# REPRODUCTIVE HEALTH *at a* GLANCE

# HAITI

April 2011

## Country Context

Haiti is the poorest country in the Western Hemisphere (GDP per capita of $660) with 55 percent of the population subsisting on less than US $1.25 per day.[1] Despite its high vulnerability, the country experienced a sustained growth rate between 2004 and 2008, and is currently slowly recovering of the devastated effects of the earthquake that destroyed its capital city in 2010. Agriculture in the form of small-scale subsistence farming accounts for 30 percent of the country's GDP and provides work for about two-thirds of all Haitians.[2]

Haiti's large share of youth population (37 percent of the country population is younger than 15 years old[3]) provides a window of opportunity for high growth and poverty reduction—the demographic dividend. For this opportunity to result in accelerated growth, the government needs to invest more in the human capital formation of its youth.

Estimated at 9.8 million in mid-2010, Haiti's population is expected to reach 15.7 million by 2050. This rapid population growth highlights the need for targeted reproductive health programs that continue the decreasing trend in total fertility rate, and increase the availability of modern contraceptives.

Gender equality and women's empowerment are important for improving reproductive health. Higher levels of women's autonomy, education, wages, and labor market participation are associated with improved reproductive health outcomes.[4] In Haiti, the literacy rate among females ages 15 and above is 63 percent. The overall net attendance at the primary school level is 48 percent for boys and 52 percent for girls but declines sharply to 18 percent and 21 percent respectively at the secondary school level. Nearly three-fifths of adult women participate in the labor force[1] that mostly involves work in agriculture.

Greater human capital for women will not translate into greater reproductive choice if women lack access to reproductive health services. It is thus important to ensure that health systems provide a basic package of reproductive health services, including family planning.[4]

## Haiti: MDG 5 Status

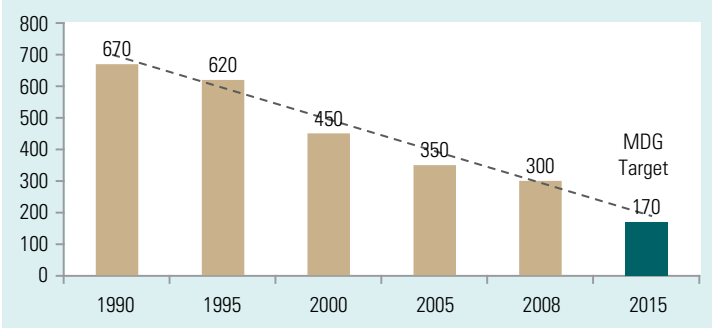
| MDG 5A indicators | |
|---|---|
| Maternal Mortality Ratio (maternal deaths per 100,000 live births) *UN estimate*[a] | 300 |
| Births attended by skilled health personnel (percent) | 26.1 |
| **MDG 5B indicators** | |
| Contraceptive Prevalence Rate (percent) | 32.0 |
| Adolescent Fertility Rate (births per 1,000 women ages 15–19) | 69 |
| Antenatal care with health personnel (percent) | 84.5 |
| Unmet need for family planning (percent) | 37.5 |

*Source:* EMMUS-IV (DHS) Final Report, HAÏTI, 2005–2006.
[a] The 2005 Cambodia DHS estimated maternal mortality ratio at 472

## MDG Target 5A: Reduce by Three-quarters, between 1990 and 2015, the Maternal Mortality Ratio

Haiti has been making progress over the past two decades on maternal health but it is not yet on track to achieve its 2015 targets.[5]

**Figure 1 ▪ Maternal mortality ratio 1990–2008 and 2015 target**




*Source:* 2010 WHO/UNICEF/UNFPA/World Bank MMR report.

## World Bank Support for Health in Haiti

The Bank's new ***Country Assistance Strategy*** under preparation (P101443) is scheduled to be approved by the Bank's executive Board on May 19, 2011.

