MADAGASCAR

Baseline report on young key populations and sexual and reproductive health and rights
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EXECUTIVE SUMMARY

- The key determinant of sexual and reproductive health for young people in Madagascar is economic. The political and economic crisis affecting the country has major impacts on SRH (as well as health status more generally) in a variety of ways, influencing both individual situations and opportunities, as well as the health services available to young people.

- Increasing poverty and high youth unemployment or underemployment is pushing young people into transactional sex for survival. The numbers of young people engaged in transactional sex in various forms are estimated to be increasing rapidly although there are no accurate statistics due to the informal or hidden nature of most of this sex work.

- Economic determinants interact with highly unequal gender norms and traditional customs to make young women particularly vulnerable. Heterosexual sexual relations are highly valued by both family and peer groups, with young people being encouraged to begin sexual relations at an early age, and multiple sexual partners being a valued goal for young men. Families often encourage their daughters to engage in some kind of transactional sex to become financially independent and contribute to the household finances.

- The very young age of sexual debut for young women, combined with unmet contraceptive needs results in high rates of unwanted pregnancy, often at a very early age (one study reported frequency of pregnancy amongst 12-year olds). The legal context which criminalises all forms of abortion, leads to widespread use of clandestine methods for terminating pregnancies. There are high rates of death amongst young women due to the complication of clandestine abortions.

- The health system in Madagascar is underfunded and insufficient to meet needs of young people (as well as the population more generally). Many young people still live in rural areas, far away from health service providers. Lack of funding has led to shortages in essential medicines such as ARVs, and also reagents for HIV testing. There is also a lack of condoms which contributes to the low rates of condom use among young people. There are very few specialised or “youth friendly” health services.

- Homosexuality is not criminalised in Madagascar, but there is continuing stigma and discrimination against LGBTI people because of the strong gender norms which value heterosexual relationships. Discrimination is particularly strong outside of Antananarivo. Whilst MSM are a recognised category, there is no recognition or discussion of other groups of LGBTI. There are very few dedicated health services for MSM and all of these are located in Antananarivo.

- Young prisoners are vulnerable in terms of SRH because of overcrowding and poor conditions in prisons e.g. lack of food. There is evidence of frequent transactional sex in prisons, but programmes such as distribution of condoms are discouraged by prison authorities as these are seen to encourage homosexual relations between prisoners.
• Very little is known about IDUs. Drug use is criminalised and so many IDUs prefer to stay hidden. But it seems that there is a large crossover between IDU and MSM groups. There are no programmes of needle exchange or other programmes dedicated to SRH of IDUs in Madagascar.

• Rates of HIV prevalence are estimated to be low in Madagascar in comparison with other countries in the region. However, there are fears that prevalence rates are actually higher than estimated given the negative determinants of SRH which exist. Further only 3% of the population has been tested for HIV.

Possible research questions to consider, given the baseline findings:

• What is “key” about key populations in Madagascar? How should key populations be defined in the context where economic determinants/poverty increase vulnerability for all young people, and especially young women?
• How can these key populations be best defined to ensure that policies target the most vulnerable in society in terms of improving SRH?
• How do young people define sex work in a context of generalised transactional sexual relations? What are the shared risks between all of those young people involved in transactional forms of sex? What are their perceptions of risk and vulnerability?
• In a context of generalised poverty and economic crisis, how can policies be better targeted to improve the SRH of young people involved in transactional sex, and in particular in forms of hidden/informal transactional sex?
• How do young people define their sexual orientation and gender identities in a context with strongly entrenched gender norms which favour heterosexuality? And how does this correspond to global definitions of LGBTI identities and rights? Who are the young LGBTI other than male homosexuals and how might their needs be better taken into account in providing SRH services for young people?
• In a context of limited economic resources, scarcity of health services and medicines, what would be the most effective policy interventions to improve SRH of young people?
• How could interventions at the level of peer groups/community networks or family be utilised to modify the proximal determinants of SRHR for young people?
INTRODUCTION

In looking at the SRHR of young people who are members of “key populations” in Madagascar, there is a need to analyse interactions between larger structural and systemic determinants of SRHR, intermediate determinants related to family, community and peer organisations, and micro individual and behavioural level determinants. This interaction will be mediated by factors related to social constructions of gender identity and sexual orientation. There is thus a complex interplay of factors which shape risks and vulnerability, with intersecting social, physical, economic and policy factors at both macro and micro levels.

