Key Words: access to safe abortion, criminalization, unwanted pregnancy, sexual rights, Madagascar, right to life, liberty and security, right to information, right to health, right to non-discrimination

Executive Summary

1. This report jointly submitted by the Association Nationale pour l'Autopromotion des Populations Vulnérables (ANAPV)[1] and the Sexual Rights Initiative.[2] Given the current legal status surrounding access to abortion in Madagascar, women's human rights continue to be severely violated. Despite the ratification of international treaties and conventions, women's rights to right to the highest attainable standard of health, the right to non-discrimination, the right to life, liberty and security of the person, the right to be free from inhuman and degrading treatment, and the right to education and information, continue to be violated. The right to the highest attainable standard of health implies the right to access health services according to the needs of women; including access to sexual and reproductive health information and services, which includes maternal health services, and safe and legal abortion services. The absence of state-provided legal abortion services violates women's right to health. The criminalization of abortion negatively impacts only women and is therefore discriminatory on the basis of gender. The right to life and liberty and security of the person implies respect for the autonomous decisions of women over her own body, therefore imposing restrictions on women's ability to decide freely on matters related to her body constitute violations of women's right to life, liberty and security of the person.
2. This report examines the legal and social barriers to women's right to access safe and legal abortion services, and provides recommendations regarding how the government of Madagascar can contribute to the realization of women's human rights, specifically their reproductive rights, through unrestricted access to safe and legal abortion services.

Progress and gaps in implementation of recommendations from previous cycle:

3. In the first cycle of the Universal Periodic Review (UPR), the state of Madagascar did not receive any recommendations related to women's reproductive rights, including safe abortion services.

Judicial framework

4. According to the article 317, ordinance n°60-161 of 03-10-60 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.
5. However, the decree n° 98-945 of the medical profession code of ethics permits abortion if it is in the best interest of the pregnant woman, specifically if her health is at risk[3]. The provision of abortion is only permitted following the consultation of two additional physicians, one of whom must be taken from a list of experts provided by the Court. The physician must attest to the fact that the life of the woman cannot be saved by any means other than the intervention contemplated[4]. Additionally, no precision is brought to the extent of "threat of the woman's life". Interpretation may differ for public and health care providers. The resulting impact is that it limits women's

[1] Association pour l'Auto-Promotion des Populations Vulnérables (ANAPV) is a non-profit organization founded by the staff members of International HIV and AIDS Alliance (IHAA Madagascar) when the organization decided to leave the country on 2009. ANAPV's mission is to provide support to vulnerable (and stigmatized) groups in the Malagasy communities, such as LGBTIs, poor women and children, sex workers, poor young people and PLHA, so that they could become autonomous, confident, and could take full responsibility of their own well-being, including full participation in political and social decision-making processes. Our support varies from capacity building, networking/alliances, partnership and advocacy. Our values are equity, inclusiveness and participation, excellence, and "go beyond". Our areas of intervention are sexual and reproductive health, community health, human rights and gender. We are closely working with a large network of organizations and associations of vulnerable groups throughout Madagascar.

[2] The Sexual Rights Initiative (SRI) is a coalition of organizations that advocates for the advancement of human rights in relation to gender and sexuality within international law and policy. The SRI focuses its efforts particularly on the work of the United Nations Human Rights Council, including its resolutions and debates as well as the work of the Universal Periodic Review mechanism and the system of Special Procedures. The SRI combines feminist and queer analyses with a social justice perspective and a focus on the human rights of all marginalized communities and of young people. It seeks to bring a global perspective to the Human Rights Council, and collaborates in its work with local and national organizations and networks of sexual and reproductive rights advocates, particularly from the Global South and Eastern Europe. The SRI partners are: Action Canada for Population and Development, Akahatá - Equipo de Trabajo en Saxualidades y Generos, Coalition of African Lesbians, Creating Resources for Empowerment in Action (India), Egyptian Initiative for Personal Rights, and Federation for Women and Family Planning (Poland).

