Resuscitating "the Forgotten Sector in a Forgotten State": Catalyzing Improved Health Outcomes in Guinea-Bissau through the Millennium Development Goals

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Acronyms and Abbreviations

BHP	Bandim Health Project
CBHI	community-based health insurance
CCA	Common Country Assessment
CHWs	community health workers
DHS	demographic and health surveillance
EU	European Union
FAO	Food and Agriculture Organization
GDP	gross domestic product
HIPC	Heavily Indebted Poor Country
IFIs	International Financial Institutions
IMF	International Monetary Fund
LICs	low income countries
MINSAP	Ministry of Public Health of Guinea-Bissau
NGO	non-governmental organization
PNDS II	National Health Development Plan (2008-2012)
PRSP	Poverty Reduction Strategy Paper
SSA	Sub-Saharan Africa
SWOT	strengths, weaknesses, opportunities, and threats
THE	total health expenditure
UN	United Nations
UNDAF	United Nations Development Assistance Framework
UNDP	United Nations Development Program
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNOCHA	United Nations Office for the Coordination of Humanitarian Affairs
UNOGBIS	United Nations Peacebuilding Support Office in Guinea-Bissau
USAID	United States Agency for International Development
WFP	World Food Program
WHO	World Health Organization

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"Effective, accountable states are essential for development. States ensure health, education, water, and sanitation for all; they guarantee security, the rule of law, and social and economic stability; and they regulate, develop, and upgrade the economy. *There are no short cuts*, either through the private sector or social movements, although these too play a crucial role."[1]

- Oxfam International

"One had the perception that in Guinea-Bissau there was merely the skeleton of a state: everything was there nominally (the ministries, the regional administration, the candidates, the parliament), but it was in a condition of complete paralysis and inefficiency. There was the seat of the administration, the functionaries etc, but – as a skeleton without muscles – they could not do anything. No control at all of the territory and the people."[2]

- Lorenzo Bordonaro

Executive Summary

The citizens of Guinea-Bissau suffer among the worst health indicators in the world. Poor health, education, and economic development in the country stem from weak governance and insufficient and volatile aid flows. At the dawn of the twenty-first century, Guinea-Bissau has joined other low-income countries in embracing the Millennium Development Goals (MDGs). The Ministry of Public Health in Guinea-Bissau seeks to reform health care through an emphasis on the MDGs. The individual MDGs provide concrete health targets, and the government's commitment to their collective pursuit has inspired reinvigorated planning and coordination. Given the strong role of improved health outcomes in fostering poverty reduction, Guinea-Bissau's achievement of the health-related MDGs could have spill-over effects beyond the health sector. With technical assistance from the World Bank and the United Nations, the Ministry of Public Health is leading a campaign to deliver high-quality, affordable care through improvements in health infrastructure, human resources, and health financing. Instituting user-fee and cost-recovery reforms remain its top priorities. Reforms beyond the health sector related

[1] Duncan Green, *From Poverty to Power: How Active Citizens and Effective States Can Change the World*, (Oxford: Oxfam International, 2008), 22.
[2] Lorenzo Bordonaro, "Living at the Margins: Youth and Modernity in the Bijagó Islands (Guinea-Bissau)," Instituto Superior de Ciências do Trabalho e da Empresa, May 2007, 210. Available at: https://repositorio.iscte.pt/handle/10071/348.

to agriculture, infrastructure, education, and water and sanitation can also contribute substantially to the health-related MDGs. With effective governmental stewardship across ministries and adequate assistance from international partners, the Ministry of Public Health's strategic plan for reform holds the potential to accelerate Guinea-Bissau's achievement of the health-related MDGs. However, renewed political instability or inconsistent donor support could jeopardize progress.

"The number of people infected by a cholera outbreak in Guinea-Bissau doubled in July to more than 600 and infections have spread to areas of the country previously considered low risk, health experts warn…. A major epidemic in 2005 infected 2,500 people and killed 400."[3]

- UN OCHA (July 2008)

"There was a standoff at the airport when soldiers tried to stop police searching the aircraft, said to contain 500kg (1,102lb) of cocaine…. Guinea-Bissau is a major hub for gangs moving cocaine from Latin America to Europe…. Last month the United Nations warned that smugglers were operating there with almost total impunity, aided by rampant corruption. It is estimated that the volume of cocaine moved through Guinea-Bissau in 2007 was worth more than its entire national income."[4]

- BBC News (July 2008)

I. Introduction

During one week in July 2008, the leadership of Guinea-Bissau faced two daunting challenges rooted in the weak governance of the small West African state: a cholera outbreak that spread quickly through the capital and the capture of a planeload of cocaine that military officials were apparently complicit in trafficking. Unfortunately, these emergency situations are all too common in this fragile, post-conflict state. Wracked by political instability since gaining independence from Portugal in 1974 and still recovering from a civil war in 1998-1999, Guinea-Bissau struggles to transform its government, economy, health system, and education sector. Although some international partners that discontinued assistance to Guinea-Bissau after the civil war are now turning increased attention to the nation's efforts to consolidate peace, combat drug trafficking, and bolster the economy, many aspects of the nation's reconstruction, especially the areas of health and education, have not been adequately prioritized, managed, or financed. Public health, in particular, has suffered as a consequence of instability in Guinea-Bissau and has not drawn the sustained attention of key actors in the government, the United Nations, or bilateral donors. Indeed, a senior official in the government of Guinea-Bissau confirms that

[3] UN Office for the Coordination of Humanitarian Affairs (OCHA), "Cholera Outbreak Escalating," accessed July 23, 2008: http://www.irinnews.org/Report.aspx?ReportId=79395.
[4] BBC News, "Guinea-Bissau Drugs Plane Seized," accessed July 20, 2008: http://news.bbc.co.uk/2/hi/africa/7516513.stm.

health is "the forgotten sector in a forgotten state."[5] As first-world governments provide unprecedented financial and technical assistance to improve health in many developing countries, the citizens of Guinea-Bissau face a life expectancy of less than 45 years, and the international community largely overlooks their plight.[6] The results of the historical deprioritization of health in Guinea-Bissau are clear: infant, child, and maternal mortality rates are among the highest in the world; contraceptive prevalence stands at less than half the average for all African countries; and there are only 12 doctors to aid every 100,000 citizens.[7] The responsibility for poor health outcomes is shared among government officials and development partners alike: combined contributions from the government and donors for health care amount to less than $8 per capita per year, substantially less then the $34 per capita necessary to provide quality and equitable coverage for all citizens.[8] By the government's own account, Guinea-Bissau is not on track to achieve any of the Millennium Development Goals (MDGs) by 2015.[9] The eight MDGs serve as a guide for developing countries in their efforts to achieve progress in poverty reduction, food security, health, and education.

While headlines emphasizing poor governance and poor health in the country remain common, there are many reasons for optimism as the citizens of Guinea-Bissau chart a course for socioeconomic development in the twenty-first century. At the heart of the nation's rejuvenated health and human development planning are the Millennium Development Goals. While Guinea-Bissau may not reach the MDGs by 2015, these targets have inspired the recently developed frameworks that will guide government policy and donor assistance in the coming decade. In this

[5] Interview notes, April 2008.
[6] 2007/2008 Human Development Index: http://hdrstats.undp.org/countries/country_fact_sheets/cty_fs_GNB.html.
[7] WHO Country Health System Fact Sheet: http://www.afro.who.int/home/countries/fact_sheets/guineabissau.pdf.
[8] Guinea-Bissau Global Fund Round 7 Proposal: http://www.theglobalfund.org/search/docs/7GNBH_1513_0_full.pdf.
[9] Guinea-Bissau: Poverty Reduction Strategy Paper (PRSP), IMF, October 2007: 23. Available at: http://www.imf.org/external/country/GNB/index.htm.

paper, I will analyze Guinea-Bissau's failing health sector utilizing the lens of the health-related MDGs and explore policy options for catalyzing the strengthening of the health care system. I will review the origins of the current fragility of the government, economy, and social sectors, evaluate Guinea-Bissau's progress toward the health-related MDG targets, analyze the primary challenges of the health care system, and present recommendations to accelerate a renewed pursuit of the MDGs. The findings emerge from the following sources: journal articles in public health, development economics, and peacebuilding; planning documents from the Ministry of Public Health of Guinea-Bissau (MINSAP), the United Nations (UN), and the World Bank; and interviews conducted with officials from MINSAP, the UN, the World Bank, and the Bandim Health Project, a demographic and health surveillance (DHS) field site in Guinea-Bissau.[10]

II. Overview of Governance and the Economy

Guinea-Bissau is a small West African nation on the Atlantic coast that shares borders with Senegal and Guinea. The population of 1.6 million is ethnically diverse, with over twenty ethnic groups that have distinct languages. The four largest ethnic groups, the Balanta, Fulani, Manjaco, and Mandinga, comprise more than three-quarters of the population.[11] Kriolu, a creolized version of Portuguese, is the most widely spoken language in the country although the official language is Portuguese. Guinea-Bissau has large animist (50%) and Muslim (45%) populations and a smaller percentage of Christians (5%).[12] Much of Guinea-Bissau's rural population engages in the production of rice, the main staple food, and cashews, the primary cash

[10] Interviews conducted by phone in February 2008 with officials from MINSAP, the UN, and World Bank and in-person in April 2008 in Guinea-Bissau with officials from MINSAP, the UN, and BHP.
[11] Jonina Einarsdottir, *Tired of Weeping: Mother Love, Child Death, and Poverty in Guinea-Bissau*, (Madison: University of Wisconsin Press, 2004), 8-9.
[12] UN OCHA, country profile: http://www.irinnews.org/country.aspx?CountryCode=GW&RegionCode=WA.

crop. Migration to the capital of Bissau has increased in recent years, and over a quarter of citizens now live there.

Guinea-Bissau struggles with poor health services, chronic poverty, and food insecurity that are rooted in the inability of the nation to build stable and effective governance institutions. After a decade-long military struggle against the Portuguese, the citizens of Guinea-Bissau held great hope for the economic and social development of their nation at the dawn of independence in 1974. Unfortunately, over three decades later, the country has made little progress. Guinea-Bissau ranks 175 out of 177 countries in the UN Human Development Index, which incorporates measures of health, education, and standard of living. The political leaders and governance institutions of postcolonial Guinea-Bissau have consistently failed to facilitate pro-poor economic and social progress, and the country has endured many critical governance failures including multiple coups, the 1998-1999 civil war, and the current drug trafficking crisis.

Origins of Instability

Academic studies of governance and community structure in Guinea-Bissau offer insights regarding the roots of weak government institutions that could inform the development of poverty reduction and public health strategies in the nation. In *Lineages of State Fragility*, anthropologist Joshua Forrest describes how Guinea-Bissau's loosely allied rural ethnic groups successfully evaded centralized control structures throughout most of the Portuguese colonial period and even after winning independence in 1974. The ethnic communities comprising Guinea-Bissau's citizenry were sufficiently *interdependent* to collectively expel the Portuguese during the colonial war and drive out their own president and two foreign armies during the 1998-1999 civil war. At the same time, they have been adequately *independent* to evade the

coordination of regional or central governments. Forrest argues that rural communities in Guinea-Bissau have generally had strong local civil society leaders that inspired their constituencies to resist outside control not out of a sense of commonality, but out of a sense of common self-interest.[13]

Amilcar Cabral, one of the most charismatic anti-colonial leaders in African history, united the rural communities of Guinea-Bissau to fight the Portuguese military during the struggle for independence in the 1960s and early 1970s. Cabral founded the PAIGC[14] in 1956 and initiated a campaign for independence. By the early 1970s, the PAIGC had driven Portuguese troops out of ninety percent of the country and "the indigenous anti-colonial forces had produced dissension within the Portuguese military of such intensity that it directly contributed to the 1974 coup in Lisbon and the subsequent reversal of Lisbon's overseas policy."[15] The Republic of Guinea-Bissau and Cape Verde declared independence in late 1973 following Cabral's assassination earlier that year. The international community recognized the nation's independence with the fall of the Portuguese dictatorship in 1974; however, Cape Verde and Guinea-Bissau separated in 1980 after Bernardo Joao "Nino" Viera led the first of many post-colonial coups in Guinea-Bissau.[16] Viera, the current president, has served as dictator and sometimes democratically-elected leader for much of the postcolonial era.

