

SITUATION ANALYSIS **OF CHILDREN AND WOMEN**

GUINEA-BISSAU

2015

TITLE

Situation Analysis of Children and Women
Guinea-Bissau – 2015

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ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
ART	Anti-Retroviral Treatment
BCG	Bacillus Calmette–Guérin
CECOME	Central Essential Drugs Purchasing Authority (Portuguese acronym)
CFAfr	Currency of Guinea-Bissau (French acronym)
CLTS	Community-Led Total Sanitation
CRC	Convention on the Rights of the Child
DTP	Diphtheria, Tetanus and Pertussis
EVD	Ebola virus diseases
FAO	Food and Agriculture Organization
FEC	Faith and Cooperation Foundation (Portuguese acronym)
FGM/C	Female Genital Mutilation / Cutting
GDP	Gross Domestic Product
HIV	Human Immunodeficiency Virus
IGME	Inter-agency Group for Child Mortality Estimation
ILAP	Light Survey for Poverty Assessment
IMC	Institute of Women and Children
INASA	National Institute of Public Health (Portuguese acronym)
INE	National Institute of Statistics (Portuguese acronym)
INEP	Instituto Nacional de Estudos e Pesquisa
MDG(s)	Millennium Development Goal(s)
MICS	Multiple Indicator Cluster Survey
NGO	Non-Governmental Organization
RESEN	Status Report on the National Education System (French acronym)
SDG(s)	Sustainable Development Goal(s)
SMART	Standardized Monitoring and Assessment of Relief and Transitions
UN	United Nations
UNAIDS	United Nations AIDS programme
UNDESA	United Nations Department of Economic and Social Affairs
UNESCO	United Nations Economic Scientific and Cultural Organisation
UNICEF	United Nations Children's Fund
US\$	United States Dollar
WFP	World Food Programme
WHO	World Health Organization



FOREWORD

At the beginning of 2014, when the people of Guinea-Bissau were enthusiastically preparing for the general elections, children and young people from all corners of the country decided to make their voice heard in the political process. Represented through over 300 organizations and networks, they started an advocacy movement which they called '*Republica di Mininus Hoje!*' ("Children's Republic Today!"). The movement was inspired by a popular film by the Guinean director Flora Gomes. In the movie, adults abandoned a war-ravaged country and their children to their own fate, following a political conflict. Left behind and alone, children organized themselves to rule the country, establishing a Government based on their rights and equity, a "children's republic". Through '*Republica di Mininus Hoje!*' children of Guinea-Bissau also organized themselves to claim their rights and demand commitment of political candidates and other adult stakeholders to place child rights at the centre of the new development agenda.

This Situation Analysis of Children and Women (2015) is a response to the strong call of children of Guinea-Bissau, and a contribution to amplify their voice. It addresses challenges and opportunities in Guinea-Bissau at various stages of the life cycle. Along with the recently concluded Multiple Indicator Cluster Survey (also supported by UNICEF) the Situation Analysis will serve as the planning backbone for UNICEF's Country Programme (2016-2020). It will also feed into the broader UN (Development) Assistance Framework (UNDAF) in planning for children by sister UN agencies as well.

The Situation Analysis will also serve as an advocacy tool to sensitize stakeholders, donors, media and the civil society on issues of children and women. This is an important piece of research, assembling information from secondary sources as well as the voices of children and women directly heard by the researchers in a few selected communities which were possible to reach. UNICEF considers this a living document and will address the need to update it in the course of the new Country Programme, should there be a change in the conditions of children.

The Situation Analysis reveals some grounds for optimism. The 2014 democratic elections have the potential to end the impact of political instability on the lives of vulnerable groups. Voices of people, especially children and women are calling for the building of a state that can uphold their rights. This will help address inequities in child rights and gender under the new Country Programme.

Despite the challenges faced in Guinea-Bissau, the enthusiastic voices of people, especially children, women and young people inspire UNICEF to believe in a Guinea-Bissau that can uphold the rights of the most vulnerable populations of the country, with equity.

It is also for this reason that this Situation Analysis reveals some grounds for optimism and concludes with a ray of hope for the future.

Abubacar Sultan

UNICEF Representative, Guinea-Bissau



EXECUTIVE SUMMARY

This Situation Analysis presents an overview of the conditions of children, adolescents, and women in Guinea-Bissau, using results of the most significant research and analysis over the last five years in areas related to the well-being of children. It is the product of a series of interviews with national and local officials and individuals, and a desk review of key reports, studies, surveys and evaluations produced between 2011 and 2015 on child rights in Guinea-Bissau by Government, UNICEF and other development partners. It also draws on a series of interviews and focus group discussions with children and young people, who were given a chance to present their perspective on the issues that most affect them. The Situation Analysis is intended to contribute to the implementation of the Government's Strategy for the period until 2025, in order to accelerate achievement of the national and international child-related goals with an emphasis on equity.

The Situation Analysis follows a child-centred lifecycle approach, while recognising that different stages of a child's development are interconnected and interdependent. Following the introduction and information related to the Guinea-Bissau context, the report looks in turn at the early years, primary school aged children and adolescents. This incorporates financing and governance issues affecting children, and a chapter that focuses on the vision for the future.

Guinea-Bissau has a small but young and rapidly-growing population, estimated at 1.8 million people in 2015, of whom 47.5 per cent are children. The country has been urbanising rapidly, with about half the population now living in towns and cities. Agriculture, forestry, fishing and livestock continue to account for about 50 per cent of gross domestic product, prominent with cashew nut cultivation. Following four decades of political instability, the country held peaceful elections in 2014, with a record turnout. Following these elections, economic growth is projected to pick up again. This is needed as the current per-capita income is still below both 1998 and pre-independence (1973) levels, food insecurity is a recurrent threat for much of the population, and Guinea-Bissau has not reached the MDG target of a maximum of 21 per cent of the population living below US\$1.25 per day. Poverty has sharp regional dimensions, and is much lower in Bissau and Bolama/Bijagós than the rest of the country.

Guinea-Bissau is a patriarchal society. In most cases, a woman filing for divorce is at risk of losing guardianship of her children. Verbal and physical disciplining is common, and violence against women is widely accepted. The informal fostering of children in other families is widespread.

High levels of morbidity and mortality among adults mean that 12 per cent of children in Guinea-Bissau have lost one or both of their biological parents. The country is prone to epidemic diseases, most notably recurrent Cholera outbreaks. However, there is some hope that the country's recent response to the Ebola virus, particularly with regard to hygiene practices and sanitation, will have reduced the likelihood of further Cholera outbreaks.

Young children's risk of losing their mothers is unacceptably high. A household survey carried out in 2014 suggests that almost one in 100 pregnancies ends in the mother's death, making Guinea-Bissau one of the 15 countries with the highest maternal mortality rates in the world. Causes of maternal death include widespread poverty, low status of women in society, persistently high fertility rates, low levels of contraceptive use, and early marriage and pregnancy. Birth spacing is limited by the rare use of contraception, and only 65 per cent of women receive four antenatal care visits (the proportion has dropped alarmingly in Bafata and Biombo in particular). Less than half of all women (45 per cent) deliver their babies with the assistance of skilled birth attendants – this is lower than the Sub-Saharan African average, and means the country has not reached the MDG target.

Child survival has improved but even today almost one in 10 children under five is unlikely to reach his or her fifth birthday. A large proportion of child deaths (36 per cent) occurs during the first 28 days of life. Preventable diseases, such as Malaria, Diarrhoea and Pneumonia account for 43 per cent of all under-five child deaths. Seeking skilled treatment in case of fever is not common among all population groups. Between 2010 and 2014, under-five mortality fell substantially for the poorest 20 per cent of the population, and among children of mothers with low educational attainment, although the gap between rural and urban areas is growing. The highest under-five mortality is seen in Gabú and Bafatá (159 and 126 per 1,000 live births respectively) or 80 and 30 per cent higher than the national average. Core vaccine coverage has increased steadily since its introduction. This has resulted in Guinea-Bissau being Polio-free since 2009 and the reported incidence of Measles as close to zero.

Guinea-Bissau has made significant improvements in recent years in combating Malaria. The proportion of children sleeping under treated bed nets has increased, or come close to the MDG target, due largely to a significant increase in the use of bed nets among the poorest quintile. The proportion of pregnant women receiving preventive treatment for Malaria has increased sharply. However, there appears to have been a sharp decline in access to antimalarial treatment among children (particularly girls), and 30 per cent of those in Bolama/Bijagós get their medication from neither a private nor a public health care facility, but rather from traditional healers or unlicensed street vendors, raising efficacy questions.

Maternal nutrition is a concern. In 2012, 11 per cent of women of reproductive age were underweight, while in 2005 approximately 58 per cent of pregnant women had iron deficiency. Infant and Young Child Feeding (IYCF) practices are sub-optimal with only 33.7 per cent of children breastfed within one hour of delivery. The proportion of mothers exclusively breastfeeding for the first six months increased dramatically from 16.1 per cent in 2006 to 52.5 per cent in 2014. Meanwhile, only 12.7 per cent of children aged 6-23 months have access to diversified food, while the majority consumes primarily staples, such as rice. Only one in twelve children in the age group of 6 – 23 months, consumes a minimum acceptable diet, which is a composite measure of diversity and frequency, and this is true even for the richest quintile of families. In 2014, 27 per cent of children were stunted, with rates highest in Oio, Bafata and Gabu, all exceeding 30 per cent, and among poorer and middle-income families. These regions and SAB also have the highest prevalence of severe acute malnutrition among children under five with prevalence exceeding 1.5 per cent.

The vast majority of infants living with HIV contract the virus from mothers either during pregnancy, delivery or breastfeeding. At 5.3 per cent, HIV prevalence in the reproductive age population is among the highest in West Africa. Around 90 per cent of women are tested for HIV during pregnancy, and if not tested it is generally the result of lack of supplies rather than acceptance of testing by women. How-

ever, despite high testing rates only 56 per cent of pregnant women who are HIV positive are enrolled in antiretroviral therapy to prevent HIV transmission from mother to child. Antiretroviral therapy sites are underfunded, and the existing health infrastructure and lack of trained staff does not allow for provision of quality care for children and mothers. This, and low retention rates, means that children born to mothers living with HIV can contract HIV during pregnancy, delivery and breastfeeding. In this context, the introduction of early diagnosis for HIV-exposed infants is a welcome development and should save lives.

As 75 per cent of the population has sustainable access to an improved water source, this has exceeded Guinea-Bissau's target of 68 per cent. However, only 61 per cent of the rural population has sustainable access, while for Oio region the figure is 40 per cent. Unimproved wells account for the largest proportion of unimproved water sources, while most of the population relies on standpipes and protected wells, with women predominately responsible for collecting it. Water is rarely treated at the household level.

Guinea-Bissau will not achieve the MDG target for access to improved sanitation. Only 25 per cent of people have access to improved sanitation against a target of 55 per cent. Nonetheless, continued progress has been made in improving sanitation during the last decade, and Guinea-Bissau is better positioned than the average Sub-Saharan African country. According to MICS 2014, open defecation is practiced by 18 per cent of the population, primarily in rural areas and households in the poorest quintile, while gains are being made, particularly in the third and fourth income quintiles.

Guinea-Bissau has the eighth worst birth registration rate in the world (24 per cent). While most parents know the steps required to register their children, very few children, both girls and boys are officially recorded by the Government before they reach the age of five. The proportion of children registered halved between 2006 and 2014, and has not recovered since, despite a national campaign in 2013.

Virtually all girls and boys, including the very young, experience some form of violence at home, be it psychological or physical. While severe physical punishment is relatively rare among one and two year olds, between 11 and 17 per cent of toddlers continue to be disciplined, through very severe measures such as beating with a wooden stick or belt.

In 2014, 13 per cent of boys and girls attended an early childhood education programme. There has been a sharp increase in the number of children attending pre-school, particularly from the poorest quintile of the population. This is partly because of a rise in services in rural, marginalised areas, with communities taking the lead in filling gaps in social service provision.

Significant progress in school enrolment has been achieved since 2000 despite the challenges caused to the education system by rapid population growth. This progress has stalled in recent years, with net primary school attendance falling from 67 per cent in 2010 to 62.4 per cent in 2014. This was true for most population categories, except the poorest quintile which saw a rise from 52 to 56 per cent, largely because of community initiatives. However, despite these setbacks, the country has reached gender parity for primary education.

Many children enrol late in schools with only 32 per cent of them starting Grade 1 at age six. There is a steady drop-out in the number of children enrolled through the years, notably between Grades 4 and 5. This is largely because only 25 per cent of primary schools offer Grade 5 and 6 classes, and these

schools are mostly located in peri-urban and urban areas. The proportion of children enrolled continues to decline between Grade 7 and 12 due to overcrowded classrooms, reduced and inadequate teaching schedules and the fact that most pupils are over-age. Only 14 per cent of children who enrol in Grade 1 complete Grade 12.

Learning achievements for children in Guinea-Bissau are low. In particular, both children and teachers often struggle with Portuguese, the language of the curriculum.

In most families in Guinea-Bissau, children are required to work to ensure the family's survival. Engaging in work is also intended to socialise and educate children to be prepared for adult life by observing habits, rules, taboos and traditional hierarchy. Girls are nearly three times more likely to work long hours domestically than boys. Even if a child continues education while assigned tasks at home, school performance worsens with the increased workload.

Similar to other age groups, various forms of violence, abuse and exploitation can affect children between 5 and 11 years. Once children reach the age of four, physically and emotionally violent discipline by their caregivers reaches its peak, after which it stabilises. Abusive disciplining of children is a persistent cultural practice. One in every five children of primary school age is disciplined using very violent methods.

Schooling opportunities for children with disabilities are virtually non-existent. In spite of public announcements in 2013 to exempt children with disabilities from any school fee until Grade 11, no legislation has been enacted. The Ministry of Education, has been revising the curriculum for several years now to make it more inclusive for children with disabilities.

The schooling system faces critical challenges to ensure that children who reach the age of 12 are able to enter secondary school. Currently, most children aged 12-17 are either at a grade not appropriate for their age, or are out of school and 24.5 per cent of children in this age cohort have never been to school. This means that many children will have to move to urban areas to complete primary school and transit to basic secondary education. This situation affects adolescent girls, children from rural areas and those from the poorest families the most.

Longer retention in education is associated with delayed marriage and childbirth and consequently more favourable health outcomes for both the mother and child. Girls are more likely to drop out of school due to early pregnancy or marriage. Husbands may not allow young wives to continue their education and even if they do, schools may evict them in case of pregnancy.

Under the Civil Code, girls and boys under the age of 16 years cannot marry without parental consent. However, in Guinea-Bissau more than 7 per cent of girls marry before they turn 15. Pre-18 marriage has increased dramatically in recent years, especially in rural areas and for young girls with no education. No studies are available to explain this rise. In 60 per cent of cases, girls who marry before the age of 18 form unions with men who are more than 10 years older and many enter into marriage as a second wife. Early marriage is also sometimes a survival strategy for poor families to become part of a larger family circle of more affluent families.

For about one in every five girls, sexual activity starts before the age of 15 and only half of those who are not married use condoms. Early sexual debut, high rates of early marriage and low levels of contraceptive use lead to high rates of adolescent pregnancy. Twenty-eight per cent of women have their first child before the age of 18. There has been a worrying increase in societal acceptance of relationships between teenage girls and older men, who often emotionally manipulate them due to the experiential and power imbalance.

An estimated 2,200 persons between 10 and 19 are living with HIV. Almost everyone in the country has heard of the virus except in Gabú where awareness is only 50 per cent. Levels of HIV testing in Guinea-Bissau remain very low, with the exception of pregnant women. Widespread stigma about the virus, limited scope of programme to encourage HIV testing, and constant interruptions in supply of test kits are likely causes of low access to HIV testing.

UNICEF's close engagement with the Youth Movement of Guinea-Bissau is a promising opportunity for sustainable development given the unstable conditions seen by the country in the recent past. This partnership stands out distinctly as hope for the future.



1. INTRODUCTION

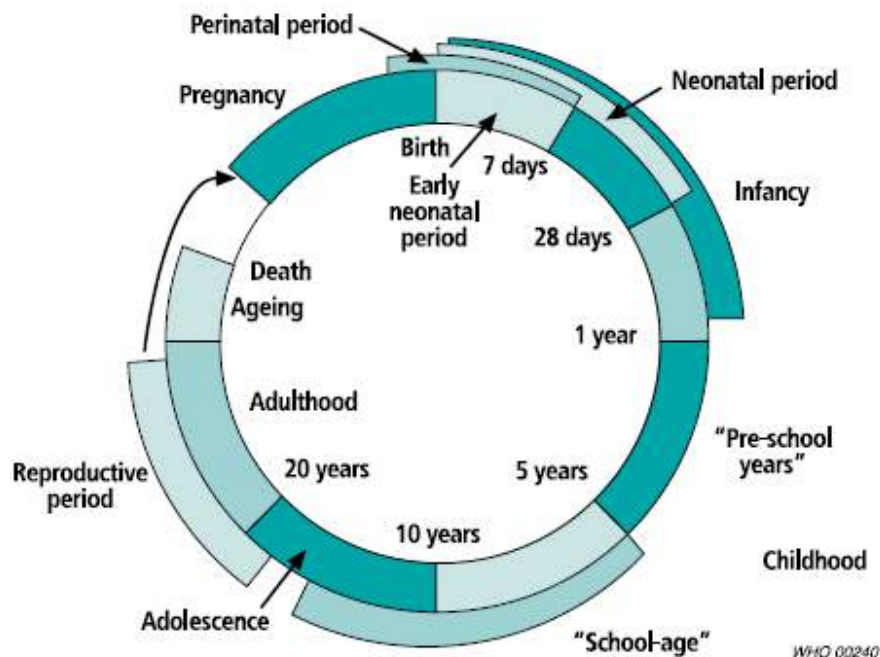
1.1 Adopting a lifecycle and child rights approach

This Situation Analysis is based on the rights defined in the Convention of the Rights of the Child (CRC). It assesses the extent to which principles stipulated in the CRC – including non-discrimination, the best interests of the child, life, survival and development, and the right to be heard – are realised, and it is intended to be used to support duty-bearers to fulfil these rights and right-holders to claim them.¹ A substantial part of the analysis is thus dedicated to assessing the degree to which children and adolescents in Guinea-Bissau are deprived of essential rights to thrive and realise their full human potential. Progress is also measured against national policies and goals, as well as against international laws and agreements to which Guinea-Bissau is a signatory (such as the Millennium Development Goals).

The Situation Analysis follows a child-centred lifecycle approach. It recognises that different stages of a child's development are interconnected and interdependent, with fulfilment of a child's rights at one stage in the lifecycle needed for development in subsequent stages.

¹ The Human Rights Based approach. Statement of Common Understanding, UNICEF SOWC 2004, Annex B

Figure 1: Stages of the Life Cycle



Source: Claesen, M. and R. J. Waldman (2000).

The lifecycle of a child is organised around three critical periods: 1) 0-5 years; 2) 6-12 years; and 3) 13-17 years. As can be seen in the figure above, the 0-5 period covers infancy and the pre-school years; ages 6-12 are broadly the years that a child should spend at primary school, while 13-17 are the years of adolescence.

1.2 Methodology

The report synthesizes secondary data sources including surveys, evaluations, research and other national data. In particular, findings of the Multiple Indicator Cluster Surveys (MICS) conducted in 2006, 2010 and 2014 are a major source of information. Studies on sociological and anthropological factors impacting the fulfilment of children's rights were also reviewed and quoted.

The main civil society organizations (CSOs) working for children and adolescents, at both national and sub-national levels were interviewed. Meetings and semi-structured discussions were held, guided by the principal consultant and two national sociologists who were part of the consulting team. Meetings were also conducted with selected institutions and ministries that had a focus on children.

Semi-structured interviews were conducted with decision makers and experts in various Ministries and other Government entities, representatives of non-governmental organisations (NGOs) UNICEF staff and a few staff of selected UN agencies.

Focus group discussions were held in five regions (Bolama/Bijagós, Cacheu, Gabú, Oio, and Quinara) with women, adolescents and children selected by local authorities.

Conversations with children focused on their current situation, their understanding of poverty, their dreams and the first thing they would do if they were President. Due to the limited time available for participatory fieldwork, the conversations took place in urban or semi-urban settings. While not representative, the conversations were an opportunity to gather a flavour of the context and for children and adolescents to express their own points of view. Extracts from their responses are included for illustrative purposes throughout the report.

Two influential youth initiatives, Parlamento Infantil and República di Mininus Hoje were reviewed and their potential assessed in more detail as hope for the future.



2. BACKGROUND

Guinea-Bissau is bordered by Senegal to the north and Guinea Conakry to the south and east, and the Atlantic Ocean to the west. Its terrain is mostly low coastal plain, and its highest point is only 300 metres. The country is divided into eight administrative regions, and the Autonomous Sector of Bissau, the capital of the country (sometimes referred to by its Portuguese acronym-SAB).

Since independence, Guinea-Bissau has undergone four decades of instability a punishing civil war in 1998-99 in which 350,000 people were displaced and 80 per cent of social and economic infrastructure destroyed (Ministry of Education, Culture, Science, Youth and Sports, 2010). The country also suffered severe brain drain, with qualified people seeking refuge and subsequently staying abroad. At the global level, Guinea-Bissau is one of the countries with the highest incidence of planned and actual coups. This clearly suggests severe institutional constraints. Although peace returned to the country in 1999, economic dynamism and development did not. Its context can therefore be described as one of fragility.² A 2014 report puts Guinea-Bissau in the second lowest (out of five) tier of countries for disaster-risk management and adaptive capacity. This suggests there is a high likelihood that disasters will cause long-term impacts now and in the future.³

Despite the country's historical fragility, in Guinea-Bissau elections generally pass off peacefully and voter turnout is usually high.⁴ Guinea-Bissau has held several parliamentary and presidential elections since 1999. It has had 11 Governments and all presidential terms have been terminated by military coups or violence (with the exception of President Malam Bacai Sanha, who died of natural causes). In 2012, the country experienced its latest coup which triggered the withdrawal of international aid and also an economic recession (World Bank 2015). The 2014 general election was possibly the freest and fairest in the country's history, with a record turnout of nearly 90 per cent for both parliamentary and presidential elections. Following the election, the newly formed Government accelerated its country planning, outlining key strategic directions for development including the enabling environment and human development, infrastructure and urban development, biodiversity and natural resources, and peace and security. The country strategy was presented at a donor round table conference held in Brussels in March 2014, and donors pledged 1.5 billion US\$ in the form of grants and soft loans.

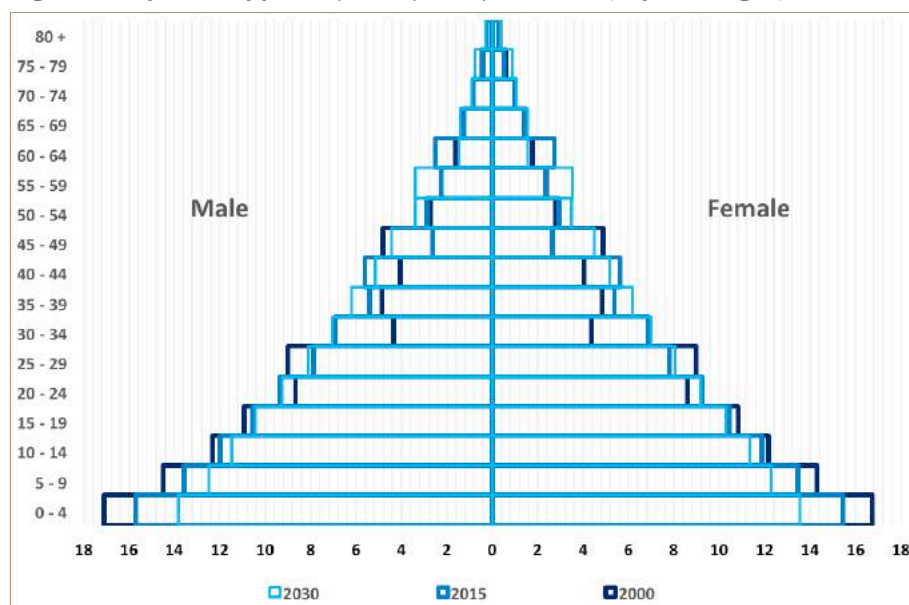
2.1 Demographic overview

Guinea-Bissau has a small but young and rapidly-growing population, estimated at 1.8 million people in 2015 (UNICEF, Africa Generation 2030). At the last census (2009) the total population stood at 1,520,830 residents, of whom 54 per cent were female and 46 per cent male (INE, 2009). An estimated 100,000 or nearly 7 per cent of all citizens, lived abroad (World Bank, 2010). With the population growing at more than 2 per cent per annum, it is expected to reach almost 2.5 million by 2030 and 3.5 million by 2050 (UNICEF, 2014a).

² Defined by the World Bank (2011a) as a period when a state or its institution lack the capacity, accountability, or legitimacy to mediate relations between citizen groups and between citizens and the state, making them vulnerable to violence. Guinea-Bissau ranks 16th on the 2014 Fragile States Index by the Fund For Peace: <http://ffp.statesindex.org/rankings-2014>.

³ ODI (2014) The Chronic Poverty Report 2014-15

⁴ In 2008 the participation rate for legislative elections was 82%. And even the troubled presidential elections in 2009 had a turnout of 60%. The aborted elections in 2012 were a low point with 55%.

Figure 2: Population pyramid, 2000, 2015, and 2030 (in percentages)

Source: UNDESA (2014).

Children under the age of 18 make up 47.5 per cent of the population. According to projections by the United Nations Population Division, this number is expected to increase from 849,000 in 2015 to 1.1 million in 2030. By 2050, it will have risen by nearly half a million to 1.3 million. Guinea-Bissau's high fertility rates and the increasing number of women of reproductive age are the driving forces behind the rising number of births and children projected for the next 15-30 years. In 2015, women had on average of 4.9 children (3.4 children in urban settings, and 6.4 in rural areas). The number of annual births will increase to 77,000 in 2030 and to 86,000 in 2050. A cumulative total of 1,100,000 babies are expected to be born over the next 15 years (UNICEF, 2014a).

Table 1: Principal population data – medium fertility decline scenario (UNDESA 2014)

INDICATORS	2015	2030	2050
Total population	1,787,793	2,472,642	3,504,224
Child population under 18	849,019	1,083,546	1,328,064
Working age population (15-64)	1,001,185	1,457,034	2,202,934
Child population under 18 (percentage)	48%	44%	38%
Working age population (15-64) (percentage)	56%	59%	63%
Total dependency ratio [dependants per 100 persons of working age (15-64)]	79	70	59
Child dependency ratio [Child dependants per 100 persons of working age (15-64)]	73	64	51
Total fertility rate (children per woman)	4.8	3.9	3.1
Life expectancy at birth (years)	55	58	63

SOURCE: UNDESA (2014).

URBANISATION AND DIVERSITY

Guinea-Bissau has until now been a predominantly rural country. According to the 2009 Population Census, more than half of all rural localities had less than 150 inhabitants (with a median population of 64 to 74 people) (INE, 2009). Nevertheless, estimates from the Population Division of the United Nations (UNDESA, 2014) indicate that in 2015 the proportion of people residing in urban areas is almost equal to rural areas (49.3 per cent). By 2030, it is expected to rise to 58.4 per cent.

The capital Bissau, is home to a quarter of the total population, a proportion which is expected to grow in coming years. Urbanisation in Guinea-Bissau will continue to put pressure on the already weak social infrastructure, including water supply, sanitation facilities, and electricity supply. The city of Bissau, for example, is said to have sufficient infrastructure only for around 200,000 people. By 2007, the latest available figure, it had more than doubled its number of inhabitants (Ministry of Public Health, 2009). Census data from 2009 indicate that 67 per cent of households in urban areas and 96 per cent in rural areas, do not have electricity (World Bank, 2015a).

Guinea-Bissau is a country of great diversity, with more than 20 languages spoken by many ethnic groups. The official language is Portuguese but it is only spoken as a first language by a small proportion of the population. The *lingua franca* is a Portuguese-based Creole, the common language of everyday life. It is, however, spoken as a first or other language by only 44 per cent of the population. Other languages include: Fula (26 per cent), Balanta (20 per cent), Mandinga (13 per cent), Papel (7 per cent) and Manjaco (7 per cent).



