EXECUTIVE SUMMARY

Childhood in Madagascar:
A PROMISE OF A FUTURE
Situation analysis of the mother and child

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The situation analysis provides a thorough analysis of child rights in Madagascar, in order to guide the vision and implementation of interventions in the context of the new UNICEF 2015–2019 country programme. In broader terms, this analysis aims to provide a comprehensive framework on the rights of the Malagasy child in order to facilitate advocacy and guide the planning of future development programmes and policies.

The situation analysis begins by presenting the national context (Section 1) and is divided into three parts: the right to survival of the mother and child (Section 2), with three sub-components: nutrition, health and water, sanitation, and hygiene; the right to education (Section 3) and the right to child protection (Section 4).

For each section, the study shows the trends in national indicators, presents an overview of the disparities in access to rights and services and analyzes the causes of the problems identified. It concludes with five major priority challenges and recommendations for the coming years in order to significantly increase the realization of the children’s and women’s rights in Madagascar.

UNICEF Madagascar
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In 2012, the Malagasy population was estimated to be between 20 and 21 million people, and continues to grow at an annual rate (2.8 per cent) higher than the average in sub-Saharan Africa (2.3 per cent). One fifth of the population is five years old or less and almost half is 15 years old or less.

The population is poorly urbanized (17 per cent) and unevenly distributed in the island’s 22 regions. Society appears to be fragmented, not because of ethnic divisions, but rather due to a partitioning into strongly hierarchical statutory groups and because of significant inequalities, especially between the highlands and the coastal areas.

Madagascar is a country with very high risk of natural disasters—hurricanes, floods, drought and locusts. These recurrent episodes endanger the physical, economic and nutritional security of the people. They reinforce their vulnerability to disease, while the public health situation appears to have deteriorated in recent years. The community’s resilience to shocks is even more limited while the state’s ability to prevent disasters and prepare for and provide an emergency response is inadequate.

Madagascar has signed the main international instruments on human rights. However, it has yet to ratify some key treaties, especially regarding the disabled, and to further align its domestic legislation with international commitments. Efforts to do this were started in 2005 but were suspended by the events of 2009.

Indeed, following the events of 2009, Madagascar has been affected by a major political crisis that has exacerbated tensions and led to the island’s economic and social decline. Significant cuts in capital expenditure and maintenance were made between 2009 and 2014, while state resources were allocated to the priorities of the transitional government, focusing on macroeconomic stability.

These trade-offs had a negative impact on the provision of basic social services, while the living conditions of the population, already precarious, deteriorated. Elections in late 2013 led the country out of the political crisis, but the return to a cycle of favorable development looks slow and difficult in a country ravaged by poverty.

Madagascar is in fact one of the world’s poorest countries. Using the threshold of US$ 2 PPP (purchasing power parity), the poverty rate in 2005 was 91 per cent while 77 per cent of the population was affected by extreme poverty at US$ 1.25 PPP. Poverty is almost universal in rural areas and children are on average more affected than adults.
2. Right to survival of the mother and child

The right to survival of the mother and child is a fundamental principle behind all other rights. It offers the opportunity for each child to grow in a supportive environment, to develop properly and become an adult. The provision of nutritious food, proper health care, safe drinking water and adequate sanitation services is crucial to allow every woman and child to thrive and be productive.

2.1. Right to nutrition

Malnutrition is recognized as a direct and indirect cause of almost half of all deaths in the world. Malnutrition and especially stunting have irremediable effects on physical and cognitive development of the child.

Current situation and key disparities

Stunting

By its magnitude, chronic malnutrition (stunting) is the most significant manifestation of undernutrition in children in Madagascar. The island ranks fourth worldwide in stunting, which affects nearly half of children under 5 years.

Stunting develops rapidly during the first two years of life: nearly a quarter of children aged 0–6 months are affected, as are 58 per cent of children 18–23 months. All age groups considered, boys (50 per cent) are more affected than girls (45 per cent).

Chronic malnutrition is more prevalent in rural areas (49 per cent) than urban (39 per cent), while regional disparities are very strong. The central highlands have the highest rates, particularly Haute Mâtisatra (65 per cent), Vakinankaratra (65 per cent) and Amoron’i Mania (64 per cent). The proportion of children suffering from chronic malnutrition also varies by education level of the mother.

In a country where teenage pregnancies are common, stunting among adolescents increases the risk of dying during childbirth and/or giving birth to low birth weight babies. In addition, undernutrition affects a quarter of women and causes fetal growth retardation in 11 per cent of newborns, which contributes to chronic malnutrition among children under 5.

Acute malnutrition

Acute malnutrition affects 9 per cent of children under 5 (of whom more than 1 per cent in severe form) and can reach twice those values when the country is hit by natural disasters and epidemics. The prevalence of acute malnutrition is mainly influenced by the level of household wealth, ranging from 10 per cent among the poorest households to 5 per cent among the richest. It increases when household food diversification and consumption are low.

Underweight

Underweight combines stunting and acute malnutrition among the indicators for monitoring Millennium Development Goal (MDG) 1. After remaining stable for almost two decades, it has slightly declined since 2003, from 38 per cent to 33 per cent in 2012 (9 per cent in severe form). However, the MDG target of 18 per cent in 2015 remains elusive.
The prevalence of underweight varies considerably by region, with maximum values recorded in the central and eastern parts of the island.

**Infant and young child feeding**

In terms of infant and young child feeding, current practices remain far from international recommendations. In Madagascar, one third of newborns are breastfed within one hour of birth and exclusive breastfeeding covers only 42 per cent of children under 6 months.

In such regions like Androy, Melaky, Diana and Menabe, this proportion falls below 25 per cent.