Although communities in Guinea-Bissau prized cooperation in the war against the Portuguese, their lack of cohesion since then has prevented the formation of a nation-state with effective governance structures that can deliver social services and promote economic growth. Forrest posits that the strengths that aided rural communities in their struggle against the

[13] Ibid., 246.
[14] African Party for the Independence of Guinea and Cape Verde
[15] Forrest, 243.
[16] Einarsdottir, 16.

Portuguese also helped them resist the control of the new state after independence. The PAIGC did not build upon traditional social and political structures of authority in rural communities, and contradicting Cabral's pro-poor teachings, "the PAIGC largely maintained the colonial administrative structure and used this…as a means to personal wealth and power."[17] While rural communities have evaded central government control, Guinea-Bissau's leaders have consistently given citizens ample reason to distrust them.

The PAIGC's agricultural reform agenda in the 1970s and early 1980s failed, and the government requested International Monetary Fund (IMF) and World Bank assistance in the mid-1980s. In the late 1970s and the early 1980s, PAIGC attempted to control rural communities by imposing state-sponsored agricultural committees, running a state marketing board, and fixing producer prices; however, "complete control over agriculture was limited by administrative weakness, and independent farming and small-scale trading were allowed to co-exist with state-run agricultural cooperatives and collectives."[18] Drought and locusts harmed the production of rice and other agricultural goods in the early 1980s, and "finding food to buy or borrow was a full time job for many."[19] One aspect of the economy that did show promise in the 1980s was cashew production. The Portuguese colonizers introduced cashew growing in Guinea-Bissau in the 1950s, and their investment paid off in the 1980s when the world price of peanuts fell and the cashew trade became Guinea-Bissau's primary export and earner of foreign exchange.[20]

However, cashews were not enough to save Guinea-Bissau's ailing economy in the 1980s. The government accrued an extremely large debt burden and became increasingly dependent on donors. A study of food security in Guinea-Bissau notes that "in the early 1980s,

[17] Jens Kovsted and Finn Tarp, "Guinea-Bissau: War, Reconstruction, and Reform," UNU World Institute for Development Economics Research (UNU/WIDER) Working Paper No. 168, 1999, 6.
[18] Ibid., 7.
[19] Laura Bigman, *History and Hunger in West Africa*, (Westport, CT: Greenwood Press, 1993), 114.
[20] Ibid., 115.

the value of exports was only 25% that of imports, and 60% of the funds raised through exports were going solely toward [servicing] foreign debt."[21] The government's level of borrowing was not sustainable, and Guinea-Bissau turned to the IMF and World Bank, which instituted a structural adjustment program (SAP) to curb government spending and borrowing. After initial increases in growth, savings, and investment, the economy suffered under the program, and livelihoods and food security were further jeopardized:[22] "the SAP increased unemployment and underemployment at the same time as it fueled inflation and caused food prices to skyrocket. Taxes went up and subsidies on food were eliminated…. As part of the reform package, the country's major employer, the state, terminated several thousand workers, cutting back others' hours and pay…. In order to eat, hundreds of unemployed became part of a growing army of newly licensed vendors. Others turned to hustling, theft, and prostitution."[23] In addition to increasing unemployment and food prices, structural adjustment alienated Guinea-Bissau's leaders from its citizens even more, particularly in rural areas. As the small nation's politicians and administrators focused their attention on the IMF, World Bank, and other donors, they turned away from the social and economic realities of the rural poor.

The increasing fragility of the government as it implemented the SAP reinforced its dependence on a large military to fortify authority. However, as the government eventually started to cut the military budget to comply with the SAP in the 1990s, its tactic of relying heavily on the armed forces failed. As President Viera attempted to reduce jobs in the military, he lost the support if its leadership and set the stage for the civil war of 1998-1999. The World Bank summarizes the general causes of the war as "failed governance, breakdown of rule of law,

[21] Ibid., 116.
[22] Kovsted and Tarp, 7.
[23] Bigman, 116.

and limited accountability and transparency of public sector management."[24] The immediate trigger of the unrest, which lasted from June 1998 to May 1999, was President Viera's sacking of the leader of the military, Ansumané Mané, after accusing him of selling arms to the Casamance rebels in Senegal. Mané then led the army in revolt against President Viera, who received military support from Senegal and Guinea. During the course of the war, two-thirds of the military and the majority of the population backed Mané. With widespread support, Mané and his troops drove the Senegalese and Guinean troops out of Guinea-Bissau and forced Viera into exile.[25]

The anthropologist Forrest paints the internal war of 1998-1999 not as a civil conflict between ethnic or geographic factions in a divided nation, but as a national struggle by the military and the population to oppose the control of the elite leadership of the country. He claims that the civil war was "another victory for rural civil society,"[26] but this was clearly a pyrrhic victory: between 2,000 and 6,000 people were killed; approximately 350,000 people, mostly residents of the capital Bissau, became internally displaced persons (IDPs); mines were laid throughout the country; and health facilities, schools, businesses, and roads were destroyed. The people of Guinea-Bissau received little external aid during the crisis. This was partially due to the country's lack of geo-political significance, the fact that there were few external refugees, and that the IDPs chose to live with families rather than form camps.[27] The overall mortality rate rose 78% and the mortality rate for children under five increased 100% during the first six months of the war due primarily to crowding and poor hygiene as IDPs moved in with families

[24] Boubacar-Sid Barry et al, "Chapter 1: A Brief Overview," *Conflict, Livelihoods, and Poverty in Guinea-Bissau*, (Washington, DC: The World Bank, 2007), 12-13.
[25] Details of the 1998-1999 civil war from Kovsted and Tarp, 10-15 and Forrest, 229-232.
[26] Forrest, 229.
[27] Hjalte Tin, "The Benefit of Failure: WFP, Food Aid, and Local Survival in Guinea-Bissau, 1998-99," Center for Development Research, Copenhagen (June 2001), 8.

in the towns surrounding the capital.[28] Food security also suffered during the war due to a variety of factors including the onset of the agricultural season (the "lean season"), when "food stocks are low and the workload involved with planting and preparing for the next season is high."[29] The confluence of the start of the war, the beginning of the lean season, and the flow of IDPs into rural communities contributed to a severe food shortage. The World Bank estimates the damage to public infrastructure during the war at $25-$30 million and the destruction of private infrastructure at $90 million.[30] Prior to the conflict, Guinea-Bissau's GDP per capita had reached its highest point in history ($206) after a steady rise during the 1990s, but it crashed by 30% to $145 with the outbreak of war in 1998.[31]

Governance and Economic Development Today

The effects of the civil war and its underlying causes continue to contribute to poor health and poverty in Guinea-Bissau today. The legacy of weak central authority, political instability, and corruption all partially explain the underperformance of the government, economy, and social sectors. The World Bank highlights the following deleterious qualities of the government: "In Guinea-Bissau, boundaries between the public and private sectors are often poorly defined. The financial accountability system remains weak, and the disclosure of information on public accounts is limited. This has contributed to the erosion of public confidence in the government and, thus, citizens' willingness to pay taxes or support government policies. As a result, indicators for the rule of law, government effectiveness, and the overall risk rating…are among

[28] Nielsen, J. et al, "Mortality Patterns During A War in Guinea-Bissau 1998-99: Changes in Risk Factors?," *International Journal of Epidemiology*, 35: 438-445 (2006), 441.
[29] Kovsted and Tarp, 14.
[30] Boubacar-Sid Barry et al, "Chapter 2: Conflict Growth, and Poverty in Guinea-Bissau," *Conflict, Livelihoods, and Poverty in Guinea-Bissau*, (Washington, DC: The World Bank, 2007), 14.
[31] World Bank WDI Online accessed on October 5, 2007.

the lowest in Sub-Saharan Africa."[32] Based on a 2005 survey, the World Bank estimates that most citizens have little trust in the military, police, judiciary, or central government, but they view schools and health centers more favorably.[33] The current drug-trafficking crisis presents the government with a significant security challenge, but it has attracted a modest increase in support from donors to reform the police, judicial, and military institutions. Poor law enforcement, widespread corruption, and Guinea-Bissau's geographic location provide an ideal transit hub for Latin American drug traffickers transporting cocaine to Europe.[34] The post-civil war political situation has been marred by ineffective presidential leadership and significant military intervention. The colorful political intrigue of recent years has included the following: the free and fair election of an opposition candidate, Kumba Yala, in 2000; two failed coup attempts in 2001; a successful coup in 2003 followed by a transitional government; and another free and fair election in 2005 through which the people of Guinea-Bissau re-elected the formerly deposed president, Nino Viera, who had returned from exile.[35]

The current per capita GDP of just $136 is very low compared to the average for Sub-Saharan Africa (SSA) of $583,[36] and both the agriculture and fishing industries in Guinea-Bissau are severely underdeveloped.[37] Despite the economy's initial post-war recovery from 1999-2000, boosted by increased cashew production, Guinea-Bissau's GDP has shown only modest signs of growth in the twenty-first century. GDP per capita averaged just $143 from 1999 to 2006.[38] A World Bank study shows that cashew production significantly impacts GDP growth in Guinea-

[32] Barry et al, "Chapter 1," 5.
[33] Ibid., 6.
[34] Destrebecq, Denis, "Cocaine Trafficking in Western Africa," UN Office on Drugs and Crime, October 2007, 6. Available at: http://www.unodc.org/documents/data-and-analysis/Cocaine-trafficking-Africa-en.pdf.
[35] Barry et al, "Chapter 2," 12-13.
[36] World Bank WDI Online accessed on October 5, 2007.
[37] Estanislao Gacitua-Mario et al, "Chapter 5: Livelihoods in Guinea-Bissau," *Conflict, Livelihoods, and Poverty in Guinea-Bissau*, (Washington, DC: The World Bank, 2007), 59.
[38] World Bank WDI Online accessed on October 5, 2007.

