Unlocking the Potential of Women and Adolescent Girls in Madagascar

Challenges and Opportunities in Health

WORLD BANK GROUP
Unlocking the Potential of Women and Adolescent Girls in Madagascar

Challenges and Opportunities in Health
# Table of Contents

Abstract ........................................................................................................................................ 6  
Acknowledgments ...................................................................................................................... 7  
Abbreviations ................................................................................................................................ 8  
Introduction .................................................................................................................................. 9  
Maternal health .............................................................................................................................. 13  
Fertility and family planning .......................................................................................................... 16  
Barriers in access to maternal, sexual, and reproductive health services .................................... 20  
Adolescent fertility ......................................................................................................................... 22  
Drivers of teenage pregnancy. ....................................................................................................... 24  
   Lack of information on SRH and contraception ........................................................................ 25  
   Limited access to quality youth-oriented FP services ............................................................. 27  
Policy recommendations ............................................................................................................... 29  
   Strategic direction 1: Address supply-side barriers in access to 
   maternal, sexual, and reproductive health services ............................................................... 31  
   Strategic direction 2: Improve girls’ knowledge on SRH, FP, and 
   prevention of pregnancy ........................................................................................................ 32  
   Strategic direction 3: Enhance access to youth-friendly SRH services, 
   and empower girls and young women to seek them .......................................................... 33  
Appendix A. Methodology of the qualitative background study .................................................. 35  
References ..................................................................................................................................... 39
Abstract

This thematic note is part of a broader mixed-method study on gender inequalities in Madagascar, which intends to illustrate the key gender gaps in the country and shed light on the unique challenges that young Malagasy women face in their educational, professional, and family trajectories. Due to the persistence of financial, social, and institutional barriers, Malagasy women and girls encounter significant disadvantages across all dimensions of well-being and are unable to access opportunities in an equal manner with men and boys in the country. They are largely constrained in their ability to accumulate human capital in education and health, and to participate in economic opportunities; and they face severe limitations in agency and decision-making, particularly with respect to family formation. Women and girls also appear to be disproportionately affected by the impacts of climate change and the COVID-19 pandemic, which further widen preexisting gender gaps and amplify vulnerability to poverty, violence, and discrimination. This thematic note provides in-depth insights into the status of women’s and girls’ maternal, sexual and reproductive health in Madagascar and proposes several strategic lines of action to improve access to professional health care by Malagasy women and girls and prevent teenage pregnancy. This note is accompanied by the overview of all study findings and three thematic notes that present in-depth insights in the following key dimensions: education, economic opportunities, and agency.
Acknowledgments

This note is part of a study on gender disparities in Madagascar; the Overview of this study is available as “Unlocking the Potential of Women and Adolescent Girls—Challenges and Opportunities for Greater Empowerment of Women and Adolescent Girls in Madagascar.” The study was conducted by a core team composed of Alina Kalle and Miriam Muller. The report benefited from important contributions by Tamara Bah, Joaquin Gustavo Betancourt, Ursula Casabonne, Fatoumata Dieng, Alexandra Jarotschkin, Francis Muamba Mulango, Esperance Mukeshimana, Stephanie Kuttner, Carmen de Paz, Sabrina Razafindravelo, Hiska Noemi Reyes, Paula Tavares, and David Seth Warren. The team is grateful to peer reviewers Andrew Brudevold-Newman, Tazeen Hasan, and Ana Maria Oviedo for their thoughtful inputs. Honora Mara edited the report. Kareem Edwards provided excellent administrative support throughout. The team worked under the guidance of Benu Bidani, Marie-Chantal Uwanyiligira, and Pierella Pacci. A team from Ivorary Consulting collected, transcribed, translated, and coded the qualitative data. This research was funded by a grant from the Hewlett Foundation. Finally, our deepest gratitude to all key informants and to the women, girls, and parents who shared their personal stories with us.
Abbreviations

CSB centre santé de bases (basic health center)
DHS Demographic and Health Survey
FP family planning
MGA Malagasy ariary
MICS Multiple Indicators Cluster Survey
MMR maternal mortality rate
PD positive deviant
SRH sexual and reproductive health
TFR total fertility rate
WDI World Development Indicators
Introduction

While gender equality matters in its own right, investments in the social and economic empowerment of women and adolescent girls have the potential to translate into long-lasting economic growth and overall development for Madagascar. According to global evidence, women’s empowerment brings instrumental value for families and for society at large, because it is positively correlated with reduced poverty and food insecurity, with improved labor productivity, and with better chances for future generations (Aguirre et al. 2012; Allendorf 2007; Mulugeta et al. 2021). Evidence also shows that investing in the human capital and empowerment of adolescent girls in particular protects progress made in childhood, accelerates productivity and economic growth, and safeguards the health of the future adult population (Levine et al. 2008). Therefore, focusing investments to ensure the health, education, and empowerment of adolescent girls is a strategic action likely to result in long-term gains for economic growth and sustainable development.

This note is part of a broader mixed-method study on gender inequalities in Madagascar, which aimed to generate knowledge and deepen understanding of gender inequalities and their drivers in Madagascar with a focus on adolescence; to explore challenges and opportunities that adolescent girls face in making decisions about family formation, education, work, and the intersection of these elements; and to identify institutions and strategies that support young women in their decisions about education, work, and family formation. The broader study has three main inputs: a quantitative analysis, a literature review, and a subsequent qualitative in-depth study. The quantitative analysis explored the status of gender gaps across multiple dimensions (human capital, economic opportunity, and women’s agency) by socio-demographic characteristics, identified regions with the most severe gender gaps, and assessed the country’s development in reducing gender disparities over the past two decades. (See box 1 for a list of the quantitative data sources used in this report.) In addition, the team has completed a review of the current legal system and a literature review on gender in Madagascar and on what works to close gender gaps across dimensions based on evidence from the Sub-Saharan Africa region (World Bank 2023).

Box 1. Sources of the quantitative data for the analysis

- Afrobarometer Round 7 Survey on gender attitudes
- Demographic and Health Survey (DHS) 2008–09 and 2021
- International Labour Organization (ILO) estimates
- Multiple Indicator Cluster Survey (MICS) Madagascar 2018
- Permanent Household Survey (EPM) 2021–2022
- United Nations Educational, Scientific and Cultural Organization (UNESCO) statistics database
- The World Bank’s Women, Business, and the Law data set 2023
- The World Bank’s World Development Indicators (WDI) database
In addition to the quantitative assessment, the team conducted qualitative research that included individual in-depth interviews, focus group discussions, and key informant interviews in three geographically diverse regions in Madagascar: Analamanga (the center and capital city), Atsimo-Atsinanana (the south), and Sofia (the north). In-depth interviews were conducted with young women ages 18–24 and with mothers of adolescent girls. A subsample of young women consisted of positive deviants—young women who managed to succeed in their educational and work endeavors despite encountering the same socioeconomic barriers as other participants. In addition, focus group discussions were held with women ages 25–34 and with mothers and fathers of adolescent girls. Key informant interviews were conducted with religious and traditional leaders, local elected officials, and representatives from civil society and from the education, health, and private sectors.

The key findings from this mixed-method study are:

- **Access to education is a challenge for all in Madagascar, but girls face additional gender-specific barriers.** Although girls outnumber boys in primary and secondary school attendance and completion, the access to schooling is very low for all children: only 36.6 percent of girls and 34.3 percent of boys ages 12–15 complete lower secondary school (WDI UNESCO statistics database 2019). Moreover, the overall rate of educational attainment remains concerningly low and a significant share of adult women is illiterate (23.9 percent vs. 21.4 percent for men; DHS 2021). Although free on paper, attending school involves multiple indirect costs—uniforms, school materials, fees, lunches, and other unforeseen expenses—that are often exacerbated by the impacts of climate change on school infrastructure. Parents are expected to make financial or in-kind contributions to the salaries of unsubsidized non–civil servant teachers, who in some cases make up most of the teaching staff. In addition to the overall scarcity of schools, existing schools often lack appropriate facilities and capacity to accommodate all students. Participation in farming and widespread engagement in labor activities interrupt the school trajectories of adolescents (both girls and boys). Although most of the barriers in access to schooling are universal, girls’ chances to complete secondary education are lowered by high involvement in domestic chores, gender-based violence in schools, limited agency, and—above all—child marriage and early pregnancy.

