

REPRODUCTIVE HEALTH at a GLANCE

HAITI

April 2011

Country Context

Haiti is the poorest country in the Western Hemisphere (GDP per capita of \$660) with 55 percent of the population subsisting on less than US \$1.25 per day.¹ Despite its high vulnerability, the country experienced a sustained growth rate between 2004 and 2008, and is currently slowly recovering of the devastated effects of the earthquake that destroyed its capital city in 2010. Agriculture in the form of small-scale subsistence farming accounts for 30 percent of the country's GDP and provides work for about two-thirds of all Haitians.²

Haiti's large share of youth population (37 percent of the country population is younger than 15 years old³) 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.

Estimated at 9.8 million in mid-2010, Haiti's population is expected to reach 15.7 million by 2050. This rapid population growth highlights the need for targeted reproductive health programs that continue the decreasing trend in total fertility rate, and increase the availability of modern contraceptives.

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.⁴ In Haiti, the literacy rate among females ages 15 and above is 63 percent. The overall net attendance at the primary school level is 48 percent for boys and 52 percent for girls but declines sharply to 18 percent and 21 percent respectively at the secondary school level. Nearly three-fifths of adult women participate in the labor force¹ that mostly involves work in agriculture.

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.⁴

Haiti: MDG 5 Status

MDG 5A indicators

Maternal Mortality Ratio (maternal deaths per 100,000 live births) <i>UN estimate^a</i>	300
Births attended by skilled health personnel (percent)	26.1

MDG 5B indicators

Contraceptive Prevalence Rate (percent)	32.0
Adolescent Fertility Rate (births per 1,000 women ages 15–19)	69
Antenatal care with health personnel (percent)	84.5
Unmet need for family planning (percent)	37.5

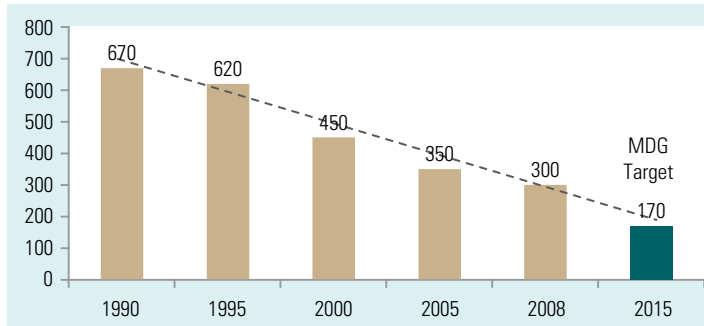
Source: EMMUS-IV (DHS) Final Report, HAÏTI, 2005–2006.

^a The 2005 Cambodia DHS estimated maternal mortality ratio at 472

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

Haiti 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 Haiti

The Bank's new **Country Assistance Strategy** under preparation (P101443) is scheduled to be approved by the Bank's executive Board on May 19, 2011.

Current Project: None

Pipeline Project:

P104400 HT (IDF) Improving Health Surveillance Closing date 4/29/2012

Previous Health Project: None

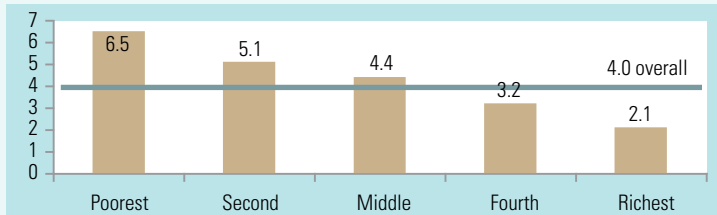


■ Key Challenges

High fertility

Fertility has been declining over time but is still the highest in the Americas, especially among the poorest. Total fertility rate (TFR) has been declining steadily from an estimated 4.8 birth per woman in 1995 to 4.0 births per woman in 2006.³

Figure 2 ■ Total fertility rate by wealth quintile



Source: EMMUS-IV (DHS) Final Report, HAÏTI, 2005–2006.

However, wide disparities exist with the TFR of women in the lowest wealth quintile being more than three times the TFR of women in the highest wealth quintile (Figure 2).³ A similar pattern can be observed in looking at the disparities between urban and rural areas: TFR among women in urban areas (2.8) is about half those living in rural areas (5.0).

