A critical examination of the barriers and social determinants of health impacting the implementation of a national sexual and reproductive health rights curriculum in Madagascar

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Abstract: Despite some international and national efforts in recent decades, Madagascar continues to make poor progress towards key sexual and reproductive health rights (SRHR) indicators. There are persistent cultural, social, political and economic barriers to accessing good quality SRHR knowledge and services globally, but particularly in regions with limited international geo-political influence, such as Madagascar. The political crisis in 2009 resulted in a stagnation and regression of SRHR services, due to the cessation of international funding, leaving youth-based services inadequate and insufficient. This paper aims to critically examine the social determinants and external factors that may influence and impact the roll-out of a national SRHR educational curriculum in Madagascar over the coming years. From the perspective of two SRHR specialists working in this context, this paper serves as a call for further action from the national and international community to address the still unmet SRHR needs of youth in Madagascar. DOI: 10.1080/09688080.2018.1555422

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Introducing SRHR education in a context with significant structural inequality and inadequate government structures

The 2009 coup d’état of Madagascar’s government caused the withdrawal of many multilateral and bilateral donors. Since then, Madagascar’s economic development has diminished dramatically. A shortage of goods and services combined with a significant reduction in tourism impacted the economy, resulting in social and economic regression and exacerbation of inequalities in the healthcare and education sectors.

Madagascar’s economic hardship has particularly affected youth-based services and SRHR education, which are often uncoordinated and poorly funded, especially in rural areas. As a result, risk factors associated with inadequate and unrealised SRHR are common across the country. In 2015, 184,000 pregnancies were unintended and it is estimated that only 58% of women have their contraceptive needs met. Cases of HIV have increased from 8,600 in 1997 to 35,000 in 2017. Preliminary research (unpublished) conducted by the authors’ organisation, a British non-government organisation (NGO) called SEED Madagascar, found that only 19% of students surveyed reported knowing how to use a condom correctly, with knowledge of STI and HIV transmission equally low in 12 southern schools.

Youth are at greater risk of exposure to risky sexual and reproductive health (SRH) behaviours and lack the appropriate guidance and education to make informed decisions regarding their SRHR. The Malagasy government has responded to the increasing needs of youth by committing to the provision of comprehensive SRHR education, youth-friendly services and greater access to SRH services. However, consideration of Madagascar’s unique context is essential in relation to a national SRHR curriculum. SEED has developed a comprehensive, rights-based SRH curriculum collaboratively with the Ministry of National Education.
SEED has observed that one of the most significant challenges is not simply normalising the biological events of puberty, but also sensitising communities to the gendered impact of early marriage and pregnancy and the wider implications these can have. Increasing engagement and sensitisation of actors – such as partner organisations, teachers and parents – at the community level to reinforce positive values and norms is essential for acceptance of SRHR messages. This may elevate the needs of youth and bring about the realisation of the urgent demand for modern contraceptive methods, STI testing and reporting systems for sexual violence.

Education
There are several key educational barriers to incorporating SRHR into a national curriculum. The MEN are currently undertaking a complete evaluation of the curriculum in general, including how SRHR fits within its current framework. At present, puberty, menstruation and traditional forms of contraception are taught informally. The collaboration between SEED and the MEN is the first nationwide, standardised SRHR framework in the educational system. However, a combination of stagnating school enrolment and high dropout rates continues to cause significant logistical problems in reaching all young people. In the southern regions, only 41% of 11–14-year-olds are in secondary education with fewer girls enrolled due to early marriage and care responsibilities. Geographical barriers are common with youth often walking long distances to access facilities. A large proportion of youth out-school means those who are arguably the most vulnerable miss out on school-based agendas. The increase in community-hired teachers, many of whom are unpaid, means that the SRHR curriculum will be delivered by teachers who potentially lack the qualifications and/or motivation to incorporate a time-consuming and culturally sensitive curriculum into their timetable. SEED has attempted to mitigate the influence of teacher opinions or incorrect interpretation of the curriculum by assisting the MEN in teacher training and feedback sessions in pilot schools. The Ministry of Health (MOH) are also collaborating with smaller NGOs to potentially reach out-of-school youth with peer educators and community-based clubs. In the long-term, weak educational frameworks and lack of departmental coordination remain significant barriers to ensuring a comprehensive SRHR education is received by all young people in Madagascar. This may
only be achieved through an increase in resources and an enforced centralised approach to SRHR.