- **Access to sexual, reproductive, and maternal health services remains limited, especially for adolescent girls and young unmarried women.** Malagasy women and girls are largely disadvantaged in knowledge on and access to maternal,
sexual, and reproductive health services, as seen from a low share of professionally assisted births (45.8 percent) (DHS 2021) and a high unmet need for contraception (14.6 percent). Maternal mortality rate is also high (335 deaths per 100,000 live births) (WDI 2017). Overall, the scarcity of health centers and prohibitive costs of consultations limit women’s and girls’ access to health services in general. At the same time, young women’s chances of seeking SRH services are further constrained by the lack of reliable sources of information on SRH, absence of quality youth-friendly clinics, and negative social norms that discourage use of family planning services among unmarried women/women without children. All those barriers contribute to high share of teenage pregnancies (31.1 percent of girls ages 15–19 have begun childbearing) (DHS 2021), which is associated with numerous risks for girls’ well-being, with potential long-term adverse effects for their education, health, employment opportunities, and vulnerability to poverty.

• **The continuum of barriers to finding good-quality employment disproportionately affects women and girls.** Malagasy women are less likely than men to participate in the labor market: 71.3 percent versus 82.4 percent respectively (EPM 2021–22). Moreover, women have limited access to better-quality jobs: only 24 percent of working women are waged employees versus 35 percent of working men, and female employees are over-represented among contributing family workers (14 percent vs. 5 percent of male workers) and in subsistence farming (32 percent vs. 23 percent respectively) (EPM 2021-22). This lack of access to better-quality jobs can be partially explained by the factual absence of jobs and the existence of legal forms of discrimination that prevent women from undertaking certain jobs (e.g., in the industrial sector). Additionally, young women lack required skills and competencies, knowledge, clear vision and instruments on how to translate their job aspirations into action. Based on the interviews, women also encounter discrimination based on their gender, ethnic origin, and physical appearance in the recruitment process; women in informal employment often face degrading working conditions, low and unstable income, and abuse and sexual harassment by their bosses.

• **Women and girls are strongly limited in their agency and decision-making power,** as manifested in high rates of intimate-partner violence (41 percent of ever-partnered women have experienced at least one of its forms) and child marriage (38.8 percent of women ages 20–24 were married by age 18) (DHS 2021). The onset of family formation occurs at a very early age for many Malagasy girls and young women. For many poor girls and their families, the decision to start a family at a very early age is driven by the lack of means, as the marriage ritual implies economic benefits for the household (a dowry). In addition, widespread negative attitudes toward unmarried women and to out-of-wedlock pregnancies often drive adolescent girls and their families to pursue marriage early, partly in order to comply with social norms and expected patterns of behavior. Importantly, practices of child marriage are diverse and show striking geographical differences. With the exception of the capital Antananarivo, child marriage is often celebrated under customary law.

Based on the in-depth interviews and focus group discussions from three regions in Madagascar, a number of intersecting and interconnected factors constrain the well-
being of Malagasy girls and women, with long-term effects on their ability to make informed life decisions and hope for a better life (figure 1). Overall, poverty and lack of means (financial, economic, and social capital) are the major barriers that prevent adolescent girls and young women from accumulating their human capital, delaying early family formation, accessing better-quality jobs, and having a hope for a better future. Additionally, patriarchal social norms and inequitable gender roles largely drive the observed inequalities: the pressure to comply with socially accepted patterns of behavior drives many young women (especially those from the poor households) to start family formation at a very early age, often compromising their chances to complete their schooling and access better-quality jobs later in life. Moreover, women’s inability to access basic services and participate in economic opportunities can be attributed to limited institutional capacity and service delivery. Finally, vulnerability to shocks and climate change poses additional challenges and disproportionately affects women by exacerbating their burden of domestic work, amplifying food insecurity and malnutrition, and obstructing access to education. Altogether these factors severely restrict the context in which adolescent girls and young women can operate and advance in life, often not leaving them options or choices. Across all themes, even when options or choices are available, young women fundamentally lack agency, or the ability to make decisions and act on them. Importantly, while gender gaps are high overall, women and girls from rural areas and poor households are particularly disadvantaged.

**Figure 1.** Structural issues affecting gender outcomes in Madagascar according to the qualitative research
This note discusses the state of women’s and girls’ maternal, sexual, and reproductive health in Madagascar and focuses on the following priority areas: maternal mortality, fertility and family planning, and adolescent pregnancy. It also presents the unique challenges and barriers that prevent Malagasy women and girls from accessing maternal, sexual, and reproductive health care and delaying early pregnancy. The note ends with a menu of country-specific policy recommendations for enhancing access to maternal, sexual, and reproductive health care, and reducing the teenage pregnancy rate. The selection of policy actions is based on the evidence of effective programs from various countries in Sub-Saharan Africa.

**Maternal health**

Maternal mortality continues to be an important problem in Madagascar. Although the country has achieved significant progress in reducing the maternal mortality rate (MMR) in the past two decades, the rate remains high. As of 2017, the MMR in Madagascar stood at 335 deaths per 100,000 live births—a decrease from 559 deaths per 100,000 live births in 2000 (WDI). Madagascar is performing better than the Sub-Saharan Africa average of 534 and some other countries in the region, such as Uganda (375) and Zimbabwe (458); however, Madagascar’s MMR is well above that of Angola (241), Rwanda (248), and Zambia (213) (figure 2). The latest available data (2018) from the Multiple Indicator Cluster Survey (MICS) suggest that maternal deaths account for 22.1 percent of all female deaths: this share is even higher among women ages 20–24 (35 percent) and 25–29 (35.7 percent). Among adolescent girls ages 15–19, 18.9 percent of all deaths are due to maternity.

The share of women receiving pre- and postnatal care is low in Madagascar. As of 2021, 10.3 percent of pregnant women ages 15–49 had not received any prenatal care, and this share is significantly higher in rural than in urban areas: 11.7 percent versus 3.4 percent (DHS 2021). The probability of receiving prenatal care increases with the level of women’s education: whereas 25.4 percent of women with no education do not receive prenatal care, only 0.7 percent of women with higher than secondary education receive no prenatal care. Likewise, only 1.6 percent of women from the richest wealth quintile do not receive prenatal care versus 8 percent of women from the middle one and 22.8 percent of women from the poorest one (DHS 2021). Importantly, more than half of all pregnant women ages 15–49 (52.6 percent) do not receive any postnatal examination. Similarly, the likelihood of receiving a postnatal examination within the first two days after giving birth increases with level of education and wealth quintile and is positively correlated with living in an urban area (DHS 2021).

Moreover, less than half of all births (46 percent) in Madagascar are attended by a skilled medical professional. It is noteworthy that the share of professionally assisted deliveries has declined over the past 30 years, from 57 percent in 1992 to 44 percent in 2012, and then slightly up again to 46 percent in 2021 (figure 3). The percentage of assisted births also differs significantly between rural (40.5 percent) and urban (74.3 percent) areas (DHS 2021), and by wealth quintile, ranging from 19.4 percent among
women from the poorest wealth group to 89.4 percent among women from the richest one. Moreover, noticeable regional disparities are observed; for the regions visited in our qualitative study, the share of professionally assisted deliveries stands at 83.6 percent in Antananarivo, 42.8 percent in Sofia, and 24.2 percent in Atsimo-Atsinanana. Indeed, references to childbirth in the hospital were most frequently expressed by women in Antananarivo, although such cases were also reported in the two other visited regions.

All my family was in the hospital. . . . I always give birth in the hospital. (Young woman, Antananarivo)

I think that people today are more inclined to go to hospitals. (Young woman, Antananarivo)

Interviewed women in Antananarivo and Atsimo-Atsinanana also reported the use of services of traditional birth attendants (matrons). A matron, a traditional practitioner without medical training, takes care of pregnant women, the delivery, and the first care of the mother and the newborn (Pourette 2018). Matrons are known for their knowledge of herbs, which they use to relieve pain and facilitate delivery. Women choose to be attended by matrons because it is cheaper than hospital assistance, or because of dissatisfaction with official health centers or a past negative experience with doctors. Matrons commonly assist women who live more than 5 km from a health center and have no alternative options. Some evidence indicates that women prefer to use the
services of matrons who live in the same village as they do in order to secure immediate help at any time of the day or night (Rasoanirainy 2013). At the same time, some women expressed concerns regarding the competence of matrons. No mentions of matrons were recorded in the Sofia region.