2.2 The Living Environment of Children and Families

2.2.1 The Social and Cultural Environment of Children and Families

FAMILY ARRANGEMENTS AND THE SOCIAL POSITION OF MARRIED WOMEN IN GUINEA-BISSAU

According to MICS 2014, the average household size in 2014 was 7.7 persons. One in four households had more than 10 members (INE, 2015b). Polygamy is a common practice in Guinea-Bissau and has only declined marginally in recent years; from 48 per cent of married women living in polygamous households in 2010 to 44 per cent in 2014. Women with no education are three times more likely to be in a polygamous marriage than those who have completed secondary school.

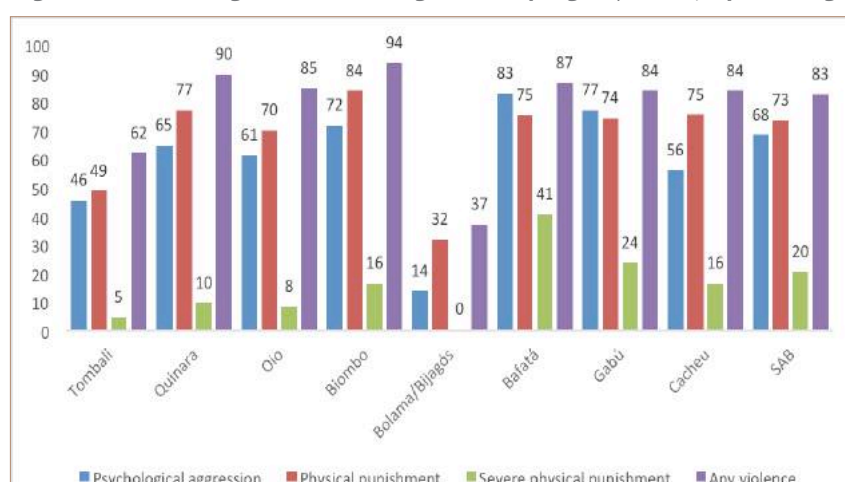
Women manage the food in the home and mainly work as market traders and vendors. They make important contributions to cashew and rice cultivation and agriculture in general, most notably during harvesting season (Bastos, 2011). Though women have the formal right to own assets, if they are married under customary law, then crops, land, household goods and livestock are considered the property of the head of the household. Women decide about the excision of girls.

Guinea-Bissau is a patriarchal society. In most cases, a woman filing for divorce is at risk of losing guardianship of her children. Several ethnic groups in Guinea-Bissau do not allow women married under customary law to ask for separation or divorce. Some other groups simply do not allow divorce at all. Where women are awarded guardianship this is usually only until the children reach the age of seven, when they may be handed over to their fathers (Afroteste, 2013).

VIOLENCE AGAINST CHILDREN AND WOMEN

Disciplining children verbally and physically is a common practice in Guinea-Bissau. According to MICS 2014, with the exception of Tombali and Bolama/Bijagós, the prevalence of physical abuse (which includes slapping and spanking) is very high. Most children get a slap on their hand, arm or back as a form of discipline. One in every five children in Bissau and Gabú is beaten with a stick or belt when parents believe that they deserve punishment. There is no difference in the forms of punishment used for girls and boys (INE, 2015b).

Figure 3: Violence against children aged 1-14 by region, 2014 (in percentages)



Source: INE (2015b).

A significant proportion of Guinea-Bissau's population (25 per cent) believes that physical punishment of children is an appropriate form of discipline. A notable exception is the islands of Bolama/Bijagós where only 6 per cent believes physical punishment is correct.

Acceptance of violence against women is also widespread. Many women believe their husbands are entitled to beat them if they argue with them or leave the house without informing them: the figures vary from 29 per cent in Quinara to 74 per cent in Bafata. By contrast, a lower proportion of men (15 per cent in Cacheu) approve of beating their wives (INE, 2015b).

FOSTERING TRADITIONS AND CARE OF ORPHANS

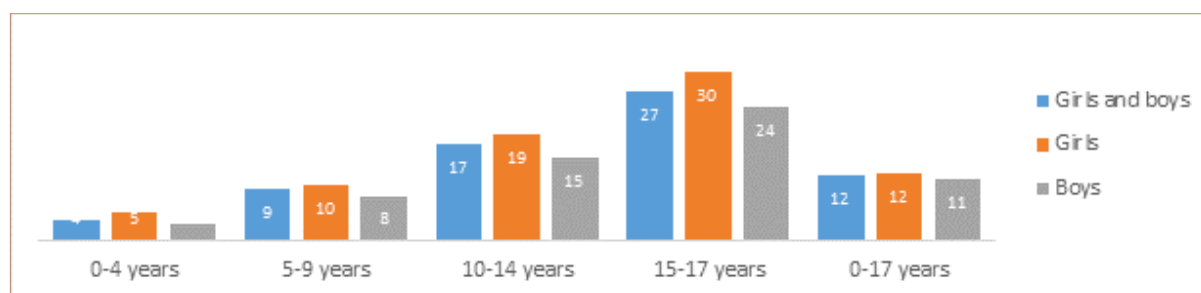
Most children live with their parents in large extended families who share their homes and livelihoods. However, as they grow older, children are more likely to live separately from their parents. This may be because of separation of parents, migration, or informal fostering. Migration is significant in Guinea-Bissau, but less than 5 per cent of children have at least one parent living abroad (though this reaches around 7 per cent for Gabú, Cacheu and Bissau). The most common reason for children to live away from their parents is the custom of placing children, most frequently girls, in the custody of family members.

Placing children in other families is a common tradition. A recent study, based on a fairly small sample (Boiro *et al*, 2010), found that around 67 per cent of all families had been entrusted with at least one child of another family. Across ethnic groups, child fostering⁵ is intended to provide children with more chances to access formal schooling, obtain new skills and expand their social networks, within the extended family and beyond. Fostering is considered to enhance the social mobility of poor children. A 2010 study and data from MICS 2014 show that entrusting children to extended families occurs equally across wealth quintiles, but that richer families are entrusted with more children than poorer families. Foster parents are obliged to treat children they are entrusted with like their own. Strong evidence of the conditions of fostered children is not available, but concerns have been raised that at times, and in particular in times of economic hardship, this traditional practice could easily turn into exploitation.

Due to high levels of morbidity and mortality among adults, 12 per cent of children in Guinea-Bissau have lost one or both of their biological parents. According to MICS 2014, it is more than twice as likely that the father has died. As would be expected, the percentage increases with age and reaches as high as 27 per cent for adolescents between 15 and 17 years (INE, 2015b).

Most orphans are cared for in their extended families. However, some are placed in residential care. According to an assessment of children in residential care, approximately 600 children and adolescents live in institutions, of whom 40 per cent are orphans. The other 60 per cent are comprised of children affected by HIV and AIDS, who have disabilities, accused of witchcraft and/or from dysfunctional and/or extremely poor families. Of 17 institutions assessed, ten are located in Bissau and only seven are legally registered. In general, working conditions in these institutions are very poor, and they have few and poorly trained staff. The very few trained psychologists, social workers and/or medical doctors work only in Bissau and with SOS Children's Villages in Gabu and Canchungo. The assessment was conducted in institutions providing residential care for vulnerable children, and did not include children living in residential religious schools (Ministry of Women, Family and Social Cohesion and UNICEF, 2015, draft).

⁵ This practice has varying meanings for different ethnic groups. The Mandingas use *karfoo* (entrust), *kuluroo kuludinya* (educate), *sooro* (give), *fuuroo* (lend). Biafadas call it *gunben* and the Balantas use the term *nrang* which means education or entrustment. The Fulani use several terms of which *négot* means educate.

Figure 4: Single and double orphans in Guinea-Bissau by age group, 2014 (in percentage)

Source: INE (2015b).

CHILDREN LIVING WITH DISABILITIES

The 2009 census found that Guinea-Bissau was home to around 14,000 people living with disabilities, of whom 2,551 were children. According to the census, only 12 children under the age of five had a mental disability (INE, 2009). This means that less than 1 per cent of the total population and a mere 0.33 per cent of all children live with a disability. Given that globally around 15 per cent of all people live with disabilities (80 per cent of whom live in developing countries), this number is disputed by stakeholders, including the Federation of Associations for Defending and Promoting the Rights of People with Disabilities. The Government also recognises the need for more reliable information on children living with disabilities, and it intends to undertake a census on citizens with disabilities as part of its Third National Development Plan.

There is limited information available on how children with disabilities are treated within the family. A recent case study on children accused of witchcraft (known locally as *Crianças Iras*), conducted by the NGO FEC (2015) shows that a considerable number suffer from a deficiency or disease. Families of *Crianças Iras* experience feelings of shame, lack of affection and neglect and, in many cases, associate the condition of the child with increasing poverty and misfortune in the family. More than three quarters of the families have come under pressure to abandon their children.



2.2.2 Environmental and epidemiological risks

RECURRENT CHOLERA OUTBREAKS

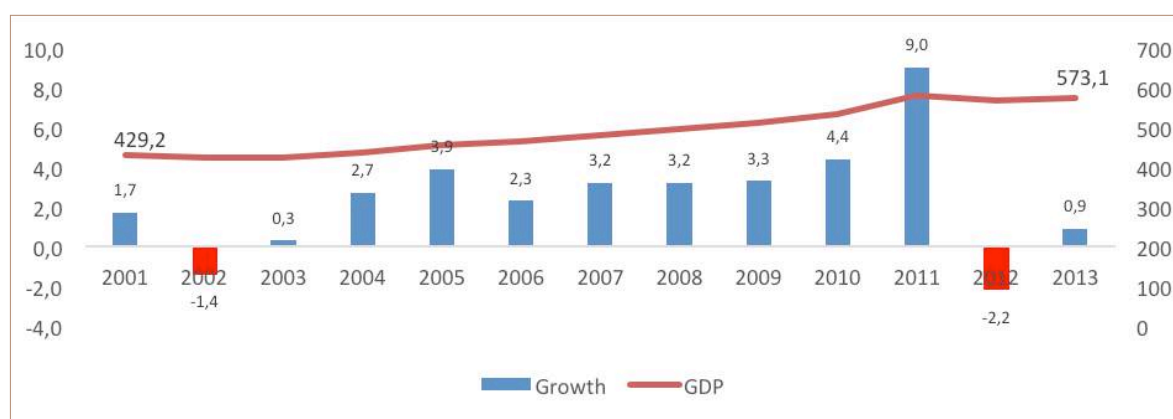
Despite an abundance of water, Guinea-Bissau has been generally spared from major floods or other natural disasters, such as droughts or earthquakes. However, poor infrastructure, as well as challenges related to safe drinking water, sanitation practices and hygiene behaviours, mean it remains prone to epidemic diseases, most notably recurrent Cholera outbreaks (see section 3.2.3 below).

As will be further detailed below, the MICS 2014 found that despite the MDG water target having been met and access to improved water sources steadily increasing over the past decade, large gaps, poor water quality and inequities remain hurdles to reducing incidence of Diarrhoeal diseases, and Cholera in particular. Indeed, in rural areas 39 per cent of households do not have access to improved water sources. Other major reasons for recurrent Cholera outbreaks are the lack of a culture of appropriate hygiene and socio-cultural traditional beliefs and practices. According to the MICS 2014, households in Guinea-Bissau rarely treat their drinking water, with less than 1 per cent of the population boiling water and only 12 per cent using chlorine to make it potable. Furthermore, though sanitation coverage has been steadily increasing over the past decade, on average 18 per cent of the population still defecates in the open. At the time of the MICS 2014, only 11 per cent of households had soap at their disposal for handwashing. All of these are risk factors for the spread of Cholera and other water-borne diseases.

To date, no confirmed cases of Ebola virus diseases (EVD) have been reported in Guinea-Bissau. However, the regional EVD epidemic and the prevention and preparedness efforts undertaken in Guinea-Bissau have further highlighted the weaknesses of the country's public health system, resulting from decades of political instability. Partners are continuing to support Guinea-Bissau to put in place the necessary systems for containment and control, including improved surveillance and communication. The regional EVD epidemic has served as yet another wake-up call to step up efforts and investment in strengthening the country's public health system in a sustainable manner for response to any epidemic.

2.3 Livelihoods and Poverty

Figure 5: Economic growth of Gross Domestic Product, 2001-2013
(at 2013 constant prices, in billions of CFAfr)



Source: World Bank 2014a

Economic growth rates have fluctuated between 3.2 per cent in the 1970s and 1.3 per cent in the 1990s, and correlate with the degree of political stability. The 1998-1999 armed conflict caused a contraction of 30 per cent of real GDP (World Bank, 2007). Between 2000 and 2014, the GDP grew at an average of 2.6 per cent per annum, well below the average of 5 per cent for Sub-Saharan Africa (World Bank, 2015a, Guengant, 2011). Current per capita income is still below both 1998 and pre-independence (1973) levels, as the economy has grown at a slower pace than population growth. GDP per capita only grew about 0.3 per cent per annum between 2004 and 2014 (World Bank, 2015a). The World Bank estimates that the 2013 GDP per capita stood at US\$ 400 (at 2005 constant prices), which is substantially lower than in 2011, as the 2012 coup sent Guinea-Bissau into a deep recession (World Bank, 2014b). Following the peaceful elections and return of external funding, economic growth is projected to pick up again. The latest IMF estimates point to a sustained economic recovery, with real GDP growth rates projected at 2.5 per cent in 2015, 4.7 per cent in 2016 and 4.8 per cent in 2017 (IMF, 2015).

Agriculture, forestry, fishing and livestock farming account for about 50 per cent of GDP, which is high by regional standards (World Bank, 2015a). The share of the primary sector in the economy has not changed significantly since independence and has actually increased since 2008. The share of services in GDP has been declining (Arvanitis, 2014).

Agriculture accounts for over 80 per cent of employment. The Government is the largest employer in the formal sector. Even though just 1.5 per cent of the population is employed in the public sector, there are more workers in the public sector than in the formal private sector (World Bank, 2015a). The inability of the formal sector to provide wage employment and/or sufficient income means most Bissau-Guinean families rely on the informal economy as their main means of survival. It is estimated that around 70 per cent of the economy is informal (Arvanitis, 2014), an increase from 59 per cent in 2000 (OECD).

Cashew nuts account for 85 to 99 per cent of the country's total exports (World Bank, 2015a) and a third of average income in most areas. The second largest crop is rice, which accounts for two-thirds of grain production and contributes three-quarters of household calorie consumption. Since the mid-1990s favourable cashew prices have led many farmers to disregard rice in favour of cashew. In Oio for instance, 100 per cent of land is used for cashew production. Overall, 90 per cent of households depend on cashew for their livelihoods (WFP, 2013).

Guinea-Bissau's monoculture rural economy is very vulnerable to external factors, including fluctuations in rainfall and international commodity prices. The agriculture sector, including cashew production, is undeveloped and largely based on rudimentary technology employed on small farm holdings. Hence, its productivity is low in spite of its importance. In 2013, cashew nut production generated no more than 12 per cent of the country's GDP (Arvanitis, 2014). Cashew is usually traded immediately for rice at the farm gate, rather than sold by farmers for cash. Because of this, a poor cashew harvest has an immediate impact on both food security and economic performance (World Bank, 2015a, Samba *et al.*, 2014).

Food insecurity is a recurrent threat for much of the population of Guinea-Bissau. A 2013 WFP survey revealed that the percentage of the rural population facing severe food insecurity increased from 20 per cent in 2011 to 40 per cent in 2013 (World Bank, 2015a). The entire region of Oio was characterised as an area of "urgency" because of food insecurity, and the regions of Bafatá, Quinara, Cacheu and

Biombo as areas of “crisis”. The remaining three regions (Gabú, Tombali and Bolama) were characterised as “under pressure” (FAO, WFP and Plan International, 2013). In 2014, four out of eight regions (or nearly 230,000 people) were in a situation characterised as being in “crisis” in terms of food security (WFP, 2014).

2.3.1 Monetary poverty

Monetary poverty has crucial implications for access to social services and child wellbeing. This holds especially true for countries like Guinea-Bissau where a significant share of household income is spent on out-of-pocket expenses for social services, because of the weak state of the public sector. Data on monetary poverty in Guinea-Bissau are scarce. Poverty analyses rely almost exclusively on household level data from the two Small Poverty Assessment Survey (ILAP) rounds of 2002 and 2010. Therefore, it is not possible to analyse current levels of monetary poverty for individuals, including children.

Extreme poverty increased most dramatically from 21 per cent in 2002 to 33 per cent in 2010, with a near doubling of the total number of people affected in only eight years (INE, 2011). Rough estimates suggest that poverty and extreme poverty further increased in 2013 (World Bank, 2015a). This means that Guinea-Bissau has not reached the MDG target of a maximum of 21 per cent of the population living below US\$1.25 per day (United Nations, 2015).

Table 2: Monetary poverty in Guinea-Bissau, 2002 and 2010

		US\$ 1			US\$ 2		
		Bissau	Other Regions	Total	Bissau	Other Regions	Total
Headcount (%)	2002	9	25	21	52	70	65
	2010	13	40	33	51	76	69
Total population	2002	28,414	217,551	245,965	157,612	607,060	764,672
	2010	48,991	434,483	483,474	189,570	824,707	1,014,277

Source: INE (2011).

Regional disparities are also significant. There is a gap of more than 25 percentage points between Bissau and Bolama/Bijagós and the other regions. In 2010, poverty rates (income per capita below US\$ 2 per day) in Bissau and Bolama/Bijagós were estimated at 51 and 47 per cent respectively, while in other regions they were above 75 per cent on average. The worst levels of poverty are found in Tombali (79 per cent), Cacheu (81 per cent) and Gabú (84 per cent). These regions also have the highest extreme poverty rates (income per capita below US\$1 per day) (INE, 2011).

“My wish is for the price of cashew to go up and the price of rice to go down” (girl, 13, Cacheu)

“I like living here because we have a lot of rice” (girl, 7, Buba)

Table 3: Monetary poverty indicators per region, 2010

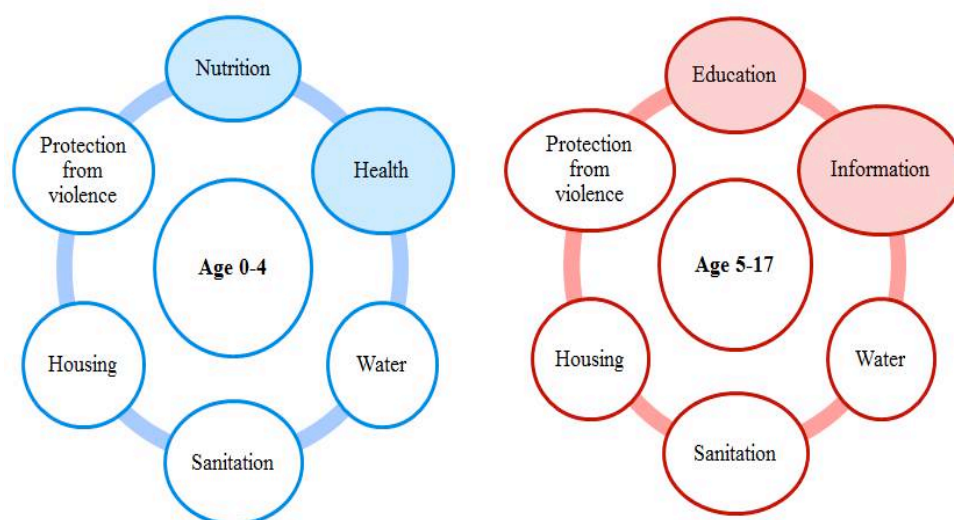
Region	Headcount		Total population	
	Less than US\$ 2 per day	Less than US\$ 1 per day	Less than US\$ 2 per day	Less than US\$ 1 per day
Gabú	84	47	161,037	90,956
Cacheu	81	43	154,160	82,044
Tombali	79	39	71,598	35,490
Bafatá	76	33	157,272	69,625
Oio	73	46	147,863	92,332
Quinara	71	41	59,836	34,780
Biombo	66	25	57,279	21,619
Bissau	51	13	189,570	48,991
Bolama/Bijagós	47	23	15,663	7,636
Total	69	33	1,014,277	483,474

Source: INE (2011).

2.3.2 Multidimensional child poverty

In order to address the needs of children through suitable policies and programmes, it is essential to understand child poverty and deprivations. This section presents the key results of a multidimensional poverty analysis that captured the extent to which children experience multiple deprivations simultaneously in ways that can impair their growth and development permanently.

The Multiple Overlapping Deprivation Analysis (MODA) methodology was used to identify, locate, and create a profile of children with single and multiple deprivations in Guinea-Bissau using MICS 2014 data. It takes the child as the unit of analysis and makes use of the lifecycle approach to reflect the changing needs of children at different stages of their lives. It maps the prevalence and depth of deprivations for each child, revealing which children experience higher numbers of deprivations simultaneously.

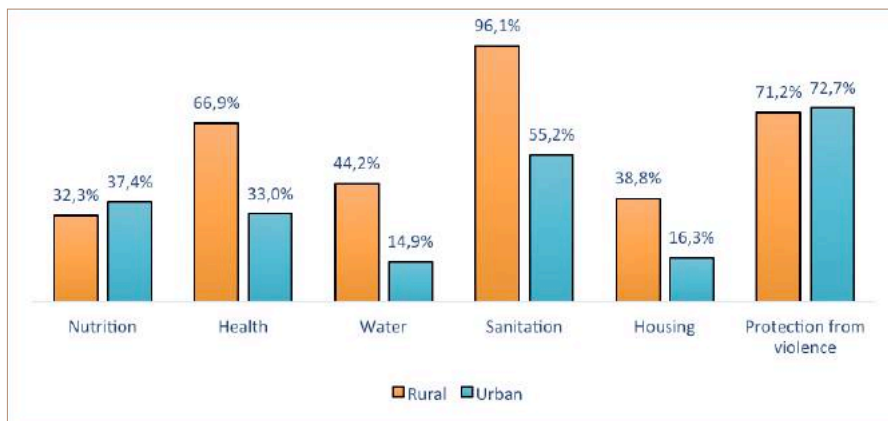
Figure 6: Dimensions of well-being used in MODA analysis for two different age groups

Source: De Millano, 2015

The vast majority of children under 18 (8 out of 10) in Guinea-Bissau are deprived of adequate sanitation. Lack of sanitation affects almost all children (96 per cent) in rural areas and more than half (55 per cent) in urban areas. This exposes children to diseases such as Diarrhoea. Access to safe drinking water also remains a concern for a third of all children (44 per cent in rural and 15 per cent in urban areas).

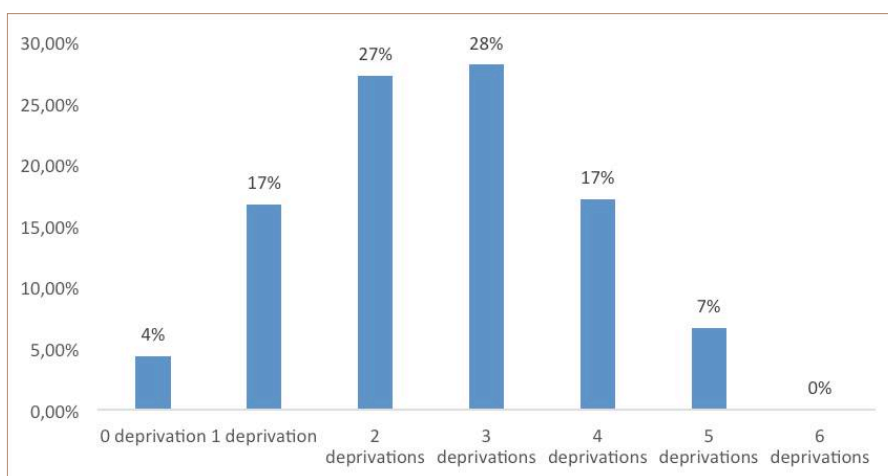
For children under five, deprivation of adequate nutrition and healthcare remains particularly high. Fifty-five per cent of all children under the age of five lack access to adequate health care (67 per cent in rural areas and 33 per cent in urban areas). A third do not have access to adequate nutrition. (Fig 7). For children aged 6-17 years, the largest deprivation pertains to education. Eighty per cent of children who reached primary school age failed to complete primary education. Amongst children under 17 years of age, 28% have three types of deprivation. (Fig 8) while 31% of children in rural areas under 5 years of age have three types of deprivation (Fig 9)

Figure 7: Deprivation Headcount Ratio (%) for children below 5 years of age, by dimension and urban/rural area

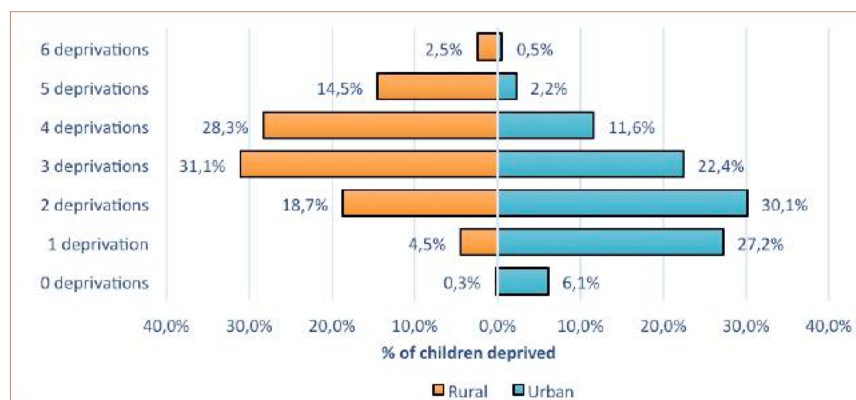


Source: De Millano, 2015

Figure 8: Number of multi-dimensional deprivations, children 0-17 years



Source: De Millano, 2015

Figure 9: Percentage of children deprived in each number of deprivations by area for children below 5 years

Source: De Millano, 2015

2.4 Systems and Services for Children

There is no one single Government entity responsible for overall coordination of policies, laws, and programmes relating to the rights of children and women in Guinea-Bissau. Several Commissions and Committees have been established to tackle specific issues, such as FGM/C, trafficking and child labour, but these work independently of each other. The two main bodies responsible for children's issues are the Ministry of Women, Family and Social Cohesion and the Institute of Women and Children (IMC). The Ministry is responsible for creating, implementing and following up Government policy on family and the fight against poverty. The IMC focuses on policy coordination and implementation of Government strategies to promote women and children's rights. The UN Committee on the Rights of the Child has recommended that Guinea-Bissau establish one single coordinating body.

The country does not have an independent ombuds-institution to protect children's rights, or human rights more broadly.

The following sub-sections look at governance, financing and budgetary issues for several sectors.



2.4.1 Healthcare System

Resources allocated to the health sector are low in both absolute and relative terms. Health expenditure has consistently been below the regional average, and total Government expenditure on health of 7.8 per cent in 2012 puts Guinea-Bissau at the low end of a large group of comparable Sub-Saharan African countries (WHO, 2014).

Per capita expenditure on health is below US\$ 35, estimated by the WHO as the amount required to cover essential health services. WHO calculations show that during the last ten years, this level was only achieved in 2009 and 2010.

In 2012, the year of the coup d'état the country reached another record low when total Government expenditures for health fell below 1.3 per cent of GDP putting a heavy burden on families. While total health expenditure is several-fold higher, the difference is covered by families and by external aid that the country depends upon. Families carry by far the largest burden of total health expenditure, contributing between 41 and 50 per cent.

Families finance a large share of total healthcare expenditure. While Government expenditure on health as a share of GDP is low, total health expenditure is several times higher. This is because Guinea-Bissau is more than averagely dependent on donor resources and families make a strong contribution to financing healthcare services. For most of the years since 2000, families have paid between 43 and 50 per cent of total health expenditure from their own pockets.

Guinea-Bissau has one national hospital and five regional hospitals, several of which are operated by religious NGOs. At the local level there are 123 health centres, some of which are also run by NGOs. The country's 114 health areas have been designed as such that each should serve between 5,000 to 12,000 people. However, around 50 per cent of the population still lives more than five kilometres from the nearest health facility. For some communities the nearest healthcare facility is more than 30 kilometres away (Ministry of Public Health, 2010a). Health facilities are often difficult to access during the rainy season, especially in the south.

