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ABBREVIATIONS AND ACRONYMS

Abota	Informal saving groups
ACT	Artemesinin-Based Combination Therapy
AD	*Acção para o Desenvolvimento* (Action for Development)
AfDB	African Development Bank
AIDS	Acquired immune-deficiency syndrome
ARV	Anti Retro Virals
BESP	Basic Education Support Project
BHU	Basic Health Unit
CADESP	Micro-Finance Unit of the Ministry of Economy
CAS	Country Status Report
CBO	Community-Based Organization
CCM	Multi-Sectoral Coordination Committee
CDD	Community Driven Development Project
CEFAG	*Centro de Educação e Formação Agrária* (Center for Education and Agricultural Training)
CEFC	*Centro de Educação e Formação Comunitária* (Center for Education and Community Training)
CENFA	*Centro de Formação Administrativa* (Administrative Training Center)
CENFI	*Centro de Formação Industrial* (Center for Industrial Training)
CESE	*Centro de Estudos Socio-Económicos* (Center for Socio-Economic Studies
CG	*Comités de Gestão* (Management Committees)
CSR	Country Status Report
DAF	*Direcção de Administração e Finanças* (Adminstrative and Finance Unit)
DANIDA	Danish International Development Assistance
DHE	Department of Hygiene and Epidemiology
EFA-FTI	Education for All - Fast Track Initiative
EOC	Essential Obstetrical Care
EU	European Union
Fanado	Male and female circumcision
FAS	*Fundação Acção Social* (Foundation Social Action)
FED	*Fundo Europeu de Desenvolvimento* (European Development Fund)
FGC	Female genital cutting
Fula	Muslim ethnic group living mainly in the east of the country
GAVI	Global Alliance for Vaccines and Immunization Alliance
GDP	Gross Domestic Product

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GER	Gross Enrollment Rate
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GIPASE	*Gabinete de Estatística e Planeamento do Sistema Educativo*
GIR	Gross Intake Rate
HDI	Human Development Indicator
HIS	Health Information System
HR	Human Resources
HRH	Human Resources in Health
IDA	International Development Agency
IEC	Information, Education and Communication
ILAP	Light Household Survey
ILO	International Labor Organization
INDE	*Instituto Nacional para o Desenvolvimento da Educação* (National Institute for Education Development)
INEP	*Instituto Nacional de Estudos e Pesquisa* (National Institute for Studies and Research)
INPS	*Instituto Nacional de Previdência Social* (National Institute of Social Security)
IPSA	Integrated Poverty and Social Assessment
JSAN	Joint Staff Advisory Note
M&E	Monitoring and Evaluation
Mandinga	Muslim ethnic group living mainly in the north and east of the country
Mandjuandade	Social club providing benefits to its members
MBB	Marginal Budgeting for Bottleneck
MDG	Millennium Development Goals
MICS	Multiple Indicators Cluster Survey
MoE	Ministry of Education
MoH	Ministry of Health
Mutualidade de Saúde	Community-based informal health insurance
NAS	National Aids Secretariat
NGO	Non-Governmental Organization
NSH	National School of Health
PER	Public Expenditure Review
PNDS	National Health Development Plan
PRSP	Poverty Reduction Strategy Plan
PSB	*Projecto de Saúde de Bandim (*Bandim Health Project)
UAC	*Universidade Amílcar Cabral* (University Amilcar Cabral)
UN	United Nations

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This study is a joint effort between the Government of Guinea-Bissau and the World Bank to provide an accurate account of the current status of the provision of key social services in Guinea-Bissau, with a focus on education, health, and social protection. The aim of the study is to update critical information regarding these three sectors in order to promote sound and credible dialogue between the country and the Bank, as well as with other development partners in the context of implementation of the PRSP.

The World Bank team consisted of Geraldo Martins (Senior Education Specialist and TTL of the study), Stephane Legros (Senior Health Specialist), and Gerold Vollmer (Consultant, Social Protection). Contributions to the study were received from peer reviewers Helene Grandvoinnet (AFTP4), Sigrun Aasland (AFTS3) and Valerie Kozel (HDNSP). Boubacar-Sid Barry (AFTP4) and Dirk Prevoo (AFTEN) provided valuable contributions. The team carried out two field visits in February and May 2007, primarily to perform data collection.

To ensure country ownership and a broad participatory approach, the Government created a multi-sector working group composed of high-level staff from different Ministries interested in the exercise. The group was lead by Paula Pereira (Ministry of Economy) and composed of Alfredo Gomes (Ministry of Education), Alfa Umaro Djalo and Augusto Paulo Silva (Ministry of Health), Romão Varela (Ministry of Finance), and Inácia Gomes (Ministry of Solidarity and Poverty Reduction). The study benefited also from the contributions of several technicians from these Ministries. The team would like to thank all of them for their collaboration and support.

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EXECUTIVE SUMMARY

A fragile state with many challenges ahead

1. **This review delivers one clear message:** Despite the deep crisis in which the social sectors in Guinea-Bissau are immersed, achieving the goal of better education, good quality health care and adequate social protection for the most vulnerable is still possible, provided the country breaks out with the "business-as-usual" approach on social sectors. Robust reforms are needed to put the country back on track for the achievement of the education and health MDGs. Clearly, some human development MDGs will not be reached by 2015, but a few are still affordable if substantial progress is achieved in the delivery of social services.

2. **Guinea-Bissau remains a fragile, post-conflict state grappling with significant social changes**. Despite attempts to rebuild the government's administration and address economic issues, following the politico-military conflict of 1998-1999, continued political tensions, frequent changes in government, and lack of ownership of policies have contributed to worsen the economic outlook and the living conditions of the population. An estimated 30 percent of its 1.5 million inhabitants live in cities and urban areas, up from 18 percent in 1991, as a result of rapid urbanization and migration.

3. **The socioeconomic context of the period covered by the review was particularly difficult.** While pressure was mounting on social services because of rapid urbanization and growing demand, delivery of such services has been constrained by poor macroeconomic performance in recent years. GDP per capita was estimated at $ 180 in 2006. The economy still suffers from the consequences of the 1998-1999 conflict, which contracted real GDP by 28 percent. During the period 2000-2005, the real GDP growth rate averaged about 1 percent, with negative growths recorded in 2001 and 2003. The fiscal situation remains precarious with government fiscal revenues representing about 14 percent of GDP. While spending on health and education remained lower than the regional average, external assistance dwindled at the same time, leading to mounting domestic arrears and huge fiscal imbalances.

4. **Not surprisingly, poverty is widespread, particularly in rural areas.** At the household level, 64.7 percent of the population was living in poverty in 2006, with 20.8 percent living in extreme poverty. Poverty also increases the vulnerability of population to an array of risks. As opportunities for non-farm wage labor have diminished considerably due to the post-war stagnation of the economy, most of the country's active population is prone to employment vulnerability. Adult unemployment rate stands at 12.4 percent, with youth unemployment

exceeding adult unemployment considerably. Vulnerable groups include children, youth and women, whose exposure to a variety of risks is high.

5. **Social indicators remain strikingly poor.** Guinea-Bissau ranked 173rd out of 177 countries in human development index in 2006. Life expectancy at birth is estimated at 47 years, and the illiteracy rate is 63 percent. According to the Multiple Indicators Cluster Survey (MICS–3) between 2000 and 2006, the infant mortality rate increased from 124 per 1,000 live births to 138 per 1,000 live births, and the mortality rate of children under age five has gone up to 223 per 1,000 live births from 203 per 1,000 live births (the 10th highest in the world). Today, two out of ten children die before they reach the age of five. Maternal mortality is estimated to be at 800 to 1,100 per 100,000 live births. Six out of 10 children who enter the first grade do not complete the full cycle of primary education. Many of those who do complete primary education remain illiterate because of the poor quality of education they receive. Social protection mechanisms are almost non-existent and large segments of the population rely on informal, community-based arrangements to cope with risks.

The education coverage has improved, but inequities persist

6. **The recent expansion of primary education coverage has been impressive, but it was not accompanied by improvements in internal efficiency and quality.** Over the last ten years Guinea-Bissau has substantially expanded its education system coverage, particularly in primary education. Today, there are twice as many students in primary education than there were ten years ago. Girls have particularly benefited from that expansion, as the gender gap has been closing steadily. However, internal inefficiencies persisted and even worsened. An inadequate structure and organization of primary education sub-cycle, combined with high repetition and drop out rates and low quality of education, has resulted in low completion rate in primary education, making it hard for Guinea-Bissau to achieve universal primary completion by 2015.

7. **Demand for secondary education is growing steadily**. As primary education enrollments increase, supported by an increase of community-financed schools and private schools (both representing together 1/3 of all primary schools) a growing demand for secondary education is emerging. Gross Enrollment Rate (GER) in secondary in 2006 was estimated at 35 percent, slightly above the 30 percent average for Sub-Saharan African countries. Private sector providers are playing a critical role in accommodating that demand. The expected expansion of primary education will continue to put pressure on enrollment in secondary education. If the current investment trends in secondary education persist, it is unlikely that private providers alone will be able to absorb the growing number of new enrollments.

8. **Guinea-Bissau must dedicate efforts to increase the provision of technical and vocational training and strengthen the emerging higher education sector.** Technical and vocational training is important to build capacities for labor market and economic development, but its current marginal status in Guinea-Bissau is far from contributing to reach that goal. The 1998-99 conflict has contributed partially to disarticulate the sector, and progress in revamping the system has been slow to come. On the other hand, Guinea-Bissau has undertaken serious efforts to build tertiary education institutions. This effort has resulted in a new panorama of higher education training in Guinea-Bissau with the opening of two universities. But there are

challenges. They include the institutional strengthening of recent initiatives, quality of learning, improved management, and the setting up of a clear legal framework for the sector.

A health system still unreachable by most of the population

9. **The current organization of the national health care system faces multiple constraints in practice**. The central Ministry often fails to provide strategic planning, to monitor implementation of the various health programs, and to ensure coordination between stakeholders. The implementation of health programs at regional and local levels is hampered by infrastructure and equipment shortages, as well as by weak management capacity. The management of the whole system is also hindered by an inadequate monitoring and evaluation system, as the consolidation of data at the central level results in low data reliability preventing appropriate decision making. Moreover, supervision of health facilities, which is essential to managing and maintaining the performance of the health network, is not conducted on a regular basis, lacking funds, and appropriate coordination and organization.

10. **As a result, the majority of the population of Guinea-Bissau has limited access to health care of good quality, which results in their poor health status**. Access to quality health care is limited and inequitable. On average, only 38 percent of the population has access to health care, and the situation is worse for the poor. Services are often of very poor quality that there are little incentives for demand. Children immunization and malaria fighting are among the most important factors likely to improve health outcomes of the population. Results achieved in these areas over the last years have been mixed. With regard to children immunization, there are clear signs that effective interventions have not been sustainable, since the immunization coverage has fluctuated considerable over recent years.

11. **Despite signs of reduced incidence, malaria remains the number one public health problem in Guinea-Bissau.** It accounted in 2005 for 35 percent of consultations in hospitals and health centers across the country and remains the first cause of mortality among children under 5. But a recent 30 percent reduction of new cases of malaria remains encouraging. These positive results can be explained, in part, by the availability and extensive use of impregnated bed nets, particularly by vulnerable groups. At present, about 60 percent of both pregnant women and children under age five are sleeping under impregnated bed nets, and 46 percent of households have at least one impregnated bed net. On the curative side, only 45.7 percent of children with a fever received appropriate treatment in 2006, mainly because the shift towards the new therapeutic scheme of artemesinin-based combination therapies (ACT) has been slow and consequently, drug shortages are recurrent.

12. **There is mounting concern that the HIV/AIDS pandemic is spreading rapidly.** Different estimates place the HIV prevalence in Guinea-Bissau's adult population in the range of 3 to 8 percent. The truth of the matter is that the prevalence has not decreased over recent years, despite all the programs that have been implemented to fight HIV/AIDS. In any case, that prevalence exceeds those for Guinea-Bissau's two neighbors, Senegal and Guinea-Conakry, where total prevalence is estimated to be between 0.4 percent and 0.7 percent, and 1.2 percent and 1.8 percent, respectively. Access to HIV/AIDS treatment is very limited. Despite the

availability of generic anti-retro-viral drugs (ARV) from Brazil and funding from the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), only 496 people received treatment in the first quarter of 2007. Challenges in this regard include the poor status of the health facilities and the poor capacity of supply-chain management. Stock ruptures of pediatric ARV and of testing supplies occurred in 2007 and in early 2008. There are still several misconceptions about HIV/AIDS forms of transmission and serious stigmas among seropositive persons.

A field of social protection still embryonic

13. **The vast majority of the population of Guinea-Bissau does not benefit from any formal social protection support.** Formal social protection arrangements, namely health insurance and pension schemes, are affordable to only a small segment of the population. Government transfer programs have limited scope and impact. Because of these limitations, various segments of the population rely on informal risk management strategies, including social networks, community mutual faith-based support and saving schemes.

14. **The social protection institutional framework is scattered and needs improvement.** The Ministry of Social Solidarity could play a key role in convening actors and in coordinating policy development fostering a better collaboration between the public and the non-governmental sector. Such a policy, however, needs to be evidence-based and has to prioritize interventions according to need and effectiveness.

Cross-cutting issues in relation to education, health and social protection

15. **Social sectors are in dire need of qualified staff.** The country should significantly increase its numbers of qualified teachers, general practitioners, midwives and nurses. In addition to lack of personnel, HR policies and management system are ill-defined. They entail regional disparities, imbalances between the capital city and the most remote rural areas, and lack of motivation of personnel who do not see linkages between performance and their career path.

16. **Poor governance and weak financing of social sectors are the main causes of low performance.** As the review indicates, failures in social services delivery in Guinea-Bissau have their root causes in the low investment and the poor management of the social sectors. Current public spending in social sectors in 2005 represented about 20 percent of the total government recurrent spending. In 2006, per capita public spending in the health sector was estimated at US$ 6, and donors have contributed the same amount. Therefore, with US$ 12 total health expenditure per inhabitant, Guinea-Bissau is not in a good position with regards to international benchmarks on health financing for developing countries.

17. **A poor public finance management constitutes a common feature across the sectors.** The budgeting process globally would require significant improvements as budget allocation procedures remains non transparent. The budget execution rate in social sectors is generally low. The under-financing of social sectors translates in the chronic problem of delayed payment of salaries and allowances, which obviously affect performance.

18. **Donor financing and coordination is insufficient.** Donor assistance is still defined too often by donors and not by the government. The immediate consequence is frequent overlaps of interventions and inefficiencies in the use of scarce resources. Political instability and the turnover rate at Ministries' level explain partly this situation. However, there are positive signs of better coordination among key actors with new institutional mechanisms put in place recently (for example, the Country Coordination Mechanism for HIV/AIDS, and the EFA-FTI partnership). The prospect for external financing of the health sector in the years to come is disturbing. The Global Fund will likely remain the single significant donor in the sector. The World Bank support for the PNDS closed in December 2007. Similarly, the AfDB and the EU, two major players in the sector, have also withdrawn from the sector.

But not all news is bad

19. The assessment indicates that, despite all the setbacks, some progress have recently been achieved in specific aspects of education and health sectors. In addition to progress on education coverage and malaria, progress have also been registered in civil service reforms in both health and education, and in some cases, like the reform to rationalize the use of teachers in the classroom, it is impressive that the government was able to get the agreement to implement the reforms, amid social tensions and disputes with unions. Last but not least, non-state actors are increasingly playing a role in the delivery of social services, sometimes with innovative approaches and good results.

20. **More importantly, most of the efforts needed to improve delivery of social services are within reach of the country.** As the review discusses, improving governance and financing of social sectors can have a huge impact on outcomes. For example, it was estimated that more than 90 percent of the relevant population would be able to complete a full cycle of primary education in a few years, if Guinea-Bissau increases the budget allocation to the education sector, improves intra-sectoral allocation and budget execution, and carry out key structural reforms. In the health sector, the low per capita public spending ($ 12 in 2006), means that there is enough leverage to increase public financing of the sector with improved results.

21. **In addition to specific recommendations to the education, health and social protection sectors (see Chapter 4); the review proposes the following agenda to move towards a better social services delivery in Guinea-Bissau (see Matrix).**

1. Improve Public Financing of Social Sectors

- The share of domestic budget effectively allocated to social sectors must be increased in order to be aligned with acceptable international and regional standards. The simple increase of budget allocation to social sectors, however, is not sufficient to improve outcomes. In order to positively impact service delivery, it is important to improve budget execution in social sectors;

- Increased spending on education and health, however, is not the sole answer. The quality and equity of spending are equally important. Improved governance, stronger

accountability mechanisms, and sound expenditure management are essential to raising the quality of social services.

- Donors' commitment is important to support reform efforts in social sectors. That will require commitment of more resources, including increasing donor support to key programs in education and health. Examples include the Fast Track Initiative in education, strengthening of health systems, and combating HIV/AIDS and malaria.

2. Accelerate and Scale Up Promising Reforms

- Despite their mixed results, some reforms undertaken in the recent past need to be pursued and achieved. In education, the adoption of a six-year primary education cycle; the provision of free primary-education; the development of new curriculum; and the investment in teachers are among measures that are likely to have a positive impact on schooling. In the health sector, reforms must include measures to develop and implement a new infrastructure plan; improve the drug supply chain system; and reevaluate the whole evacuation process for patients.

- Non-state actors, including NGOs, are playing an increasingly important role in service delivery. In order to extend service delivery coverage -- particularly to the poor -- and to improve quality, it is important to forge partnerships with these non-state actors. This will improve and/or scale up various promising initiatives they are currently undertaking.

- It is time to develop coherent, sustainable and equitable social protection mechanisms geared towards safeguarding the well-being of the population of Guinea-Bissau. It is important for the Government to step up efforts to formalize the sector and to develop a coherent policy framework. Such framework should be designed in the context of development of a broader social protection development agenda.

- The social protection development agenda must include efforts to support well-tested informal social protection mechanisms, which for the foreseeable future will continue to be the main mechanisms available to the vast majority of Guinea-Bissau's population to cope with risks.

3. Ensure Institutional Development of Social Sectors

- Strengthening policy framework is one important step towards a stronger institutional capacity in social sectors. Sector policies and programs must factor a strong link with the PRSP. While the health sector has a clear long-term strategic framework orientation (PNDS), the education sector and the social protection lack strategic orientation. Strategic and policy orientations in the health sector must be consolidated, through the subsequent phases of PNDS. Developing an explicit long-

term education policy and strategic framework is a priority. The same is true for social protection.

- Monitoring and evaluation information systems across the sectors must be developed. Successful design and implementation of reforms cannot take place without reliable information. An action plan to develop monitoring and evaluation systems in social sectors would help to clearly identify priority needs in the short-term and medium-term. Government and development partners could come together with an harmonized schedule for priority household surveys covering key social sectors issues.

- Effective human resources management, including capacity development strategies and programs at all levels, is crucial for improved service delivery. Capacity development must take into account the kind of capacity needed to implement reforms in these sectors. The new human resources strategy and action plan in the health sector should be effectively used to create linkages between planning, production and deployment of personnel. In education, the newly developed but incomplete HR management system needs to be consolidated.

MATRIX OF POLICY PRIORITIES FOR THE SOCIAL SECTOR

Objectives	Issues and Obstacles	Expected Outcomes	Actions/reforms
Increase the share of the domestic budget effectively allocated to social sectors	Historically, domestic budget allocations to social sectors have been low.	The share of domestic budget to education and health reach the international and regional acceptable standards.	More transparent budget process.
	The security sector absorbs a huge share of recurrent budget.	High execution of budget.	High execution of budget.
	The rate of budget execution is low.		
			Perform PER for the social sectors.
Improve governance and accountability in social sectors	Intra-sectoral allocations, particularly in education sector did not favor primary education.	Primary education absorbs at least 50% of the education budget.	
Increase donors' support to key programs in education and health	External assistance to social sectors dwindled over the last years.	Increased support to education and health (ex. through country coordination mechanism for HIV/AIDS, and the EFA-FTI partnership.	Review the organizational structure of the MoH. Implement the HR plan in the education and health sectors.
Improve HR management	Lack of clear strategy definition & need of implementation of action plans.	HR plan are effectively used to take decisions.	
Develop and/or consolidate long term strategies for the social sectors	Sector plans are lacking in education and social protection.	The health, education and social protection sectors have well-defined sector policies.	Develop the Education Sector Plan. Develop the Social Protection Multi-

			Sector Plan. Update the PNDS.
Strengthen the M&E system	M&E is a bottleneck for adequate policy decisions.	Policy-decisions based on M&E outputs.	Development of a M&E plan for the sector. Institutional support for the social sectors Ministries.
Enhance institutional framework of social protection	Institutional framework for social protection is scattered.	New harmonized institutional framework for social protection.	Develop and enforces laws on social protection.