Most of the young women give birth at the matron’s home, because they cannot afford to go to the hospitals.... (Young woman, Antananarivo)

I was afraid to give birth in a matron’s house because it was my first birth. So, I preferred to go to the hospital. (Young woman, Atsimo-Atsinanana)

Other scenarios of childbirth in the studied regions included assistance by female relatives or no assistance at all. Women in all regions shared their experience of being assisted by a female relative at home: a mother, mother-in-law, godmother, grandmother, aunt, or cousin. The services of midwives (sage-femme) were also mentioned on several occasions. In several cases, women delivered their baby without any assistance, particularly when it was too late to travel to the nearby hospital or when female relatives were busy caring for other relatives because of illness. Importantly, it seems that young women are largely constrained in their decision on where to give birth, and delivery at home often occurs out of necessity rather than because of personal preference. Notably, there were no reports of deliveries accompanied by women’s partners.

I was afraid to contradict my parents. It was what they had said, and I had to respect them. I gave birth at a time when there were a lot of people in the

---

3 In contrast to matrons, midwives receive formal training and are considered skilled medical professionals in Madagascar.
house. I was going to ask them to take me to the hospital but I was too shy to tell them. (Positive deviant [PD]4 who owns a business, Sofia)

When I gave birth, my mother was not there because my grandfather was very sick, so I was the only one to give birth at home, but it was okay, it was a midwife who helped me to give birth since I was at home. (Young woman, Antananarivo)

Evidence suggests that women and girls in Madagascar are likely to suffer disproportionately from multifaceted negative impacts of climate change and the COVID-19 crisis (de Paz, Gaddis, and Muller 2021; Harivola 2021). Some of those negative impacts include, for instance, increases in maternal and infant mortality, reduced access to health care, an increase in unplanned pregnancies, and heightened food insecurity and malnutrition. It is further estimated that large service disruptions in Madagascar caused by the COVID-19 pandemic have the potential to leave 81,600 women without access to facility-based deliveries and 645,100 fewer women receiving family planning services, which could result in an 18 percent increase in infant mortality and a 12 percent increase in maternal mortality (GFF 2021). Likewise, evidence from other climate-affected countries suggests that natural disasters lower women’s life expectancy more than men’s, both directly by killing women at a higher rate than men and indirectly by killing women at an earlier age because of higher morbidity and worse economic impacts (Erman et al. 2021). When disasters lead to a decline in food consumption, women are twice as likely as men to suffer from malnutrition and girls are twice as likely as boys to die from malnutrition (PMNCH 2014).

In summary, the uptake of maternal health services remains concerningly low in Madagascar, and only a very small share of Malagasy women enjoys professional health care. Limited access to maternal health services can partially explain the high MMR. Thus, efforts to enhance access to maternal health care should be a development priority for Madagascar as a strategy to curtail maternal deaths and prevent pregnancy-related complications.

Fertility and family planning

Madagascar’s total fertility rate (TFR)5 is high and strongly correlated with place of residence, wealth quintile, and level of education. As of 2021, the TFR was 4.2 births per woman, decreasing from 4.6 births per woman in 2018 (DHS 2021; MICS 2018). A gap persists between rural (4.6 births per woman) and urban (3.2 births per woman) areas (DHS 2021). TFR correlates strongly with wealth quintile and is lowest among women from the richest households (figure 4). Moreover, in line with global trends, higher educational attainment in Madagascar corresponds with a lower TFR (DHS 2021).

---

4 A positive deviant (PD) approach implies a focus on researching individuals who confront similar challenges and constraints as their non-PD peers but who employ strategies and behaviors that help them overcome those constraints and achieve positive outcomes in their educational and professional endeavors.

5 The TFR of a population is the average number of children born to a woman over her lifetime.
In recent years, however, the TFR among women with higher and secondary education has shown a tendency to increase, although a reverse trend is observed for women with no education or with only primary education (figure 5). Finally, the TFR among women who were first married by age 18 stood at 5.4 in 2018, in contrast to 3.5 among women who first married at age 25 or older (figure 6). Therefore, delaying women’s age at first marriage and at first birth is positively correlated with a reduced TFR.

Figure 4. Total fertility rate among women ages 15–49, by wealth quintile, Madagascar, 2003, 2008, and 2021

Births per woman


Figure 5. Total fertility rate among women ages 15–49, by level of education, Madagascar, 2003, 2008, and 2021

Births per woman


Notably, the wanted fertility rate in Madagascar is also high and only slightly lower than the TRF. In 2021, the wanted fertility rate was estimated at 3.8 births per woman (with the TRF at 4.3 births per woman)—see figure 7. The wanted fertility rate is significantly higher in rural (4.1) than in urban (2.8) areas, among women with no education (5.5) compared to those with primary (4.0), secondary (3.3), and higher education (2.2), and among women from the lowest wealth group (5.8), compared to women from the middle wealth group (3.9) and the highest one (2.4). According to married women and men ages 15–49, the ideal number of children is 4 (as reported by 34.4 percent of women and 30.0 percent of men). Nearly a quarter of all women (24.4 percent) and a third of men (29.5 percent) believe that more than 6 is the ideal number of children in the household. Interestingly, the proportion of married women ages 15–49 who do not want to have a child (or another child) decreased between 2009 and 2021 from 43 percent to 37 percent (DHS 2021). This tendency confirms that fertility and childbearing are highly valued and accepted in Malagasy society.
Figure 6. Total fertility rate in Madagascar, by age at first marriage, 2008 and 2018

Births per woman

![Graph showing total fertility rate in Madagascar, by age at first marriage, 2008 and 2018.](image)

Source: Demographic and Health Survey 2008; Multiple Indicator Cluster Survey 2018.

Figure 7. Total and wanted fertility rates among married women ages 15–49, by selected socio-demographic characteristics, Madagascar, 2021

Births per woman

![Graph showing total and wanted fertility rates among married women ages 15–49, by selected socio-demographic characteristics.](image)

Source: Demographic and Health Survey 2021.
The observed high rate of wanted fertility is among the factors that partly explain low use of contraception among Malagasy women. In 2021, contraceptive use was 49.7 percent among married women ages 15–49, a 3.1-percentage-point increase from 2018 (figure 8). The use of contraception among married women differs only slightly by place of residence but is higher in urban (52.1 percent) than in rural (49.2 percent) areas (DHS 2021). In terms of education, only minimal disparities in use of contraception are observed among married women with primary, upper-secondary, or higher education (52.2 percent, 55.2 percent, and 54 percent, respectively), although the use of contraception remains particularly low among women with no education (31.6 percent). The use of contraception increases with the wealth quintile: from 32.3 percent among women from the lowest wealth quintile to 55.4 percent among women from the highest one. By region, the lowest use of contraception is recorded in Androy (10.5 percent) and the highest in Itasy (69.4 percent). The unmet need for contraception remains high, at 14.6 percent (DHS 2021).

**Figure 8. Contraceptive use and needs of women ages 15–49 currently married or in a union, Madagascar, 2018 and 2021**

<table>
<thead>
<tr>
<th></th>
<th>2018</th>
<th>2021</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contraception prevalence, any method</td>
<td>46.6</td>
<td>49.7</td>
</tr>
<tr>
<td>Contraception prevalence, modern method</td>
<td>40.6</td>
<td>42.7</td>
</tr>
<tr>
<td>Unmet need for contraception</td>
<td>18.4</td>
<td>14.6</td>
</tr>
</tbody>
</table>

Sources: Demographic and Health Survey, 2021; Multiple Indicator Cluster Survey, 2018.