Global research has shown that the strongest determinants of adolescent health in general are structural factors such as national wealth, income inequality, and access to education (Viner et al., 2012). In the case of Madagascar, the highly degraded economic situation in the country can be seen as a key determinant factor in health outcomes for all of the population, both through the government’s inability to fund key public services including health services, and through the effects of poverty and economic inequality which restrain people’s health seeking choices and may force them into risky and dangerous behaviours. For young people, this interacts with determinants such as highly unequal gender norms, family structures and peer group relationships to produce particular situations of risk and vulnerability.

Although there are not yet sufficient data on the SRHR of young key populations in Madagascar, it might be argued from the available evidence that the particular configurations of social determinants of health in the country render specific groups, eg young women, acutely vulnerable in terms of negative health outcomes, and limited access to sexual and reproductive rights. The importance of the socio-economic determinants in conjunction with the strong social hierarchies and power inequalities created by deeply anchored gender norms, may limit the impacts of any individual or community level interventions on SRHR, and point to the need for wider structural change in order to effect real positive changes in SRHR for young people and particularly those who are members of key populations.

BASELINE FINDINGS

Socio-economic and Political Determinants

The economic and political situation in Madagascar, marked by political instability and crisis and widespread poverty, provide a structural context which has generally negative impacts on the health of the population. Public services, including health and education, lack funding and are often reliant on external donors for funding for essential services.

1 The definition of who exactly belongs to these key populations will be discussed further in this paper.
Poverty affects a significant proportion of the population and is particularly marked in rural areas of Madagascar where 78% of the population live. According to World Bank estimates, levels of poverty in rural areas are twice those in urban areas. Recent estimates indicate that 90% of the population live on less than $2 per day (Burke et al., 2017), and that extreme poverty impacts 56.5% of the population (IMF, 2017). The context of poverty creates specific health risks for young people, who constitute a majority of the Malagasy population. The impact of economic determinants of health is evident for example in rates of adolescent pregnancy which are four times higher for girls in the poorest quintile of the population than for those in the richest quintile.

Recent statistics suggest that 46% of the population are under the age of 25 years old (UNFPA, 2014). These young people face problems of poverty and of unemployment, as a World Bank Report states, poverty in Madagascar has a ‘predominantly young face’ (World Bank, 2014). 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 (ILO, 2014). Lack of formal employment means that many young people are pushed into informal sectors, principally in agriculture (ILO, 2014) but also in small business, domestic work or transactional sex work. The latest figures suggest that 69% of young people are involved in informal employment and 55% in domestic employment (mainly young women) (ILO, 2017). Many of the key informants interviewed mentioned the rapidly growing numbers of young women (and increasingly also young men) involved in transactional sex, and attributed this primarily to the worsening economic situation in the country. A qualitative study carried out by PSI which explored the reasons that young women become involved in sex work, 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 (PSI, 2018).

Extreme poverty is clearly a factor of vulnerability for young people who are members of key populations. Data from the 2011 EDS Survey shows that 53,1% of MSM and 54,1% of IDU had monthly incomes of less than 100 000 ariary (46$). The same survey also showed that 99.7% of MSM had received money for sex from at least one partner in the previous month.

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 who are worried about their legal responsibilities and the consequences of treating minors without parental consent. This is a problem for young people who wish to access SRH services without their parents’ knowledge because of fear of rejection or punishment by their families.

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2 World Bank, 2015.
3 ENSOMD 2012-2013 INSTAT.
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 which is an advance in this area. 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. Currently only 3% of the population have been tested for HIV.

Abortion is illegal in Madagascar and penalties for practicing abortions are high. According to the law any person caught performing or attempting to perform an abortion is subject to penalties such as imprisonment or a fine. Medical and paramedical personnel are subject to suspension from the practice of their profession for a minimum of five years up to life. The Penal Code contains no expressed exceptions to the general prohibition of abortion (even for women who have been raped), and a recent revision has reinforced the criminalisation of abortion for therapeutic reasons. A national stakeholder’s consultation on the decriminalization of abortion was initiated jointly by the Ministry of justice and the Ministry of health in 2007 with the support of some UN agencies. It resulted in a national debate, which incited strong opposition from the churches. Finally, the consultation was stopped and all attempts to launch a reform bill to decriminalize abortion were halted. The legal prohibition of abortion means that 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 (Focus Development, 2007).

There is no law prohibiting same sex sexual activity for people over the age of 21. However, homosexuals can be prosecuted for acts that are “indecent or against nature with an individual of the same sex under the age of 21” and LGBTI people can be at risk of prosecution for corruption of a minor for sexual activity with someone 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 people from discrimination.

