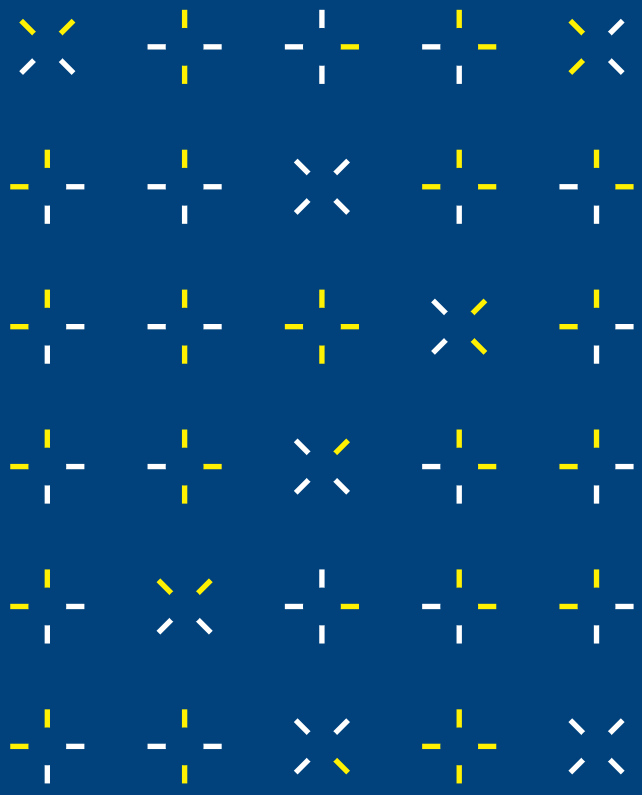
SEXUAL AND REPRODUCTIVE HEALTH OF ADOLESCENTS AND YOUNG PEOPLE IN MADAGASCAR

A SOCIO-ANTHROPOLOGICAL APPROACH



EXECUTIVE SUMMARY

MÉDECINS DU MONDE

AUTHOR OF THE REPORT

Marie-Laure Deneffe Dobrzynski

STEERING COMMITTEE

Beatriz Beato Sirvent *(MdM-F General Coordinator in Madagascar)*;
Magali Bouchon *(MdM-F Social Sciences Advisor)*;
Anne Cheyron *(MdM-F Support Officer, Africa Unit)*;
Matthieu Favre *(MdM-F Desk Officer, Africa Unit)*;
Céline Lesavre *(MdM-F AYSRH-Antananarivo Program Coordinator in Madagascar)*;
Joseph Zahiri *(MdM-F Medical Advisor, Africa Unit)*;
Hery Zo Andriamahenina *(MdM-F Medical Coordinator in Madagascar)*

CONTACT

magali.bouchon@medecinsdumonde.net

KEYWORDS

Sexual and reproductive health of young people; Unwanted pregnancy (UWP), Madagascar, Family planning (FP), Contraception, Abortion, Socio-cultural determinants (SCD); Sexuality education; Sexual and reproductive rights.

CONTEXT AND RATIONALE

According to the World Health Organization, every day 800 women worldwide die from complications related to pregnancy or childbirth, with 13% of these deaths resulting from abortion procedures. Over 220 million women have family planning needs which are not being met and of 208 million pregnancies each year, 86 million are unwanted and almost half of these end in an abortion. In Africa, 95% of abortions are considered unsafe as they are carried out in inadequate conditions.[1] Adolescents are particularly vulnerable and maternal mortality is the second leading cause of death worldwide for girls aged 15 to 19.[2] The Sexual and Reproductive Health (SRH) situation in Madagascar is particularly alarming, with a high maternal mortality rate (353 maternal deaths per 100,000 live births),[3] a low contraceptive prevalence rate among 15-19-year-olds (13.7%)[4] and 20-24-year-olds (28.8%),[5] a fertility rate in adolescents (15-19-year-olds) of 163 births per 1,000 women, and abortion being the country's second leading cause of maternal mortality, with most deaths among young women.[6]

To help reduce the morbidity and mortality associated with unwanted pregnancies and abortions in women aged 10 to 24 years, Médecins du Monde (MdM) and its national partners are running an SRH programme for young people in Antananarivo. As part of this programme, MdM has carried out a socio-anthropological survey with the aim of confirming and consolidating findings made by its teams, adapting its approaches, communicating the reality of the situation and supporting SRH advocacy.

The survey's objective was to provide a qualitative analysis of the socio-cultural and community-based determinants of unwanted pregnancies and their management, as well as of barriers to SRH services, especially for young people aged 10-24.