**Current Project:** None

**Pipeline Project:**

P104400 HT (IDF) Improving Health Surveillance Closing date 4/29/2012

**Previous Health Project:** None

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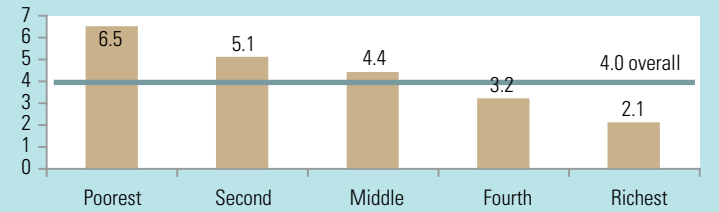
## Key Challenges

### High fertility

**Fertility has been declining over time but is still the highest in the Americas, especially among the poorest.** Total fertility rate (TFR) has been declining steadily from an estimated 4.8 birth per woman in 1995 to 4.0 births per woman in 2006.[3]

**Figure 2 ▪ Total fertility rate by wealth quintile**




*Source:* EMMUS-IV (DHS) Final Report, HAÏTI, 2005–2006.

However, wide disparities exist with the TFR of women in the lowest wealth quintile being more than three times the TFR of women in the highest wealth quintile (Figure 2).[3] A similar pattern can be observed in looking at the disparities between urban and rural areas: TFR among women in urban areas (2.8) is about half those living in rural areas (5.0).

**Adolescent fertility rate is high (69 births per 1,000 women aged 15–19 years) affecting not only young women and their children's health but also their long-term education and employment prospects.** Births to women aged 15–19 years old have the highest risk of infant and child mortality as well as a higher risk of morbidity and mortality for the young mother.[4, 6]

**Early childbearing is more frequent among the poor**. While 30 percent of the poorest 20–24 years old women have had a child before reaching age 18, only 12 percent of their richer counterparts did (Figure 3). Furthermore, this wide disparity in early childbearing has been persistent over time across cohorts.

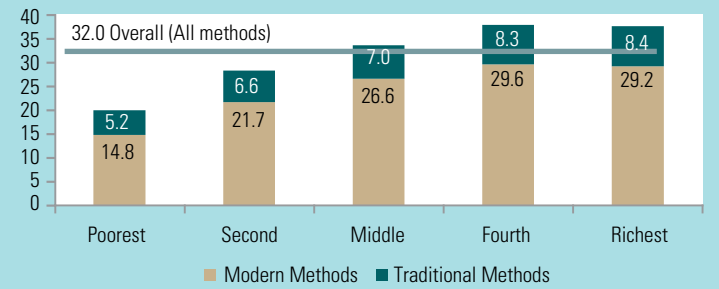
**About a third of married women use contraception**. Married women in the wealthiest quintile are twice more likely to use modern contraception than their poorest counterparts (29.2 percent and 14.8 percent respectively) (Figure 4).

**Modern contraceptive methods are more frequently used than traditional methods** (24.8 percent and 7.2 percent, respectively).[3] Injectables are the most commonly used modern method among married women (11.0 percent), followed by condoms (5.3 percent) and the pill (3.3 percent). Use of long-term methods such as the IUD and implants are negligible.

**Figure 3 ▪ Percent women who have had a child before age 18 years by age group and wealth quintile**


*Source:* EMMUS-IV (DHS) Final Report, HAÏTI, 2005–2006 (author's calculation).

**Figure 4 ▪ Use of contraceptives among married women by wealth quintile**




*Source:* EMMUS-IV (DHS) Final Report, HAÏTI, 2005–2006.

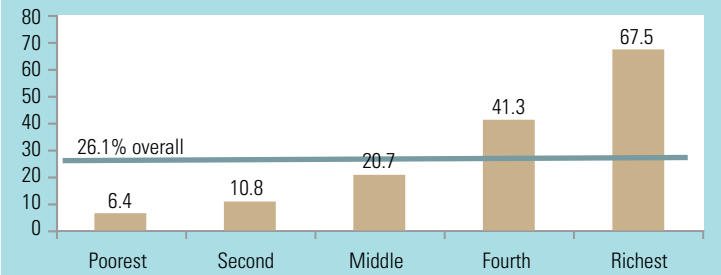
**Unmet need for contraception is high at 38 percent[3] indicating that women may not be achieving their desired family size.**[7] This is especially the case for women in the poorest quintile where unmet need reaches 44 percent.

**Health concerns or side effects of modern contraceptive methods are the predominant reasons women do not intend to use them in the future.** Nearly 60 percent of women not intending to use contraception cited health concerns or side effects as the main reason.[3] About 17 percent expressed opposition to use, primarily by themselves, their husband, or due to their religion. Cost and access are lesser concerns, indicating further need to strengthen family planning services.