Country Development Goals	Issues and Obstacles	Expected Outcomes	Action/reforms
Develop a free, single six-year cycle of basic education	Lack of adequate number of schools in rural areas, teachers need training, schools are poorly staffed. Girls education insufficient; Lack of monitoring for quality and performance; school fees reduce access.	Access to basic education is increased and quality improved (primary completion rate increased from 42% (2006/07) to 75% (end 2012).	Develop new curriculum for primary education. Create new teacher training institutions. Develop and implement a new model of pre-service teacher training.
Restructure secondary and vocational training education	Secondary education is not being able to accommodate demand; the sub-sector lacks harmonized curriculum. Vocational training has been almost dismantled following the 1998-1999 conflict.	Secondary education is able to accommodate the growing demand. Skills development strategy is under implementation by end of 2010. Setting up legal and regulatory framework for vocational training.	Forge partnership with NGOs. Develop new curriculum for secondary education.
Improve access to health care	Only 38% of the population has access to health care.	Increased segment of the population have access to health care of good quality	Develop and implement the health infrastructure plan Improve the drug supply chain Reevaluate the whole evacuation process (mid-term strategy aimed at increasing retention).
Reinforce the HIV/AIDS Program	Current interventions have not proven to be effective.	The spread of the epidemic is stopped.	Evaluation of previous and current interventions/and action plan to boost results.
Develop social protection for the disadvantaged	The epidemic is not retreating.		Action plan prepared to strengthen the existing formal social programs

Specific programs for children	The existing social security system covers a very small part of labor force; the pension schemes are financially unsustainable. Child suffers from abuse, child trafficking and begging, genital cutting, etc.	Formal social protection mechanisms in place. Pension schemes reaches a larger segments of population**.**	Strengthen capacity of INPS (technical assistance). Set out a public-private oversight for INPS. Strengthen behavior change communication, enforcement of law.

1. INTRODUCTION

1. Since the last Poverty Assessment and Social Sectors Strategy Review for Guinea-Bissau was done in 1994, the political, macroeconomic, and social context of the country have dramatically changed. Following the first multi-party and democratic elections in 1994, the country entered a period of renewed hope for development; political stability, emerging democratic institutions, and relatively good economic governance have nurtured that hope. In 1998, unfortunately, an eleven-month-long military conflict plunged the country into a severe crisis, the consequences of which persist today. In addition to the loss of human lives and destruction to infrastructure, the conflict provoked severe brain drain, with the most qualified human resources seeking refuge and staying abroad. But perhaps the most lasting consequence of the conflict is the political and institutional instability that it produced. Almost ten years after the end of the conflict, the return to a normal life for the majority of the population is slow and the country continues to face institutional perturbations that have severe economic and social repercussions.

2. Social sectors have been particularly affected by the conflict. Human development indicators continue to be poor, and social sector development suffers from severe constraints. Prospects for sustainable progress are severely constrained by very low public investment in the social sectors and, consequently, a high dependency on donor support. Over the last twenty years, the World Bank has been involved in active dialogue with Guinea-Bissau regarding the social sectors, particularly with respect to the education and health sectors. In recent years, the Bank has actively supported these sectors through major investment projects such as the Basic Education Support Project (1997–2005) and the implementation of the National Health Development Plan (1997–2007). In May 2008, The Bank approved a 10 million US$ for the education sector, mainly for payment of teachers' salaries, as a measure to ensure continuity in the provision of education services. The Bank is also supporting the preparation of a Country Status Report (CSR) on education to help the country move towards the development of a sound and credible education sector plan, as well as a the preparation of a Community-Driven development Project (CDD) that includes social sectors.

3. How, in the context of state fragility and current social transition, Guinea-Bissau can effectively restore the delivery of basic social services? The main purpose of this review is to assist the Government of Guinea-Bissau in its efforts to improve the efficiency and efficacy of basic social service delivery. It was agreed with the Government that the review would cover the sectors of education, health, and social protection – the latter including vulnerable groups, the pension scheme, and social assistance programs. Therefore, the review seeks to: (a) analyze current outcomes on education, health, and social protection in Guinea-Bissau; and (ii) identify challenges and opportunities towards the expansion and improvement of social service delivery. It is expected that the recommendations of the review will help the Government identify strategic

paths toward strengthening the social sectors in the medium term by ensuring an appropriate transition from a post-conflict environment to long-term development, through policy considerations, and institutional .development. It is also expected that this review will help inform the work on the ISN, CSR and CDD project, as well as the implementation of the recently approved grant by the Global Fund for the health sector.

4. The methodology of the review relied mostly on desk review of available literature and data. These include recent assessment work such as the 2005 Integrated Poverty and Social Assessment (IPSA), the 2007 Joint Staff Assessment Note (JSAN) on the Poverty Reduction Strategy Paper, and the 2004 Public Expenditure Review (PER). Quantitative and qualitative data are used to assess the status of delivery of social services in each sector. Whenever possible, the team used the most recent data available. In some cases, primary sources of information (including non-treated administrative data) were used to compile and/or cross-check information. It is worth mentioning that while the education and health sectors have a set of data and information produced mainly in the context of investment and donor support projects, data on social protection are scarce. To overcome this constraint, during the fieldwork, the team met with government officials, UN staff, NGO representatives, and other key people in Bissau, and held focus groups with vulnerable population groups across the country. The research was complemented by a scan of available documents and literature. Part of the analysis on social protection is based on data from the 2002 Light Household Survey (ILAP), preliminary results of the 2006 Multiple Indicator Cluster Survey (MICS), and the 2005 Light Household Survey.

5. The report is divided into four sections. After a brief introduction in Section I, Section II provides the country context, including demographic and socio-economic status of the population. Section III presents an overview of current outcomes in social sectors, including a background description of the education, health and social protection sectors. Section IV discusses the main findings of the review and presents recommendations to improve delivery of basic social services.

2. SOCIOECONOMIC CONTEXT OF SOCIAL SERVICE DELIVERY

6. This chapter is an attempt to put Guinea-Bissau's basic social service delivery into context. The first section presents demographics, poverty and socioeconomic data, since they are important dimensions of social service delivery. Demographic factors may have direct and indirect effect on the demand for social services. It determines, for example, the number of school-age children, the size of the labor force, and the number of elderly people. Poverty profile is an important predictor of the level of demand for basic social services, and the macroeconomic performance indicates the capacity and limits of the public sector to finance social sectors in a sustainable way. Section two discusses population vulnerability and risks, which in part may trigger special social protections needs. It presents an overview of vulnerable groups and the main risks they face in their day-to-day live.

2.1. DEMOGRAPHICS, MACROECONOMIC PERFORMANCE AND POVERTY

7. **Guinea-Bissau is a small, fragile state in West Africa grappling with significant social transition.** The country is home to 1,500,000 inhabitants, most of whom are young. An estimated 41.7 percent (0.58 million people) is under 14 years of age.[1] The population has been growing at an average rate of 3.1 percent in recent years – from about 900,000 inhabitants in 1991. The large share of young population presents an enormous challenge for the education sector, which is supposed to accommodate an increasingly important number of newcomers to schools.

8. **The urban population has been growing steadily** as a result of rapid urbanization and migration. Today, an estimated 30 percent of the population lives in urban areas compared to 18 percent in 1991. The average population density is about 30 inhabitants per km2, but the population is unevenly distributed across different geographical areas, with major concentrations in the coastal areas. Bissau, the capital city, concentrates about 30 percent of the country's population, and it is overwhelmingly registering significant pressure on demand for basic social services.

9. The economy of Guinea-Bissau relies mainly on agricultural production, which accounts for 60 percent of GDP and 90 percent of exports. About 80 percent of the population live in rural areas and rely on agriculture as the main source of employment. Apart from cashew nuts, which represent the main source of income for rural households, agricultural production includes

[1] US Bureau of Census estimates the total population to be 1.38 million.

rice and other cereals, fruits, fishing, livestock, and forestry products. The economy as a whole is predominantly informal. The unemployment rate among people aged 15 and plus was estimated at 12.4 percent nationwide in 2006, with a rate of 19.3 percent in the capital city of Bissau and 10.2 percent in the other regions.

10. **Macroeconomic performance has been poor in recent years**. GDP per capita was estimated at $ 180 in 2006. The economy still suffers from the consequences of the 1998-1999 conflict, which contracted real GDP by 28 percent. Since then, economic growth has been sluggish. During the period 2000-2005, the real GDP growth rate averaged about 1 percent, with negative growths recorded in 2001 and 2003. Fiscal situation remains precarious with government fiscal revenues representing about 14 percent of GDP. Government efforts since 2000 to restore economic stability have showed mixed results. The road towards economic recovery has been hampered by the slow pace of policy reforms and insufficient donor support.

Table 1: Government Recurrent Expenditures and Public Investment by Sector in 2005

	Current primary expenditure	Public Investment
Socio-educative sectors	5.6	1.6
Health	1.7	0.9
Education	3.7	0.7
Economic Sectors	3.6	
Agriculture	0.3	0.3
Fisheries	0.2	
Infrastructure	0.3	2.3
Industry and energy	0.1	2,0
Institutional Sectors	2.6	
Presidency and Prime Minister	0.7	
Parliament	0.7	
Judiciary	1.2	
Security Sector	7,0	
Other	6.5	9.2
Total	**27.2**	
GDP in billion CFA	148.7	

Sources: Ministry of Finance and Ministry of Economy.

11. **Social sectors have suffered from the sluggish economic progress of recent years.** The security sector has been absorbing a huge part of the recurrent budget. 80 percent of the government recurrent primary spending goes to wage bill. The 7,000 security sector personnel represent 60 percent of all civil servants in Guinea-Bissau, and they absorb nearly half of the wage bill. Public investment in education and health has not been robust. In 2005, public investment in both sectors represented 1.6 percent of GDP (Table 1).

12. **Poverty is widespread with higher incidence in rural areas**. At the household level, 64.7 percent of the population was living in poverty in 2006, with 20.8 percent living in extreme

poverty.[2] The impact of the 1998 conflict, political instability and poor economic performance over the last few years have contributed to high rates of poverty in Guinea-Bissau. An important feature of poverty in Guinea-Bissau is the high incidence of poverty for men compared to women, which is partly explained by the fact that unlike men, women in Guinea-Bissau generally engage in various income-generating activities. Poverty on an aggregate level remains lower in urban than in rural areas, but urban households are becoming more vulnerable to particular shocks than rural populations because they cannot survive on subsistence agriculture.

13. **The incidence of poverty is uneven among gender and age groups**. A breakdown by gender and age group reveals that the incidence of poverty is higher for women below 31 years of age and above age 65 compared to men (up to 3 percentage points of difference in the poverty headcount measures). By contrast, women tend to be better off compared to men within the 31–65 age cohort (2 to 10 percentage points of difference in the poverty headcount measures).[3] This relative wealth in comparison to men may be attributed to that fact that women traders dominate the informal market while men mostly seek salaried employment, which is hard to find given the bleak situation of a large part of the private sector. Regression analysis undertaken for the IPSA indicated that in rural areas, female heads of households were 23 percent more likely to meet the food needs for the household than male heads of household. Additionally, female-headed households in rural areas were found to have consumption levels 20 percent higher on average than households headed by males.

14. **Widows and divorced women are particularly prone to poverty**. Indeed, in rural areas, the level of consumption by heads of household that are widowed or divorced was found to be significantly lower compared to households headed by those who are single or married (19 percent and 15 percent (monogamous), and 16 percent (polygamous) respectively. In urban areas, single households' consumption level was 35 percent higher than that of the divorced and widowed.[4] The relatively high incidence of poverty among widowed and divorced women may relate to some discriminatory social practices against this category of population. For many traditional communities, in the event of the husband's death, the surviving widow and her descendents are "inherited" by a male relative of the deceased, often the oldest brother. The rationale of these practices is to guarantee family cohesion and to provide a safety net for the widow and her offspring, as she will move in with the relatives of her deceased husband. A woman that for one reason or another decides to or is forced to live on her own does not have a place in the traditional family structure and is subject to ostracism. With the ongoing erosion of traditional values, many widows find themselves on their own and having to fend for themselves.

[2] The incidence of poverty was measured by the headcount poverty index. The poor represent the share of the population with levels of consumption per equivalent adult below a purchasing power parity adjusted at $ 2 per day.
[3] All figures in this paragraph are from the IPSA Poverty analysis based on the 2002 ILAP.
[4] World Bank 2006.

2.2. POPULATION VULNERABILITY AND RISKS

2.2.1. Main Sources of Risk

15. **The majority of Guinea-Bissau's population is not only chronically poor but also vulnerable to an array of risks**. A household can be considered vulnerable when it is likely to be exposed to income insecurity due to shocks; it is chronically poor when it has a very low level of assets and is expected to remain that way. Households that are both vulnerable and chronically poor are most likely not to recover from shocks should they occur since they have only limited access to risk management instruments. It is these households that are in special need of social protection.

Table 2: Main Sources of Risk in Guinea-Bissau

	Household Level	**Meso/Macro Level**
Health Risks	Death	
	Illness/Disability	
	Harmful practices (excision, abandonment of twins)	
	HIV/AIDS	
	Building safety	
Social Risks	Lack of social network,	
	Gender discrimination	
	Orphanhood	
Economic Risks	Unemployment	Degradation of rice paddies
		Cyclical harvest losses
		Cashew dependency
Political Risks		Conflict Political instability

2.2.2. Idiosyncratic risks

16. Vulnerability to idiosyncratic (household) risk factors is mainly determined by the household's socioeconomic characteristics (assets, income, dependency ratio, household break-down etc.). Exposure to risk is also often the result of culturally ascribed attributes, defining, for example, the status of women or children within the household.[5]

[5] Tovo and Bendokat 2006.

17. **Death and illness**. The death of the breadwinner of the family creates significant costs for the family, as tradition often requires expensive funerals.[6] In addition, in most cases, death of the main breadwinner does not only translate into a significant loss of income for the household, but also yields a weakened support network and diminished social capital.[7] Inheritance rights and the status of the surviving partner still depend to a large extent on customary laws. Widows and their descendants pass under the guardianship of a brother of the deceased husband, who, in turn for taking care of the widow, also inherits all assets

18. **But these traditional systems are under strain** as a result of loosened family ties, basic poverty of the successor leading to his incapacity to provide for the widow, as well as the economic empowerment of many women who are not willing to subordinate themselves to another man's household, preferring to live on their own, often at the expense of their social position. Similarly, negative health shocks, such as acute or chronic illness of family members, put households under considerable strain. Medical services, in most cases, need to be paid for upfront, although the cost of treating an illness or injury is significantly less than the income lost as a result of it.[8]

19. **Building safety is a critical issue**. Many houses, especially in rural and peri-urban areas, have thatched roofs (and these are always the houses of the poorest). As a consequence, homes often burn down because of hearth fires that get out of control. Affected families lose everything and have only informal coping mechanisms at their disposal, aside from punctual assistance by non-governmental actors such as Caritas.

2.2.3. Covariate Risks

20. **Most of the country's active population is prone to employment vulnerability.** About 80 percent of the population is employed in the primary sector, with most engaging in labor-intensive subsistence agriculture. A low level of agricultural diversification, relative isolation of many communities, and the low level of monetization of the economy in rural areas provide farmers with very little room for investing in capital goods or building up savings as a buffer against external shocks. Degradation of rice paddies and substandard cashew husbandry and harvesting practices reflect a low level of farming capacity. This vulnerability is exacerbated by cyclical harvest losses due to insufficient rainfall, intrusion of salty water into rice paddies (in the case of mangrove rice cultivations), and plagues of insect and other pests.[9]

21. **Opportunities for non-farm wage labor have diminished considerably due to the post-war stagnation of the economy**. This is reflected in the adult unemployment rate in the capital, where the formal sector is most important, of 14.36 percent. In rural areas, only 7.91 percent consider themselves unemployed.[10] Youth unemployment is, in accordance with a pattern found throughout sub-Saharan Africa, much higher than adult unemployment.

[6] For example among the Papel it is customary to bury a large number of objects (textiles etc.) with the deceased as a symbol of his wealth during his lifetime.
[7] Lourenco-Lindell 2005.
[8] Gertler and Gruber 1997.
[9] WFP 2006.
[10] ILAP 2002

22. **Cashew dependency is a potential source of food insecurity.** A large majority of the population working in agriculture also own cashew plantations, currently covering 180,000 hectares (or 5 percent of the country's land area, the largest percentage globally),[11] with cashew amounting to 98 percent of total exports. Small farms account for 80 percent of cashew plantations averaging between 2 and 3 hectares in size. According to the Ministry of Agriculture, cashew farming employs 82 percent of the rural workforce.[12] The cashew sector continues to grow rapidly, as large areas of the country are being turned into plantations. This poses several risks for the population. First, plantations are usually unprotected monocultures, in which the introduction of pests might be potentially devastating. In addition, the lack of crop diversification exposes small farmers to the risk of fluctuations in the price of cashews on the world market. Usually, farmers exchange their harvest directly for imported rice at the farm gate instead of being paid in cash. The 2006 and 2007 cashew seasons, however, were characterized by a steep drop in prices, switching from a ratio of two sacks of rice per sack of cashews to two to two-and-a-half sacks of cashews per sack of rice. The situation was exacerbated by unrealistic price fixing, reportedly leading to widespread hunger.

2.2.4. Vulnerable Groups

23. While the majority of the population of Guinea-Bissau is exposed to structural vulnerability due to poverty and a low level of assets, some population groups are especially vulnerable to one or several risks either because they are more likely to experience a shock or because they do not possess the adequate assets to manage these risks. Among the vulnerable groups, one can cite children, youth and the elderly. The paragraphs below provide an overview of the main risks that may affect these different categories of population.

Children

24. **Children are vulnerable to a variety of risks.** While the early years are critical in terms of child survival, a large number of children aged 5–14 are vulnerable to exploitation, negligence, and abuse, which stunt their development and bar them from building much needed human capital. This is especially true for working children, children living away from home, orphans and twins, and child beggars. Despite considerable efforts to register all children, only 38.9 percent of all infants aged 0–59 months have been registered. While there is no significant variation with regard to gender, the percentage of registered children is especially low in the south of the country (Quinara, Tombali, and Bolama-Bijagos) where only 20 percent have been registered by their parents, compared to 57 percent in the Autonomous Sector of Bissau. When asked about reasons for not registering their children, 34.2 percent of parents attribute it to the excessive cost of doing so, 25.7 percent say that registration offices are too far away, while 18.9 percent do not know where to register their children.[13]

[11] Chasse 2006.
[12] World Bank 2006.
[13] MICS 2006.

25. **As elsewhere in West Africa, child labor is widespread in Guinea-Bissau**. Of all children aged 5–14, 39.2 percent are believed to be engaged in some form of child labor.[14] This figure is very much in line with the estimated average for West and Central Africa, which is 42 percent—the highest of any sub-region in the world.[15] Most of the activity involves work in the family enterprise and is therefore predominantly farm work. Children start helping on the family farm from a very early age by, for example, harvesting cashew nuts, which is traditionally an activity undertaken by women and children. Only 2.1 percent of all children in the 5–14 age bracket have a paid job outside their homes. Many children, however, work and attend school at the same time. Of all child workers, 53.7 percent say that they also attend school and of all students, 37 percent say they also work.[16]

26. **Orphans are in particular need of increased protection**. 11.3 percent (about 11,000 children in absolute terms) of Guinean children are single or double orphans, and their percentage increases with age. Among 15–17-year-old adolescents, 22.8 percent are orphans. In terms of school enrollment, the ratio of orphans to non-orphans is 0.97, putting orphans only at a slight disadvantage.[17] Also, their sexual debut tends to be slightly earlier than that of non-orphans: 23.67 percent of non-orphan girls aged 15–17 report sexual activity before turning 15. Among the orphaned girls, this proportion increases to 25.12 percent, corresponding to a ratio of 1.06.[18]

27. **Many children do not live with their biological parents, even if they are still alive**. This can largely be attributed to the custom of placing children of both genders, but more frequently girls, in the custody of relatives [*meninas ou meninos dadas/os para* criação]. Frequently, the receiving household is in an urban area where the relative covers lodging of the child and other costs and sometimes his/her school fees as well. In return, the child is expected to do household chores. Data also shows that most of the children get placed with families in the city—among the MICS sample, less than half of the children sampled in Bissau actually lived with their parents and the richest quintile of families had the highest percentage of children living with neither parent, though both were still alive (20.1 percent). Also, this practice starts at an early age; in fact, between ages 5–9, 15.4 percent of children already live with neither parent, although both biological parents are in fact alive. Not all children are placed with their extended family as some live with strangers. Regardless of whether they live with kin or not, living away from their immediate family from an early age puts children at risk—especially female children—of falling victim to mistreatment, neglect, and abuse as child servants.[19]

[14] This is based on the MICS definition: A child is considered to be involved in child labor under the following classification: (a) children aged 5–11 who completed at least one hour of economic activity or at least 28 hours of domestic work during the week preceding the survey, and (b) children aged 12–14 who completed at least 14 hours of economic activity or at least 28 hours domestic work during the week preceding the survey. Source: childinfo.org.
[15] www.childinfo.org.
[16] MICS 2006.
[17] MICS 2006.
[18] MICS 2006.
[19] Kielland and Tovo 2005.