METHODOLOGY

The methodology used for this survey was approved by the Malagasy Ministry of Public Health's Ethics and Biomedical Research Committee. It began with documentary research, followed in March 2018 by a four-week period of data collection in Antananarivo using a qualitative methodology that triangulated individual interviews, group interviews and observation. The survey was conducted in 24 fokontany (neighbourhoods) spread over five districts of Antananarivo. Its participating focus groups were young people, care providers, social and educational professionals, parents, community and religious leaders and representatives of key SRH bodies for young people. The locations chosen were places where young people live, meet, train or attend school, as well as healthcare and prevention centres. 96 individual interviews and 53 group interviews were carried out and a total of 409 people were surveyed, including 262 young people.

RESULTS

Barriers hindering access to contraception for young people:

The low contraceptive prevalence rate, low number of nulliparous girls and women attending family planning clinics, low age at first pregnancy followed by multiple pregnancies and short birth spacing are all findings leading to the conclusion that young people lack the capacity to effectively protect themselves against unwanted pregnancies.

A variety of socio-cultural barriers also hinder access to contraception for young people, including fear of side-effects, the stigma attached to unmarried women using contraceptives, refusal by sexual partners to use contraceptives, parents opposing access to contraceptives for young women and the fact that unmarried women are not identified as targets for contraception because of social and religious expectations of abstinence before marriage.

Access to contraception for young people is further complicated by the poor quality of family planning (FP) services in public primary healthcare centres, with lack of confidentiality, for example, and unfriendly reception by centre staff. Attendance at these centres is also limited by conflicts of values, the requirement for parental permission, ignorance of the fact that contraceptives are free of charge and thus concern about the cost, lack of trust in the quality of the products, unsuitable opening hours and long waiting times. These barriers contribute towards the development and continuation of healthcare pathways outside of public primary healthcare centres, with young people turning to street vendors selling phytotherapy products (herbal remedies) and allopathic drugs, or to traditional birth attendants , pharmacists and private health service providers. A study of these healthcare pathways shows that the demand is not so much for contraceptives as for abortifacients. It would seem, therefore, that young women more commonly develop strategies for dealing with unwanted pregnancies than for preventing them.

Adolescent sexuality with a high risk of unwanted pregnancies

For communities, the most legitimate channels for delivering sexuality education to young people are parents and teachers. However, in a society where sexuality outside of marriage is taboo, this restricts access to information for young people who turn to their peers and pornography for answers to their questions. Thus, peers and pornography become their main source of knowledge about sexuality, conveying norms that encourage early sexual activity and risky sexual behaviour, while the normative parental framework is losing its influence over young people's sexuality. Furthermore, the environment in which young people live generates socio-economic,

psychological and emotional vulnerabilities which expose them to sexuality-related risks and gender-based inequalities and violence. Young people thus engage in early and risky sexual behaviour as there is no enabling framework in place to guide them towards effective strategies for preventing unwanted pregnancies.

The influence of social stigma on the outcome of adolescent pregnancy

Mainly due to the existing social and religious norms imposing sexual abstinence before marriage, a young single woman becoming pregnant is seen as a sign of social disorder. Single mothers are stigmatised as "child mothers" and their children as "zaza sary". In this context, abortion or early marriage are two strategies for repairing this social disorder and avoiding social stigma. When a pregnancy is announced, the reactions of the girl's partner and parents have a major influence on the outcome of the pregnancy, and the girl herself has little say in her own fate. Those in school are more likely to resort to an abortion, as continuing their pregnancy would not only expose them to the social stigma of being a single mother or force them into an early marriage, but would also oblige them to abandon their education. Yet abortion practices are a frequent cause of maternal morbidity and mortality, and the care pathway for abortions is usually limited to self-medicating with herbal remedies and biomedicine products bought from street vendors on the advice of peers. For reasons of cost, matrons and especially private health centre staff are only consulted as a last resort in the event of the failure of or complications arising from self-medicating.

Young people are particularly vulnerable to sexuality-related risks. Yet, conflicts of values within society and programmes when it comes to the active sexuality of young people:

- hinder the implementation of effective actions to inform young people about sexuality-related risks and enable them to protect themselves from these risks;
- pressurise young people who experience unwanted pregnancy into leaving school or entering into an early marriage, or expose them to the stigma of single motherhood;
- influence abortion decisions, with abortions becoming a strategy for avoiding the social risks related to pregnancy, while also exposing them to the morbidity and mortality risks of unsafe abortions.[7]

RECOMMENDATIONS[8]

The recommendations from MdM's survey seek to bring about social change by developing a global approach involving society as a whole, strengthening the capacities of young people to protect themselves against sexuality-related risks and promoting an enabling environment.

To facilitate this change, we suggest focusing on the following three areas in particular (in conjunction with the recommendations made by UNFPA in its report on preventing adolescent pregnancies):[9]

- promoting comprehensive sexuality education[10] in line with documented international recommendations;[11]
- campaigning against gender-based inequalities and violence;
- improving access to contraception for young people through an SRH rights-based approach and harm reduction activities.