Bissau.[39] Low world market prices for cashews and the weakening U.S. dollar (world cashew prices are tied to the dollar, while Guinea-Bissau's currency, the CFA, is tied to the euro) have detracted from cashew sector revenues. Although cashew production is steadily increasing, it has not translated into improved livelihoods for the poor. In 2005, nearly 65% of people lived below the absolute poverty line of $2 per day and 22% lived below the extreme poverty threshold of $1 per day.[40] Two areas of potential government revenue that have yet to be fully exploited are offshore petroleum and bauxite mining. Oil exploration recently began, and the government has just signed a bauxite mining agreement with Angola.[41]

Given the high level of poverty and food insecurity in Guinea-Bissau, residents in both rural and urban areas depend on a diversity of income generation activities and informal social safety nets. In rural areas, people raise chickens and goats and grow a variety of vegetables and fruits in addition to the primary agricultural activities of cashew and rice production. Due to the poor transportation infrastructure, rural producers have very limited access to markets, and "the constraints in accessing markets, and transforming and conserving their products, each year lead to the rotting and wastage of tons of products, particularly fruits and horticultural produce."[42] Despite the blessings of abundant rain and fertile soil, Guinea-Bissau's agriculture sector is severely underdeveloped. According to the UN, "only 36% of the total available arable land is cultivated due to a lack of agricultural inputs, expertise, and a lack of drainage and irrigation systems."[43] The fishing sector is also underexploited in Guinea-Bissau. Fish serves as a primary source of food for those living in Guinea-Bissau's archipelago, but most mainland coastal

[39] Ibid., 15.
[40] Guinea-Bissau PRSP (2007), 46.
[41] "Oil-rich Angola Plans Bissau Bauxite Mine," Reuters, June 26, 2008: http://africa.reuters.com/country/GW/news/usnL26198997.html.
[42] Gacitua-Mario et al, "Chapter 5," 62.
[43] UN OCHA, country profile: http://www.irinnews.org/country.aspx?CountryCode=GW&RegionCode=WA.

residents turn to fishing only during the lean season. Fishing holds great potential as a means of generating income and contributing to food security. Although the domestic fishing industry is underdeveloped, the government derives significant income from the sale of fishing rights to foreign governments.[44]

Most residents in Bissau, the capital, engage in informal economic activities.[45] Many women maintain urban gardens, and they are "particularly important in ensuring the regular supply of fresh foods" in the capital.[46] Female traders often sell fruits, vegetables, cashew wine, roasted groundnuts, fish, firewood, and coal. Men normally attempt to string together a variety of activities including construction, dock, and transportation jobs. Most positions in the formal sector are public sector jobs (civil servants, soldiers, police officers, teachers, and health care workers), and they are held predominantly by men. Urban households must patch together various economic activities to meet the basic food needs of all of their members.[47] Few citizens in Guinea-Bissau have access to considerable savings and most rely on informal social safety nets to smooth consumption during difficult times. When in need, Guineans usually turn first to family members and then to their neighbors. Many villages have social clubs or rotating savings groups that can provide economic assistance. Of course, people who live in extreme poverty, especially those that have migrated from their families or are divorced women, have less access to the aid of social safety nets.[48] A principal factor that precludes entrepreneurs of all sizes from starting or growing businesses is the lack of credit in Guinea-Bissau. In its November 2007 review of the government's recently completed Poverty Reduction Strategy Paper (PRSP), the

[44] Gacitua-Mario et al, "Chapter 5," 70-73.
[45] Ibid., 63.
[46] Ibid., 64.
[47] Information on rural and urban livelihoods is derived from Gacitua-Mario et al, 60-66.
[48] Estanislao Gacitua-Mario et al, "Chapter 3: Institutions, Social Networks, and Conflicts in Guinea-Bissau," *Conflict, Livelihoods, and Poverty in Guinea-Bissau*, (Washington, DC: The World Bank, 2007), 31-33.

IMF highlighted this problem and called on the government to facilitate the creation of banks and credit opportunities in Bissau and rural areas.[49]

Food security remains a daunting challenge for households and communities in Guinea-Bissau. Rice production rebounded after the war to 106,080 tons in 2000, but decreased sharply in 2003 to 66,420 tons partially due to instability caused by a military coup that year. Guinea-Bissau imports rice to smooth consumption, and farmers often barter cashews for imported Indian rice. Rice production has not returned to its peak level of the early 1990s. The World Bank fears that cashew production undermines rice production and contributes to food insecurity. It cites the cashew boom of the 1990s as a primary cause of the shortfall in rice production, which is "due mainly to the increased reallocation of agricultural land and labor force to cashews."[50] The Bank advocates greater self-sufficiency in rice production, but emphasizes that high-yield seeds and improved transportation infrastructure are necessary to make this a reality.[51]

Guinea-Bissau produces one-sixth of the world's cashews and the nuts make up 90% of the country's total exports. Constraints on the cashew industry include "cumbersome administrative arrangements, a weak legal system, and an absence of credit that lead to high transaction costs for cashew buyers and exporters, which help decrease the farm-gate price of the raw nuts."[52] The government impedes progress by not reforming unclear property and investment laws, not catalyzing growth of the banking sector, and by charging export taxes. The World Bank and IMF identify the processing of cashews as a potential source of significant

[49] "IMF Executive Board Concludes 2007 Article IV Consultation with Guinea-Bissau," Public Information Notice 07/133. Available at: http://www.imf.org/external/country/GNB/index.htm.
[50] Boubacar-Sid Barry et al, "Chapter 6: Cashew Production, Taxation, and Poverty in Guinea-Bissau," *Conflict, Livelihoods, and Poverty in Guinea-Bissau*, (Washington, DC: The World Bank, 2007), 83
[51] Ibid., 84.
[52] Barry et al, "Chapter 6," 77.

revenue for growers in Guinea-Bissau. Currently, growers only sell raw cashews to traders and do not engage in processing that could add value to the sale of the commodity. Other challenges in the cashew sector include a lack of research on how to improve disease resistance and the uneven decline of cashew prices over the last 20 years.[53]

The country's dependence on a single cash crop, despite favorable agricultural conditions for diversification, is "a disaster waiting to happen" and "like playing Russian roulette" according to UN officials.[54] Guinea-Bissau received 1,000 tons of food aid in 2006 in response to low rice production and low cashew sales resulting from foreign buyers' refusal to pay the high prices recommended by the government.[55] Although the government does not legally set export prices for cashews, it recommended that farmers demand a price for their cashews that was higher than the world market price. Farmers followed the government's advice and traders from India, the only major buyer of the country's cashews, refused to purchase the nuts. Farmers' inability to sell their cashews contributed substantially to the food security crisis that year. The IMF argues that the government's price-setting recommendations in 2006 served to "disrupt the export supply chain" and "harm economic growth."[56] The food security crisis of 2006 was particularly harmful because the government did not have an adequate early warning system in place and was slow to alert the World Food Program (WFP) as the crisis developed.[57] Due to the dependence on the underdeveloped cashew sector, lack of crop diversification, lower than necessary rice production, and poor economic policies, a state of food insecurity exists in Guinea-Bissau such that many people regularly survive on just one meal a day.[58]

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[53] Ibid., 80-81.
[54] "Guinea-Bissau: Hunger in a Land of Plenty," OCHA, February 20, 2007: http://www.irinnews.org/Report.aspx?ReportId=70272.
[55] Ibid.
[56] "IMF Executive Board Concludes 2007 Article IV Consultation with Guinea-Bissau."
[57] "Guinea-Bissau: Hunger in a Land of Plenty," OCHA, February 20, 2007.
[58] Gacitua-Mario et al, "Chapter 5," 63.

In addition to its poverty reduction and public health challenges, Guinea-Bissau lags behind all other countries (except its West African neighbors of Burkina Faso and Sierra Leone) on the Human Development Index due to its underperforming education sector. Literacy rates currently stand at only 58% for men and 27% for women.[59] Schools have poor attendance rates, especially for girls, and high teacher-to-student ratios. The standard teacher-to-student ratio is 1:39, but if only adequately trained teachers are considered, the ratio jumps to 1:96.[60] Only 54% of boys and 36% of girls between the ages of 7 and 12 attend school. Few teenage girls complete secondary school due to early marriage, pregnancy, or the need to assist in income-generating activities for the household. [61] In its 2007 PRSP, the government recognizes that education should be an important priority in the nation's effort to combat poverty, and it is now partnering with the World Bank to implement reforms. The Bank is currently funding an emergency program to pay all teacher salaries.

Fifteen years after independence, a former high-ranking government official concluded that the state of Guinea-Bissau was "not yet a nation."[62] Today, nearly 35 years after independence, the country still struggles to develop a forward-looking national identity and a functional, transparent administrative bureaucracy. The government has been ineffective at cultivating public or private institutions that provide health security or engender economic growth. The citizens of Guinea-Bissau pay the price for this failure in the currency of unrealized dreams of self-sufficiency and years of life lost to disease.

[59] UN OCHA, country profile: http://www.irinnews.org/country.aspx?CountryCode=GW&RegionCode=WA.
[60] Guinea-Bissau PRSP (2007), 18.
[61] Ibid.
[62] Kovsted and Tarp, 9.

III. The Pursuit of the Health-Related Millennium Development Goals

Why Health is at the Heart of the MDGs

The primary development actors in Guinea-Bissau (the government, UN, and World Bank) all base their strategic plans on the Millennium Development Goals articulated in the United Nations Millennium Declaration of 2000 and agreed to by heads of state in the developing world. The MDGs are targets intended to accelerate human development and poverty reduction at the beginning of the twenty-first century. Health plays a major role in six of the eight MDGs.[63] In this section, I will examine why health holds such a prominent position in the MDGs and assess their potential and limitations for Guinea-Bissau.

While promoting health has long been lauded as a worthy goal of development programs, advocates and researchers are providing increasing evidence that health is an essential driver of social and economic development. Results from development programs in recent decades have confirmed that the assumption that economic growth will naturally lead to improved health, food security, and education for communities in poor countries is deeply flawed. Actually, development research has revealed that improvements in health outcomes are necessary to ensure sustained reductions in poverty. In her study of the relationship between health and business, Rodriguez-Garcia argues that "A body of empirical research has validated the health-development link paradigm by demonstrating that income cannot rise among the poor if there are no concomitant improvements in their health status (ECLAC, 1992; UNDP, 1992; WHO, 1991; World Bank, 1993). Studies also show that increased income alone does not automatically lead to improved health status (ECLAC, 1992; UNDP, 1996; WHO, 1991). While higher living standards and improved purchasing power generally accompany economic growth, they do not

[63] Adam Wagstaff et al, "Millennium Development Goals for Health: What Will It Take to Accelerate Progress?" *Disease Control Priorities in Developing Countries*, (Washington, DC: The World Bank, 2006), 182.

necessarily translate into human development (UNDP, 1992)."[64] Intricate linkages exist among health, economic development, education, and peacebuilding that require nuanced empirical research. While each of these areas can reinforce or undermine progress in the others, it is becoming increasingly clear that health plays a primary role in human development and human security. The World Health Organization (WHO) recognizes the importance of health in strengthening communities and economies, and at the 1991 International Health Conference in Accra, the organization emphasized that "No longer were health status and development entities to be pursued independently…. For the first time, positive health status was seen as being an essential objective of and a condition for development. Most important, it was recognized that greater wealth, whether for countries, communities, or individuals, is not a sufficient guarantee of improving health status because of the random nature of the allocation of resources."[65] Based on their experience in the field, UN agencies further examined the complex relationships between health and economic growth during the 1990s and affirmed the crucial role of health in poverty reduction in the 2000 Millennium Declaration and the Millennium Development Goals.

While the benefits of strong health to livelihoods and economic productivity are straightforward — healthy citizens can work or study more and avoid costly treatments or drugs — some researchers argue that development practitioners should shift their orientation to view health as the ultimate goal of economic growth rather than the other way around. In addition to detailing the contributions of health to economic growth in her study, Rodriguez-Garcia advocates that improved health should be the explicit goal of development planning and practical steps should be taken to ensure that the benefits of economic growth are used to improve health outcomes. In their prescription for sequencing reforms following the 1998-1999 civil war in

[64] Rosalía Rodriguez-Garcia et al, *Microenterprise Development for Better Health Outcomes*, (London: Greenwood Press, 2001), 32.
[65] Ibid., 10.

Guinea-Bissau, Tarp and Kovsted recommended prioritizing the health and agriculture sectors. It is clear that their advice has gone unheeded and that poor health in Guinea-Bissau still holds back economic and social development today. For centuries, Portugal extracted wealth from the Guinean territory while ignoring the health and education of its people. Amilcar Cabral, the independence leader, recognized that health and education would not only drive Guinea-Bissau's economy after independence but would also ensure success in the fight for freedom. In the liberated territories during the war against the Portuguese, Cabral institutionalized these sectors and regularly exclaimed, "with hospitals and schools we can win the war!"[66] Perhaps the greatest tragedy in the history of the young nation is its failure to act upon the wisdom of its national hero and effectively deliver health services. Many more children have fallen victim to easily preventable diseases in the years since independence than the number of soldiers who died during the nation's long and bloody struggle for freedom.