Table 3: Living Arrangements and Orphan Status of Children under 17 years of age

		Lives with both parents	Lives with neither parent				Does not live with biological parents	One or both parents dead
			Only father alive	Only mother alive	Both alive	Both dead		
Sex	Male	62.3	1.2	2.5	11.9	1.3	16.9	11.4
	Female	57.5	1.4	2.5	15.6	1.5	21.0	11.2
Region	SAB	48.4	1.7	3.4	18.4	1.9	25.4	13.9
	East	76.1	.5	1.1	7.5	1.1	10.1	6.5
	North	55.4	1.4	2.9	14.9	1.4	20.7	13.3
	South	61.7	1.6	2.3	15.0	1.0	19.9	9.8
Milieu	Urban	50.1	1.8	3.3	17.9	1.9	25.0	13.7
	Rural	64.9	1.0	2.0	11.6	1.2	15.8	10
Age	0-4	67.6	0.7	.6	8.1	0.4	9.8	5.4
	5-9	61.9	1.1	2.1	15.4	0.8	19.4	9.1
	10-14	55.6	1.6	3.8	16.8	1.8	24	15.4
	15-17	44.8	2.5	5.5	17.5	4.6	30.2	22.8
Income quintiles	Poorest	61.3	1.1	2.6	14.4	1.3	19.3	11.4
	Poor	64.4	1.1	2.0	12.4	1.3	16.9	10
	Mid-income	65.2	.9	2.0	10.0	1.1	14	10.6
	Rich	60.8	1.2	2.1	12.6	1.4	17.2	10.4
	Richest	46.1	2.3	3.9	20.1	2.1	28.3	14.4
Language of head of household	Balanta	53.2	1.3	4.0	21.4	1.4	28.0	11.6
	Fula/Mandinga	72.6	.8	1.3	8.0	1.4	11.5	8.8
	Brames	49.6	1.5	2.1	13.0	1.6	18.2	14.7
	Other	51.5	2.4	3.7	18.0	1.2	25.2	12.4
Total		**59.9**	**1.3**	**2.5**	**13.7**	**1.4**	**18.9**	**11.3**

Source: MICS 2006.

28. **As in all of sub-Saharan Africa, orphans are usually cared for within the wider family network and are almost never placed in institutional care.** This family-based solidarity is put under increased strain because of HIV/AIDS. According to Caritas, the Catholic charity, there are an estimated 6,000 AIDS orphans in the country at this time. With the looming AIDS crisis, their numbers are likely to grow over the next decade and provisions will have to be made to support their caregivers.

29. **Trafficked child beggars, known as *talibes*, are a group that deserves special attention.** It is an accepted practice among the Muslim ethnicities to provide their male children with a religious education, which traditionally not only comprises teaching of the Holy Scriptures, but also strict discipline and begging for alms by the students. Traditional schools are very common in Fula and Mandinga communities; according to a recent study commissioned by UNICEF the total number of students attending Coranic schools in the East, South, and Bissau is estimated to be over 22,000.[20] These children are potentially at risk of being sent to Senegal by their Coranic masters, where they will live in abject poverty, have no access to health care and

[20] INEP, 2006.

Box 1. Legal Protection of Children

The government of Guinea-Bissau has ratified a number of pertinent international treaties aimed at ensuring the legal protection of children, such as the Convention on the Rights of the Child, the Optional Protocol to the Convention on the Rights of the Child on the Sale of children, Child prostitution and Child Pornography, and the Optional Protocol to the Convention regarding children affected by armed conflicts. In addition, the Convention of Ottawa, concerning the banning of all anti-personnel landmines, was ratified in 2000. The harmonization of domestic laws, however, which would be necessary in order to ensure compliance with these international agreements, has not yet been concluded.

There is no comprehensive child policy in the country. There is, however, some pertinent legislation, the "*Estatuto Jurisdicional de Menores*" (1971), which offers the basic legal framework for child protection.

Guinea-Bissau, however, has not ratified ILO conventions 138 and 182 determining the minimum age for child labor and the worst forms of child labor. The General Labor Law sets 14 as the minimum working age and makes school attendance obligatory. Furthermore, it forbids the employment of children under 18 years of age in heavy or dangerous work. However, these provisions are not enforced.

Several groups of vulnerable children fall through the legislative cracks. These are notably child beggars, as there is no law forbidding this practice, and mostly female child servants, whose status are not regulated either.

Source: Instituto da Mulher e Criança.

formal schooling, tend to be malnourished and in poor health, and often be victims of violence. A recent survey found that 28 percent of the children begging in Dakar (30 percent of the *talibes* and 12 percent of the street children) originated from Guinea-Bissau.[21] Parents often claim to be aware of their children's fate abroad, though in most cases the children have lost contact with them. While far from being endemic like in the cities of neighboring Senegal, increasing urbanization is leading to a noticeable increase in this phenomenon in the capital of Guinea-Bissau.

Youth

30. **Youth in Guinea-Bissau face enormous difficulties in their transition to economic independence.** Not being able to attain the roles that are socially ascribed to them, that is, getting married and starting their own households, youth are stuck in a "social moratorium," extending the period of youth well into the 30s.[22] This stands in stark contrast to developed countries, where young people are seen as the locus of cultural production, often prompting adults to try to extend their youth. In Guinea-Bissau, asymmetric control over resources causes young people to be highly dependent on patrilineal or matrilineal family support. As observed elsewhere in the region, the economic and social marginalization of large numbers of young people adds to smoldering inter-generational tensions.

31. **Youth unemployment exceeds adult unemployment considerably**. An analysis of available unemployment data by age cohort reveals that the percentage of unemployed individuals aged 15–24 is consistently higher than that of adults, regardless of milieu or gender. The magnitude of the phenomenon however differs considerably when these variables are taken into account, ranging from 12.03 percent unemployment among girls residing outside the capital to 46.87 percent among Bissau's male youth population. The elevated unemployment rate among

[21] Understanding Children's Work, 2007.
[22] This paragraph is based on Henrik Vigh's anthropological field work. See Vigh 2006.

male urban youth can be attributed in part to the differing gender roles in the labor market. While women dominate the informal market, young men aspire and are expected to enter the formal labor market. Despite the very limited job opportunities in the formal sector, young men often choose not to engage in labor that is seen as traditionally female, and thus rest idle.

Table 4. Unemployment Rate Among Adult Population (%)

	15–24 age cohort	25–60 age cohort
Bissau	40.15	14.36
Bissau Male	46.87	16.31
Bissau Female	29.29	11.61
Rest of Country	15.74	7.91
Rest of Country Male	19.34	8.30
Rest of Country Female	12.03	7.53

Source: ILAP (2002), Authors' Calculations.

32. **In order to break free from this situation of dependence, young people frequently seek access to patrimonial networks**. Association with a *homi grandi*, a man of status, brings the prospect of employment and social advancement; access to such a network is often based on family and ethnic ties. As pointed out by Vigh, the practice of enlisting in pro-government paramilitary militias in the 1998 war by more than 1,000 young men in Bissau, was to a large part driven by the expectation of socioeconomic advancement.

33. **Urban youth are in a precarious situation as they do not inherit land, having to rely on the "economy of affection," which is supported by relatives**.[23] Nevertheless, Bissau and the bigger regional capitals attract many migrants. According to a study by the WFP,[24] population growth in Bissau is estimated at 6 percent annually, versus more modest growth in regional capitals, which for the two southern provinces, Quinara and Tombali, was estimated at 1.5 percent and 2 percent respectively. While data on the composition of the stock of migrants is not available, it can be assumed that most of these internal migrants are in fact young people. During fieldwork, almost all women in the *tabancas* visited affirmed the absence of one or more of their sons. Young women usually stay behind helping in the household and taking care of the children, which creates a rupture in the family and leads to estrangement. This trend is likely to continue and accelerate in the coming years, bringing with it the typical problems of urban youth in developing countries: increased social tensions, risky social behaviors, and delinquency.

34. **Increased internal and external migration is reported**. Many young men dream of moving to Europe as a solution to hardship; illegal migration, however, is as costly as it is dangerous. A place on a fishing boat from Senegal to the Canary Islands is reported to cost a minimum of CFAF 600,000. The share of Guineans among the 31,000 illegal migrants that made

[23] Vigh 2006.
[24] World Food Program 2006.

it to Europe from West Africa on this maritime route in 2007 is unknown, but repatriations are reported to be common.[25]

35. **Youth is also a period of sexual experimentation and risk-taking**.[26] In Guinea-Bissau, sexual relations with non-cohabiting partners are reported to be frequent (60.6 percent), especially in the capital (82.5 percent). While only 6 percent of all young women report more than one sexual partner within the last 12 months, no more than 38.8 percent have used a condom with their last non-cohabiting partner. Condom use, however, is much higher in urban areas such as Bissau (48.5 percent) and is correlated with education level and income. Additionally, traditional practices may increase vulnerability to infection, especially among young girls (Box 3).

Table 5: Condom Use During the Last High Risk Sexual Encounter
percentage of women aged 15–24

		Percentage of women reporting sex with non-cohabiting partner within last 12 months	Percentage of women reporting condom use at last sexual encounter with non-cohabiting partner
Region	SAB	82.5	50.1
	East	39,0	23,5
	North	50,0	28,8
	South	53.6	23,8
Milieu	Urban	80,0	48,5
	Rural	41.3	20,1
Age	15–19	74.4	36.4
	20–24	49.9	41.5
Level of education	None	31.9	17,3
	Primary	77.9	40.5
	Secondary and up	89.5	52.0
	Non-formal	44.4	23,4
Income quintiles	Poorest	35.5	12,1
	Poor	40.3	14,7
	Middle income	51.8	26,0
	Rich	64.3	39.2
	Richest	83.7	53.5
Total		**60.6**	**38.8**

Source: MICS 2006 (preliminary report).

36. **However, new forms of social organization among young people can be observed**. Youth clubs and community-based youth associations have multiplied both in urban and rural Guinea-Bissau. There exists a plethora of youth organizations; some have legal personality, but most do not. Often, they are neighborhood initiatives that are formed to respond to a number of needs that are perceived as urgent—water and sanitation problems, health issues, and employment opportunities (or the lack thereof) are the main concerns. Several national youth platforms have emerged to represent young people's interests.

Women

[25] Reuters.
[26] Zewdie 2006.

37. **The situation of women in Bissau Guinean society is undergoing considerable changes**. Traditional gender roles increasingly cease to make sense when faced with a contracting formal sector and increased internal migration. Especially in the urban environment, it is now often the women who are the households' providers through their activities in the informal market, while their husbands are unable to secure long-term employment. Traditionally, however, almost all ethnic groups, regardless of their religion, are organized into patriarchal structures. Women and children are subordinate to and under the guardianship of the (male) head of the household, the *chefe de família*. In this position, the husband enjoys a monopoly on power, so that, for example, 51.6 percent of all women deem it justified for their husbands to beat them for any reason.[27]

38. **The incidence of polygamy is high and early marriage is common in Guinea-Bissau.** Around half of all marriages (48.8 percent) are estimated to be polygamous.[28] This practice is not only common among the Fula and Mandinga Muslim ethnic groups, but also among the mainly animist Balanta, and it is more widespread in rural than in urban areas. While the legal minimum age for marriage is 14 for girls and 16 for boys, 7.3 percent of all girls marry before turning 15 and 27.3 percent are married before their 18th birthday. Among wives aged 15–19, 51.2 percent have a husband that is 10 years their senior; in the capital region, this proportion reaches more than two-thirds of married women in this age group. Early marriage is clearly linked to income, as among the poorest quintile, 8.5 percent are already married by age 15; this number drops to 4.5 percent in the richest quintile.[29]

39. **Female genital cutting (FGC), called "*fanado*" in Creole, is very common in Guinea-Bissau.** Apart from greatly diminishing a woman's capacity to experience sexual pleasure, this practice puts women at heightened risk for reproductive and urinary tract infections, various forms of scarring, and infertility, as well as infection with HIV/AIDS and other communicable diseases. According to the latest MICS data (Table 6), around 44.5 percent of women in the country have been subjected to this procedure, which is usually performed during adulthood. Female genital cutting is almost exclusively practiced among Muslim ethnic groups; in fact among the Fula and Mandinga, the two major Muslim groups in Guinea-Bissau, more than 95 percent of women have undergone the procedure. While there is a burgeoning public discourse about the practice in the country, with a draft law being discussed by parliament and some NGOs campaigning against the practice, there are still many women who themselves believe that the practice of *fanado* should, in fact, continue. This is related to the socio-cultural significance of the ritual.

[27] MICS 2000.
[28] MICS 2006.
[29] MICS 2006.

Table 6: Percentage of Women aged 15–49 having undergone FGC and their opinion about the practice

		Percentage of cut women	Percentage of women that believe the practice should	
			continue	discontinue
Region	SAB	32.1	10,8	81.3
	East	92.7	64.5	28.7
	North	28.7	18.8	63.1
	South	36.3	31.8	46.1
Milieu	Urban	39.0	14.9	76.1
	Rural	48.2	37.1	47.5
Education	None	54.4	40.3	44.4
	Primary	34.5	14.5	74.2
	Secondary +	21.3	3.6	90.8
	Non-formal	91.8	62.0	17.6
Language of head of household	Balanta	6.2	4.3	79.7
	Fula/Mandinga	95.2	59.5	30.0
	Brames	6.5	3.5	82.9
	Other	38.5	19.3	68.4
Total		44.5	27.9	59.3

Source: MICS 2006

The Elderly

40. **The elderly, age 65 and over, make up only a very small percentage of the population**. This is not surprising in a country like Guinea-Bissau where the current life expectancy at birth is 47 years. However, the highest incidence of poverty occurs among heads of households over age 66, with 75.6 percent living in poverty, almost ten percentage points above the national average of 64.7 percent.[30] This elevated figure may be explained by the fact that the old and ailing are usually cared for by their children. The elderly only head their own households in circumstances where they do not have such a social safety net at their disposal.

[30] ILAP 2002.

3. OUTCOMES IN SOCIAL SECTORS: OVERVIEW AND CHALLENGES

3.1. THE HUMAN DEVELOPMENT OUTLOOK

41. This chapter presents the current outcomes in education, health and social protection. It begins by providing an overview of where Guinea-Bissau stands with regard to critical human development indicators, particularly those expressed by the Millennium Development Goals (MDGs). It then goes on to offer in more details the main challenges in education, health and social protection, respectively in sections two, three, and four.

42. **The human development outlook is weak**. In 2006, Guinea-Bissau ranks 173rd out of 177 countries in human development index. Most social indicators have stagnated or even declined over the last few years. Life expectancy at birth is estimated at 47 years, and the illiteracy rate is 63 percent. Population growth, including the sizeable growth of the urban population in recent years, poses a complex challenge to the country to improve its economic performance, while reinforcing effectiveness and efficiency in the provision of basic social services.

43. **Guinea-Bissau is off track regarding the achievement of most of the education and health MDGs.** According to the Multiple Indicators Cluster Survey (MICS–3) between 2000 and 2006, the infant mortality rate increased from 124 per 1,000 live births to 138 per 1,000 live births, and the mortality rate of children under age five has gone up to 223 per 1,000 live births from 203 per 1,000 live births (the 10th highest in the world). Today, two out of ten children die before they reach the age of five. Maternal mortality is estimated to be at 800 to 1,100 per 100,000 live births. Social protection mechanisms are almost non-existent and large segments of population rely on informal, community-based arrangements to cope with risks.

44. **In the education sector, despite considerable progress in coverage in recent years, the country is far from reaching universal primary completion**. Six out of 10 children who enter the first grade do not complete the full cycle of primary education. Many of those who do complete primary education remain illiterate because of the poor quality of education they receive**.** Gender gap in primary education has been gradually closing, but bias still remains between socio-economic groups.

Table 7: Education and Health MDGs in Guinea-Bissau

	MDG Benchmark (2015)	Current Situation (2006)
Universal Primary Education Completion	100 %	42%
Gender Parity in Primary Education (ration girls to boys)	1:1	0.9
Infant Mortality (per 1,000 births)	47	138
Under Five Mortality (per 1,000 births)	80	223
Maternal Mortality (per 100,000 births)	229	800
Estimated HIV/AIDS Prevalence	5.9	8.7

Source: Ministry and Education, and MICS 3.

3.2. THE EDUCATION SECTOR

3.2.1. Access to Education

45. **The most visible sign of progress in education in Guinea-Bissau is the large increase in coverage in recent years**. With nearly 300,000 students enrolled in primary and secondary education in 2005, the education system holds today twice as many students as in 1995. In primary education, the number of students more than doubled over the same period, from 105,430 to 252,479. This increase in coverage, particularly in recent years, is a result of the unprecedented public effort to increase the supply of new classrooms and to stimulate demand. It is also associated with the growing involvement of private providers and local communities in the provision of primary education service.[31]

Table 8: Number of Schools and Students in Primary Education in 2006 and Percentage of Private and Community Schools

	Bafatá	Biombo	Bissau	Bolama	Cacheu	Gabu	Oio	Quínara	Tombali	National
Number of primary education schools (1-6)	277	55	127	46	228	167	277	72	135	**1384**
Number of classrooms	539	323	1056	158	748	324	439	163	360	**4110**
Students	35605	23405	50952	7273	41087	27392	31363	12585	22817	**252479**
Pupil/classroom ratio	66	72	48	46	55	85	71	77	63	**61**
Percentage of private primary schools	3.0	18.2	64.6	2.2	11.1	3.0	1.4	5.6	6.7	**12**
Classrooms in good shape	27.3	47.4	41.3	31.0	55.4	55.6	55.4		33.3	**46.1**

[31] The number of primary schools grew from 650 to 1,334 over the same period (an increase of about 100 percent). Today, community and private schools represent 20 and 12 percent of all primary schools in the country respectively.

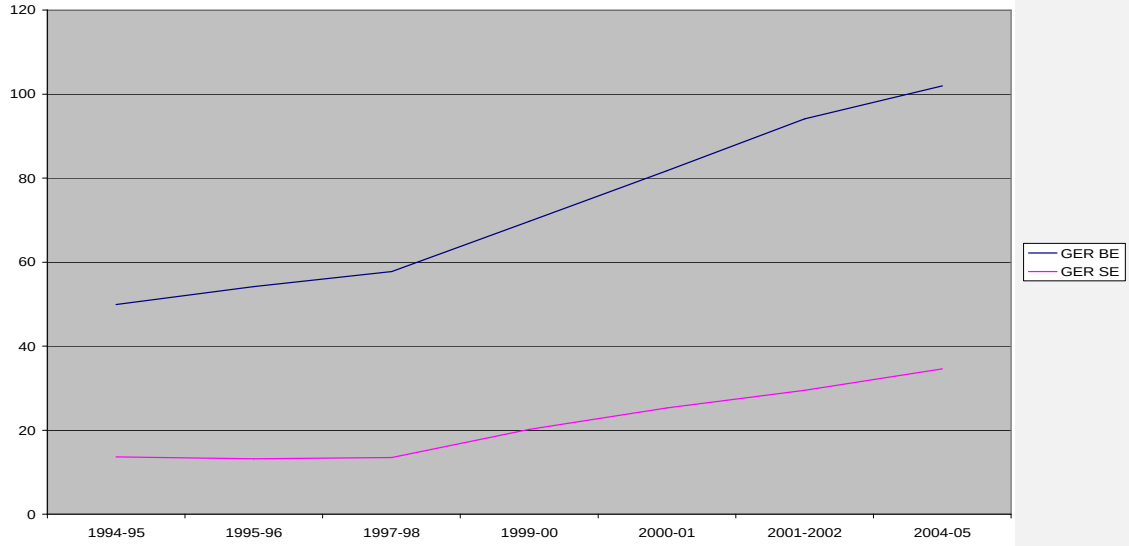
Percentage of community primary schools	27.4	1.8	1.6	2.2	14.9	16.8	29.7	23.6	35.6	**19.4**

Source: GEPASE

46. **Gross Enrollment Rate (GER) in primary education has steadily increased.** GER rose from 53 percent in 1995 to 102 percent in 2005, reflecting the growing accommodation capacity of the system (Figure 1). However, the net enrollment rate in primary education is at 45 percent. Gross and net enrollment rates are highly divergent because of widespread delayed enrollment. While the theoretical age group for children in the primary cycle is 7 to 12 years old, the actual age group of students in this cycle ranges from 6 to about 18 years.

47. **Gross Intake Rate (GIR) has been high over the recent years**. Consistent with the increase in participation in primary education, as expressed by the raising levels of enrollment across the primary education sub-cycle, the intake rate in the first grade has been high in recent years. It was estimated at an average of 120 percent during the period 2002–2005.[32] This high value reflects the presence in the group of new entrants into the first grade of over-aged children. Keeping the GIR at 100 percent or more is important to achieve in the medium term the objective of universal primary completion.

Figure 1. GER in Primary and Secondary Education



Source: Ministry of Education.

48. **Secondary education has followed a similar pattern**. The number of students enrolled in this level of education more than tripled between 1995 and 2005, rising from 15,000 to

[32] GIR for the school year 2004-05, the last year for which data are available, is estimated at 137.4 percent.

50,000. The private sector, with 12.4 percent of enrollments in 2005, played a catalytic role in this expansion, as the government investment in the sector remained very modest.[33] Private schools, however, are unevenly distributed across the country, with most of the schools concentrated in the capital and its outskirts.

49. Further development of secondary education seems to be constrained by a limited supply of schools. This expansion in enrollment has contributed to increase the GER in secondary education to 35 percent, a value slightly higher than the average 30 percent for sub-Saharan African countries in 2005. In 2005, the transition rate from primary to secondary education was 75 percent. From 2002 to 2005, the GIR in the first year of the secondary cycle averaged 36 percent. A limited intake capacity, the high opportunity costs, and the low external efficiency of secondary education may explain families' decision not to enroll their children in this level of education.

