MADAGASCAR

PAC-FP COUNTRY BRIEF

Postabortion care (PAC) provides a comprehensive approach to preventing morbidity and mortality caused by abortion complications (PAC Consortium, 2014). As per the U.S. Agency for International Development (USAID) PAC model, a critical component of PAC is providing access to family planning (FP) counseling and services. Providing these services helps meet the reproductive intentions of women who most clearly demonstrate an unmet need for FP, reduces unintended pregnancies, and prevents repeat abortions, thus reducing maternal deaths (Curtis, Huber, and Moss-Knight, 2010). The information below highlights the Republic of Madagascar's investment in providing PAC and FP services to women in need.

POLICIES, LEADERSHIP, AND GOVERNANCE

The country's national policy on family planning (FP) and reproductive health (RH) is outlined in a number of documents, including the 2005 National Heath Policy, the 2008 Madagascar Action Plan (Poverty Reduction Strategy Paper) (2008), the Family Planning Sectoral Plan 2007–2012 (2007), and the Integrated Strategic Plan for Family Planning and Procurement of Reproductive Health Products 2016–2020 (2016). Guided by the principles of equity and accessibility, the latter document highlights five key strategies through which the country aims to increase the overall contraceptive prevalence rate to 50%, reduce unmet need to contraception from current levels to 9%, and increase contraceptive prevalence among youth (aged 15 to 24) to 46% (Health Policy Plus, 2016). In 2003, Madagascar renamed the Ministry of Health to the Ministry of Health and Family Planning, placing RH at the center of the country's health agenda (The World Bank, 2011). However, despite this commitment, the country has not yet explicitly outlined policies related to postabortion care (PAC).

Legal Status on Abortion

Madagascar permits abortion only to save the life of the woman.

PAC TRAINING AND STANDARDS

In Madagascar, human resources norms and procedures for PAC include emergency care, counseling, and integrated services with direct links to the community. Public and private clinics, such as those operated by international organizations (e.g., Marie Stopes and Population Services International [PSI]) have specific PAC protocols and clinical guidelines for doctors and midwives. For example, PSI developed a national training curricula and practical guide for the use of misoprostol for PAC. While the government has not approved or adopted this document, franchise private clinics attached to PSI are actively using it.

STRENGTHENING SERVICE DELIVERY

In Madagascar, international organizations play a central role in supporting the Ministry of Health's efforts to strengthen service delivery and provide PAC services to women. For example, IntraHealth International trained more than 250 healthcare providers in the provision of long-acting and permanent FP methods and PAC (IntraHealth International, 2016). Similarly, through the Mikolo project, Management Sciences for Health implemented a system strengthening initiative that aimed to increase community-based service

PAC·FP THE POSTABORTION CARE FAMILY PLANNING PROJECT
Expanding contraceptive methods and informed choice to PAC clients

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delivery of basic health services and build the capacity and systems of local nongovernmental organizations and communities to sustain services (Management Sciences for Health, 2017). Through this project, MSH trained more than 5,500 community health volunteers to provide contraceptives, including modern contraceptives (e.g., Sayana-Press). The increased availability of these services resulted in 100,000 new clients using FP in these communities (Management Sciences for Health, 2017). However, despite support from international organizations, access to PAC remains limited. Manual vacuum aspiration and misoprostol for PAC are only available at secondary and tertiary health facilities and only as provided by doctors and midwives.

BARRIERS TO PAC

Women in Madagascar face multiple barriers to accessing PAC and FP services. From a policy standpoint, current legislation and norms around PAC contribute to a restricted environment for the provision and use of these services. Limited access to health services further exacerbate these challenges: only 40% of the Malgasy population live within five kilometers of most health centers (Sexual Rights Initiative). Women who live close to health centers are often unaware of PAC and RH services and face stigma from the community and providers. At the facility level, poor quality of care, a lack of privacy, negative provider attitudes, long wait times, and inappropriate service fees are compounding barriers to FP counseling and methods" after within PAC.

FINANCING MECHANISMS

Madagascar does not have a national health insurance plan, but the government provides subsidies to make PAC services, including postabortion FP, more affordable.

Madagascar has committed to increasing the national FP budget by 5% every year, including to support the purchase of contraceptive commodities (FP2020, 2016).

MADAGASCAR		Year	Source
Demographic/background indicators			
Country population	25,570,000	2017	World Bank[1]
Total fertility rate	4.2	2016	
Age at first birth	20.1	2008–09	Demographic and Health Survey, 2008–09
Maternal mortality per 100,000 live births	498		
Newborn mortality per 1,000 live births	24		
Infant mortality per 1,000 live births	48		
Under-five child mortality per 1,000 live births	72		
Facility-based deliveries	35%		
Proportion of women who attended at least one antenatal visit in the past five years	86%		
Proportion of women who received a postnatal check after a live delivery	65%		
Abortion and FP-related indicators			
Number of abortions	75,000	2011	Alliance Nationale pour l'Autopromotion des Populations Vulnerables and Sexual Rights Initiative
Number of maternal deaths caused by abortion	575 (2nd highest cause of maternal death)		
Number of unintended pregnancies	182,000	2017–2018	FP2020 Core Indicator 2017–18 Summary Sheet
Number of unintended pregnancies averted due to use of modern contraceptive methods	844,000		
Number of unsafe abortions averted due to use of modern contraceptive methods	186,000		
Number of maternal deaths averted due to use of modern contraceptive methods	2,300		
Modern contraceptive prevalence rate, all women of reproductive age (WRA)	25.2 %		
Knowledge of FP, all WRA	94%	2008–09	Demographic and Health Survey, 2008–09
Contraceptive use by type		2017–2018	FP2020 Core Indicator 2017–18 Summary Sheet
Long-acting and permanent methods			
Sterilization (female)	3.9%		
Sterilization (male)	0.3%		
Intrauterine device	2.1%		
Implant	14.9%		
Short-acting methods			
Injection (intramuscular and subcutaneous)	62.2%		
Pill	12.1%		
Condom (male)	2.8%		
Condom (female)	0.0%		
Other modern methods (e.g., cycle beads, and lactational amenorrhea method)	1.8%		
Unmet need for FP[2] (2018)	19%	2008–09	Demographic and Health Survey, 2008–09
Unmet need for birth spacing	10.0%		
Unmet need for limiting	9.0%		

[1] https://data.worldbank.org/indicator/SP.DYN.TFRT.IN

[2] Women with unmet need are those who are fecund and sexually active but are not using any method of contraception, and report either not wanting any more children or wanting to delay the next child. The concept of unmet need points to the gap between women's reproductive intentions and their contraceptive behavior.

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