Sex work is not criminalised and registration processes exist for sex workers, and those who are registered are required to carry a health card and have regular health visits, but this involves only a very small minority of the estimated total of sex workers (Kruse et al., 2003). Sex worker 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 they are over the age of 18. There is a legal framework against sex tourism and child sexual exploitation (law of 2007) and National Action Plan.

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4 Interview UNAIDS, April 2018.
But these are rarely applied and in practice “it has become normal to see children involved in prostitution” (Rakotomamonjy, 2014). 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.5

There is a legal framework preventing discrimination against PLVIH in Madagascar which should work towards eliminating discrimination and stigmatisation. 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 VIH and their families. However, evidence shows that discrimination persists, and provides a barrier to access to services.

Education

Education levels remain low for the majority of young people, with girls and young women in particular often failing to finish secondary education. Less than 10% of school aged young people were enrolled in secondary education in 2010 (World Bank, 2014). The recent crises have led to a decrease in school enrolment amongst 6 to 14 year olds, declining from 77% in 2005 to 69% in 20126. Enrolment rates are much lower in rural than in urban areas. Difference in enrolment according to geographical situation and the socio-economic situation of parents suggest that there is high inequality in access to education. Primary reasons for dropping out of education are lack of money to pay for school, pressure to help with household work, and for girls and young women, becoming pregnant (Herrera et al., 2015). Young women who leave education early have few options for employment outside of the informal sectors of small business, domestic work, or transactional sex work. Further research shows that young women who become mothers whilst they are under eighteen are far more likely to be working in low-quality informal jobs (Herrera et al., 2016). There is thus a vicious circle which forms between poverty, lack of education, teenage pregnancy and low-quality employment.

Health System

Madagascar’s annual per capita spending on health (14$) is one of the lowest in the world (Bonds et al., 2018). Health services in Madagascar suffer from a lack of resources, and limited capacities. Public health centres provide many services, including sexual and reproductive health services, but for much of the population access to these services remains limited. A major barrier is the cost of health services, although the Government is attempting to increase health coverage by instituting an insurance based service to reduce or remove point of service charges (Garchitorena, A. et al, 2017).

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5 Interview ECPAT, April 2018.
6 Annuaires statistiques de l’éducation.
However, even where charges are removed or reduced many people still do not access health services because they live too far away from the nearest health centre – most of the population lives more than 5km from the nearest health facility. Currently, health efforts are largely fragmented, and aid has been directed to individual health centres and hospitals or to local NGOs rather than to, and through, the Ministry of Health. This has led to the development of a small private health sector that is supported by local NGOs and faith-based organizations, as well as private for-profit health centres (Marks et al., 2016). Recent research estimates that only 60%–70% of Madagascar’s inhabitants have access to any form of primary healthcare, with only 32% of the poorest quintile having access to primary care (World Bank, 2014). Travel distances of over 10 km to the nearest health facility are not uncommon (Marks et al., 2016). Rural populations are clearly worst off in this respect.

Some types of medicines should be provided free of charge including contraception, testing for HIV and other STIs, and ARVs. However, there have been major problems of lack of supply. Interviewees at the Ministry of Health, for example, pointed to a rupture in the stock of reagents for carrying out HIV tests, and there is also a major shortage of condoms which means that distribution which should be free in all health centres is in fact limited. Ruptures in stocks of ARVs have also occurred. A nurse working in the main prison in Antananarivo noted that there had been no ARVs to treat HIV positive inmates from October 2017 to April 2018. Faced with the penury of stocks of HIV tests and of ARVs, health services have chosen to prioritise pregnant women for testing, and have focused on MTCT as the major activity for HIV prevention efforts.

This context of lack of access to the health system, low quality of health care available and lack of stocks of vital medicines, is clearly an important determinant of young people’s negative health outcomes generally, and of their SRHR. For young women, one issue that is particularly relevant is the lack of access to contraceptives, with a continuing unmet need (SADC, 2012). The latest DHS found that only 32.5% of young women aged 15-24 declared using a contraceptive method even if more than 90% of them affirmed knowing about family planning methods (ANAPV, 2014).

Even where health services are available and accessible in terms of geographical distance, there is evidence that young people choose not to consult for sexual and reproductive health services because of fear of the prejudices and judgement of health professionals. They believe that in asking for contraception or for treatment for STIs for example, they will be judged as sexually promiscuous.