Although the MDGs span a wide range of health priorities, they are not a prescription of all the steps that a country must take to improve its population's health. They do not advise governments on how to identify performance gaps in the management of hospitals or clinics or how to design and implement improvements to each link of the chain of health care delivery. How, then, can the MDGs assist a fragile state like Guinea-Bissau in comprehensively transforming public health? Policymakers, administrators, and health care professionals in Guinea-Bissau must utilize the MDGs as a guide on two levels: first, as literal achievement targets related to some of the country's most critical public health priorities; and second, as a means of galvanizing the internal and external resources, motivation, and ownership necessary to create a health system capable of delivering high-quality and equitable care. The six health-related MDGs provide concrete targets to dramatically improve health in Guinea-Bissau. They

[66] Bordonaro, 114.

also provide the intangible benefit of a platform for development advocates to lobby for change. The separate goals may not add up to a complete framework for reform; however, taken as a whole, the MDGs do have the potential to radically improve health outcomes in Guinea-Bissau and other low income countries.

The Health-Related Millennium Development Goals

Goal 1*—eradicating extreme poverty and hunger*. This goal includes as a target the halving between 1990 and 2015 of the proportion of people who suffer from hunger (measured in terms of the prevalence of underweight children under the age of 5). The target implies an average annual rate of reduction of 2.7%.

Goal 4*—reducing child mortality*. The target is to reduce by two-thirds between 1990 and 2015 the under-five mortality rate, equivalent to an annual rate of reduction of 4.3%.

Goal 5*—improving maternal health*. The target is to reduce by three-quarters between 1990 and 2015 the maternal mortality ratio, equivalent to an annual rate of reduction of 5.4%.

Goal 6*—combating HIV/AIDS, malaria, and other diseases*. The target is to halt and begin to reverse the spread of these diseases by 2015.

Goal 7*—ensuring environmental sustainability*. This goal includes as a target the halving by 2015 of the proportion of people without sustainable access to safe drinking water and basic sanitation.

Goal 8*—developing a global partnership for development*. This goal includes as a target the provision of access to affordable essential drugs in developing countries.

Source: Adam Wagstaff et al, "Millennium Development Goals for Health: What Will It Take to Accelerate Progress?" *Disease Control Priorities in Developing Countries* (World Bank, 2006).

Progress toward the Health-Related MDGs in Guinea-Bissau

The MDG targets recommend measuring progress using 1990 as the baseline year and 2015 as the end point. More than half of the way through the monitoring period, Guinea-Bissau is not on track to achieve any of the health-related MDGs as defined in the Millennium Declaration:

Goal 1 *- Eradicating extreme poverty and hunger*: The country's Poverty Reduction Strategy Paper records malnutrition among children under five at 33% in 1990 and 27% in 2002.[67] Progress toward combating hunger has been slow and it is very unlikely that Guinea-Bissau will

[67] Guinea-Bissau PRSP (2007), 20 and 46.

reach the MDG 1 target by 2015. Moreover, 30% of children under five experience "retarded growth," and 28% of births are considered low-weight.[68] A WFP vulnerability assessment reports that 34% of households are "very highly vulnerable" to food insecurity and an additional 28% fall into the "vulnerable" category.[69]

Goal 4 - *Reducing child mortality*: Children are more likely to die at a young age in Guinea-Bissau than in most any other country in the world, and the situation has worsened since the 1998-1999 civil war. In 1990, the infant mortality rate was 142 per 1,000 live births. In 2000, the infant mortality rate was measured at 124, but it then rose to 138 in 2006. The under-five mortality rate dropped from 240 (per 1,000) in 1990 to 203 in 2000; however, it then rocketed to 223 in 2006. [70] It is clear that the further deterioration of the already deficient health, water, and sanitation infrastructure during the war contributed to these staggering figures. In contrast, the average infant mortality rate for Sub-Saharan Africa (SSA) is 92 per 1,000 live births (86 for all LICs), and the average under-five child mortality rate for SSA is 149 (136 for all LICs).[71] Malaria, neonatal causes, diarrhea, and acute respiratory infections account for roughly equal shares of the cause of death among children in Guinea-Bissau.[72]

Goal 5 - *Improving maternal health*: Like infant and child mortality, maternal mortality has grown more severe in recent years. The maternal mortality ratio increased from 914 (per 100,000 births) in 1990 to 1,279 in 2000.[73] In the same year, the average maternal mortality ratio stood at 841 for SSA and 768 for all LICs. Guinea-Bissau is obviously far from achieving the 2015 maternal health target of a maternal mortality ratio of 229. The total fertility rate (births per

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[68] Ibid., 19-20.
[69] UN OCHA, country profile: http://www.irinnews.org/country.aspx?CountryCode=GW&RegionCode=WA.
[70] UNICEF 2006 Multiple Indicator Cluster Survey Three (MICS3): http://www.childinfo.org/mics3_surveys.html.
[71] 2004 figures. Health Systems 20/20 Fact Sheet: Guinea-Bissau (March 2008): http://healthsystems2020.healthsystemsdatabase.org/reports/Default.aspx.
[72] WHO Country Health System Fact Sheet: http://www.afro.who.int/home/countries/fact_sheets/guineabissau.pdf.
[73] UN Common Country Assessment (December 2006), 48.

woman) in Guinea-Bissau is over 7, compared to 5 for both SSA and LICs, and contraceptive prevalence (% of women ages 15-49) is just 8%, compared to 21% for both SSA and all LICs.[74]

Goal 6 *- Combating HIV/AIDS, malaria, and other diseases*: The HIV/AIDS rate in Guinea-Bissau is rising rather than reversing. It may now be as high as 8.7% according to a recent government proposal submitted to the Global Fund.[75] A World Bank official notes that HIV rates are higher in urban areas and along the main transport routes from Bissau to the Senegalese border.[76] Not only is the health system incapable of treating most AIDS patients, but government planners warn that citizens are "already so poor that they cannot bear the cost of caring for their [infected] loved ones or for children orphaned by AIDS."[77] Malaria represents the most frequent cause of morbidity and mortality among children[78] and is responsible for over 10% of deaths among citizens of all ages.[79] Malaria, HIV/AIDS, and other diseases pose serious challenges to household economic security in Guinea-Bissau due to expensive out-of-pocket fees and productivity lost to illness or caring for sick family members.

Goal 7 *- Ensuring environmental sustainability*: Deadly cholera outbreaks in 2005 and 2008 reveal that the provision of clean water and adequate sanitation remain serious challenges in Guinea-Bissau. According to the government, only 55% of citizens have access to potable water and they must travel an average of thirty minutes to reach the water source. Over a third of the households in the country do not have toilets or latrines, and there is no organized system for

[74] 2000 figures. Health Systems 20/20 Fact Sheet: Guinea-Bissau (March 2008).
[75] Global Fund Round 7 Proposal: http://www.theglobalfund.org/search/docs/7GNBH_1513_0_full.pdf.
[76] Interview notes, April 2008.
[77] Guinea-Bissau PRSP (2007), 19.
[78] African Development Bank, "Guinea-Bissau Results Based Country Strategy Paper 2005-2009," (November 2005), 26.
[79] WHO Country Health System Fact Sheet.

waste removal and treatment. Rural households have even less access to drinking water and sanitation facilities than residents of Bissau.[80]

Goal 8 *- Developing a global partnership for development*: Essential drugs are often not available at health centers due to a poorly managed supply-chain system, yet drugs still remain one of the major health costs for patients.[81] Also, the delivery of anti-retroviral treatment (ART) "remains poor, and in 2006 only 80 Bissau-Guineans were receiving ART (using drugs donated by Brazil)."[82] It is clear that the people of Guinea-Bissau do not have dependable access to affordable essential drugs, and drug procurement policies and the supply chain must be reformed.

Reflecting on Guinea-Bissau's dismal health indicators, it is difficult not to develop a sense of pessimism regarding of the country's chances of achieving the MDG targets. However, it is important to remember that the MDGs are global targets and each country must tailor them to its particular context. UNDP recommends that each country develop local targets and advises, "No stigma should be associated with setting national targets that are less ambitious than the global MDGs. History shows that successful target setting critically depends on striking a judicious balance between ambition and realism."[83] The MDGs are not intended to shame countries into stronger performance, but are meant to motivate development planners. In this sense, Guinea-Bissau is currently achieving some success as the government, UN Country Team (UNCT), and the World Bank actively incorporate the MDGs into their health sector strategies.

It is important to remember that Guinea-Bissau had just exited a civil war that heavily damaged its health system and economy when the MDGs were announced in 2000. Easterly has

[80] Guinea-Bissau PRSP (2007), 20.
[81] Interview notes, February 2008.
[82] Economist Intelligence Unit, "Country Profile 2008: Guinea-Bissau," 21.
[83] "MDGs: Misunderstood Targets?" UNDP International Poverty Center (January 2007).

presented a strong critique of the MDG process arguing that African countries face far greater odds of meeting the MDG targets due to the methods of measuring success.[84] Yet the fact that Guinea-Bissau lags behind most every country (in Africa or elsewhere) in health and economic development is obvious by any measure. However, there is little value in shaming Guinea-Bissau's leaders and chastising them for a likely failure to achieve the global MDG targets by 2015. The priority for the nation's policy makers and public health stewards must now be to boldly establish a robust health system. The MDGs are starting to play a central role in this project due to both the particular priorities that they establish, and perhaps more importantly, the motivation and coherence in development planning that they reinforce. The government of Guinea-Bissau has explicitly utilized the MDGs in shaping its new poverty reduction strategy paper. Its PRSP proclaims, "The MDGs are an end, but also a means for the development of human capital without which growth and poverty reduction cannot be achieved."[85]

IV. Public Health in Guinea Bissau: Policy, Financing, and Delivery

Gaps in the Health System

The above review of Guinea-Bissau's progress toward the health-related MDG targets exposes many gaps in the prevention and treatment of disease and illness in the country. Ministry of Public Health officials in Guinea-Bissau and their international partners are primarily concerned with the overarching themes of access to treatment and drugs, quality of services, and affordability. A closer examination of the health system components of infrastructure, human resources, and financing helps reveal how development planners can address these challenges.

[84] William Easterly, "How the Millennium Development Goals Are Unfair to Africa," *Brookings Global Economy and Development Working Paper 14* (November 2007).
[85] Guinea-Bissau PRSP (2007), 7.

Health services in Guinea-Bissau are provided almost exclusively by a national health system coordinated by the Ministry of Public Health (MINSAP). The Catholic Church also administers a small number of health centers across the country. There are some private clinics in the capital run by public sector health workers who provide private services in the evening; however, private care in Guinea-Bissau is unlikely to be of higher quality than public care at this point in time (despite perceptions to the contrary).[86] The public health system consists of the central hospital in Bissau (Simao Mendes National Hospital), four smaller referral hospitals in the towns of Bafata, Cacheu, Gabu, and Tombali,[87] and approximately 115 community health centers throughout the country. Although Guinea-Bissau is only about the size of the U.S. state of Maryland, the health centers do not provide sufficient access in this largely rural nation with very poor roads and undependable, expensive public transportation. In 2002, only about 37% of the poorest households and 46% of the wealthiest households had access to health services.[88] Many hospitals and health centers were damaged during the 1998-1999 civil war, and some still have not been fully repaired. The government's PRSP notes, "Access to health care infrastructure is still weak…. Bissau, with more than 300,000 inhabitants, has a weak network of health centers, which causes an overload at the National Hospital, the only structure that serves the entire nation…. The four regional hospitals are in the same situation regarding needs. Access to complete reproductive care is still weak."[89] A World Bank official shares that "equipment is often obsolete or poorly maintained" and regular stock-outs require health care workers to reuse

[86] Interview notes, April 2008.
[87] Although eleven regional referral hospitals physically exist, only four are functional.
[88] Interview notes, February 2008.
[89] Guinea-Bissau PRSP (2007), 20.

supplies, "infringing on basic rules of hygiene."[90] The drug distribution system is mismanaged, the cold chain is poorly maintained, and essential medicines are frequently unavailable.

