



UNIOGBIS

United Nations Integrated Peace Building
Office in Guinea-Bissau



UNITED NATIONS
HUMAN RIGHTS
OFFICE OF THE HIGH COMMISSIONER

Original: English

**HUMAN RIGHTS SECTION, (UNIOGBIS-HRS)-
OHCHR
REPORT ON THE RIGHT TO HEALTH IN
GUINEA-BISSAU
APRIL 2017**

Report on the Right to Health in Guinea-Bissau

Executive Summary

This report examines the right of all individuals to the highest attainable standard of physical and mental health in Guinea-Bissau and has been jointly prepared by the Human Rights Section of the United Nations Integrated Peace-Building Office in Guinea Bissau (UNIOGBIS), and by the Office of the United Nations High Commissioner for Human Rights (OHCHR), between January 2016 and March 2017.

The purpose of this report is to contribute to the improvement of the right to health in Guinea-Bissau. The report does not provide a comprehensive overview of the present health situation in the country but aims at outlining major issues of concern, including the main factors affecting the fulfillment of the right to health in the country. It presents the normative, institutional and policy framework, key achievements and challenges ahead. The report examines the national health system, and major health concerns, namely maternal and child health, sexual and reproductive rights, HIV/AIDS, tuberculosis, and malaria, as well as mental health, and international cooperation in the health sector. It also considers various determinants of health, and of access to doctors and medicines, and examines the political and other changes necessary to improve accountability. The report presents a rights-based approach to the National Health Care system, including the availability, accessibility, acceptability and quality framework, as well as elements related to monitoring, participation and accountability.

The report stresses the strong links between health and the peacebuilding process in Guinea-Bissau and underscores that good governance and human rights are essential components of State building and peacebuilding, and are critical to the achievement of the highest attainable standard of physical and mental health. The report emphasizes that efforts to improve the health situation have been consistently undermined by political instability, due to frequent changes in administration within the Ministry of Health (MINSAP) and other key health bodies. At the same time, the report observes that poor general health itself impedes political progress, as it reduces life expectancy, inhibits the ability of individuals to access education and to participate actively in public life and economic activities, and it accentuates poverty. The report further highlights that ongoing political instability has weakened the productive infrastructure, increasing the vulnerability of the population, especially in rural areas. It stresses that a healthy society is more able to claim its rights, support development and hold the government to account.

The report concludes that despite improvements in mothers' and child survival, additional efforts are required to reduce maternal and child mortality rates, increase life expectancy and ensure the realization of the right to health, including through a comprehensive reform of the health care system. The report also concludes that important deficits in participation and accountability are among the key factors stymying progress in the health care system. It underscores that although data collection has significantly improved, health monitoring from a human rights perspective remains limited, and calls for improved participation, monitoring and accountability as key factors to securing improved health system performance and the realization of the right to health.

The report introduces a set of recommendations to contribute to the improvement of the realization of the highest attainable standard of physical and mental health in Guinea-Bissau. It recommends, among others, that with a view to uphold its obligations to respect, protect and fulfill the right to health, the Government should: introduce an accountability mechanism into the health care system at all levels; adopt a basic law on health; outline a clear policy and plan to achieve universal health coverage; strengthen efforts to further reduce neonatal, infant and maternal mortality; develop and make available, throughout the country, a uniform patients' rights charter; establish a functional national complaints mechanism accessible to all; regulate the supervision of health care professionals and their activities; and ensure that appointments and promotions are done transparently, competitively and made on the basis of merit.