### Poor Pregnancy Outcomes

**While use of antenatal care is widespread, institutional deliveries are less common.** About 85 percent of pregnant women receive antenatal care from skilled health personnel (49 percent from physicians).[3] Further, 54 percent of pregnant women have 4 or more antenatal visits. However, the quality of antenatal care is uneven, and most women do not benefit from the minimum tests recommended by the WHO (namely, blood pressure, urine test and blood test). Further, more than one out of two pregnant women are not informed about the signs of pregnancy complications. Finally, only a small proportion (26 percent) delivers with the assistance of skilled health personnel. Indeed, 66 percent of women deliver with "matrons", who are not considered skilled health personnel.[3] Important disparities exist among wealth quintiles with 67 percent of women in the wealthiest quintile delivered with skilled health personnel, only 6 percent of women in the poorest quintile obtained such assistance (Figure 5). Further, 63 percent of all pregnant women are anaemic (defined as haemoglobin < 110g/L) increasing their risk of preterm delivery, low birth weight babies, stillbirth and newborn death.[8]

**Figure 5 ▪ Birth assisted by skilled health personnel (percentage) by wealth quintile**




*Source:* EMMUS-IV (DHS) Final Report, HAÏTI, 2005–2006.

**Postnatal care is effectively used mostly by those women who delivered in a health facility.** Of those women who did not give birth in a health facility, 81 percent never received a postnatal care, and only 13 percent got postnatal check-up within two days of delivery.[3]

**The majority of women who indicated problems in accessing health care cited concerns regarding services providers not available at the health facilities and/or inability to afford the services** (Table 1).[3]

**Table 1. Reasons for not delivering in a health facility (women age 15–49 years)**

| Reason | % |
|---|---|
| At least one problem accessing health care | 97.3 |
| Concerned no provider available | 87.7 |
| Getting money for treatment | 78.4 |
| Having to take transport | 44.7 |
| Distance to health facility | 42.7 |
| Concerned no female provider available | 42.0 |
| Not wanting to go alone | 28.1 |
| Getting permission to go for treatment | 16.7 |

*Source:* EMMUS-IV (DHS) Final Report, HAÏTI, 2005–2006.

**Human resources for maternal health are limited with** only 0.25 physicians per 1,000 population, but nurses and midwives are slightly more common, at 0.11 per 1,000 population.[1]

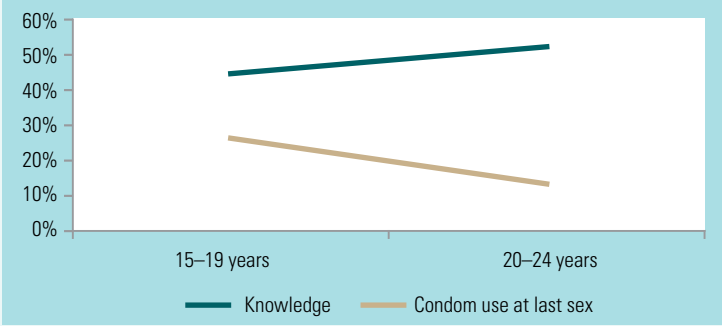
The high maternal mortality ratio at 300 maternal deaths per 100,000 live births[3] indicates that access to and quality of emergency obstetric and neonatal care (EmONC) remains a challenge.[5]

## STIs/HIV/AIDS prevalence is low but a growing public health concern

About 2 percent of the adult population has HIV (**highest national HIV prevalence rate in the world outside of sub-Saharan Africa**); prevalence among females is higher than among males (2.3 percent and 2.0 percent, respectively) with women of childbearing age comprising 60 percent of the HIV positive population.[1]

**There is a large knowledge-behavior gap regarding condom use for HIV prevention.** While 45 percent of young women are aware that using a condom in every intercourse prevents HIV, only half of them report having used condom at last intercourse (Figure 6). This gap widens among older aged women likely due to the fact that the chances of using condoms as a form of contraception diminishes with marriage.

**Figure 6 ▪ Knowledge behavior gap in HIV prevention among young women**




*Source:* EMMUS-IV (DHS) Final Report, HAÏTI, 2005–2006 (author's calculation).