The health system in Guinea-Bissau is severely understaffed, and health care workers lack sufficient training and incentives to provide high-quality care. About a quarter of doctors and nurses left the country during the civil war, and many continue to emigrate for higher paying jobs abroad.[91] Health care workers in Guinea-Bissau receive low wages compared to most countries in SSA and salary payments are often months in arrears.[92] The government raises this concern in its PRSP, confirming that "the functioning of services is affected by the lack of qualified human resources" and "demoralization in the health profession is rampant due to the precarious working conditions and low pay."[93] In an attempt to boost staff motivation, the Ministry of Public Health (MINSAP) is currently lobbying the Ministry of Finance, which controls the health budget, to increase salaries for health workers (anywhere from 25% to 100%, depending on the position). MINSAP also hopes to substantially improve incentives for staff working overtime. While health care worker salaries in Guinea-Bissau are comparable to those in Liberia and Sierra Leone, two other poor post-conflict nations in West Africa, overtime work incentives have not been adjusted in many years and are significantly lower than those of peer countries.[94] In addition to a deficient monetary incentive system, MINSAP's promotion policy is not transparent. A World Bank official notes that the result is a lack of motivation among workers as they realize that there is no linkage between promotions and performance.[95]

[90] Interview notes, February 2008.
[91] Economist Intelligence Unit, "Country Profile 2008: Guinea-Bissau," 21.
[92] Interview notes, February 2008.
[93] Guinea-Bissau PRSP (2007), 20.
[94] Interview notes, February 2008.
[95] Ibid.

The low number of skilled health care workers and technicians directly impacts the health of the citizens of Guinea-Bissau. The density of health care workers in a country is inversely associated with maternal, infant, and under-five mortality.[96] The Joint Learning Initiative recommends a minimum density of 2.5 (per 1,000 citizens) doctors, nurses, and midwives to reach 80% coverage for skilled birth attendance and measles immunization.[97] Guinea-Bissau had just .12 doctors per 1,000 people in 2004, which was far lower than the average for SSA (.22 physicians per 1,000 people). Less than 35% of births were attended by a skilled health care professional in the country that year (compared with 53% for SSA and 46% for all LICs), a rate that has not improved in the last decade. [98] Guinea-Bissau's bewildering maternal mortality ratio of 1,279 deaths per 100,000 births makes the correlation between density of skilled health care workers and maternal mortality quite clear. Furthermore, Guinea-Bissau does not have an adequate number of pharmacists, and there is a lack of qualified technicians to conduct HIV/AIDS testing on a national scale.[99]

Educational and training opportunities for health care workers are limited and supervision is poorly managed. The building that housed the national school of public health, which trains physicians, nurses, and technicians, was destroyed during the civil war. It has not been rebuilt due to a lack of funding, and the school of public health has temporarily relocated to the national university, which is not furnished with the equipment or materials necessary for a medical education. The construction of a new school of health with proper equipment would cost approximately $2 million; however, donors have refused to fund this project.[100] Guinea-Bissau

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[96] Andy Haines et al, "Achieving Child Survival Goals: Potential Contribution of Community Health Workers," *The Lancet*, Vol. 369, 2121–31, June 23, 2007, 2121.
[97] Joint Learning Initiative, *Human Resources for Health*, Cambridge, MA: Global Equity Initiative, Harvard University (2004).
[98] Health Systems 20/20 Fact Sheet: Guinea-Bissau (March 2008).
[99] Economist Intelligence Unit, "Country Profile 2008: Guinea-Bissau," 21.
[100] Interview notes, February 2008.

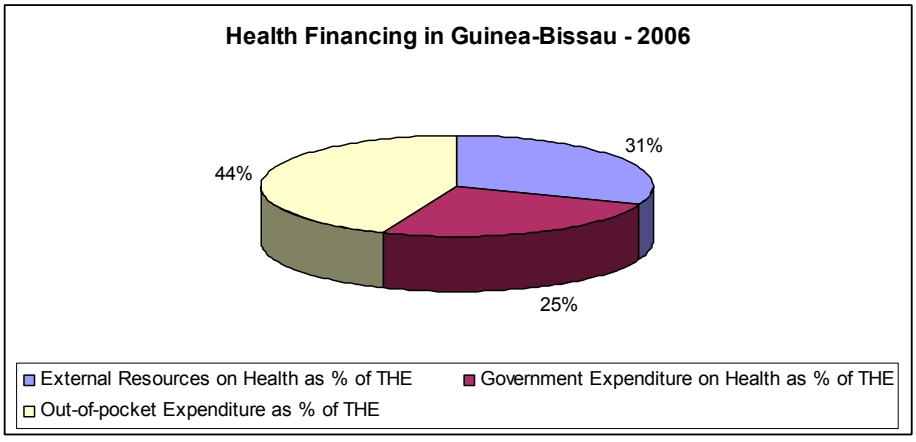
depends on Cuban doctors to train most of its medical personnel. Cuba also provides scholarships to a small number of Guinean doctors to study medicine in Havana.[101] In-service training for both managers and health care workers is insufficient, and managers require greater guidance on how to motivate their supervisees. A World Bank official notes that "[an improved] supervision scheme would motivate the staff and contribute to better efficiency and quality of care by providing immediate feedback aimed at correcting wrong practices and answering logistical needs."[102] To prepare and support a cadre of health workers properly equipped and motivated to make significant strides toward the health-related MDGs, the Ministry of Public Health must radically reform medical education, in-service training, and supervision.

A source of great potential in Guinea-Bissau's health care system is its large cadre of community health workers (CHWs), which comprise nearly three-quarters of the entire health work force.[103] Studies in many African and South Asian countries have shown that pragmatic use of CHWs focused on prevention and treatment of ailments like malaria and diarrhea can lead to a substantial drop in child mortality.[104] An official from MINSAP explains that CHWs in Guinea-Bissau serve as liaisons between the small number of health care professionals (doctors, nurses, and midwives) and community members. The CHWs primarily work on prevention activities related to maternal and child health. They try to identify pregnant women at risk and encourage them to visit health centers. The effectiveness of CHWs is uneven across districts, and as with professional health care workers, poor motivation related to improper incentives, resources, and supervision detracts from their performance. CHWs working in districts where NGOs are present

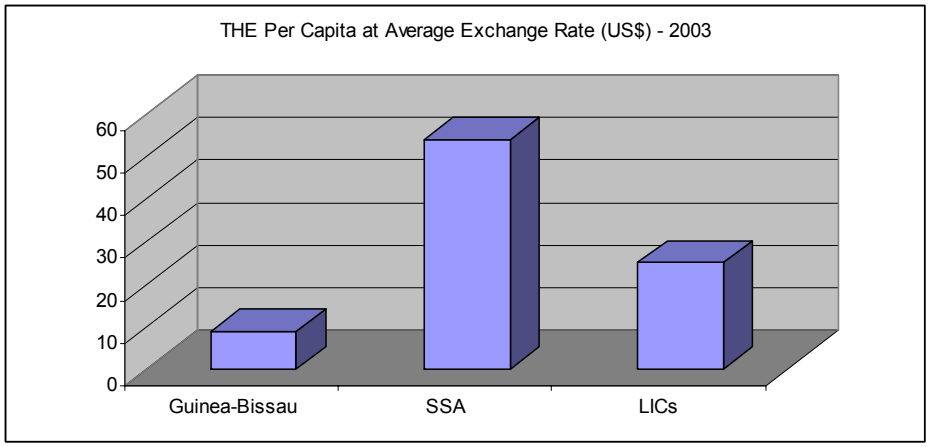
[101] Ibid.
[102] Ibid.
[103] WHO Country Health System Fact Sheet.
[104] Haines, 4.

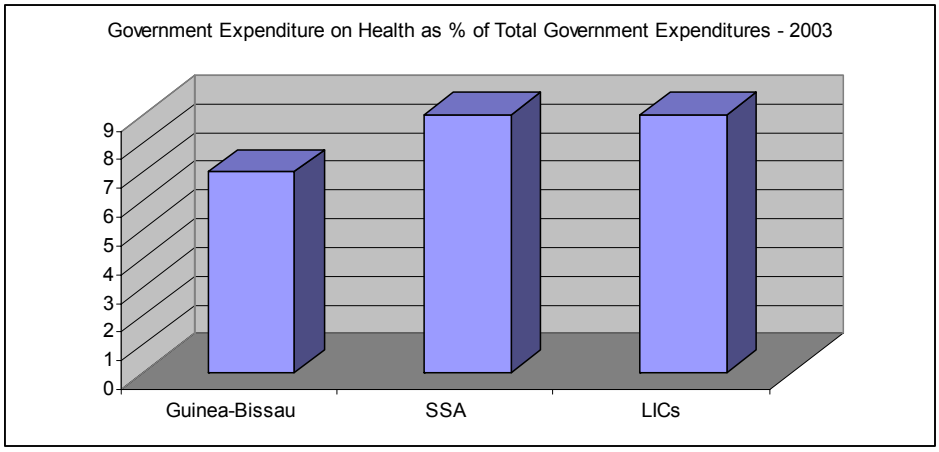
tend to perform better due to the likelihood of increased training and resources.[105] The NGOs Plan International and Effective Interventions, which operate small projects in Guinea-Bissau, train CHWs in a limited number of districts. MINSAP has yet to fully realize the potential of CHWs as behavior change agents. Given the relatively high level of confidence that citizens have in health workers, it is likely that the health system could make far more effective use of CHWs. The World Bank survey on trust in institutions reveals that citizens actually trust in health centers and schools far more than any other institutions, including religious organizations, traditional leaders, and NGOs.[106] A clear opportunity exists for CHWs to partner with communities and facilitate high-quality health promotion activities.

One of the major roadblocks to a fully functioning health system in Guinea-Bissau is the challenge of financing. As the chart below shows, nearly half of annual total health expenditure (THE) comes directly out of the pockets of individual patients.[107] Guinea-Bissau has made little progress toward developing social protection and community insurance schemes to pool resources for health care. Moreover, the very small size of the private sector and government mismanagement result in limited tax revenues to put toward financing health care.

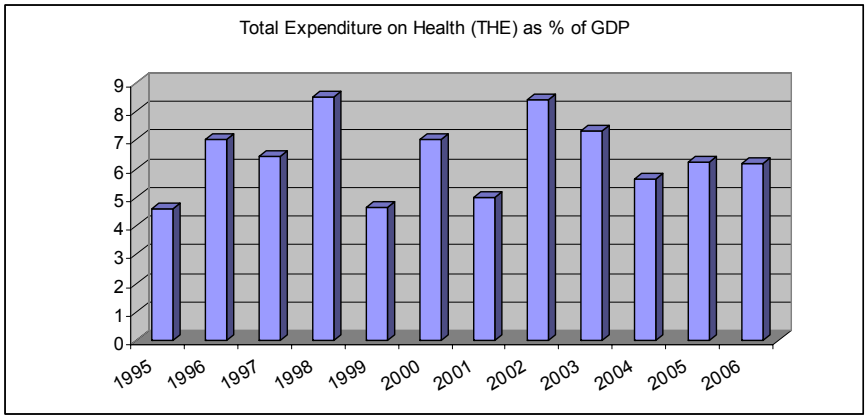


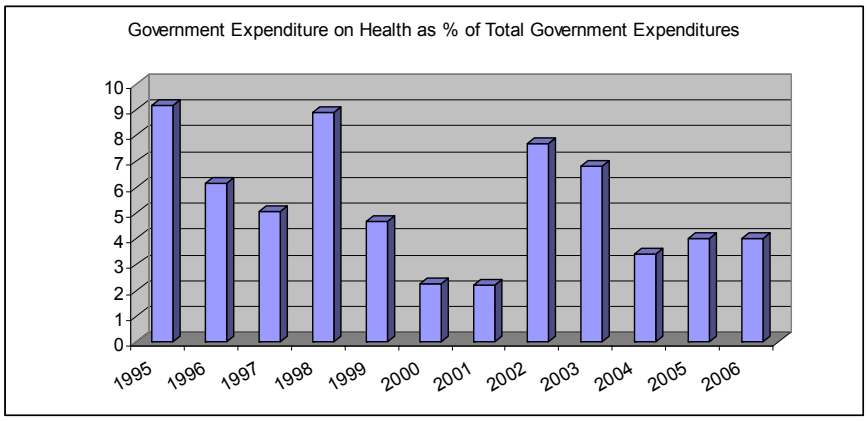
[105] Interview notes, February 2008.
[106] Gacitua-Mario et al, "Chapter 3," 35.
[107] All health financing figures based on WHO National Health Account Database and Health Systems 20/20 Database.