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7 Interview, April 2018.
8 Interview, April 2018.
9 Interview UNAIDS, April 2018.
10 Interview ECPAT, April 2018.
The Ministry of Health has attempted to create a network of youth friendly health centres, but an interviewee at the Ministry admitted that this network which currently comprises 95 health centres (of the 2600 total in the country) is not really functional and needs “renewing” because many of the medical staff who were initially trained have either retired or moved. The Ministry is currently seeking funding to train more medical staff for youth friendly services.\textsuperscript{11} The Ministry of Youth and Sport is working in partnership with the Ministry of Health to establish Youth Centres and Spaces across the country which can inform young people on issues including SRHR, and can refer them to health centres when needed. There is still not sufficient funding for establishing these Youth Centres in all areas of the country, and where they do exist, they are frequented by a majority of young men. Young women do not come because they are busy with household tasks, or because they feel ashamed to come and consult these services.\textsuperscript{12}

Young people generally thus fail to consult for SRH issues, but access to health services may be even more complicated for key populations because of the added stigma and discrimination they face because of their sexual orientation, gender identity, or perceived sexual practices. A representative of ASOFRAMA an organisation working with people from key populations recounted that at health centres they are told that they are to blame for their illnesses.\textsuperscript{13} The problems may be even worse for young people from these key populations as they are denial about their health risks and are ashamed to go to health centres or clinics.\textsuperscript{14} There are currently only six health centres which have staff who have been trained to deal with SRH issues of MSM, and all of these are located in Antananarivo.\textsuperscript{15}

Access to health services for young people living with HIV is more developed in Antananarivo than in other regions of the country where there may be no available services. Lack of money to pay for medicine is also a problem as even though charges are minimal, they are still beyond the means of many, especially young people who do not have any income. A study on discrimination against people living with HIV in hospitals showed that 36% felt they had experienced discrimination, including being refused hospital treatment because doctors felt that they posed a risk of infection to other patients and to medical staff. Only 53% of health care staff correctly answered questions on modes of HIV transmission (Andrianasolo et al., 2010). The study reported that older age and higher levels of education were likely to reduce the discrimination experienced, suggesting that young people living with HIV, and especially those with a low education level, are likely to be the most discriminated against.

\textsuperscript{11} Interview, April 2018.
\textsuperscript{12} Interview Ministry of Youth and Sport, April 2018.
\textsuperscript{13} Interview ASOFRAMA, July 2017.
\textsuperscript{14} Interview ASOFRAMA, July 2017.
\textsuperscript{15} Interview UNAIDS, April 2017.
In the absence of high quality and accessible health services, many Madagascans still turn to traditional healers and other forms of alternative medicine. This is also the case for members of key populations. Key informants mentioned that members of key populations do not want to use conventional medicine but would prefer to use traditional medicine and marabout healers. In Mahjunga, for example, there are relatively high rates of HIV infection amongst MSM, but many of these are not taking ART because they prefer to be healed by Marabout. Sometimes MSM believe that they are “possessed” by a spirit of their ancestors and will thus take part in traditional spiritual and healing ceremonies rather than consult doctors. These ceremonies may also be sites of transmission of infection as it is reported that they are the occasion for Women may also refuse to use modern methods of contraception because they believe that this is harmful and again prefer to resort to traditional healers and methods.

The lack of accessible and affordable health care must be regarded as a key negative determinant on the health of young people in Madagascar, and any policies that aim to improve SRH for young key populations thus need imperatively to take this into account. Even before considering specific policies or programmes targeted at HIV or at YKPs, there is an unmet need for basic healthcare provision for all young people.

Structures of Gender Inequality

Research has shown the persistence of traditional attitudes and norms towards gender and sexuality in Madagascar which in conjunction with the existing socio-economic and political systems, create a context within which young women have little control over their sexuality or reproductive health and rights. Similarly, traditional gender norms impact on the SRHR and the general health and wellbeing of persons belonging to gender or sexual minorities.

There are strong norms concerning sexual relations which constrain the sexual behaviour of young people and may create risks for their SRH. 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. Late entry into sexual activity (over 15 years old for a girl or over 18 for a boy) is severely discouraged and there are widespread beliefs that this might lead to mental illness or sterility. As one report explains, there is a strong peer pressure for adolescents to engage in sexual relations which will “initiate” them into their peer group (Focus Development, 2012). 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. Pressure to start heterosexual relations early mean that early marriage and pregnancy is common in Madagascar and is legitimised by various local and traditional norms and practices (Ravazoazanany et al., 2012).

16 Interview ASOFRAMA, July 2017.
UNICEF found that 12% of girls are married before the age of 15, and 41% before the age of 18 (UNICEF, 2014). 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). There is also peer pressure not to use condoms during sex. Young people tend to associate use of condoms with prevention of HIV and thus do not wish to use condoms for fear of stigmatisation by their peers (Gastineau and Hanitrianaina, 2008).