### Technical Notes

Improving Reproductive Health (RH) outcomes, as outlined in the RHAP, includes addressing high fertility, reducing unmet demand for contraception, improving pregnancy outcomes, and reducing STIs.

The RHAP has identified 57 focus countries based on poor reproductive health outcomes, high maternal mortality, high fertility and weak health systems. Specifically, the RHAP identifies high priority countries as those where the MMR is higher than 220/100,000 live births and TFR is greater than 3.These countries are also a sub-group of the Countdown to 2015 countries. Details of the RHAP are available at *www.worldbank.org/population*.

The Gender-related Development Index is a composite index developed by the UNDP that measures human development in the same dimensions as the HDI while adjusting for gender inequality. Its coverage is limited to 157 countries and areas for which the HDI rank was recalculated.

### Development Partners Support for Reproductive Health in Haiti

| | |
|---|---|
| **WHO/PAHO:** | Safe motherhood, EmONC |
| **UNFPA:** | Reproductive health and rights |
| **UNICEF:** | Child protection; under-5 mortality |
| **USAID:** | Health systems strengthening; skilled birth attendance |
| **CIDA:** | Health systems strengthening; EmONC |
| **IDB:** | Cholera, nutrition and social protection |
| **Clinton Foundation:** | Health system strengthening |

In addition, there are hundreds of NGOs working in the sector, albeit in a fragmented manner.

## Key Actions to Improve RH Outcomes

### Strengthen gender equality

- Support women and girls' economic and social empowerment. Increase school enrollment of girls. Strengthen employment prospects for girls and women. Educate and raise awareness on the impact of early marriage and child-bearing.

### Reducing high fertility

- Address the issue of opposition to use of contraception and promote the benefits of small family sizes. Increase family planning awareness and utilization through outreach campaigns and messages in the media. Enlist community leaders and women's groups.
- Provide quality family planning services that include counseling and advice, focusing on young and poor populations. Highlight the effectiveness of modern contraceptive methods and properly educate women on the health risks and benefits of such methods.
- Promote the use of ALL modern contraceptive methods, including long-term methods, through proper counseling which may entail training/re-training health care personnel.
- Development partners should work closely with Government in the context of emergency relief and reconstruction to secure reproductive health commodities and strengthen supply chain management.

### Reducing maternal mortality

- Improve the quality of antenatal care, and educate pregnant women about the importance of delivery with a skilled health personnel and getting postnatal check. Encourage and promote community participation in the care for pregnant women and their children.
- Promote institutional delivery through provider incentives. Provide vouchers to women in hard-to-reach areas for transport and/or to cover cost of delivery services.
- Target the poor and women in hard-to-reach rural areas in the provision of basic and comprehensive emergency obstetric care (renovate and equip health facilities).
- Address the inadequate human resources for health by training more midwives and deploying them to the poorest or hard-to-reach districts.
- Strengthen the referral system by instituting emergency transport, training health personnel in appropriate referral procedures (referral protocols and recording of transfers) and establishing maternity waiting huts/homes at hospitals to accommodate women from remote communities who wish to stay close to the hospital prior to delivery.

### Reducing STIs/HIV/AIDS

- Strengthen Behavior Change Communication (BCC) programs via mass media and community outreach to raise HIV/AIDS awareness and knowledge.
- Integrate HIV/AIDS/STIs and family planning services in routine antenatal and postnatal care.
- Focus on adolescents, youth and married women in providing information, education and communication on HIV/AIDS.