The vast majority of children (83 per cent) are breastfed up to the age of two while 90 per cent of children aged 6–8 months benefit from the introduction of complementary foods. However, major deficiencies are observed during the time when complementary food is introduced, as well as in the quality of the food.

In 2012, the percentage of children aged 6–23 months receiving a minimum diversified diet was limited to 31 per cent.

Regarding micronutrient deficiencies, data from 2008 indicate a 50 per cent rate of anaemia among children under 5 years and 46 per cent among women. These levels are lower than in 2003 due to the introduction in 2006 of the Mother and Child Weeks Health (SSME) including biannual deworming campaigns.

In the absence of survey data on vitamin A deficiency, it is not possible to estimate its magnitude. Some biannual supplementation campaigns are conducted during the SSME. However, in 2012, only 43 per cent of children 6–59 months had benefitted from them, much less than in 2008 (72 per cent). Similarly, the iodine status of the population is unknown. According to the most recent data, 53 per cent of households consumed adequately iodized salt in 2008.

Generally speaking, iodine and iron deficiencies appear to be strongly correlated with the level of economic well-being of the household as well as regional affiliation (Androy and Anosy regions are a cause of concern).

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1 These guidelines recommend: (i) to breastfeed the child within one hour after birth; (ii) exclusively breastfeed until six months of age, and (iii) introduce appropriate complementary foods from six months on, while continuing breastfeeding up to the age of two or more.
Main challenge: reduce chronic malnutrition among children under 5

Despite efforts by the government with the establishment of a National Nutrition Policy (NNP) in 2004, the creation of the National Nutrition Office (ONN) in 2005 and the organization of awareness or supplementation campaigns, chronic malnutrition still affects nearly half of young children.

Causal Analysis

Chronic malnutrition among children under 5 is related to poor fetal development of the child (small body size, low birth weight, micronutrient deficiencies) and/or growth retardation after birth (acute malnutrition and micronutrients deficiencies).

The main root causes of poor maternal and child care practices are often related to social norms: lack of exclusive breastfeeding and beliefs about the poor nutritional value of breast milk, administration of tambavy², dietary restrictions imposed on mothers (fady) and low protein in the Malagasy food diet. Moreover, food insecurity and poverty are forcing households to reduce daily rations and protein consumption in favor of foods with low nutritional value.

Besides, women’s status and their low educational level contribute significantly to the persistence of high levels of child malnutrition. The small number of women using family planning and the trivialization of gender-based violence (early marriage/labour, sexual violence and exploitation of girls) encourage teen pregnancy and feed the intergenerational cycle of malnutrition. Unsanitary living conditions and diseases are also known to cause chronic malnutrition.

Faced with these challenges, the response of health services is largely inadequate, firstly in terms of capacity for institutional management, coordination and funding at the central level and secondly, in terms of accessibility, response to malnutrition and means for health education in the field.

Recommandations

Upstream

- Strengthen advocacy for nutrition, coordinate interventions for nutrition and support the government to ensure inter-sectoral coordination in the Scaling Up Nutrition (SUN) movement.
- Improve existing information management and supervision systems within institutions in order to establish a culture of collective responsibility in the area of nutrition. This will also identify opportunities for interventions that can be integrated with emerging social protection programmes.

Downstream

- To the extent that an effective fight against chronic malnutrition requires the coordinated and integrated implementation of specific nutrition actions as well as actions in nutrition-sensitive sectors, it is necessary to ensure greater convergence and integration of nutrition programmes with the sectors of health and water, sanitation and hygiene.
- Harmonize the activities of community workers involved in the field of nutrition with those involved in the field of health.
- Improve nutrition of infants, young children and women, especially pregnant women, focusing on behaviour change for the promotion and protection of breastfeeding practices and complementary feeding. Dietary diversification and fortification of complementary foods with nutritional supplements will be prioritized.
- Continue to support the fight against micronutrient deficiencies through supplementation and deworming for women and children, and support for food fortification, especially salt iodization.
- Continue to address acute malnutrition by ensuring improved performance and the gradual increase in service coverage.
- Better prepare vulnerable coastal areas prone to cyclones and droughts, emergency management and strengthened coordination of the various actors in the field.

² Tambavy refers to both the remedies made from decoctions and infusions and the plants used; beliefs affirm they have ancestral paediatric virtues.
The development of the child is inextricably linked to her/his health and that of the mother. The incidence of diseases, but also the availability, access and availability of both preventive and curative care, are key factors.

**Current situation and key disparities**

**Right to health for the mother**

**Maternal mortality**

By signing the Millennium Declaration, the Malagasy government has pledged to reduce maternal mortality by three quarters between 1990 and 2015, from 529/100,000 live births (1992) to 127/100,000 live births.

Two years before the 2015 deadline, MDG 5 remains elusive. The maternal mortality rate has been stagnant over the past two decades, and remains high at 478/100,000 live births in 2012.

Of the estimated 3,650 maternal deaths due to pregnancy-related complications every year, only 491 occurred in hospitals. Thus, over 86 per cent of maternal deaths happen outside the health system.

**Access to maternal health services**

Coverage of antenatal care declined by 4 points since 2008. In 2012, 82 per cent of mothers had access to antenatal care and 51 per cent to at least four visits. Care received in the course of a prenatal consultation appears to be random and variable, while tetanus vaccination during pregnancy is in sharp decline compared to 2008.

Disparities in access to prenatal care depending on place of residence are moderate, although some regions are disadvantaged, for example, Melaky. Access to prenatal care is more sensitive to socio-demographic variables, including women’s level of education and household wealth.

With regards to the rate of skilled delivery, it has stagnated at 44 per cent since 2008 and has wide disparities. This rate doubles when moving from rural to urban areas, and triples when the mother’s education is at least at secondary level. It is almost three times higher in the richest than in the poorest households.