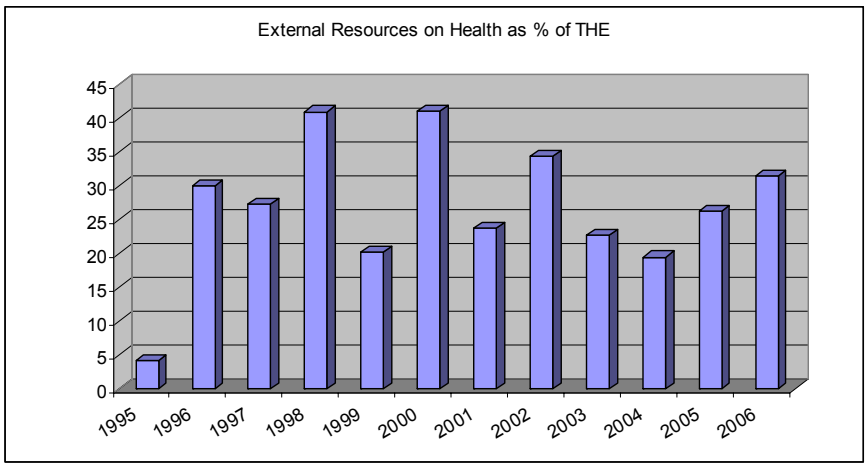




Total spending on health care has averaged under 6% of GDP since 2004 and less than $12 per capita per year for the last decade. The government contribution toward health as a percentage of the total government budget averaged only 4.4% from 1999-2006. This share is lower than the average for SSA and LICs and is less than a third of the 15% that African countries committed to in the Abuja Declaration. Although the percentage of total health spending from external sources has risen slightly in recent years, donor financing for health care over the last decade has been erratic, with yearly contributions ranging from under 20% to over 40%.







In Guinea-Bissau, the share of total health spending directly borne by citizens is far greater than the contributions of the government or donors. The out-of-pocket payments required for health services discourage people from seeking care and contribute to the impoverishment of those who do access assistance. A UN official acknowledges that "If you don't have money to pay for emergency treatment or for transportation to a hospital, you suffer the consequences, which can mean death in some cases in Guinea-Bissau." Recognizing both the danger of high

out-of-pocket fees and the need for citizens to continue to contribute directly to the poorly financed health system, the Ministry of Public Health recently introduced new user-fee regulations. The regulations set fair rates for drugs fees, lab tests, and medical services and provide a method of cost-recovery for the health system. Previously, health care providers charged for services "under the table." The user-fee reforms provide a legal, transparent mechanism for payments. A successful cost-recovery system is particularly important for ensuring the dependable provision of essential medicines. Surcharges at each level of the drug distribution chain (national, regional, and local) provide funding to reinvest in purchasing drugs. Inspired by the Bamako Initiative, the government previously tried to implement fees for drugs and services in the 1990s, but poor management of the cost-recovery system and the outbreak of war in 1998 derailed the reform efforts. According to Scheiber et al, "the Bamako Initiative shows that user fees may be an important revenue source where institutions are weak, resources limited, and the choice is between having drugs and or not having them."[108] The post-war wave of user-fee reforms does seem to have had some success. A 2006 World Bank study states that "the resources are being collected and managed in a relatively transparent manner," and "it has contributed to improve the availability of drugs and the access to health services at affordable costs."[109] However, officials from MINSAP, the UN, and the World Bank all recently expressed grave concerns that the user-fee and cost-recovery system is not functioning properly and drug availability is still erratic.[110] Despite the challenges of implementing the user-fee system, MINSAP has emphasized its commitment to cost-recovery efforts in a new national action plan that stresses accountability of managers and health care providers at all levels.

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[108] George Scheiber et al, "Financing Health Systems in the 21st Century," *Disease Control Priorities in Developing Countries*, (Washington, DC: The World Bank, 2006), 227.
[109] "Guinea-Bissau Integrated Poverty and Social Assessment (IPSA): Transition from Post Conflict to Long-Term Development," World Bank Report No. 34553-GW (May 2006), xxii-xxiii.
[110] Interview notes, February and April 2008.

Planning and Partnerships

As a post-conflict fragile state, Guinea-Bissau faces severe challenges in planning a health system to deliver basic services that will help the country significantly reduce child and maternal mortality and reverse the spread of HIV/AIDS and malaria. It is clear that Guinea-Bissau must improve training for health care workers and increase access to pharmaceuticals in order to one day reach the health-related MDGs. Given the poverty of its people and government, Guinea-Bissau turns to external actors for aid. While MINSAP has received substantial technical and financial assistance from the United Nations and World Bank, the aid from donors over the years has been very uneven, and as of January 2008, no major donor would commit to strengthening the health care system as a whole.

Given its chronic political instability and low international profile, Guinea-Bissau has received less external assistance than many of its African peers. Many donors discontinued aid to the nation following the civil war. The World Bank notes that "frequent changes in government, combined with lack of accountability and ownership of government policies, have in recent years eroded international support."[111] Some bilateral and multilateral organizations have renewed support to Guinea-Bissau, but "aid levels have been lower and more erratic in the post-conflict period."[112] Fragile states need dependable donor flows to facilitate long-term planning and investment. In their study on aid flows to forgotten fragile states, or "Difficult Partner Countries" (DPCs), that includes Guinea-Bissau, Dollar and Levin advise:

> In addition to their high aid-dependence, DPCs are by definition very weak capacity countries. In weak capacity countries, the duration needed for any aid-financed program to produce results is likely to be longer than in a country with similar poverty levels but stronger institutions. Turning the tap of aid on and off frequently may therefore be the wrong way to

[111] "Guinea-Bissau: Staff Report for the 2007 Article IV Consultation," IMF, August 2007, 3.
[112] Ibid., 6.

> achieve the results donors are looking for. Since difficult partnership countries have greater development challenges than other aid recipients, as evidenced by their lagging performance on the Millennium Development Goals, it is important for the donor community to look more closely at their aid allocation patterns to these forgotten states.[113]

Dollar and Levin provide evidence showing that the volatility of aid flows to DPCs is twice as high as assistance to other LICs, even when sudden shifts in aid due to episodes of political instability are excluded.[114] The World Bank's 2005 analysis of Guinea-Bissau's development framework planning capacity reports that the government's capacity in formulating development strategies and effectively coordinating various ministries is weak.[115] Although government officials in Guinea-Bissau have made it difficult for donors to trust in their administrative capacities, most donors have not provided even a low level of steady technical or financial assistance to aid the country in stabilizing its economy or rebuilding its health or education sectors. Jonina Einarsdottir, a long-time scholar of Guinea-Bissau, laments that its citizens are "doubly damned — first for living in conditions of bad governance, and second for being denied aid for just the same reason."[116]

The International Monetary Fund (IMF), the World Bank, and the UN have served as the primary supporters of the government following the 1998-1999 civil war. The World Bank and UN agencies have also provided technical and financial aid to the health sector. Other donors that have contributed at various points to the health sector in the post-war era include the European Union, African Development Bank, Portugal, Cuba, Italy, France, Brazil, China, Denmark, and the Netherlands. The United States, a major donor for HIV/AIDS and health in much of Africa, has largely ignored public health in Guinea-Bissau following the civil war,

[113] Victoria Levin and David Dollar, "The Forgotten States: Aid Volumes and Volatility in Difficult Partnership Countries," DAC Learning and Advisory Process on Difficult Partnerships (January 2005), 113.
[114] Ibid.
[115] "Guinea-Bissau: Enabling Country Capacity to Achieve Results," World Bank (2005).
[116] Jonina Einarsdottir, "International Aid, Partnership, and Child Survival," *The Lancet*. Vol. 365, March 26, 2005.

though it has provided a small amount of assistance to security sector reform and the cashew industry.

Following the civil war, the IMF and World Bank have funded an emergency recovery plan designed to restructure government spending, greatly reduce the number of civil servants and soldiers, and overhaul the education sector. Guinea-Bissau is participating in the Heavily Indebted Poor Country (HIPC) debt relief program. But the implementation of reforms has been slow due to political instability, and the country has not yet fully qualified to receive the planned debt relief. The IMF and World Bank affirm that "Over the medium term, Guinea-Bissau will continue to depend on external assistance to finance its current and capital expenditures. Current levels of fiscal revenues are not sufficient to cover the government's financing needs, and there is little room to improve revenue collection."[117] The IFIs warn that to mobilize donor aid, the government "would need to demonstrate a clear break with the past and firmly commit to implementing key structural reforms and effective expenditure management."[118] In many developing countries, governments' adherence to IMF conditions has decreased the wage bill for health services and precipitated worsened health outcomes including increased tuberculosis mortality rates.[119] In Guinea-Bissau, however, the IMF and World Bank have recognized that both the health and education sectors are greatly understaffed and underfunded (with corresponding poor outcomes), and the IFIs have explicitly recommended increased government spending in these areas. The IMF has even earmarked emergency funding specifically geared toward paying teacher salaries and reforming the education system.

[117] "Guinea-Bissau: Staff Report for the 2007 Article IV Consultation," IMF, August 2007, 21.
[118] Ibid.
[119] Stuckler, David et al, "International Monetary Fund Programs and Tuberculosis Outcomes in Post-Communist Countries," *PLoS Medicine*, Vol. 5, Issue 7. July 2008.

The World Bank has played a major role in advising the government on developing its health system. The Bank provided the government with technical support during its preparation of the Poverty Reduction Strategy Paper (PRSP) released in 2007. The PRSP describes the government's medium and long term goals regarding economic growth, infrastructure, health, education, government, and security sector reforms. The Bank has also provided technical assistance and funding to MINSAP for the first national health action plan (PNDS I from 2003-2007) and technical assistance for the second national health action plan (PNDS II from 2008-2012).[120] The PNDS II reflects health priorities that the government set forth in the PRSP. The public health goals in both documents evolve directly from the health-related Millennium Development Goals, and the MDGs are explicitly used as monitoring tools. Despite its strong guidance in developing the PNDS II, the World Bank has paradoxically not approved any health system funding for the 2008-2012 strategic planning period. MINSAP plans to present the PNDS II to donors in Bissau and Dakar during the summer of 2008 in hope of attracting essential funding for its reform program. Given the meager percentage of the country's national budget dedicated to health, MINSAP will also need to lobby hard among politicians and administrators within its own government.[121] Despite the apparent low prioritization of the health sector by the government administration as a whole, senior World Bank and United Nations officials laud the dedication and technical competence of the MINSAP strategic planning team that contributed to the PRSP and PNDS II.[122]

Through WHO, UNICEF, UNFPA, and UNDP, the United Nations has also provided significant technical and financial support to improve health in Guinea-Bissau. WHO staff

[120] In addition to its support of the first national action plan for health, the World Bank has also provided technical assistance and funding for the national HIV/AIDS program and a small amount of funding for community-based health initiatives.
[121] Interview notes, February and April 2008.
[122] Ibid.

members assisted MINSAP's planning team in developing the current national action plan, and they regularly provide technical advice concerning maternal health, human resources development, and user-fee and cost-recovery reforms. UNICEF funds and organizes immunization campaigns, mosquito net distribution, and sanitation and waste management projects in some districts. UNFPA provides technical assistance in the areas of reproductive health and maternal health. Of the three agencies, UNICEF contributes the highest level of funding. All three operate under the auspices of the United Nations Country Team (UNCT) led by UNDP in close coordination with the UN Peacebuilding Support Office (UNOGBIS). The UNCT's core assessment and planning documents, including the Common Country Assessment (CCA) and Development Assistance Framework (UNDAF), use the MDGs to structure and monitor their activities in coordination with the government of Guinea-Bissau. The UN team advised the government on its current five-year national HIV/AIDS control plan and UN staff members have played a central role in the development of malaria and HIV/AIDS proposals to the Global Fund. UNDP has served as the recipient organization of grant money from the Global Fund for malaria control in Guinea-Bissau.

