Linking Policy to Programming

Situational analysis on young key populations' sexual and reproductive health and rights in Madagascar

This brief presents the findings of a situational analysis of the sexual and reproductive health and rights (SRHR) of young key populations (YKPs)[1] in Madagascar, undertaken by HEARD, University of KwaZulu-Natal. The analysis was part of a larger, multi-country project (2017-2020) which seeks to strengthen the legal and policy environments for YKPs and improve their SRHR in Southern Africa[2]. The analysis brought together existing and new data in order to capture the political, legislative, socio-economic and socio-cultural issues that affect the SRHR of YKPs. Data collection included qualitative and quantitative data from published and grey literature and existing data sets, as well as primary data obtained through key informant interviews with actors from government, international organisations or NGOs working with young people on issues of SRHR.

Key Findings

The Socio-Economic and Legal Context

The economic and political situation in Madagascar, marked by political instability and crisis and widespread poverty, provides a structural context which has negative impacts on SRHR. Public services, including health and education, lack funding and are often reliant on external donors for funding for essential services. Poverty affects a significant proportion of the population and is particularly marked in rural areas where 78% of the population live.

The context of poverty creates specific health risks for young people. Recent statistics suggest that 46% of the population are under the age of 25 years old [1], Young people aged 15-24 face immense difficulties in entering the labour market, and 75% of the unemployed in the country are under 30 years old [2]. Lack of formal employment means that many young people are pushed into informal sectors, principally in agriculture but also in small business, domestic work or transactional sex work. Many key informants mentioned the rapidly growing numbers of young women (and increasingly also young men) involved in transactional sex and attributed this to the worsening economic situation in the country. A study carried out by PSI found that the vast majority of the women interviewed engaged in transactional sex to be able to buy basic necessities for themselves or their families. Many also had other forms of employment, but these were not by themselves sufficient for economic survival [3].

The legal context is also a determinant of young people's health, particularly in the context of strict laws regulating sexual behaviour and access to SRH services. Young people under the age of 18 cannot legally receive any medical treatment without their parents' consent, and this law is generally strictly adhered to by doctors and medical centres. A law passed in December 2017 has finally made it legal for minors to receive family planning and contraception advice and treatment without their parents' consent. However, HIV testing or treatment is still unavailable for minors without parental consent, and this was noted as a major barrier to more widespread testing.[3] There is also a lack of information about this law, which means a continued restriction of access to contraception for young people.

Abortion is illegal in Madagascar and harsh penalties are in place for any person caught performing or attempting to perform an abortion. The Penal Code contains no expressed exceptions to the general prohibition of abortion, and a recent revision has reinforced the criminalisation of abortion for therapeutic reasons. Many young women turn to clandestine abortions which are a serious risk to their health. Because of the clandestine nature of abortion, there are few accurate statistics, but one study found that in some urban centres such as Toliara more than half of young women between the ages of 15-24 had already had at least one abortion, and that 52.4% of the pregnancies of young women aged 15-24 in Antananarivo had resulted in abortion [4].

There is no law prohibiting same sex sexual activity for people over the age of 21. However, LGBTI can be prosecuted for acts that are "indecent or against nature with an individual of the same sex under the age of 21". Transgender persons are legally allowed to identify with their chosen gender and are not criminalised for this. There is no law which protects LGBTI from discrimination.

Sex work is not criminalised but is illegal for young people under the age of 18, and various associations report that police make use of this legal provision to harass and exploit young sex workers who may be arrested and forced to engage in sex with the police officers if they do not have documents to prove that their age. There is a legal framework against sex tourism and child sexual exploitation (law of 2007) and National Action Plan. But these are rarely applied and in practice "it has become normal to see children involved in prostitution" [5]. The reasons for the non-implementation of the laws against sex tourism and child sexual exploitation are often linked to corruption and the fear of losing clients and revenue if it is reported or if the clients are prosecuted.[4]

In 2006 a law was passed on the prevention of HIV and on the protection of the rights of people living with HIV. The law prohibits any discrimination against people living with HIV and their families. However, evidence shows that discrimination persists, and provides a barrier to access to services.