6 Women with unmet need for contraception are those who are fertile and sexually active but are not using any method of contraception, and who report wanting to delay the next child or not wanting any more children.
Barriers in access to maternal, sexual, and reproductive health services

Malagasy girls and women face several challenges in accessing (general) health care services. According to the DHS 2021, 70 percent of Malagasy women ages 15–49 experience at least one barrier in accessing health care. For example, more than half of all women (56.7 percent) reported that getting money to pay for treatment is a significant problem. About 33.7 percent of women report long distances to the nearby health facility as a problem in accessing healthcare. The lack of healthcare facilities is particularly urgent in the southern regions, where it is not uncommon to have 35-45 health facilities per 100,000 women ages 15-49, in contrast to 65-75 health facilities per 100,000 women ages 15-49 in the western and eastern regions (2018 Madagascar Census). Other problems that Malagasy women encounter in access to health care services include unwillingness to go alone (31.3 percent), and the need to get permission to seek treatment (15.2 percent) (DHS 2021). Notably, these problems affect rural and urban women nearly equally, but with important differences observed by wealth quintile and level of education. Women with more education and from nonpoor households generally encounter fewer problems in accessing health care than do their counterparts with no education and from poor households (figure 9).

Figure 9. Percentage of women ages 15–49 who reported having at least one problem in accessing health care, by place of residence, education, and wealth quintile, Madagascar, 2021

<table>
<thead>
<tr>
<th>Place of residence</th>
<th>Education level</th>
<th>Wealth quintile</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>No education</td>
<td>Q1</td>
</tr>
<tr>
<td>Urban</td>
<td>Primary</td>
<td>Q2</td>
</tr>
<tr>
<td>Rural</td>
<td>Lower secondary</td>
<td>Q3</td>
</tr>
<tr>
<td>No education</td>
<td>Upper secondary</td>
<td>Q4</td>
</tr>
<tr>
<td>Primary</td>
<td>Higher</td>
<td>Q5</td>
</tr>
</tbody>
</table>

Source: Demographic and Health Survey, 2021.

In line with the quantitative data, women interviewed for this study reported that one of the main reasons they have difficulty accessing health care is the lack of basic health centers and professional doctors in the vicinity of their homes. Despite the presence in some communes, such as Soamanova in Atsimo-Atsinanana, of a basic health center for first contact, most rural areas are far from a hospital for more serious illnesses.
We don’t have a doctor here because the hospital is located after the river in Anosibe. It’s far away…. (Young woman, Atsimo-Atsinanana)

As the doctor is quite far from here, the person who delivers us is, you want his name? It’s Betaza [name of a traditional healer] who delivers us. (Young woman, Atsimo-Atsinanana)

The inequitable spatial distribution of the (female) medical workforce is also a barrier to access to care for girls and young women in the areas studied. Study participants reported that, even when medical facilities exist in their area, those facilities lack doctors. Even more important, women appear to be reluctant to consult with male doctors in maternal units because of feelings of shame.

The existing health centers in this commune … are not equipped with really competent doctors. Most of them are just paramedics. But there is nothing we can do about it, they are the main people in charge of the health services around here. If someone gets sick, they are taken to them…. (PD, Atsimo-Atsinanana)

According to the participants, health care costs are high and prevent women from seeking professional maternal, sexual, and reproductive health care. For instance, the need to pay for contraception was reported as one of the factors preventing its use by interviewees who have no alternative family planning (FP) services available free of charge. Women in the sample also reported having to pay for contraception, even though some clinics are expected to provide it for free. In addition, the costs of medical consultations and professionally assisted childbirth are beyond the means of most women. Women are also required to cover the costs of potential surgical interventions and cesarean delivery. In some cases, women also need to pay for their transportation to the nearest health facility.

Yes, it’s really bad, when I was going to have my child. I only did ultrasound once because I couldn’t afford it. (Young woman, Antananarivo)

There are also those who say they don’t have money for that [contraception]…for example, you have to pay MGA 1000 (US$0.25) every 3 months, they say they don’t have that amount (Young woman in Atsimo-Atsinanana)

Importantly, in Atsimo-Atsinanana, women are asked to pay slightly more for the birth of a boy than of a girl. Several participants in the region confirmed that the costs of delivery depend on the sex of the baby. For example, delivery assisted by a traditional birth attendant costs about 15,000 Malagasy ariary, or MGA, (US$3.50) for a girl and MGA 20,000 (US$4.00) for a boy. In the hospital, costs are significantly higher: MGA 77,000 (US$15.70) for a girl and MGA 78,000 (US$15.90) for a boy. The difference in payment is explained by the higher likelihood of a boy to earn money in the future when compared to a girl. There were no similar reports from the other two visited regions.

They see that men earn more money than women, that’s why they increase the rate. (Young woman, Atsimo-Atsinanana)
Yes, if you have a child, it’s always like that! Whether it’s healers or doctors, the bill is always higher for boys than for girls. (Young woman, Atsimo-Atsinanana)

Moreover, many young women reported the poor quality of services offered at hospitals as an obstacle. Participants in the sample noted dissatisfaction with doctors’ treatment, believing that the services received were not helpful for their condition. It appears that women generally have low trust in doctors and professional health care. Such low confidence in professional health services could potentially be attributed to their inability to benefit from those services because of prohibitive costs of care and scarcity of facilities, equipment, and medical staff.

There is also a popular opinion among participants that paying doctors increases the chances of being treated with dignity and in a friendly manner. For this reason, women who can afford the additional expense prefer to hire a midwife to accompany them during pregnancy visits and for delivery in the hospital. This option, however, is not available for the majority of interviewees.

When I gave birth, we took a particular midwife, we really took her. It wasn’t a midwife... how can I put it... it was a midwife that we really took and we paid separately and yes, she took care of me until I was discharged from the hospital because we paid money for her […] because the people in the maternity ward mistreat the patients and don't care about them. If you get a midwife, you can be sure that she will keep an eye on you. (PD with a business, Antananarivo)

Overall, the availability of quality maternal health services appears to be inadequate in Madagascar. Because of the lack of health facilities and prohibitive costs of care, many women in Madagascar might therefore opt for home delivery, which can be associated with a range of complications for both mother and newborn. This problem is further compounded by the lack of transportation or the inability to pay for it in order to access hospitals. Additionally, women often reported doubt in prescribed medical interventions, low trust in doctors, and negative experiences in communicating with medical staff. Finally, women are reluctant to consult male doctors regarding SRH, which might be another explanation for their preference for traditional birth attendants.

Adolescent fertility

Partly attributed to the above-mentioned barriers in access to maternal, sexual, and reproductive health services, adolescent fertility is a common phenomenon in Madagascar. Madagascar’s adolescent fertility rate of 104 births per 1,000 women ages 15–19 is above the average of 98 in Sub-Saharan Africa (figure 10). This rate is lower than the rate observed in Mozambique (168), Angola (140), and Zambia (119), but higher than that registered in Rwanda (32), Zimbabwe (96), and Uganda (109). Importantly, the adolescent fertility rate decreased only slightly between 2000 and 2020, falling from 145 to 104 births per 1,000 women ages 15–19, respectively.
According to DHS 2021 data, 31.1 percent of adolescent girls ages 15–19 have already begun childbearing. The share of girls ages 15–19 who have already begun childbearing is higher in rural (35.6 percent) than in urban (15.5 percent) areas. In Madagascar, as in several other countries within and outside Africa, adolescent fertility decreases as the level of education and wealth quintile increase. For example, the share of teenage girls ages 15–19 who have already begun childbearing stands at 47.7 percent among those form the poorest households versus 12.2 percent among those from the richest ones. The country also has visible regional disparities in the patterns of adolescent fertility. The highest share of adolescent girls 15–19 who have already begun childbearing is observed in Sofia (50.4 percent), and the lowest is in the capital city Antananarivo (13.5 percent). In the Atsimo-Atsinanana region, this share stands at 46.9 percent—strongly above the national average (figure 11).

Teenage pregnancy is associated with numerous risks for girls’ well-being—with potential long-term adverse effects for their education, health, and employment opportunities. Evidence from Madagascar indicates that teenage pregnancy often interrupts girls’ schooling trajectories and might leave young women in an insecure financial situation, increasing their vulnerability to violence and poverty.

---

7 This share includes adolescent girls ages 15–19 who (1) have already given birth and (2) have been or are pregnant with their first child.
Interviewees reported teenage pregnancy as one of the central reasons for dropping out of school with little chance of returning. Although Madagascar adheres to a policy that enables students to return to school after delivery with no stipulated period of absence, pregnant students are reportedly expelled on a regular basis (HRW 2022). Girls often drop out because of feelings of shame, sadness, and low self-esteem following their pregnancies. In addition, pregnant girls might encounter mocking and bullying from their peers for the very fact of becoming pregnant out of the wedlock.