The Government operates one model nutritional rehabilitation centre at the national level, 9 inpatient treatment centres, and 14 outpatient treatment programmes (OTP) in five regions of the country (Biombo, Bafata, Gabu, Oio, and Farim). Treatment of severe acute malnutrition is a life-saving service and while concerted efforts are underway to implement and scale up services the number of treatment facilities is inadequate and creates barriers to access. Additionally, early identification of children with severe acute malnutrition through active case finding at the community level is not regularly implemented, and instead, children that present at health facilities are passively screened by health workers, with a bias towards selection of children that appear visibly thin.

Health facilities infrastructure is degraded and lacks essential equipment and consumables. Health centres operate as semi-autonomous units: the Government pays salaries but offers little other support, financial or otherwise, and nurses (or the doctor if one is present) must manage the health facility in a self-sustainable manner. Recent evaluation found that 95 health facilities are in need of rehabilitation, mainly water supply and electricity (Ministry of Public Health, 2014a).⁶ In spite of ef-

6 The total cost was estimated to be nearly US\$4 million.

forts to scale up coverage of services and improve infrastructure,⁷ the service delivery capacity in the health system is generally weak.

In recent years all health centres have been equipped with a cold chain powered by solar panels to preserve vaccines. A recent evaluation found that these were operational in 72 per cent of health facilities (Ministry of Public Health, 2014a).

There is a critical shortage and unequal distribution of health personnel, particular in rural areas. Over half of healthcare professionals are concentrated in the capital, and 80 per cent of physicians are based in urban areas. Nurses and midwives remain in short supply in rural areas. In 2010, no more than 8 per cent of all people working in the public sector worked in health. The latest available data shows that the ratio of medical personnel per 10,000 population is extremely low. The 2010 ratio of 0.45 doctors per 10,000 people was below the 2004 rate of 1 doctor per 10,000 people.⁸ The number of nurses and midwives has also declined from seven per 10,000 people in 2004 to 5.5 in 2010.⁹

All levels of health workers suffer from low wages, which are often paid late, leading to frequent strikes. The quality of formal training provided to health personnel is insufficient for them to perform their roles resulting in low morale and high staff turnover (African Health Workers Observatory, 2010). After the 2012 coup, health workers' salaries were not paid for months following the donor withdrawal of budget subsidies: this indicates very narrow fiscal capacity to provide funding for health services.

Guinea-Bissau has a highly deficient drug supply system. The Central Essential Drugs Purchasing Authority (CECOME) is unable to satisfy the needs of the population, owing to low managerial capacity, weak collaboration across key health programmes and inadequate funding. An evaluation of drug procurement and management system in four regions found that 91 per cent of health facilities had experienced stock-outs in drugs and consumables (Ministry of Public Health, 2014a).

The country relies almost entirely on external financial assistance for the procurement of essential drugs, vaccines and commodities for the treatment of major killers (Malaria, Tuberculosis, HIV/AIDS and vaccine-preventable diseases). The weak managerial capacity of CECOME (the Central Medical Store of Guinea-Bissau), and lack of collaboration across programmes, also undermines the continuity of this external support.

Financial barriers are a major obstacle to accessing health care. Health centres in Guinea-Bissau must generate revenues through the sale of drugs and through consultation fees to be able to pay their expenses, including renewal of stocks of medicines and incentives for auxiliary staff. However, because of frequent stock-outs of essential drugs through the CECOME system, health centres and hospitals revert to the private sector to procure drugs at a relatively higher cost, which is then transferred on to the patient who generally does not have the financial capacity to afford costs.

As of December 2013 medical procedures were declared free for women and children in selected areas of the country with donor support. This immediately resulted in increased coverage of health

7 Many health facilities were damaged or completely destroyed during the 1998-99 conflict.

8 For comparison, in the same year the average across low income countries was 0.21.

9 <https://www.hfgproject.org/resources/health-systems-database/country-profiles/guinea-bissau/>

care. This policy was initially introduced in four regions and then scaled up nationally in October 2014. Recent data have shown a very steep increase in demand for the 14 healthcare procedures covered by the community health programme. In the regions where the programme began first, within a year the number of procedures for women increased by more than 30 per cent and the number of procedures for children under the age of five even tripled (EMI, 2015). Recent simulations further indicate that this policy could have increased the number of institutional deliveries by as much as 40 per cent (Ministry of Public Health, 2014b). Because the costs of the interventions are reimbursed by external partners, the income of the health facilities has also increased significantly.

National policies address the principal killers of children and women, but require significant investment. To achieve Millennium Development Goals (MDGs) 4 and 5 by 2015, the Government of Guinea-Bissau is implementing the National Operational Plan to Accelerate Child and Maternal Mortality Reduction (POPEN) 2011-2015. This promotes the delivery of integrated health, nutrition, HIV/AIDS and water, sanitation and hygiene interventions, including service decentralization for some of the hardest-to-reach communities. It integrates interventions by the Ministry of Health under the National Policy for the Development of the Health Sector 2008-2017 and the National Food and Nutrition Policy; by the Ministry of Energy and Natural Resources under the National Water and Sanitation Sector Master Plan 2010-2020; and by the National Secretariat to Fight AIDS under the Third National HIV/AIDS Strategic Plan (PEN-III) 2012-2016.

The National Health Development Plan (PNDS) covers the period 2008-2017 and focuses on two priority areas: strengthening the capacity of the National Health Service (2008-2012) and improving the health outcomes of the population (2013-2017). The former is to be achieved by reinforcing governance and improving infrastructure, equipment, human resources and pharmaceuticals. Health outcomes will be improved through inter-sectoral collaboration and integrated disease surveillance. Monitoring and evaluation and the development of essential care and referrals will also be strengthened.

2.4.2 Water and sanitation

Budget allocations for water and sanitation are very low, even compared with other social sectors. According to an economic and financial analysis undertaken in 2012, in 2011 around 0.3 per cent of total public expenditure was allocated to the water and sanitation sector, about the same as the year before. This budgetary allocation is one of the smallest of all public sectors.

2.4.3 Education System

In Guinea-Bissau, total public budgetary provision for the education sector is below that of comparable countries. Between 2002 and 2013 total expenditure on education grew in real terms by 7.3 per cent per year. However the proportion of total expenditure spent on education did not grow at the same rate: between 1996 and 2004, it fluctuated between 11 and 17 per cent. Public spending on education made up 2.8 per cent of GDP over the same period. Between 2008 and 2012, current expenditure on education accounted for about 11-12 per cent of total current expenditure, a share that was only 1 percentage point higher than in 1997. In 2013, it increased slightly to 13 per cent.

Guinea-Bissau also does not meet the targets for expenditure on primary education. The largest share of current expenditure is dedicated to financing the first two cycles of basic education (i.e. 46 per cent), a fall of nine percentage points since 2010. Consequently, Guinea-Bissau no longer meets the Edu-

cation for All-Fast Track Initiative (EFA-FTI) recommended relative budgetary allocation for primary education of 50 per cent. Compared with other low-income countries Guinea-Bissau spends a higher share on both basic and secondary education, in spite of the sharp drop in Primary education (Ensino Basico 1 and 2). It also spends less than half of what these countries spend on tertiary education and post-graduate education (Government at all 2015).

Inequality in public education is less than other countries in the sub-region by some measures. Guinea-Bissau spends 35 per cent of its education budget on the most educated 10 per cent of the current generation. This compares with 47 per cent for the sub-region and as much as 70 per cent for Chad.

Families make a strong contribution to the financing of education in Guinea-Bissau. Estimates for 2010, calculated from ILAPII data, indicate that around half of all expenditure on education is paid out of the pockets of parents and caregivers of children. Half of this total is spent on secondary education. Families contribute most of the cost of pre-school (62 per cent) and secondary education (65 per cent). Primary education is still financed primarily from public sources, and families finance about 35 per cent of all expenditures (Government at all 2013).¹⁰ These figures are relatively high compared with other countries in West and Central Africa (UNICEF, 2014b).

Unit public expenditure on education in Guinea-Bissau is relatively low. The total expenditure per child aged 6-14 was about CFAfr 20,000 in 2002 (in 2013 constant prices). In 2013, it was CFAfr 25,000 after having been CFAfr 30,000 in 2010 and 2011. Expressed in GDP per capita, about 10 per cent is spent on a child in pre-school and in primary school. Just over 5 per cent of GDP in 2010 was spent on children in basic education. These expenditure rates are significantly lower than for comparable low-income countries, and raise the question whether they are enough to ensure good quality universal education. An important contributing factor to this low unit expenditure are the very low teacher salaries (both compared with other low income countries and by international standards. (Government at all 2013).

2.4.4 Child Protection System

The Ministry of Women, Family and Social Cohesion co-ordinates social care services in Guinea-Bissau. As it effectively has no presence at regional or local level, the Ministry is both the policy maker and a direct service provider, albeit with very limited capacity. The IMC and various specialized agencies, such as the Committee for the abandonment of Harmful Practices (CNAPN) have some implementing capacity below central level.

While plans have been made for family and juvenile justice courts in the regions, these are not operational, though the Regional Court of Bissau includes a civil court with a labour, family and juvenile section (Guerreiro et al., 2011). The number of judges and prosecutors in Guinea-Bissau is very limited. Between 14 and 20 per cent of all judges (15 out of 79) and prosecutors (11 out of 80) are women (UN Women, 2014). This low number should not but may influence the course of justice in a deeply patriarchal society.

Small units in the Ministry of Interior and the Ministry of Justice support child victims of exploitation and abuse, and both are mandated to conduct investigations into crimes involving children. Overlap-

¹⁰ An analysis published by UNICEF (2014b) found broadly similar shares: 54% overall, 43% for primary, 66% for lower secondary, 70% for upper secondary and 73% for higher education.

ping mandates and coordination challenges further hinder their already limited capacity to assist and protect victims.

Direct protection services for children and women are generally financed by external sources and have low national coverage. The Government works closely with the civil society. For example the border authority refers trafficked children to an NGO to facilitate their return from Senegal to Guinea-Bissau, as there is no Government reception centre in place at the border.

2.4.5 Social Protection System

Guinea-Bissau does not have any non-contributory or contributory social protection scheme. The Government has had plans to establish an emergency social assistance fund that would allow assistance to people who have suffered calamities. However, this has not been possible due to lack of funding.

Conditional or unconditional cash transfers and social assistance programmes are virtually non-existent, except for a trimestral payment of CFAfr 10,000 for vulnerable people, mostly adults and children with disabilities. The number of people eligible for an invalidity or disability allowance is estimated at 10,000 to 13,000 (Arvanitis, 2014). To get registered as a beneficiary, individuals go directly to the Ministry, which reviews their living conditions, at times including a home visit, before making a decision. In 2007 the number of people actually receiving the stipend was estimated to be 2,000 (Udelmann Rodrigues et al., 2007). The Ministry estimates the total number to be 2,500, but it does not keep a database of beneficiaries. Recent estimates suggest that among the total number of 2,500 beneficiaries, 1,500 have disabilities with the remaining 1,000 categorised as “other”. Payment is erratic and its size is relatively low.

As part of the Government Strategy 2025, a social protection system covering the majority of the population is planned to be put in place, with priority given to the most vulnerable, in particular women, children and refugees (Republic of Guinea-Bissau, 2015).

2.4.6 Investing in the Human Potential of Guinea-Bissau’s Children and Youth

The age structure of the population will undergo significant changes in the next 15 to 30 years. Guinea-Bissau’s dependency ratio (the number of dependents per 100 working age population) currently stands at 79. It is expected to fall to 59 in 2050 as fertility rates drop to 3.1 allowing the number of potential workers to increase relative to the number of dependents. This shift in the population structure opens a favourable demographic window during which gains in economic growth (the so-called demographic dividend) may be obtained (UNICEF, 2014a). However, the promise of the so-called demographic dividend can be realised only if investments in young children and adolescents are prioritised in Guinea-Bissau *today*. Children born today will enter the labour force in 20 years or so. The structural transformation sought by Guinea-Bissau in its 2025 vision requires investment in maximising the human potential of its children, adolescents and youth.

2.4.7 MDGs – What was achieved, what remains to be done; SDGs next

Table 4: Taking stock of key inequalities and Guinea-Bissau's progress toward the Millennium Development Goals using MICS 2014 data

Millennium Development Goal/Indicator	Sex		Region				MDG target
	M	F	Best		Worst		
0-4 years							
Goal 1: Eradicate Extreme Poverty and Hunger							
1.1 Proportion of population below \$1.25 (PPP) per day	n.a	n.a	n.a				21%
1.8 Prevalence of underweight children under five years of age	18%	16%	Bolama / Bijagós	10%	Bafatá	24%	13%
Goal 4: Reduce Child Mortality							
4.1 Under-five mortality rate	96	82	Biombo	42	Gabú	159	75
4.2 Infant mortality rate	60	51	Biombo	21	Gabú	88	44
4.3 Proportion of 1 year-old children immunised against measles	81%	81%	Cacheu	93%	Gabú	74%	88%
Goal 6: Combat HIV/AIDS, Malaria and Other Diseases							
6. Percentage of women who received ARVs for pre-vention of mother to child transmission of HIV	-	56%	n.a	n.a	n.a	n.a	80%
6. Percentage of children living with HIV enrolled into ART	-	8%	n.a	n.a	n.a	na	100%
6.7 Proportion of children under 5 sleeping under insecticide-treated bed nets (both sexes)	81%	81%	Tombali	89%	Bafatá	63%	n.a.
6.8 Proportion of children under 5 with fever who are treated with appropriate antimalarial drugs (both sexes)	33%	23%	Oio	40%	Gabú	16%	n.a.
Goal 7: Ensure environmental sustainability							
7.8 Proportion of population using an improved drinking water source (total)	75%		Bissau	97%	Biombo	39%	68%
7.9 Proportion of population using an improved sanitation facility (total)	13%		Bissau	33%	Oio	3%	55%
5-11 years							
Goal 2: Achieve Universal Primary Education							
2.2 Proportion of pupils starting Grade 1 who reach last grade of primary	75%	72%	Cacheu	95%	Tombali	46%	100%
Goal 3: Promote Gender Equality and Empower Women							
3.1 Ratio of girls to boys in primary education	1.0		Gabú	1.1	Cacheu	0.9	1.0
3.1 Ratio of girls to boys in secondary education	0.8		Bolama / Bijagós	0.9	Oio	0.4	1.0

Millennium Development Goal/Indicator	Sex		Region				MDG target
	M	F	Best		Worst		
Goal 5: Improve Maternal Health							
5.4 Adolescent birth rate	106		Bissau	57	Oio	164	n.a.
Goal 6: Combat HIV/AIDS, Malaria and Other Diseases							
6.2 Condom use at last high-risk sex (female)	-	53%	Bissau	67%	Oio	28%	95%
6.3 Proportion of population aged 15-24 years with comprehensive correct knowledge of HIV/AIDS (female)	-	23%	Bolama / Bijagós	36%	Gabú	2%	95%
Goal 2: Achieve Universal Primary Education							
2.3 Literacy rate of 15-24 year-olds (female)	-	51%	Bissau	77%	Gabú	22%	100%
2.3 Literacy rate of 15-24 year-olds (male)	70%	-	Bissau	88%	Gabú	36%	100%
Goal 5: Improve Maternal Health							
5.1 Maternal mortality ratio (per 100,000)	-	900					233
5.2 Proportion of births attended by skilled health personnel	-	45%	Bissau	78%	Oio	25%	81%
5.3 Contraceptive prevalence rate (female)	-	16%	Biombo	30%	Oio	4%	100%
5.5 Antenatal care coverage (at least four visits with any care provider)	-	65%	Bissau	78%	Biombo	51%	100%
5.6 Unmet need for family planning	-	16%	Bolama / Bijagós	23%	Tombali	13%	0%

CHILDREN AND THE LIFECYCLE

"I want children to be healthy and have the opportunity to go to school. But I also want them to be cheerful and motivated, as I see many children with dirty clothes and sad faces in the streets." (girl, 17, Bubaque)

The previous sections of the report have looked at the contextual factors that affect the well-being of all children. The next chapters specifically follow the logic of the lifecycle approach. Trends and disparities will be analysed for the following age groups separately: 1) the early years: 0-5; 2) the primary school age years: 6-12; 3) the adolescent years: 13-17; and 4) the years of adulthood: 18 and over.¹¹ The analysis will pay particular attention to equity and disparities, as well as to trends and progress made in recent years. Progress towards the MDG targets shows significant disparities by sex, region, and educational level of the mother/women and income quintile of the household.

¹¹ The information available does not always accord exactly with these precise age groups. However, indicators will be discussed such that the overlap is minimal and it will be noted where certain information refers to an overlapping age group.



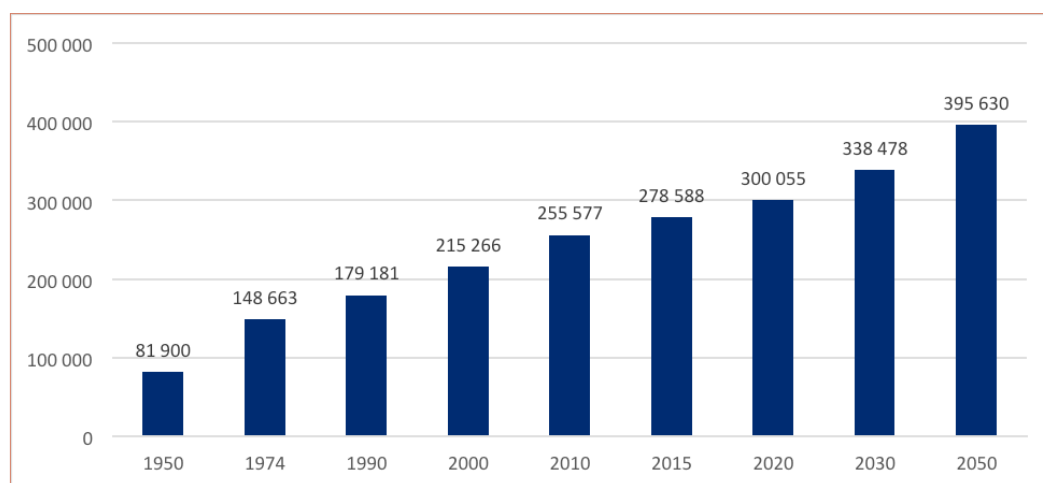
3. THE EARLY YEARS: A HEALTHY START

The 1,000 days from the beginning of a pregnancy to a child's second birthday offer a unique window of opportunity to shape healthier and more prosperous futures. Good nutrition during this 1,000-day window can have a profound impact on a child's ability to grow, learn, and escape poverty. It can also shape a society's long-term health, stability and prosperity and in turn brings enormous benefits throughout the lifecycle and across generations. Today, undernutrition is still a leading cause of death of young children throughout the world. It is estimated that 45% of all child deaths (3.1 of the 6.9 million child deaths in 2011) are related to undernutrition, including poor maternal nutrition resulting in fetal growth restriction, sub-optimum breastfeeding, stunting, wasting, and micronutrient deficiencies (Black, RE et al (2013).

For infants and children under the age of two, the consequences of undernutrition are particularly severe, often irreversible, and reach far into the future. Then, in the next three years of the child's development (aged 2-5), she or he continues to develop physically, cognitively and emotionally, taking small steps towards getting ready for school.

A total of 15.5 per cent of the population of Guinea-Bissau (summing to 280,000) were children under 5 in 2015.

Figure 10: Children aged 0-4, 1950-2050 (based on medium fertility projections)



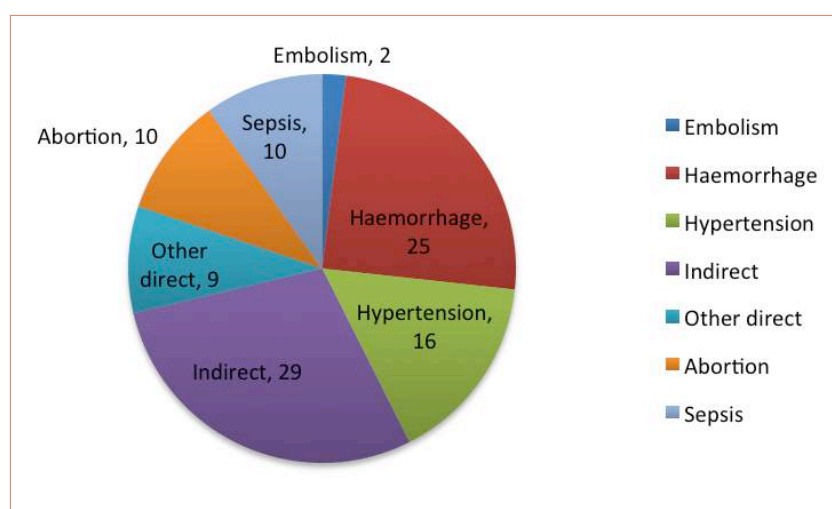
Source: UNDESA (2014).

3.1 The State of Maternal, Neonatal and Child Health

3.1.1 Maternal and child mortality

Maternal mortality is a matter of grave concern in Guinea-Bissau. The MICS 2014 suggests that the number of maternal deaths could be as high as 900 per 100,000 live births (INE, 2015b), making Guinea-Bissau one of the 15 countries with the highest maternal mortality rates in the world. It is also far from the MDG target of 300 deaths per 100,000 live births which, despite representing a two-thirds reduction since 1990, would in itself be a very high level.

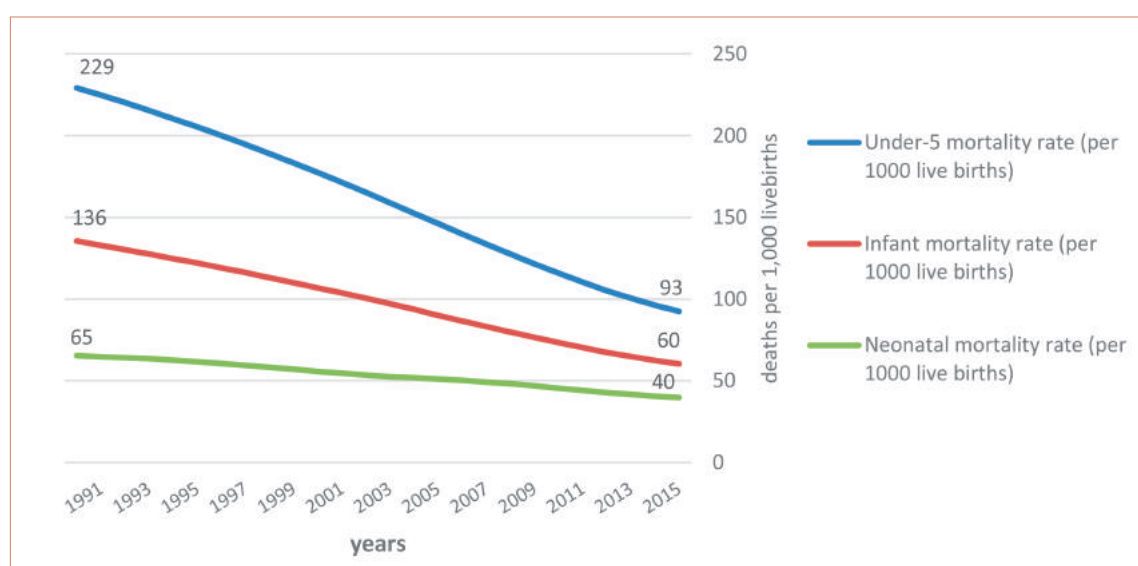
Figure 11: Regional estimates for causes of maternal death, Sub-Saharan Africa, 2013



The causes of maternal deaths are similar to those prevailing in many countries in Sub-Saharan Africa. They include widespread poverty, the low status of women in society, persistently high fertility rates and low levels of contraceptive use. In addition, 22 per cent of girls get married before the age of 18 and could become mothers-at-risk soon thereafter.

Child survival has improved, but even today almost one in 10 children under five is unlikely to reach his/her fifth birthday. Between 1990 and 2013, it is estimated that under-five mortality fell by nearly 50 per cent from 225 deaths per 1,000 live births to 124, equivalent to a 2.6 per cent decline per annum (The UN Inter-agency Group for Child Mortality Estimation-IGME). According to MICS 2014, significant progress in child survival has put Guinea-Bissau within reach of the 2015 MDG target of 75 deaths of under-five children per 1,000 live births.¹² MICS 2014 estimated an under-five mortality rate of 89 per 1,000 live births, infant mortality 55 per 1,000 live births, and neonatal mortality 36 per 1,000 live births (INE, 2015b). Similarly, the IGME estimates for 2015 were 92 per 1,000 live births (uncertainty range 69 – 120) for under-five mortality, 60 per 1,000 live births for infant mortality (uncertainty range 47 – 76), and 40 per 1,000 live births for neonatal mortality (uncertainty range 28 – 55).

12 With the adjustment of the 1990 estimate by the Interagency Group for Mortality Estimation from 240 to 225, the MDG target also moved from 80 to 75.

Figure 12: Child mortality estimates, 1990-2015 (per 1,000 live births)¹³

Source: UNICEF (2014d) and INE (2015b).

Progress has been slowest for neonatal mortality due to persistently low rates of skilled birth attendance, low access to emergency neonatal care interventions, early pregnancies and high malnutrition rates among pregnant women. According to WHO/MCEE 2015 estimates, neonatal mortality accounts for 44 per cent of all U5 mortality. Major causes of neo-natal deaths include complications associated with pre-term delivery (11 per cent), asphyxia (13 per cent) and sepsis (10 per cent). Preventable diseases, such as Malaria, Diarrhoea and Pneumonia, remain major child killers: together they account for 27 per cent of all under-five child deaths. According to MICS reports, IMCI indicators have deteriorated between 2010 and 2015: Malaria treatment coverage dropped from 51% to 28%, diarrhoea treatment from 53% to 16.6% and Pneumonia treatment from 35% to 14.5%.

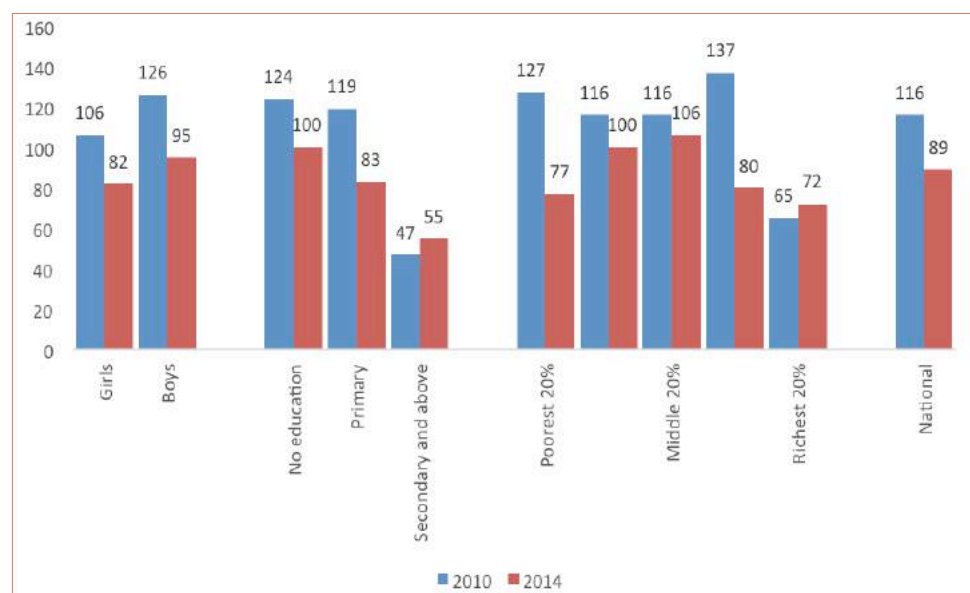
Although disparities in child survival remain substantial, progress has been faster for certain deprived groups, including children born to the poorest and least educated mothers. According to MICS 2014, child mortality declined by 20-30 per cent between 2010 and 2014 among children with mothers with no or only primary education. Mortality among boys remains higher than girls, but it declined at a faster rate. On the other hand, the gap between urban and rural areas is growing.