In addition to providing previous smaller grants to fight malaria, the Global Fund has conditionally approved a grant proposal from the Guinea-Bissau Country Coordinating Mechanism (CCM) for $44 million to combat HIV/AIDS from 2008-2012. Based on the sum of total health expenditure in 2006 of $20.6 million (including 44% in out-of-pocket expenditures), the award from the Global Fund would represent roughly 43% of annual total spending on health. While the size of this potential injection of cash is staggering, it will not necessarily translate into a stronger health care system or progress toward the health-related MDGs beyond Goal 6, which is focused on halting the spread of HIV/AIDS. The extent to which the very large

Global Fund grant can contribute toward reaching the MDGs will depend upon how successfully the Ministry of Public Health, the primary recipient of the grant, can leverage the funds earmarked for AIDS toward strengthening the health system as a whole. There is some reason for optimism. The Global Fund is gradually recognizing the importance of allowing funding to be used for broader health priorities and now includes a "Health Systems Strengthening Strategic Actions" component in its grants. MINSAP expects to receive an average of $560,000 per year through this window for planning, training, and logistics.[123] This amount, however, represents just 2.7% of current total spending on health. Given the broad challenges it faces related to providing access to high-quality and affordable care, MINSAP will certainly need to utilize a substantially greater portion of the Global Fund grant to properly implement the PNDS II and improve health infrastructure, human resources, and drug availability.

Beyond the financial benefits of Global Fund support, the process of forming a Global Fund Country Coordinating Mechanism (CCM), a planning and management committee with members from the government, United Nations, civil society, and People Living with HIV/AIDS, potentially provides important spill-over effects for the health sector in general in Guinea-Bissau. This widely representative body of influential leaders wrote the $44 million HIV/AIDS proposal and will monitor the MINSAP's implementation of the grant. The CCM therefore reinforces coordination of HIV/AIDS and other health programming.[124] The Global Fund also strongly encourages its recipient countries to manage HIV/AIDS programming according to the "Three Ones" articulated by UNAIDS: one national plan, one national coordinating body, and one national monitoring and evaluation system. Guinea-Bissau has thus far been successful at initiating these components of coordinating the fight against HIV/AIDS.

[123] Global Fund Round 7 Proposal, 49.
[124] Interview notes, April 2008.

The Country Coordinating Mechanism conducted a SWOT analysis of Guinea-Bissau's health system and a list of national health priorities (presented on the following page) as part of its successful 2007 HIV/AIDS proposal to the Global Fund.

SWOT Analysis of the Health System

Conducted by the Global Fund Country Coordinating Mechanism in Guinea-Bissau, which represents the government, civil society, United Nations, and People Living with HIV/AIDS[125]

Strengths:
- A network of health centers all adhering to the same medical information system;
- Decentralization of management to regional level: regional health teams & regional drug stores;
- Involvement (though only partial and tentative) of communities in the management of health zones;
- A network of community-managed care structures is semi-operational in some regions;
- Some regions are very organized and record the country's best medical indicators;
- The medical information system manages to provide only partial, but useable, data;
- There is an independent research body for health in Guinea-Bissau (the Bandim Health Project).

Weaknesses:
- Poorly distributed human resources, concentrated mainly in Bissau and regional towns;
- Social workers, midwives, and laboratory technicians are greatly under-represented;
- Quality of care and performance of personnel have deteriorated due to a lack of supervision and career advancement opportunities;
- Poor salaries and systematic late payments;
- The funding of health care depends on external aid;
- Insufficient capacity for the coordination of external aid;
- The withdrawal of funds by some of the country's traditional partners and sponsors;
- Serious problems with supply of electricity;
- Lack of structure and discipline in the management of property, drugs, and logistics;
- Very poor and incomplete planning cycles;
- Poor monitoring and evaluation processes.

Opportunities:
- A human resources plan is under development;
- A new health sector framework is under development;
- New funding initiatives with potential to strengthen the health system, such as the Global Fund;
- Increasing organization of civil society, in particular groups working with vulnerable people (with the capacity to lobby for funding from public and private sources);
- Good capacity for the management of external resources at central level.

Threats:
- Movement of managers to other countries and international institutions;
- Some communities do not support the health system (there have been cases where communities have permitted the theft of health equipment and resources like solar panels, motorbikes, and telephones);
- Lack of a multi-sectoral vision of health limits the mobilization of internal resources both for the health budget and the development of teaching curricula;
- Corruption and a lack of certainty regarding procedures and career paths.

National Priorities for Addressing Health System Constraints

1. Developing a human resources plan focused on quantity, quality, and objective distribution;
2. Strengthening the monitoring and evaluation system, targeting both the national information system and operational research (including the creation of a national health institute);
3. Increasing management capacity at all levels through training and better use of management and auditing tools;
4. Increasing staff motivation through performance-based incentives, improved working conditions, and more training opportunities.

[125] Adapted from the Global Fund Round 7 Proposal, 41.

V. Charting a Course for Achievement of the Health-Related MDGs

With its commitment to achieve the Millennium Development Goals, Guinea-Bissau has agreed to eradicate hunger, radically decrease child and maternal mortality, reverse the spread of AIDS and malaria, improve access to safe drinking water and sanitation, and provide affordable drugs. While much of this work must be coordinated by the Ministry of Public Health and its partners, reforms across multiple sectors in Guinea-Bissau are necessary to achieve the health-related MDGs. Strong health outcomes will positively impact economic growth and the consolidation of peace, but it is clear that the country must make substantial progress to build and sustain a fully functioning health system.

Strengthening the Health System

User fees and Cost Recovery

Senior officials from MINSAP, the World Bank, and the United Nations agree that the top priority for improving the health system is to successfully implement the user-fee and cost-recovery reforms.[126] A functioning cost-recovery program would allow each level of the health system to accrue modest profits to reinvest in drug procurement and supplies. The public health planners in the country see this as crucial to add an element of sustainable financing to the health system. While they know that this will only contribute a modest percentage of total funds spent on health, a cost-recovery mechanism is necessary to regularize the availability of drugs. For the cost-recovery program to function adequately at the local level, community committees must better police the collection and re-investment of fees for drug procurement. At the national and regional levels, MINSAP must bolster management capacity and enforce regulations. The transparency of official user fees protects patients from over-charging. However, MINSAP

[126] Interview notes, February and April 2008.

should carefully monitor how user fees affect health-seeking behavior and consider targeted reductions in fees for the poorest citizens.

Insurance

In the early 1990s, the World Bank highlighted a community-based health insurance (CBHI) pilot program in Guinea-Bissau as a model for other developing countries.[127] Unfortunately, CBHI in Guinea-Bissau did not survive as a viable form of health financing due to political instability at the national level and lack of community ownership at the local level. Other countries in West Africa and beyond have improved risk-pooling through CBHI. Guinea-Bissau should explore the feasibility of CBHI models used by its neighbors, Senegal and Guinea, who have had greater success at implementing insurance programs. MINSAP officials must remember that commitment at the national level is necessary to inspire ownership at the local level. Senegal has created a government institution dedicated to fostering the development of CBHI programs that Guinea-Bissau may wish to emulate.[128] If citizens do not witness improved quality of services and competence of health center staff, they are unlikely to support programs that require them to pool their resources before they need to seek care. Moreover, many health financing programs require strong community oversight to function properly. MINSAP's national and district staff members must implement a realistic incentive structure for community leaders who volunteer to monitor CBHI programs or the performance of health centers.

Human Resources for Health

To strengthen its health system, Guinea-Bissau will need to educate far more doctors, nurses, and midwives. MINSAP has prioritized human resources development in its 2008-2012 strategy, but donor support will be necessary to construct a new school of health. In addition to

[127] Per Eklund and Knut Stavem, "Community Health Through Prepayment Schemes in Guinea-Bissau," *Financing Health Services through User Fees and Insurance*, (Washington, DC: The World Bank, 1995).
[128] "The Business of Health in Africa," International Finance Corporation (2007), 25.

radically improving education for health professionals, MINSAP must also invest in regular training for all staff throughout their careers. Great strides must be made in improving salaries, overtime premiums, and incentives for serving in isolated rural areas. Without motivating incentives and empowering guidance from supervisors, performance is unlikely to improve. A recent study performed by the Bandim Health Project at the National Hospital in Guinea-Bissau reveals that proper salary incentives and supervision can substantially improve health care provider performance in the treatment of malaria.[129] MINSAP must facilitate the flow of information up and down the chain of command of the health system. If health care professionals understand how epidemiological data and feedback that they send up the communication chain impacts the performance of the health system, they may participate more actively in information sharing activities.

With over 4000 community health workers,[130] Guinea-Bissau could make much better progress at delivering crucial health and hygiene promotion messages to both its rural and urban citizens. Like other aspects of the health system, the CHW program holds great potential for increased effectiveness. Research from Africa and beyond reveals that CHW programs can "substantially reduce" child mortality and that CHWs often follow simple clinical practice guidelines better than nurses and doctors.[131] A recent *Lancet* study by Haines et al reports, "A growing array of effective interventions can be delivered in the community. These encompass behavioral interventions to promote healthy behavior, such as hand washing and breastfeeding; preventive interventions, such as insecticide-treated nets for malaria and micronutrients; and more complex tasks, such as prevention of mother to child transmission of HIV and case

[129] Peter Aaby et al, "Reduced In-hospital Mortality After Improved Management of Children Under 5 Years Admitted to Hospital with Malaria: Randomized Trial," *British Medical Journal*, 335(7625): 862; October 27, 2007.
[130] WHO Country Health System Fact Sheet.
[131] Haines, 2125.

management of childhood illnesses such as malaria, pneumonia, and neonatal sepsis."[132] A revitalization of the CHW program in Guinea-Bissau could improve access to health care and further empower community ownership of health services. However, CHWs will need sufficient training and performance incentives. Haines et al warn that CHWs "are not a panacea for weak health systems and will need focused tasks, adequate remuneration, training, supervision, and the active involvement of the communities in which they work."[133]

Conditional Cash Transfers and Microenterprise Development

Governments in Latin America have enjoyed great success at strengthening household economic security and health through conditional cash transfer programs. By linking social protection grants with health and education requirements, governments can help poor families bolster food security and improve health. Brazil's Bolsa Familia and Mexico's PROGRESA programs could serve as models for Guinea-Bissau. As Oxfam reports, Mexico has made great strides in improving child health and empowering women through its conditional cash transfer program:

> Mexico's PROGRESA program reaches over 2.6 million rural households and links cash benefits and nutritional supplements to mandatory participation in health and education programs. Several design features directly target women. Mothers are designated as beneficiaries and receive the cash transfers. The entire family – primarily pregnant and lactating mothers and children under five – is required to follow a schedule of clinic visits, and women attend monthly health education lectures. Children must achieve an 80% rate of school attendance, and financial incentives are slightly higher for girls' attendance. PROGRESA has had a positive impact on child and adult health, has increased household food expenditure, and has increased women's control over their additional income.[134]

Given existing constraints to health care quality and access, Guinea-Bissau may not be ready for conditional programs. However, the government should carefully consider how it might increase its capacity to implement such programs in the near future. Evaluations of conditional cash transfer programs in many countries show that they can improve maternal and child health,

[132] Ibid., 2123.
[133] Ibid., 2121.
[134] Green, 50.

nutrition, and school attendance.[135] Clearly, the government of Guinea-Bissau would need to raise the necessary resources for conditional cash transfer programs through increased donor assistance or radically improved tax revenue generation.