Less than two thirds of mothers are covered by postnatal care.

In the area of fertility, indicators declined until 2008 and then changed little, with a synthetic fertility index stabilized at around 5 in 2012. Knowledge of modern methods of contraception is almost universal in urban areas and strong in rural areas. Yet, only one third of married women use them, as do very few adolescents.

Adolescent pregnancies, a worrying phenomenon, are increasing: in 2012, 37 per cent of girls aged 15–19 had begun childbearing, compared to 32 per cent in 2008. This proportion is 2. 5 times higher in rural than in urban areas and there are wide disparities by level of education and wealth of the girl. Beside, unsafe abortions are the cause of many teenage deaths.
Right to life and health for young children

Child mortality
By signing the Millennium Declaration, the Malagasy government has pledged to reduce by two thirds the under-five mortality between 1990 and 2015 (MDG 4), or from 166/1,000 live births in the early 90s to 54/1,000 live births in 2015.

Significant progress has been made since the under-five mortality rate was reduced to 62/1,000 live births in 2012. However, the rate of decline, which was sustained between 1992 and 2003, has greatly slowed down over the past decade.

Under-five mortality varies from one region to another, 97/1,000 live births (Betsiboka) to 36/1,000 live births (Analamanga). The place of residence is influential, at the expense of rural children. Mortality rates also vary according to the level of education and wealth of the mother.

As a highlight, neonatal mortality only slightly decreased over the last 20 years. Thus, the share of neonatal mortality in under-five mortality went from 24 per cent in 1992 to 33 per cent in 2008 and 42 per cent in 2012.

The progress made during the last decade regarding child mortality is the result of achievements in the fight against malaria and community-based management of childhood diseases.

Vaccine coverage
About 44,000 children die each year (120 a day) before their fifth birthday, mostly from diseases that are preventable through vaccination.

As part of the policies implemented to achieve MDG 4, the area of vaccination has set itself a target of increasing the coverage of children under 1 by routine vaccination to at least 90 per cent at national level and at least 80 per cent in each health district.

However, according to survey data, vaccination coverage for all antigens is below these targets. After a period of progress between 2003 and 2008, it deteriorated between 2008 and 2012. The rate of children under 1 fully immunized went up from 47 per cent in 2003 to 55 per cent in 2008, then fell back to 38 per cent in 2012. The coverage for BCG tuberculosis and measles vaccination recorded significant declines, while coverage for the third dose of the diphtheria, pertussis and tetanus (DPT) vaccine.

The rate of children under the age of 1 fully vaccinated

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<th>Year</th>
<th>2003</th>
<th>2008</th>
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<td>Rate</td>
<td>47%</td>
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Severe deprivation is four times higher in rural than urban areas.

vaccine declined slightly. However, the coverage rate for the third dose of polio has remained steady.

Severe deprivation in immunization, as measured by the rate of children aged 12–23 months who have not been vaccinated, has also increased for four years. Nationally, the rate rose from 13 per cent in 2008 to 18 per cent in 2012. Severe deprivation is four times higher in rural than in urban areas, and appears to be very strong in some regions like Menabé (53 per cent) and Melaky (38 per cent).

As far as immunization is concerned, the great challenge is the mobilization of demand and supply of quality services, combining high-performance systems for the cold chain and monitoring, to keep immunization rates at acceptable standards.

**Morbidity and access to care**
The main reported diseases affecting children aged 1–5 years are: acute respiratory infections (7 per cent), diarrhea (18 per cent) and malaria (53 per cent). These diseases are exacerbated by chronic malnutrition. Over the past five years, the prevalence of the three killer diseases for children has increased: the prevalence of acute respiratory infections rocketed from 3 per cent in 2008 to 11 per cent in 2012, diarrhea from 8 per cent to 11 per cent and fever from 9 per cent to 14 per cent.

Access to health care remains low, regardless of the disease. In 2012, only 41 per cent of children with symptoms of acute respiratory infection were taken to a health centre, and a third was treated with antibiotics. In the case of diarrhea, treatment was sought in less than half of the cases and only a quarter of children received appropriate treatment. Finally, less than half of children with fever were taken to a health provider: 31 per cent were prescribed antibiotics and only 11 per cent received an antimalarial. This percentage appears to be in decline compared to 2008 (20 per cent) and 2003 (34 per cent).

However, the prevention of malaria has seen significant progress since 2005 with the distribution of long-lasting insecticide-treated nets to pregnant women and children, coupled with awareness campaigns.

For young people, multiple concurrent sexual partnerships are a status symbol. Young men and women aged 15–24 years are more likely than their older counterparts to practice it, and less likely to use condoms than the latter. Thus, entry into active sex life often leads to early pregnancy and/or sexually transmitted illnesses (STIs).

**Early sexual intercourse**
In Madagascar, there is a strong trend in early sexual intercourse, often causing teenage pregnancies. In 2012, 20 per cent of women aged 15–19 reported having had their first sexual intercourse before age 15, against 17 per cent in 2008.

Faced with these realities, the response of education and health services remains inadequate. School sex education appears only in secondary school, but few students attend. In terms of content, the programme is out of date, encouraging abstinence as a means of contraception while most students are already sexually active. Moreover, adolescents rarely go to health services, of which they have a negative perception.

**STIs and HIV and AIDS**
By the end of 2011, UNAIDS estimated the HIV prevalence at 0.4 per cent in individuals aged 15–49 years, and 0.16 per cent for those aged 15–24 years old. The target for HIV is one of the few MDGs likely to be achieved by 2015.