Compared to 2010, the under-five mortality rate for children born to the poorest mothers of Guinea-Bissau fell by 50 deaths per 1,000 live births. As a result, according to MICS 2014, the poorest 20 per cent of the population now outperform all other groups bar the richest 20 per cent. These unusual figures may be partly a result of a significant increase in the use of insecticide-treated bed nets among targeted low-income groups, which reduced Malaria-related morbidity. In the same period there was also a major scale-up of access to and use of basic health services including mass immunization and young child feeding practices in the most disadvantaged regions, through scaling-up of community-based services and improvement of healthcare delivery.

¹³ The target for under-five mortality at national level is 75, and for infant mortality is 44.

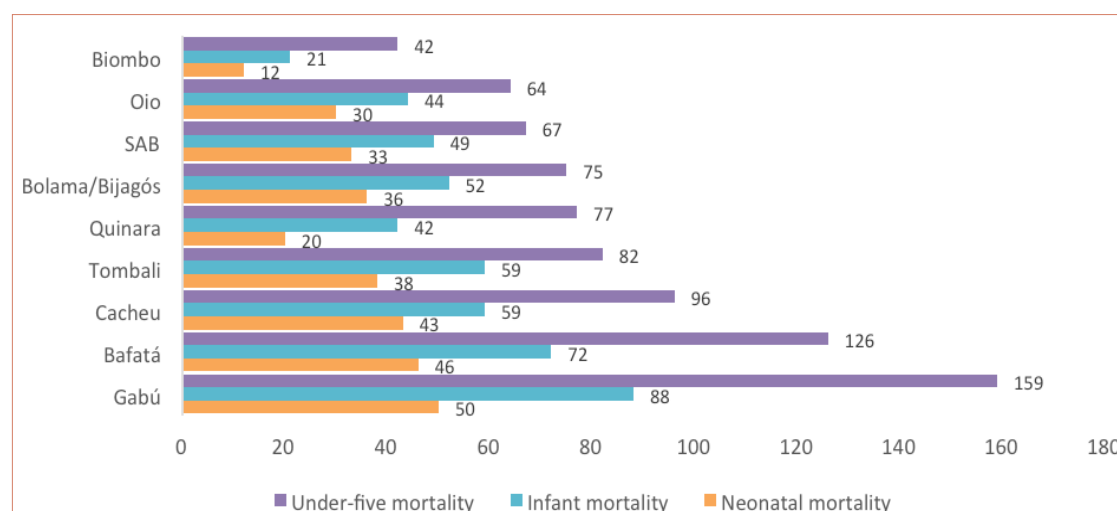
There are large disparities in child survival across regions. Biombo has the lowest child mortality rate at 42 deaths per 1,000 live births, more than 50 per cent lower than the national average. At the other end of the spectrum, Gabú and Bafatá have the highest mortality rates (159 and 126 per 1,000 live births respectively) or 30 and 80 per cent higher than the national average.

Figure 13: Disparities in under-five child mortality estimates, 2014 (per 1,000 live births)



Source: INE (2010 and 2015b).

Figure 14: Child mortality by region, 2014 (per 1,000 live births)

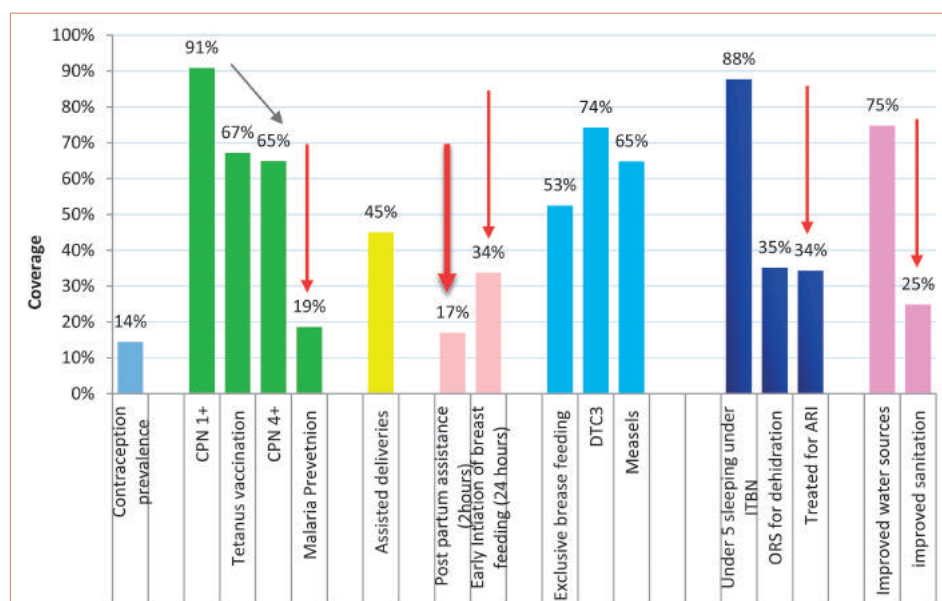


Source: INE (2015b).

3.1.2 Critical gaps in the continuum of care for mothers and children

Coverage of essential maternal and child health interventions along the continuum of care is irregular, with large gaps at key junctures in the life journey of children.

Figure 15: Gaps in continuum of care



Source: INE 2015b

Birth spacing is an important determinant for child survival. Under-five mortality among children of women who have another baby within two years of the previous birth is as high as 174 per 1,000 live births. By contrast, the child mortality rate among women who wait four years between births is only 57 per 1,000 live births and has barely increased in recent years. The MDG target of universal access to reproductive health remains far out of sight. Contraceptive use does increase with age, but only reaches a maximum of 22 per cent among women aged 35-39. The least likely to use contraception are girls aged 15-19 (8 per cent), especially those who have no children yet (4 per cent). As would be expected, the level of education of the woman has a significant influence on the use of contraceptives.

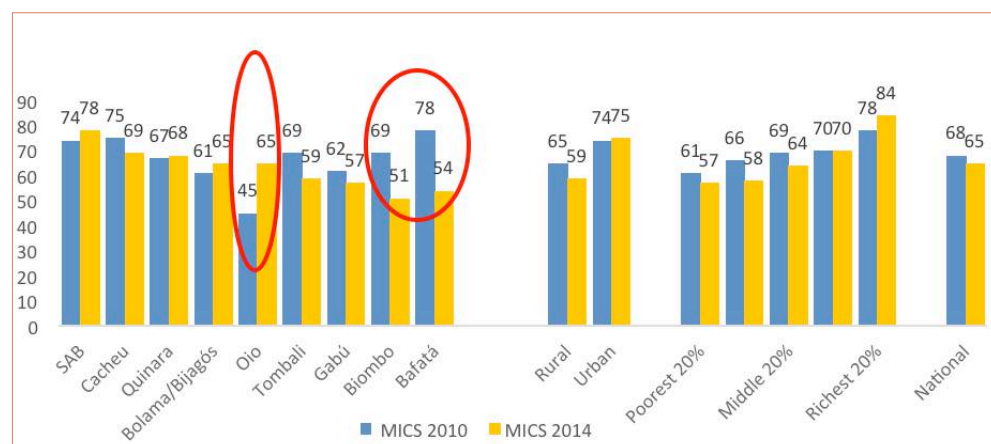
ANTENATAL CARE

In 2014, more than nine out of ten pregnant women in Guinea-Bissau attended their first antenatal care visit by a skilled health personnel. However, there are two main concerns regarding antenatal care. First, there is a sharp drop between the percentage of women attending at least one antenatal care visit (91 per cent) and those attending the recommended four visits or more (65 per cent). This appears to be because many pregnant women start seeking antenatal care late in their pregnancy, such as during the third trimester. There is thus a strong need to promote early antenatal care during the first trimester of their pregnancy as well as retention in antenatal care up to skilled birth delivery. This will ensure that complications during pregnancy and at birth are detected early and adequately dealt with.

Second, there has been no improvement in the percentage of pregnant women attending the required four or more antenatal care visits with any care provider since 2010. Coverage, in fact, dropped to 65 per cent in 2014 on average compared to 67 per cent in 2010. It remains below 80 per cent in all regions, including Bissau. Most worryingly, in Bafata and Biombo, it declined by 20-25 percentage points to 54 and 51 per cent respectively. By contrast, in Oio, coverage increased by 20 percentage points from 45 to 65 per cent. These regional variations in attendance are not easily explained using available evidence and would require further in-depth analysis.

Women in urban areas, especially those in the richest quintile and/or who have completed higher education, are much more likely to have made the recommended four antenatal visits than their peers in rural areas and the poorest families.

Figure 16: Women attending at least four antenatal care visits, 2010 and 2014 (in percentages)



Source: INE (2015b).

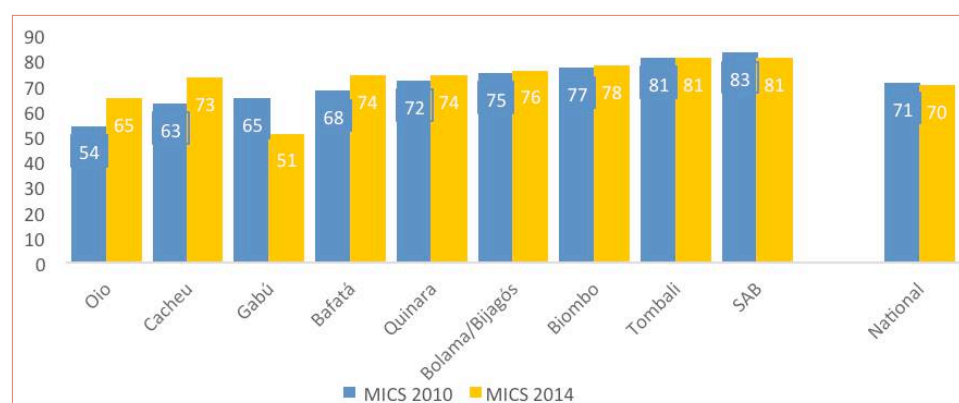
MALARIA VACCINATION

Only 19 per cent of pregnant women receive Malaria prevention treatment (they are entitled to three doses per pregnancy). This is a major lost opportunity for the country. For more on Malaria, see *Prevention of Malaria* below.

TETANUS VACCINATION

National immunization coverage of pregnant women against Tetanus was only 70 per cent in 2014, with slow progress since 2006 (68 per cent in 2006, 71 per cent in 2010). Coverage rates are lowest in Oio (64 per cent) and Gabu (51 per cent) (INE, 2015b). There are significant differences in Tetanus immunization coverage between urban and rural areas (78 and 68 per cent respectively). Despite this, there has been no reported case of neonatal tetanus since 2012. However, in order to eliminate congenital tetanus, further efforts will be required to increase and sustain higher Tetanus immunization rates among pregnant women.

Figure 17: Immunization of pregnant women against tetanus, 2010 and 2014 (in percentages)



Source: INE (2010 and 2015b).

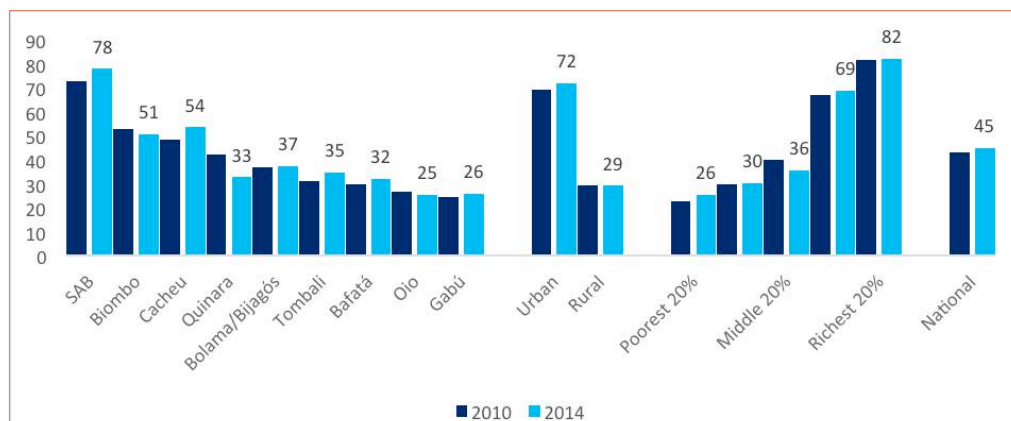
SKILLED BIRTH ATTENDANCE

Progress concerning women having access to skilled birth attendance at delivery has considerably slowed, irrespective of place of residence. Less than half of all women (45 per cent) deliver their babies with the assistance of skilled birth attendants. This is below the average for Sub-Saharan Africa (56 per cent in 2010), and means that Guinea-Bissau has not reached its MDG target of 81 per cent (United Nations, 2015).

Low rates of skilled attendance at birth are a factor behind the persistently high levels of maternal deaths highlighted earlier. Indeed, recent evidence has shown that in Guinea-Bissau, 57 per cent of maternal deaths occur at home (Mané *et al.*, 2014) and that half of women who face complications during delivery at home arrive too late at hospital (Ministry of Public Health, 2012a).

There are large differences in skilled birth attendance between rural and urban areas. Women who deliver in urban settings (72 per cent) are nearly three times more likely to be assisted by any type of professional personnel than those in rural areas (29 per cent). Only 3 per cent of rural women receive assistance at birth from doctors due to a major shortage of qualified health professionals across the country. Traditional birth attendants are still involved in 13 per cent of deliveries in rural areas. In urban and rural areas, 3 and 6 per cent of women respectively still report delivering without any assistance. The rates are particularly low for Gabú and Oio where women rely mostly on friends and family. More than most regions, Tombali and Bolama/Bijagós rely to a significant extent on traditional midwives (INE, 2015b). Increasing access to skilled birth attendance is of paramount importance for reducing maternal and neonatal deaths in Guinea-Bissau.

Figure 18: Births attended by qualified professional personnel, 2010 and 2014 (in percentages)



Source: INE (2010 and 2015b).

COMMUNITY-BASED INTERVENTIONS

Family practices and health interventions typically delivered through community-based care or outreach, such as family planning and breastfeeding promotion, have low coverage rates. Contraceptive prevalence remains low at 14 per cent; and only 53 per cent of infants less than six months of age are exclusively breastfed.

CHILDREN'S VACCINATION

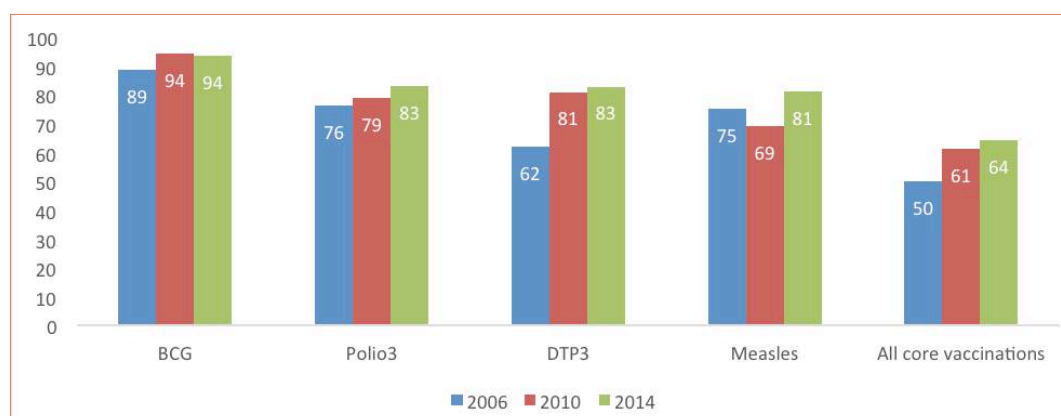
The four core vaccines are BCG (which protects against Tuberculosis), DTP (against Diphtheria, Tetanus and Pertussis), Polio, and Measles. Immunization for all children is far from achieved. Only 37 per cent of children under one year of age are fully vaccinated. 90 per cent coverage rate for BCG has been reported in MICS 2014.

The coverage of the four vaccines has increased steadily since their introduction. Guinea-Bissau has been Polio free since 2009, and reported incidence of Measles is close to zero. Health days and national vaccination campaigns, especially those focussing on the hardest-to-reach, have contributed to this positive trend. During these campaigns a coverage rate of 95 per cent was achieved. With no difference between boys and girls, today all vaccines have coverage of more than 80 per cent, except DTP3, which only reaches 76 per cent. However, a larger proportion of children may not be fully immunised, as different children may have missed different vaccines (INE, 2015b; Aaby, 2015). DTP3 vaccination coverage requires three visits to a healthcare facility and is therefore considered a good proxy for healthcare coverage in general (UNICEF, 2015b).

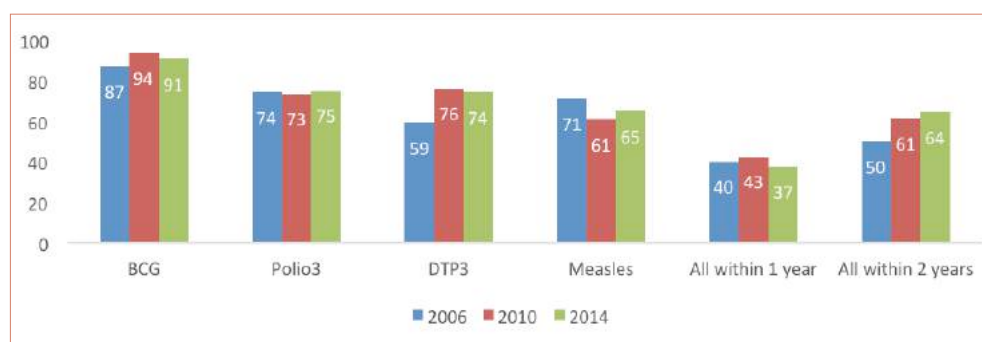
Progress has slowed in the past four years. National coverage for all four core vaccinations was 64 per cent in 2014. At 56 per cent, vaccine coverage among the poorest quintile was 20 percentage points lower than for the richest (76 per cent). Regional disparities are not very deep. Most regions have coverage rates close to the national average. Nevertheless, two regions stand out: Cacheu (88 per cent) and Bafatá (46 per cent). Further research would be required to determine the reasons.

Only 37 per cent of all children are fully vaccinated in the first 12 months, down from 43 per cent in 2010 (INE, 2015b). Nine out of ten children who are immunised receive most vaccinations within the first year. However Measles vaccine only has 70 per cent coverage after one year. Generally, an increasing proportion of children only complete their doses in the second year. This downward trend can be observed for all vaccines except Polio 3. Recent research confirms these trends, showing an increase in the median age at which children received their Measles vaccination (Aaby, 2015).

Figure 19: Immunization coverage for the four core vaccines (under two years of age) 2006-2014 (in percentages)



Source: INE (2006, 2010 and 2015b).

Figure 20: Immunization during the first year, 2006-2014 (in percentages)

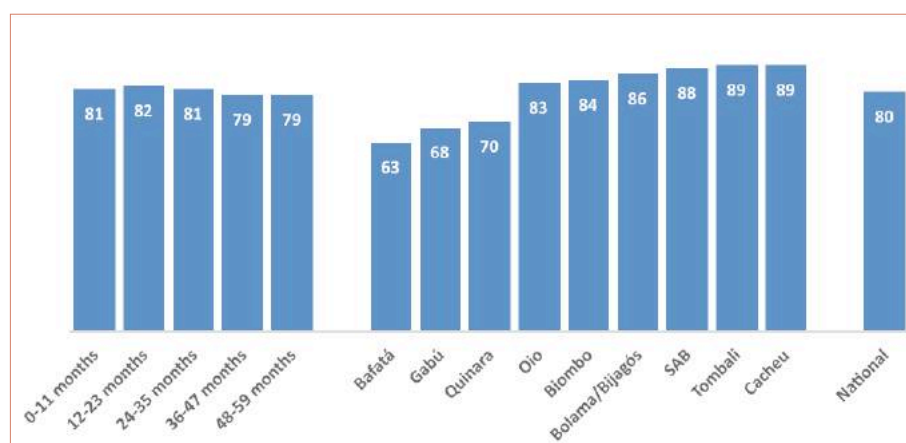
Source: INE (2006, 2010 and 2015b).

PREVENTION OF MALARIA

Malaria is a significant burden to families and the health system. In 2012 Malaria prevalence was 8 per cent in the general population and 9 per cent in children under five years of age. Gabú recorded Malaria prevalence of 12 per cent for the general population and 17 per cent for children under five. Cacheu reported the lowest prevalence with Malaria affecting 2 per cent of the population (INASA, 2013).

The latest INASA evaluation, despite a very low sample size, showed that more than a third of all deaths over a period of nearly three years (2010-2012) were due to Malaria (INASA, 2013). At the same time, 2014 Ministry of Health data reveal that for more than ten years the number of deaths has been on a steady decline. In fact, while the speed of reduction has diminished since 2007, the total recorded deaths in 2012 were around a third of those in 2003. While this trend is encouraging, more needs to be done to reduce the burden of Malaria.

Access to insecticide-treated bed nets is nearly universal following a massive distribution campaign in 2011 and a replacement campaign in 2014. The campaign had a major impact on the poorest households, and poor children and families are more likely to sleep under treated nets than the average Bissau-Guinean. A total of 83 per cent of all MICS respondents in 2014 reported sleeping under a bed net the night before the survey. Although baseline data are not available for 1990, Guinea-Bissau is either close to or has reached the MDG target, due to near universal coverage and use of bed nets.

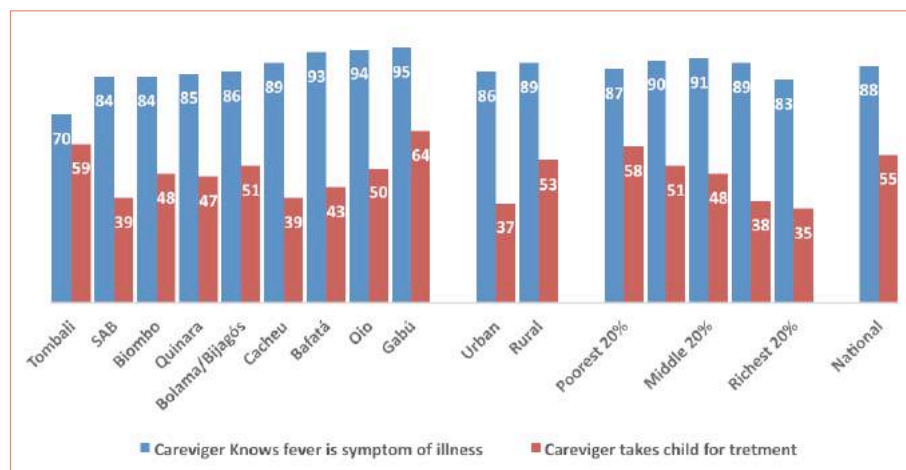
Figure 21: Children under five years sleeping under a treated bed net, 2014 (in percentages)

Source: INE (2015b).

CARE-SEEKING IN CASE OF FEVER

Fever is recognised as an important symptom of illness. Except for Tombali, in every region of the country 84 per cent or more of all women know that they should take their children to the nearest health facility if s/he has fever. However, in spite of the high level of awareness, seeking treatment in case of fever is not common among all the population (INE, 2015b). Families across the country often resort to non-formal ways of treating fever through homemade medicines or by going to traditional healers.

Figure 22: Knowledge and practice of mothers with regard to fever, 2014 (in percentages)



Source: INE (2015b).

ACCESS TO ANTIMALARIAL TREATMENT

Most children who are treated for fever receive paracetamol or another painkiller rather than appropriate anti-malarial treatment. Antimalarial drugs, which are prescribed by national protocol in case of fever, are provided in around 13 per cent of all suspected cases. An even lower proportion is treated the same day or the day after. Access to anti-malarial treatment for children is highest in Oio where 40 per cent of children treated for fever receive antimalarial drugs and about 20 per cent get a combined treatment. It is also higher in rural areas than urban areas.

Most drugs are obtained from public facilities, following scaling up of large scale community health interventions. However, in Bolama/Bijagós a significant proportion (30 per cent) of people get their medication from neither a private nor a public health care facility (INE, 2015b). One explanation for this high share could be that people in the islands make much use of the services of traditional healers and procure their medicines from street vendors. Procurement of medication from unauthorised sales points raises concerns, as this medication may be of sub-standard quality, while Malaria treatment by traditional healers may be of limited effectiveness. As all Malaria treatment has been free of charge since May 2015, continued widespread traditional practices around treatment indicate an urgent need to complement activities aimed at increasing access to antimalarial treatment with behaviour change communication to increase the uptake of effective interventions.

Access to antimalarial treatment for any kind for children has dropped dramatically since 2010, and girls have been more affected by this trend than boys. In 2014, girls were significantly less likely to be prescribed any kind of antimalarial drugs than boys. Access to anti-malarial treatment fell in all regions, to a half or even a sixth of their level in 2010. Gabú and Bafatá, which were outperformers in 2010, now are far behind the national level of antimalarial treatment (INE, 2015b). There is no documented evidence on the reasons behind this drop, but it may be because of a contraction in activities to promote access to treatment and to ensure continuity of supply.

While access to antimalarial treatment for children has decreased, the opposite is the case for women. The proportion of women who received at least one preventive antimalarial treatment during pregnancy increased from 20 per cent in 2010 to 70 per cent in 2014. However, while some of those women also receive a second treatment, only 19 per cent receive the third treatment authorised in national protocols. Given that 65 per cent of women attend four antenatal care visits, this is another missed opportunity in the continuum of care, and Malaria prevention services could be better integrated into antenatal care.

3.1.3 The nutrition of children and pregnant women

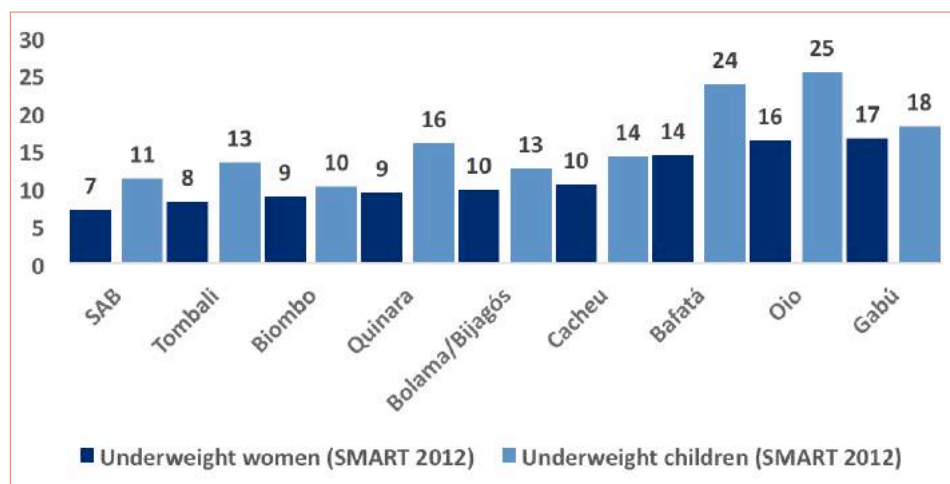
MALNOURISHED PREGNANT WOMEN

As indicated above, the right nutrition during the 1,000 days from the beginning of pregnancy to a child's second birthday can have a profound impact on a child's ability to grow, learn, and rise out of poverty. The flip side of this is a vicious cycle of undernutrition in which stunted girls grow into short statured women, who then become mothers of stunted children. To stop this vicious cycle, it is important to address malnutrition before a child's conception. These factors are particularly important in Guinea-Bissau given high levels of malnutrition among women, inclusive of micronutrient deficiencies, under nutrition and over nutrition.

The latest data on micronutrient deficiency from 2005 (WHO), indicate that as many as 58 per cent of pregnant women suffered from iron deficiency. Given continued high levels of poverty across the country, it is likely that nutrient deficiencies, including anaemia, also remain high. Anaemia increases the risks of post-partum complications, notably haemorrhage, which contributes to one in four maternal deaths.