[3] LPED, B. G. (2011). *Santé de la Reproduction et Avortement à Antananarivo, Madagascar.* Bulletin d'Information sur la Population en Afrique et à Madagascar

[4] FISA, F. S. (2007). *Rapport sur l'avortement clandestin à Madagascar.* Antananarivo: Focus Development.

access to safe abortion services. The implicit exception under the abortion law could exclude interpretation of what may be considered a mental health threat which can be also life threatening[5].

6. The Act of 17 April 1920 (derived from the French law): suppresses the complicity and incitement to abortion and contraceptive propaganda, it prohibits any advertising or propaganda, by any means whatsoever, in favor of abortion or contraception. 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.[6]

Political and Social Context

1. The Government has expressed particular concern about maternal, morbidity and mortality resulting from unsafe abortion. Action to address the issue was integrated into a population policy in 1990 that focused on reducing the total fertility rate through family planning[7]. The Policy of Safe motherhood encompasses a Road Map of Maternal and neonatal mortality intended to reduce maternal deaths. This Road Map has been launched by the Ministry of Health and Family Planning for 2005-2015 but the government is failing to build the capacity of all individuals, family and members of community in term of health awareness campaign including information to improve their overall health[8].

2. Recognizing that unsafe abortion is a violation of women's right to life and health, over 40% of women who have undergone an abortion are supportive of its legalization[9]. Assistance services known as "post-abortion care" for women with unwanted pregnancy are available, however, access to such services remains limited as they do not have national coverage yet and the issue of sexual and reproductive health remains taboo by conservative Malagasy society.

3. In 2008, the President of Madagascar rejected some organizations' attempts to pass a law to decriminalize abortion[10]. The fact that there are very few social dialogues on such issues does not encourage the Government to take action on the issue. There have been no attempts to introduce to liberalize abortion through new legislation[11]. There is no serious advocacy being done for abortion legalization, thus, there is little pressure to reform abortion laws.

4. The press has remained relatively silent on the issue, its actions have been very limited in informing, and giving thoughtful analysis on the situation, as they should do. Due to taboo related to sex and specifically abortion, discussing abortion legalization is difficult within malagasy society. Civil society members and activists are still very cautious when it comes to discussing these issues openly. The outcome of a Malagasy women pregnancy is determined by social and religious power. Religious leaders are very conservative, and they are very influential in the malagasy society. They are strongly against the practice of abortion in Madagascar. "It is believed that decisions regarding one's own body, does not belong to the human being, the solution is to prevent and not to try to find solutions after the fact" said a priest. When asked about the case of many deaths due to illegal abortions, the priest said that there are other causes of mortality, other than abortion, which should attract more attention including, for example, maternal mortality due to malaria. Rather than recognize the need to provide post-abortion care, religious authorities insist on sexual education[12] which they believe should be based on avoiding sexual intercourse outside marriage and using contraceptives to prevent pregnancy for married women.

5. Despite there being an increased need to provide reproductive health programs and services, Madagascar has not been able to offer such services for women, both because of a lack of financial resources, and because public health is not prioritized. Policies with regard to access to reproductive health services have been set in place but their implementation remains a significant challenge. Reproductive health services and assistance are free of

[5] WHO, World Health Organization. (2012). *Safe abortion:technical and policy guidance, second Edition.* Geneva: WHO
[6] http://www.memoireonline.com/04/09/2035/m_Le-Planning-Familial-a--Madagascar0.html
[7] Population Policy Data Bank maintained by the Population Division of the Department for Economic and Social Affairs of the United Nations Secretariat
[8] FNUAP. (2012). *Evaluation indépendante du programme de pays - annexes Madagascar*
[9] FISA, F. S. (2007). *Rapport sur l'avortement clandestin à Madagascar.* Antananarivo: Focus Development.
[10] Midi Madagascar. (2008, June). *Madagascar : refus catégorique d'une loi autorisant l'avortement*. Consulté le February 2014, sur avortementivg.com: http://www.avortementivg.com/article-20494764.html
[11] Finlay, J. E. (2012). *Reproductive Health Laws Around the World.* Harvard: Program on the Gloabl Demography of Aging
[12] Madagascar Tribune. (2008). *Madagascar Tribune web.* Consulté le February 2014, sur http://www.madagascar-tribune.com/Mise-en-garde-de-L-Eglise,4290.html

charge like many other services in public health centers but their accessibility remains limited due to a lack of awareness to the existence of the services by the general public and the limited coverage; as 40% of the Malagasy Population live within five kilometers of most health centers.