*They were in the same class when the girl got pregnant and the girl stopped her studies because of the pregnancy. Pregnancy is also a common cause. You can't hide the pregnancy when its time comes…. Pregnancy is one of the most common reasons girls leave school.* (Young woman, Atsimo-Atsinanana)

*It was when I was in school that I got pregnant and that was the cause why I left school because when they saw me, the other students were grumbling…. After that I left school because I was ashamed.* (Young woman, Atsimo-Atsinanana)

Moreover, teenage pregnancy imposes a significant economic and financial burden on women, forcing them to combine care and work activities right after childbirth. The situation becomes even more urgent in the event of separation or absence of the partner. In some cases, young women continue living with their parents after giving birth, which can inflict an additional financial and economic burden on the household, further trapping it in poverty and food insecurity.

Importantly, although in most cases marriage precedes childbearing in Madagascar, in some cases pregnancy can be the reason that girls rush to form a union. Because of social norms and prejudices, young women try to avoid the status of a single or unmarried mother. In some cases, young women have no aspirations to form a family early but are forced to do so in order to avoid any social judgments. In the southern region, the fear of having an unmarried pregnant daughter pushes parents to formalize her union as soon as she begins a relationship with a partner.

*Precisely, early pregnancy is the reason why they get married at the age of 16. There are also those who have sex outside and when the girl gets pregnant, they get married.* (Mother of an adolescent girl, Antananarivo)

**Drivers of teenage pregnancy**

Among the factors associated with teenage pregnancy in Madagascar, the main driver is child marriage. For that reason, efforts to eliminate the practice of child marriage are likely to reduce teenage pregnancies as well. In addition to child marriage, teenage pregnancy can be linked partly to supply-side barriers such as lack of health care facilities, limited availability of contraception and FP services, lack of medical staff, and so on. Finally, teenage pregnancy in Madagascar is also driven by the lack of information on SRH and contraception, as well as limited access to quality youth-oriented FP services.
services. Because the previous section discussed the supply-side and financial barriers in access to maternal and SRH services, this section will discuss the drivers specific to teenage pregnancy in Madagascar.

**Lack of information on SRH and contraception**

Young women interviewees exhibited very limited knowledge about their sexual and reproductive health. In all three regions visited, women receive information about menstruation from their mothers, sisters, or school teachers but with very limited explanations. In fact, only a small share of girls received precise information about the menstrual cycle, and those girls were mainly in Antananarivo. In contrast, many young women in Atsimo-Atsinanana admitted that they first learned about menstruation after they started having their periods. In all regions, in their conversations with daughters, mothers try to include recommendations on hygiene management and bodily cleanliness, and warnings about not having any physical contact with boys. Nevertheless, detailed explanations on the relationship between menstruation and sexual activity are often missing, likely because of stigmatization of the topic in general. In some cases in our sample, women started menstruating for the first time after they got married.

*I was bleeding for a long time. They asked the teacher what it was and he said that it was not a disease and that all women had it. He told us to go home.* (Young woman, Atsimo-Atsinana)

*Aaah my mom didn’t tell me anything…. The first time I had them, my mother congratulated me and told me some things.* (Young woman, Atsimo-Atsinana)

Similarly, there appear to be many misconceptions and myths regarding the use of contraception, which can partially explain its low utilization rate among young women. Young women in Antananarivo expressed fears of becoming infertile if they use contraceptive methods, and girls in Atsimo-Atsinanana reported their beliefs that contraceptive methods would make them sick and give them headaches. Apprehension and concern about the use of contraceptive methods by young women who have not yet given birth are prevalent. Many also believe that FP represents a danger to the health of women who use it.

*Generally, people say it’s not good and that it carries risks of making you infertile.* (Young woman, Antananarivo)

Low levels of knowledge on SRH and contraception can be attributed partly to the lack of reliable and credible sources of information. For instance, schools—often the first source of information on SRH for young women—generally lack comprehensive sex education as part of the curriculum. In some cases, schools set up sessions dedicated to sex education through partnerships with nongovernmental organizations and health centers. Otherwise, adolescent girls learn about human anatomy and reproduction during science classes, where they obtain information on the menstrual cycle and
natural FP. Different participants indicated that those classes often provide incomplete and sometimes incorrect information, which can compromise girls’ health outcomes and fail to protect them against unwanted pregnancy.

Moreover, despite the existence of media campaigns on SRH and FP, their outreach remains limited, especially in the provincial regions. According to key informants, awareness-raising activities mainly contain information on pregnancy, FP, and contraception and are broadcast via television and radio channels at the national level. Although these activities represent a positive development, some key informants raised concerns about the limited outreach of such programs, partly because of the language barrier. Because radio campaigns are broadcast in Malagasy, some communities in the provincial regions—who use dialects—might be unable to understand the messages.

*Lately, in order to prevent early pregnancy, unwanted pregnancy and possibly other obstacles that young people might face, there is an advertisement that has been circulating a lot. I personally thank them for making this advertisement because it really helps young people to realize their dreams.* (Young woman, Antananarivo)

*On the radio, for example, they often use official Malagasy. However, local dialects should be prioritized in radio sensitization.* (Key informant in the health sector, Atsimo-Atsinanana).

Furthermore, women generally opt to get SRH and FP information from social media because they fear going to the health center and encountering social judgment. In Antananarivo, Facebook is the preferred tool by which young women find recommendations on contraceptive methods. Several participants mentioned participating in or knowing about discussion groups that advertise the sale of contraception. Seeking FP information from sources other than official health centers or trained educators, however, can pose certain risks to young women’s health, especially in cases when they have preexisting health conditions that require medical consultations.

Finally, tabooization of SRH topics and the subsequent lack of a dialogue between parents and children significantly hinder girls’ knowledge on contraceptive methods. The weight of tradition, which creates distance between parents and children, makes it difficult to discuss SRH. This difficulty makes it an almost taboo subject within the family, especially between parents and young women. Girls reported being afraid to talk to their mothers about sexual health.

*The ancestral tradition points to a lack of communication. Normally you are supposed to explain to your daughter that during her period she should do this, that. And yet, that doesn’t exist here. That is the concern.* (Key informant, health sector, Atsimo-Atsinanana)
Limited access to quality youth-oriented FP services

Despite legal provisions recognizing the right of all individuals to SRH, adolescent girls and young women continue to be constrained in their ability to benefit from those provisions. Law No. 2017-043 establishing the general rules governing reproductive health and family planning provides, “No individual may be deprived of this right (to SRH), which he or she enjoys without discrimination on the basis of age, sex, wealth, skin color, religion, ethnicity, marital status or any other situation.” This provision is an innovation because access to contraception was previously reserved only for individuals who had reached a certain age. Despite the adoption of this law and this new provision, adolescent girls and young women might still be restricted in their access to SRH services. For example, doctors sometimes refuse to help an underage girl who wishes to use a contraceptive method.

In Madagascar a young person who asks for access to contraception is stigmatized... Even the doctors at the CSBs, there are doctors who are very, uh, very strict when a young person asks for access to contraceptive services....

(Key informant, nongovernmental organization at the national level)

Participants in the sample reported potential discrimination against young women who wish to access FP services or SRH information before they have begun childbearing. As mentioned earlier, SRH services and FP efforts are targeted toward pregnant women and mothers, rather than as a preventive measure for younger women or those who are not yet mothers. Some participants in Antananarivo reported cases of young women going to health centers specifically to receive SRH information, but those women seem to be a minority. Evidence from the three regions shows that FP services are often not designed to accommodate the needs of adolescents or young women. Interestingly, even some young women themselves supported the idea that such services should be primarily available for adults or women with children. These findings are in line with the global literature that indicates that, in many developing countries, young women and adolescent girls report being discouraged from accessing SRH services for fear of receiving a negative reception from clinic staff (Kiluvia and Tembele 1991; Otoide, Oronsaye, and Okonofua 2001; Rasch et al. 2000; Richter and Mlambo 2005; Wood and Jewkes 2006). Moreover, unmarried adolescent girls might feel discouraged from seeking SRH and FP services, fearing negative and judgmental reactions from their family or community.