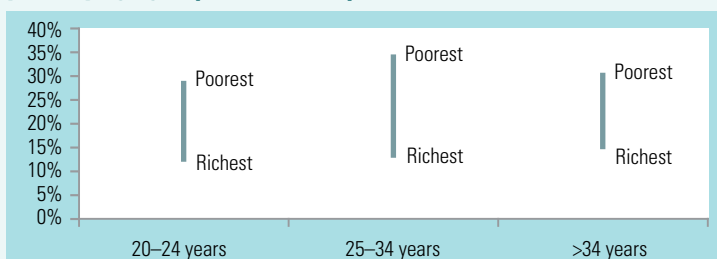
Adolescent fertility rate is high (69 births per 1,000 women aged 15–19 years) affecting not only young women and their children’s health but also their long-term education and employment prospects. Births to women aged 15–19 years old have the highest risk of infant and child mortality as well as a higher risk of morbidity and mortality for the young mother.^{4,6}

Early childbearing is more frequent among the poor. While 30 percent of the poorest 20–24 years old women have had a child before reaching age 18, only 12 percent of their richer counterparts did (Figure 3). Furthermore, this wide disparity in early childbearing has been persistent over time across cohorts.

About a third of married women use contraception. Married women in the wealthiest quintile are twice more likely to use modern contraception than their poorest counterparts (29.2 percent and 14.8 percent respectively) (Figure 4).

Modern contraceptive methods are more frequently used than traditional methods (24.8 percent and 7.2 percent, respec-

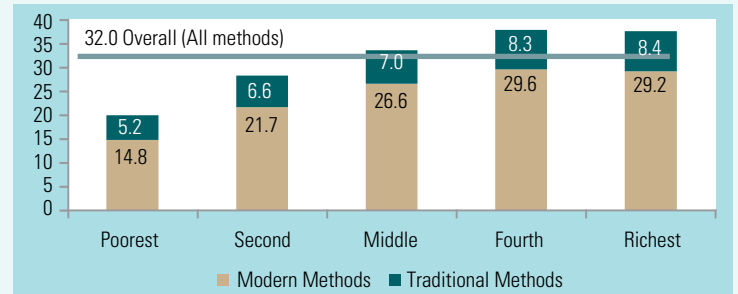
Figure 3 ■ Percent women who have had a child before age 18 years by age group and wealth quintile



Source: EMMUS-IV (DHS) Final Report, HAÏTI, 2005–2006 (author’s calculation).

tively).³ Injectables are the most commonly used modern method among married women (11.0 percent), followed by condoms (5.3 percent) and the pill (3.3 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: EMMUS-IV (DHS) Final Report, HAÏTI, 2005–2006.

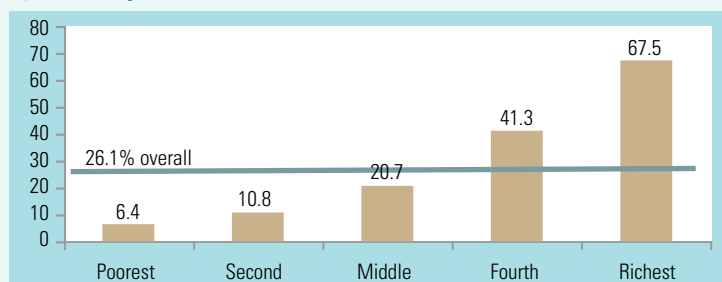
Unmet need for contraception is high at 38 percent³ indicating that women may not be achieving their desired family size.⁷ This is especially the case for women in the poorest quintile where unmet need reaches 44 percent.

Health concerns or side effects of modern contraceptive methods are the predominant reasons women do not intend to use them in the future. Nearly 60 percent of women not intending to use contraception cited health concerns or side effects as the main reason.³ About 17 percent expressed opposition to use, primarily by themselves, their husband, or due to their religion. Cost and access are lesser concerns, indicating further need to strengthen family planning services.

Poor Pregnancy Outcomes

While use of antenatal care is widespread, institutional deliveries are less common. About 85 percent of pregnant women receive antenatal care from skilled health personnel (49 percent from physicians).³ Further, 54 percent of pregnant women have 4 or more antenatal visits. However, the quality of antenatal care is uneven, and most women do not benefit from the minimum tests recommended by the WHO (namely, blood pressure, urine test and blood test). Further, more than one out of two pregnant women are not informed about the signs of pregnancy complications. Finally, only a small proportion (26 percent) delivers with the assistance of skilled health personnel. Indeed, 66 percent of women deliver with “matrons”, who are not considered skilled health personnel.³ Important disparities exist among wealth quintiles with 67 percent of women in the wealthiest quintile delivered with skilled health personnel, only 6 percent of women in the poorest quintile obtained such assistance (Figure 5). Further, 63 percent 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.⁸

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



Source: EMMUS-IV (DHS) Final Report, HAÏTI, 2005–2006.