Structures of Gender Inequality

The positive value attributed to heterosexual sexual relations by both parents and peer group, encourages young people to become sexually active at a young age. For girls, the average age of first sexual relations is between 12 and 13 years old, although it is not unusual for girls aged 10 to be sexually active. For boys, the average age is 14 to 17 years old. Early marriage and pregnancy are common in and are legitimised by various local and traditional norms and practices [6]. UNICEF found that 12% of girls are married before the age of 15, and 41% before the age of 18 [7]. A study of adolescent sexuality in the South West Region of Madagascar found that girls' first pregnancy generally coincides with their first sexual relations (often between the ages of 12 and 15).

Early sexual debut for girls is linked to gendered norms which judge that women should be younger than men in a sexual relationship. Girls and young women engage in multiple sexual relations in search either of emotional or material gains, whilst for young men there is a strong peer pressure to prove their masculinity through having as many female sexual partners as possible. Economic factors are important, as often girls' sexual debut is a transactional sexual relationship involving the man providing presents to the girl and her family.

There is strong heteronormative pressure in society [8]. Young LGBTI people may thus prefer not to reveal their sexual orientation or gender identity for fear of discrimination and stigmatisation.

Gender inequality also underlies a high level of sexual and gender-based violence which is another key issue with regard to SRHR of young people, linked to discriminatory gender norms and lack of legal structures to prevent SGBV, or pursue perpetrators. One report showed for example that 14% of girls aged 15-19 have been victims of sexual violence.

Key issues per young key population group

Young sex workers

Sex work is widespread across Madagascar, but there is a real problem in that many studies have treated sex workers as a homogenous group thus failing to recognise the different categories of transactional sex that exist on a wide continuum. The National Strategic Plan against HIV estimated a total of around 63,000 sex workers in the country [8] but this figure includes only recognised sex workers who are working in bars, nightclubs, hotels etc and does not take account of wider forms of transactional sex which most concern young people. A more recent study noted a large increase in the number of sex workers between 2012 and 2016, probably due to the worsening economic situation in the country [9]. The majority of young sex workers (15-24 years old) had their first sexual relations before the age of 18, and 45% of them had their first sexual relations before the age of 15. HIV prevalence rates are estimated at 5.6% for sex workers, with rates of 4.9% for those aged 15-19 and 6.4% in the 20-24 age group. Sex workers surveyed were also revealed to have high levels of syphilis and other STIs [9].

Many of the young women engaging in transactional sexual relationships would not identify themselves as sex workers and one of the challenges of research in this area is thus to reach out to these "invisible" sex workers to find out more about their SRHR needs. In terms of programmatic implications, it is not clear that claiming more rights for sex workers would be of great benefit as many of those involved in transactional sex would not want to be identified as or claim rights as sex workers.

Sex tourism is a growing problem in Madagascar and affects mainly girls, although boys are also being affected in greater numbers in recent years. There is a national legal framework in place which criminalises both prostitution and sex tourism, but these laws are extremely rarely applied. In fact, there seems to be a de facto acceptance that with the economic crisis ongoing in the country, transactional sex is a necessity for the survival of many people [10]. Children get involved in sex tourism at an average age of 13 and it is usually their first sexual experience. Parents are often aware of and may encourage children's sex work.

Young lesbian, gay, bisexual, transgender and intersex individuals (LGBTI)

Homosexuality is not criminalised, but the age of consent is higher than that for heterosexual relationships, and LGBTI people may also face discrimination and stigma which can lead many to hide their status. This means there are no reliable estimates of the size of the LGBTI population, and in particular transgender and lesbian populations are hidden. If they do reveal their sexual orientation or gender identities, young LGBTI people risk being thrown out of their homes by their families, and there have even been cases when young people have been killed by their families because they are seen to be bringing shame on them.[5]

HIV prevalence rates are estimated to be 14.8% for MSM, far higher than those of the general population. A 2018 study by PSI found that the majority of the MSM interviewed cited economic reasons as their main motivation for engaging in sex with other men. Most of the MSM interviewed were "hidden" or "discrete" MSM, who had not revealed their sexual orientation or sexual activity to their families or friends. A previous study revealed that many of these MSM had incomplete knowledge on condom use and only used a condom when they felt that their sexual partner was not in good health [11]. Strongly entrenched gender norms, unsupportive family and peer group structures, comprise strong determinants of the health of MSM, and create situations of risk and vulnerability for their SRHR.