A fourth focus area, "Mitigating young people's socio-economic, psychological and emotional vulnerabilities" would also be relevant in light of the survey's findings and was actually one of the key recommendations to come out of the interviews conducted.[12] The documentary research carried out ahead of the survey also supported this approach as a means of improving SRH among young people. However, this is not part of MdM's direct remit.

To ensure the sustainability of actions when MdM withdraws at the end of the project, we

therefore recommend supporting the implementation of initiatives by MdM's institutional partners aimed at bringing about the necessary social change:

- Ministry of Health: an FP programme, an SRH programme for young people - including a system for awarding a label to primary healthcare centres as "*Centre Ami des Jeunes*" [young-people-friendly],[13] and a gender-based violence prevention and management programme;
- Ministry of Education: broad dissemination of new Comprehensive Sexuality Education curricula;
- Ministry for Young People and Sport: peer education in the field of SRH for young people,[14] awareness-raising about SRH for young people via social networks and other new information and communication technologies, and telephone helplines for young people (e.g. Allo Fanantenana and 147 SOS)

To ensure the participation of society as a whole and the socio-cultural acceptability of activities, we recommend:

- involving young people, parents, community and religious leaders, care providers and social and -educational professionals in reflection and decision-making at different stages in the implementation of activities (using and, if necessary, re-energising, existing discussion forums in the fokontany, healthcare facilities and secondary schools);
- working together with parents and teachers to raise their awareness and train them in intergenerational dialogue and comprehensive sexuality education for young people);
- taking into account the socio-cultural determinants of the different focus groups when defining awareness-raising and mobilisation activities, co-constructing them and adapting the communication tools and vectors (adapting the content, language and images used, drawing on people accepted as legitimate by the group to discuss the subject) ;
- giving young people a voice in the search for individual and collective solutions by creating discussion forums for them: meetings, media, etc.;
- supporting reflection and advocacy by civil society to secure effective sexual and reproductive health rights for young people.

The activities suggested for putting these recommendations into practice are outlined in the full report.

1. World Health Organization (WHO), Department of Reproductive Health and Research: *Unsafe abortion. Global and regional estimates of the incidence of unsafe abortion and associated mortality in 2008*, sixth edition (online), Geneva : WHO Library Cataloguing in Publication-Data, 2011, Available at: www.who.int/reproductivehealth/publications/unsafe_abortion/9789241501118/en/.

2. World Health Organization (WHO), press release: 'WHO calls for stronger focus on adolescent health'. Available at: www.who.int/mediacentre/news/releases/2014/focus-adolescent-health/en/, consulted on 6 Oct. 2016.

3. World Health Organization (WHO). *Trends in maternal mortality: 1990-2015 Estimates by WHO, UNICEF, UNFPA, World Bank Group and the United Nations Population Division.* Executive summary, 2015, page 8.

4. This percentage is for modern methods to which could be added 4.1% for traditional and local methods (periodic abstinence, withdrawal and other popular local methods). ENSOMD 2012-2013.

5. This percentage is for modern methods to which should be added 6.6% for traditional methods. ENSOMD (National Survey on Monitoring Indicators of the Millennium Development Goals) 2012-2013.

6. Republic of Madagascar, United Nations System, *Madagascar. Common Country Assessment 2012*. April 2013.

7. As well as the risks related to the illegality of this practice.

8. The full set of recommendations is given in the full report. The full report exists only in French language and can be asked for at DSP@medecinsdumonde.net. This is only a summary.

9. Cf. UNFPA *Girlhood, not motherhood: Preventing adolescent pregnancy*, 12/2015. Available at: www.unfpa.org/publications/girlhood-not-motherhood

10. Definition of comprehensive sexuality education: "Age-appropriate, culturally relevant approach to teaching about sexuality and relationships by providing scientifically accurate, realistic, non-judgmental information." Source: UNESCO, 2009. *International technical guidance on sexuality education: An evidence-informed approach for schools, teachers and health educators*. Paris, UNESCO. Available at: http://unesdoc.unesco.org/images/0018/001832/183281e.pdf

11. UNESCO, *Comprehensive sexuality education: Updating key concepts, topics and learning objectives. A world review*, 2017.

12. Recommendations made by young people, parents and community leaders on this subject: help with school fees for the most underprivileged; setting up vocational training centres for early school leavers ; creating leisure centres for young people; creating jobs for young people; and providing material support for young people (donations of clothes, etc.).

13. Madagascar Ministry of Public Health. National Strategic Plan 2018-2020 for Sexual and Reproductive Health for Adolescents and Young People.

14. MdM has a partnership with four young people's peer educator organisations which the ministry helped to set up.