Yet, the knowledge, attitudes and behaviours of adolescents and young people around STIs and HIV and AIDS remain poor. In 2012, only half of young people aged 15–19 said they had heard of STIs. Similarly, only 21 per cent of girls aged 15–19 and 24 per cent of boys of the same age had comprehensive knowledge of HIV and AIDS. Geographical disparities are very significant, since some rural areas recorded less than 10 per cent.
Main challenge: reduce maternal and neonatal mortality, particularly in the most vulnerable families

Maternal and neonatal mortality has declined substantially but remains at levels of concern. Progress is insufficient and rarely involves vulnerable segments of the Malagasy society. On the ground, we see that only the rich, urbanized, educated population with health insurance can easily access the health care system and choose health services.

CAUSAL ANALYSIS

The main causes of maternal deaths identified in Madagascar are ante and postpartum hemorrhage (20 per cent), abortion complications (16 per cent), eclampsia/severe preeclampsia (13 per cent), uterine rupture (8 per cent) and prolonged / obstructed labour (8 per cent). Thromboembolic disease and complications from anesthesia are among other direct causes (15 per cent) of maternal deaths. Indirect causes include malaria, anemia, hepatitis, heart disease and tuberculosis. The main factors that increase the likelihood of death are: the delay in arrival in health facilities (71 per cent), delays in transferring patients and administration of appropriate care (27 per cent) and the delay due to lack of medical supplies (23 per cent).

The main direct causes of neonatal deaths globally are prematurity (33 per cent), infection (27 per cent) and asphyxia (26 per cent), which are usually fatal within the first 24 hours of life for infants. In addition to the direct causes of neonatal mortality, there are indirect ones, often related to malnutrition or poor health of mothers, especially teenage girls.

Lack of or inadequate medical assistance and appropriate monitoring during pregnancy, childbirth and postpartum may be explained by various factors, including poor supply of health services, limited access to these services and weak demand and poor uptake of services.

The main reason why women receive sub-optimal care before, during and after pregnancy is the weak supply of health services and the degradation of the quality of care. According to the Ministry of Public Health, over two thirds (68 per cent) of maternal deaths have at least one cause related to the quality of the services offered, most often the failure to give proper care.

Health facility staff is inadequate and may, in addition, lack skills, regardless of professional categories (paramedics, general practitioners, pediatricians, etc.) In addition, human resources tend to be concentrated at the central level, to the detriment of health facilities at the peripheral level as well as in rural areas. In 2010, 41 per cent of the staff in the health sector was responsible for 21 per cent of the population.

In addition, the lack of medical supplies affects the majority of basic health centres and hospitals. Regarding emergency obstetric and neonatal care (BEmONC), only a fraction of basic health centres have efficient management of drugs for complications during pregnancy, childbirth and for the newborn. In total, only 22 (0.6 per cent) out of 3,470 health facilities have adequate technical facilities to provide BEmONC.

Furthermore, significant financial and physical barriers restrict the accessibility of health services. Two thirds of women list health care costs as a major obstacle and 42 per cent mention the long distances between their home and a health facility. At the same time, the lack of transport for health agents hinders the implementation of mobile and outreach strategies, which aim to bring basic health services close to vulnerable and isolated populations.

The lack of knowledge and empowerment of women explains the fact that few of them attend health services. Some are unaware of the benefits of getting appropriate care and do not know what to do if a complication occurs. Others simply cannot care for themselves or their babies: in 2012, 15 per cent of women said they did not have permission to go for treatment.
Early sexual intercourse and marriage are other important causes of maternal and neonatal mortality, in a context where adolescents are not physiologically ready to give birth. In addition, poor nutrition and hygiene practices often result in the death of women and newborns.

Moreover, the lack of community participation slows progress. The National Policy on Community Health (NPCH) is not enforced while outreach strategies are not well targeted. The strategy of integrated implementation of the NPCH has been slow to materialize due to the crisis, so many health actors work at the community level in a vertical and disparate manner. We also need to point out the absence of a national policy and strategy for health communication, to guide behaviour change programmes and stimulate demand for health services.

Finally, qualitative barriers limit the continued use of health services, including low availability of health care providers and medication, staff absenteeism in health centres, poor reception of patients and lack of compassion in the provision of care.

All these problems are rooted in structural causes, including the absence of a strategic framework for managing the health sector, lack of organizational and institutional capacity, budgetary constraints, lack of social policies, persistence of unfavorable social norms, illiteracy and poverty.

**RECOMMANDATIONS**

From the above analysis comes a series of recommendations that can help meet this challenge:

**Upstream**
Support the government, in coordination with partners, to:

- Make a quick situation analysis of the health system by focusing on interventions at community level, in preparation to update the development plan for the health sector (PDSS 2015–2019).

- Provide and coordinate technical assistance to draft strategic and policy guidance documents, including the protocol for managing diseases that kill children.

- Mobilize resources and strengthen advocacy for the rational distribution and efficient use of government funds and resources from different global alliances (GAVI and Global Fund to Fight AIDS, Tuberculosis and Malaria).

**En aval**

Strengthen the health system in its different components:

- Strengthen the public health system’s human resources through the recruitment and placement of doctors and paramedics in sufficient numbers, to make sure that health centres are up and running.

- Improve the link between the public health system and community-level activities.

- Ensure the functionality of the SALAMA supply chain for the purchase and supply of health inputs at institutional and community levels.

- Maintain existing infrastructure.

- Strengthen the information management system and implement innovative actions that will provide real-time data for better management.

- Develop and implement a strategy for behaviour change, to help the health system support a process based on the human rights-based principles of inclusion and participation.
The realization of the right to safe drinking water, adequate sanitation and proper hygiene has consequences on infant mortality, chronic malnutrition, access to primary education (especially for girls), incidence of disease and—more broadly—poverty.

