advocacy and community participation, and involve men in supporting women's health and wellbeing.

Reducing high fertility

- Address women's concerns regarding the side-effects of modern contraceptive methods, the issue of opposition to use of contraception and promote the benefits of small family sizes. Increase family planning awareness and utilization through outreach campaigns and messages in the media. Enlist community leaders and women's groups.
- Promote the use of ALL modern contraceptive methods, including long-term methods, through proper counseling which may entail training/re-training health care personnel.
- Promote a range of options for adolescents and youth including formal education, vocational training, skills development, micro-credit schemes, and income generating activities.

Reducing maternal mortality

- Promote institutional delivery through provider incentives and generating demand for the service. Improve the quality of antenatal care and during antenatal care, educate pregnant about the importance of delivery with a skilled health personnel and getting postnatal check. Encourage and promote community participation in the care for pregnant women and their children.
- Target the poor and women in hard-to-reach rural areas in the provision of basic and comprehensive emergency obstetric care (renovate and equip health facilities). Implement risk-pooling schemes and make emergency transport arrangements or provide transport vouchers to women in hard-to-reach areas.
- Address the inadequate human resources for health by training more midwives and deploying them to the poorest or hard-to-reach districts.

Reducing STIs/HIV/AIDS

- Strengthen Behavior Change Communication (BCC) programs via mass media and community outreach to raise HIV/AIDS awareness and knowledge. Focus on adolescents, youth and married women in providing information, education and communication on HIV/AIDS.
- Integrate HIV/AIDS/STIs and family planning in routine antenatal and postnatal care services. Promote the use of STI treatment kits, and syphilis treatment for pregnant women.

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This profile was prepared by the World Bank (HDNHE, PRMGE, and AFTHE). For more information contact, Samuel Mills, Tel: 202 473 9100, email: smills@worldbank.org. This report is available on the following website: *www.worldbank.org/population*.