According to the 2012 National Nutrition Survey (SMART), 11 per cent of women of reproductive age are underweight. Prevalence of underweight among women varies considerably across the country. It is highest in Gabu (16.5 per cent), Oio (16.3 per cent), and Bafata (14.3 per cent) and lowest in Bissau (7.1 per cent) and Tombali (8.1 per cent). Comparing the prevalence of underweight among women and young children using 2012 SMART data shows that the regions with the highest incidence of underweight among women (14-17 per cent in Bafata, Oio and Gabu) also have the highest prevalence of underweight among children (18-25 per cent). Meanwhile, MICS 2014 shows that overweight and obesity are increasingly prevalent among women as a result of poor dietary diversity and unfavourable eating habits.

Figure 23: Proportion of women aged 15-49 and children underweight, 2012 (in percentages)



Source: Ministry of Public Health (2013a)

Note: Data on underweight for women and children are from SMART 2012

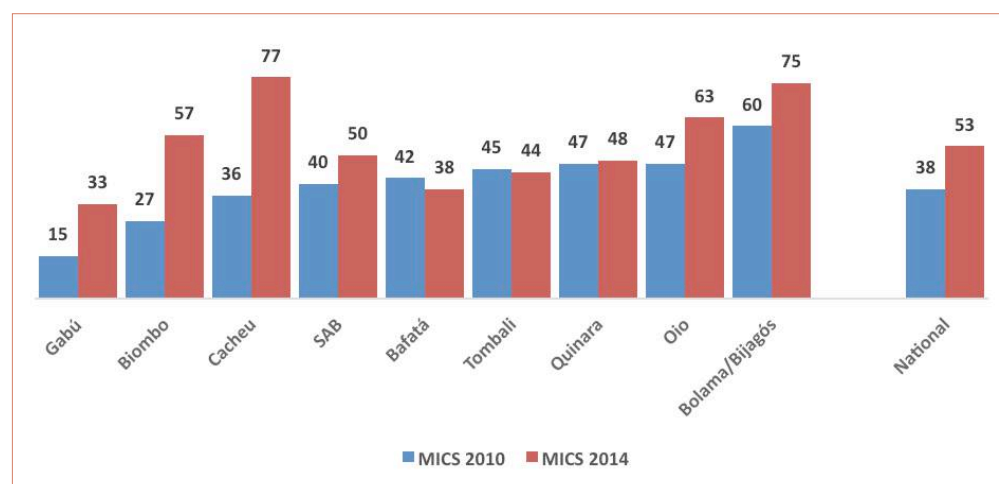
Nutrition outcomes of children are impacted if the mother is an adolescent. Adolescent fertility is three times higher in low middle income countries than in high income countries. Pregnancies in adolescents have a higher risk of complications and mortality in mothers and children and poorer birth outcomes than pregnancies in older women. Furthermore, pregnancy in adolescence will slow and stunt a girl's growth (Black, RE et al 2013). This is particularly relevant to Guinea-Bissau as 37.1 per cent of women 20 – 49 were married before age 18 and 28.3 per cent of women 20 – 24 had at least one live birth before the age of 18. In efforts to address the first 1,000 days adolescents must be included in the interventions.

EARLY AND EXCLUSIVE BREASTFEEDING

In 2014, only 33.7 per cent of children were breastfed within one hour of delivery. Early initiation of breastfeeding is linked to the low percentage of women receiving skilled delivery at birth (only 45 per cent nationally). This is partly the result of a widespread belief that colostrum is not good for the new born and that water and other liquids need to be introduced before six months of age. Women are thus not informed about the value of early breastfeeding, including for preventing life-threatening infant diseases such as Diarrhoea. Most children are thus deprived of this natural immunity transmitted by their mothers and are therefore more vulnerable to life-threatening diseases.

Exclusive breastfeeding rates have been rising steadily from 27.9 per cent in 2006 to 52.5 per cent in 2014, a 24.6 percentage point increase. Yet, today, little more than half of all mothers breastfeed exclusively for the first six months of the child's life (INE, 2015b). Low levels of exclusive breastfeeding continue to be found in Bafata (38 per cent), Gabu (33 per cent), and Tombali (44 per cent). These regions also have the highest prevalence of severe acute malnutrition among young children (6 to 8 per cent, i.e. higher than internationally-acceptable levels). Meanwhile, Cacheu, Biombo and Oio saw a large increase in exclusive breastfeeding between 2010 and 2014, with rates doubling in that period (INE, 2015b).¹⁴

Figure 24: Exclusive breastfeeding during first six months, 2010-2014 (in percentages)



Source: INE (2010 and 2015b).

¹⁴ The 2012 nutritional survey, which used a different methodology, found even higher breast feeding rates across the board; a 67 per cent national average and all regions above 60 per cent, except for Bafatá (which also scored the lowest, with Cacheu, in the MICS) (Ministry of Public Health, 2013a).

DIVERSIFICATION OF INFANT FEEDING

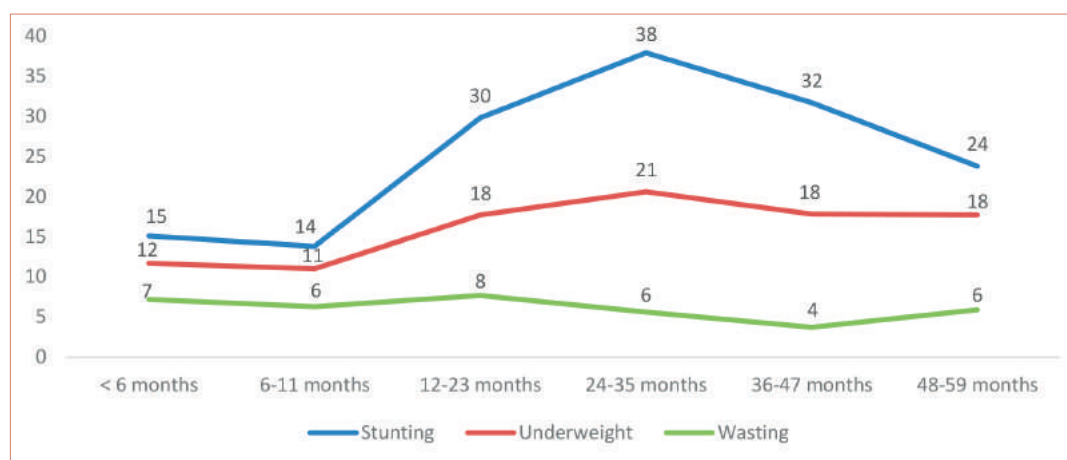
On reaching the age of six months, a child needs more food and nutrients to develop physically and cognitively. Children 6 – 23 months are at particular risk of malnutrition due to a shift from exclusive breastfeeding to introduction of complementary foods, which are often poor in quality and inadequate in quantity in addition to being less hygienic. Children 6 – 23 months also have a higher prevalence of mortality and acute malnutrition than older children and are the most vulnerable to stunting.¹⁵

MICS 2014 data show that only 12.7 per cent of children 6 – 23 months have access to diversified food (measured by minimum dietary diversity as a daily diet made up of four or more different food groups). Even among the richest households, less than 20 per cent of children receive a minimally diversified diet. Majority of children receive a daily diet composed largely of rice, and not much else.¹⁶ This is true across all regions except Tombali (34.1 per cent), which is a region rich in forest and other natural resources. A Bissau-Guinean proverb says: “*A criança está bonita, come arroz*” (The child is looking good because it eats rice). Only one in twelve children, including those below the age of one, consume diverse meals frequently enough to meet minimum standards as measured by the indicator on minimum meal frequency. Other food crops such as cassava, vegetables, fruits, meat, are produced for sale and not widely consumed by the household or child.

STUNTING

Children who reach the end of the first 1000 days of life, may have accumulated deprivations from maternal undernutrition during pregnancy, from low early and exclusive breastfeeding rates, undiversified diets, and/or from exposure to diarrhoeal diseases amongst other morbidities. As a consequence, high levels of child undernutrition, particularly chronic malnutrition persist among young children. In 2014, almost one in three children (27 per cent) were stunted, compared to 32 per cent in 2010. Chronic malnutrition is highest at the age of three, which is also the moment when damage done to the brain in the past will be irreversible. This means that chronic undernutrition not only contributes to child mortality, it can also have negative effects on cognitive development in early childhood.

Figure 25: Child undernutrition by age, 2014 (in percentages)



Source: INE (2015b)

¹⁵ Preventing moderate acute malnutrition through nutrition sensitive interventions (2014).CMAM Forum

¹⁶ During focus group discussions, children were asked what their preferred meal would look like. Frequently, they would start with rice, even though they were told they could ask for anything they wanted.

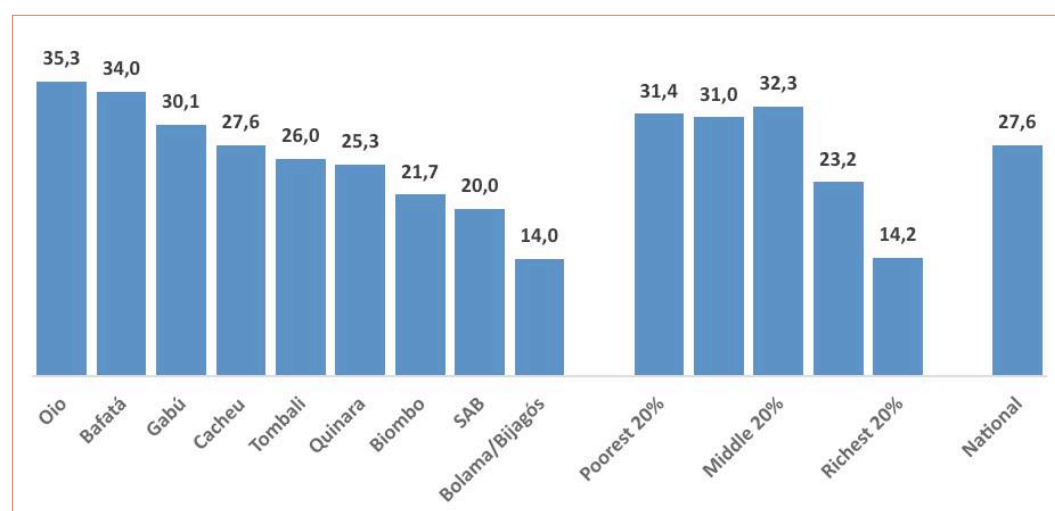
Stunting is a marker of poverty and cumulative deprivations throughout the early years of life. Malnutrition in infants and young children is a result of multiple deprivations including nutritional status of the mother, infant and young child feeding practices, quality of health care, hygiene practices, and quality of water and sanitation infrastructure. In order to appropriately address chronic malnutrition it is imperative to include measures to manage acute malnutrition also.

There are significant regional differences in stunting rates. Stunting is highest in Oio, Bafata and Gabu at 30-35 per cent, while even in Bissau 20 per cent of children are stunted. Significant disparities are found across income quintiles. Children living in poor and middle-income households are twice as likely to be stunted as children living in the richest households.

Furthermore, limited education opportunities for women manifest in the nutrition outcomes of their children. Stunting and wasting are inversely correlated with mother's level of education. Children of mother's with no education have a stunting prevalence of 30.8 per cent, which is higher than the national average. Those with mothers with primary, secondary, and technical levels of education have stunting prevalence of 26.6 per cent, 18.2 per cent, and 10.9 per cent, respectively. This is a significant difference and illustrates the linkages between education and nutrition.

Chronic undernutrition in early childhood diminishes individuals' capabilities for the rest of their lives. It has negative consequences on school participation, learning achievement and, later in life, adult productivity.

Figure 26: Child stunting by region, 2014 (in percentages)



Source: INE (2015b). Note: the data for Bolama/Bijagos are not statistically representative and are only presented here for illustrative purposes.

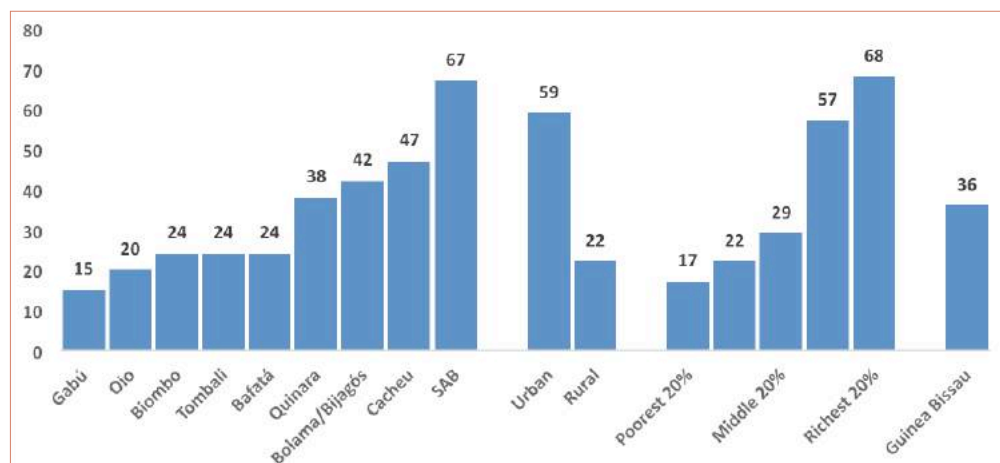
3.1.4 HIV and AIDS among pregnant women and infants

The vast majority of infants living with HIV contract the virus from their mothers either during pregnancy, delivery or breastfeeding. HIV in women and children is also interrelated with other health conditions, such as malnutrition. HIV and malnutrition are inextricably connected. Malnutrition accelerates

progression of HIV infection, while HIV infection exacerbates malnutrition by weakening the immune system and impacting nutrient intake, absorption, and utilisation.

An estimated 6,100 children under 15 are living with HIV in Guinea-Bissau (UNAIDS, 2014). At 5.3 per cent, HIV prevalence in the reproductive age population is among the highest in West Africa. A national surveillance study of pregnant women attending antenatal care revealed an average 5 per cent HIV prevalence among pregnant women, ranging considerably across regions from 1 to 8 per cent (Ministry of Public Health, 2014c). HIV testing is fully integrated into antenatal care, and in 2014, around 90 per cent of women were tested for HIV during pregnancy. Antenatal testing reveals around 2000 HIV positive pregnancies per year. Only 56 per cent of pregnant women were enrolled in antiretroviral therapy to prevent HIV transmission from mother to child (National AIDS Programme, 2014). Frequent interruptions of supplies of HIV tests are the major barrier to uptake of testing, and the data suggest that when women are routinely offered HIV tests and properly counselled, HIV testing acceptance rates are almost universal.

Figure 27: Pregnant women successfully offered an HIV test and who received the results during antenatal care, 2014 (in percentages)



Source: INE (2015b).

Low enrolment in antiretroviral therapy, and low retention and adherence to regimens means that children born to mothers living with HIV can contract HIV during pregnancy, delivery and breastfeeding. Without treatment, two thirds are likely to die before their second birthdays. AIDS-related deaths are preventable and children born to mothers living with HIV should be diagnosed as soon as possible and enrolled in antiretroviral therapy. Early diagnosis of HIV-exposed infants only started recently, and in 2014 only a quarter of HIV-exposed infants were tested for HIV before two months of age (National AIDS Programme, 2014).

Children living with HIV are likely to develop some AIDS-related symptoms, but due to an absence in routine HIV diagnosing procedures they are unlikely to be diagnosed in time. Recent introduction of routine HIV testing in UNICEF supported pilot malnutrition management sites revealed that up to 30 per cent of children undergoing malnutrition treatment are living with HIV. Low diagnostic capacity, along with generally low access to treatment for children (only 10 out of 40 antiretroviral therapy sites provide antiretroviral therapy for children), are among the reasons why coverage for children does not exceed 8 per cent. Apart from limited peer support programmes, no systematic and coordinated ac-

tion is in place to promote treatment enrolment, retention and adherence. Antiretroviral therapy sites are underfunded, and the existing health infrastructure and lack of trained staff does not allow for provision of quality care for children and mothers. No social support schemes are available to provide incentives for members of families affected with HIV who provide critical care for their children and other members living with HIV (National AIDS Programme, 2014).

A total of 21,000 children have lost one or both parents to AIDS-related illness. This places them in an extremely precarious situation, especially when they themselves are also living with HIV (National AIDS Programme, 2014).

3.2 The physical environment of the child – a threat to child health

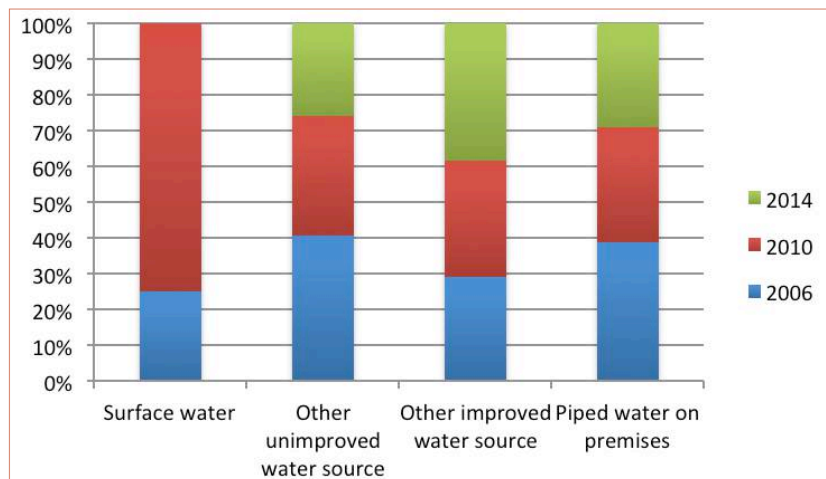
Poor water, sanitation and hygiene coupled with poor hygiene practices, is a major health hazard that impacts the lives of children and causes multiple deaths due to severe diarrhoea. In addition, it has now been established that poor sanitation, especially open defecation, is an important contributing factor to chronic undernutrition (Chambers and von Medeazza, 2014). Without piped water in the home, women are forced to spend large parts of their day fetching water: time they cannot use to care for their children or to make economic contributions to their families. The absence of private and decent sanitation facilities also endangers children's, particularly girls', right to education, as they may decide or be forced to stay at home rather than attend classes.

3.2.1 Access to improved water sources has increased but large gaps and inequities remain

Guinea-Bissau has reached its national MDG water target for the proportion of the population with sustainable access to an improved water source. The target was 68 per cent, and currently 75 per cent of the population has access to improved water sources, above the average for Sub-Saharan Africa (64 per cent) (UNICEF, 2015b). The target for urban areas (73 per cent) was surpassed by a large margin (92 per cent in 2014). In rural areas however, the MDG target was not met: 61 per cent in 2014 against a target of 66 per cent for 2015.

There are significant regional and wealth disparities. Piped water in the home is practically only available to the richest quintile in the cities of Bissau and Gabú. In other regions, people rely more on standpipes and protected wells, with or without hand pumps. More than 50 per cent of the poorest quintile still depend on unprotected wells. While their situation has improved since 2010, this improvement was only half or less than the improvement of any other quintile except the richest, who already had near universal access to safe drinking water (INE, 2015b). This means that despite the laudable achievement of Guinea-Bissau reaching the national MDG target for water, important inequities still persist both amongst different socio-economic groups and between locations.

Most of the improvement in water sources has come from boreholes and protected wells rather than water being piped directly to the household (which has in fact decreased slightly). The use of surface water has practically decreased to nil.

Figure 28: Drinking water sources, 2006-2014 (in percentages)

Source: INE (2006, 2010 and 2015b)

Note: Access to piped water from neighbours is not included in the category of piped water on premises. Bottled water is considered unimproved. Surface water includes water from a river, canal or lake. The main difference between “other improved” and “other unimproved” is the level of protection of the water source.

Cloth is mainly used for filtering water, with less than 1 per cent of the population boiling water and only 12 per cent using chlorine to make it potable.¹⁷ Even though the absolute share of households using chlorination is persistently low, it has nearly doubled every four years since 2006 (from 4 per cent in 2006 to 7 per cent in 2010 to 12 per cent in 2014). Currently, in Bolama/Bijagós and Bissau, only one in four households treat their drinking water properly. Interestingly, the richest 20 per cent of the population primarily uses the same methods as other Bissau-Guineans, with the exception that they can afford to use chlorine tablets more than the others. This general practice of inappropriate water treatment has changed little over the years.

For those families who do not have water installations in their home, almost always females older than 15 years fetch water. According to the MICS 2014, some younger girls are made to fetch water for the household, but boys are completely exempted from the task.

3.2.2 Low access to improved sanitation is a major concern

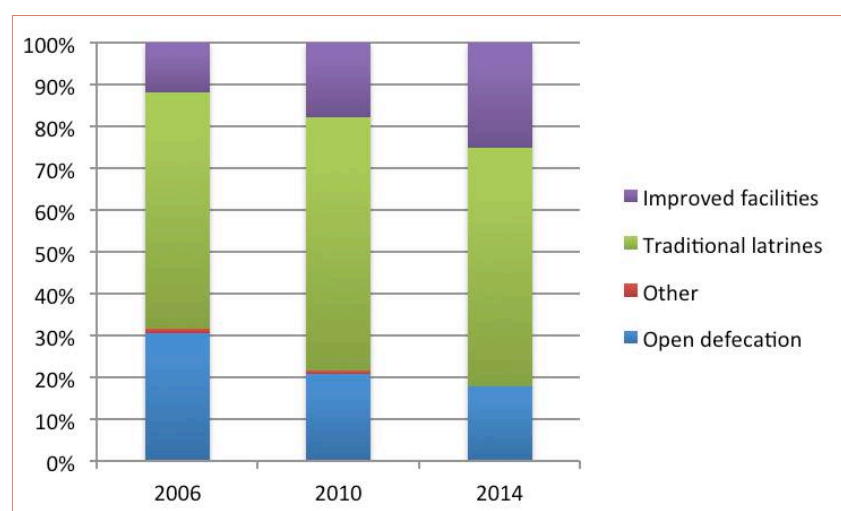
Guinea-Bissau will not achieve the MDG target for access to improved sanitation. Using an estimated 1990 baseline (United Nations, 2015), the national MDG target for improved sanitation is 55 per cent (63 per cent for urban areas and 52 per cent) for rural areas. The current rates (25 per cent nationally, 51 per cent in urban areas and only 5 per cent in rural areas) mean that Guinea-Bissau is far from reaching these targets. Nonetheless, continued progress has been made in improving sanitation during the last decade, and Guinea-Bissau is in a better position than the average Sub-Saharan African country (19 per cent) (UNICEF, 2015b).

In Bissau, about 60 per cent of households have their bathroom or latrine connected to a septic tank. In all other regions, this proportion does not exceed 5-8 per cent. Currently 57 per cent of households

¹⁷ Safe storage is also essential to ensure consumption of safe drinking water. Safe storage means that water is fetched, transported and stored with clean hands, without touching the water, in a clean container, stored with a lid, placed at a height (not on the ground) out of reach of animals/children, and served with a handle-bar cup.

depend on traditional latrines (which are considered to be unimproved sanitation). The use of latrines is lowest among the poorest 20 per cent of households, two-thirds of whom defecate in the open.

Figure 29: Use of sanitation facilities, 2006-2014 (in percentages)



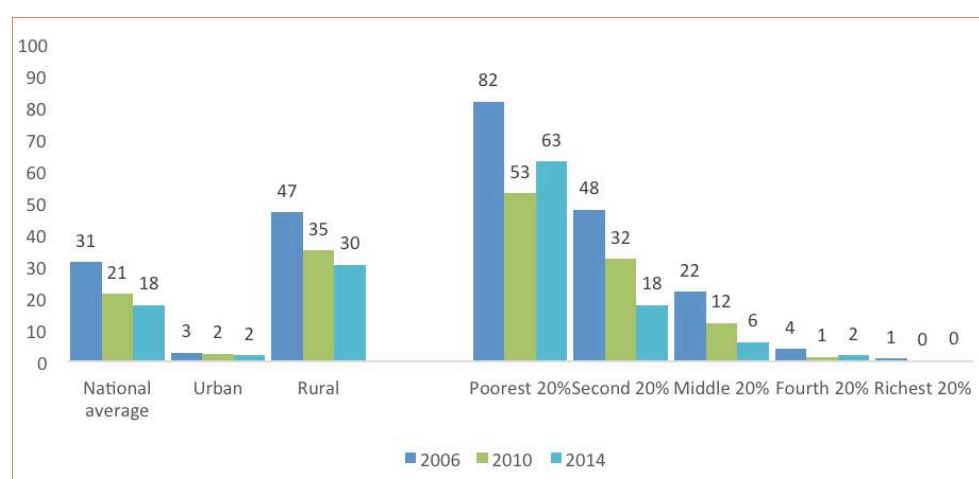
Source: INE (2006, 2010 and 2015b).

Note: An improved sanitation facility is defined by the WHO-UNICEF Joint Monitoring Group as one that hygienically separates human excreta from human contact. Traditional latrines are not part of its definition for improved sanitation.

3.2.3 Open defecation is still widespread and handwashing with soap is rare

According to MICS surveys, open defecation still occurs in rural areas and is practiced by most households in the poorest quintile, although it is steadily declining. Prevalence of open defecation declined from 31 per cent in 2006 to 18 per cent in 2014. This is below the average for Sub-Saharan Africa (25 per cent in 2012) and close to the global average of 14 per cent. Due to the lack of appropriate sanitation facilities, progress in eliminating open defecation has been slowest among the poorest quintile of households, two-thirds of whom (63 per cent) continue to defecate in the open. The overall reduction is mainly due to the major decline in open defecation among populations in the third and fourth income quintiles.

Figure 30: Open defecation, 2006-2014 (in percentages)



Source: INE (2006, 2010 and 2015b).

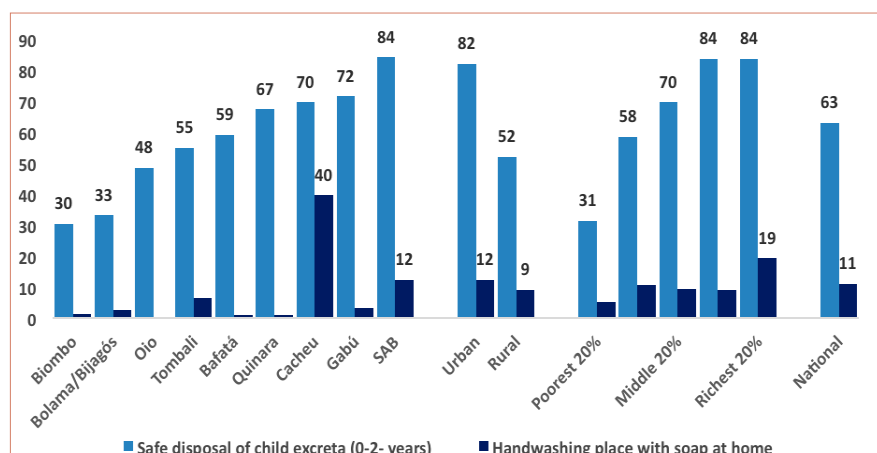
Sub-optimal use of latrines partly results from traditional concepts of hygiene. It is believed that to be hygienic people should not always defecate at the same place to avoid coming in contact with faeces and risk of contracting disease and they should therefore avoid latrines. Together with the geophysical conditions of Guinea-Bissau and weakened immunity among those that live in precarious conditions, these beliefs have been a factor behind frequent Cholera outbreaks (Ministry of Public Health, 2009).

Despite traditional beliefs, the people in Guinea-Bissau are very open to changing their behaviour when a comprehensive approach to promote sanitation is in place. Reducing open defecation in Guinea-Bissau has been largely due to the scaling-up of the Community-Led Total Sanitation (CLTS) approach, which combines community dialogue triggering collective behaviour change and includes supportive mechanisms such as technical follow-up, public certification and declaration of communities having reached Open Defecation Free status. In recent years, around 800 communities have been declared Open Defecation Free and the country by the end of 2015, over 1000 communities are expected to be certified as Open Defecation Free. Most people in Guinea-Bissau safely dispose of their small children's faeces (0-2 years). The exception are families that defecate in the open, who as stated above, are primarily in the poorest quintile of the population. Only 31 per cent of families in the poorest quintile dispose of their young children's faeces safely.

According to the MICS 2014 it was rare to have a dedicated place for handwashing with soap within the home across all households (11 per cent nationally), except in Cacheu (40 per cent). Even among the richest quintile of Bissau-Guinean households, soap was available for hand washing for less than 20 per cent; while for the poorest quintile the figure was 5 per cent, less than half the national average (INE, 2015b). In general, washing hands with soap is not a common practice in Guinea-Bissau. The soap is mainly used to wash the body, clothes and dishes (Ministry of Public Health, 2009).