Postnatal care is effectively used mostly by those women who delivered in a health facility. Of those women who did not give birth in a health facility, 81 percent never received a postnatal care, and only 13 percent got postnatal check-up within two days of delivery.³

The majority of women who indicated problems in accessing health care cited concerns regarding services providers not available at the health facilities and/or inability to afford the services (Table 1).³

Table 1. Reasons for not delivering in a health facility (women age 15–49 years)

Reason	%
At least one problem accessing health care	97.3
Concerned no provider available	87.7
Getting money for treatment	78.4
Having to take transport	44.7
Distance to health facility	42.7
Concerned no female provider available	42.0
Not wanting to go alone	28.1
Getting permission to go for treatment	16.7

Source: EMMUS-IV (DHS) Final Report, HAÏTI, 2005–2006.

Human resources for maternal health are limited with only 0.25 physicians per 1,000 population, but nurses and midwives are slightly more common, at 0.11 per 1,000 population.¹

The high maternal mortality ratio at 300 maternal deaths per 100,000 live births³ indicates that access to and quality of emergency obstetric and neonatal care (EmONC) remains a challenge.⁵

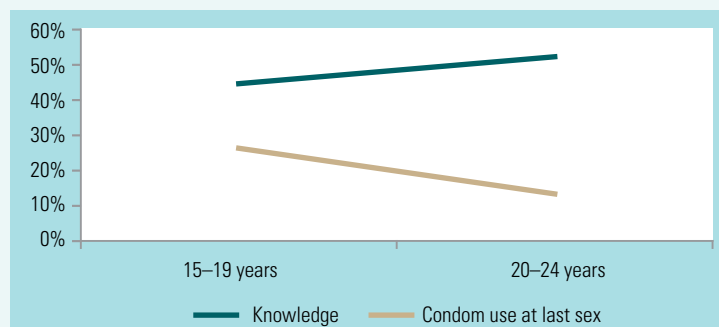
STIs/HIV/AIDS prevalence is low but a growing public health concern

About 2 percent of the adult population has HIV (**highest national HIV prevalence rate in the world outside of sub-Saharan Africa**); prevalence among females is higher than among males (2.3 percent and 2.0 percent, respectively) with women of child-bearing age comprising 60 percent of the HIV positive population.¹

There is a large knowledge-behavior gap regarding condom use for HIV prevention. While 45 percent of young women are aware that using a condom in every intercourse prevents HIV,

only half 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: EMMUS-IV (DHS) Final Report, HAÏTI, 2005–2006 (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 sub-group 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.

Development Partners Support for Reproductive Health in Haiti

WHO/PAHO:	Safe motherhood, EmONC
UNFPA:	Reproductive health and rights
UNICEF:	Child protection; under-5 mortality
USAID:	Health systems strengthening; skilled birth attendance
CIDA:	Health systems strengthening; EmONC
IDB:	Cholera, nutrition and social protection
Clinton Foundation:	Health system strengthening

In addition, there are hundreds of NGOs working in the sector, albeit in a fragmented manner.

■ 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.

Reducing high fertility

- Address 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.
- Provide quality family planning services that include counseling and advice, focusing on young and poor populations. Highlight the effectiveness of modern contraceptive methods and properly educate women on the health risks and benefits of such methods.
- Promote the use of ALL modern contraceptive methods, including long-term methods, through proper counseling which may entail training/re-training health care personnel.
- Development partners should work closely with Government in the context of emergency relief and reconstruction to secure reproductive health commodities and strengthen supply chain management.

Reducing maternal mortality

- Improve the quality of antenatal care, and educate pregnant women 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.

- Promote institutional delivery through provider incentives. Provide vouchers to women in hard-to-reach areas for transport and/or to cover cost of delivery services.
- 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).
- Address the inadequate human resources for health by training more midwives and deploying them to the poorest or hard-to-reach districts.
- Strengthen the referral system by instituting emergency transport, training health personnel in appropriate referral procedures (referral protocols and recording of transfers) and establishing maternity waiting huts/homes at hospitals to accommodate women from remote communities who wish to stay close to the hospital prior to delivery.

Reducing STIs/HIV/AIDS

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

References:

1. World Bank. 2010. World Development Indicators. Washington DC.
2. 2009 CIA World Factbook – Haiti.
3. Ministère de la Santé Publique et de la Population (MSPP), ENQUÊTE MORTALITÉ, MORBIDITÉ ET UTILISATION DES SERVICES, EMMUS-IV, HAÏTI, 2005–2006, Institut Haïtien de l'Enfance (IHE). Pétion-Ville, Haïti, and Macro International Inc., Calverton, Maryland, USA, January 2007.
4. World Bank, Engendering Development: Through Gender Equality in Rights, Resources, and Voice. 2001.
5. Trends in Maternal Mortality: 1990–2008: Estimates developed by WHO, UNICEF, UNFPA, and the World Bank.
6. WHO 2011. Making Pregnancy Safer: Adolescent Pregnancy. Geneva: WHO. http://www.who.int/making_pregnancy_safer/topics/adolescent_pregnancy/en/index.html.
7. Samuel Mills, Eduard Bos, and Emi Suzuki. Unmet need for contraception. Human Development Network, World Bank. <http://www.worldbank.org/hnppublications>.
8. Worldwide prevalence of anaemia 1993–2005: WHO global database on anaemia/Edited by Bruno de Benoist, Erin McLean, Ines Egli and Mary Cogswell. http://whqlibdoc.who.int/publications/2008/9789241596657_eng.pdf.