Health and healthcare
Malagasy healthcare expenditure is one of the lowest in the world with only US$21 spent per capita annually\(^1,2\). The public health sector is mainly financed externally by bilateral and multilateral organisations, limiting the Malagasy government’s overall control over budget allocation or centralised policy planning to address key indicators. Responding to annual epidemics of bubonic and pneumonic plague, regular outbreaks of cholera and droughts, with subsequent malnutrition, have limited the prioritisation of SRHR on the national healthcare agenda. This makes accessing even basic SRH services extremely difficult and problematic when referring to essential services in a national curriculum. In an attempt to meet the needs of youth, the government has committed to a global partnership, Family Planning 2020, supporting the reproductive rights and freedoms of Malagasy women\(^4\). This will be especially important in the southern regions where the levels of STIs are 1.1%, higher than the national average of 0.3%, and fertility rates average 7–10 children in rural areas\(^3\). While male and female condoms are generally accessible in urban areas, the pill and long-acting reversible contraception methods, such as the intrauterine device or implant, are not consistently available and healthcare workers are not trained in implantation. In some rural areas, where there is reliance on community health workers, deficit infrastructure and supply chain challenges make access to even male condoms extremely limited and sometimes non-existent. The impact of conservative values, especially for female youth, makes confidentiality in remote areas very difficult and limits youth-friendly services. This dearth of resources is a colossal limitation to young people seeking to practice healthier SRHR behaviours, and while they can actively advocate for improvements to services, a large-scale injection of finance into the health system and a shift in budget allocation priorities are required. As such, the private and non-governmental sectors have played a vital role in improving the SRHR of youth in Madagascar by increasing access to services and disseminating important SRHR messages. The commitment to Family Planning 2020 will hopefully see a rise in availability and access to modern contraceptives, youth-directed services and youth-friendly training for healthcare workers who can reach rural areas and vulnerable sectors of Malagasy society.

Economic stability
The long-term economic stability of Madagascar is unknown. The country is currently the tenth poorest in the world, with over 70% of the population living below the poverty line of US$1.90 a day\(^1,2\). Natural resource extraction and traditional farming practices have contributed to the loss of habitat and agricultural land at an alarming rate, with gross profit failing to trickle-down to those most in need\(^3\). A donor orphan, receiving one of the lowest aid allocations globally\(^5\), the country continues to lack the basic financial security to ensure SRH services are provided to youth for the foreseeable future. The cycle of economic insecurity is bolstered by the social prominence of gender disparities and inequalities. Women’s economic participation is frequently impacted by the assignment of stereotypical gendered roles, i.e. as the carer and homemaker. Adequate SRHR education – which is founded on themes such as gender equality, early marriage, advocacy and unintended pregnancy – is imperative to boost sustainable economic growth. Empowering women through improved education is linked to decreased high-risk and early sexual practices, while comprehensive family planning reduces birth rates and improves birth spacing\(^2\). When women are provided with reproductive choices they are more likely to engage with informal and formal labour markets and thus contribute to the currently weak economy\(^7\). Alongside the personal empowerment realised through educational attainment and its associated opportunities, women would be better placed to contribute to Madagascar’s economy, whilst reducing burdens associated with the high population growth of 2.7%. Over 60% of the population is below the age of 25\(^1\) and without adequate SRHR education, youth will continue to practice risky behaviours leading to reduced educational attainment and limited future employment prospects. Without the financial, political or educational means, young people remain unable to advocate for their SRHR and poor SRH behaviours will self-perpetuate.

Macro-factors exacerbating the social determinants of health
Lack of coordination
While there are multiple organisations working in Madagascar to improve and advocate for the

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\(^1\) Grant, R, Shoham, T. Reproductive Health Matters 2018;26(52):62–66

\(^2\) MacArthur, K, et al. Social Science & Medicine 2009;69:1715–24

\(^3\) World Health Organization. Global Health Observatory Data Repository. Accessed on 10th July 2020. Available at: https://www.who.int/gho/data

\(^4\) Johns Hopkins University. Fact Sheet on Malagasy Women. 2019. Available at: https://www.jhu.edu/centers/jhics/international/centers/cepm/cepm-factsheet-on-malagasy-women

\(^5\) United Nations Children’s Fund. UNICEF Country State of the World’s Children Report 2020. Available at: https://www.unicef.org/reports/13552

\(^6\) World Health Organization. Global Health Observatory Data Repository. Accessed on 10th July 2020. Available at: https://www.who.int/gho/data
SRHR of young people, coordination and cross-communication is difficult between smaller regional organisations and large national and international NGOs. As a result, there are major gaps in SRH provision, knowledge dissemination and data collection, alongside probable duplication of focus. This reinforces the inability of young people to exercise their SRHR or potentially act upon information they obtain. For positive behaviour changes to be observed, stakeholders need to collaborate through open dialogue and form a coordinated approach to filling these gaps. Recognising this, SEED facilitated a national SRHR conference in January 2018 and created an online SRHR platform\(^6\) to share the SRHR curriculum which was developed in collaboration with the MEN. These activities sought to actively connect youth-focused organisations with the wider SRHR network, such as members from the existing Population Health Environment Network, in addition to the MEN, to provide an advocacy platform and an opportunity for their voices to be heard.

**International community influence**

Madagascar’s isolation as an island limits the opportunity for migration to mainland Africa and reduces external interest from the international community. The fallout of its social, political, and economic instability is unlikely to significantly spill over the borders to neighbouring countries, and, therefore, issues related to its epidemics or the SRHR of Malagasy youth are arguably not addressed with the same urgency as countries in sub-Saharan Africa. With Madagascar receiving significantly less funding in comparison to some neighbouring countries, – Madagascar only received US$112 million from USAID in 2017, in comparison to the regional average of US$235 million per country\(^5\) – the lack of interest from the international community reinforces the high risk of the many SRHR factors negatively plaguing the island. The deficiency of data which demonstrates the main SRHR trends in Madagascar creates an environment where key Malagasy SRHR actors lack the international incentive, pressure and support to promote and enforce a national SRHR curriculum.