Table of Contents

EXECUTIVE SUMMARY	2
I. Introduction	4
II. Context and the Underlying Determinants of Health	5
A. Endemic Poverty	6
B. Deficits in Access to Food and Education	6
C. Deficits in Safe Drinking Water and Sanitation	6
D. Deficits in Infrastructure	7
III. Normative, Institutional and Policy Framework	7
A. National Legal and Policy Framework	9
B. The National Public Health System	10
C. National Health Institutions	11
IV. The National Health Care System: A Human Rights-Based Approach	11
A. Availability	12
1. Availability of health care infrastructure and goods	12
2. Availability of health care services	13
B. Accessibility	14
1. Non-discrimination	14
2. Economic accessibility	15
3. Physical accessibility	15
4. Information accessibility	16
C. Acceptability	16
D. Quality	16
1. Data to inform planning	17
2. Health care education	17
3. Health care practice and knowledge and capacity limitations	18
V. The Accountability Framework	18
VI. Health-related Issues in-focus	19
A. Child and Maternal Mortality	20
1. Vaccination Coverage	20
2. Community health programme	21
3. Improvements in Antenatal care and Maternal Mortality data collection	21
4. Insufficient availability of skilled birth attendants, leading to poor quality care	21
5. Insufficient accessibility of key health care goods, services and facilities	22
6. Cultural norms discouraging women from attending healthcare facilities for deliver	22
B. Sexual and Reproductive Rights	22
1. Lack of women's agency in their own reproductive health	23
2. Low contraceptive utilization	23
3. Adolescent pregnancy and early, forced and child marriage	23
4. Female genital mutilation	24
C. HIV/AIDS	24
D. Tuberculosis	24
E. Malaria	25
F. Mental Health	25
G. Access to Medicines and the Right to Health	27
VII. Activities of UNIOGBIS Human Rights component in relation to the right to health	28
VIII. Conclusions and recommendations	30

Report on the Right to Health in Guinea-Bissau

I. Introduction

1. This report concerns the right of all individuals to the highest attainable standard of physical and mental health in Guinea-Bissau and has been jointly prepared by the Human Rights Section of the United Nations Integrated Peace-Building Office in Guinea Bissau (UNIOGBIS), and by the Office of the United Nations High Commissioner for Human Rights (OHCHR).

2. The right to health is an inclusive right, which contains both freedoms and entitlements. Freedoms include the right to control one's health, including the right to be free from non-consensual medical treatment and experimentation. Entitlements include the right to a system of health protection that provides equality of opportunity for people to enjoy the highest attainable standard of health. More specific entitlements associated with the right to health include the rights to maternal, child and sexual and reproductive health; a healthy workplace and natural environment; the prevention, treatment and control of diseases, including access to vaccination and essential medicines; and access to safe and potable water.¹

3. The right to health is closely related to the enjoyment of a number of other human rights contained in major international human rights treaties, including the rights to food, housing, work, education, life, equality, privacy, and participation, access to information, the prohibition of torture, and the freedoms of association, assembly and movement. Non-discrimination and equal treatment are among the most critical principles of the right to health.²

4. The primary responsibility for the realization of human rights, including the right to health, lies upon the State. However, many actors in society—individuals, local communities, intergovernmental and non-governmental organizations, health professionals, private businesses and other stakeholders—have responsibilities regarding the realization of human rights, including the right to health.³

5. The right to health is subject to progressive realization. This means that the State has a specific and continuing obligation to move as expeditiously and effectively as possible towards the full realization of the right to health. More broadly, the State has an obligation to take steps, individually and through international assistance and cooperation, towards the full realization of the right to health. Although subject to progressive realization and resource constraints, the right to health imposes on the State various obligations of immediate effect, which include the guarantees of non-discrimination and equal treatment, as well as the obligation to take deliberate, concrete and targeted steps towards the full realization of the right to health, such as the development of a national public health strategy and plan of action.

6. Between January 2016 and March 2017, the Human Rights Section of UNIOGBIS undertook focused research and consultations, and conducted site visits, to monitor the human rights situation at national, regional and specialty health care facilities, with a view to assist the State in the fulfillment of its obligations to respect, promote and protect the right to health. Health care facilities visited included the national hospital of reference, Simão Mendes, the national Military Hospital, the mental health Centre Osvaldo Maximo Vieira, the Raoul Follereau Hospital for Tuberculosis (TB), and Cumura Hospital, which acts as the national reference centre for leprosy and provides specialized treatment for HIV, TB and maternal and paediatric care. UNIOGBIS also visited four regional hospitals located in Catio (Tombali), Bafatá (Bafatá), Mansoa (Oio), and Tite (Quinara). In addition, it carried out unannounced visits to “Type B” and “Type C” health care institutions in Quinara, Tombali, Oio, and Bafatá regions.⁴

7. UNIOGBIS and OHCHR wish to express their deepest appreciation to the Government of Guinea-Bissau, particularly to the Ministry of Health (MINSAP) and the National Health Institute (INASA), the Ministry of Justice, the Ministry for Education, and the Ministry for Women, Children and Family Cohesion, for their collaboration in the collection of information, including in informative meetings and consultations. They are also grateful to the United Nations Country Team in Guinea-Bissau, in particular to the World Health Organization (WHO), the United Nations Children's Fund (UNICEF), the United Nations Population Fund (UNFPA), the Joint United Nations Programme on HIV/AIDS (UNAIDS), the United Nations Development Programme (UNDP) and

¹ United Nations Committee on Economic, Social and Cultural Rights (CESCR), “General Comment No. 14 (2000): The right to the highest attainable standard of health”, E/C.12/2000/4, 11 August 2000.