High rates of open defecation and low rates of handwashing with soap are conducive to Cholera outbreaks. Nearly three decades after the first internationally notified Cholera epidemic in 1986, the disease remains a public health problem, although considerable progress has been made over the last 10 years. The numbers of cases and casualties have gone down dramatically from 26,967 cases and 961 deaths in 1996 to 470 cases and 30 deaths in 2013. In 2014, only two deaths and around a dozen cases were reported (National Epidemiological Service data). This was partially because of accelerated work to improve water quality (new boreholes, water systems treatment, supply of chlorine and other commodities, extensive hygiene and hand washing with soap promotion, scaling up of community mobilization, and scale up of effective approaches to improve sanitation).

Figure 31: Hygiene practices, 2014 (in percentages)



Source: INE (2015b).

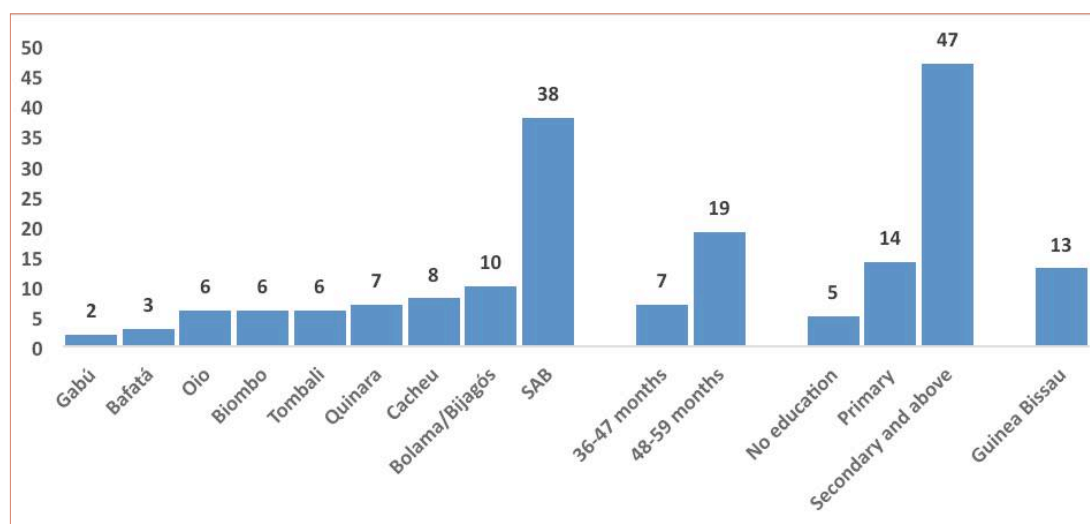
In conclusion, while Guinea-Bissau has met its MDG target for drinking water, progress around sanitation and hygiene, especially elimination of open defecation and adoption of handwashing with soap, needs to be accelerated. Lack of improved sanitation facilities and poor hygiene practices worsen child morbidity and mortality rates across the country. Global evidence has proven that improvements in use of water, sanitation and hygiene facilities and services can significantly reduce incidence of diarrhoea and pneumonia.

3.3 Early Development and Care of the Child

The first five years of a child's life include critical moments when physical health, mental alertness, emotional development, social competence and readiness to learn are taking shape. Events (negative or positive) experienced by a child during early years have a direct and lasting impact on brain architecture, and in turn will affect how the child develops learning skills as well as social and emotional abilities in later life. In the early years children also learn more quickly than at any other time of life. It has been shown that love, nurturing and mental stimulation help the child develop a sense of trust and security that improves self-confidence as the years pass.

In 2014, 13 per cent of boys and girls attended an early childhood education programme. However, in Bissau, the percentage of three to five year old children attending such programmes is much higher (at 38 per cent) than in all other regions (from 2 per cent in Gabu to 10 per cent in Bolama / Bijagos). Educated mothers are nine times more likely to send their children to a pre-school programme (47 per cent) than mothers with no education (5 per cent) (INE, 2015b).

Figure 32: Pre-school attendance, 2014 (in percentages) 3-5 years old



Source: INE (2015b).

3.3.1 Children's Readiness for School (5-6 years old)

Studies have shown that early childhood education leads to higher levels of primary school enrolment and educational performance. Children's readiness for school helps them make a smooth transition from home and pre-school to primary school. This then positively affects employment opportunities later in life. A recent learning assessment in Guinea-Bissau also showed they are likely to do better in Portuguese language both in Grade 2 and Grade 5 (Government at all, 2015).

The proportion of five and six year old children in first grade of primary school who attended a year of pre-school increased from 10 per cent to 31 per cent between 2006 and 2010, and remained stable at 29 per cent in 2014. Children from the poorest quintile of households saw the greatest progress, from 4 per cent in 2006 to 29 per cent in 2014. In contrast, children in the fourth wealth quintile registered a steep decrease in pre-school attendance from 43 per cent in 2010 to 26 per cent in 2014. These trends are reflected in the strong decline observed in urban areas compared to rural areas.

There are three types of early childhood education programme in the country. Community or NGO-led early learning programmes are more likely to be found in rural areas. Children living in urban or peri-urban areas are more likely to attend public pre-school programmes. The richest among them are most likely to attend private sector programmes. In the past few years, there has been a steady deterioration of state education for urban residents. By contrast, those living in rural, marginalised areas where Government services were largely non-existent have benefited from NGO-led services, with communities taking the lead in filling gaps in social service provision.

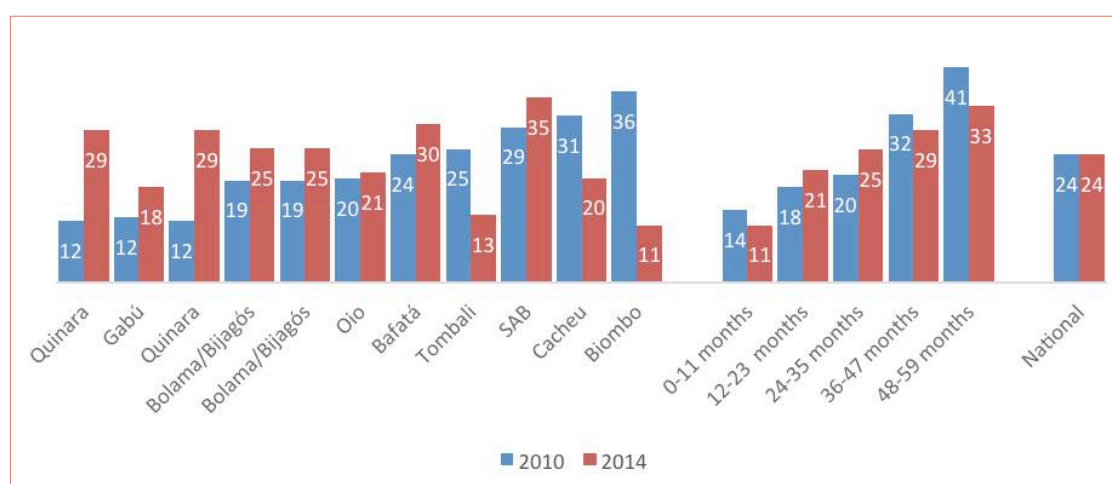
The significant increase in children attending pre-schools is mainly a result of private and religious initiatives. The proportion of children attending community-led pre-schools now stands at 32 per cent, compared to 21 per cent in 2010. Meanwhile, the Government is also making efforts to improve school readiness. While there were no public pre-primary schools at all in 2000, their share grew from 16 per cent in 2005/06 to 22 per cent in 2012/13. In fact, between the academic years 2010/2011 and 2012/2013, the number of pre-primary schools of all types; community, private and public; virtually doubled. During the same period the total number of children attending pre-school grew from 10,264 to 19,267 (Government at all, 2015). Access, however, is constrained by relatively high costs. The fee for a public pre-school in Bissau is CFAfr 6,500 per month (about US\$11-12). In other regions it is significantly less, at CFAfr 500-1,000. Private kindergartens can charge CFAfr 10,000 to 50,000 per child per month.

3.3.2 Birth registration

Birth registration is central to ensuring that children are counted in vital statistics, and it facilitates access to basic services such as health, social protection and education. Knowing the age of a child will help to protect the children from labour, marriage, trafficking and sexual exploitation.

Guinea-Bissau has the eighth worst birth registration rate in the world (24 per cent). While most parents know how to register their children, still very few officially register them (boys and girls alike). A dramatic decline in birth registration was seen between 2006 and 2010 when the birth registration rate halved. In 2006, the country was at the level where the West and Central African sub-region is today (45 per cent), but now it stands at only at one-third of the global rate (about 65 per cent) (UNICEF, 2013d). This situation has not improved in recent years despite a national campaign in 2013.

Children are more likely to be registered as they grow older. Only 11 per cent of all children are registered within the first year of life. This rate doubles over the next three years, and by the time children reach the age of five, 33 per cent are registered. At regional level different trends can be observed. While Biombo, Tombali and Cacheu saw birth registration rates fall by 12 to 25 percentage points between 2010 and 2014, birth registration rates more than doubled in Quinara. Wealth is a significant determining factor. Even though only 43 per cent of children from the richest quintile of households are registered, they are four times more likely to be registered than children from the poorest quintile.

Figure 33: Children registered before the age of five, 2010 and 2014 (in percentages)

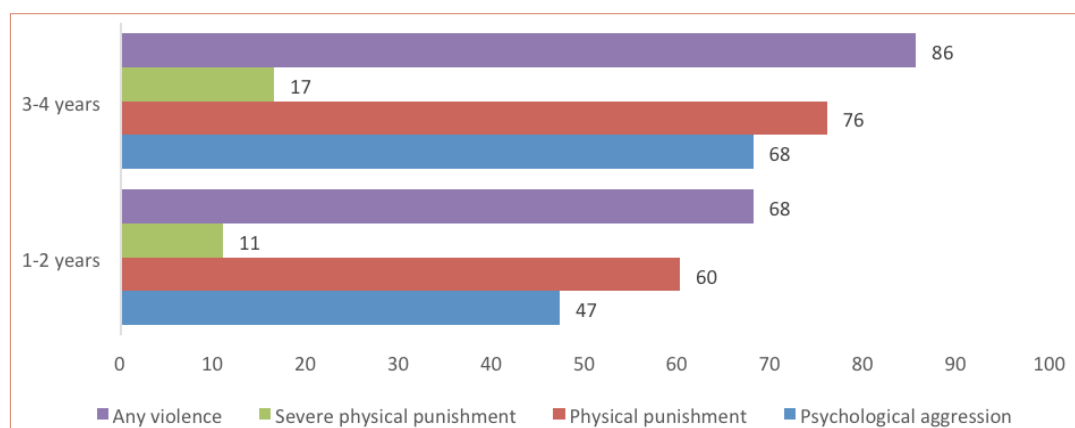
Source: INE (2010 and 2015b).

Although registration of a child's name and nationality is free of charge for children under seven years of age, this continues to depend on extensive campaigns organised by the civil registration services and large-scale advocacy to secure the support and engagement of partners. The quality of registration services, distance from service points, and the cost for parents to travel to register continue to be the major obstacles to increasing birth registration rates. Though most people know how to register a birth, many do not see the importance and benefits of birth registration. Focus group discussions conducted in Gabú in 2013 found that many people consider that girls who do not study (and do not yet have a birth certificate) do not actually need one, because when a girl gets married it will be the right and the duty of her husband to authorise her travel in any case (Afroteste, 2013).

The Ministry of Justice and its main partners involved in birth registration are working systemically, both centrally and at lower levels, to promote a number of initiatives to improve birth registration rates and strengthen the routine civil registration system. Despite the lack of funds and weakness of the system, important interventions are being supported. Strategic partnerships are being fostered between the Ministry of Justice and civil society organisations to increase awareness and promote community birth registration initiatives, targeting vulnerable families and communities with low rates of birth registration, namely refugee children, children living on the islands, children in regions where rates continue to be extremely low, but also children living in urban settings. In addition, institutional agreements have been put in place between the Ministries of Health and Education to implement joint interventions.

3.3.3 Violence at home

Virtually all girls and boys, including the very young, experience some form of violence at home, be it psychological or physical. Severe punishments are used slightly less against children aged 1-2, but by the time they turn 3-4 the figures become closer to the average for older children. While the various MICS rounds do not allow for easy comparison of trends over the years, it appears that the only reduction has been in severe physical punishment of children under five. However, between 11 and 17 per cent of toddlers continue to be disciplined using very severe measures such as beating with a wooden stick or belt.

Figure 34: Violence against children below 4 years, 2014 (in percentages)

Source: INE (2015b).

3.3.4 Female genital mutilation and cutting

In Guinea-Bissau, female genital mutilation and cutting (FGM/C) is practised at early age although young girls and adolescents between 10-14 years old continue to be the main group affected by the practice (43 per cent) showing that it is still associated to a transitional period when the girl reaches puberty and that the cultural ceremony to womanhood is still relevant for those communities who perform FGM/C. Currently, 16 per cent of all girls below five undergo the practice. It is believed that the introduction, in 2011, of Law 14 to 'Prevent, Fight and Suppress Female Genital Mutilation' has accelerated a trend where a girl undergoes the procedure long before she endures the rituals that lead her to womanhood (Alode, 2013). No data exists that allow for trend analysis of FGM/C prevalence for girls below five years. Overall, the situation of girls affected by FGM/C has improved in recent years with the proportion of women between 15 and 49 years that have a daughter who is excised going down from 39 per cent in 2010 to 30 per cent in 2014 and with the 13 per cent of women 15-49 years old supporting the practice (2014) against 34 per cent in 2010. FGM/C is practised across all regions irrespective of levels of education and wealth, with Gabu and Bafata with the highest rates, 96 and 87 per cent and Biombo and Cacheu within the regions with lower FGM/C cases, 5 and 16 per cent respectively (INE, 2015b).

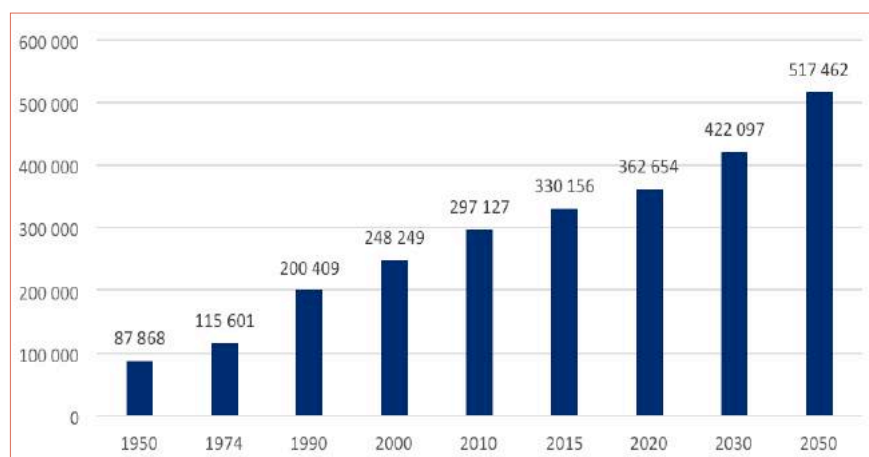




4. THE FORMATIVE YEARS (6-12 YEAR OLD CHILDREN)

Young children at this stage of their lives enter a period where formal education should become a major part of their daily experience. According to the Education Law of 2011, basic education in Guinea-Bissau spans the first nine years of schooling and is organised in three cycles. The first basic education cycle is Grades 1-4 (EB1), and the second cycle, Grades 5-6 (EB2). These first two cycles are free and compulsory, and constitute the full cycle of primary education. Grades 7-9 (EB3) complete the full basic education cycle. Secondary education consists of general secondary education from Grades 10-12 as well as various forms of technical and professional training.

Figure 35: Number of children aged 6-12 (1950-2050)



Source: UNDESA (2014).

Since Guinea-Bissau's independence, the cohort of primary school age children nearly tripled from 115,600 in 1974 to 330,000 in 2015. Today it makes up 18 per cent of the total population. Their number is projected to rise by an additional 30,000 by 2020, and to increase by a further 50 per cent to reach 517,000 by 2050 (UNDESA population statistics). Significant progress in school enrolment has been achieved since 2000 despite the challenges caused to the education system by rapid population growth. This progress has stalled in recent years. The education sector has also been adversely affected by frequent and prolonged teacher strikes (largely because of systematic arrears in pay) that have impeded the normal functioning of schools, reducing the number of teaching/learning hours and the quality of education provided.

4.1 Children's primary school journey

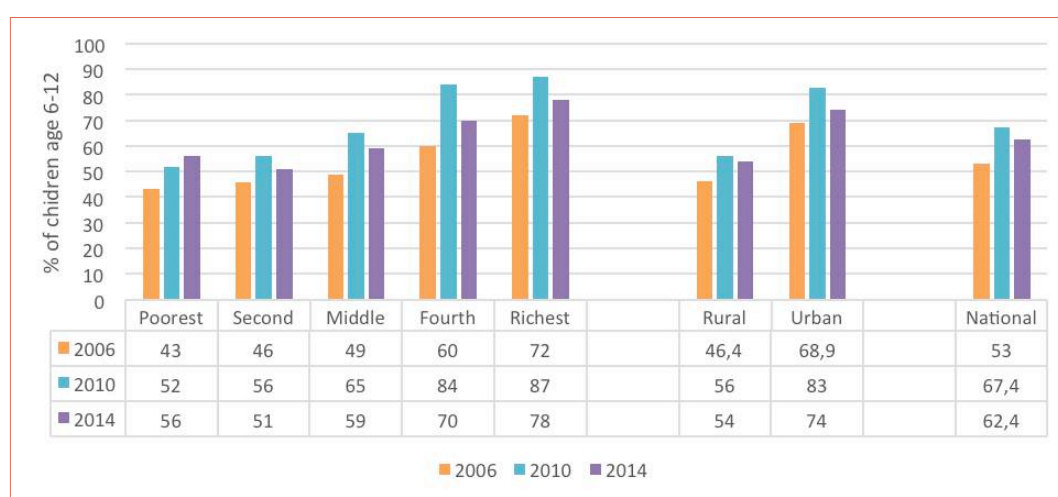
In Guinea-Bissau a child's school journey should begin with pre-school at age five and then continue with enrolment into Grade 1 at the age of 6. Without repetition, a child should finish the first two cycles of basic education (corresponding to primary school) at the age of 12 and achieve full basic education by the age of 15.

4.1.1 Attending primary school

Primary school attendance improved from 53.7 per cent in 2006 to 67 per cent in 2010. MICS data indicate that net school attendance then fell to 62.4 per cent in 2014. In 2012/13, 44 per cent of children between the ages of 6 and 11 (104,184 children) were out of school (Government et al, 2015). The number of out-of-school children is likely to have increased further since the decline in net attendance between 2010 and 2014, as the number of primary school age children continued to grow at a rapid pace.

The decline in primary school attendance affected almost all population categories. In urban areas, average net attendance actually declined from 83 per cent in 2010 to 74 per cent in 2014. Similar trends were observed in Bissau. For the poorest quintile of households, however, net attendance increased from 52 per cent in 2010 to 56 per cent in 2014. This latter trend is likely driven by communities and initiatives from families and parents who get together to pay teachers and construct a simple school building instead of waiting for a government-led initiative. However, these efforts are insufficient to keep up with the increase in the school age population and are not sustainable given the high levels of poverty. Most of the poorest households live in rural areas where, in 2014, just 54 per cent of school age children were able to attend primary school at the right age.

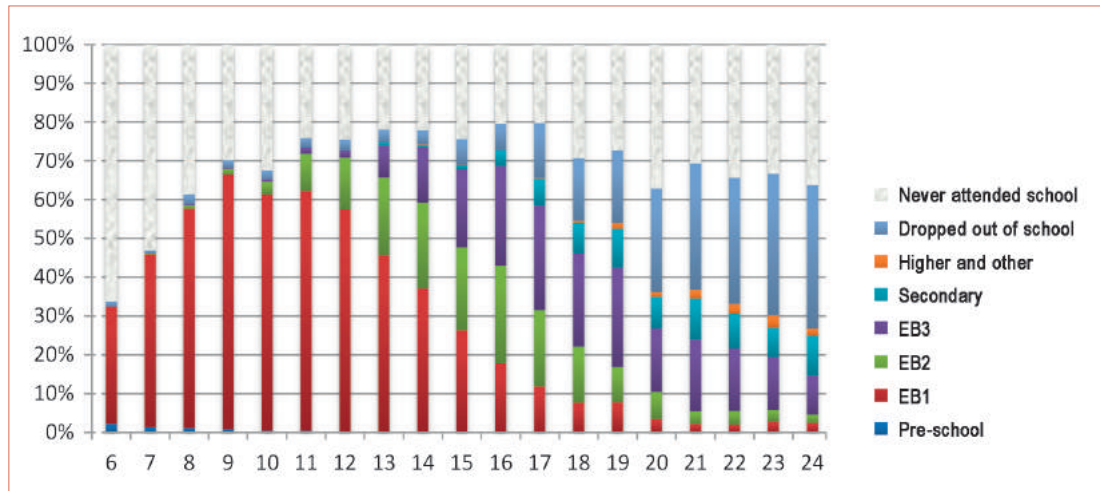
Figure 36: Net attendance in Grade 1 to 6 by wealth quintile and residence 2006-2014 (in percentages)



Source: INE (2006, 2010 and 2015b).

4.1.2 Starting school on time

Most children enter the school system late for various reasons and many teenagers are still attending primary school. The graph below shows the distorted profile of schooling due to late entry, shortages of classrooms and teachers, and the high number of schools not offering Grades 5-9. Only 32 per cent of children start Grade 1 at age six. At the age of 10, instead of starting EB2 (Grade 5), 61 per cent of children are still enrolled in EB1 and 32 per cent have never been to school. At the age of 12, instead of being in EB3 (Grade 7), 57 per cent are still in EB1 and 24 per cent have never been to school.

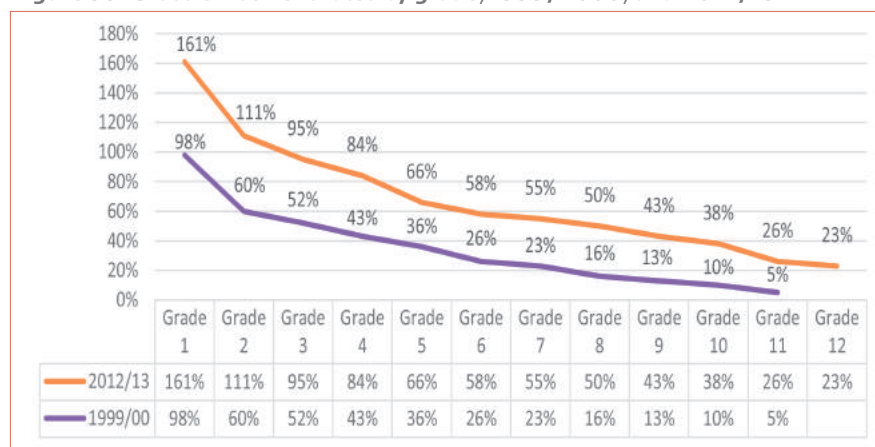
Figure 37: Proportion of children aged 6-24 at various stages of schooling

Source: RESEN calculations, based on ILAP (2010)

Distance is an important factor preventing children from starting school at the right age. Many children have to walk long distances to reach their school, and parents may not want them to make this daily round trip. Statistical analysis confirms that school attendance decreases as distance to school increases (Government at all, 2013, INE, 2015a). Communities have responded to the lack of nearby schools by establishing community schools. In 2013 these made up 20 per cent of all schools offering Grades 1-6, and 32 per cent of all pre-primary schools (Government at all, 2015b). However, these initiatives place a burden on communities and parents who collect monthly contributions to cover teacher salaries and school running costs.

4.1.3 Completing the primary education cycle

There are many reasons why children are not able to complete a full cycle of primary education. Distance to school, poor education quality, high repetition rates and the fact that children tend to enter the system late contribute to a very high gross enrolment rate (161 per cent) in Grade 1 which drops dramatically to 111 per cent in Grade 2. This decline is equivalent to 1/3 of children dropping out after just one year of schooling or having to repeat Grade 1.

Figure 38: Gross enrolment rates by grade, 1999/2000, and 2012/13

Source: Government at all (2015).

In Guinea-Bissau's agriculture-driven subsistence economy, child labour also has a negative impact on children's education and the likelihood to complete the first six years of education. Not all children are

involved in work inappropriate for their age in terms of its nature or the time it takes up, but all children are asked to help with housekeeping and many generate income. While this does not all qualify as child labour it is probable that any increase in the number of hours of work per week reduces the likelihood of going to school. The latest child labour study by the National Statistics Institute confirms that working in family businesses is an important reason for not attending classes (INE, 2015a). A similar conclusion had already been drawn by a 2011 study, which recorded work as a reason for not going to school for one in four boys (Effective Intervention, 2011). This conclusion is supported by a 2010 study in Biombo where the school dropout rate reached 30 per cent during the cashew harvesting season (SNV, 2010). Furthermore, even if a child continues education while assigned tasks at home, school performance worsens with the increased workload (Government of Bissau et al, 2015).

The second key moment when children fail to move to the next grade is between Grade 4 and 5 when the gross enrolment rate falls from 84 to 66 per cent. This is largely because only 25 per cent of primary schools offer Grade 5 and 6 classes, and these schools are mostly located in peri-urban and urban areas. The proportion of children enrolled continues to decline between Grade 7 and 12 due to overcrowded classrooms, reduced and inadequate teaching schedules and the fact that most pupils are over-age. All of this leads to high repetition rates and drop-outs. In the end, only 14 per cent of children who enrol in Grade 1 actually complete Grade 12. Just 62 per cent of an age group enter school at the right age, and of them only 76 per cent complete Grade 6. Completion rates have declined since 2010 from 86 to 76 per cent. Of all children, including those over-aged and those who will never enter school, only 22 per cent complete Grade 6.

Most children who go to school are involved in some kind of child labour, but not all children who work actually go to school. The proportion of working children who work in dangerous conditions is high; the national rate is no less than 60 per cent. In the regions of Quinara and Bolama/Bijagós, 80 per cent of all children between five and 14 years work more hours than they should, and nearly all do this in dangerous conditions. During the cashew harvest many of these children are asked to carry heavy loads of fruits (Germain and Handem, 2008). Even if the work itself is not dangerous, children who are involved in petty trade or move around to sell nuts or fruits are at risk of sexual abuse. Sometimes they engage in commercial sex to avoid punishment when they are unable to reach the income level expected (UNICEF, 2011a).

4.1.4 Learning achievements in Grade 2 and Grade 5

Attendance and completion are not the only two concerns for children in this age group. Learning achievements for children are also very low.

A 2011 study found that 52 per cent of boys and 63 per cent of girls between seven and 17 years could not read words. More than half of boys and two-thirds of girls could not complete a simple sum (Effective Intervention, 2011). The education system in the country has not yet developed an annual or end of cycle national exam. According to the learning achievement assessment included in the RESEN 2015, in Grade 2, average scores in Portuguese and Maths are generally low for almost all types of pupils, whether they attend public, community or faith-based schools, or are in urban or rural settings. Only pupils in private schools seem to score better in both Maths and Portuguese (Government et al, 2015).

Even more concerning is the sharp decline in average Portuguese and Maths scores between Grade 2 and Grade 5. In Portuguese, the mean score drops by 8 points from 48 to 40. The decline in scores is particularly pronounced in Maths and occurs for all categories of schools and pupils. While boys perform 6-8 points better in Grade 2, this difference disappears by Grade 5.

Schools in urban areas score better because of the concentration of private schools in these settings. These schools are able to attract more qualified teachers because they offer better salaries than the public sector. Teacher training colleges are unable to train teachers in sufficient numbers to replace retiring teachers and recruit new ones to absorb the growing school population, every year. A large proportion of teachers who are not fully qualified are mainly teaching in state schools or in rural areas. Teachers' average Portuguese and Maths scores in Grade 5 are very poor, at 77 and 58 out of 100 respectively. Low teachers' qualification might explain the drop in achievement by both pupils and teachers from Grade 2 to Grade 5, when more difficult content needs to be taught and learned.