Table 9: Progress in School Enrollment and GER in Primary and Secondary Education

School Year	**1991-92**	**1995-96**	**1997-98**	**1999-00**	**2000-01**	**2001-2002**	**2004-05**
EBE(1-4)	67054	86305	99337	123307	149640	176886	209871
EBC (5-6)	13964	19125	19386	27712	32015	37955	42608
ESG(7-9)	5854	12580	13167	20004	25424	30509	38273
ESC (10-11)	852	2177	2754	5030	7541	9049	12234
Population (years old)							
7-10 years	129751	144342	152242	160574	164909	169362	183453
11-12 years	48889	55510	58548	61752	63420	65132	70550
7-12 years	174927	199852	210790	222326	228329	234494	254004
13-15 years	63200	72205	76157	80325	82494	84721	91769
16-17 years	37185	42483	44809	47261	48537	49847	53993
13-17 years	100385	114689	120966	127586	131031	134569	145765
Gross Enrollment Rate (%)							
EBE	51.7	59.8	65.2	76.8	90.7	104.4	114.4
EBC	28.6	34.5	33.1	44.9	50.5	58.3	60.4
EBE+EBC	46.3	52.8	56.3	67.9	79.6	91.6	99.4
ESG	9.3	17.4	17.3	24.9	30.8	36.0	41.7
ESC	2.3	5.1	6.1	10.6	15.5	18.2	22.7
ESG+ESC	6.7	12.9	13.2	19.6	25.2	29.4	34.6

Source: GEPASE

50. **Tertiary education has been growing**. An important feature in the development of the education system in Guinea-Bissau in recent years is the increasing supply of tertiary education as a result of a surge in demand. Two universities were opened recently: the University Colinas do Boé, a private university created in 2003, and the University Amílcar Cabral, a public university established in 2004. These two universities accounted for 3,000 students enrolled in higher education in 2005 (excluding students who benefit from scholarships abroad). Despite this

[33] The growth of private schools providing secondary education has been remarkable. In 2000, private schools accounted for 6 percent of enrollments.

surge in the availability of higher education, the tertiary education GER is at a mere 3 percent, well behind the average of 6 percent for sub-Saharan African countries.

51. **Early childhood education and technical and vocational education remain two marginal sub-sectors**. Early childhood education is supplied mostly by private providers. Most schools are concentrated in urban areas. In 2005, these schools enrolled about 7,500 children and employed 250 teachers (40 percent unqualified). Coverage is only 2 to 3 percent of the population of relevant age group. Technical and vocational training is still suffering from the effects of the conflict of 1998-99 that contributed decisively to disarticulate the sub-sector. Three out of the four schools that were publicly run before the conflict are currently closed[34]. There are a few emerging private sector initiatives enrolling several hundreds of students in different specialties, most of which are located in the capital city.

Box 2. The Case of Higher Education in Guinea-Bissau

Guinea-Bissau has long lived without any higher education institution. In the late 70s, the government started progressively to create higher education schools in order to respond to the critical needs of the country. In 1979, a teacher training school (*Escola Tchico Té*) was opened in Bissau to train secondary education teachers. Followed then the creation of the law school (1979), the school of physical education and sports, and the faculty of medicine (1986). The law school was transformed into a faculty of law in 1990.

Despite the emergence of these schools, most of higher education training continued to be provided abroad (mostly in Portugal, Cuba and the former Soviet Union). Some of these schools were supported by bilateral cooperation. For example, the Faculty of Law was supported by the Portuguese Cooperation, and the Faculty of Medicine, by the Republic of Cuba. By the late 90s, the crisis in the former communist block led to a significant decrease of the number of scholarships offered to young students of Guinea-Bissau. At the same time, the increasing number of graduates from secondary education put an enormous pressure on tertiary education. Not only existing higher education institutions were unable to absorb the increasing demand, but also the variety of proposed courses was insufficient to meet the demand of the labor market. Discussions about setting up a national university became more intense.

The important question to answer on that regard was how to create a university without diverting the scarce resources from the other levels of education. As the experience of some Sub-Saharan African countries shows, higher education institutions are often a serious competitor for funds with primary and secondary education (and often with big advantages), but at the same time may be a source of disturbances related to students' and/or teachers' demands. The answer found was to create a public university with a private management. Created in 2004, the University Amilcar Cabral (UAC) is managed by a private foundation composed of the government of Guinea-Bissau and a private Portuguese university (*Universidade Lusófona*). Students pay enrollment and tuition fees and teachers are paid using primarily these collected resources. Enrollment fee is approximately US$ 20 and tuition fee is US$ 300 per year per student. The government usually does not transfer resources to the university, but has helped with investment costs (improvement of infrastructure, equipment, etc.). In 2005/06, there were about 2,000 students enrolled in 13 different courses, and the university functioned normally.

This model is still at its early stage, but seems to be a promising solution to the recurrent problem of financial sustainability of many African Universities. Of course, much needs still to be done, particularly to ensure the quality of training in order to meet the demand of the labor market. The main challenges of higher education today include: (i) institutional strengthening of recent initiatives; (ii) assuring quality of learning; (iii) assuring equity (for example by offering scholarship to the poorest students); (iv) setting up a legal framework for tertiary education; and (v) promoting a democratic and transparent management of these institutions.

[34] CENFI (the industrial school located in Bissau) was destroyed during the conflict and CEFAG and CEFC (two agricultural schools located in the countryside) ceased their activities after the conflict. CENFA (the administrative school in Bissau) is the only center that was able to gradually restart its activities.

52. **Enrollment in primary education is influenced by location of the school. .**According to the Integrated Poverty and Social Assessment (IPSA) 2005, while 96 percent of households in Bissau are located 30 minutes or less from a primary school, only 79 percent of households on average for the rest of the country are located at that same distance. In other words, primary schools are accessible to more households in Bissau than in other regions. School access remains geographically uneven across the country, with various communities, particularly in the south and the islands, being the most disadvantaged.

53. **The gender gap in primary education has been closing, but disparities still remain**. Increased enrollment in primary education was favored by an overall positive trend in girls' enrollment. The gender gap has been gradually closing, to a ratio of 0.9 girls per enrolled boy. In 2005, girls represented about 47 percent of enrollments in primary education. Compared to1995, this represents a 6 percent increase in the share of girls to boys. This average, however, hides disparities across regions. In the capital, 52 percent of primary education students are girls. Gabu and Bafatá, with nearly 50 percent of girls' enrollment, are two other regions where equity was achieved. In all other regions, girls' enrollment stands below 50 percent, ranging from 40 percent in Oio, to 43 percent in Cacheu, 45 percent in Quinara and Biombo, and 46 percent in Tombali and Bolama/Bijagos. The impressive achievement of girls' enrollment in Gabu and Bafatá (two predominantly Muslim regions) seems to be the result of the sustained joint effort by the Government, several development partners, and NGOs through targeted interventions in girls' education.

54. **Girls' enrollment drops off at higher levels of the education system**. In secondary education, girls are underrepresented. They account for only 39 percent of enrollments nationwide, with great disparities between regions. Their share in enrollment ranges from 25 percent in Oio to 42 percent in Bissau. In tertiary education, girls are highly underrepresented.

55. The previous brief overview suggests that while there has been substantial progress in coverage, enormous challenges remain to improving the performance of the education system, and the prospects for Guinea-Bissau to achieve the MDG of universal primary completion and gender equity by 2015 are still bleak. While enrollment has substantially increased and the gender gap in enrollment has gradually been diminishing in recent years, most children of the relevant age group do not complete a full primary education cycle.

3.2.2. Internal Efficiency

A system with multiple inefficiencies

56. Despite the positive trends in coverage, the education system presents several inefficiencies, the most important of which are:

57. **The current structure and organization of the primary education, which was inherited from the former colonial system, raises serious problems of efficiency and equity.** The primary education cycle is divided into two sub-cycles: elementary primary education of four years, and complementary primary education of two years. Most schools offering the elementary sub-cycle do not offer the complementary sub-cycle. Because schools offering

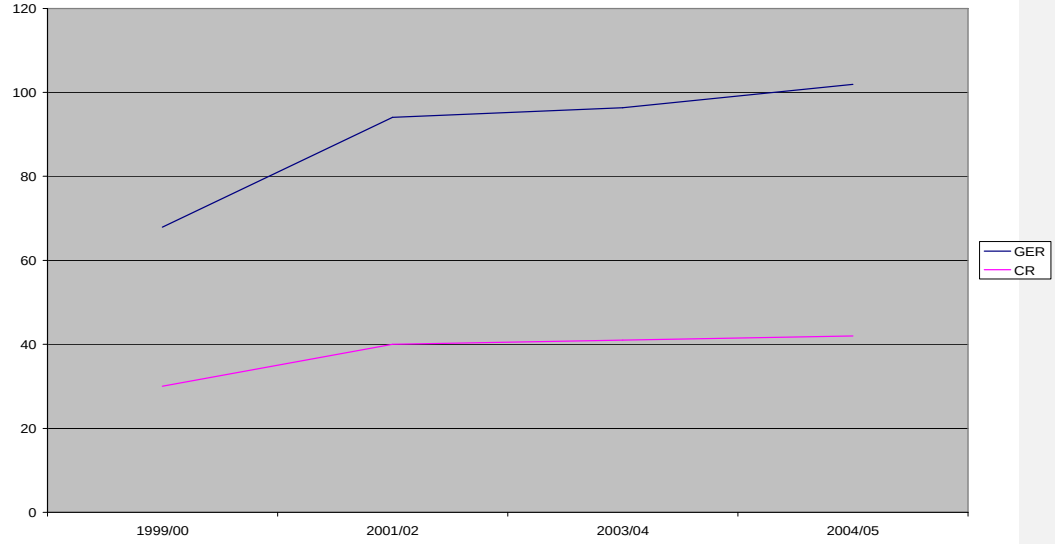
primary complementary education are mainly located in urban areas, children from rural areas can hardly complete a full six-grade primary education. This structural inefficiency is a huge source of waste because children who do not complete a six-year education are more likely to remain illiterate.[35] This picture has started to change as the reform to integrate the two sub-cycles into one single cycle was initiated in 2002, but much still remains to be done. While most primary schools now offer the full six grades of education, in many schools education still ends at the fourth grade or less. On the pedagogical side, the curriculum content of the new unified system is yet to be finalized. Consequently, the reform is still an incomplete endeavor with inherent implications for the performance of the education system.

58. **Repetition and dropout rates are high.** Although the repetition rate has been declining,[36] it is still relatively high across the system. In primary education, the average repetition rate is 15.2 percent. In secondary education, 13 percent of all enrolled students in 2005 were repeaters. Repetition is high at all grades of primary education, even in those where it should have been an exception.[37] In 2005, 17.2 percent of students in grade one and 13 percent of those in grade three were repeaters. The high repetition rate imposes a significant cost on the education system because scarce public resources are wasted. If one considers the overall budget allocated to primary education in 2005, the cost of repetition is CFAF 264 million (approximately US$ 525,000). To make things worse, the system is also hit by frequent dropping out of students across different levels. In 2005, the dropout rate in primary education was estimated to be 7 percent. The dropout rate is mainly associated with students' and parents' dissatisfaction with the quality of education, as well as with changes in perceptions by parents about the value of the school.

59. **More striking, however, is the low completion rate in primary education, estimated at 42 percent in 2005.** Figure 2 below shows the discrepancy between enrollment and completion in primary education. While the GER has steadily increased in recent years, the completion rate has increased only modestly. The low completion rate is a result of a low survival rate across the primary education system. In 2005, only 58 percent of the cohort of children who had entered primary school four years earlier was retained through grade four. Not surprisingly, education attainment in Guinea-Bissau, measured as the average years of schooling, is only five years.

[35] Analysis shows that in Guinea-Bissau, while 78.7 percent of people having completed six grades of schooling can read, only 54.2 percent of those with up to a 4th grade education can read. (Mingat, A. et al., 2001).
[36] In 1995, the repetition rate was estimated at 31 percent in primary education and the dropout rate was 35 percent.
[37] The rule in primary education stipulates that students in grades one, three, and five must benefit from automatic promotion to the following grade. This rule, however, is not respected by many teachers.

Figure 2. GER and Completion Rate in Primary Education



Source: Ministry of Education.

3.2.3. Relevance and Quality

60. **The quality of education is low**. Guinea-Bissau does not apply a student learning assessment system to track learning achievements of its students, nor does it participate in any regional or international learning assessment process; hence, there is no objective way to measure learning achievement of students. The common perception, however, is that learning achievement is very low. The poor learning environment and the insufficient teacher training and motivation are perceived as the main factors that affect students' learning outcomes. The language of instruction is also an issue. While the official language of instruction is Portuguese, in many classrooms programs are taught in part in *creole* (the national language), as many teachers have not mastered the official language.

61. **The learning environment is poor**. Despite considerable efforts made in recent years to provide low-cost classrooms to a growing number of primary school students, 32 percent of classrooms at the primary level are still considered to be in bad shape. Many classrooms are categorized as *barracas* (shacks made of palm leaves or bamboo) that flood when the rains come. Textbooks are sorely lacking as they have not been distributed to students since 2004, when the World Bank-financed Basic Education Support Project (BESP) closed. The ratio of one textbook per student in the principal subjects that had been achieved in the 2002–2003 academic

year has vanished.[38] In secondary education, the curriculum has not been revised for decades and there is no harmonized curriculum throughout the system. Each school chooses and implements its own curriculum, some of which are of questionable relevance. Textbooks are practically non-existent and most of the time students are forced to use texts prepared by their teachers [*apontamentos*] in lieu of textbooks.

62. **Teachers' qualifications and performance levels need to be improved.** Teachers are at the center of any education system. In Guinea-Bissau, the substantial increase in enrollment in recent years has put enormous pressure on the recruitment of new teachers. The number of teachers in primary education has increased from 3,269 in 2001 to 4,327 in 2005. Teacher training programs have not kept up with the demand because of the low capacity of the two teacher training colleges (423 students enrolled in 2005). As a result, contractual teachers have been hired. In 2005, contractual teachers represented 20 percent of active primary education teachers. While this responded to the quantitative needs of teachers in the system, there remained great concerns regarding the qualifications of these teachers. About 63 percent of teachers did not have the appropriate pedagogical training. Most of them were recruited locally and did not hold adequate academic training. The same is true for secondary education, where the only existing teacher training college [*Escola Tchico Té*] trained an average of 80 teachers annually between 2001 and 2005, against an estimated demand of 120.

63. **Inefficient organization of the learning process has resulted in a shortage of teachers in public schools.** In primary education, teachers used to work only four hours a day. Many teachers used their remaining free time to teach in private schools as a strategy to increase their revenues, while public schools often suffered from a shortage of teachers. In 2006 the government launched a reform whereby teacher's hours in the classroom were extended from four to eight hours a day. This was supported by a 50 percent increase in salaries but also resulted in a reduction of 40 percent of primary education teachers in public schools and 35 percent in secondary schools. The measure seems promising, but it is still too early to evaluate its full impact.

64. **Teachers' motivation needs to be improved**. The systematic arrears in salary payments appear to discourage some teachers. Although there is no consistent data to prove it, teachers' absenteeism is reported to be high. While the main causes of absenteeism include participation in traditional ceremonies, travel to the capital of the region to receive salaries, and engaging in agriculture and farming activities, which serve as complementary sources of revenue, teachers' strikes and other perturbations of the system disrupted 20 percent of the officially planned number of school days in 2005. As a result of these disruptions, curriculum coverage is often incomplete and, consequently, students' learning is negatively affected.

65. **The issue of quality in tertiary education has hardly been discussed.** The development of higher education will surely put on the agenda the issue of its quality and relevance. While the oldest national tertiary education institutions such as the law school and the

[38] During the life of the BESP, textbook printing was supported by the project. After the project closed in 2004, the government was unable to pay the costs of reprinting and therefore textbooks were no longer printed for distribution to students.

teacher training school for secondary education are reputedly of good quality and relevance,[39] it is still too early to draw any conclusions in that regard for the two new universities. The first group of trained young people will only leave these universities in 2008. Some concerns have, however, been expressed about the relevance of some proposed training courses as well the quality of the faculty.

3.2.4. Management of the Education Sector

66. To put the main features of the management of the education system in context, a brief account of the administrative arrangements in Guinea-Bissau's education system is important. The system is managed by one central Ministry in charge of all levels of education (from preschool to higher education). The central Ministry has several departments, some of which possess a degree of administrative and financial autonomy, mainly attributable to their nature or mission. The National Institute for Education Development (INDE) and the School Printing House [*Editora Escolar*] are two examples of departments that enjoy some autonomy. The system consists of eight peripheral levels that coincide with the administrative division of the country. There are eight regional directorates of education (plus the directorate of the capital city). Each directorate is responsible for the local management of the education system; including: (i) the supervision of schools; (ii) the collection of education statistics; (iii) the recruitment of contractual teachers, if necessary; and (iv) the provision and distribution of pedagogical inputs to schools.

67. **The management of the system in recent years has been tumultuous**. There is no recent memory of a school year that has begun on time (e.g. in respect of the school calendar approved by the MoE); has gone without sometimes relatively long paralysis due to teachers' strikes; and has closed on time. This turbulent picture is in large part due to the country's financial crisis, which hinders the capacity of the government to pay teachers' salaries on time. Although all civil servants are affected by this constraint, the education system is perhaps the area where the crisis is most visible. A very influential teachers' union in the sector and the relatively high sensitivity of education issues has made the sector a permanent battlefield between teachers and the various governments, and the management of the system suffers as a result.

68. **A long-term strategic education plan is still lacking**. It is clear that without a nationally developed and endorsed education plan the sector will fail to implement sound education and training policies. Many attempts have been made in the recent past to develop such a plan. In 2000, a Letter of Education Policy was developed, setting the vision and the objectives for the development of the education sector. The letter, however, was not translated into a sector plan with quantitative and qualitative targets because there was no coherent statistical data on which to base the plan. In 2003, efforts were undertaken to develop an Education For All (EFA) Plan,

[39] Many civil servants and top officials from different Ministries with a recognized, solid background and performance are people who were trained in these institutions. Trained teachers from *Tchico Té* have been employed as secondary education teachers in Cape Verde, where many of them have gone in search of better salaries, as well as by the private sector in Guinea-Bissau.

following the commitments of the 2000 EFA Conference in Dakar. This plan, however, did not have a coherent financial framework and was never endorsed by the Government. The frequent turnover of ministers and top officials in the sector did not favor the finalization of the process.

69. More recently, in 2007, the Ministry of Education, with support from development partners, embarked on a process of development of an Education Sector Plan. The process is under way and is expected to be completed by the end of 2008. Having a strategic education plan is now crucial for Guinea-Bissau to give clear orientation to its long-term education goals and objectives, but is also one of the eligibility criteria for the Education For All – Fast Track Initiative (EFA-FTI). In the current context of heavy constraints to domestic and external financing of the sector, this would be an opportunity to benefit from additional funds, such as the catalytic fund, to tackle supply and quality issues in the education sector.

70. **There is insufficient monitoring and evaluation information for policy decisions.** Despite efforts made in the past to revamp the monitoring and evaluation system in the Ministry of Education, the current situation is still fragile. Availability of relevant and pertinent data is a major concern of all education stakeholders. School surveys are now hardly organized and when they are, data are often fragmented or incomplete because many schools and/or directorates simply do not send data to the center, or they send them with substantial delays. By May 2007, part of the data from the 2005/06 school survey had not yet been received by GEPASE, the Ministry of Education unit responsible for statistical work. Data collected are often treated with delays and, naturally, are seldom used by policy decision makers.

71. The main causes of this weakness are: (i) financial difficulties in carrying out consistent data collection; (ii) organizational problems related to transmission and collection of questionnaires; and (iii) institutional weakness at the central level to treat questionnaires and conduct analysis. In 2002 and 2003, the Basic Education Support Project financed the school surveys that allowed the collection of data from all regions on an ad hoc basis. Since then, school surveys have been carried out sporadically and are often incomplete. Without specific, well-targeted support, it is unlikely that the MoE will be able to tackle the issue of developing a sound monitoring and evaluation system in the near future.

72. **Financial management is a critical issue.** As mentioned above, the financial management of the sector is problematic. First, the Government's inability to pay teachers' salaries in a timely manner often provokes disputes with teachers' unions and leads to losses in the calendar year. Second, contractual teachers are not paid regularly, partly because of the dense bureaucratic measures needed to develop their payroll, but also because these teachers are often neglected with regard to pay. Given the pressure to pay salaries to all civil servants and the insufficiency of funds, the Government has, in the past, often opted to pay salaries to the so-called effective teachers (civil servants) to calm their spirits, while delaying payment for the contractual ones. In the long run, the mounting arrears of contractual teachers' salaries will lead to a strike of this group of teachers, or in many cases, of a larger group of teachers as a sign of solidarity with their peers.

73. **Public funding to schools is limited**. It is important to stress that the limited financial capacity of the government associated, in some cases, with questionable priorities in terms of resource allocation through the sectors, makes it difficult to finance beyond salaries. As a result,

schools are underfunded. Because regional directorates are less able to compete for funds in the public treasury compared to their central-level peers, the more distant a school is from Bissau, the less probable that it will receive public funds.