² *Ibid.*

³ *Ibid.*

⁴ “Type B” (healthcare clinics) and “Type C” (basic healthcare posts).

the United Nations Entity for Gender Equality and the Empowerment of Women (UNWOMEN), for their collaboration in the collection and verification of the information contained in this report. Finally, this report could have not been prepared without the contributions of the personnel and users of the medical facilities visited, civil society organizations, international partners, regional organizations and members of the local population who shared their knowledge, experience and views about the national health care system and the status of the implementation of the highest attainable standard of physical and mental health in Guinea-Bissau.

II. Context and the Underlying Determinants of Health

8. The Republic of Guinea-Bissau has a population of 1.888 million people,⁵ whose history since independence from Portugal in 1973 has exposed the country to current political instability, poverty and challenges in the delivery of basic social services. Guinea-Bissau's political challenges, have had profoundly negative impacts upon the living conditions of the population, including their right to health.⁶

9. The country is currently ranked 178 of 188 countries in the Human Development Index (HDI), with an HDI value of 0.424.⁷ Guinea-Bissau's HDI remains below the average of 0.523 for countries in Sub-Saharan Africa, and below the average of 0.497 for countries in the low human development group.⁸ Moreover, when Guinea-Bissau's HDI is adjusted for internal inequality, the HDI falls to 0.257, indicating significant internal disparities in key human development indicators such as life expectancy.⁹

10. The country is divided into eight administrative regions,¹⁰ which are in turn subdivided into 36 sectors, with the addition of Bissau as an independent autonomous sector. However, the health sector is divided into 11 regions, which are further subdivided into 114 "health districts (or areas)" defined on the basis of geographical criteria.¹¹ Health outcomes and access to care vary greatly across these zones.

11. About 50 per cent of the population live in urban areas,¹² with significant variations of health outcomes, and access to care. Over 40 per cent of the population still lives five kilometres away from the nearest primary health care facility.¹³ There are few tertiary services available; the few people with financial means seek access to higher-quality services in Senegal, Portugal or other countries. A part of the health care budget finances health treatments abroad of up to 300 Bissau-Guineas per year.

12. Guinea-Bissau is ethnically diverse. Five main ethnic groups represent around 85 per cent of the population, but there are at least 12 different ethnic groups in the country.¹⁴ Portuguese is the country's official national language while many groups also use their own language. Language barriers have an impact on access to health care of the population.

13. Ongoing political instability has weakened productive infrastructure, increasing the vulnerability of the population—especially those in rural areas—and accentuating poverty.¹⁵ Guinea-Bissau has been hampered in

⁵ See United Nations Statistics Division, "World Statistics Pocketbook", available at <http://data.un.org/CountryProfile.aspx?crName=guinea-bissau> (last accessed on 12 March 2017). It should be noted that according to the *Instituto Nacional de Estatística da Guiné-Bissau* (National Statistical Institute of Guinea-Bissau), the population was of 1514,451 in 2014.

⁶ The reports issued by the United Nations Secretary-General on the situation of Guinea-Bissau, and presented to the United Nations Security Council are available at <http://www.securitycouncilreport.org/un-documents/guinea-bissau/> The Reports issued by the Universal Periodic Review Mechanism of the United Nations Human Rights Council are available at <http://www.ohchr.org/EN/HRBodies/UPR/Pages/GWSession21.aspx> The reports issued by other United Nations Human Rights Mechanisms are available at <http://www.ohchr.org/EN/Countries/AfricaRegion/Pages/GWIndex.aspx>

⁷ UNDP, "Human Development Report 2016", available at http://hdr.undp.org/sites/default/files/2016_human_development_report.pdf (last accessed on 21 March 2017), p. 200.

⁸ *Idem*, p. 209.

⁹ *Idem*, p. 208.

¹⁰ These comprise Cacheu, Oio, Biombo, Bafatá, Gabu, Quínara, Tombali and Bolama-Bijagós. See Law No.4 of 2 December 1997 on the Political and Administrative Organization of the Territory, art. 1-11.