Young people who inject drugs

Injecting drug use is a relatively recent phenomenon in Madagascar, and one is which is also under-explored in statistics and research. There is to date only one major study that has been carried out on the subject. IDUs in Madagascar are estimated to have an HIV prevalence rate of 7.1%, much higher than that of the general population. A recent socio-demographic study of IDUs in three cities iestimated that there are approximately 1-2% of the adult population in each city who are IDUs [12]. Of these, the majority are male. Women make up 35% of IDUs in Antananarivo, and only 10% in the other cities studied. But over 85% of these women in all cities were also sex workers, as opposed to between 30 and 40% of male IDUs. IDUs are also predominantly young. Between 13% and 23% are aged 15-19 and between 38% and 50% aged 20-24. The survey revealed high levels of risk-taking behaviour. The practice of needle sharing, and re-use is widespread. And only a minority of IDUs surveyed had correct knowledge about prevention and transmission of HIV. Thus, despite the relatively small number of IDUs, there is a need for further investigation as to their risks and vulnerabilities and the determinants which surround these.

Young prisoners

Prisons are overcrowded, and conditions are poor. Young prisoners are not always held in separate facilities but may be mixed in with adult prisoners. Harsh prison conditions are a source of disease and psychological distress for detainees. Prisoners have become ill through overcrowding, lack of hygiene and medical care and poor nutrition [13]. The current food allowance is acknowledged to be insufficient even by the ministry officials responsible for the prison service who have had to introduce an emergency programme to feed the most malnourished prisoners to prevent deaths in prison.[6] In fact, prisoners rely on food parcels from family and friends to survive and the poorest prisoners whose families cannot afford to bring extra food suffer. In 2018, Amnesty International reported that prisoners in Tsiafahy prison were living in an 'overcrowded hell'. This included lack of medical care. Prisoners with tuberculosis, for example, were locked in a separate room, and had to pay bribes to be able to go to see a doctor [13]. Unsafe same-sex sexual activity and the spread of STIs have been reported to occur in prisons. Prison nurses reported that transactional sex was common, with inmates swapping food for sex. This may be the only way for some prisoners to survive if their families cannot bring them extra food parcels.[7] UNAIDS reports that 7169 condoms were distributed in 2016 as part of an HIV prevention programme in prisons [14].

However, at the time of writing, the only NGO which had been intervening on SRH issues in prisons, was unable to continue its activities because of the termination of their funding. There is also reticence amongst the prison authorities to allow the distribution of condoms in prison as they believe that this will encourage sexual activity between the inmates.[8]

Conclusion

There is very little information about certain young key populations in Madagascar, but a social determinants of health framework allows us to understand the complex interplay of structural, systemic and proximal determinants that may lead to risk and vulnerability for these young people. The importance of socio-economic determinants and specifically the high levels of poverty in Madagascar cannot be overlooked but must also be understood as mediated by highly entrenched structures of gender inequality which impact on family, peer and community networks. Improving SRHR for young people in key populations thus calls for interventions not only at individual level but through policies which tackle these wider systemic and proximate determinants of health.

1 Groups of young people considered 'key populations' in the HIV response include sex workers, lesbians, gays, bisexuals, transgender and intersex people, people who inject drugs and prisoners
2 HEARD collaborates in this project with the United Nations Development Programme (UNDP) and African Men for Sexual Health and Rights (AMSHeR).
3 Interview UNAIDS, April 2018.
4 Interview ECPAT, April 2018.
5 Interview ASOFRAMA, July 2017.
6 Interview, April 2018.
7 Interview, April 2018.
8 Interviews, April 2018

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Further information:

Further details on this multi-country research project can be found on https://www.heard.org.za/research-post/linking-policy-to-programming-2/ and on https://www.africa.undp.org/content/rba/en/home/about-us/projects/linking-policy-to-programming.html

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