Prevailing norms relating to sexual relations also encourage relations in which the male partner is older than the female partner. Often adolescent girls or young women enter into sexual relations with men one or two generations older than them. Early sexual debut for girls is linked to gendered norms which judge that women should be younger than men in a sexual relationship, and which allow older men to gain prestige from the youth and virginity of their female sexual partner. Older men can gain prestige from having a younger sexual partner, particularly if she is still a school girl (Focus Development, 2012). Multiple sexual partnerships are encouraged, although for different reasons for young women and young men. Girls and young women engage in multiple sexual relations in search 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. These transactional sexual relations are not viewed as sex work by either the girls or the men involved (Ravazoazany et al, 2012).

Traditional gender norms which encourage heterosexual relations create a complicated situation for young people who with different gender identities or sexual orientation. Even though homosexuality is not illegal, there is strong heteronormative pressure in society (CNLS, 2013). Young LGBTI people may thus prefer not to reveal their sexual orientation or gender identity for fear of discrimination and stigmatisation. 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 the family. There are also reported cases of LGBTI people being harassed or beaten up in the street (Moueimne, 2013). Some sources indicate that there is a belief in Madagascar that homosexuality “does not exist” (Human Rights Report, 2010) which may lead many young people to repress their sexual orientation and/or gender identity. When it is acknowledged, homosexuality is often associated with transvestitism and transgender identity, as the most visible homosexuals – mainly in Antananarivo – are transvestites or transgender (although the term of transgender is not used even by groups working with LGBTI and MSM), who are also frequently involved in sex work.

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17 Interview ASOFRAMA, July 2017.
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 (ENSOMD 2012-2013). The government has adopted a National Strategy and Action Plan against Gender-based Violence (20117-2021) but there is as yet no evidence of how this might be effective in combating violence against girls and women, including sex workers. There is so far, no research or government policy on prevention of violence against LGBTI people.

Family

Family relations and networks have been shown to be an important proximal determinant of health for young people globally, but may be complicated for many young people in Madagascar, and particularly for young women. The economic context of poverty described above means that adolescent girls and young women (and to a lesser extent boys) can be viewed as sources of income for their families. Girls may be taken out of school early to save money for the family and encouraged to work or to engage in transactional sex to earn money for the family. In some communities, it is widely accepted that a family will provide a separate room or hut for their daughters as soon as they reach puberty so that they can engage in transactional sexual relations with visiting men and support themselves economically. Transactional sexual relations with foreigners are particularly valued because of the high prices that they pay. Interviewees described the fact that in some regions, particularly in the North of Madagascar, it is viewed as a source of pride by families if their daughters manage to find a foreign man for sexual relations, and they will encourage the girls to register on internet sites to “meet” foreigners. This is not viewed as sex work, and he girls concerned will not identify themselves as sex workers.

Economic determinants intersect with traditional norms that favour transactional sex for young girls, such as “Moletry” which involves parents marrying their very young daughters in exchange for money or oxen, or “Sakafom-bahiny” where girls are given to foreigners or strangers for a night as a “welcome present” (Rakatomamonjy, 2014). In some communities, parents arrange a marriage for their daughters at birth in return for oxen, and the girl is then sent to the husband’s house from the age of seven (although this can be negotiated so that the girl stays at home until she is 12). In some rural areas, the traditional practice of “Tsenan’ampela” (girl markets) continues. From the age of 13, girls go to cattle markets, where they try to attract cattle owners and negotiate a price for a “marriage,” which can last for a night or the duration of the market (from Friday to Monday. They are generally paid around $3 per night, and return home after the market.
As confirmed by the UN special rapporteur on modern forms of slavery during her mission to the country in 2012, early forced marriage remained a concern in many communities, where parents forced girls as young as 10 to marry. She noted that victims of such arrangements were also likely to be victims of domestic servitude and sexual slavery.

Fragile family contexts are also an important determinant in the negative health of young people who with minority sexual orientations or gender identities, who may be forced to leave their families because of negative views and rejection. ECPAT reports that the majority of boys involved in sex work are vulnerable because of their fragile family context. Whilst for girls the major driver of involvement in sex work is economic, for these boys, economic necessity is only a smaller part of a wider picture of family rejection and a subsequent exodus from their family homes.  

*Peer Influence*

Along with the family, the influence of peer groups is a major determinant of health for young people. As noted above, there is strong peer pressure on young people to engage in sexual activity. A recent study by Médecins du Monde on unwanted pregnancy amongst young women in Antananarivo found that adolescent boys experience strong peer pressure to have sexual relations with girls, as one 15-year-old explained, ‘If you haven’t had sex yet then the others will say that you’re like a girl, you’re not a man’ (Médecins du Monde, 2018). The study also found that the major sources of information on sex for adolescents were their peers and pornography. Girls and boys talked about going to watch pornographic films to find out about sex, and to copying the sexual behaviours they saw in the films (Médecins du Monde, 2018).