74. **Human resource management remains deficient**. Much still remains to be done to allow the Ministry to access and analyze the data necessary to make effective policy and planning decisions. With the support of the BESP, some work was accomplished regarding the improvement of the personnel management system. In 2003, the MoE set up the Individual Staff Record [*Processo Individual do Funcionário*] wherein data on personnel was collected and entered into a central database containing the academic qualifications, other training experiences, and professional career evolution of every staff member. This data has allowed the Government to make more informed decisions when appointing new candidates to posts and in determining human resources development needs across the sector. However, the system still needs to be put into an electronic format. In addition, the database at MoE needs to be harmonized with that of the Ministry of Finance and the Ministry of Public Administration.

75. **The Ministry of Education's payroll system needs to be improved**. There is no harmonized database on personnel between the Ministry of Education, the Ministry of Finance, and the Ministry of Public Administration; hence, each of these three Ministries often provides discordant figures about the correct number of teachers to be paid. On the other hand, the payroll system is not entirely credible. When available, cash is gathered for the entire system in the Ministry of Education. Regional representatives then travel to Bissau to collect the payroll for their schools, gather the cash together, take public transportation back to their region and hand deliver payments to each of the schools. Often, one person will sign for the payment of a number of people. Needless to say, inefficiencies and the possibility of leakage are inherent in the system.

3.2.5. Institutional Capacity

76. **Government effectiveness in the sector has been seriously affected by political and institutional instability in the country.** With seven different ministers over the last seven years, the education sector never really had an opportunity to take root and time to develop and implement medium- and long-term policies. This resulted in decreased government capacity to effectively deliver education services, particularly in remote and underprivileged areas. With a rising demand for education coming from families and communities, religious organizations (the Catholic Church, Muslim charities), NGOs, and community-based organizations (CBOs) have appeared to fill the gap of education provision in these areas. Several NGOs are reported to be active in the education sector, but according to a capacity assessment undertaken recently by PLACON, only a few NGOs have the capacity to effectively deliver education services.

77. **Communities are playing a greater role in service delivery**. Community participation in school management and community ownership have been enhanced as the role of the community increases in the management of schools and, in many cases, in the process of school building. Many community schools in recent years have been promoted by NGOs through a process that relies on community empowerment. In the region of Bafatá, for example, Plan International has backed a process through which community members take an active part in the

construction of classrooms and in the follow-up of the academic performance of their children. Community members control teachers' presence in schools and incentives are provided to families to send girls to school. In remote areas across the country, communities often contribute to the costs of education, for example by paying part of teachers' salaries and/or allowances. Of course, communities' voice and accountability in these schools are stronger than in publicly managed schools.

78. **The institutional capacity in the Ministry of Education needs to be improved.** In addition to the political volatility and high turnover rate at senior levels of government that disrupt services delivery, visible signs of declining institutional capacity in the ministry include: (i) the very low quality of infrastructure; (ii) the scarcity of resources to cover current expenses; (iii) frequent arrears in salary payments; and (iv) a pronounced brain drain phenomenon that impoverishes the human capital available in the sector.

79. **In fact, the effectiveness of the institution as a whole is at stake.** Some of its best departments in the past are now sinking into a crisis. For example, in the recent past, INDE was an example of dynamism in the development of education studies and research, the development of curricula and school programs, and the planning and implementation of in-service teacher training courses. Today, the erosion of capacity almost limits its action to this latter activity. Another example is *Editora Escolar*, which once was considered one of the best institutions in the country. It autonomously conceived and developed school manuals of acceptable quality and, at times, ensured their careful distribution among schools everywhere. It is uncertain if these capacities still exist as many qualified staff has abandoned the house, mainly because of a lack of financial sustainability in its operations.

80. **The legal and regulatory framework in the sector needs to be strengthened.** Frequent changes in the structure of the ministry constitute a barrier to the development of a sound and coherent legal and regulatory framework. The rule of law is not always clear when it comes to the internal role of the departments and units within the ministry. Organic law is often non-existent or does not keep pace with changes in the structure and organization of the ministry. By the same token, not every unit has its tasks clearly defined, with cases of overlap and confusion of roles and responsibilities. Needless to say, these conditions do not favor transparency and accountability in the process of service delivery. Challenges also include the development of a regulatory framework for the emerging higher education sub-sector as well as the strengthening of the internal capacity of the ministry to perform oversight and exercise appropriate supervision duties with regard to non-state actors.

3.2.6. Cost and Financing of Education Services

81. **Budgetary provisions for the education sector continue to be below average for sub-Saharan African countries.** Guinea-Bissau has not always prioritized education in its allocation of public spending. Between 1996 and 2004, public spending on education represented 2.8 percent of GDP compared to the average 3.8 percent for sub-Saharan African countries. The education share of the Government's budget fluctuated between 11 percent and 17 percent over

the same period. It has even declined between 2003 and 2005, when average current public spending on education was only 10.7 percent of the total recurrent government spending.[40]

82. **The execution rate of the education budget has been low**. One reason for this underinvestment in the education sector is the difference, at times very significant, between the assigned budget to the sector and the executed budget. In the context of heavy resource constraints and competition between different government institutions for meager resources, the education sector is often unable to get an adequate share. This tendency persists. Between 2003 and 2005, for example, the average execution rate of the education recurrent budget was only 62 percent.[41] If the education budget had been executed at 100 percent, average current spending in the sector would have been at 15 percent of the total government current spending.

Table 10: Guinea-Bissau and the EFA-FTI Benchmarks

	EFA-FTI benchmarks	***Guinea-Bissau***
Service Delivery		
Average annual teacher salary (as multiple of GDP per capita)	3.5	6.3
Pupil-teacher ratio	40/1	53
Spending on inputs rather than teachers (as % primary educ. spending)	33	20
Average repetition rate (%)	10	15
System financing		
Government revenues (as % of GDP)	14-18	18
Education recurrent spending (as % of government revenues)	20	11
Primary education recurrent spending (as % education recurrent spending)	50	37
Private enrollments (as % of total)	10	12

83. **Current expenditure on inputs other than salaries and allowances is very limited**. Between 2003 and 2005, an average of 80 percent of the recurrent public spending on education went to salaries and other allowances for personnel; hence, very little is left for investment in quality. In the past, investment projects represented the primary source of financing of non-salary items. As these projects became rare in the sector, the financing of quality dropped dramatically. Not surprisingly, the sector is suffering from a lack of basic resources for recurrent costs—textbooks, paper and toner for printers, gas for generators, maintenance of facilities, or resources for inspectors to visit schools.

84. **The intra-sector allocation of public resources does not favor primary education**. The share of recurrent expenditure on education that went to primary education was around 37

[40] Recurrent education expenditure (excluding debt service and common expenditures) accounted for 9.4 percent of the total government recurrent budget in 2003. It remained at 9.9 percent in 2004 and rose to 13 percent in 2005.
[41] The execution rate was 50 percent in 2003 and 2004, and 86 in 2005.

percent for the period 2003–2005. On average and for the same period, secondary education received 39 percent of the recurrent education budget, while about 20 percent was allocated for tertiary education. This means that on average only 4 percent of recurrent government spending went to primary education in the course of 2003–2005. Recurrent spending on primary education as a percentage of total recurrent education spending is well below the benchmark allocation of 50 percent recommended for low-income countries for primary education efficiency and quality.

85. **Unit costs are low at all levels of the education system**. The unit costs across different levels of the education system are low. In absolute terms, unit cost is estimated to be CFAF 10,000 (US$ 22) in primary education and CFAF 27,000 (US$ 60) in secondary education. In higher education, the cost per student stands at about CFAF 37,000 (US$ 86). Unit cost in primary education is low at any standard, and it cannot ensure universal primary education of quality.

86. **Capital expenditure remains low**. Investment expenditure in education remains low compared to regional and international standards, and depends essentially on external sources.[42] Investment expenditure in education was estimated at CFAF 1.7 billion (or 1.3 percent of GDP) in 2003. It then rose to CFAF 2.7 billion (1.9 percent of GDP) in 2004, only to fall to CFAF 1 billion (0.7 percent of GDP) in 2005. This decrease probably reflects the closing of the World Bank-financed BESP in 2005, with no other large external investment in the sector under implementation. It is noteworthy that capital expenditure in the sector in 2003 and 2004 was financed entirely by external sources, while in 2005, probably because of the shortage of external resources, the Government financed 30 percent of expenditure.

3.2.7. Assessment of Recent Policy Reforms

87. **Policy reform efforts have been undertaken in recent years with encouraging results**. Guinea-Bissau has undertaken various education policy reforms in recent years to address the many issues plaguing its education system. Among the key ones with direct impact on families and schools are the following: (i) the elimination of school fees for primary education in academic year 2001/02; (ii) the free provision of textbooks to primary school pupils, beginning in academic year 2000/01; (iii) the development of an integrated basic education system of six years beginning in academic year 2001/02; (iv) the adoption of a low-cost model of infrastructure development in primary education; and (v) the provision of higher education to a growing number of young people. Some key features of these reforms include:

88. *Free primary education*. In 2001, the government decided to eliminate enrollment and tuition fees in public primary education schools in line with the poverty reduction policies in social sectors, as expressed in the interim PRSP. The policy was simultaneously believed to remove barriers to schooling of most children in rural areas, especially girls. Fees that had been imposed were not uniform across the country (they could go up to US$ 20 a year per student) and the very legal existence of these fees led to misconduct and abuses in many schools. It is believed that the rapid growth in enrollment registered in the subsequent years was a

[42] Capital expenditure on education between 1998 and 2005 was guaranteed by a few partners as follows (US$ million): World Bank (14.5), Plan International (6.0), World Food Program (1.9), and UNICEF/FNUAP (4.0).

consequence of this measure (it is also likely that many dropouts returned to school as a result of this dramatic change in policy), which was complemented by the provision of free meals in schools for many students in various parts of the country.

89. *Free textbooks for primary education students*. In tandem with free enrollment and no tuition fees, the government also decided to ensure free distribution of textbooks to primary education students. The measure had a direct impact on families. The cost of a kit of three textbooks was about US$ 10 and transferring this cost from parents to the government was particularly welcomed by families with several children enrolled in schools. The measure seemed to benefit girls' schooling as some evidence suggests that when families are unable to support the schooling of all their children, they will more likely decide to finance the education of their male children.

90. *The development of a single six-year basic education system.* This is an important policy measure, the objective of which was to improve the efficiency of the system (by making more effective use of teachers) and to reduce inequities between rural and urban areas. Children from rural and remote areas would likely drop out after completing the fourth grade of primary education because pursuing further studies would require them to "emigrate" to the nearest urban center, where complementary primary education is provided. The reform required not only that primary elementary schools adapt to provide 5^{th} and 6^{th} grade schooling, but also that the curricula be adjusted and teachers trained to teach at all levels of primary education.

91. *Expansion of infrastructure*. In the late 1990s, most primary education classrooms were constructed at a cost of US$ 13,000 or more. This unit cost would have made it difficult to keep pace with the recent increase in the demand for primary education. As a result, the government decided to construct classrooms at half of that cost. Community involvement in infrastructure development, which was carried out with support from NGOs and more recently in the context of the implementation of the BESP, has further facilitated the decrease in the cost of a classroom to an average of US$ 4,000.

92. *A prudent tertiary education policy*. While continuing to take advantage of the scholarships offered to its students by several countries to pursue post-secondary training abroad, in the beginning of the 2000s Guinea-Bissau moved toward the creation of a national university. With more than 2,000 students graduating annually from secondary education, it was no longer possible to continue to rely only on training abroad to create the critical mass necessary for the development of the country. The process of creating the public university was founded on the idea that a public tertiary education institution should not place additional strain on already very limited government resources. This idea was realized through the creation of a federation comprising the existing higher education institutions before the conception of new courses, and the setting up of a private management model. The university is managed by a private foundation and students pay enrollment and tuition fees, which cover a large portion of the university's recurrent costs. The financial burden of tertiary education on the government did not increase, as demonstrated by the absolute values of annual government transfers to higher education.[43] With

[43] In 2004 and 2005, the total government financial transfer for tertiary education was, respectively, CFAF 274 million and CFAF 305 million, with more than 80 percent of these amounts going toward the payment of scholarships abroad. Of these totals, UAC received CFAF 52 million and CFAF 28 million respectively.

its adopted cost-recovery model, tertiary education is likely to develop without getting a larger share of the government budget in the near future.

93. **These policies, however, have not had the full expected impact on the development of the education sector.** The main causes of this counter performance are the very low level of public investment in the sector, which has severely constrained sustainable progress, and the persistent institutional instability, which has jeopardized the successful completion of several measures. Free primary schooling led to a significant increase in enrollment, but raised the problem of how to accommodate the additional number of children given the scarcity of resources. The construction of hundreds of classrooms in recent years by means of external support helped in part to address the problem. In addition, for many schools, the collected fees were the only resources available to meet the needs of a minimal set of pedagogical inputs. By eliminating the fees and not being able to provide pedagogical inputs or transfer money to schools, the government has in practice contributed to the further degradation of the learning environment of most of the schools. The same is true regarding free textbook distribution, which, ultimately, has led to a shortage of textbooks in classrooms.

3.3. THE HEALTH SECTOR

3.3.1. Access to Basic Health Care

94. **The health status of the population of Guinea-Bissau is among the worst in Africa.** Infectious diseases like malaria, tuberculosis, HIV/AIDS, and diarrhea are among the main sources of morbidity and mortality. The percentage of assisted deliveries by qualified personnel was estimated to be 39 percent in 2006. Cholera outbreak is recurrent, causing many victims, particularly among the children and elderly. Poverty is usually associated to the poor health status of the population, but the country's failure to effectively respond to the needs of the population through improved health services is a major factor.

95. **Access to quality health care is limited and inequitable.** Overall, access to quality health care for the population is limited. Public health centers and hospitals are often inaccessible for a large proportion of the population, either because they are distant from villages or their services are of such poor quality that they do not stimulate demand. On the other hand, a discrepancy remains between access by the rich and poor to health care. In 2002, about 37 percent of the poorest households had access to health services compared to 46 percent of the wealthiest. Consequently, the rate of usage of medical services was only 9 percent for the poor, as opposed to 19 percent for the rich. Access was higher in Bissau than in the rest of the country (55 percent compared to 38 percent on average).

Table 11: Progress Towards Achievement of the Health MDGs

Health MDG	1990	2000 MICS2	2006 MICS3	2015 Target
MDG 4. Reduce under 5 & infant mortality				
(under five mortality per 1,000 births)	240	203	223	**80**
(infant mortality per 1,000 births)	142	124	138	**47**
MDG 5. Reduce maternal mortality				
(maternal mortality per 100,000 births)	914	822	800	**229**
MDG 6. Figth HIV/AIDS, Malaria & TB				
(HIV/AIDS prevalence)	5.9	8	8.7	**5.9**

Source: MoH.

96. **Access was seriously affected by the 1998-99 armed conflict**. The conflict damaged part of the national health infrastructure in the capital city and in other parts of the country. It also contributed to disarticulation of the structure and organization of the national health care system as many professionals left the country and did not return after the conflict. Although reconstruction efforts are underway,[44] much remains to be done to ensure appropriate access to quality health care for the population. Today, seven out of eleven regional hospitals are still closed or provide only limited health services, thereby limiting the access of the population to health care.[45]

Immunization Coverage

97. **Progress on immunization coverage has been mixed**. Since 1995, vaccination coverage among relevant population groups has had its ups and downs. The immunization rate among the under-five age group decreased until 1999, increased significantly between 2000 and 2004, and then decreased again in 2005. It increased again in 2006, with particularly encouraging results for certain antibodies such as BCG, DTP3, and Polio3, with respectively 90 percent, 83 percent and 78 percent coverage. However, despite sustained national campaigns supported by some development agencies, particularly UNICEF and WHO, several indicators on immunization stand below PNDS targets. In 2006, the tetanus immunization rate (TT2) for pregnant women was estimated at 52 percent; the proportion of children below one year of age fully vaccinated stalled at 54 percent, against a target of 78 percent; and the immunization rate for measles was at 65 percent, against a target of 80 percent.

98. **Several organizational constraints have hampered immunization efforts**. Deficiencies in the organization of immunization services are associated in large part with the unfavorable organizational context in which the health care system is evolving. Problems of

[44] The EU, AfDB, and World Bank have recently invested heavily in health infrastructure rehabilitation and construction. For instance, the national hospital is being fully revamped, and many health centers, health posts, and housing facilities are being renovated. There are no new foreign funds projected for 2008 to pursue and complete this effort.

[45] In addition to the capital city, only four regions (Bafatá, Cacheu, Gabu and Tombali) had a primary regional referral hospital operational in 2006 (these hospitals represent the first level of reference).

physical accessibility, lack of resources for advanced strategies, poor maintenance of the cold chain, and unmotivated personnel are among the factors that affect the current organization of the system, with direct impact on immunization coverage. To address the issue, an immunization plan (2005–2009) has been developed in collaboration with the international community. The plan is realistic and viable and, if well implemented, is likely to offer an opportunity to promote vaccination coverage to larger groups of population.

3.3.2. Critical Challenges for Public Health

Malaria

99. **Malaria remains the number one public health problem in Guinea-Bissau.** In 2005, it accounted for 35 percent of consultations in hospitals and health centers across the country and remains the primary cause of mortality among children under 5. But recent outcomes on malaria prevention are encouraging. From 2005 to 2006, there was a 30 percent reduction of new cases of malaria, (175.012 cases in 2005 against 131.171 cases in 2006) even though access of children to malaria treatment has worsened, mainly because the shift towards the new therapeutic scheme of artemesinin-based combination therapies (ACT) has been slow and consequently, drug shortages are recurrent. In 2006, only 45.7 percent of children with a fever received appropriate treatment.

100. **These positive results can be explained, in part, by the availability and extensive use of impregnated bed nets, particularly by vulnerable groups.** At present, about 60 percent of both pregnant women and children under age five are sleeping under impregnated bed nets, and 46 percent of households have at least one impregnated bed net. The priority now is to strengthen the network of impregnating centers in order to increase access to impregnated bed nets by the poorest populations.

101. **The country's application to the Global Fund was approved.** Guinea-Bissau is expected to receive US$ 12 million in 2008 to implement the malaria component of its national policy over the next five years. These resources should help reduce the incidence of malaria, to provide broader access to new treatment methods, and to reduce the economic burden of the disease. Activities will include the introduction of ACT countrywide, staff training, distribution of impregnated bed nets during vaccination campaigns, impregnation campaigns through appropriate centers, and strengthening of the system of monitoring and evaluation.

HIV/AIDS

102. **Despite the lack of reliable epidemiological data, there is mounting concern that the HIV/AIDS pandemic is spreading rapidly**. The country still lacks reliable data on HIV prevalence and AIDS-related deaths, but available information suggests rising HIV prevalence and AIDS-related mortality. According to WHO estimates in 2005, about 32,000 people in the

country were living with HIV/AIDS, of which 3,200 were under 15.[46] It can be assumed that a large part of these do not know that they are infected. The National HIV/AIDS Secretariat has estimated HIV-1 prevalence in 2005 at 2.5 to 3 percent. UNAIDS estimate in 2005 put HIV prevalence among the adult population of Guinea-Bissau in the 2–6 percent range (with a median value of 3.8 percent), and the MICS-3 led by UNICEF calculated a prevalence of 8.7% in 2006. In any case, these rates exceed those for Guinea-Bissau's two neighbors, Senegal and Guinea-Conakry, where total prevalence is estimated to be between 0.4 percent and 0.7 percent (Senegal) and 1.2 percent and 1.8 percent (Guinea-Conakry) respectively.[47] Among the factors contributing to HIV transmission are the early onset of sexual relations (55 percent of the population is sexually active by age 15) and the high poverty incidence, which leads to prostitution of younger girls; the relatively high incidence of sexually transmitted diseases (STDs);[48] and the low use of condoms. Information from a variety of sources indicates that there is a substantial urban bias in HIV infection (in particular in the main transportation axis from Bissau to Senegal) and that without a more intensive prevention campaign, transmission rates are likely to increase dramatically. A sentinel study is planned for 2008 to get better information on HIV infection rates and their distribution.

103. **Access to HIV/AIDS treatment is very limited**. AIDS-related mortality in 2006 was estimated at 3,600 (NAS) and 2,700 (UNAIDS). Mother-to-child transmission has also been increasing over the years. The 2006 transmission rate was 9 percent, up from less than 1 percent in 2005. Recent data shows that no more than 8.6 percent of all pregnant women were tested for HIV during prenatal care and that only 7.1 percent of all women had actually received their results.[49] Despite the availability of generic ARVs from Brazil and funding from the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), only 496 people received treatment in the first quarter of 2007,[50] up from none in 2004. The poor status of the health facilities and the poor capacity of supply chain management are limiting factors. Stock ruptures of pediatric ARV and of testing supplies occurred in early 2007.

104. **Knowledge of HIV/AIDS forms of transmission is relatively low among the population**. About 86 percent of the population claims to have heard of HIV/AIDS. However, the knowledge of methods of transmission is weak. Eighty-seven percent of 15 to 24 year olds claim to know how HIV is transmitted, but only 7 percent are able to correctly identify two methods of transmission (12.7 percent urban and 3.4 percent rural). Serious misconceptions on HIV transmission exist, with 32 percent of respondents declaring that HIV is spread through divine intervention, 51 percent declaring that it can be spread through sharing food bowls, playing or sleeping together, and 72 percent saying it can be transmitted by mosquito bites. Only 10 percent of people interviewed knew that these three modes of transmission were incorrect (behavior study, 2006).