Table 5: Learning achievement assessment results in Portuguese and Mathematics

	Portuguese		Mathematics
	No. of observations	Average score / 100	Average score / 100
Grade 2			
Pupils	1950	48	50
Teachers	150	92	91
Public school	1274	43	45
NGO, faith-based	73	50	58
Private school	202	68	66
Community school	386	55	56
Urban	574	53	55
Rural	1361	46	48
Boys	1050	51	54
Girls	900	45	46
Grade 5			
Pupils	2075	40	31
Teachers	146	77	58
Public school	1249	37	29
NGO, faith-based	129	35	27
Private school	237	57	39
Community school	430	42	34
Urban	800	42	31
Rural	1245	38	31
Boys	1245	40	31
Girls	830	39	31

Source: RESEN calculations, based on ILAP

Teacher motivation and absenteeism are a serious concern as they further erode the quality of education. The main causes of absenteeism include participation in traditional ceremonies, travel to the regional centre to receive salaries, and engaging in agriculture and farming activities to increase income (World Bank, 2009). Systematic arrears in salary payments have also contributed; as for several years they led to frequent and prolonged teachers' strikes. Strikes lasting 45-48 days took place between 2011-12 and 2013-14 academic years, meaning that nearly 30 per cent of teaching days were lost. Low salaries also have an adverse effect on teachers' motivation. Primary school teachers in Guinea-Bissau earn about half the salaries of teachers in comparable low-income countries in Africa, and about 65 per cent of the level recommended by the Education For All- Fast Track Initiative.

Mastery of Portuguese language is another significant obstacle to quality learning. Although Portuguese is the formal language of instruction, it is foreign to many children as well as teachers. As a consequence,

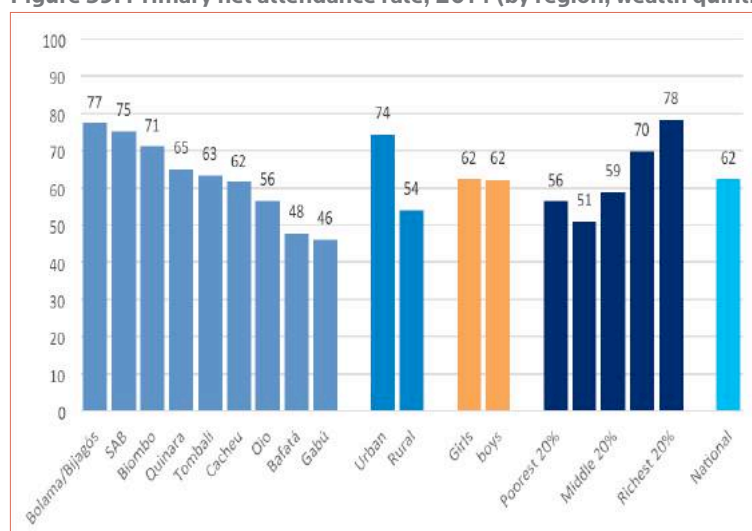
children do not understand well the content of lessons taught in Portuguese, while teachers assimilate limited content during their training.

In conclusion, the schooling pathway for young children remains fraught with obstacles, preventing them from fulfilling their educational potential. The demand for education is high with 80 per cent of children entering school. In the end however, only 34 per cent complete Grade 5, 22 per cent enter lower secondary school, 18 per cent complete basic education and a mere 12 per cent are able to start upper secondary education. Furthermore, considering the low level of learning achievements, children who are not able to complete, at least Grade 6 have very limited literacy and numeracy skills.

4.1.5 Disparities in the journey towards basic education

Only three regions have a net primary attendance rate close to the national average of 67 (Quinara, Tombali and Cacheu). The gap between the urban and rural rates is 20 points (74 and 54 per cent respectively). The most under-performing regions are Gabú and Bafatá, where less than half primary school age children actually attend school. Meanwhile Bolama/Bijagós and Bissau are the best performing regions. Nonetheless, even in these two regions, just three out of four children attend primary school at the appropriate age.

Figure 39: Primary net attendance rate, 2014 (by region, wealth quintiles, residence and gender) (in percentages)



Source: INE (2015b).

Comparing schooling attendance between boys and girls, it appears that Guinea-Bissau has reached gender parity for primary education. Despite a small drop between 2006 and 2010, the national primary education gender parity index reached 1 in 2014.

4.2 Violence affecting children aged 5-11

Various forms of violence, abuse and exploitation can affect children between 5 and 11 years. Once children reach the age of four, physically and emotionally violent discipline by their caregivers reaches its peak, after which it stabilises. Abusive disciplining of Bissau-Guinean children is a persistent cultural practice that has not changed for at least eight years. In fact, violent disciplining of this age group has slightly increased. Like for the smallest children, only severe physical punishment has diminished, by about 30 per cent. Nevertheless, still one in every five children of primary school age is disciplined using very violent methods. Moreover, part of the decline in severe punishment has been offset by an increase in less violent physical punishment.

4.3 Young child labour

According to the MICS 2014, children between five and 11 years are now less involved in child labour, but still considerably more than any other age group. Around the world, children are routinely engaged in paid and unpaid forms of work that are not harmful to them; however, nearly 56 per cent of children aged 5-11 years in Guinea-Bissau are engaged in child labour. This means that they perform tasks for which they are either too young or which are hazardous and may therefore compromise their physical, mental, social and educational development. Compared with 2010 when the national average for this age group stood at 63 per cent, the situation has slightly improved (INE, 2015b).

In most families in Guinea-Bissau, children are required to work to ensure the family's survival. Engaging in work is also intended to socialise and educate children to be prepared for adult life by observing habits, rules, taboos and traditional hierarchy (Udelsmann Rodrigues *et al.*, 2007). Labour is a progressive process where, at every stage of life from a very early age, children are given tasks and responsibilities that contribute to their social and cultural education (Handem, 2013). Virtually every child in Guinea-Bissau, in rural areas and cities alike, is required to conduct some age-acceptable tasks. Children take part in cashew harvesting, for which the entire family is mobilised, in particular women and children. From an educational point of view this form of child labour may not be considered exploitation.

Many children are working long hours including too many hours of domestic work. In general children do not get paid for the work they do (in 2008 just 2.1 per cent earned money from their work (Germain and Handem, 2008)). While prevalence has decreased slightly during the last four years, still 51 per cent of all children aged 5-17 years and 52 per cent of children aged 5-14 years are engaged in child labour.¹⁸ There are no big differences between boys and girls. Girls are nearly three times more likely to work long hours domestically than boys. Nearly 5 per cent of all children perform more than 28 hours of domestic work per week. In Biombo, this is one in six for girls and in Bafatá even one in five. While these are figures for all girls, they are likely to be even higher for girls that are entrusted with families away from their biological parents.

4.4 Children with disabilities

Schooling opportunities for children with disabilities are virtually non-existent. In spite of public announcements in 2013 to exempt children with disabilities from any school fee up and until Grade 11, no legislation has been enacted. Therefore, like any other child, children with disabilities pay tuition fees from Grade 7. The Government of Guinea-Bissau does not have a policy on inclusive education nor the equipment needed to respond to the special needs of children with disabilities. Teachers trained for regular schools do not receive any training that help them cater for the special needs of children with disabilities. Interviews with persons with disabilities reveal that teachers in regular schools are not well prepared and do not always have the patience to spend the extra time required by children with special needs. The Ministry, however, has been in the process of revising the curriculum for several years now to make it more inclusive for children with disabilities.

¹⁸ Internationally, child labour is commonly estimated for the age group 5-14. The MICS 2010 round estimated child labour for that specific age group. The MICS 2014 round extended the child labour cohort to children aged 5-17. In 2014, the child labour rate for 15-17 year old children was lower than the national average. Therefore, the child labour rate for the group aged 5-14 was 52 per cent.



5. THE ADOLESCENT YEARS

Girls and boys between 12 and 17 years of age are likely to experience intense physical, sexual, psychological, emotional and economic changes. While they are learning to think and act independently from adults, adolescents may struggle with their identity, experiencing life as a world of contradictions. At this age, multiple deprivations and their synergistic effects may have profound consequences.

Adolescents encounter new and complex challenges in their second decade of life. The onset of puberty and greater personal freedom make adolescents, and girls in particular, acutely vulnerable (UNICEF, 2012d). As adolescents start engaging in risky behaviours, mutually reinforcing vulnerabilities come into play: early sexual debut, HIV and sexually transmitted infection risks, early marriage, teenage pregnancy, and school dropout are all closely interlinked. This period of life is particularly challenging for girls, who are often forced to abandon childhood and take on adult roles before being physically and emotionally ready.

Adolescents are resourceful, courageous, and well aware that their futures depend not only on what adults can do for them, but also on what they can do for themselves. When healthy, enrolled at school at an appropriate education level, and well protected with full access to age-appropriate services, adolescents have the capacity to thrive, achieve their full potential and contribute to society.

There are an estimated 240,000 adolescents aged 12 to 17, accounting for 13.4 per cent of the total population of Guinea-Bissau.

5.1 Maximising the protective effect of schooling for adolescents

The schooling system faces critical challenges to ensure that children who reach the age of 12 are able to enter secondary school. As things stand, most children aged 12-17 are either at a grade not appropriate for their age, or are out of school. This runs counter to the new Education Law of 2011, under which children aged 12 to 17 should be attending EB3 (Grades 7 to 9), secondary education (Grades 10 to 12) or technical and vocational training.

Only 1.8 per cent of children aged 12 are actually attending the correct school cycle for their age: EB3 (Grade 9). Most 12 year olds (57.3 per cent) are still attending EB1 (Grades 1 to 4), which should have been completed at age 10. A total of 13.4 per cent of children aged 12-17 are attending EB2 (which should have been completed by the age of 12). However, most worryingly, 24.5 per cent of children in this age cohort have never been to school. This negative pattern gets even worse for children who reach the age of 17: 12 per cent of them are still attending EB1 and only 14.2 per cent are actually in secondary education.

The reasons for low school enrolment and attendance among adolescents are multiple and have their roots in the late entry in school and high repetition rates (21 per cent in EB1, 18 per cent in EB2, and 17 per cent in EB3 (Government et al, 2015) throughout the primary school cycle highlighted earlier.

Only 25 per cent of primary schools offer the full cycle of primary education up to Grades 5 and 6. The lack of schools offering EB3 and secondary education is prevalent across the country but is particularly concerning in Quinara, Bafata and Tombali. This means that many children will have to move to urban areas to complete primary schooling and transit to basic secondary education. This situation poses challenges for adolescent girls, children from rural areas and those from the poorest families, the most.

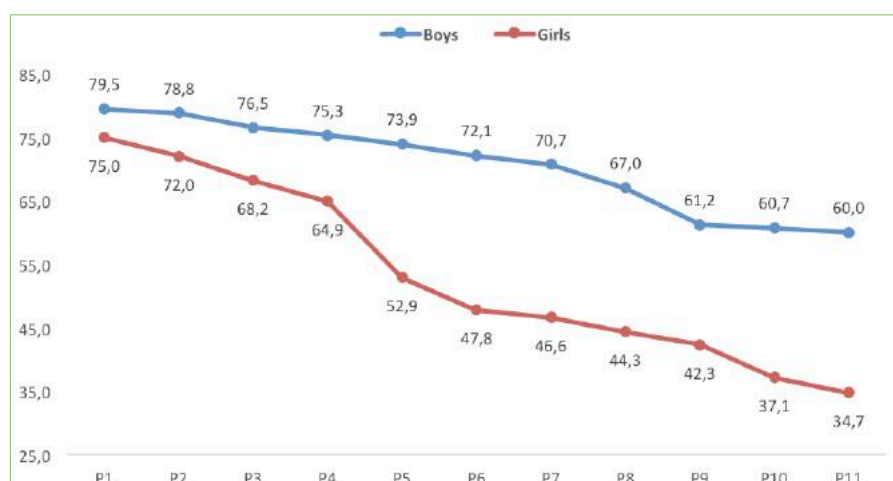
Figure 40: Likelihood of completing primary and secondary education by grade and region, 2010 (in percentages)



Source: ILAP 2010, Government et al 2015

As shown in the graph below, the gap between boys and girls remains limited (4 percentage points) when entering primary school and widens steadily during the primary education cycle. The gap widens dramatically at Grade 5 with a 21 percentage point difference between the proportion of boys (74 per cent) and girls (53 per cent) attending the grade.

Figure 41: School enrolment by grade and gender (in percentages)



Source: RESEN calculations, based on ILAP, 2010

There are no opportunities for out-of-school children to attend catch-up courses. Technical vocational education and training is very limited, and mainly available in Bissau. This situation is a lost investment. As children transit into adolescence, the protective impact of education on health-related behaviours becomes of great importance. Longer retention in education is associated with delayed marriage and child-birth and consequently more favourable health outcomes for both the mother and child (UNICEF, 2015a).

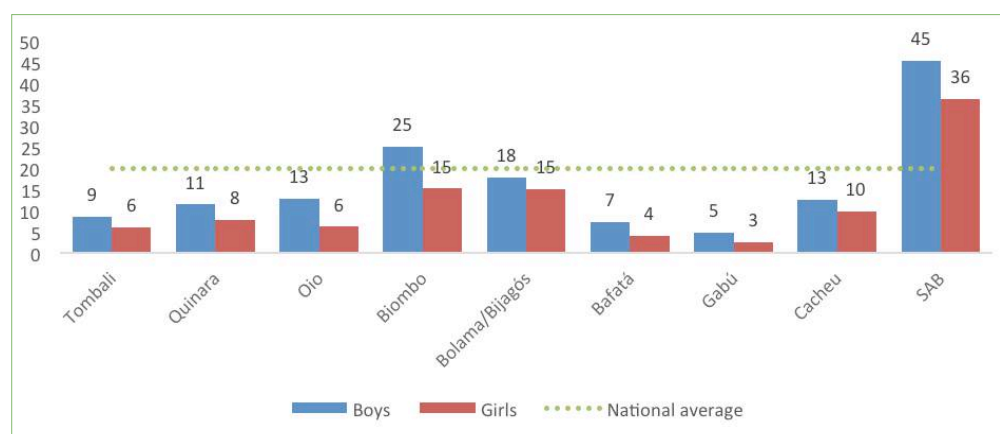
Girls are more likely to drop out of school due to early pregnancy or marriage. While husbands may not allow young wives to continue with education, schools may also expel them if they become pregnant. Only 8 per cent of women aged 20 to 45 years who were married before they turned 18 complete secondary education (INE, 2015b). Moreover, girls who enter school late, as many of them do, are more likely to drop out in order to get married.

Table 6: Likelihood of access to primary and completion of various cycles by socio-economic characteristics, 2010 (in percentages)

			Enter first grade	Complete Grade 6	Complete Grade 9	Complete Grade 11
National			77	63	51	46
Richest	Urban		83	66	60	54
			91	83	72	69
		Boys	93	89	80	78
		Girls	90	75	65	62
	Rural		68	49	40	39
		Boys	72	62	50	49
		Girls	64	37	32	28
Poorest	Urban		67	49	40	33
			87	75	53	46
		Boys	89	84	72	70
		Girls	84	65	54	43
	Rural		57	37	30	23
		Boys	61	50	39	36
		Girls	52	37	23	15

Source: RESEN calculations, based on ILAP, 2010

Figure 42: Attendance in Grades 7-9 and Grades 10-12 by gender and region, 2014 (in percentages)



Source: INE (2015b).

5.2 Child marriage

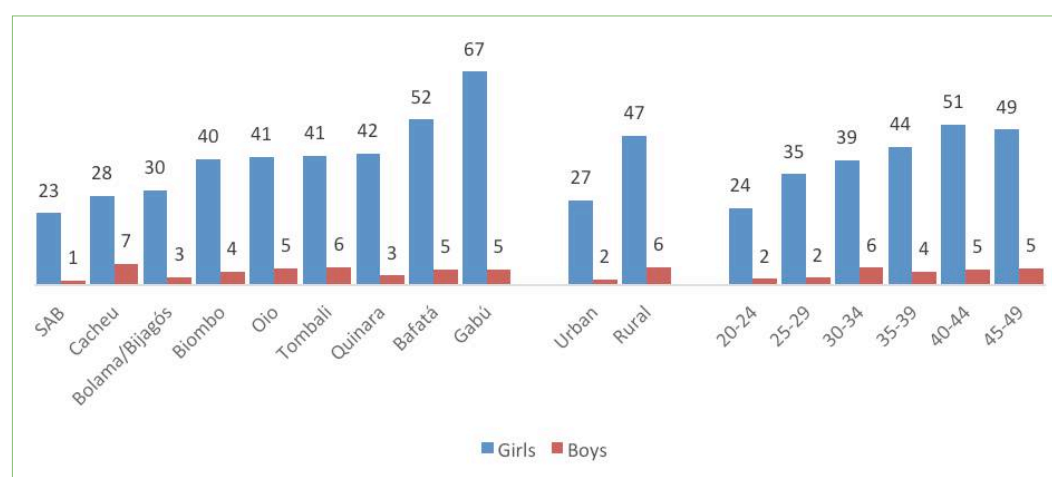
According to Article 1601(a) of the Civil Code (2007), girls and boys under the age of 16 years cannot marry without parental consent. However, in Guinea-Bissau more than 7 per cent of girls marry before they turn 15. Among 15-19 year old girls, 3 per cent reported in 2010 that they had married before the age of 15; by 2014 this indicator had fallen to 2 per cent. This suggests that pre-adolescent marriage may have

become slightly less prevalent.¹⁹ Although boys are legally able to marry from the age of 16, marriage of boys before the age of 15 is negligible and less than 4 per cent enter union before their 18th birthdays.

On the other hand, nearly two-fifths of all females in Guinea-Bissau marry before the age of 18, primarily through customary practices (INE, 2015b).²⁰ Unlike marriage before 15, comparison of the various MICS rounds shows that, after some stability between 2006 and 2010, pre-18 marriage has increased dramatically in recent years, especially in rural areas and for females with no education. No studies or other information sources are available to explain this steep rise. A possible explanation is that reporting has increased, because rates have gone up for all age groups, while one would expect reports for one age group to be similar to an older age group a few years later. Currently prevalence in Guinea-Bissau is close to the West and Central African average and well above the global average (UNICEF, 2015b).

Early marriage occurs across the country with considerable regional variations. Bissau is the only region where less than one in four girls is married before the age of 18. In Bafatá and Gabú the figures are as high as 52 and 67 per cent respectively. Nearly 50 per cent of girls in rural areas and 21 per cent in urban are married before the age of 18. Figures for both urban and rural areas are about 4 percentage points above the global averages.

Figure 43: Marriage before the age of 18 by sex, 2014 (in percentages)



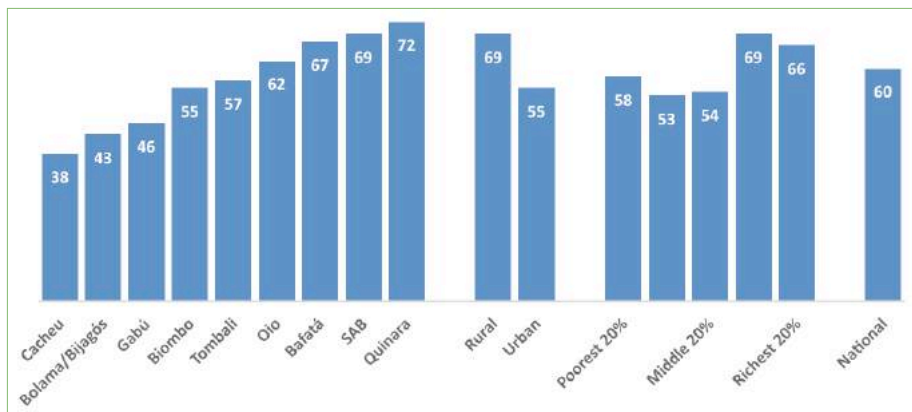
Source: INE (2015b).

In 60 per cent of cases, girls who marry before the age of 18, form unions with men who are more than 10 years older, and many enter into marriage as a second wife. Long before the girls reach the age of marriage (this could be when they are three or four years old), the two families enter a pre-matrimonial contract. This practice is considered to protect girls, and also to be an effective way of avoiding the risk of out-of-marriage pregnancy that would decrease her chances to get married (Udelsmann Rodrigues *et al.*, 2007).

¹⁹ National, rural and urban figures have remained more or less stable since the MICS in 2006. Still, interestingly the age group of 15-19 year old girls shows a significant decline. A possible explanation is that there was increased reporting on women between 2010 and 2014.

²⁰ Worldwide, more than 700 million women alive today were married as children. More than one in three (or some 250 million) were married before the age of 18, and more than 10 per cent married before 15 years. The average rate for girls under 18 years in Sub-Saharan Africa is 37 per cent (C. Harper *et al.*, 2014).

Figure 44: Marriage of girls aged 15-19 to spouse who is 10 or more years older, 2014 (share of all girls married aged 15-19) (in percentages)



Source: INE (2015b).

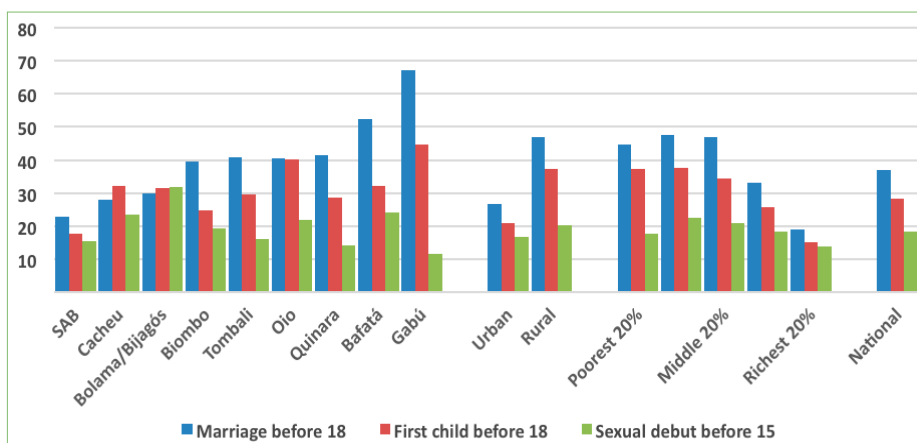
Early marriage is also sometimes a survival strategy for poor families who are then able to become part of the larger family circle of more affluent families. This provides advantages such as access to land (UNICEF, 2011a). One out of every three women married before the age of 19, lives with one or more co-wives. Amongst the Balanta, it is common that a girl's aunt fosters her to become her co-wife (Germain and Handem, 2008; Einarisdóttir *et al.*, 2010). While in most cases polygamous marriage is with a considerably older spouse, men as young as 19 (7 per cent) or 25 (12 per cent) have more than one wife (INE, 2015b). In several regions the mean age of marriage is around 16 years.

5.3 Teenage pregnancy

Early sexual debut, high rates of early marriage and low levels of contraceptive use lead to high rates of adolescent pregnancy. Forty per cent of girls are married and 28 per cent have their first child before the age of 18 (INE, 2015b). Guinea-Bissau has one of the highest rates of teenage pregnancy in Sub-Saharan Africa, at 104 births per 1,000 adolescent girls in 2014. Nevertheless, this is 25 per cent less than in 2010.

Association between early marriage and teenage pregnancy, and to a lesser extent between early marriage and sexual debut before the age of 15, has been seen across the regions, income quintiles and geographic location.

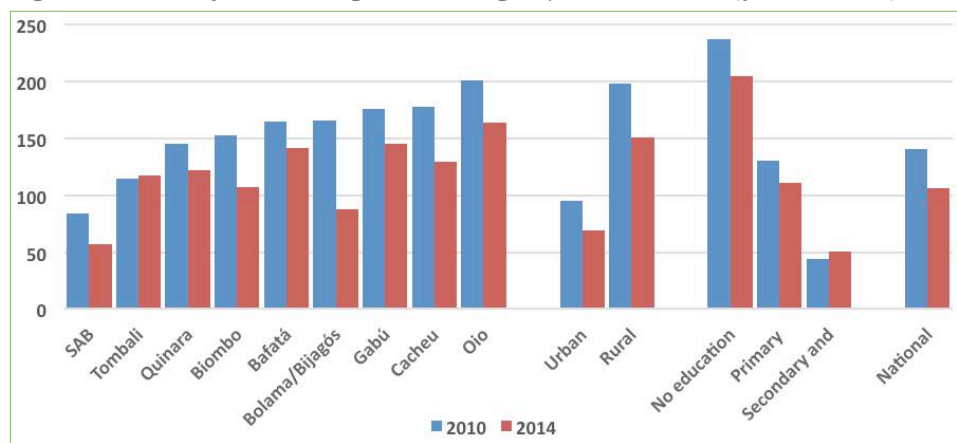
Figure 45: Marriage before 18, first child before 18 and sexual debut before 15 for women aged 15-49, 2014 (in percentages)



Source: INE (2015b).

Child marriage and subsequent teenage pregnancy is a major cause of school dropout. Once married, most husbands will not allow their newly wedded child spouse to continue her education. Even if she is allowed, once she gets pregnant a girl is often not allowed to continue her education by the school (Afroteste, 2013).

Figure 46: Fertility rates among adolescent girls, 2010 and 2014 (per thousand)



Source: INE (2010 and 2015b).

Adolescent birth rates have declined in all regions and for all education levels, except in Tombali and among girls with secondary and/or higher education. While teenage pregnancy is much less common among well-educated girls, the phenomenon increased in this group from 44 per 1,000 in 2010 to 51 per 1,000 in 2014. However, speed of progress and absolute disparities are considerable.

5.4 Sexual and reproductive health of adolescents

CATORZINHAS

High teenage pregnancy rates, early sexual debut and intergenerational sex can be illustrated by the phenomenon called “*Catorzinhas*” (“fourteen-year-olds”). Recently, relationships between teenage girls and older men have increasingly featured in public discourse and the term ‘*catorzinhas*’ has come into use to describe them. ‘*Catorzinhas*’ are increasingly a theme in popular songs, and the public is showing an increased tendency to look away and/or look at this with sympathy. In other countries the term “sugar daddies” is often used to describe such intergenerational relationships.

The men involved are usually 40-55 years old and typically already have families. In exchange for sex in a seemingly conscious and consensual relationship, they offer teenage girls luxury items, such as designer clothes, top-range mobile phones, and a way of life with a lot of public visibility that the girls otherwise would not be able to afford. Girls are also promised support for future education at private schools. While in many cases it appears that girls’ relationships with their “sugar daddies” are consensual, power differentials constrain girls’ choices at every turn.

When the teenage girls get pregnant they experience a double rejection; by their “partner” and by their family. Young girls may not be able to understand the meaning of emotional manipulation. This immaturity, and the ‘choices’ it fosters, puts them at risk on a daily basis as they become involved with men who give them what they ‘want’ but abuse them (Harper *et al.*, 2014). This painful experience of being used and abandoned may negatively impact their future ability to enter into affectionate relationships.

The social position of women influences their capacity to exercise control over their own health. According to local customs, women who want to seek advice or treatment from a medical facility are required to ask their husbands for permission (Ministry of Public Health, 2008a). This obviously affects their health-seeking behaviour, particularly in the area of sexual and reproductive health. Women's lack of control over their own health has been observed across the female population and does not depend on age, region of residence, income and/or education level.

For about one in every five girls, sexual activity starts before the age of 15. This has not changed significantly since 2006. The MICS 2014 data show that girls who are now between 15 and 17 years are as likely as young women between 18 and 24 to have had sex before the age of 15. However, a study undertaken in the same year found that 40 per cent of 350 interviewed girls between 15 and 19 years had their first sexual activity before the age of 15 years. It further reveals that 11 per cent were younger than 11 years, and only 20 per cent had never had sex (INEP, 2014).

Half of the girls who are not married use condoms. The percentage is somewhat higher for young men (70 per cent). For both young men and women condom use has been steadily increasing over the years, although not enough to reach the MDG target of 95 per cent.