*The sexual and reproductive health of young key populations*

One of the complications of studying young key populations is the difficulty in defining who are these key populations with a complex economy of transactional sex institutionalised within the economy and also legitimised by strong gender norms relating to sexuality and sexual relations. This means that the category of sex workers is very difficult to establish as it conflates with a wider population of young women, many of whom are engaged in some form of transactional or forced sexual activity. Young MSM are also difficult to define and describe as a group with a large degree of fluidity in sexual orientation and gender identities present. There is a significant cross-over amongst the different groups of young key population, with many MSM being involved in sex work, and also IDU.

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18 Interview, April 2018.
The proportion of male IDU who have sex with men is estimated at 25.2% (CNLS, 2013), whilst Madaids reported that all of the IDU whom they work with are MSM. The levels of risk and vulnerability of nearly all young people, and particularly young women, also points to a need to expand understandings of key populations beyond narrowly defined population groups, and to look at the complex pathways to vulnerability of young people more generally. It is also important to consider the range of SRH issues faced by young people, and to move beyond a narrower focus on HIV. Although HIV is clearly a concern in Madagascar, the prevalence rates continue to be relatively low. Other SRH issues such as early and unwanted pregnancy or clandestine abortion should also be priorities when considering the health risks of young people. Both the generalised vulnerabilities of young people and the multiple nature of the key SRH risks, point to a need to widen the discussions and focuses of interventions for key populations.

The bulk of the research and literature on key populations in Madagascar concerns sex workers, there is far less research on LGBTI people or on IDUs or prisoners. Although there is more research on sex workers, there are still large gaps, particularly with relation to the “hidden” sex work that exists in the country, and on the links between various forms of transactional sex which take place, with many of those who engaging in transactional sex, not self-identifying as sex workers and not being reachable through the established sex worker networks or geographical locations. LGBTI groups are generally subsumed under the category of MSM, and there is no research on transgender or lesbian young people, for example. Similarly, there is very little information on young IDUs or prisoners, although as mentioned above, the categories of IDUs and MSM seem to overlap to a great extent.

Existing data seem to point to a degradation in SRH status and outcomes for young people over the past decade. This decline in health evidenced by a rise in infection with HIV and other STIs, unwanted pregnancies and clandestine abortion, was also signalled by various key informants. This deterioration is indicated in the figure on the next page, which shows that the proportion of boys and girls having their first sexual relationship before the age of 15 increased from 29% to 36% for boys and 37.5% to 41% for girls between 2008 and 2012. The proportion reporting having at least one STI in the previous twelve months also increased, whilst condom use declined.

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19 Interview, April 2018.
In contrast to the other countries studied in this project, there is a low HIV prevalence in Madagascar with only 0.4% HIV prevalence amongst the general population of adults aged 15-49 (Spectrum Madagascar, 2015). A third (33.5%) of women and 28.6% of men living with HIV are under the age of 25 (CNLS, 2016) but this is not particularly significant considering the age distribution of the general population. There are however higher HIV prevalence rates amongst MSM (14.8%) and IDU (7.1%), and SW (5.5%) (CNLS, 2016). There are no prevalence data for prisoners as most have not been tested. And some caution should be exercised regarding these HIV prevalence figures, as there is some doubt as to whether they are accurate., particularly those relating to sex workers. Prevalence figures are only an estimation (Blanchon, 2015), and key informants suggested that prevalence may be higher than that is reported in official figures.20 Because prevalence is low, and the risks of HIV are not believed to be great, and because of the stigma attached to testing, 97% of the Madagascan population has never been tested for HIV.

A major SRH issue in Madagascar is early and unwanted pregnancy. The most recent ENSOMD survey revealed that 37% of young women between the ages of 15 and 19 years old had already had at least one child. 76% of young women had never used any contraception, and only 13.7% had used a modern contraceptive method.21 As abortion is illegal, young women resort to clandestine abortion using drugs purchased from private suppliers or traditional “herbal” medicines. The use of these methods results in a high mortality rate for adolescents. Of the ten women who die from pregnancy related causes each day in Madagascar, three are adolescent girls (UNFPA, 2012).