¹¹ Guinea-Bissau, "Plano Nacional de Desenvolvimento Sanitário II 2008-2017" (National Health Development Plan II 2008-2017), PNDS II, Bissau, 2008, p. 15.

¹² According to the "World Statistics Pocketbook" (see footnote 5), in 2015, 49.3 per cent of the population lived in urban areas. See also "Human Development Report 2016" (see footnote 7), p. 224. According to the *Instituto Nacional de Estatística da Guiné-Bissau*, about 41 per cent of the population lived in urban areas in 2014.

¹³ PNDS II (see footnote 11), p. 15.

¹⁴ Guinea-Bissau, "Terceiro Recenseamento geral da população e habitação da Guiné-Bissau" (General population census 2009), III RGPH, 2009, available at www.stat-guinebissau.com/Censo2009/Default.html (last accessed on 13 March 2017).

¹⁵ World Bank, "Conflicts, Livelihoods and Poverty in Guinea-Bissau", Washington D.C., 2007.

implementing effective public health policies and providing core health care goods, services and facilities and it remains heavily dependent on international development aid for basic service provision. Over 90 per cent of the health budget comes from international partners, including the Global Fund, the European Union, the World Bank, the Swedish International Development Cooperation Agency (SIDA), the Global Alliance for Vaccines and Immunization (GAVI) and United Nations agencies and programmes. Further, the state of health of the population and effective access to doctors and medicines are determined by a number of social, economic and cultural factors, which are the underlying determinants of health. In Guinea-Bissau, these include, among others, poverty, as well as challenges in access to safe drinking water and adequate sanitation, core infrastructure, and education, as outlined hereinafter.

A. Endemic Poverty

14. Widespread poverty underscores the vulnerability of the entire population. 69.3 per cent of the population of Guinea-Bissau live below the national income poverty line. 80.4 per cent of the population live in multidimensional poverty, *i.e.* suffer from deprivations in terms of education, health and living standards in the same household; while 58.4 per cent of the population live in severe multidimensional poverty.¹⁶ The Special Rapporteur on Extreme Poverty and Human Rights, who visited the country in 2014, observed the link between poverty and ill health, noting that maternal mortality rates in Guinea-Bissau were among the highest in the world and that Bissau-Guineans have a very low life expectancy,¹⁷ which according to the 2016 Human Development Report, is of 55.5 years.¹⁸

B. Deficits in Access to Food and Education

15. A significant proportion of children under age five remains underweight, which puts them at greater risk of dying from common infections. It should be noted that poor nutrition in the first 1,000 days of life is also associated with impaired cognitive ability and reduced school and work performance.¹⁹ A foreseen technical cooperation agreement between the Government of Guinea-Bissau, the Government of Brazil and the World Food Programme (WFP) on technical support towards the sustainable national school meals programme is a welcome step towards improved access to food by children of schooling age.

16. Education is a key social determinant of health, both directly in terms of improved health literacy, and indirectly in terms of higher educational attainment, and it is closely correlated with improved health outcomes. Educational attainment is limited in Guinea-Bissau. In 2014, the net rate of primary school completion was 75.7 per cent, while the net rate of enrolment in the first year of primary education is 31.1 per cent.²⁰ Moreover, 40.1 per cent of the adult population is illiterate.²¹ Comprehensive health education, including on sexual and reproductive health, is virtually non-existent. This constrains the ability of the population to improve their own health. UNICEF, the World Bank and the Global Education fund are major actors providing support to the education sector.

C. Deficits in Safe Drinking Water and Sanitation

17. The availability of safe, potable water and adequate sanitation facilities in Guinea-Bissau has gradually improved, but challenges remain. Although three-quarters of the population had access to improved water sources in 2014, there was a significant contrast between urban and rural areas, with 92 per cent of urban dwellers using sources of improved water, whereas only 61 per cent of rural residents used such sources.²² A recent waterpoint

¹⁶ Human Development Report 2016 (see footnote 7), p. 218. See also UNDP, “Africa Human Development Report 2016: Accelerating Gender Equality and Women’s Empowerment in Africa”, pp. 26 and 168.

¹⁷ “Report of the Special Rapporteur on extreme poverty and human rights, Magdalena Sepúlveda Carmona, Addendum, Mission to Guinea-Bissau”, A/HRC/29/31/Add.1, 1 April 2015, paras. 5, 8 and 54.