Current situation and key disparities

Right to drinking water

According to the Joint Monitoring Programme (JMP)\(^3\), the national utilization rate of drinking water went from 29 per cent in 1990 to 48 per cent in 2011, 17 points away from the 2015 target in the context of the MDGs.

The number of people without access to drinking water rose sharply between 1990 and 2011, from 3.2 to 10.4 million people. Only 28 per cent of public primary schools and 58 per cent of public health facilities are equipped with drinking water.

Globally, Madagascar is the fifth country with the most alarming indicators regarding access to drinking water, which show very low rates compared to the average in sub-Saharan Africa.

![Right to drinking water trends](image)

Right to sanitation

Globally, Madagascar ranks eighth among the worst performing countries in terms of improved sanitation. National access to sanitation has experienced slow growth between 1990 and 2011, from 8 per cent to 14 per cent, according to the JMP. Nineteen per cent of the Malagasy people in urban areas have access to sanitation while only 11 per cent do in rural areas.

We need to point out that the number of people without access to improved sanitation has increased significantly, from 10.3 million in 1990 to 18.4 million in 2011. Only 18 per cent of students in public primary schools have functional latrines and disparities between rural areas (13 per cent) and urban (47 per cent) are very strong. In contrast, 93 per cent of health facilities (public and private) have latrines.

In 2011, 39 per cent of the population still practiced open defecation, and up to 90 per cent in some rural areas like Atsimo-Antsinanana, Menabe Melaky and Androy.

Right to hygiene

Data are scarce and incomplete in this area. According to a recent survey conducted in four regions of the southern part of the island, a tiny fraction of households has water and soap, and can properly get rid of young children’s feces.

\(^{3}\) JMP—a UNICEF and WHO programme that monitors water supply and sanitation—is the official UN mechanism tasked with monitoring progress towards achieving the MDGs 7c.
Main challenge: accelerate access to safe drinking water, sanitation and good hygiene practices

The main challenge for the sector is to increase access to safe drinking water and reduce—then remove in the longer term—the practice of open defecation. Meeting this challenge will help to counter the spread of waterborne and oral-fecal diseases, while improving the achievement of the right to survival for children who are highly vulnerable to diarrhea-related diseases.

**CAUSAL ANALYSIS**

The main causes for the low achievement of the right to water and sanitation are the following: high costs of access to safe drinking water and sanitation, limited physical access to infrastructure (insufficiency and poor functionality), persistence of unhealthy practices in hygiene and disposal of feces, lack in people's knowledge of the health impact of inappropriate practices and poor water quality.

These obstacles to the improvement of people's living conditions find their origins in deeper problems, particularly the lack of institutional control, low prioritization of the sector, gaps in the policy framework, lack of a sector-based approach, poor management, high centralization, poor financing for the sector, weak implementation capacity, low involvement of the private sector and village communities in project development and management, and resistance to change and the social norms in some areas in excreta management, as well as poverty, low educational level of families and natural disasters.

**RECOMMENDATIONS**

The following recommendations are drawn from the key points raised by the analysis and cover six broad areas.

**Upstream**

- Scaling-up requires coordinated action of all parties to develop an action plan, with a timetable and appropriate funding. This should be at the heart of the process to develop a sector-based approach based on existing strategy documents and built on the experiences of successful improvements in the field and the results of a sustainability analysis. In addition, policies and programmes should integrate more vulnerable populations on the basis of equity.

- The issue of low decentralization/devolution should be addressed. Although it goes beyond the issue of water, sanitation and hygiene, it is crucial for the sector because it determines the support to be provided to communities so that they can manage the provision of services and the creation of incentives to encourage private sector involvement.

**Downstream**

- A sustainability strategy for the sector should be developed and adopted by all stakeholders. The development of this strategy is a priority and could take place under the guidance of the Ministry of Water with support from partners.

- A national awareness campaign on sanitation and hygiene should be launched to highlight problems and encourage behaviour change, specifically targeting women and children and ensuring that issues of equity and poverty are highlighted. Given that these issues are matters of national emergency, launching this campaign should be considered a priority.

- It is necessary to launch a study on the development of the needs and capacity of the private sector in Madagascar, focusing on the strengths and weaknesses of this sector at national and local levels, and including a comparative analysis of countries where the private sector contributes effectively to the development of services.

- Regarding financial resources, the following initiatives are necessary: advocacy to increase the budget as soon as the new government addresses key principles such as costs issues in the water and sanitation sector; establishment of a database and a performance management system; and an increase in budget execution rates, especially related to devolution.
3. Right to education for the child

All children should have access to, and complete their basic education. The education they get should allow for their intellectual development and ensure equal opportunities for all.

**Current situation and key disparities**

**Access to preschool education**
In recent years, the number of children attending preschool has risen to 240,000 in 2012. However, these numbers are still very low and the underdeveloped sector is depriving thousands of young children from being adequately prepared to start primary school.

In 2010, the net enrollment ratio (NER) at the preschool level was a mere 0.2 per cent but the gross enrollment ratio (GER) was 19 per cent due to the large number of children aged 3 and 4 who attended this cycle before the legal age of 5 years. According to the latest survey available, the situation has normalized in 2012, with a net rate of 7.7 per cent and a gross rate of 10 per cent.

Disparities in access are very significant at this level of education: dominated by the paying private sector, preschool education is largely an urban phenomenon and is accessible only to the wealthiest households. The sole region of Analamanga is home to almost one third of institutions in this cycle.

**Access to primary education**
To keep its commitments and achieve MDG 2, Madagascar needs to achieve a NER of 100 per cent in 2015. Yet, far from showing progress, the trend in recent years shows a decline in enrollment.

Since 2009, the school system has failed to keep up with population growth, leading to a decline in enrolment rates: the GER in primary schools fell from 139 per cent in 2005 to 118 per cent in 2010 and 108 per cent in 2012 as the NER lost 14 points during the same period, from 83 per cent to 73 per cent then to 69 per cent.