Yes, although I don’t think it should be for children [underage individuals]. Normally it should be people who have already had children. (Young woman, Antananarivo)

This is the case in Befelatanana. It is after they have given birth that they sensitize women to use family planning and advise them on the most effective methods and the different methods. (Young woman, Antananarivo)

8 Centres santé de bases (CSBs) are basic health centers.
The very fact of seeking FP services by young women can negatively affect their social status and spread rumors about their sexuality and reputation. Participants from Antananarivo reported that young women who consult SRH or FP centers are perceived in a negative light. People might start spreading rumors about their sexual life, number of partners, or potential pregnancy or abortion. The fear of social rejection is among important reasons that deprive young women of access to SRH services.

*The girl is always afraid of being criticized by society, because if she goes to these health centers, people would think that she is pregnant, or that she has had an abortion, and they are judged and so they do not dare to have medical consultation. People even claim that if she used contraceptive methods, it is because she was a prostitute.* (Young woman, Antananarivo)

*It’s society’s concern about what people will say…. And this is an obstacle to coming to see doctors at the CSB level for health reasons... especially for women, especially when it comes to sexual health. Sometimes it is considered a shame.... Often, the real obstacle is the gossip in society: “so-and-so went to consult there....”* (Doctor, Antananarivo)

Male partners also influence women’s decisions to seek SRH or FP services. In Atsimo-Atsinanana, for example, men perceive the use of contraception by their wives as an act of infidelity or a lack of love. Because childbearing is considered proof of the wife’s love for her husband, pregnancy is the expected outcome of a romantic relationship. According to a midwife interviewed in Atsimo-Atsinanana, men might accuse their wives of adultery or infidelity if they express the desire to use contraception. As a result, some women seek FP in secret, fearing for their male partners’ negative reactions or prohibition.

*Generally, here, the goal of a man who gets involved with a woman is to make her a child. “If you really love me, you must get pregnant with me.”* (Midwife in an individual interview, Atsimo-Atsinanana)

In addition, climate change and other natural crises exacerbate negative gender norms and inequalities, negatively affecting women’s decision-making around health (Erman et al. 2021). A qualitative study undertaken in Amboasary Atsimo and Ambanja in Madagascar’s southeast and northwest regions, respectively, sought to collect information on how gender norms and SRH decision-making relate to efforts to build greater resilience to climate change (Harivola 2021). The study found that food and resource scarcity resulting from flooding or drought influences decisions on whether or not to use sexual, reproductive, and maternal health services—such as whether or not to buy contraceptive methods and whether or not to give birth in a health center. For example, a health care worker reported that the number of deliveries in Sampona’s basic health center had fallen by half during a recent period of food scarcity because women felt shame that their families could not provide adequate food for their stay at the center.

*Finally, Malagasy traditional values enshrine children as the primary wealth of parents in all regions of the country, with potential implications for poverty. This*
traditional thinking has resulted in the perception that the more children a couple has, the more society will consider the man to be virile and vigorous. It is important to note that, although global evidence indicates a strong positive correlation between a country’s total fertility rate and poverty headcount, countries with a lower poverty rate tend to display a lower total fertility rate than their counterparts with high incidence of poverty. These findings also imply that efforts to accelerate demographic transition through the promotion of women’s reproductive and economic rights, and maternal and child health, can offer huge potential for poverty reduction (DeJong 2000; Wietzke 2020).

In summary, Malagasy women are largely deprived in access to professional health care, which partly explains the underutilization of pre-and postnatal care, the low share of assisted deliveries, the high maternal mortality rate, and the high rate of adolescent fertility. Women encounter numerous barriers in access to health care services, with poverty and lack of means playing a crucial role. Additionally, women in the studied regions reported a scarcity of health care facilities, equipment, and medication; poor quality of treatment; and low trust in doctors’ competence. In addition to supply-side factors, numerous drivers contribute to the high rate of early pregnancy, including a lack of information on SRH and contraception and limited access to quality youth-friendly FP services. Teenage pregnancy has strong adverse impacts on girls’ education, because most pregnant girls or adolescent mothers in the studied regions no longer had the option to continue their schooling. In addition, early pregnancy places girls in a precarious financial situation—especially in the event of separation from her partner, which is also not uncommon. Thus, improving access to maternal, sexual, and reproductive health services and reducing the rates of teenage pregnancy should be an utmost priority for Madagascar.

Policy recommendations

Preventing maternal mortality and enabling steady access to professional health care services and facilities matter not only for women’s well-being but also for their families and economies at large. Recent research demonstrates the huge adverse consequences of maternal mortality on infant and child morbidity rates, loss of economic opportunities, and intergenerational transmission of poverty in the families and communities where women die from pregnancy-related complications (Miller and Beližán 2015). Evidence from South Africa shows that maternal mortality comes with high financial costs and lost opportunities for children’s education (Knight and Yamin 2015). Likewise, in rural Kenya, maternal mortality imposes significant economic shocks on families, often forcing households to resort to negative coping strategies such as borrowing money for the funeral and selling assets (Kes et al. 2015). Therefore, tackling maternal mortality and ensuring affordable and accessible health care services can help bring economic and social gains for Madagascar.

Likewise, reducing adolescent fertility is a development priority for Madagascar. Adolescent mothers face negative health, education, and economic outcomes. Teenage mothers have higher maternal mortality rates and complications related to pregnancy
and childbirth than do older mothers (Klugman et al. 2014; Sagalova et al. 2021; UNICEF 2008; WHO 2007, 2014). Based on evidence for Sub-Saharan Africa, teenage pregnancy is associated with poor academic performance and increased likelihood of school dropout (Barmao-Kiptanui, Kindiki, and Lelan 2015; Maemeko, Nkengbeza, and Chokomosi 2018). Research also finds that negative effects carry over into the next generation: children born to adolescent mothers are more likely to face lower educational outcomes, to be unemployed, and to have lower earnings (Hoffman and Maynard 2008; Male and Wodon 2016).

Table 1 summarizes the main identified barriers and policy recommendations for enhancing access to maternal, sexual, and reproductive health services and for reducing adolescent fertility. Based on the mixed-methods analysis, the following strategic directions have been identified:

- **Strategic direction 1:** Address supply-side and financial barriers in access to maternal, sexual, and reproductive health services.
- **Strategic direction 2:** Improve girls’ knowledge on SRH, FP, and prevention of pregnancy.
- **Strategic direction 3:** Enhance access to youth-friendly SRH services, and empower girls and young women to seek them.

Priority policies should focus on alleviating financial barriers to health care, which can be achieved through the provision of vouchers and subsidies for vulnerable populations, including for coverage of transportation fees and medication. Moreover, specific actions are required to improve the code of conduct of medical personnel and guidance on communication with patients. In addition, improving girls’ knowledge on SRH, FP, and prevention of pregnancy is essential so that they can make decisions about the timing and composition of their families. Improving such knowledge and decision-making will not be possible, however, without training and sensitizing health care staff on how to work/communicate with adolescent/young patients. Table 3 summarizes the main identified barriers and policy recommendations for enhancing access to maternal, sexual, and reproductive health services and reducing Madagascar’s teenage pregnancy rate.