Access to a comprehensive package of sexual and reproductive health services, including contraceptives, and comprehensive sexuality education

6. Although Malagasy women have increasingly begun to use contraceptives, both oral and injected, there continues to be an unmet need[13]. The last DHS showed that among women 15 to 19 years: 32% have already begun childbearing (56% of them being in the South Ihorombe region), 26% are mothers (48% of them being in the Southwest region), and only 28% of them have access to information on family planning. More than 70% of women who are sexually active confirmed the need for family planning in 2009, compared to 29% in 2004[14]. 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. Malagasy young people are reluctant to use contraceptive methods for many reasons. The first and foremost would be the misinformation. For example, some young people believe that contraceptive methods can lead to sterility or have many side effects on the body, that condom use is unpleasant for sex, and that contraceptives do not prevent unintended pregnancy.
7. In 2007, legislation was passed to restrict young people under the age of 18 to form a civil union, unless they received authorization from their parents[15]. The result is that it is publically understood that pregnancies before the age of 18 are not encouraged which leads to women under this age, who are sexually active and experience an unwanted pregnancy, to seek unsafe abortion. In general 17% of young women have their first sexual intercourse before the age 15, in some regions like Ihorombe, more than 52% have their sexual course before 15.This, coupled with the fact that contraceptive prevalence is limited, means that girls are likely to have more than one abortion by the time they are 18.
8. The limited access to health services remains the biggest challenge as 40% of the Malagasy Population is living more than 5km far from any health center[16]. It is hard for them to get to the health center so they are unable to receive enough information about planning familial along with prevention means and also difficult to access to the contraceptives methods.
9. Programs for sexual education do not target young people in early age at the time they might experience their first sexual intercourse. Targets of planning family programs are mainly young people already sexually active which leaves younger adolescents uninformed[17]. Some High schools have introduced sexual education providing means of prevention of unwanted pregnancies and safe sex but such programs are not systematically offered to the secondary school where young people might enter into sexual relations.

Unsafe abortion: violation of women's right to health, right to life

10. In many cases, to protect patients and their families from imprisonment or fines, doctors do not release information pertaining to unsafe abortions. As a result, data on the incidence of unsafe abortion in Madagascar is extremely limited. Consequently, deaths due to complication related to unsafe abortions are hard to track because they are often not reported, especially in rural areas where only 32.3% of women give birth in health facilities. Between 2008 and 2009, more than 50% of rural populations sought out services from traditional providers[18]. An estimated rate of 40% of maternal mortality in rural areas is related to complications resulting from unsafe abortion[19].

[13] Baromètre de la SADC, 2012.
[14] Institut National de la Statistique. (2008-2009). *DHS, Demographic Health Survey.* Antananarivo, Madagascar: Institut National de la Statistique.
[15] Faits et Chiffres. (2011). *Les Jeunes Malgaches.* Antananarivo
[16] FNUAP. (2012). *Évaluation indépendante du programme de pays - annexes Madagascar*
[17] LPED, B. G. (2011). *Santé de la Reproduction et Avortement à Antananarivo, Madagascar.* Bulletin d'Information sur la Population en Afrique et à Madagascar
[18] Faits et Chiffres. (2011). *Les Jeunes Malgaches.* Antananarivo
[19] Population Policy Data Bank maintained by the Population Division of the Department for Economic and Social Affairs of the United Nations Secretariat. (s.d.). Consulté le February 2014, sur www.un.org/esa/population/publications/abortion/doc/madaga.doc

11. 75,000 abortions per year are recorded by the Ministry of Health around the Island[20]. Maternal deaths due to unsafe abortion are considered to be the second leading cause of maternal mortality and morbidity in the country[21]. An estimated 575 maternal death occurred as a result of unsafe abortion[22]. In 1997, 43.2% of maternal deaths were caused by spontaneous abortions and / or induced in a hospital in the capital[23]. The rate of abortion is reportedly increasing, to be 8 times higher during the last 10 years[24].