This worrying trend for the future is coupled with disparities. The most pronounced ones pertain to the household head’s level of education and wealth: the NER is 84 per cent if the household head has reached high school and 54 per cent if she/he is uneducated. Similarly, the rate rises to 82 per cent for children from the richest households and 52 per cent for the poorest.
The NER also varies according to place of residence (86 per cent urban and 66 per cent rural) and by region. There is a divide between the southern and western parts of the country where deprivation is significant, and the most advantaged eastern and northern ones. However, gender disparities are minimal, as parity at the primary level has nearly been achieved with an index of 0.98 in 2012, according to the Ministry of National Education.

Net primary enrollment ratio by region in 2012

Access to secondary school
Access to secondary education remains very limited in Madagascar. In 2012, GER in secondary school was limited to 46 per cent and 28 per cent for NER. So, just over one fourth of children aged 11 to 14 attend secondary school.

Children from the richest households are five times more likely to go to secondary school than those from the poorest. Similarly, a child in an urban setting has twice as many chances as a child from rural areas to attend high school. Regional disparities in access to secondary school are also marked: Analamanga ranks first, followed by Diana, Antsinanana, and Analanjirofo Haute Matsiatra while the regions of Androy and Melaky are in the last spot. Gender disparities are more pronounced than in primary education and remain limited in secondary school, with a gender parity index of 0.90.

Declining quality of education and school exclusion
The internal efficiency of the education system is very poor. The repetition rate in primary school is high, namely 17 per cent in 2012. Nationally, the dropout rate went up from 13 per cent to 19 per cent between 2008 and 2010. According to a recent study, the dropout rate between CP1 and CM1 increased by 5.5 percentage points between 2008 and 2011. The number of students leaving school before CM2 increased from 469,000 in 2008 to 724,000 in 2011 (+ 255,000 pupils).

School dropout is getting worse in the poorest rural areas, where enrollment rates are already very low. Regional disparities have widened: dropout rates increased the fastest after 2009 in the regions of Androy and Anosy Atsimo-Andrefana, Boeny and Melaky.

Exclusion from school is a major challenge in Madagascar, and it is intensifying. In addition to the thousands of students who drop out each year, more than 18 per cent of children aged 6–14 have never been to school—and this rate reached 21 per cent in rural areas in 2012 (2 per cent in the capital). Thus, less than three years from the deadline for the MDGs, nearly 1.5 million children aged 6–12 years had no access to primary school and grew up on the fringes of basic education.

The loss of efficiency and quality of the Malagasy education system is reflected in the progressive deterioration of student achievement in mathematics and especially in French.
Main challenge: ensuring universal, inclusive and quality primary education

According to the Constitution, the government has the obligation to fulfill the right to education for all children on the island. In the context of the MDGs, it is committed to education and the universal completion of primary school by 2015. Yet, three years before the deadline, the country is still far behind. As if these weren’t worrying enough, trends in recent years show a rise of school exclusion and degradation of learning conditions. In this context, achieving universal access of children to quality primary education still appears as the main challenge in education. The future of Madagascar depends on it.

CAUSAL ANALYSIS

The decline in access to quality primary education is rooted in a complex web of causes.

The most significant ones are the costs of education (tuition and school supplies) that weigh on households, in the absence of a policy and measures on free education to support disadvantaged families. Distance to school is also a key problem in rural areas; it is related to the mismanagement of the school map, as well as an inequitable distribution of schools and teachers.

Poor teaching conditions are another deterrent for children and their families. The country is facing a severe shortage of trained staff; more than two thirds of teachers (called FRAM) in primary and middle schools have no training. Overcrowding and lack of teaching materials, teacher absenteeism and school violence are other barriers to learning. Similarly, schools do not promote the integration of children with disabilities and pregnant students.

Another problem is that teaching methods are inadequate and inconsistent. The Malagasy education is based on three distinct pedagogical approaches that are the result of a fuzzy curricular policy and in constant transition.

In addition, there are adverse factors related to demand. Thus, being an orphan is a barrier to education, especially in poor families. Labour also diverts many children from school, as well as disease or poor nutritional status. Finally, natural disasters are often the cause of the destruction of schools.

Most of these problems are rooted in the lack of political will to make education a national priority, strengthened by the government’s wait-and-see attitude between 2009 and late 2013. This fact has led to a decline in financial resources allocated to the sector and a growing dependence on external financing. In the absence of strong leadership, well-managed curricula, efficient information management systems, mechanisms of accountability and inspection offices, mismanagement and poor leadership of the sector led to the decline of the system and the quality of education. Poverty, high prevalence of illiteracy and social norms that discourage schooling for some categories of disabled children are other root causes of poor performance of the education system as well as school exclusion in Madagascar.
RECOMMENDATIONS

Ensuring the continuity of basic education services and supporting the recovery of the education system, weakened by five years of deep crisis, is a priority today. This can be done by prioritizing primary education while increasing the supply of education services at the preschool and secondary levels.

Several recommendations are suggested:

Upstream

› Continue to support the implementation of the Ministry of National Education’s Interim Education Plan (2013–2015) in three strategic areas: (i) access, (ii) quality and (iii) institutional capacity building, and support the formulation and monitoring of a future education sector-based plan that is extended to the entire sector.

› Strengthen information management systems in the sector, namely the collection, analysis and use of statistical data to accelerate the publication of statistical yearbooks, strengthen planning capacities at all levels, and ensure better management of the education system.

› Support decentralization/devolution of the management system at regional and district levels to improve efficiency and strengthen supervision of schools and teaching staff.