Correspondence Details

This profile was prepared by the World Bank (HDNHE, PRMGE, and LCSHH). 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.

HAITI REPRODUCTIVE HEALTH ACTION PLAN INDICATORS

Indicator	Year	Level	Indicator	Year	Level
Total fertility rate (births/woman ages 15–49)	2005–06	4	Population, total (million)	2008	9.9
Adolescent fertility rate (births/1,000 women ages 15–19)	2005–06	69	Population growth (annual %)	2008	1.6
Contraceptive prevalence (% of married women ages 15–49)	2005–06	32	Population ages 0–14 (% of total)	2008	36.7
Unmet need for contraceptives (%)	2005–06	37.5	Population ages 15–64 (% of total)	2008	58.9
Median age at first birth (years) from DHS	2005	21.9	Population ages 65 and above (% of total)	2008	4.3
Median age at marriage (years)	—	—	Age dependency ratio (% of working-age population)	2008	69.7
Mean ideal number of children for all women	2005–06	3	Urban population (% of total)	2008	46.8
Antenatal care with health /sonnel (%)	2005–06	84.5	Mean size of households	2005–06	5
Births attended by skilled health /sonnel (%)	2005–06	26.1	GNI/capita, Atlas method (current US\$)	—	—
Proportion of pregnant women with hemoglobin <110 g/L)	2008	63.2	GDP/capita (current US\$)	2008	729
Maternal mortality ratio (maternal deaths/100,000 live births)	1990	670	GDP growth (annual %)	2008	1.3
Maternal mortality ratio (maternal deaths/100,000 live births)	1995	620	Population living below US\$1.25/day	2003	54.9
Maternal mortality ratio (maternal deaths/100,000 live births)	2000	450	Labor force participation rate, female (% of female population ages 15–64)	2008	58.4
Maternal mortality ratio (maternal deaths/100,000 live births)	2005	350	Literacy rate, adult female (% of females ages 15 and above)	2004	62.8
Maternal mortality ratio (maternal deaths/100,000 live births)	2008	300	Total enrollment, primary (% net)	—	—
Maternal mortality ratio (maternal deaths/100,000 live births) target	2015	170	Ratio of female to male primary enrollment (%)	—	—
Infant mortality rate (per 1,000 live births)	2008	54	Ratio of female to male secondary enrollment (%)	—	—
Newborns protected against tetanus (%)	2008	50	Gender Development Index (GDI)	—	—
DPT3 immunization coverage (% by age 1)	2005–06	47.9	Health expenditure, total (% of GDP)	2007	5.3
Pregnant women living with HIV who received antiretroviral drugs (%)	2005	6.7	Health expenditure, public (% of GDP)	2007	1.2
Prevalence of HIV (% of population ages 15–49)	2007	2.2	Health expenditure/capita (current US\$)	2007	35
Female adults with HIV (% of population ages 15+ with HIV)	2007	52.7	Physicians (per 1,000 population)	1998	0.25
Prevalence of HIV, female (% ages 15–24)	2007	1.4	Nurses and midwives (per 1,000 population)	1998	0.11

Indicator	Survey	Year	Poorest	Second	Middle	Fourth	Richest	Total	Poorest-Richest Difference	Poorest/Richest Ratio
Total fertility rate	DHS	2005/06	6.6	5.0	4.4	3.0	2.0	3.9	4.6	3.3
Current use of contraception (Modern method)	DHS	2005/06	14.8	21.7	26.6	29.6	29.2	24.8	-14.4	0.5
Current use of contraception (Any method)	DHS	2005/06	20.0	28.3	33.6	37.9	37.6	32.0	-17.6	0.5
Unmet need for family planning (Total)	DHS	2005/06	44.2	43.3	36.6	34.0	31.6	37.5	12.6	1.4
Births attended by skilled health personnel (percent)	DHS	2005/06	6.4	10.8	20.7	41.3	67.5	26.1	-61.1	0.1

National Policies and Strategies that have Influenced Reproductive Health

1995: The Government launched an ambitious decentralization plan that relies on a network of Communal Health Units for the delivery of basic health services, which include reproductive health services. However, progress has been very limited, and not all communities benefit from rally health posts, mobile clinics, health agents, and local trained birth attendants.