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## HAITI REPRODUCTIVE HEALTH ACTION PLAN INDICATORS

| Indicator | Year | Level | Indicator | Year | Level |
|---|---|---|---|---|---|
| Total fertility rate (births/woman ages 15–49) | 2005–06 | 4 | Population, total (million) | 2008 | 9.9 |
| Adolescent fertility rate (births/1,000 women ages 15–19) | 2005–06 | 69 | Population growth (annual %) | 2008 | 1.6 |
| Contraceptive prevalence (% of married women ages 15–49) | 2005–06 | 32 | Population ages 0–14 (% of total) | 2008 | 36.7 |
| Unmet need for contraceptives (%) | 2005–06 | 37.5 | Population ages 15–64 (% of total) | 2008 | 58.9 |
| Median age at first birth (years) from DHS | 2005 | 21.9 | Population ages 65 and above (% of total) | 2008 | 4.3 |
| Median age at marriage (years) | — | — | Age dependency ratio (% of working-age population) | 2008 | 69.7 |
| Mean ideal number of children for all women | 2005–06 | 3 | Urban population (% of total) | 2008 | 46.8 |
| Antenatal care with health /sonnel (%) | 2005–06 | 84.5 | Mean size of households | 2005–06 | 5 |
| Births attended by skilled health /sonnel (%) | 2005–06 | 26.1 | GNI/capita, Atlas method (current US$) | — | — |
| Proportion of pregnant women with hemoglobin <110 g/L) | 2008 | 63.2 | GDP/capita (current US$) | 2008 | 729 |
| Maternal mortality ratio (maternal deaths/100,000 live births) | 1990 | 670 | GDP growth (annual %) | 2008 | 1.3 |
| Maternal mortality ratio (maternal deaths/100,000 live births) | 1995 | 620 | Population living below US$1.25/day | 2003 | 54.9 |
| Maternal mortality ratio (maternal deaths/100,000 live births) | 2000 | 450 | Labor force participation rate, female (% of female population ages 15–64) | 2008 | 58.4 |
| Maternal mortality ratio (maternal deaths/100,000 live births) | 2005 | 350 | Literacy rate, adult female (% of females ages 15 and above) | 2004 | 62.8 |
| Maternal mortality ratio (maternal deaths/100,000 live births) | 2008 | 300 | Total enrollment, primary (% net) | — | — |
| Maternal mortality ratio (maternal deaths/100,000 live births) target | 2015 | 170 | Ratio of female to male primary enrollment (%) | — | — |
| Infant mortality rate (per 1,000 live births) | 2008 | 54 | Ratio of female to male secondary enrollment (%) | — | — |
| Newborns protected against tetanus (%) | 2008 | 50 | Gender Development Index (GDI) | — | — |
| DPT3 immunization coverage (% by age 1) | 2005–06 | 47.9 | Health expenditure, total (% of GDP) | 2007 | 5.3 |
| Pregnant women living with HIV who received antiretroviral drugs (%) | 2005 | 6.7 | Health expenditure, public (% of GDP) | 2007 | 1.2 |
| Prevalence of HIV (% of population ages 15–49) | 2007 | 2.2 | Health expenditure/capita (current US$) | 2007 | 35 |
| Female adults with HIV ( % of population ages 15+ with HIV) | 2007 | 52.7 | Physicians (per 1,000 population) | 1998 | 0.25 |
| Prevalence of HIV, female (% ages 15–24) | 2007 | 1.4 | Nurses and midwives (per 1,000 population) | 1998 | 0.11 |

| Indicator | Survey | Year | Poorest | Second | Middle | Fourth | Richest | Total | Poorest-Richest Difference | Poorest/Richest Ratio |
|---|---|---|---|---|---|---|---|---|---|---|
| Total fertility rate | DHS | 2005/06 | 6.6 | 5.0 | 4.4 | 3.0 | 2.0 | 3.9 | 4.6 | 3.3 |
| Current use of contraception (Modern method) | DHS | 2005/06 | 14.8 | 21.7 | 26.6 | 29.6 | 29.2 | 24.8 | –14.4 | 0.5 |
| Current use of contraception (Any method) | DHS | 2005/06 | 20.0 | 28.3 | 33.6 | 37.9 | 37.6 | 32.0 | –17.6 | 0.5 |
| Unmet need for family planning (Total) | DHS | 2005/06 | 44.2 | 43.3 | 36.6 | 34.0 | 31.6 | 37.5 | 12.6 | 1.4 |
| Births attended by skilled health personnel (percent) | DHS | 2005/06 | 6.4 | 10.8 | 20.7 | 41.3 | 67.5 | 26.1 | –61.1 | 0.1 |

### National Policies and Strategies that have Influenced Reproductive Health

**1995**: The Government launched an ambitious decentralization plan that relies on a network of Communal Health Units for the delivery of basic health services, which include reproductive health services. However, progress has been very limited, and not all communities benefit from rally health posts, mobile clinics, health agents, and local trained birth attendants.