12. Clandestine abortion is a common practice for young Malagasy women. 53.5% of young women (15-24 years) from urban area responded that they sought out an abortion in 2007. This practice is not new as about 50% of women in their 40s declared having recourse to at least once to abortion before the age of 25. Many women undergo abortion at younger ages, especially women in rural areas. Some women opt for clandestine abortion more than once. This is the case for women from different age groups. Up to as many as 50% of women in urban areas have sought out abortion services[25].

13. Challenges posed by the restrictive law imposed on women's access to abortion, together with strong pressures from religious and social beliefs against abortion lead women to seek out clandestine abortion. The cost of clandestine abortion varies in accordance with the quality of the service. The cheapest are those performed by unqualified providers using inappropriate or outdated methods of inducing abortion. These unsafe abortions often result in severe health complications or death. These services affect young women with poor economic status and with lower levels of education[26].

14. Generally, unsafe abortion can be a traumatizing experience for women[27]. Apart from physical consequences that could lead to hemorrhage, sterility, cervical cancer[28], following labor complication, and sometimes death, women have also declared experiencing psychological after-effects, including anxiety.

15. Some private health care clinics provide "Post-abortion care" known as a veiled reference for abortion. They are known for offering abortion services, mainly with medical treatment and rarely with chirurgical intervention[29], but disguise their service as "post abortion care", so there is no liable prosecution. There are no explicit promotions of such centers; public awareness regarding their existence is only from word of mouth[30].

Stigma and discrimination

16. Economic factors and gender norms are the main reasons women seek abortion services[31.] Seventy per cent of clandestine abortions result from pressure from partners. Male partners often urge their female partner to seek an abortion. Social norms make it difficult to women to discuss openly issues related to their reproductive health and rights with their partners. Women lack the ability to make autonomous choices regarding their health and their bodies[32]. In malagasy culture, being married and having a child is a sign of a fulfilled and successful life. Throughout their lives, boys and girls are educated to become 'fathers' and 'mothers', based on constructed gender roles and stereotypes[33] Becoming a wife changed the course of so many women's life in Madagascar as it determines their place in the community. Once married the society expect them to take responsibilities within their family. This commitment for women is demonstrated by the submission to their husbands; they must be tolerant and trustworthy, they must acquire those behaviors if they want to sustain the marriage and avoid shaky relationship. For them respecting their husband requires their submission, which also concerns the area of sexuality. "Submission to the sexual needs of the husband would allow the woman to keep the stability of the couple and a way to avoid the husband's extramarital affairs" says a woman from Antsirabe.