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21 ENSOMD 2012-2013 INSTAT
Female 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 sex work and 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 (CNLS, 2013) but this figure includes only those 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 (CNLS, 2017). Many of these sex workers are young. 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. In the city of Toamasina, 71% of young sex workers surveyed had their first sexual relationship before the age of 15 (CNLS, 2017). 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 (CNLS, 2017). Sex workers surveyed were also revealed to have high levels of syphilis and other STIs (CNLS, 2017).

Cole (2004) describes a complex economy of transactional sex which also has an institutionalised dimension with a large marriage market via the internet whereby Madagascan women seek to meet and marry foreign men. Participation in the sexual economy can lead to upward social mobility, but also to downward mobility, stigmatisation, and risk of HIV and other STIs. Transactional sex for young women is also mixed up with family dynamics with parents sometimes encouraging their daughters to engage in transactional sexual relations with rich and/or foreign men to help to support the family economy as noted above. Various key informants suggested that in some areas families will provide a separate house for their daughters when they reach puberty so that they will be able to pursue these transactional sexual relationships as freely as possible.

In a study of sex work in Antananarivo (Stobenau et al., 2009), sex workers described distinctions between low, middle and high forms of sex work, with the distinction being based on location, price per client, and women’s ethnic and racial identity. Women identified with the lower forms of sex work tended to be considered as « black » whilst women in the other two categories were considered as « white » or « côtier »). The «high » category of sex workers was used to describe those who worked in establishments frequented by tourists, and women described what they did as « looking for foreign husbands ». Whilst women in the middle and lower categories worked on the streets in either the city centre or in poor neighbourhoods and described their work as « looking for money ». Partnership categories between paying and non-paying partners are not always distinct. Women may not always distinguish between clients and regular partners and this relationship fluidity can increase women’s health vulnerabilities (Stobenau et al, 2009).
In Antananarivo, sex work provides some women with earnings which far exceed what they could expect to earn in either the formal or informal economies (Stobenau et al., 2009). At the same time, in general sex work is highly stigmatized and sex workers are marginalized (Stobenau et al., 2009).

The complexities of sex work and continuum of various forms of transactional sexual relationships in Madagascar mean that different types of capital, social, and symbolic, as well as economic, need to be taken into account in thinking about risks and vulnerabilities for sex workers. Also, many of the young women (and to an extent young men) 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 status and 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 (ECPAT, 2014). 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 (Blanchon, 2015). 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.

Men who have sex with men

As mentioned above, homosexuality is not criminalised in Madagascar, but the age of consent is higher than that for heterosexual relationships, and LGBTI people may also face discrimination and stigma. Discrimination may lead many LGBTI people to hide their status and so there are no reliable estimates of the size of the LGBTI population, and in particular transgender and lesbian populations are hidden. In fact, transgender identities are unrecognised, and even MSM groups and those working with them use the label transvestite rather than transgender to describe a man who dresses as a woman.

The estimated size of the MSM population is around 15,000 people, although again this estimate is probably far smaller than the real number of MSM in the country, many of whom remain hidden. HIV prevalence rates are estimated to be 14.8% for MSM, far higher than those of the general population. There is also estimated to be low knowledge of HIV status amongst MSM at only 19.3% and low condom use, with only 57.2% of MSM stating that they regularly used a condom (ESC 2014). 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 (PSI, 2018). This was true for young MSM as well as for older 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 (PSI, 2012). As mentioned above, 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.

There are some associations and groups working to advance the rights of MSM in Madagascar and there is a need for further research into the ways in which these association and networks could counterbalance the negative impacts of other determinants, and provide positive support for MSM in order to improve their health and wellbeing.

**Injecting drug users**

Injecting drug use is a relatively recent phenomenon in Madagascar, and one 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. This may be due to the low number of IDUs estimated, at around 2000 people for the whole country (Focus Development, 2012). The criminalisation of drug use deters users from identifying themselves, however, and so estimates of the numbers of IDUs are probably too low. 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 in Madagascar - Antananarivo, Toamasina et Antsiranana – estimated that there are approximately 1-2% of the adult population in each city who are IDUs (Focus Development, 2012). 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 which could impact negatively on the health of young IDUs. 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.

**Prisoners**

Madagascan prisons are overcrowded and conditions are poor. In 2013, it was reported that the country’s 82 prisons and detention centres had a capacity for 10,319 inmates but held 18,719, including 805 women, 465 boys, and 29 girls (Human Rights Report, 2013).
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. In a number of documented cases, prisoners have become ill through overcrowding, lack of hygiene and medical care and poor nutrition (Handicap International, 2012). The current food allowance of one portion of dry manioc per day per prisoner 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.\textsuperscript{22} 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. Food also becomes a currency of exchange in prisons, including in exchange for sexual relations. In 2018, Amnesty International reported that prisoners in Tsiafahy prison were living in an ‘overcrowded hell’ (Amnesty International, 2018). 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 (Amnesty International, 2018).