[46] World Health Organization.
[47] World Health Organization, UNAIDS/WHO Global HIV/AIDS online database.
[48] Slightly less than 7 percent of all respondents (age 15–49) reported an episode of STDs in 2005. On average, each person contracts one STD during his/her lifetime. Most cases of STDs, especially for men, are not reported because they seek help through traditional healers. Health facilities have reported an average of 9,000 cases per year over the last three years.
[49] MICS 2006.
[50] This correspond to less than 40 percent of people identified as needing access to ARV treatment and to less than 10 percent of the estimated number of people requiring treatment.

105. **Prevention knowledge among population groups differs widely.** Knowledge of methods of prevention is much lower in rural areas than it is in urban areas. Of all women living in urban areas, 91.6 percent say that they have heard of HIV/AIDS, with almost half (47.2 percent) correctly identifying three modes of prevention (abstinence, being faithful, consistent condom use). In rural Guinea-Bissau, more than half of the women have neither heard of HIV/AIDS nor know how to prevent it. At the regional level, there are also differences in prevention knowledge. The southern part of the country (Quinara, Tombali, and Bolama-Bijagos) lags behind considerably, with 70 percent of women being unaware of even one mode of preventing the disease. Knowledge about prevention of an HIV infection is also positively correlated with income level. While only 12.4 percent of the poorest women are able to correctly identify the ABC prevention methods, this figure increases to 51 percent among the top income quintile.

Box 3. Sexuality and HIV/AIDS in Guinea-Bissau

Several sociocultural attitudes toward sexuality and some sexual practices contribute to the vulnerability of a large part of the population to HIV/AIDS.

Male circumcision and female excision, both referred to as *fanado* are widespread. While male circumcision is the norm everywhere, female genital cutting is mostly practiced among Muslim populations. Justified not only by claims of "hygienic" concerns, female excision is widely regarded as a prerequisite for marriage. Both women and men are at great risk of contagion as circumcision ceremonies are usually held for many young men and women concomitantly, using the same knife for the operations. *Fanado* is a ceremony charged with symbolism, marking the transition from adolescence to adulthood. Among the Balanta, for example, the ritual of *fanado* is a feast characterized by heavy drinking and socially acceptable heightened sexual activities among the community, extending even to what has been described as rape.

As observed elsewhere in sub-Saharan Africa, often young women engage in occasional sexual relations with older men in exchange for money and gifts. While their sexual encounters are clearly "contractual," the girls themselves do not see themselves as sex workers and are thus also not organized as such.

Male promiscuity is socially acceptable among all ethnic groups. Female promiscuity, however, while severely punished among the Fula, is reported to be tolerated among the Mandinga and animist ethnicities. Among the Balanta, it is accepted practice for a married man to engage in sexual relations with any female guests staying under his roof (*Bnanhga*).

Resistance to condom use as an "alien" object is common in rural areas and increases with age. Even if more widespread among the young urban population, condom use is reported to be low and irregular. Among Muslim populations, HIV is regarded as just punishment by God and condoms are seen as an open invitation to adultery.

These traditional practices, in combination with a very low level of knowledge about prevention and an expressed resistance to condom use, are nothing short of a time bomb with regards to the spread of HIV/AIDS.

Source: INEP (CESE) (2005).

106. **Misconceptions about HIV contribute to risky behavior and serious discrimination against infected people**. Only 37 percent of the 15 to 24 age group reported use of condoms in casual sexual relationships, but this seems to be an overestimated figure given the limited availability of condoms in the country, which is linked to a reported resistance to condom use in

the same age group for a variety of reasons.[51] The practice of female genital mutilation that in the past has victimized an estimated 272,000 girls and women represents a serious risk of spread of the disease. Misconceptions about HIV also lead to the end of marital relationships in 50 percent of cases when one partner informs the other about being contaminated, or to expulsion from families in about 30 percent of cases.

107. **Nonetheless, a serious stigma against seropositive persons persists.** According to recent MICS data, 75.2 percent—an overwhelming majority—of the population holds one or several discriminatory opinions against people living with HIV/AIDS. Of these, 41.8 percent think that an HIV-positive teacher should be banned from exercising her profession, 48 percent would not buy vegetables from an HIV-positive seller, and 20.6 percent would refuse to take care of a person living with AIDS. Given these numbers, it is not surprising that almost half of the people in the sample said that they would keep the seropositivity of a member of their household a secret.[52]

Table 12: HIV/AIDS Prevention Knowledge, Women aged 15–49

		Heard about HIV/AIDS	Knows 3 modes of prevention	Knows no mode of prevention	Number of women
Region	SAB	95.3	52.3	13.9	2,338
	East	66.2	22.2	56.9	1,751
	North	67.9	28.1	46.4	3,033
	South	39.7	11.9	70.0	888
Areas	Urban	91.6	47.2	18.2	3,232
	Rural	59.4	21.9	57.8	4,778
Level of education	None	59.5	20.7	57.4	4,557
	Primary	85.7	43.7	25.9	2,092
	Secondary and up	98.3	55.8	9.8	1,254
	Non-formal	56.7	9.7	69.9	98
Income quintiles	Poorest	45.3	12.4	70.7	1,495
	Poor	60.4	20.9	58.9	1,432
	Mid-income	67.1	26.2	50.3	1,489
	Rich	85.2	42.3	25.6	1,624
	Richest	95.1	51.1	14.5	1,970
Total		**72.4**	**32.1**	**41.8**	**8,010**

Source: MICS 2006 (preliminary report).

108. **Information, Education, and Communications (IEC) are not effectively used as tools to influence behavior**. Available material is not widely distributed and very little use is made of materials from other lusophone countries. The use of billboards has not yet been piloted and

[51] The number of condoms available in-country through public and private channels over the past three years has been low (2004: 140,000; 2005: 290,000; 2006: 350,000). This is in part due to weak capacity of national NGOs to ensure adequate distribution.

[52] A total of 5,799 were women polled for the MICS.

since 2006, a conflict between the National AIDS Secretariat and the journalists union has been jeopardizing the effectiveness of part of the national media in conveying HIV/AIDS messages. Some community radio stations convey messages on HIV/AIDS on a contractual basis, but these contracts are not always honored because of poor management of these stations. The more successful IEC activities are spearheaded by NGOs, such as Step Up and smaller national NGOs and CBOs. Their messages are more varied than radio programs (fidelity, abstinence, condom use). Their impact is, however, geographically limited and heavily dependent on donor funding. Limited access to condoms also reduces the impact of their messages. It is worth mentioning that the school curriculum has been adapted to include information on HIV/AIDS, but implementation has not yet started because of a lack of funding.

3.3.3. Management of the Health Sector

109. **The current organization of the national health care system faces multiple constraints.** The current health care system is three-tiered—central, regional, and local—with each level being entitled to offer different types of care. At the central level, The Ministry of Health (MoH) is responsible for defining policies and strategies, setting out regulations and technical orientation, and providing operational and logistical support for different programs and health activities. It also ensures supervision and monitoring and mobilization and coordination of external aid.[53] At the regional level, there are 11 regional health directorates whose function is to translate national policies into operations, and perform monitoring and evaluation. At the local level, the country is divided into 37 sectors and is organized into 114 health areas including type A, B and C health centers, depending on the level of care provided. The basis at this level is a primary health care system through which a minimum package of services covering immunization, malaria, reproductive health, nutrition, and HIV/AIDS is offered. At the local level, communities [*tabancas*] are organized around the so-called Basic Health Units (BHUs) that make available to the population essential drugs for primary health care needs. Among the 697 existing BHUs, 466 are currently operational, ensuring basic care, prevention, and health care promotion.

110. **This system is well organized in theory, but faces multiple constraints in practice**. The center often fails to provide strategic planning, monitor implementation of the various health programs, or ensure coordination between stakeholders. The implementation of health programs at regional and local levels is hampered by infrastructure and equipment shortages, as well as by weak management capacity.

[53] The MoH encompasses two General Directorates (Public Health and Health Infrastructure); twelve sub-Directorates (including Finance and Administration, Hospital Care, Primary Care, Drugs, Hygiene and Epidemiology, Human Resources, and HIV/AIDS); three inspections (General, Pharmacy, and Administrative and Financing), two National Institutes (Health and Blood), three Centers (Essential Drugs Purchasing, Mental Health, and Motor Rehabilitation); and one National Health School. It has one national referral hospital (Hospital Simão Mendes) and two Referral Centers (Pneumonology and Management of Leprosy).

Human resources management

111. **A human resources strategy was recently produced**. The lack of a clear human resources strategy was perceived as the main obstacle to health developments. Developing a new national HR strategy (the previous one was developed in 1997) is therefore a key element in improving the performance of the health sector. Efforts were developed in that direction under the guidance of the World Bank through a Bill Gates Trust Fund. The new strategy addresses the fundamental questions necessary to ensure strengthening of the whole health system through improved performance (e.g. planning, production, deployment, performance management, and regulation and administration). The challenge is now for the MoH to translate this brand new strategy into comprehensive action plans.

112. **The sector is in dire need of qualified staff**. The ratio of one physician per 10,000 inhabitants is extremely low, as is the ratio of two nurses per physician. Lack of personnel remains an issue. Estimated needs require that the country double its number of general physicians, and increase by one-third the number of nurses and midwives currently working. In addition to the lack of personnel, placement of health personnel is biased in favor of urban areas. In addition, the HR deployment policy and promotion system is not transparent; it entails regional disparities, imbalances between the capital city and the poorest regions, and lack of motivation of personnel who do not see linkages between performance and their career paths.

Table 13: Estimated Needs of Key Staff in the Health Sector in 2006

HRH Guinea-Bissau	In Place	Estimated Needs	Lacking
Physicians/GPs	30	56	26
Foreign specialist physicians	30	30	0
Nurses	261	368	107
Midwives	162	528	96
Health technicians	40	82	42

Source: MoH.

113. **The Government is considering new incentive schemes for health personnel**. The Government intends to introduce monetary and other incentives, including the construction of staff housing in a few regions, in order to encourage staff placement in remote areas. A new salary grid is about to be implemented, aimed at motivating personnel through a significant salary increase for health workers. The proposed salary increase would range from 25 percent for technicians to 100 percent for specialists. Other monetary incentives such as overtime pay for night duty, premiums for isolated areas, and times when personnel are “on call” are also being

updated. It is not clear if all 12,000 civil servants[54] would be affected by this wage adjustment policy.

114. **Training institutions have limited capacity.** The National School of Health (NSH) is responsible for training all nurses, midwives and health technicians in Guinea Bissau. The school was totally destroyed during the 1998-1999 conflict and since then has not been rebuilt. The Amílcar Cabral University's campus is hosting the school, but it offers very limited facilities for students, administrative personnel, and faculty. There are 12 full-time faculty and over 200 students currently enrolled in three- to four-year programs. The NSH has no library, no reference or teaching materials, and no textbooks or learning materials for students. The lack of equipment is prevalent throughout the system and the need for a curriculum update is crucial. The training plan currently in place will not be able to fill the gaps for several years yet. Pairing with Northern institutions may be an option to provide opportunities for staff to acquire and/or improve their pedagogical skills and to help the school to stay on track with modern capacity-building strategies and programs. A school of medicine with 90 students at present is functioning with support from the Cuban government, which brought 34 physicians to Guinea-Bissau in 2005 (mostly general practitioners) to ensure training in the school.

Monitoring and Evaluation (M&E)

115. **Management of the health system is hindered by an inadequate monitoring and evaluation system**. In fact, most of the relevant data are collected in the regions, but their consolidation at the central level remains weak, resulting in low data reliability.[55] The Department of Hygiene and Epidemiology (DHE), responsible for Health Information System (HIS), lacks the capacity to analyze data and to use it for decision-making purposes. With the support of a few donors, including the World Bank, the French Cooperation and the Global Fund, efforts are under way to enhance the health M&E system by allowing a regular flow of information from health facilities to the center and vice versa. In 2006, the IDA-financed project in particular signed a contract with the Bandim Health Project [*Projecto de Saúde de Bandim* PSB], an autonomous health organization funded by DANIDA, to support data collection and treatment. The French Cooperation is providing technical assistance to the DHE with the support of an epidemiologist. However, the DHE will still require few years of technical support and an intense training program for its staff to be fully operational. Technical leadership of the department also has to be strengthened to improve the quality of work and ensure better management of the whole technical team.

116. **Supervision of health activities is not conducted on a regular basis.** Supervision is essential to managing and maintaining the performance of the health network, but it is a rare event in Guinea-Bissau. The last supervision mission occurred in October 2006, financed by the PNDS, and another one has been planned for 2007; an adequate supervision system should include six teams visiting two regions at least twice a year. A supervision manual was revised in 2005. Each team produces a report based on established guidelines. Unfortunately many problems identified during the 2006 supervision, in particular a lack of drugs and supplies and difficulties with fleet maintenance, remained unattended. Moreover, the supervision system

[54] The security sector is not included.
[55] IDA signed a contract with DANIDA in 2006 to help strengthen data collection and treatment.

suffers from a lack of coordination and organization. Many vertical programs supervise their activities on their own, and the concept of integrated supervision is not yet fully implemented. Integration would bring with it several benefits, among them achievement of economies of scale and higher efficiency. Such a supervision scheme would also motivate staff and improve the efficiency and quality of care by facilitating prompt feedback aimed at correcting wrong practices and at responding to logistical needs.

117. **A reliable analytical and patrimonial accounting system is missing**. This system is crucial to the sound management of health-related public finances, facilities, and vehicle fleets, along with maintenance activities. At present, the lack of control from the central to the regional level is striking. There is no organized supervision to control expenditure at decentralized levels; consequently, there is a lack of transparency and efficiency in the use of scarce resources. Auditing of public expenditures remains a rare event, the last one having been carried out in 2006 with the support of the AfDB. In that context, a Public Expenditure Review would be highly useful as it would provide key information to decision makers on the technical efficiency of resource allocation and management.

118. **Decentralization is not yet being considered.** A common aim of decentralization is to bring government nearer the people and to encourage community participation. At the moment, no decentralization process is envisioned for the health sector in Guinea-Bissau. The administrative link with the regions and districts remains very hierarchical and highly centralized. An internal debate about a policy aimed at decentralizing power and distributing key tasks to the regions should be initiated without delay. Many points could be discussed from a medium term perspective, such as legal status, appropriate mix of decentralization types, financial flow efficiency, level of control and regulation from the central level, level of empowerment of regional directorates/committees, governance rules, and matching the scale of the local needs with the scale of decentralized organization. At any rate, such a reform would require technical assistance to prepare the regions and local units for planning, monitoring, and management capacity.

Drug management logistics

119. **The logistics of drug management needs to be improved**. Along with human resource management and supervision activities, equitable access to drugs is the other requirement for good performance of the health care system. Most regional deposits/warehouses are facing a serious financial situation. Some of them are unable to continue to buy drugs because they are highly indebted, which has a negative impact on the distribution of drugs. For example, in 2005, the hospital of Mansoa in the North could only purchase approximately 10 percent of the necessary drugs through the existing system and had to buy the remainder outside of the system. There are also some cases of mismanagement, whereby working capital disappeared in some places. The absence of reference documents for the list of drugs and therapeutic protocols at various levels does not offer a favorable context for improvement of the situation in the short term.

3.3.4. Institutional Capacity

120. **The country's health priorities are reflected in the National Health Development Plan (PNDS 2003–2007).** The plan outlines clear strategies for improving population health. It is both a crucial strategic document and an operational tool that encompasses four major national strategies: (i) the accessibility and quality of the minimum package of activities and standard care; (ii) institutional capacity building; (iii) human resource development in the management of programs and service delivery; and (iv) promotion of inter-sector collaboration in disease prevention. The PNDS was financed largely by international aid sources. As the current PNDS comes to a close in December 2007, the government has launched the process of developing the next plan (PNDS II), which will cover the period 2008–2012. The process is being led by the Ministry of Health, with technical and financial support from development partners, other government ministries, and civil society. It would take six to nine months. Three UN agencies (WHO, UNICEF, and UNFPA) and the World Bank have jointly committed to providing technical and financial support to the entire process.

121. **A roadmap (2007-2009) to reduce maternal and neonatal mortality has been approved.** The roadmap was approved in November 2006 with the support of development partners. Its general objective is to reduce maternal mortality from 818 per 100,000 live births to 205 per 100,000 live births and neonatal mortality from 55 per 1,000 live births to 20 per 1,000 live births before 2015. Specifically, the "roadmap" plans to increase the availability of emergency obstetric and neonatal services and to strengthen the utilization and quality of such services. Intervention strategies will focus on strengthening the resolution capacity of the facilities offering Essential Obstetrical care (EOC) at different levels, improving the financing system to sustain EOC, and building partnerships with NGOs and communities to promote maternal and neonatal health. The main activities of the roadmap will include supervision, physical rehabilitation, equipment vehicles and drug purchasing, training, and communication. This excellent detailed plan requires US$ 3 million over the next three years, but it remains unfunded as no external donors have yet expressed an intention to finance part of the planned interventions.

122. **Capacity building is critical.** The MoH lacks a capacity-building program for its staff at the central and regional levels. The directorates of the MoH require intensive, ongoing training aimed at strengthening the skills and knowledge of their personnel in order to achieve better outcomes. The main fields identified that require capacity building are planning, monitoring, computer science, and program management. Specific training on the Marginal Budgeting for Bottlenecks (MBB) technique is envisioned in partnership with UNICEF.[56] The MBB is among those approaches and tools that have been used to overcome the issue of health service coverage by assessing the impediments to faster progress in the health sector in the country, identifying ways to remove such obstacles, and estimating both the costs of removing them and the likely impacts of their removal on MDG outcomes.

[56] MBB tool recently developed by UNICEF, the World Bank and WHO, and tested in several countries is a response to this demand. The tool focuses on those interventions that the literature has found effective for the improvement of health MDG outcomes and that can be implemented in a development context. The MBB approach is a country-specific designed to help manage and plan specific health systems and programs.

123. **Donor coordination needs to be improved**. The MoH is not yet in the driver seat to take the lead in donor coordination. Donor assistance is still defined too often by donors and not by the MoH, which causes overlaps and inefficiencies in the use of limited resources. Political instability and the turnover rate in the Ministry do not help. However, there are positive signs of better coordination among key actors. Two institutional mechanisms put in place recently are worth mentioning: the Inter-Agencies Coordination Committee on Immunization and Surveillance, and the Multi Sectoral Coordination Committee (CCM) for the Global Fund. The former has been performing well. Last year, it received from GAVI an award of US$ 135,000 for good performance. The CCM for the Global Fund is composed of 16 representatives of different organizations, including society, government, NGOs, faith-based organizations, the private sector, academia, and PLWHIV/AIDS. It now meets frequently to discuss relevant issues and propose solutions.

3.3.5. Health Financing

124. **Total public spending on the health sector is very low**. In 2006, per capita public spending in the health sector was estimated at US$ 6 and donors have contributed the same amount. Therefore, with US$ 12 total health expenditure per inhabitant, Guinea-Bissau is not in a good position regarding international benchmarks on health financing for developing countries and is a long way from reaching international commitments on public financing of the sector.[57] Household expenditures on health are estimated at an average of US$ 1.5 to US$ 2.0 per capita per year, corresponding to a total amount of US$ 2 to US$ 3 million.

125. **The share of the government budget allocated to the sector has been declining**. It has decreased (Table 4) from 11.8 percent in 2002 to 7.9 percent in 2006 (2.18 percent to 1.84 percent of GDP during the same period). This is partly explained by the country's macroeconomic constraints, which is linked to the low priority accorded to the sector by the government. The annual budget preparation is a cumbersome process that requires tough negotiations with the regions. Budget execution is affected by poor dialogue between the MoH and the Ministry of Finance, which has tended to occur mainly in the context of problem solving. Delays in paying health personnel's salaries are chronic; two- to three-month salary arrears are recurrent. The problem can be explained in part by the weak capacity of the Direction of Administration and Finance (DAF) of the MoH; the recent creation by the health authorities of the Direction of Computer and Finance management is part of the Government's efforts to overcome this weakness.

[57] According to the Abuja Agreement per capita health public spending in developing countries should reach at least US$ 25.

Table 14: Government Recurrent Budget for the Health Sector (2002–2007)

Year	Allocation (xCFAF 1,000)	% Gov. budget	% GDP	Execution (actually paid)	Execution rate
2002	3,509,200*	11.8	2.2	1,126,453	36.2
2003	3,509,200	11.8	2.2	888,076	25.3
2004	2,333,300	8.2	1.6	1,110,651	47.6
2005	2,618,500	7.1	1.7	1,398,279	53.4
2006	3,197,112	7.9	1.8	1,374,364	43
2007	3,782,481	9	2		

Source: Ministry of Health.

* By default as no budget was submitted in 2002.