**Table 3. Policy recommendations to improve access to professional health care by Malagasy women and girls**

<table>
<thead>
<tr>
<th>Barriers</th>
<th>Term</th>
<th>Policy recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Strategic direction 1: Address supply-side barriers in access to maternal, sexual, and reproductive health services</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| Low coverage of health care facilities                                  | Long term     | • Improve availability and accessibility of maternal health care services.  
• Expand access to frontline health care providers.                     |
| Prohibitive costs of treatment                                          | Short term    | • Provide vouchers and subsidies for health care for vulnerable populations, including for transportation fees and medication. |
| Preference for traditional birth attendants (partly because they are more affordable) | Medium term   | • Acknowledge and address the important role of traditional medicine.  
• Educate and sensitize pregnant women on how to recognize dangerous symptoms during pregnancy.  
• Educate traditional healers and midwives to treat pregnancy complications. |
<p>| Staff misconduct                                                        | Short term    | • Train medical staff on effective communications with patients.  |</p>
<table>
<thead>
<tr>
<th>Barriers</th>
<th>Term</th>
<th>Policy recommendations</th>
</tr>
</thead>
</table>
| **Strategic direction 2: Improve girls’ knowledge on SRH, FP, and prevention of pregnancy** | Low levels of knowledge and existence of misconceptions on the use of contraception | Medium term | • Improve the availability of technical and reliable information on contraception and its use, especially in schools, by expanding existing initiatives.  
• Strengthen education, edutainment, and social marketing and develop awareness-raising campaigns on SRH to counteract misconceptions and harmful beliefs around the use of contraception. |
| **Strategic direction 3: Enhance access to youth-friendly SRH services, and empower girls and young women to seek them** | Inadequate access to SRH health services especially for adolescents and young women | Short-term | • Train and sensitize health care staff on how to work/communicate with adolescents/young patients. |
| | | Medium term | • Establish youth-friendly clinics and set up guidelines for implementation of quality standards for clinics. |
| | Limited girls’ agency in decisions on pregnancy and seeking SRH services | Long term | • Create a supportive environment for girls’ school education*  
• Use community mobilization programs and adolescent empowerment programs to encourage girls to delay family formation. |


Note: FP = family planning; SRH = sexual and reproductive health.
a. See Note 1, “Challenges and Opportunities in Education.”

**Strategic direction 1: Address supply-side barriers in access to maternal, sexual, and reproductive health services**

Priority efforts should focus on improving overall availability of health care institutions and expanding access to them among Malagasy women. General investments in infrastructure, staff, and supply provision would strongly contribute to improving access to professional health services among vulnerable women, especially those living in remote areas (WHO 2012). Expanding access to frontline health care providers offers an alternative strategy for addressing the lack of access to adequate maternal health care. One strategy for facilitating access is to delegate some clinical tasks from higher-level health care providers to mid- or lower-level providers, including community-based health workers and traditional birth attendants. Making medical care more widely available for women can have positive effects on the actual use of professional support during and after pregnancy, as seen in Indonesia, where the Bidam Di Desa (village midwife) program, which trained midwives and deployed them to rural areas throughout the country, has significantly increased the proportion of attended births (Ensor et al. 2008; Ensor et al. 2014).

Lifting financial constraints for vulnerable women will be necessary to ensure that the required maternal health services are available and accessible regardless of income. Ensuring broader affordability of maternal health care services to women through policy or legal mechanisms can bring a positive change to maternal and newborn health. Global evidence suggests that reducing fees for maternal health care services or providing women with vouchers or subsidies to seek medical support increases the percentage of attended births and reduces the rates of newborn and maternal mortality (Alfonso et al. 2015; Johri et al. 2014; Rasella et al. 2021).

While improving access to modern health care services, it is important to acknowledge and address the important role of traditional medicine in some
regions of Madagascar. Efforts in that regard should focus on (1) engaging traditional healers and midwives in advocacy among their clients on the importance of pre- and postnatal care, and (2) educating women on how to recognize dangerous symptoms during pregnancy and when to seek professional support. An intervention in Nigeria that provided monetary rewards for traditional birth attendants for each received client increased the share of women receiving postnatal and neonatal care (Chukwuma et al. 2019). In addition, encouraging expectant mothers to seek professional medical support before, during, and after pregnancy can be achieved through community-mobilization and couples-counseling interventions that aim to educate expectant mothers on pregnancy-related topics and explain the importance of seeking timely support. Information and awareness-raising efforts can also play a key role in promoting health-enhancing norms among the population (George and Branchini 2017).

Ensuring high quality of professional services and treatment from medical staff can also bring gains for the improved use of professional health care services in Madagascar. Attitudes of health care providers and managers can present an obstacle to women’s access to maternal and SRH services and diminish their motivation to seek professional support. Enhanced quality of treatment / consultations can be achieved through specific policies to strengthen existing institutional capacity and implement standardized procedures, protocols, and manuals for staff in respect to communication with female patients.

**Strategic direction 2: Improve girls’ knowledge on SRH, FP, and prevention of pregnancy**

With regard to adolescent pregnancy, a systematic review of interventions found that SRH education, counseling, and contraceptive availability are effective in increasing adolescent knowledge related to sexual health, contraceptive use, and decreasing adolescent pregnancy (Salam, Faqqah, and Sajjad 2016). Adolescents in Madagascar should have access to comprehensive sexuality education as part of the school curriculum. Such education should include both biological aspects and social-emotional issues of reproduction, covering a broad range of topics, including decision-making about sex and relationships, sexual health and well-being, and prevention of sexually transmitted infections and pregnancy (UNESCO 2009, 2014). Ideally, the development, content, and implementation of comprehensive sexuality education programs should involve the specific adolescent target group so that the programs can maximize program relevance, quality, and effectiveness and reflect the varying challenges, perceptions, and behaviors among different communities and groups of youth (UNFPA 2014). Participants in the qualitative assessment reported that various efforts in this direction deployed in the past few years have not yet had any result.

A related priority in this area is to address common beliefs and misconceptions regarding the use of contraception among young and unmarried girls. Because of the taboo or anticipated harm attached to contraception, women who use this type of service are stigmatized. Mass media can be used to improve knowledge of methods
and to change social norms about use. Community mobilization and one-on-one counseling by satisfied contraceptive users who can share their experiences are also ideal strategies to dispel pervasive myths. An additional strategy that can reduce belief in myths, particularly among women, is the training of health workers to interact and share information with patients (Gueye et al. 2015). Digital health has potential in this regard, because it offers a way to avoid stigmatization and shame among prospective users. For instance, SRH information sent by text message to young people on their ability to reject contraception-related myths and misconceptions in Kenya was associated with a statistically significant drop in the average absolute number of myths and misconceptions believed (Gichangi et al. 2022).

**Contraceptive social marketing, which combines demand- and supply-side features, has been an important intervention strategy for increasing both the acceptability of certain contraceptives**—mostly condoms and the pill—and their use (McCleary-Sills, McGonagle, and Malhotra 2012). Such campaigns often conduct market research to better understand their target audience and then use a combination of advertising, public relations, special events, sponsorships, and personal communication to reach their target clients. They use community, mass, and electronic media, and edutainment not just to convince clients to use their product but also to make it the desirable option, and thus the norm. Edutainment approaches in particular make messages accessible and appealing to target audiences. In South Africa, a social marketing campaign produced a significant change in perceptions about unwanted pregnancies and intentions to use contraception (Branson and Byker 2018). Similar programs could achieve gains for the reduction of adolescent fertility in Madagascar.

**Strategic direction 3: Enhance access to youth-friendly SRH services, and empower girls and young women to seek them**

**Improving access to SRH services tailored for the needs of adolescents and youth is also fundamental.** Expanding the availability of services through school-based provision or through better-equipped and more available health care centers could help remedy this problem. Global evidence suggests that the provision of school-based health services reduced the birth rate among girls ages 15–18 by 5 percentage points (Lovenheim, Reback, and Wedenoja 2016). Moreover, eliminating the costs associated with receiving treatments or consultations in SRH facilities has also proven to increase use of contraception and family planning among young women. For instance, provision of free contraception methods along with information on how to use them can strongly reduce the total fertility rate. In Madagascar, for example, according to key informants some civil society organizations have carried out massive dissemination of contraceptive methods in remote areas of southern Madagascar, significantly reducing the birth rate in this area over the past 10 years.9

---

9 Between 2008 and 2021, the total fertility rate in Menabe fell from 4.8 to 3.9 births per woman; in Atsimo Andrefana from 6.2 to 5.6 births per woman; in Vatovavy Fitovinany from 6.5 to 4.5 births per woman; and in Haute Matsiatra from 6.4 to 4.3 births per woman (DHS 2008–09, 2021).
The services provided to adolescents and young women need to be youth friendly. A recent review of the main factors influencing access to youth-friendly SRH services in Sub-Saharan Africa indicates that interventions in this area should focus on intensive training of health workers and putting in place guidelines for implementation of quality standards for clinics to offer services according to the needs and preferences of youth. Interventions aimed at improving the youth friendliness of services in other countries can be of value in Madagascar as well. For example, in South Africa, the National Adolescent Friendly Clinic Initiative included high-profile media campaigns, a clinical component aimed at reducing physical and social barriers to accessing reproductive health services, and an education component focused on sex education and life skills. The initiative’s education component involved building dedicated spaces at clinics for youth education and socialization—called “chill rooms”—and employing local youth to facilitate sex education programs. Participants of the National Adolescent Friendly Clinic Initiative program completed more years of schooling, compared to nonparticipants (Branson and Byker 2018).