There is no available data on the HIV prevalence amongst prisoners, as there is no comprehensive testing system in place. A practice of offering prisoners extra food as an incentive to be tested has been questioned as unethical and has thus been discontinued in some prisons. Unsafe same-sex sexual activity and the spread of STIs have been reported to occur in prisons (Rights in Exile, 2018). Prison nurses reported that transactional sex was common, with inmates swapping food for sex. Given the lack of food rations in prisons, transactional sex may be the only way for some prisoners to survive if their families cannot bring them extra food parcels.\textsuperscript{23} UNAIDS reports that 7169 condoms were distributed in 2016 as part of an HIV prevention programme in prisons (UNAIDS, 2018). 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 from the Global Fund. 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.\textsuperscript{24}

\textsuperscript{22} Interview, April 2018.
\textsuperscript{23} Interview, April 2018.
\textsuperscript{24} Interviews, April 2018
CONCLUSIONS AND AREAS FOR FURTHER RESEARCH

There is very little information about certain young key populations in Madagascar, but the social determinants framework outlined above 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, as these socio-economic conditions have various direct and indirect impacts on health outcomes.

But these socio-economic determinants 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 which tackle these wider systemic and proximate determinants of health. Another question which merits exploration is that of the possible role of associations and networks of key populations in mobilising peer support and thus counteracting some of the negative determinants described above.

The generally low prevalence rates of HIV in Madagascar, coupled with the presence of some other very pressing SRHR issues such as forced and early marriage and pregnancy, lack of access to contraception and abortion, widespread transactional sexual relations which are often not classified as “sex work”, may lead to a questioning of who are the “key populations” in Madagascar, and whether it may be pertinent to widen the categorisation to include young women more generally. Having said this, there is clearly a need for more research and data on some key populations, and particularly on some of those which have remained more invisible in previous research such as transgender individuals, IDUs or prisoners.

Finally, a question remains as to levels of funding and resources for different interventions aimed at improving the SRHR of young people. In a context of poverty and very limited resources for the health care system, the granting of increased funding and investment in the prevention of HIV and treatment for people living with HIV in Madagascar has caused a polemic with strong arguments from some sides that it is wrong to spend so much money on such a small fraction of the population when there are other health care priorities that have not received funding (Ranjalahy et al., 2011). The HIV response has so far been largely independent of and separated from other SRHR interventions (and indeed out of the control of the Ministry of Health). So it could be interesting to explore how these resources might be better targeted at more integrated services that would benefit the health of all young people in Madagascar.
Indicators that exist suggest a decline in the SRH of young people in Madagascar in the last ten years or so, despite various interventions and external donor funding to promote SRHR. In this context a first and major question would be to explain the declining SRH outcomes, and to identify which determinants of health are those which are principally responsible for this decline. The economic situation of the country is clearly an important determinant but it is important to try to understand how this interacts with other systemic or proximate determinants to affect the health status of individuals within key populations and to make certain more vulnerable than others. This understanding will allow for planning better policies and interventions to reduce vulnerability and improve SRH of these young people.

In the first instance research could focus on providing more comprehensive baseline knowledge of the composition of the YKP groups in Madagascar, including questions on their specific SRHR needs, risks and vulnerabilities.

- Who are the YKPs (and particularly young prisoners, IDU, LGBTI other than MSM)?
- It is possible to define KP groups in a situation with multiple health vulnerabilities and where the over-riding determinants of risk seem to affect all young people in the country?
- What are the particular risks and vulnerabilities of YKPs?
- Why or how are they not accessing SRHR services?
- Why given the equally strong structural and systemic determinants, do some young people have more negative health outcomes than others?
- What is it in the biographical/narrative stories of these young people which might suggest differing proximal and individual determinants which change health outcomes?

Further research could focus on:

- How do young people define sex work in a context of generalised transactional sexual relations? What are the shared risks between all of those young people involved in transactional forms of sex? What are their perceptions of risk and vulnerability?
- How can services for young sex workers better respond to the needs of young people involved in hidden forms of sex work and transactional sex?
- How do young people define their sexual orientation and gender identity? And how does this correspond to global definitions of LGBTI identities and rights? Who are the young LGBTI other than male homosexuals?
- How could interventions at the level of peer groups/community networks or family be utilised to modify the proximal determinants of SRHR for young people?
- What is the pertinence of studying young key populations in Madagascar? And is a focus on KPs and on HIV obscuring other more important SRHR challenges such as teenage pregnancy?
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