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[20] LPED, B. G. (2011). *Santé de la Reproduction et Avortement à Antananarivo, Madagascar.* Bulletin d'Information sur la Population en Afrique et à Madagascar
[21] Jeanne, V. (2013). *Interruption volontaires des grossesses clandestines.* Antananarivo: INSPC
[22] LPED, B. G. (2011). *Santé de la Reproduction et Avortement à Antananarivo, Madagascar.* Bulletin d'Information sur la Population en Afrique et à Madagascar
[23] Baromètre de la SADC, 2012.
[24] Jeanne, V. (2013). *Interruption volontaires des grossesses clandestines.* Antananarivo: INSPC
[25] FISA, F. S. (2007). *Rapport sur l'avortement clandestin à Madagascar.* Antananarivo: Focus Development.
[26] FISA, F. S. (2007). *Rapport sur l'avortement clandestin à Madagascar.* Antananarivo: Focus Development.
[27] FISA, F. S. (2007). *Rapport sur l'avortement clandestin à Madagascar.* Antananarivo: Focus Development.
[28] FISA, F. S. (2007). *Rapport sur l'avortement clandestin à Madagascar.* Antananarivo: Focus Development.
[29] http://www.vsinnovations.org/assets/files/MSM_VSI%20Miso%20TRAIN%20Brief%202010%2003%2017F.pdf
[30] Mosher, S. W. (2013, March). *Marie Stopes and the Charade of "Post-Abortion Care"*. Consulté le February 2014, sur Population Research Institute: http://pop.org/content/marie-stopes-and-charade-%E2%80%9Cpost-abortion-care%E2%80%9D
[31] Jeanne, V. (2013). *Interruption volontaires des grossesses clandestines.* Antananarivo: INSPC
[32] Midi Madagascar. (2008, June). *Madagascar : refus catégorique d'une loi autorisant l'avortement*. Consulté le February 2014, sur avortementivg.com: http://www.avortementivg.com/article-20494764.html
[33] PSI, Genre et mécanisme de prise de décision en matière de Planning familial à Antsirabe et Antsohihy (Mai 2012)

17. Male partners exert considerable control and pressure on women to abort or keep the pregnancy. Marriage changes the course of the lives of many women in Madagascar as it seen to determine their place in the community. “People respect you more when you're are in couple” says a young woman from Antsohihy[34].

18. The fear of being left behind dictate the behaviors of so many women as the Malagasy society lacks tolerance regarding single mothers. “You will be frowned upon and considered as someone who has a deleterious behavior” says a young girl from Antsohihy. A gender assessment from different regions highlighted the hurdles faced by those single mothers. Those reports state that single mothers are rejected by their family as they are considered as ‘shameful’ and are undervalued compared to other women in the community. Other married women hate single mothers for fear of losing their husbands who will be attracted by these single women. It is the same for the children of single mothers, sometimes shunned by society[35]. Thus, girls and women prefer to perform unsafe abortion rather than being single mothers, even if the act is very dangerous for them.

Recommendations for actions:

19. Establish policies and programs to provide all individuals with good-quality and accessible family planning services, including emergency contraception, within a comprehensive package of sexual and reproductive health information and services. Such policies and programs must meet the particular needs of young women (specifically, between the ages of 15-49), poor women, HIV-positive women and survivors of rape.

20. Systematize and make compulsory the implementation of comprehensive sexual education programs, for all age levels, focusing on how to avoid unwanted pregnancy including reference to health care counseling and services on contraceptive methods.

21. Increase access to youth friendly sexual and reproductive health services free from judgment for young people.

22. Review and promote wider understanding of the extent of the exception of the law according to the code of medical profession for health care providers and for wider public. Ministry of health and the ministry of justice along with health professionals should work together and define clearly an exhaustive list but not limited when abortion is not against the law.

23. Amend the current law regarding abortion with a view to decriminalize women’s access to safe abortion services by removing restrictions to the service.

24. Establish public awareness raising campaign aimed at increasing women’s knowledge of the current legal context surrounding abortion, the complications of miscarriage and unsafe abortion; and where to obtain appropriate services and information.

25. Remove barriers to women’s access to abortion services, including third-party authorization or notification clauses.

26. Increase access to services for case management of complications resulted from unsafe abortion.

27. Implement programs for rapid access to post-abortion care regardless of the permissibility of abortion.

28. Create public awareness raising campaigns aimed at eliminating negative gender stereotypes and norms, particularly those related to deconstructing women’s ‘role’ in society, the family and within relationships.

[34] PSI. (2012). *Genre et mécanisme de prise de décision en matière de Planning familial à Antsirabe et Antsohihy.* Population Service International

[35] ANDRIAMIZANA, C. G. (2013). *Rapport d’analyse du genre au niveau des groupes ethniques dans la région de DIANA.* Projet Mahefa/JSI- USAID PSI