126. **Budget execution rate is low.** Public health investment is also aggravated by the low budget execution rate. Table 4 above shows that the Government has allocated an average of 9.3 percent of the recurrent budget to the health sector over the period 2002–2006, but the real share of the health budget is less significant because of the low budget execution rate. In 2006, from an allocated budget of CFAF 3.2 billion (US$ 6 million), the MoH spent only CFAF 1.4 billion (US$ 2.6 million), which represents a 43 percent budget execution rate. To make things worse, salaries and allowances for personnel accounted for more than 80 percent of the executed budget. In 2006, they represented 83.5 percent of all expenditures; thus, little is left for non-personnel expenditures, including oil for vehicles, food, clothes, drugs, and office materials. On the other hand, non-personnel expenditures are unevenly distributed across different budgetary lines. While expenditures related to medical evacuations, mainly to Senegal and Portugal, amounted to four times as much of the budget as originally planned, reaching CFAF 489 million (US$ 1 million),[58] drug expenditures continued to fall short of annual needs. Of an estimated need of CFAF 353 million (US$ 660,000) in 2006, the Government spent only CFAF 25 million (US$ 47,000), despite calls from most international donors urging the government to dramatically increase its spending on drug purchases.

[58] In 2006, 590 patients, mostly with chronic diseases such as cancers, renal and hearth failures, were evacuated to Portugal and Senegal.

Box 4. The Burden of Medical Evacuations

Medical evacuations continue to capture a high share of non-personnel health expenditures. Many patients, especially with cardiological, neurological, and nephrological conditions, are sent over to Portugal under the umbrella of a collaboration protocol signed between the two countries offering care for a maximum of 300 patients in 2006. The bilateral agreement offers free hospital care, including complimentary diagnosis and therapy, as long as these functions are performed in public hospitals, as well as transportation between the airport and the hospital in an ambulance, whenever the situation justifies it. The financial responsibility associated with the treatment of evacuated patients is also shared by both countries: air transportation is paid by the government of Guinea-Bissau through the health current budget, and the costs for the entire medical assistance are paid by the Portuguese government. Some money is also made available by the Embassy of Guinea-Bissau in Lisbon in the form of allowances for patients with chronic conditions that are forced to stay permanently or for a long time in the Portuguese territory. Similar arrangement also exists with the government of Senegal with a growing number of evacuations being made over the last years.

127. **Health expenditures are mainly funded by contributions from development partners**, representing nearly 86 percent of total health expenditure in 2006. Main multilateral contributors include the AfDB, the World Bank, and UNICEF. Twelve percent of sector financing is provided by GAVI and the Global Fund. Bilateral partners, mainly Portugal, but also China, Sweden, Denmark, France, and Brazil, contributed 23 percent of foreign aid in 2006.

Table 15: Health Expenditure by Source in 2006

Source of Financing	Amount (Euros)	%
Government	**2,095,000**	**13.9**
IDA	1,430,154	9.5
AfDB	2,693,000	17.8
WHO	616,930	4.1
UNICEF	1,817,599	12
UNFPA/UE	11,317	0.7
Global Fund	1,839,932	12.2
GAVI	68,000	0.5
Chinese Cooperation	560,000*	3.7
French Cooperation	186,247	1.2
Portuguese Cooperation	1,797,935	11.9
Brazilian Cooperation	80,000*	0.5

Source: PNDS and GAVI report.
* Estimates.

128. **Guinea-Bissau is still one of the most under-aided countries in the world**. Most major donor agencies and bilateral cooperation (US, Swedish, Dutch, British, Germany) are either absent or not resident in Guinea-Bissau, in part because of chronic political instability since the 1998 conflict. As a result, the prospects for external health financing in the years to come is bleak. The World Bank's support of the PNDS came to a close in December 2007; similarly, the AfDB and the EU, two key players in the sector, are also withdrawing. Further EU support to the health sector is not expected before the ninth European Development Fund (FED).

Box 5. Cost Recovery (Bamako Initiative)

In Guinea-Bissau, the cost recovery system is in disarray. Since 2003 when the Bamako Initiative was introduced as a strategy to co-finance the health sector, several bottlenecks have been identified. Among those are ineffective management of funds, high mobility of the population, lack of capacity of the management committees, and inadequate supervision from the central level.

The ineffective management of funds is explained mainly by the weak participation in the process by members of the management committees [*Comités de Gestão*, CG], who are elected representatives of the communities. The task is undertaken on a volunteer basis and is not remunerated. It is in fact quite demanding, as a member of the CG is supposed to regularly commute to other villages other than his own, covering distances that vary from 10 to 40 kilometers. Having to cover such distances is obviously not a motivating factor in the context of a voluntary activity. Some elected representatives in the CG were clearly expecting some sort of material and/or financial benefits; when these expectations were not fulfilled, they gave way to feelings of frustration, absenteeism, and a lack of zeal and devotion to the community cause. It was also noted that the head of the Health Center is in charge of funds management, carrying through expenditures that he judges necessary and convenient. As an immediate consequence, cases of misuse of funds for other ends not defined in the procedures of communitarian co-management are frequently noticed. Examples of these wrong practices are numerous in various health centers across the country. Drug sales funds are most commonly used for personal needs of the health staff, particularly to compensate for salary payment delays, or to support the cost of running facilities that normally would have been financed by the government budget. Besides law motivation, members of CG, particularly the young ones, frequently abandon the task as a result of migration, and the vacant positions are not promptly filled. Lack of capacity of CGs to appropriately manage funds recovered is also another impediment to their effectiveness. Capacity strengthening remains an issue. Central level supervision is errant and often necessary corrective measures have not been taken.

Most recently, the government has been taking steps to address the problem. Corrective measures include training sessions for members of the CG. Accounting and financial management tools have been distributed as well folders with administrative documents and forms, including receipts and statement of expenditures to encourage transparent management of funds. The health regional teams have been reinforced with technicians in charge of managing treasury in the regions, reducing therefore the work load of the regional financial administrators. It is thus expected that these administrators will be able to devote more time to follow up the management work of the CG. At the central level, efforts envisage an increasing role of monitoring and supervision. The government seems to be aware of the importance of allocating some money to finance supervision and monitoring activities. Some material incentives (e.g. bicycles) to encourage and reward the work of relevant members of the CG are also being considered. The potential impact of these measures on the effectiveness and efficiency of cost recovery is yet to be determined.

129. **Cost recovery has been modest**. User fees have been adopted by the Government since 2003 in order to recover part of the cost of health services. The total cost recovered in 2006 represented about 4 percent of the health sector budget. Resources were primarily used to pay incentives to medical staff (20 to 30 percent), and to pay for drugs and maintenance costs (30 to 60 percent). Evidence from focus groups conducted in 2005 suggests that the poorest members of the population have difficulties even paying for basic costs of adult or children consultation services, or for essential drugs. In practice, community leaders in villages determine who should be exempt from payment, based on their knowledge of villages' households. A waiver/exemption policy targeting the indigent and vulnerable groups, such as pregnant women and children under age five, has never been envisioned by the authorities.

130. **Health insurance is only available for workers in the formal private sector.** Mandated by law, the insurance fund is managed by the *Instituto Nacional da Previdência Social* (INPS). The system covers only 6,400 individuals employed in 1,622 firms, which is far below the pre-war level and can be partially explained by the weakness of the private sector. The INPS is constituted as a financially and administratively independent organization, but stands falls the oversight of the Ministry of Labor. Its main characteristics are defined by the legislator, including the conditions of affiliation, contributions, and benefits. Although the country's 12,500 civil servants and their dependants are guaranteed medical assistance by law[59] and contribute 18 percent of their salaries, they do not have any functioning insurance coverage. Medical assistance is provided to these civil servants on a selective basis.

131. **The insurance system is financed by earmarked payroll contributions.** The employee component amounts to 8 percent of the gross salary, the employer pays 14 percent. On top of that, employers pay a premium of 2 to10 percent of accident insurance depending on the type of work. Benefits currently provided by the INPS include the following: (i) sickness benefits (medical, remedies) foresee a 25 percent co-payment by the insured (50 percent for dependents); (ii) salary compensation during time of idleness due to sickness; (iii) evacuations abroad; (iv) family coverage (up to three children); (v) invalidity benefits (upon official declaration of invalidity); (vi) pension benefits (minimum of 10 years of enrollment, state minimum pension is CFAF 20,000 per month—currently 979 enrollees); and (vii) widow(er) benefits. Furthermore, there are plans to offer social housing and to construct a private clinic.

132. **Informal sources, however, confirm that services are often not available.** Changes in management are frequent, often more than once a year, and preference is usually given to political appointees over technicians. Non-compliance and arrears by companies are the norm. In fact, only 2.5 percent of the eligible companies actually comply in paying their contributions; in absolute numbers, this means only 40 companies. When funds are available, disbursement is reported to be excruciatingly slow, which translates into low levels of confidence in the institution among employers and employees. Currently, INPS is in the process of introducing electronic data management with the support of the Portuguese Cooperation.

133. **There are no private commercial insurance companies in Guinea-Bissau to date.** INPS has made no attempt to insure workers in the informal sector, who are estimated to represent about 80 percent of the country's workforce. According to the director, a prerequisite of their enrollment would be to build up their trust in the structure.

134. **Community-based health insurance funds have been growing exponentially in West Africa over the last decade**.[60] Guinea-Bissau, lagging behind in this area, has only recently had its first pilot experiences with informal community-based insurance under the guidance of non-governmental actors.[61] Each member of the community participating in the insurance scheme pledges to contribute a certain amount annually, which is then administered by a community-based organization. Fees are adjusted to the annual income cycle as payment comes due in the

[59] Decree-Law no. 30-A/92, article 645.
[60] Gottret 2006.
[61] AD – Mutualidade de Saúde de Varela, Cacheu province.

harvest season. The funds are exclusively devoted to covering medical assistance of the members. According to the experience of one such community-based health insurance scheme, there must be a minimum of 150–200 members, each contributing a minimum of CFAF 1,000 annually. No co-funding from external sources is sought and, given the small scale of operations, risk-pooling effects are low. While potential demand for such community-based insurance schemes is estimated to be high, the main stepping stone in the Guinean context is the poor quality on the supply side. The insured depend on basic public health services as community-based schemes have only limited means to provide these services themselves. In 2001, only 99 out of the 639 health posts were considered operational and had sufficient stocks of medication.[62]

3.4. THE SOCIAL PROTECTION SECTOR

135. **The following table gives an overview of existing social protection mechanisms in Guinea-Bissau.** Risk management strategies are grouped according to whether they focus on prevention, mitigation, or coping with risk. Preventive measures aim to reduce the probability of a negative shock, while mitigation measures decrease the potential negative impact of a manifested shock, and coping strategies try to relieve the impact of the shock once it has occurred.[63]

Table 16: Social Protection Mechanisms in Guinea-Bissau[64]

	Formal Public	Formal Private	Informal
Prevention	Information campaigns (HIV, vaccinations etc.) Regulatory framework Education	Mission Schools	Community schools
Mitigation	**Health Insurance** (private sector employees)		Community-based health insurance
	Pensions (civil servants)		Family-based care of elders
		Microfinance	*Abotas* (savings groups)
		Private banking, money lenders	Informal loans
			Migration/Remittances
Coping	**Transfer programs** \Subsidized drugs		Dissaving
	Food aid	Charities	Restriction of consumption Begging

[62] José Antonio Mendes Pereira: Power Point Presentation 11/2006.
[63] Holzmann and Jorgensen (2000).
[64] The table is modeled on Bendokat and Tovo 1999.

3.4.1. Formal Safety Nets

136. **Formal social protection refers to public or contractual, market-based arrangements.** The public sector contributes to risk prevention efforts by providing information and regulation and basic social services (see the detailed analysis in the education and health chapters, respectively). In terms of risk mitigation, the government offers limited but obligatory health insurance coverage for workers in the private sector and a pension fund for civil servants. There is also a transfer program for the handicapped, still in its early stages of development, which can be classified as a risk coping program, in addition to food aid provided by the WFP in targeted communities throughout the country.

Pensions

137. **The formal pension system covers only a small part of the population.** Beneficiaries are civil servants, including teachers and retired members of the government, as well as ex-combatants of the 1974 independence war, numbering 2,817 individuals at present. In order to qualify for pension benefits, the eligible individual has to either reach the legal retirement age of 60 years, combined with 40 years of service as a civil servant or, alternatively, be 40 years of age and demonstrate 15 years of service if judged unfit for work. Surviving direct ascendants can request a lump sum payment equaling six months of the pension with no possibility of an extension beyond that period. Designed as a pay-as–you-go system, based on a 6 percent payroll contribution, tax is applied to the salaries of roughly 12,250 civil servants (including 5,135 teachers).[65] Pension deductions go into the general budget, which leads to frequent disbursement problems. The Ministry of Labor and Civil Service would like to introduce an autonomous pension fund for civil servants.

138. **Benefits are unevenly distributed among eligible groups.** Monthly average disbursements of benefits amount to CFAF 196 million. However, 31 percent of these payments go towards 192 ex-members of the government and ex-deputies, who are guaranteed 80 percent of their last base salary as a pension. Arrears of several months are frequent. INPS offers retirement benefits for retired workers in the private sector after a minimum of 10 years of enrollment. These benefits are extended to the surviving partner along with a one-time payment of CFAF 100,000 to cover funeral-related expenses.

139. **A government transfer program aims to provide assistance to a range of vulnerable groups.** The program, managed by the Ministry of Social Solidarity, currently covers around 2,500 beneficiaries. The funds stem exclusively from the sale of official stamps. Targeting criteria, however, do not seem very clear; the Ministry does not possess any data collection mechanisms to that end. Individuals are expected to apply directly to the Ministry, which checks their background and decides whether or not to enroll them. Out of the 2,500 beneficiaries, 1,500 are people living with a disability and another 1,000 are categorized as “others.” Beneficiaries are eligible to receive CFAF 10,000 quarterly. Given the amounts allocated and the frequent payment delays, none of the beneficiaries can rely exclusively on this form of assistance. The

[65] MFPT/Serviço de Gestão de Base de Dados 03/05/2006.

government does not dispose of any emergency funds that would permit it to intervene in cases of man-made or natural disasters. The ministry currently plans to support a program of social pharmacies [*farmácias sociais]* that provide drugs at a subsidized rate for pre-qualified patients.

140. **Given the weak capacity of the government, non-state actors fill an important gap in terms of providing health and education services, especially in rural areas.** The Catholic Church entertains a dense network of mission schools and health posts, often run in collaboration with the government. Evangelical churches originating from Brazil are increasingly present, especially in the capital, often attracting the poor in part because they provide food and other support. Only a few international NGOs are present in Guinea-Bissau. Several, however, focus on vulnerable groups, most prominent among them being PLAN International which provides 16,000 children in the region of Bafatá with a basket of social services financed by sponsors from Europe and North America. SOS Children Villages currently hosts more than 300 orphaned and/or destitute children in their three facilities.

141. **Social assistance for orphans and vulnerable children (OVC) is very limited.** Recent data from the MICS shows that only 7.5 percent of all children classified as orphaned and vulnerable have in fact received some sort of social assistance, of which 4.4 percent received medical support and 4.8 percent education support. Coverage rates for the east are the highest with 11.6 percent, which can be attributed to PLAN's activities in Bafatá and parts of Gabú.

Informal Risk Management Strategies

142. **Bissau Guineans rely mainly on informal arrangements to manage** as formal social safety nets reach only a very small and relatively well-off segment of society. Informal risk management instruments, however, tend to be ineffective. Risk pooling takes place on a very low level as informal instruments usually involve only a very limited number of individuals. Obligations between parties are often based on mutual trust and customary law and may be difficult to enforce when necessary.

143. **Most informal arrangements focus on mitigation and coping measures for negative shocks that have already occurred**. Rarely do the poor have the capacity to take preventive measures to avoid negative outcomes. Community schooling, however, is an example of a preventive measure, as it would build human capital and generate income. As a response to the ongoing crisis in the education sector, communities have built schools and raised funds for their operation.

144. **Social assistance networks are critical to determining people's fate in times of need**. These networks, however, are not always resilient when faced with acute idiosyncratic shocks like medical emergencies, but they are even less able to cushion covariate shocks, be they natural disasters such as lack of precipitation, or man-made ones such as prolonged conflict or macroeconomic downturns. Social capital cannot function as a direct substitute for missing economic capital in times of need as the two are in fact mutually reinforcing. Not everyone benefits equally from such social networks of assistance, which makes it crucial to unpack them to be able to identify the most vulnerable groups in the population.

145. **Many Bissau Guineans can expect to rely first and primarily on their immediate kin for assistance**. While there are differences according to ethnic group with regard to the division of responsibilities, usually parents (matrilineal or patrilineal), uncles, and cousins provide a safety net by, for example, "joining stoves," i.e. merging households in times of need or providing ad hoc assistance in kind or in cash. In a small household survey undertaken among urban households in the neighborhood of Bandim in Bissau, reliance on receiving gifts several times a month or regularly was reported by over 50 percent of households. Households led by women captured in the sample were relatively more reliant on gift giving than male-headed households.[66]

146. **A variety of informal risk mitigation strategies are utilized by the poor.** These strategies can be horizontal or vertical, rooted in traditions or "modern," and entail different levels of reciprocity. Patrimonial networks, often leading upstream via several intermediate steps to a *homem grandi*, i.e. a "wealthy man", are often based on kin and ethnicity. They may be based on obligations to traditional chiefs, although this allegiance is increasingly disappearing in urban areas. Individuals with a regular income usually have a large number of direct dependents and an even larger number of friends, family, and acquaintances that ask them for support on a regular basis. In times of economic contraction, however, such vertical networks may dry up; when a firm lays off an employee this may easily throw a whole chain of dependents into poverty. Horizontal networks, on the other hand, involve contacts with a similar socioeconomic standing and encompass a variety of relatives - family and non-family alike.

147. **Informal measures may include risk sharing over time (informal loans) as well as across space (remittances**).[67] Kin-based support frequently involves exchanges between urban and rural relatives with transfers going both ways, depending on need. For example, it is quite common for women and youth to seasonally migrate to "their" village during the cashew harvest season (May–July) in order to improve their income, while relatives from the countryside expect to be hosted by their relatives in the city when they come to market or send their children to be fostered by family in town during the school year.

148. **Participation in informal rotating saving schemes [*abotas*] is a widespread practice, especially among women engaged in the informal** economy. Usually members are from the same socioeconomic strata and also the same age group. Due to the low and often irregular contributions of the members, these funds are often minimal. In addition, management of the funds is generally quite weak because of the limited competence of the members and the prohibitive cost of professional services. While *abotas* are mostly used as a source of credit to members, sometimes these savings schemes have a clear protective dedication. Some women, however, are too destitute to participate in an *abota* due to their limited and/or irregular income. Other informal safety nets take the form of organized wage-sharing groups among (male) day workers [*surni*] and social clubs [*mandjuandades*], providing not only recreational but also limited income opportunities for its members.[68]

[66] Lourenço 2005.
[67] Alderman 2001.
[68] World Bank 2006

149. **Mutual faith-based support networks are a complementary safety net for some**. Adherence to evangelical churches of Brazilian or American origin has been on the rise among the urban poor, providing for a tighter community than the more institutionalized Catholic Church. However, conversion to an evangelical church may also lead to marginalization in the community of origin and disruption of social networks.

150. **Risk coping, however, frequently leads to dissaving, both in financial and human capital**, and may lead to a reduction in consumption (for example eating only one meal a day) and the sale of investment goods. It may also lead to children dropping out of school due to the inability of their families to cover the direct or indirect costs of schooling. In the worst cases, families are forced to live on the streets and beg for subsistence.

Box 6. Health Mutual Faith-Based Organization in Varela

With the support of the ILO, in 2003, the national NGO *Acção para o Desenvolvimento* – AD set up a mutual health organization in the area of Varela, situated in the Northern region of Guinea-Bissau, not far from the Senegalese border. Following a feasibility study and door-to-door information work, each family in the community that decided to enroll was asked for an initial contribution of CFA 500 and agreed to annual fees of CFA 1100 per enrolled family member up to a maximum of six persons per household. Upon enrollment, each registered member received an insurance card from AD. In 2005, the organization counted 120 members. The *Mutualidade de Saúde* covered urgent care, small surgeries, pre-natal care, obstetric care, hospitalization and evacuation services to Ziguinchor, Senegal and a lump sum for hospitalized patients. The organization's aims as a community-based organization went beyond service provision in that it offered sensitization and training on the prevention of illnesses and activities to strengthen community cohesion.

Although not rigorously evaluated, the experience so far can be described as mixed. While potential demand for such community-based insurance schemes is estimated to be high, enrollment actually turned out to be sluggish. AD attributes this to the poor quality of services on the supply side. Due to the limited funds of the community-based insurance the beneficiaries depend on services by public health posts and the public Sao Domingos hospital. An additional reason might be that insurance the flat rate asked per insured presents a prohibitively high cost to the local population. This is confirmed by experience elsewhere that has shown that community-based insurances may not reach the poorest. According to an evaluation by the STEP in 2005, the organization was faced with several difficulties: sluggish demand by the population, lack of health professionals in the area's public health posts, low managerial capacity of staff, lack of information about the organization among the community and an "assistentialist" mentality.

Source: Interview with AD, Statutes of the Mutualidade de Saúde de Varela.

4. SUMMARY OF FINDINGS AND RECOMMENDATIONS

4.1. GENERAL FINDINGS AND RECOMMENDATIONS

151. The central message of this review is that Guinea-Bissau cannot afford to continue with its "business-as-usual" approach if it is to achieve the goal of better education, quality health care and adequate social protection for its population. Robust reforms are needed to put the country back on track for the achievement of the education and health MDGs. From the review, it is clear that while some human development MDGs will not be reached by 2015, a few are still attainable if substantial progress is achieved in the delivery of social services.