› Revive dialogue on key structural reform policies, initiated mostly in the context of the reform of basic education that began in 2008, namely the policy on curriculum and language (languages of instruction and education) and the extension of the primary cycle from 5 to 7 years.

› Facilitate and support the coordination of external support to the education sector within a harmonized framework by encouraging the establishment of social protection mechanisms.

Downstream

› Strengthen teacher training and encourage the development of a proactive teacher policy, particularly one that supports the establishment of a real status for FRAM teachers, in order to facilitate their retention through training, certification schemes and adequate processes for professional development.

› Support the realization of a truly universal and free primary education, and consider in this context compensation mechanisms and adequate related measures (for schools, teachers, parents and children).

› Strengthen and diversify existing rehabilitation devices to better meet the needs of excluded children, and more specifically support the inclusion of children with disabilities.

› In order to overcome challenges related to the accessibility of schools and overcrowding in classrooms, support the implementation of an ambitious programme to build new classrooms, giving priority to regions and underserved areas and those with a high level of exclusion in primary school.

› Adopt a focused approach to support the most disadvantaged areas, promoting a sense of equity to reduce the most glaring disparities between regions, backgrounds and standards of living.

› Strengthen the ownership of schools by the community by developing partnerships and strengthening accountability mechanisms at all levels of the system, relying in particular on the scale-up of the programme-contract approach.
All children have the right to be protected against all forms of violence, exploitation, and abuse. Some of them are particularly vulnerable because of their gender, age, socioeconomic status or their membership of a marginalized group.

4. Right to child protection

Current situation and key disparities

- Violence and exploitation

We only have fragmented information on the abuse and exploitation of children, which seems to be socially condoned. At school, violence is a common phenomenon, and it is widely accepted and practiced in the family and in institutions.

- Child trafficking

In 2007, more than 300,000 children were trafficked. This serious form of exploitation affects 2 per cent of children below 9 years, 6 per cent of 10–14 year olds and 10 per cent of those aged 15–17 years. Some children are hired to go begging in the streets, others are placed within families by their own parents or middlemen and there are also children who are kidnapped to supply international networks. More than 70 per cent of trafficked children receive no compensation for their labour and the vast majority of cases reported to the police are not subject to any investigation.

- Gender-based violence

There is no specific study on violence involving girls but the last national survey demonstrates the importance of the phenomenon. In 2012, women aged 15–19 were most affected by sexual and physical abuse, compared to their older counterparts. On average, 14 per cent were victims of sexual violence, while the figure is 7.5 per cent or less in the older age groups. Similarly, 15 per cent of girls aged 15 to 19 were victims of physical violence, compared to 12 per cent or less among older women. The vast majority of victims do not seek assistance following the abuse.

Sexual exploitation

The phenomenon of sexual exploitation is a multifaceted one. It is visible in some areas known for sex tourism. Moreover, young women occasionally practice ‘survival’ prostitution: this ‘disguised’ sexual exploitation often receives the connivance of family members, the community or local middlemen. In addition, since social norms do not condemn these practices, many teenagers trade sex for gifts or money, especially when they first have sex. In some areas, customs are in direct conflict with the rights of girls: a ‘girls market’ in the southern part of the island, arranged early marriage in exchange for dowry in the northern side of the island, and public concerts encouraging prostitution and sexual abuse in some areas of the eastern part.

> 300,000 children
children were trafficked in 2007

CHILD TRAFFICKING

- <9 years: 2%
- 10-14 years: 6%
- 15-17 years: 10%

14% Of girls aged 15–19 are victims of sexual violence and 15% of physical violence
Early or forced marriage
In 2012, nearly half of Malagasy women aged 20–24 were married before the age of 18 years and 14 per cent before 15 years—figures that are much higher than the average in sub-Saharan Africa. However, also in 2012, only 34 per cent of girls aged 15–19 reported being married or in union, which suggests a decline in early or forced marriage. Girls married early are more vulnerable to domestic violence than their elders.

50%
Of Malagasy women aged 20–24 were married before the age of 18 and 14% before the age of 15 in 2012

Children with disabilities
In Madagascar, children with disabilities number more than half a million and represent about one fifth of those excluded from primary school. Only 11 per cent of these children are in school. The government has signed the Convention on the Rights of Persons with Disabilities in 2007, but it has not yet been ratified. There continues to be a colossal deficiency in terms of adapted infrastructure (school, work, public spaces), support, advocacy and promotion of the rights of people with disabilities.

Right to identity
Birth registration still does not cover all children but is increasing: 17 per cent of children under 5 years were not registered in 2012, compared to 25 per cent in 2003 and 20 per cent in 2008. Such advances have been made in 2004 following the launch of the National Programme for the Rehabilitation of Birth Registration.

This rate of unregistered children is related to several factors: ignorance of the law by the population, long distances to official registration offices, poor affordability or too short a registration period and traditional beliefs. These barriers mainly affect children living in remote areas and poor children. In 2012, the rate of non-registration reached 28 per cent among the poorest families and 6 per cent among the richest. Similarly, there are wide disparities between rural and urban areas, with 20 per cent and 3 per cent rates of non-registration respectively.

Children deprived of a family environment
In 2012, 13 per cent of children lived with neither of their biological parents. In total, 1 in 10 children lived with neither of their biological parents, even if both were alive. This phenomenon is most prevalent in the Diana (21 per cent) and Sava (18 per cent) regions.

Abandoned children
The abandonment of children in Madagascar is a troubling reality. Most children living without their biological parents are placed with relatives or with more affluent families and/or those living in the city. This practice, known as ‘fostering’, most often leads to child exploitation, abuse and permanent separation from parents.