Having sexual relationships with older men significantly increases the risk of HIV transmission for girls, and the larger the age gap the more likely that the girls will be infected. Nineteen per cent of girls aged 15-24 in Guinea-Bissau report having their first sex with a man more than 10 years older. Secondary analysis of MICS 2010 data indicates that girls who attend school, have comprehensive knowledge of HIV and have ever been tested for HIV are less likely to be involved in cross generational sex. Living in Bissau, Bafata and Gabu, as well as living in polygamous union, increases the chances of intergenerational sex.

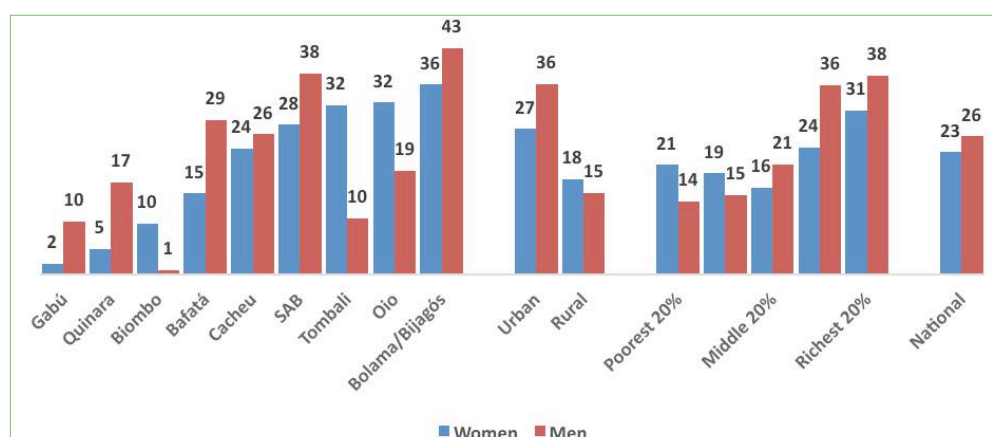
5.5 HIV and AIDS among adolescents

As adolescents become sexually active and may begin to experiment with drugs and alcohol the risk of HIV worsens, in particular for girls. Low knowledge of HIV prevention, low access to commodities, early sexual debut and cross-generational sex all contribute to high risk of HIV for girls. Simultaneously the perception of risk of HIV among adolescents is very low.

An estimated 2,200 persons between 10 and 19 years are living with HIV (UNICEF, 2013c). The latest available prevalence studies for young people between 15 and 24 years found that girls are three times more likely to be living with HIV than boys of the same age: 4.2 and 1.4 per cent respectively (Ministry of Public Health, 2010d). A national sentinel surveillance study found 3.2 per cent HIV prevalence among pregnant women using antenatal care aged 15-19 (INASA 2010), indicating that HIV transmission is continuing in the population, and is increasingly affecting adolescents.

Virtually all men and women across all areas of Guinea-Bissau have heard about AIDS, except in Gabú, where the awareness rate is only 50 per cent (INEP, 2014; INE, 2015b). The rate of comprehensive knowledge of HIV transmission remains low (INASA, 2010; INEP, 2014; INE, 2015b), though a 50 per cent increase has been observed among women over the last five years.²¹ Nevertheless, the national average of 23 per cent for women and 26 per cent for men is far from the MDG target of 95 per cent.

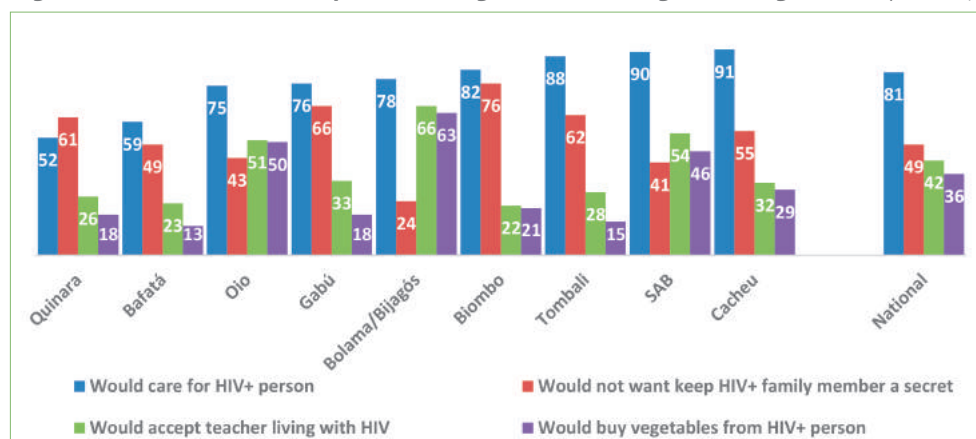
21 Historically most surveys and studies researched the knowledge of women. In fact, the MDG indicators related to HIV and AIDS are only for women, not men. Therefore, only in the last MICS round men were also asked the same questions as women about HIV and AIDS. This means that no trends are available on knowledge by men.

Figure 47: Comprehensive knowledge of HIV of people aged 15-49 by sex, 2014 (in percentages)

Source: INE (2015b).

Adolescents do not differ significantly from the general population with regard to their knowledge of HIV transmission and acceptance of people living with HIV, but they are significantly less likely to use HIV-related services. According to MICS 2014, only around a third of girls and boys aged 15-19 knew where to take an HIV test, compared to 55.2 per cent in the general population. Only 4.8 girls and 1.8 boys took HIV tests in the 12 months prior to the survey. The difference is probably the result of increasing uptake of HIV testing in pregnancy across the country. While knowledge of HIV status can be critical for one's health and can have a major impact on reducing the spread of HIV, levels of HIV testing in Guinea-Bissau remain very low. Widespread stigma around HIV and AIDS, the limited scope of programmes to encourage HIV testing, and constant interruptions in supply of test kits are likely causing low access to and uptake of HIV testing.

Over the last 20 years HIV-related mortality in the world has decreased by 30 per cent, except among adolescents, among whom a 50 per cent increase has been recorded. The reasons for this high increase in mortality are multiple, ranging from challenges associated with maintaining adherence to treatment once vertically-infected children reach adolescence, to poor access to and utilisation of HIV-related services such as HIV testing for behaviourally-infected adolescents. Little data on adolescents living with HIV is available in Guinea-Bissau, but considering the very low treatment coverage for under 15s (8 per cent) (National AIDS Programme, 2014), low retention and adherence to treatment, HIV related mortality and morbidity could be very high.

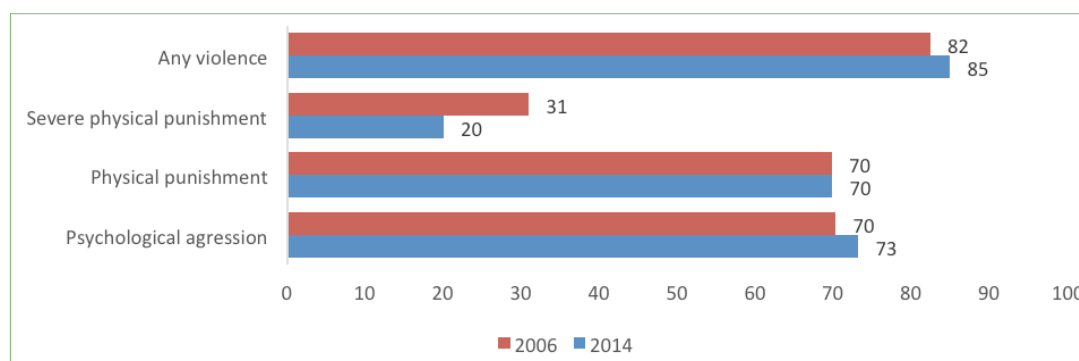
Figure 48: Attitudes towards persons living with HIV among women aged 15-49, 2014 (in percentages)

Source: INE (2015b).

5.6 Violence

The proportion of children aged 10 to 14 subjected to physical and emotional discipline is similar in nature and severity to that of children aged between five and nine. However, the likelihood of severe physical punishment decreases over time while psychological abuse becomes more prevalent.

Figure 49: Violence against children aged 10-14, 2006 and 2014 (in percentages)



Source: INE (2006 and 2015b).

5.7 Adolescent labour

Prevalence of child labour among 12-14 year-olds has increased in recent years, from 40 percent in 2010 to 45 per cent in 2014 (INE, 2015b). Almost all adolescents are asked to help in and around the house and a great majority are involved in economic activities. However, few are asked to do so for more hours than is appropriate for their age. However, in Biombo, Bolama/Bijagós and Gabú the prevalence of child labour is three to five times the national average. Young adolescents are expected to do too many hours of domestic (between 18 and 24 per cent) or economic work (between 23 and 34 per cent), which undoubtedly affects their schooling. While girls are three to four times more likely to be engaged in domestic labour, twice as many boys are involved in economic activities.

Older adolescents in rural areas are as much involved in child labour as their counterparts in urban areas. Yet, 12-14 year olds are four times more likely to work age-inappropriate hours when they live in rural areas (INE, 2015b).





6. THE REPÚBLICA DI MININUS HOJE

The Governments' 2025 Strategy recognises the economic difficulties, social tensions and eruptions of violence in the past four decades but stresses that this negative cycle is not insurmountable. The Strategy is intended to ensure that the vicious cycle of instability and poverty is left behind and that Guinea-Bissau is on the path of sustainable development. It emphasises that children and young people are the foundation of national revival and that they continue to be affected by the legacy of the country's challenges (Republic of Guinea-Bissau, 2015).

For nearly 20 years, young people between 12 and 17 have had the opportunity to get elected as members of the Guinea-Bissau Children's Parliament. This independent youth body has its own general assembly with 102 Members of Parliament elected through 100 participating schools²², throughout the country. Each region has its own Members and President, who feed the Children's Parliament with information on children in their localities. The Parliament is a proven stepping stone for future career in politics or civic activism.²³ The Children's Parliament has its own annual budget of CFAfr 4 million furnished by the Government and sits within the building of the National People's Assembly. It therefore has direct access to members of the Assembly, including the Specialized Committee, and participates in periodic Parliamentary sessions. The National People's Assembly holds periodic special half day sessions dedicated to children where the Children's Parliament formally participates, including in the preparation of the session's resolutions.

In the planning of the Strategy, leaders of civil society and local initiatives presented their own visions, which, to a large degree, match the one of the Government. Inspired by a popular film, civil society organizations created a broad platform of more than 350 organizations entitled *Respublica dos Mininos Hoje* (The Republic of Children Today), to present their vision for the country and highlight that investing in children and adolescents should be a cornerstone of the country's development. The initial aim of the initiative was to obtain the commitment of all presidential candidates as well as political parties to the rights of children in Guinea-Bissau through the signing of a Declaration of Commitment.

The movement *República di Mininus Hoje* was inspired by the movie named "*República di Mininus*" of the Guinean Director Flora Gomes which tells the story of a fictitious African country ravaged by war where adults failed to rule and left, abandoning children to their own fate. Children then organized themselves and established their model of Government. Like the country depicted in the movie. With the support of UNICEF, the movement was first publicly launched mid-December 2013. As a result of one of the recommendations at a national consultation held during autumn of 2013 and organised by the Children's Parliament, the initiative quickly grew into a nationwide network called "*República di Mininus Hoje*".

²² Any student not attending these 100 schools can participate in activities and is welcomed as observer, but will not be able to be elected.

²³ On several occasions during field work for this report it appeared that interviewees were former members of the Children's Parliament.



The Presidential elections of April and May 2014 were the first target. These elections were to end nearly two years of transitional Government and re-establish constitutional order. The movement carefully planned several steps towards obtaining the commitment of all Presidential candidates to a better future for children.

The movement publically launched a manifesto in March 2014 describing how children and young people see a country that places child rights at the center of governance. Following the launch, the movement sought to establish alliances with a wide range of actors from the civil society (cultural, sports, and religious), international organizations and the private sector at a forum at the end of March, 2015. The public was then also targeted in order to obtain popular political support in the run up to the Presidential elections. Regional committees were established to help with this public mobilization throughout the country.

The first success was achieved by the signing of a commitment by all candidates to the Presidential and Legislative Elections to promote the child as a factor of national unity. Public advocacy was further strengthening with the release of a video statement by American actor Danny Glover, who played the lead part in the movie that inspired the creation of the movement, calling on all children, adults, politicians and voters. The Electoral Observation Missions were not forgetting and also met in April, just before the elections.

After the peak of the success around the elections, the movement took some time to prepare a National Agenda for the Guinean Children Agenda. This Agenda was presented to the President of the Republic, Vice President of the National Assembly and to the Government witnessed by several Ministers and other high level officials of the Government during the celebration of the 25th anniversary of the Convention on the Rights of the Child. The President of the Supreme Court of Justice, the Attorney General of the Republic, by several members of the executive, civil society and international community were there to witness the act of delivery.

As part of the reforms initiated after the 2014 elections, the Government initiated revision of the Constitution. In late 2014, the National Committee for the Revision of the Constitution of the Republic was established to propose amendments. One of the Committee members is a leader of the National Youth Council and an active member of the República di Mininus Hoje movement.

Constitutional reform is seen as an excellent opportunity to enshrine the visions of Government, civil society, children and adolescents in a Constitution that respects, protects and facilitates the fulfilment of the rights of all children in Guinea-Bissau, everywhere and always.



7. CONCLUSIONS AND POLICY RECOMMENDATIONS

7.1 Conclusions

Despite significant challenges and risks, Guinea-Bissau has made some progress towards its national targets, including a few of the Millennium Development Goals over the past five years. If implemented in full, the country's 2025 Strategy will create opportunities for sustainable development and address issues including inclusive growth, equality, and human rights. These efforts have been assisted by free elections and a vibrant civil society.

Some progress has been made towards developing an enabling national policy and legislative framework to prioritise child development concerns. The lack of coordination mechanisms on children's rights at the Government level remains a concern.

The country faces many challenges. Maternal mortality and HIV transmission remain stubbornly high, and poverty rates, particularly child poverty rates, continue to be of great concern. The situation is aggravated by a precarious macroeconomic climate, in which GDP growth oscillates rapidly, as a result of internal and external shocks. This makes budgetary planning, including the planning of services for children, particularly problematic.

Not all progress is dependent on the economic situation. Children's rights and needs are not always well understood by professionals working with children, by parents, by children themselves or by the general public. The views of the child may often not be taken into account because of the dominant role of parents or legal guardian in the justice system and the healthcare system. Production of disaggregated data, and developing strong alliances to assist and empower the most disadvantaged children and young people is also crucial.

Addressing these issues requires action at a range of levels, from legislation, policy and resource allocation, to working in communities to tackle harmful social norms. Wider understanding of the best interests of the child would be beneficial for resolving the child rights issues which Guinea-Bissau faces in a range of areas, including corporal punishment, female genital mutilation and child marriage.

Clear leadership for child rights from the Government, with support from civil society organisations and development partners, can make a great difference for all the country's children, including those most marginalised.

7.2 Policy Recommendations

EARLY YEARS

Analyse the impact of poverty and malnutrition on pregnant women and young mothers, and consider what social protection, healthcare and other measures can be introduced to address this. More specifically:

1. Consider community activities to build awareness of the needs of pregnant women and young families.
2. Ensure that pregnant women and young children receive malaria prevention treatment, particularly in higher-burden areas such as Gabu.
3. Take measures to improve enrolment, retention and adherence to regimens in antiretroviral therapy for pregnant women living with HIV.
4. Promote early antenatal care during the first trimester of their pregnancy and continuation of antenatal care up to skilled birth delivery, particularly in low-reach areas such as Biombo and Bafata.
5. Facilitate rapid expansion in skilled birth attendance through training and budgetary support for the healthcare system, particularly in rural areas and low coverage regions such as Oio and Gabu.
6. Expand promotion of early initiation of breastfeeding and exclusive breastfeeding for the first six months, particularly in Gabu, Bafata and Tombali.
7. Continue to support the Ministry of Justice to improve birth registration rates by improving the quality of registration services, developing ways to register birth closer to the place of residence, and reducing the cost for parents. Use communication activities to improve demand for birth registration, including for girls, children living in remote areas, including the islands.
8. Work at all levels to communicate the importance of diverse food sources for infants.
9. Continue with lifesaving interventions to prevent Malaria, provide immunization services and improve infant and young child feeding practices in the most disadvantaged regions, but scale this up to other communities which have high levels of under-five mortality, notably in Gabu and Bafata.
10. Reinvigorate efforts to promote immunization coverage, particularly for the poorest quintile, and in Bafata.
11. Analyse why caregivers do not seek medical assistance if their children have fever, and consider what can be done to address the barriers.
12. Rapidly expand early coverage of antimalarial treatment for children under five, particularly for girls and in Gabu and Bafata. Consider what can be done to promote medications being sourced from accredited health facilities.
13. Intensify efforts to reduce the prevalence of female genital mutilation and cutting, including rapid analysis of the factors behind demand, and expansion of communications activities to address the problem.
14. Scale up provision of early child education facilities. Consider how to support community-based kindergartens.

THE FORMATIVE YEARS

1. Investigate why Gabu and Bafata have particularly low levels of school attendance, and consider how to support attendance in these areas.
2. Improve access to education for children with disabilities through legislation, policy, teacher training, curriculum revision, and work with parents and children to ensure they are ready to attend.
3. Investigate the reasons why teacher pay is often delayed, and advocate with stakeholders to overcome this problem and ensure that children's education is not disrupted.
4. Consider what should be done to improve the attractiveness of the teaching profession, and work with stakeholders to improve enrolment in teacher training and retention in the sector, and to reduce teacher absenteeism.
5. Consider how to promote quality education for all children given the limited linguistic ability of many teachers and children in Portuguese language.
6. Consider how to support community efforts to provide education for their children, reduce the burden on parents, better integrate community schools with state education where appropriate, and ensure that they provide quality education.
7. Conduct research on the impact of child labour in Guinea-Bissau on education, including enrolment, attendance, and quality of educational performance. Develop recommendations on how to address the impact of child labour on children's education.
8. Develop services to identify and prevent dangerous labour by children.

ADOLESCENCE

1. Widen provision of later primary and secondary education opportunities, particularly in Quinara, Bafata and Tombali, and for adolescent girls, children from rural areas and those from the poorest families.
2. Greatly expand access to alternative, technical and vocational education and training for adolescents.
3. Make efforts to ensure that pregnant adolescents have the opportunity to continue their education, by policy changes to end expulsion for pregnancy, and community activities to ensure they can decide to continue.
4. Improve awareness of HIV and its causes among adolescents, and improve access to services for these adolescents.
5. Analyse the reasons behind the recent sharp rise in girl child marriage, especially in rural areas and for women with no education, including cultural, socioeconomic, and policy issues, and make recommendations to reduce the phenomenon.
6. Work with the media to highlight the dangers to adolescent girls of the “Catorzinhas” phenomenon, and to develop strategies at national and community level to reduce its prevalence.

GENERAL

1. Create a single Government entity responsible for overall coordination of policies, laws, and programmes relating to the rights of children and women in Guinea-Bissau, and an independent ombuds-institution to protect children's rights, or human rights more broadly.
2. Increase expenditure on health, education, other essential social services and social protection to bring it into line with the levels recommended internationally.
3. Reduce the formal and informal costs of essential services to families, particularly the poorest.
4. Accelerate provision of community-level services, to ensure that those living far from healthcare facilities can access services.
5. Address the significant challenges to infrastructure, particularly in the healthcare system.
6. Overhaul the country's drug supply system.
7. Ensure that healthcare staff are available, particularly in rural areas, and are trained to provide quality care for children and mothers.
8. Expand water supply and sanitation for the home and reduce reliance on unprotected wells, particularly in areas outside Bissau, in regions with poor indicators such as Oio, and among poorer quintiles.
9. Promote treatment of water at household level, washing hands with soap, and use of latrines. Address the cultural barriers that exist and consider how other material barriers can be overcome.
10. Expand child protection and judicial services to prevent, identify and respond to abuse, violence and neglect of children.
11. Conduct in-depth analysis of the reasons behind the high levels of violence against children of all ages, and develop recommendations to reduce this problem including policy, front-line service provision, and communications activities.
12. Develop social support schemes to support and provide incentives for vulnerable groups in the population, including members of families affected with HIV who provide critical care for their children and other members living with HIV.



8. REFERENCES

- Aaby, P. (2015): Bandim health project: A platform for testing real-life effects of health interventions since 1978
- Abt Associates (2014): Health Finance and Governance Project. Health System Report: Guinea-Bissau
- African Health Worker Observatory (2010): Human Resources for Health. Country Profile Guinea-Bissau
- Afroteste (2013): Estudo sobre conhecimentos, atitudes, e práticas sobre os direitos das mulheres e meninas nas regiões de Bafatá, Gabú, Oio e Bolama/Bijagós
- Alanet (2012): Analyse économique et financière du secteur de l'eau et de l'assainissement
- Alode, M.A. (2013): Programme l'autonomisation communautaire (PAC) pour promouvoir l'abandon des mutilations génitales féminines/excision (MGF/E) en Guinée-Bissau: Evaluation externe finale
- Arvanitis, Y. (2014): African Economic Outlook. Guinea-Bissau
- Bastos, L. (2011): Relatório final do projeto de recolha e codificação do direito consuetudinário vigente na república da Guiné-Bissau
- Black, RE et al (2013). Maternal and child undernutrition and overweight in low-income and middle-income countries. *The Lancet*, 382, 427 – 451.
- Boiro, H., J. Ribeiro Butiam Có and R. Kuipon (2010): Etude sur le confiage des enfants en Guinée-Bissau. Profil socioéconomique des parents et type d'enfants destinés au confiage. Unpublished draft
- Chambers, R. And G. Von Medeazza (2014): Reframing undernutrition: Feacally-transmitted infections and the 5 A's
- Claesen, M. and R. J. Waldman (2000): The evolution of child health programmes in developing countries: from targeting diseases to targeting people
- De Milliano (2015): CC-MODA for Guinea-Bissau – Technical Report (Draft): Results of deprivation analysis for all children aged 0-17. Economic Policy Research Institute
- Effective Intervention (2011): Lacunas de conhecimento nas zonas rurais da Guiné-Bissau EMI, 2015: Estudo de viabilidade da gratuidade para a prestação de cuidados de saúde materno-infantis na Guiné-Bissau no contexto do Projecto H4+, Final report
- FEC, Filipa Gonçalves e Sofia Alves (2015) Crianças Irã: uma violação dos direitos das crianças.
- Food and Agriculture Organization, World Food Programme and Plan International (2013): “Com caju tutu bem?": Impact de la mauvaise campagne de commercialisation de la noix de cajou sur la sécurité alimentaire des ménages
- Germain, L. and A. Handem (2008): Análise da situação das crianças órfãs e vulneráveis na Guiné-Bissau. Elementos para uma estratégia nacional de protecção social para orfaos e crianças vulneráveis
- Government of Guine Bissau, UNESCO, Global Partnership for Education and UNICEF (2013), Relatório da Situação dos Sistemas Educativos Nacionais (RESEN). Preliminary results
- Government of Guine Bissau, UNESCO, Global Partnership for Education and UNICEF (2015), Relatório da Situação dos Sistemas Educativos Nacionais (RESEN). Preliminary results
- Guengant, J-P (2011): Comment bénéficier du dividende démographique? La démographie au centre des trajectoires de développement dans les pays de l'UEMOA. Contribution à l'analyse de la situation en Guinée-Bissau
- Guerreiro, S., A. L. Santos Dias, B. N'Dami, C. Silva, F. Semedo and H. Pires (2011): Access to Justice Assessment in Guinea-Bissau: Regions of Cacheu and Oio and Bissau Autonomous Sector
- Handem, J.S (2013): Cartografia de actores e análise de mecanismos de coordenação e colaboração dos intervenientes na protecção e apoio à crianças vítimas de tráfico na Guiné-Bissau
- Harper, C., N. Jones, E. Presler-Marshall and D. Walker (2014): Unhappily ever after. Slow and uneven progress in the fight against early marriage. Overseas Development Institute
- International Monetary Fund (2015): Regional Economic Outlook: Sub-Saharan Africa
- Ministry of Education, Culture, Science, Youth and Sports (2010): Plano Trienal de Desenvolvimento da Educação 2011–2013
- Ministry of Public Health (2010d): Inquérito de seroprevalência de VIH na comunidade
- Ministry of Public Health (2012): Plan opérationnel de passage à l'échelle nationale (POPEN) des interventions a haut impact (IHI). Stratégies pour l'accélération de la réduction des mortalités maternelles, néonatales et infant-juvénile en Guinée-Bissau
- Ministry of Public Health (2013): Deuxième enquête nationale sur l'état nutritionnel des enfants de moins de 5 ans et des femmes en âge de procréer (15 à 49 ans) en République de Guinée-Bissau
- Ministry of Public Health (2014a): Estudo de viabilidade da gratuidade para a prestação de cuidados de saúde materno-infantis na Guiné-Bissau no contexto do Projecto H4+

- Ministry of Public Health (2014b): Rapport de l'étude de base de l'Initiative H4+
- Ministry of Public Health (2014c): Vigilância sentinel nas gravidas na Guiné-Bissau
- Ministry of Women, Family and Social Cohesion and UNICEF (2015) (draft), Situation Analysis of Children in Residential Care
- Ministry of Public Health (2014) National AIDS Programme
- National Statistical Institute (2006): Enquête par grappes à indicateurs multiples 2006
- National Statistical Institute (2009): Recenseamento Geral da População e Habitação,
- National Statistical Institute (2010): Inquérito aos indicadores múltiplos (MICS 2010)
- National Statistical Institute (2011): Inquerito Ligeiro para Avaliação da Pobreza II. Resultados definitivos
- National Statistical Institute (2015a): Enquête nationale sur le travail des enfants en Guinée-Bissau
- National Statistical Institute (2015b): Inquérito aos indicadores múltiplos (MICS)2014. Preliminary results
- Republic of Guinea-Bissau (2015): Guinea-Bissau 2025. Sol na iardi. Plan stratégique et opérationnel 2015-2020
- Samba, A., I. Lona, R. Jorge, D. Mendes and I.A. Lopes (2014): Rapport de la mission conjointe CILLS/FAO/PAM/Gouvernement d'évaluation préliminaires des récoltes 2014/2015 en République de Guinée-Bissau
- SNV Netherlands Development Organisation (2010): O impacto da campanha do cajú sobre o abandono escolar na região de Biombo
- Udelsmann Rodrigues, C., A. Handem, and A. Bérard da Costa (2007): Towards functional and coordinated mechanisms for child protection in Guinea-Bissau.
- United Nations Children's Fund (2012): Progress for children. A report card on adolescents
- United Nations Children's Fund (2013): Towards an AIDS-free generation Children and AIDS. Sixth Stocktaking Report
- United Nations Children's Fund (2014): Levels and trends in child mortality. Report 2014. Estimates Developed by the UN Inter-agency Group for Child Mortality Estimation
- United Nations Children's Fund (2014a): Generation 2030 – Africa. Child demographics in Africa
- United Nations Children's Fund (2014b): Equity: A key thread in national education policy
- United Nations Children's Fund (2015): <http://data.unicef.org/>. Accessed February 2015
- United Nations Educational Science and Culture Organization (2015): Base d'indicateurs du Pôle de Dakar, <https://www.iipe-poledakar.org/fr/indicateurs/base-dindicateurs>. Accessed February 2015
- World Bank (2010): Migrations and remittances, Factbook 2011. Second Edition
- World Bank (2011): Main report. Vol. 1 of World report on disability
- World Bank (2011a): World Development Report 2011
- World Bank (2014a): Guinea-Bissau, Country Economic Memorandum. Terra ranca! A fresh start
- <http://data.worldbank.org/country/guinea-bissau>. Accessed February 2015
- World Bank (2015a): Guinea-Bissau, Country Economic Memorandum. Terra ranca! A fresh start
- World Food Programme (2013): Guinea-Bissau: Food Security Assessment Results
- World Food Programme (2014): Cadre Harmonisé d'analyse et d'identification des zones à risque et des populations en insécurité alimentaire au Sahel et en Afrique de l'Ouest. Résultats de l'analyse de la situation de l'insécurité alimentaire aiguë actuelle. Guinée-Bissau
- World Health Organization (2014): Global Health Expenditure Database
- World Bank (2014b):World Development Indicators. <http://data.worldbank.org/country/guinea-bissau>. Accessed February 2015