152. **The review shows that social indicators in Guinea-Bissau remain alarmingly poor.** Illiteracy is high and life expectancy is low. Six out of 10 children who enter the first grade do not complete the full cycle of primary education. Many of those who do complete primary education remain illiterate because of the poor quality of education they receive. On average, only 38 percent of the population has access to health care; the situation is much worse for the poor. Maternal mortality and under-five mortality are still very high - two out of ten children die before they reach the age of five. It is highly unlikely that Guinea-Bissau will achieve the MDG targets on maternal mortality and under-five mortality by 2015. Social protection mechanisms are almost non-existent and large segments of population rely on informal, community-based arrangements to cope with risks.

153. **But not all news is bad.** The assessment indicates that, despite all the setbacks, some progress has recently been made in specific aspects of education and health sectors. Education coverage at all levels has dramatically increased in recent years. Today, there are twice as many students in primary education than there were ten years ago, while the gender gap in primary education has almost been closed. Secondary education is expanding considerably, with a Gross Enrollment Rate (GER) in 2006 estimated at 35 percent, slightly above the 30 percent average for Sub-Saharan African countries. Guinea-Bissau has also undertaken serious efforts to build tertiary education institutions, and has established a national university based on a promising public-private partnership model. In the health sector, the immunization coverage has presented mixed results and progress in the fight against malaria, although fragile, is encouraging.

154. **More importantly, most of the efforts needed to improve the delivery of social services are within reach of the country.** As the review discusses, improving governance and financing of social sectors can have a huge impact on outcomes. For example, it was estimated that by simply increasing the budgetary allocation to the education sector from the current 11 percent to 20 percent, and by allocating 50 percent of that to primary education, the Government would be able to raise the completion rate from 42 percent to 96 percent. In the health sector, the

low per capita public spending ($ 12 in 2006), means that there is enough leverage to increase public financing of the sector with improved results.

155. **The review proposes a four-point agenda to move towards improved delivery of social services in Guinea-Bissau.** Beyond the specific recommendations made for each sector, looking across all the social sectors, there is a set of pillars that emerge as common points, and that deserve to be tackled in a broader way:

1. **Improve Public Financing of Social Sectors**

- The share of domestic budget effectively allocated to social sectors must be increased in order to be aligned with acceptable international and regional standards. The simple increase of budget allocation to social sectors may have a huge impact on service delivery, particularly in the achievement of universal primary education;

- Increased spending on education and health, however, is not the sole answer. The quality and equity of spending are equally important. Improved governance, stronger accountability mechanisms, and sound expenditure management are essential to raising the quality of social services.

- Donors' commitment is important to support reform efforts in social sectors. That will require commitment of more resources, including increasing donor support to key programs in education and health. Examples include the Fast Track Initiative in education, strengthening of health systems, and combating HIV/AIDS and Malaria. Equally essential, therefore, is the renewal of funding by development partners.

2. **Accelerate and Scale Up Promising Reforms**

- Despite their mixed results, some reforms undertaken in recent past need to be pursued and achieved. In education, the adoption of a six-year primary education cycle; the provision of free primary-education; the development of new curriculum; and the investment in teachers are among measures that are likely to have a positive impact on schooling. In the health sector, reforms must include measure to: develop and implement a new infrastructure plan; improve the drug supply chain system; and reevaluate the whole evacuation process for patients.

- Non-state actors, including NGOs, are playing an increasingly important role in service delivery. In order to extend service delivery coverage -- particularly to the poor -- and to improve quality, it is important to forge partnership with these non-state actors This will improve and/or scale up various promising initiatives they are undertaking

- It is time to develop coherent, sustainable and equitable social protection mechanisms geared towards safeguarding the well-being of the population of Guinea-Bissau. It is

important for the Government to step up efforts to formalize the sector and to develop a coherent policy framework. Such framework should be designed in the context of development of a broader social protection development agenda

- The social protection development agenda must include efforts to support the well-tested informal social protection mechanisms, which for the foreseeable future will continue to be the main mechanisms available to the vast majority of Guinea-Bissau's population to cope with risks.

3. Ensure Institutional Development of Social Sectors

- Strengthening policy framework is one important step towards a stronger institutional capacity in social sectors. Sector policies and programs must factor a strong link with the PRSP. While the health sector has a clear long-term strategic framework orientation (PNDS), the education sector and the social protection lack strategic orientation. Strategic and policy orientations in the health sector must be consolidated, through the subsequent phases of PNDS. Developing an explicit long-term education policy and strategic framework is a priority. The same is true for social protection.

- Monitoring and evaluation information systems across the sectors must be developed. Successful design and implementation of reforms cannot take place without reliable information. An action plan to develop monitoring and evaluation system in social sectors would help to clearly identify visualize priority needs in the short-term and medium-term.

- Effective human resources management, including capacity development strategies and programs at all levels, is crucial for improved service delivery. Capacity development must take into account the kind of capacity needed to implement reforms in these sectors. The new human resources strategy and action plan in the health sector should be effectively use to create linkages between planning, production and deployment of personnel. In education, the newly developed but incomplete HR management system needs to be consolidated.

4.2. SPECIFIC RECOMMENDATIONS TO IMPROVE DELIVERY OF SOCIAL SERVICES

4.2.1. The Education Sector

Access and Quality Improvement

156. **The recent expansion of primary education coverage has been impressive, but it was not accompanied by improvements in internal efficiency and quality.** Over the last ten years Guinea-Bissau has substantially expanded its education system coverage, particularly in primary

education. Girls have particularly benefited from that expansion, as the gender gap has been closing steadily. However, internal inefficiencies persisted and even worsened. An inadequate structure and organization of primary education sub-cycle, combined with high repetition and drop out rates and low quality of education, has resulted in low completion rate in primary education, making it hard for Guinea-Bissau to achieve universal primary completion by 2015.

157. **Demand for secondary education is growing steadily**. As primary education enrollments increase, supported by an increase of community-financed schools and private schools (both representing together 1/3 of all primary schools) a growing demand for secondary education is emerging. Private sector providers are playing a critical role in accommodating that demand. The expected continuing expansion of primary education will continue to put pressure on enrollment in secondary education. If the current investment trends in secondary education persist, it is unlikely that private providers alone will be able to absorb the growing number of new enrollments.

158. **Implementing short-term reforms**. Adopting a six-year primary education cycle is critical to ensure that a growing number of children complete a six-year basic education and that the basic skills are mastered by all children. A new curriculum for the six-year model of primary education has been drafted under a pilot program. The process now needs to be scaled up and quickly rolled. Restructuring the primary education architecture; providing free primary education of six classes to children; addressing the issue of repetition; investing on teachers and making a more rationalized use of them; and introducing some measurement of learning achievements are among measures that are likely to have positive impact on schooling.

159. **Making more rational use of teachers in the classroom**. Doubling the timing teachers spend in classrooms from four to eight hours should be consolidated and improved. The measure will help to accommodate additional students without the need to increase, in the short run, the number of graduates of teacher training colleges. The setting up of an integrated basic education system will also reduce the number of teachers needed at this level (the current complementary primary sub-cycle curriculum is taught by six teachers; the new integrated curriculum will require no more than three teachers for all subjects).

160. **Mitigating the impact of the HIV/AIDS epidemic**. Reform of the use of teachers' time is also important to mitigate the potential impact of the HIV/AIDS epidemic. HIV/AIDS has a negative impact on the education system and is an important element to consider in efforts to achieve universal primary education. Assuming that teachers are affected in the same proportion as adults in general, approximately 280 primary education teachers are likely to be infected with HIV/AIDS. With absent or sick teachers, substitutes will be needed to avoid disruptions to schooling.

161. **Rethinking teacher training**. The current model of primary education teacher training is inadequate, costly, and lengthy.[69] More effective initial teacher training could be achieved by developing a combination of pre-service training, in-service support and training, and continuous professional development, limiting therefore the initial training time. In this way, it would be

[69] Teachers graduate from teachers training college after a full three years training course. The entrance requirement to these colleges is the completion of 9th grade of secondary education.

possible to reduce the cost to the system if teachers leave the profession (Lewin, 2000) and also increase teacher supply by placing teachers in the classroom quickly. This is consistent with an international trend toward greater training of teachers in schools, driven by the desire to improve the relationship between training and classroom practice.

162. **Revamping technical and vocational training**. Technical and vocational training is important to build capacities for labor market and economic development, but its current marginal status in Guinea-Bissau is far from contributing to reach that goal. The destruction and subsequent crisis of the technical and vocational education sub-sector represents an opportunity for the country to revamp the system, by setting up an appropriate legal and regulatory framework and by transforming the current supply-driven vocational training system into a demand-driven system (thereby increasing its relevance), focusing mainly on public-private partnership. This includes the establishment of vocational courses for young people that meet the demands of the labor market, and the creation of opportunities for rural dwellers to get technical qualifications for employment. Improving the capacity of the country's human resources is crucial for economic growth. In the process of rebuilding the sector, the government should clearly define its policy with respect to vocational training, including the role of the public sector, and ensure that vocational training institutions are financially sustainable.

163. **Guinea-Bissau must dedicate efforts to strengthening the emerging higher education sectors.** The country has witnessed over the last years a wide effort to structure and expand the supply of higher education. This effort has resulted in a new panorama of higher education training in Guinea-Bissau with the opening of two universities. But there are challenges. They include the institutional strengthening of recent initiatives, quality of learning, improved management, and the setting up of a clear legal framework for the sector.

Institutional Development

164. **Prioritizing actions for better results**. As discussed above, the weak performance of Guinea-Bissau's education system is mainly due to a combination of three interconnected and mutually reinforcing factors: (i) low investment in the sector; (ii) the deficient structure and organization of the education system; and (iii) poor sector management. Acting on these three factors is important in order to ensure better education service delivery, but this will require that policy priorities be defined. An important first step in that direction is to develop an explicit long-term strategic education plan that defines the vision, establishes objectives and priorities, and sets a clear timetable for implementation. The PRSP addresses these topics in a general way but cannot serve as a reference policy document for the sector. For example, while the PRSP highlights the importance of increasing access to education, it does not include key actions for achieving this objective. Various actions are listed in its education component, but lack prioritization and costing.

165. **Strengthening the education management information system**. Successful design and implementation of reforms cannot take place without reliable information. Also, information is the key to improving internal management and reinforcing the planning function of the Ministry of Education. Strengthening of the information system will require a specific action plan that includes training and training support, as well as provision of materials (equipment and other

inputs) to strengthen the institutional capacity of the Ministry of Education to produce statistical information on a regular basis.

166. **Improving school-based management**. Incentives may involve capitation grants to schools, increased participation of parents and communities in school management, and the generation of information about inputs, outputs, and outcomes, as well as dissemination of this information to local stakeholders. These measures are likely to create accountability mechanisms and improve transparency at the school level, by enabling parents and students to use information to lobby for school performance. The capitation grant incentive might also be used as a pro-girl policy in order to stimulate girls' enrollment and attendance in basic and secondary education.

Financing

167. **Improving inter- and intra-sectoral allocation to meet universal primary education**. Progress toward this goal will require more resources and better policies. One first important step might be to mobilize adequate domestic financial resources to the sector. A recent estimate indicates that Guinea-Bissau would be able to considerably increase the completion rate in primary education by increasing the by increasing budget allocation to the education sector from the current 11 percent to 20 percent, and by allocating 50 percent of that allocation to primary education. If this measure is kept in parallel with high budget execution and key structural reforms to ensure greater internal efficiency of the system, including less repetition and dropout and an integrated primary education cycle, more than 90 percent of the relevant population would be able to complete a full cycle of primary education in a few years.[70]

Box 7. Key Policy Options for Guinea-Bissau to Reach Uuniversal Primary Education

Goal	Policy choices
Expand supply and ensure retention	Better intra-sectoral allocation of the recurrent budget More cost-effective use of teachers Alternative models of pre-service teacher training Equitable funding across schools (per student allocations) Appropriate education management information system Planning for HIV/AIDS impact
Improve quality	Control of teacher absenteeism Increased hours and days of training Free distribution of textbooks to schools and students Curriculum revision to improve relevance Teacher network and resource centers (in-service teacher training) Simple school monitoring and reporting system

[70] Brossard, Mathieu, Éléments d'Analyse du Secteur de l'Education en Guinée-Bissau, Pôle de Dakar (BREDA), Mai 2003.

	Periodic assessment of student learning outcomes School health and nutrition program Parents involved in school councils with decision-making power.

4.2.2. The Health Sector

Access and Quality Improvement

168. **The majority of the population of Guinea-Bissau has limited access to health care of good quality, which results in their poor health status**. Services are often of very poor quality that there are little incentives for demand. Children immunization and malaria fighting are among the most important factors likely to improve health outcomes of the population. Results achieved in these areas over the last years have been mixed. On the malaria front, there are signs of reduced incidence of the disease, particularly among children, but new, most effective treatments are not yet accessible to large parts of the population. With regard to children immunization, there are clear signs that effective interventions have not been sustainable, since the immunization coverage has fluctuated considerable over recent years.

169. The **HIV/AIDS epidemic is a big concern.** There are indications that the disease is spreading. The increase in prevalence rate over the last years suggests that strategies used so far to fight the disease have not been effective. Low knowledge and misconception of HIV/AIDS forms of transmission, serious stigmas against seropositive persons, and limited access to treatment are among factors that hinders progress on this front.

170. **Prepare a new infrastructure plan** aimed at completing what was initiated under PNDS 1 and the ninth FED. Seven regional hospitals (out of 11) and four health areas (out of 114) are still not operational. New housing for health personnel has to be planned in a few remote regions.

171. **Reevaluate the whole evacuation process for complicated** patients**, suffering mainly from non-communicable diseases**. Many patients are evacuated under vague criteria; others wait for months and eventually die. Clear and transparent rules on the decision-making process of the Medical Board [*Junta Médica*] are urgently needed. A mid-term strategy aimed at increasing the retention power of health facilities has to be prepared. At time same, it is urgent to promote public-private partnerships to increase the power of retention of the health system and in so doing, reduce the number of evacuations abroad and improve the drug distribution network.

172. **Invigorate the drug purchasing and supply chain system.** Currently, most of the regional warehouses are bearing huge financial burdens. The system requires significant investment in infrastructure as access to drugs for the population and particularly the vulnerable groups is limited.

Institutional Development

173. **Review the MoH organizational structure and strengthen key MoH directorates and departments**. Leadership within the Administrative and Financial, Hygiene, and Epidemiology Directorates has to be reinforced, allowing closer dialogue with other entities and facilitating achievement of better outcomes. The MoH could reduce its current total number of twelve directions through an appropriate merging policy aiming at reducing operational costs at the

central level. It could also engage in a decentralization process combining devolution and decentralization with a view to increasing the efficiency and equity of the whole health system.

174. **Use the new national HRH strategy and action plan to create linkages between HR planning, production, and deployment.** Demand for health personnel responding to national norms has to be clearly documented and communicated. Innovative ways of taking advantage of the diaspora settled in Portugal should be considered. Promote close collaboration between the public sector and FBOs and NGOs, seeking areas where complementarities exist and coherence of interventions through information sharing and cross-fertilization.

Financing

175. **Increase the execution rate of the MoH budget.** Public spending has been low in recent years, demonstrating a declining trend. Mechanisms for cost recovery are not effective, and donor contributions amount to only US$ 6 per capita. Further financial efforts from the government and development partners are necessary if Guinea-Bissau is to meet the MDGs. In terms of public finance management, a unique budget should be produced yearly. Linkages between budget and treasury directorates have to be strengthened with the goal of eliminating the existing gap between the executed and paid budget. In addition, there is a need to improve coordination in the PNDS/PRSP process so as to ensure that limited budgetary resources are targeted to the poor.

176. **Perform a PER for the health sector**. The study would examine the flow of funds with a focus on public policy, and the performance of the system in ensuring and financing public provision of health care. Financing and provision are either highly regulated or managed outright by the State, but the rationale for state involvement in financing and provision must be explicitly justified, and its consequences explicitly acknowledged. Public involvement in finance and provision is often defended by reference to theoretical abstractions such as economies of scale and market imperfections. These conditions may hold, but they must be supported by evidence rather than based on mere assumptions.

177. **Ensure sustainability of health financing.** The multiplicity of sources of funding care, including donor contributions, raises the question of sustainability—the availability of funding over the medium and long term. This issue grows particularly acute when certain types of care depend on funding (such as from donors) that might not be sustained. The study would also focus on efforts to be developed toward strengthening health systems with regard to the health-related MDGs and specific diseases, such as malaria, AIDS, TB, conditions affecting mothers and children, and nutrition.

178. **Strengthen capacity of the INPS.** The INPS has a great potential for extending its coverage and services. However, it should be put under public-private oversight to assure good governance. Strengthening the capacity of INPS could be done through technical assistance to create a better image and instill greater confidence, increase the contribution of the private sector and of public companies, reduce payment delays, and increase the number of beneficiaries through the creation of new regimes for the informal sector. INPS should seek external collaboration to review its business model aiming at strengthening its weak health insurance

scheme. By the same token, it would be important to launch multiple pilot initiatives to create community health mutualities, taking advantage of recent UNFPA supported initiatives.

4.2.3. The Social Protection Sector

179. **The vast majority of the population of Guinea-Bissau does not benefit from any formal social protection support.** Formal social protection arrangements, namely health insurance and pension schemes, are affordable to only a small segment of the population. Government transfer programs have limited scope and impact. Because of these limitations, various segments of the population rely on informal risk management strategies, including social networks, community mutual faith-based support and saving schemes.

180. **The institutional framework is scattered and needs improvement**. The Ministry of Social Solidarity could play a key role in convening actors and in coordinating policy development fostering a better collaboration and between the public and the non-governmental sector. In order to assume this role, the Ministry would benefit from an organizational analysis, identifying strengths and weaknesses of its current configuration. Further, it needs to develop a coherent strategy with a focus on coordination and supervision of interventions instead of attempting to act as a direct implementation body. Its transfer program needs to be reconfigured and endowed with the necessary means to function properly. Also, the Ministry's staff is in need to build the capacity of its staff in order to successfully fulfill its obligations.

181. **A multi-sectoral social protection policy is needed.** Guinea-Bissau would benefit from a multi-sectoral social protection policy based on the PRSP and the *Lei do Enquadramento da Protecção Social*. Such a policy, however, needs to be evidence-based and has to prioritize interventions according to need and effectiveness. Policy development should include all stakeholders (government, NGO's, civil society and to some extent the private sector) in order to create broad-based ownership. Until now, there has been no thorough analysis of the efficiency of existing interventions in the social sectors. In order to identify the approaches with the biggest impact and the greatest cost effectiveness, such a review appears to be indispensable.

182. **Interventions need to be prioritized.** While the PRSP's focus on vulnerable groups is a step in the right direction, a prioritization of interventions within the document is necessary, adapting it to the resource-constrained environment. Instead of creating new infrastructures for the different groups, synergies with existing structures, both governmental and non-governmental, should be sought to avoid duplication and assure best use of existing resources. The lack of reliable household-level data must be addressed expediently as an indispensable basis for informed, evidence-based programming as targeting interventions without data can only be based on assumption.

183. **Measures to improve child wellbeing and protection must focus on behavior change communication, legal reform and enforcement of legal norms.** In this regards, sequencing is essential.[71] The population must be informed about harmful practices such as the worst forms of

[71] Kielland and Tovo 2005.

child labor and child begging. The education system must strive to accommodate working children. International commitments such as the CRC and its protocols as well as pertinent ILO conventions need to be transformed into directly applicable domestic law. Efforts to register all children must be stepped up. Child trafficking as practiced with talibe children needs to be prohibited and perpetrators prosecuted. Additionally, Guinea-Bissau has to be prepared to accommodate the expected rise in HIV/AIDS orphans, with a focus on strengthening affected households. Also, currently there are no halfway houses to assist women and children fleeing from domestic strife or otherwise in need.

184. **Young people need more employment opportunities.** Given the enormous difficulties young people face in successfully transitioning into the labor market, priority should be given to active labor market interventions, comprising microfinance, traditional apprenticeships and insertion into the formal sector. Providing employment opportunities in the smaller regional towns could attenuate the rural exodus towards the capital. HIV/AIDS prevention efforts among young people need to be stepped up based on international evidence of what successful approaches with this age group. Finally, youth civil society should be supported in its efforts to channel young people's energy towards constructive aims.

185. **Provisions need to be made to assure women's access to land ownership.** Widows and divorced women in poverty need to be targeted in needs-based social assistance programs. With regards to the nefarious practice of female genital cutting, given the still large approval for it among the population and the ritualistic significance of fanado, the emphasis should be on grassroots behavior change communication within communities. Only in sequence, the practice should be forbidden.

186. **Social assistance programs should target the elderly and disabled people**. There is currently no legislation ensuring equal treatment for people living with disabilities and there is a need for information and education campaigns to raise awareness of the rights of the handicapped. Community-driven assistance programs to the disabled are in dire need of assistance. On the other hand, given the high poverty incidence among elderly household heads,, social assistance programs should target them, especially in the cases where the elderly turn caregivers of their grandchildren.

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