In a similar fashion to conditional cash transfer programs, the WHO has proposed linking microenterprise development and health through "health 'conditionalities' for credit."[136] In such programs, community members participate in health promotion activities as a requirement for continued access to credit or other small business development services. For example, the WHO has recommended tying loan eligibility to clients' participation in functional literacy or health education classes.[137] There are many models that integrate microenterprise and health promotion components to varying degrees.[138] If the government or its NGO partners in Guinea-Bissau decide to implement such programs, they should ensure that both the business services provided and the health behavior requirements are appropriate for the targeted communities.

Data Collection, Monitoring, and Evaluation

MINSAP must greatly improve its monitoring and evaluation of the health system. Practical and consistent information collection is at the core of effective monitoring. The Bandim Health Project (BHP), operating in Bissau for three decades, represents a greatly underutilized resource for training public health staff to collect and analyze health system performance data.[139] Although BHP, a demographic and health surveillance (DHS) program, has produced hundreds of high-quality epidemiology articles for an international audience, little of its expertise has translated into a more robust health system in Guinea-Bissau. The donors funding BHP should

[135] Ibid., 209
[136] Rodriguez-Garcia, 96.
[137] Ibid.
[138] See Rosalía Rodriguez-Garcia et al, *Microenterprise Development for Better Health Outcomes*, (London: Greenwood Press, 2001).
[139] http://www.bandim.org/.

broaden the program's scope of work to include training activities that build the monitoring and evaluation capabilities of managers in the public health system throughout the country.

Achieving the Health-Related MDGs through Reforms Beyond the Health Sector

There are many broad policy options beyond the health sector that could aid the government of Guinea-Bissau in achieving the health-related MDGs. The following are recommendations pertaining to improvements in rule of law, livelihoods, food security, and infrastructure. The government will require a high level of external assistance to implement such reforms, and the recent conclusion of the PRSP process could facilitate the re-engagement of donors. Most of the suggested policies focus on encouraging economic growth. A senior official from MINSAP argues that increasing the incomes of the poor would be one of the most effective ways of precipitating improved health outcomes in the country. His conclusion echoes one of the key messages of the World Bank's 1993 *World Development Report* on investing in health, which states that governments must "foster an economic environment that enables households to improve health."[140]

Governance and Rule of Law

The government must redouble its efforts to combat corruption and increase accountability and transparency in all ministries. It should implement legal reforms that are pro-poor and that encourage investment, both domestic and foreign, in private enterprises of all sizes. Enforcement of government regulations is not only necessary to bolster user-fee and cost-recovery reforms in the public health system but is also a prerequisite to facilitate the growth of

[140] *World Development Report 1993: Investing in Health*. The World Bank. (New York: Oxford University Press, 1993), 6.

private health providers and insurers.[141] The government must also carefully manage the potential growth of the mining and oil industries to avoid corruption and ensure that it collects sufficient tax revenue from foreign companies. Donors should assist Guinea-Bissau in developing the oil industry and setting up a development fund for petroleum revenues. With the assistance of the UN and bilateral donors, East Timor, another small, desperately poor former Portuguese colony, has established a successful development fund with oil revenues that could serve as a model for Guinea-Bissau.

Agriculture and Fishing

The government should work with donors to develop agricultural research and extension programs to promote Green Revolution practices in Guinea-Bissau, especially for rice production. Incorporating high-yield seed varieties could boost production and help reduce dependency on imported rice. Since agriculture is the primary driver of economic growth in Guinea-Bissau and most people in rural areas depend on it for their livelihoods, the government should budget appropriately and lobby for donor aid to foster agricultural growth. Rice production should be increased to decrease dependency on rice imports. The current practice of relying primarily on trading cashews for rice imports has led to increased food insecurity in recent years.

The government should facilitate the continued development of the cashew sector with donors and private sector actors through revising unclear investment and property laws and not interfering with cashew prices as it did in 2006. Growers should attempt to move up the value chain and process cashews rather than only exporting them for processing in other countries. According to the World Bank, processing cashews in-country "could generate significant

[141] "The Business of Health in Africa," International Finance Corporation (2007), 17.

growth, with potentially large benefits and less vulnerability for the poor."[142] Given the food security challenges posed by Guinea-Bissau's dependency on rice for consumption and cashews for trading, farmers should also attempt to diversify their crops to reduce food security risks and increase trade potential. To decrease dependency on rice, growers should increase the production of other kinds of subsistence crops, and to cope with the vulnerabilities of the cashew trade, they should also explore the production of other cash crops like peanuts. These are not easy solutions as cultural preferences regarding subsistence crops and the need to move up the value chain for commodity crop production remain significant challenges. Nevertheless, given the severe food security situation, the government should provide encouragement and incentives for farmers to explore how to adapt their crop choices and growing patterns.

The fishing industry in Guinea-Bissau is largely undeveloped and should be expanded in an environmentally sound manner. During the 1990s, the World Conservation Union (IUCN) managed a small-scale fishing project that could serve as a model for participatory community fishing and processing projects.[143] The government should explore opportunities for expanding large-scale fishing as well. This will require proper licensing, monitoring, and infrastructure investment. The government has licensed fishing rights to the EU and neighboring countries, and it must develop the capacity to carefully monitor and enforce these agreements to avoid the depletion of fish stocks.

Small Business Development and Financial Services

The government should encourage greater donor, NGO, and private sector involvement in business skills training, microfinance, and savings programs (regardless of whether the programs explicitly include health promotion components). Training in management skills could

[142] Gacitua-Mario et al, "Chapter 5," 67.
[143] Eric Baran and Philippe Tous, *Artisanal Fishing, Sustainable Development, Co-management of Resources: Analysis of a Successful Project in West Africa*, (Gland, Switzerland: IUCN, 2000).

help many microentrepreneurs in urban areas make their businesses more profitable. Business skills trainings would likely especially benefit women as they play the primary role of traders in the capital. The government should also develop simple and fair registration and tax regulations that facilitate, rather than preclude, an entrepreneur's transition into the formal sector. The government might be able to gradually increase its weak tax base by providing the proper incentives for microentrepreneurs to register their businesses. The government must continue to encourage the opening of private banks in Bissau and also promote the expansion of savings and credit opportunities outside of the capital. Financial services are crucial for private enterprises of all sizes to expand. It will be very difficult for entrepreneurs to move up the value chain in cashew processing or the fishing industry without access to loans of an appropriate size at reasonable interest rates. While the government should encourage the expansion of microfinance institutions in poor communities, it must monitor them to ensure that their lending practices are ethical and the most appropriate for encouraging small business growth in very poor communities.

Transportation, Water, and Electricity Infrastructure

Poor transportation infrastructure in Guinea-Bissau severely precludes agricultural producers' access to markets. The government should prioritize investment in infrastructure to reduce transaction costs and encourage private sector growth. While the government should seek donor support for infrastructure improvements, of equal importance is the need to budget for the equipment and materials necessary to maintain its transportation infrastructure in the years to come. The government should explore developing a workfare program that best utilizes local, unemployed labor for infrastructure projects. Businesses need a dependable supply of electricity to operate, and it will be difficult for Guinea-Bissau to attract investment without significantly

improving sensibly-priced electricity production. Furthermore, the government should collaborate with development partners to increase access to safe drinking water. It should develop programs to assist communities in maintaining water distribution systems and should facilitate regular community education programs regarding sanitation and hygiene.

Education

The government should focus on increasing school enrollment, especially for girls, and work carefully and respectfully with community leaders to identify ways of keeping girls in school longer during their teen years. The government should evaluate the potential for the use of conditional cash transfer programs in the poorest communities to encourage school attendance. Education and public health officials should partner to improve child health by exploring options for increasing immunization and supplemental micronutrient coverage for school-age children. Moreover, education officials should seek a partnership with the WFP to provide school feeding programs, particularly during the lean season, to combat malnutrition and encourage attendance. Since schools are already severely understaffed with properly trained teachers, the government must identify ways to rapidly increase its capacity to educate more teachers. Finally, the government should prioritize fair compensation for teachers to foster higher levels of motivation.

Disaster Preparedness

While many of the policy options mentioned above have the potential to reduce emergencies stemming from food insecurity, the government will also need to improve its monitoring of food availability and access. The government should develop clear procedures to follow when it detects that food shortages are likely to develop. It should take advantage of technical assistance from the WFP and FAO to develop well-functioning and practical early

warning systems and should maintain regular communication with UN officials regarding food security.

VI. Conclusion

Poor prioritization on the part of the national government and donors has degraded health in Guinea-Bissau to its status as "the forgotten sector in a forgotten state," and the citizens of Guinea-Bissau ultimately bear the burden of this curse in poor health and unrealized productivity. The rejuvenated planning efforts of the Ministry of Public Health inspired by the Millennium Development Goals have the potential to transform the health system in Guinea-Bissau, but this renaissance will not be possible without concomitant commitments from other government ministries and international partners.

Many health sector reform attempts in Guinea-Bissau since the early 1990s related to user fees, insurance, and human resources have been thrown off course by political instability. The 1998-1999 civil war, 2003 coup, and regular irresponsible political and military maneuvers have disrupted vital planning and operations and provided donors with a rationale for decreasing support. It is clear that institutional reform in any sector in Guinea-Bissau is nearly impossible without political stability. Since the last presidential election in 2005, the military has interfered in politics less than usual and traditionally antagonistic political parties have collaborated to a greater extent, but the current drug trafficking crisis and the upcoming parliamentary elections (scheduled for November 2008) provide new risks to political stability.

The Ministry of Public Health in Guinea-Bissau admits that it is still quite far from providing high-quality health services to its citizens, but guided by the MDGs, it has designed a

practical plan to tackle its shortcomings that has been praised by the UN and World Bank.[144] Yet the hard reality is that no donor has stepped forward to help fund this plan. Though the Global Fund conditionally approved a grant to assist the country's HIV/AIDS program, no donors have agreed to partner with Guinea-Bissau on comprehensive health system reform. The World Bank, European Union, and the African Development Bank have all scaled down their financial support of the health care system. Although the United States recently announced a $48 billion surge in its effort to combat AIDS and malaria in Africa, Guinea-Bissau will not receive one cent directly from the U.S. to assist in preventing or treating disease or reducing child or maternal mortality.[145] USAID actually has a large program specifically designed to assist African countries to strengthen their health care systems known as Health Systems 20/20.[146] However, no technical or financial assistance from this program will benefit the citizens of Guinea-Bissau. As Guinea-Bissau gradually improves governance and consolidates peace, it needs increased budgetary support from the international community. Government leaders must strive to improve accountability, transparency, and administrative effectiveness to attract this most necessary assistance. The achievement of the health-related MDGs surely depends upon their success.

[144] Interview notes, February and April 2008.
[145] However, the U.S. does partially fund multilateral initiatives like the Global Fund.
[146] http://www.healthsystems2020.org/.

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