Finally, initiatives empowering adolescent girls and young women to exercise their agency and deliberately delay early family formation are equally important. One proven method of increasing girls’ agency over SRH decisions is through adolescent empowerment programs. Typically, such programs incorporate the following range of interventions: (1) life skills training to teach girls about health, nutrition, money, finance, legal awareness, communication, negotiation, decision-making, and other relevant topics; (2) vocational and livelihood skills training to equip girls for income-generation activities; and (3) safe spaces for girls. Evidence from Sub-Saharan Africa shows that adolescent empowerment programs are highly effective in increasing girls’ knowledge on SRH and preventing teenage pregnancy (Baldwin 2011; Muthengi and Erulkar 2011). Similarly, community mobilization programs appear promising in promoting positive social norms around the use of contraception and reducing stigma around the discussion of SRH topics (Diop et al. 2004; Erulkar and Muthengi 2009).
Appendix A. Methodology of the qualitative background study

This report is based on qualitative data collected in three regions of Madagascar in June and July 2022. Before the qualitative data collection with young women and parents of adolescent girls, existing quantitative data was analyzed, followed by a literature review, a review of the current legal system, and 10 key informant interviews. The key informants interviewed included a range of representatives from relevant government institutions, development partners, researchers, nongovernmental organizations active in relevant areas, and activists. The interviews followed a series of questions intended to explain girls’ and young women’s experiences in relation to education, family formation, and labor market participation. Key informant interviews helped to reflect on and discuss barriers, facilitators, and other important aspects of observed gender gaps in the country. Findings from the interviews informed the design and focus areas of the subsequent qualitative research.

On the basis of those key informant interviews, initial quantitative data analysis, and literature review, a subsequent dedicated qualitative data collection effort focused on exploring the issues faced by young women in Madagascar. The overall qualitative research aimed to generate knowledge about a range of factors that contribute to gender inequalities in education, family formation, employment, and access to health care, with a particular focus on adolescent girls and young women. Building on a life-cycle approach, the study focused on the issues young women in selected regions face in their educational, family, and work trajectories. This research followed the principles of protection of human subjects outlined by the Belmont Report (National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research 1979) and the World Health Organization’s “Putting Women First: Ethical and Safety Recommendations for Research on Domestic Violence against Women” (WHO 2001). All research protocols were submitted to an ethical review board for approval before data collection. In addition, all World Health Organization and national COVID-19 protocols were followed to ensure the safety of the research team and participants.

The qualitative data collection took place in three regions in order to capture the geographical diversity of Madagascar. In addition, selected regions differ significantly in terms of gender disparities observed (Table A.1). In particular, the Analamanga region was represented by the capital city Antananarivo, which displays the lowest proportion of illiterate women (8.7 percent) and the lowest share of women ages 20–24 who married before the age of 18 (17.9 percent) (DHS 2021). In Antananarivo, two urban communities were chosen with a concentration of industrial companies, businesses, and stores in each area. Atsimo-Atsinanana and Sofia regions were selected because they have high rates of illiteracy among adult women (54 percent and 25 percent, respectively) and high prevalence rates of child marriage (54.5 percent and 65 percent, respectively, of women ages 20–24 were first married by age 18) (DHS 2021). The districts of Mandritsara (Sofia region) and Vangaindrano (Atsimo-Atsinanana region) were selected because
they display large gender disparities in favor of boys in secondary school enrollment and attendance rates.

**Table A.1. Justification of the choice of regions for the study**

<table>
<thead>
<tr>
<th></th>
<th>Analamanga (capital Antananarivo)</th>
<th>Atsimo-Atsinanana</th>
<th>Sofia</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Women’s illiteracy rate</strong></td>
<td>8.7 percent</td>
<td>54 percent</td>
<td>25 percent</td>
</tr>
<tr>
<td><strong>Child marriage rate</strong></td>
<td>17.9 percent</td>
<td>54.5 percent</td>
<td>65 percent</td>
</tr>
<tr>
<td><strong>Net secondary school attendance rate</strong></td>
<td>54.8 percent (vs. 45 percent of boys)</td>
<td>16.5 percent (vs. 23.1 percent of boys)</td>
<td>21.6 percent (vs. 22 percent of boys)</td>
</tr>
</tbody>
</table>


Data collection used the following three main instruments:

1. **Key informant interviews** with a wide range of representatives from the education, health, and private sectors; religious and traditional leaders; elected officials; and representatives from civil society.

2. **Focus group discussions** with women ages 25–34 and mothers and fathers of adolescent girls. Because of COVID-19 considerations, each focus group consisted of up to five persons.

3. **In-depth interviews** with young women ages 18–24 and mothers of adolescent girls. A subsample of young women for individual in-depth interviews consisted of positive deviants (PDs). A PD approach implies a focus on researching individuals who confront similar challenges and constraints as their non-PD peers but who employ strategies and behaviors that help them overcome those constraints and achieve positive outcomes that are unusual in their own contexts. The advantage of the PD approach is the ability to identify solutions that some individuals already employ (Pascale and Monique 2010). In this study, the PDs consisted of young women who (1) completed high school without interruptions, (2) reentered school after dropping out, (3) completed professional training, or (4) launched their own small business.

Interview guides for the different groups of interviewees or focus groups included questions related to the aspects of education, family formation, and labor market participation of young women in Madagascar. Local authorities, particularly the
fokontany (chiefs) supported the recruitment of participants for the individual in-depth interviews and focus group discussions. The research team provided them with the desired criteria as well as the quotas to be reached for each subsample of participants. The local authorities were then responsible for identifying potential participants. Volunteers who came to register were screened to ensure that they met the criteria (age, status as a parent of an adolescent girl, educational background, and so on). Additionally, snowball sampling complemented the volunteer-based sampling in identifying the four types of positive deviants. See table A.2 for a summary of the study participants, their region, and which activities they participated in.

**Table A.2. Distribution of study participants, by region and instrument of data collection**

<table>
<thead>
<tr>
<th>Region</th>
<th>Analamanga</th>
<th>Sofia</th>
<th>Atsimo-Atsinanana</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>FGD</td>
<td>IDI</td>
<td>KII</td>
</tr>
<tr>
<td>Young women ages 18–24</td>
<td>2</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Young women ages 25–34</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Mothers of adolescent girls</td>
<td>1</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Fathers of adolescent girls</td>
<td>1</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>PD (completed high school)</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>PD (reentered school after dropping out)</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>PD (completed professional training)</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>PD (created small business)</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Representatives from civil society</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Representatives from education sector</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Representatives of health sector</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Religious and traditional leaders</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Representatives from private sector</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Local elected officials</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Total</td>
<td>6</td>
<td>8</td>
<td>6</td>
</tr>
</tbody>
</table>


Note: FGD = focus group discussion; IDI = in-depth interview; KII = key informant interview; PD = positive deviant.

All individual interviews and group discussions conducted in Malagasy were voice-recorded, transcribed, and translated into French. Generic coding, a method of coding that involves classifying each interviewee’s statements into previously established thematic codes, was used (Huberman and Miles 2003). As new information became available, the list of preestablished codes was revisited and expanded.

The team encountered several challenges during fieldwork. The research team encountered a language barrier in the Atsimo-Atsinanana region. Most group discussions were conducted in the presence of the focal point, who provided translation from the local dialect to official Malagasy and vice versa. Because that translation occurred only at the end of each discussion so as not to cut off the interviewees’ answers, it is possible that the rephrasing could have distorted some of the comments. In addition, many factors such as the interviewer’s attitude, the interviewee’s social status, and existing
taboos come into play in interview situations, affecting the authenticity and richness of the information collected. These factors elicited reactions described from some of the interviewees during the various interviews including inhibition (manifested in either abrupt and underdeveloped responses during interviews or limited participation in focus group discussions) or defensive attitudes (specifically in the case of one traditional leader in the Atsimo-Atsinanana region).
References