**Lessons learnt and ways to move forward**

Through the process of advocating for a national SRHR curriculum, multiple areas relating to the social determinants of health need to be addressed. This will lead to the realisation of the intended impact of the curriculum and safeguard the sustainability of the key messages and practices. To propel SRHR in Madagascar forward, social factors need to be considered, and investment in community engagement and shifting attitudes increased. Reinforcing positive SRHR values and norms at the local level is key to guaranteeing that all young people have access to appropriate knowledge and resources, regardless of school attendance, and that SRHR knowledge is disseminated in a receptive and nurturing environment.

The intersectionality of social determinants which affect the SRH of youth will not be fully addressed by a comprehensive SRHR curriculum alone. A coordinated approach with open dialogue is needed to bridge the gaps in services and information dissemination, alongside securing a strong partnership with the MEN and other SRHR actors.

Discussions with the MOH, which is currently creating an SRH curriculum for primary schools, have taken place. SEED is actively advocating for a rights-based and comprehensive approach to the Ministry’s forthcoming project. By collaborating with the Ministries of Education and Health, SEED can maximise project success and curriculum compliance, whilst also providing a voice to call for change for those affected by structural, social and economic inequalities. The change in national policy to incorporate a rights-based approach to SRH education is the start of a country-wide movement to support and encourage young people to advocate for their SRHR and improve corresponding SRH services. Through SEED’s collaboration with the MEN, a robust SRHR curriculum has been established and a firm two-year strategy outlined.

This paper examines the barriers to achieving a national SRHR curriculum and improving the SRHR of youth in Madagascar. Its objective is to raise the profile of the neglected SRHR of Malagasy youth and act as a call for action, directed to the international community, to engage with and bolster the Malagasy government’s efforts in addressing the needs of their youth population.

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References

1. Central Intelligence Agency. “The world fact book: Madagascar,” [Online]; 2018 [cited 2018 April]. Available from https://www.cia.gov/library/publications/the-world-factbook/geos/print_ma.html
2. The World Bank. Madagascar: 2014 public expenditure review. Education and health. Washington (DC): World Bank, US; 2014.
3. Healy T. The deep south. Washington (DC): World Bank Group; 2018.
4. Madagascar FP2020 Core Indicator Summary Sheet; 2015. Available from:https://tacpdf.com/madagascar-family-planning-2020.html
5. USAID. “U.S. foreign aid by country: Madagascar” [Online]; 2017 [cited 2018 Aug 31]. Available from https://explorer.usaid.gov/cd/MDG?fi
6. SRHR actors for increased development of young people. Available from https://safidy.org/

Résumé

En dépit de quelques efforts nationaux et internationaux ces dernières décennies, Madagascar continue d’accomplir peu de progrès sur les indicateurs de santé et droits sexuels et reproductifs (SDSR). Des obstacles culturels, sociaux, politiques et économiques persistants s’opposent à l’accès à des connaissances et des services de SDSR de bonne qualité partout dans le monde, mais plus précisément dans les régions ayant une influence géopolitique internationale limitée, comme Madagascar. La crise politique de 2009 a abouti à une stagnation et une régression des services de SDSR, du fait de la cessation du financement international, ce qui a causé l’inadaptation et l’insuffisance des services axés sur les jeunes. Cet article souhaite examiner de manière critique les déterminants sociaux et facteurs externes qui peuvent influencer et affecter le déploiement d’un programme éducatif sur la santé et les droits sexuels et reproductifs à Madagascar ces prochaines années. Dans la perspective de deux spécialistes de SDSR qui travaillent dans ce contexte, l’article lance un nouvel appel à l’action de la communauté nationale et internationale pour répondre aux besoins encore insatisfaits de SDSR des jeunes à Madagascar.

Resumen

Pese a algunos esfuerzos internacionales y nacionales en las últimas décadas, Madagascar continúa haciendo pocos progresos para cumplir con los indicadores clave de salud y derechos sexuales y reproductivos (SDSR). Existen persistentes barreras culturales, sociales, políticas y económicas para acceder a conocimientos y servicios de SDSR de buena calidad a nivel mundial, pero en particular en regiones con limitada influencia geopolítica internacional, como Madagascar. La crisis política en 2009 produjo estancamiento y retroceso de los servicios de SDSR, debido al cese de financiamiento internacional, lo cual causó que los servicios dirigidos a jóvenes fueran inadecuados e insuficientes. Este artículo procura examinar críticamente los determinantes sociales y factores externos que podrían afectar e impactar el lanzamiento de un currículo educativo nacional de SDSR en Madagascar en los próximos años. Desde la perspectiva de dos especialistas en SDSR que trabajan en este contexto, este artículo sirve como un llamado a que las comunidades nacional e internacional continúen adoptando medidas para abordar las necesidades aún insatisfechas de SDSR de las personas jóvenes en Madagascar.