In addition, more and more parents choose to place their children in institutions instead of raising them themselves. Abandoned by their families, many institutionalized children are placed in approved adoption centres, often subsidized by foreign partners and subject to many pressures. In 2012, the Child Rights Committee expressed concern about the high number of illegal international adoptions.

Street children
The phenomenon of street children is an emerging one, which has been on the rise since the 2009 crisis. Street children are exposed to multiple physical abuses. Most live from begging and searching through garbage.

They are often pushed to the streets by their own parents (70 per cent) and the majority of them live with a family member (79 per cent). Girls living on the street are often victims of sexual exploitation. They sell sex to support themselves or as a result of pressure from a third party. Others engage in domestic work and join the ranks of exploited child labourers.

0,5 million
Children with disabilities represent a fifth of those excluded from primary school

No birth registration rate in 2012

28% In the poorest families
6% In the richest families

Rural area 20% Urban area 3%

13% of children lived with neither of their biological parents in 2012
Child labour

In 2007, 1.9 million children aged 5–17 years or more than one in four were economically active. A quarter of these children were subjected to harmful work and 7 per cent to hazardous work. It seems that the phenomenon has slightly decreased in 2012. Child labour is more common in rural (24 per cent) than urban areas (17 per cent). By age category, 10 per cent of children below 10 years old, 26 per cent of 10–14 year olds and 53 per cent of 15–17 years are economically active.

The worst forms of child labour are not documented at the national level, but occasional surveys show that children are carrying out demanding domestic or agricultural work, nocturnal activities (in restaurants, night shops, grocery stores and eateries) or endanger their own lives by working in gemstone and salt mines.

Children in conflict with the law

The Malagasy Constitution guarantees that a child shall not be subject to prosecution or detention, while a draft law on child protection in conflict with the law is being drafted. But in reality, there is still a lot of room for improvement. In January 2013, 439 children were living in detention centres, including 26 girls. Of this total, 70 were convicted and the others were awaiting trial.

Upon a child’s first appearance before the judge, she/he generally has no lawyer. Preventive detention is almost systematic and can last very long. In addition, although the age for criminal responsibility is set at 13 years old, younger children are sometimes imprisoned.

Only 21 prisons out of 44 have a minors’ area, and most incarcerated children are exposed to all kinds of violence; girls being particularly vulnerable to sexual abuse.
Main challenge: lay the foundation for an integrated child protection system to reduce exploitation, violence and the unnecessary separation of vulnerable children from their families

The inventory noted numerous violations of children’s rights to protection and the long road that lies ahead to build a protective environment for vulnerable children. So far, the categorical approach to child protection and limited resources have not made it possible to detect, manage and rehabilitate child victims and those in danger.

CAUSAL ANALYSIS

The causes of persistent violations of children’s rights to protection are multiple, complex and often specific to each type of violation.

For child victims of abuse, violence and exploitation, the main causes are the social acceptance of sexual exploitation of children by parents, friends and communities; the financial gains it represents for needy families; impunity for trafficking networks; and growing demand for domestic workers, sex tourism and illegal adoption. Other factors are also involved such as ignorance of the law by parents, persistence of practices contrary to the rights of the child or non-enrollment/dropout from school.

As for children deprived of a family environment, the main causes are changes in family structure, including the blending of families and the slow disappearance of extended families and communities as safety nets to protect endangered children. Similarly, taboos and discrimination encourage the abandonment of twins, disabled children and those born out of marriage. The lack of alternatives to foster families and the increasing availability of institutions for vulnerable children, including those approved for adoption, are also key elements.

Concerning children in conflict with the law, the main causes found for human rights violations are the lack of a legal framework that accurately regulates diversion measures for children in conflict with the law; pressure by victims and the community for a child committing a crime or an offense to be severely punished; low enforcement of diversion by judges; lack of parental support and supervision; lack of attention to the processing of juvenile cases in jurisdictions; lack of training of judges and the virtual absence of social services in courts.

Most problems have their origin in the prevalence of customary law over modern law, a weak legal and regulatory framework that is only partially aligned with international standards, the lack of a child protection policy and weak social services, poor governance of the police and justice systems as well as the socio-political crisis and poverty.

RECOMMENDATIONS

Given the situation, it is urgent to lay the foundation for an integrated child protection system to reduce exploitation, violence and the unnecessary separation of vulnerable children from their families. To meet this challenge, the following recommendations could be implemented:

Upstream

- Support the reform of laws, policies and regulations for vulnerable children and victims of violence, abuse and exploitation, in accordance with the set of values, principles and international conventions on the rights of the child.
- Advocate strongly for the government and civil society to establish a national framework for child protection and institutionalize governance bodies with adequate resources for effective implementation, both nationally and in the regions.
- Make sure the government allocates adequate funding to child protection systems, based on the child protection networks model, which promotes resource mobilization and efficiency of interventions.
- Help strengthen coordination mechanisms involving all relevant stakeholders and ensure inclusion and participation of all relevant stakeholders in charge of the care, protection and general well-being of children and their families. This implies the involvement of actors in other key sectors than social affairs, especially health, education, security, gender, social protection and media, as well as new donors.
- Help strengthen the system for collecting and analyzing quantitative and qualitative data, especially on children living in institutions, child abuse, adoption and children with disabilities.

Downstream

- Build the capacity of all members of child protection networks to improve services for children and their families at community and district levels. This will involve developing a strong component of quality models in districts and target communities, to be monitored and documented so as to increase the use of national and local systems.
- Improve institutional capacity to provide adequate services to children and their families; the programme will help to ensure that services are delivered at the community and district levels, both routinely and in emergency situations.
- Contribute to promoting positive social standards and behaviour in targeted communities, in particular by encouraging abandonment of early marriage and corporal punishment, both of which are prohibited by Malagasy laws.
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Layout and graphic design
Andriantoavina RAKOTOMANANA