¹⁸ Human Development Report 2016 (see footnote 7), p. 200.

¹⁹ United Nations, “The Millennium Development Goals Report”, New York, 2015, p. 22.

²⁰ Instituto Nacional de Estatística da Guiné-Bissau (National Statistical Institute of Guinea-Bissau), UNICEF, UNFPA, UNDP, International Partnership for Human Development, “Guiné-Bissau - Inquérito aos Indicadores Múltiplos 2014: Principais Resultados” (Guinea-Bissau Multiple Indicator Cluster Survey 2014: Key Findings), MICS 5, 2014, March 2015, pp. 12-13.

²¹ Human Development Report 2016 (see footnote 7), p.233.

²² MICS 5 (see footnote 20), p. 8. Improved sanitation facilities are those that hygienically separate human excreta from human contact (see WHO/UNICEF Joint Monitoring Programme (JMP) for Water Supply and Sanitation, “Improved and unimproved

inventory carried out by UNICEF shows that over 50 per cent of all installed handpumps are either not functioning or functioning with deficiencies, gearing population to use unsafe water sources. Moreover, only 13 per cent of people in the country used improved sanitation facilities that were not shared in 2014. Two per cent of the rural population shared sanitation facilities, as opposed to 27 per cent of urban dwellers.²³ Similarly 30.2 per cent of the rural population practiced open defecation, as opposed to 1.7 per cent of urban residents.²⁴ These are key drivers of ill health, especially of epidemics. Poor access to safe water and sanitation facilities is the main cause of diarrheal diseases, including cholera.²⁵

18. Community-Led Total Sanitation (CLTS) initiatives have been run by non-governmental and multilateral organizations in collaboration with communities, to eliminate open defecation and reduce fecal-oral transmission of diseases. Interventions under this initiative include capacity-building around construction of latrines, and critical moments of hygiene. Communities engaged in the CLTS initiatives are required to have an operational sanitation committee. This represents a good practice of participation of the population in addressing health risks, particularly amongst vulnerable groups, by virtue of their rural location. In total, 1,170 *tabancas* (village, in Bissau-Guinean creole) have thus far been declared Open Defecation Free (ODF) since 2010 mainly through funding by UNICEF (1,118 villages).²⁶ Although challenges remain, this is a significant achievement in the improvement of the social determinants of health.

D. Deficits in Infrastructure

19. Supporting infrastructure for economic activities is weak throughout Guinea-Bissau. The road network is limited and in a fragile condition; telephony is inconsistently available, seaports are “obsolete and dilapidated”, and electricity is in scarce supply throughout the country.²⁷ The fragile road network and unreliable connections between the islands and the main continent prevents effective transport of patients in need of transfer or evacuation. Inconsistent, expensive telephony inhibits communication between health facilities. The country’s precarious seaports impede access to key health care goods, and the lack of electricity directly compromises the ability of health care facilities to utilize key equipment such as ventilators, radiological machines, or even to perform basic procedures with lighting. While the Government is expected to provide electricity to health care facilities, this is inconsistently done, and many facilities must pay for fuel for backup generators to ensure continued functioning of basic equipment.

20. On 2 March 2017, MINSAP announced that through an initiative led by UNICEF and funded with 1,400 million FCFA (about 2.1 million Euros) by the European Union, USAID and The Netherlands, it would refurbish and equip, *inter alia*, with solar panels and potable water, 45 health centres in the interior of the country (out of a total of 145 centres). A USD 15 million UNDP Solar for Health Project is planned to start in March 2018, covering both health care and administration facilities.

III. Normative, Institutional and Policy Framework

21. The enjoyment of the highest attainable standard of health was first recognized in the Constitution of WHO in 1946 as “a fundamental right of every human being without distinction of race, religion, political belief, economic or social condition”. Guinea-Bissau became a member of WHO in 1974.²⁸

22. The foundations for the international legal framework for the right to health are laid down in article 25 (1) of the Universal Declaration of Human Rights, which states that “[e]veryone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability,

water sources and sanitation facilities”, available at <https://www.wssinfo.org/definitions-methods/watsan-categories/>, (last accessed on 27 March 2017).

²³ *Ibid.*

²⁴ República da Guiné-Bissau, Ministério da Economia e Finanças (Republic of Guinea-Bissau, Ministry of Economy and Finances), UNICEF, UNFPA, UNDP, Plan, International Partnership for Human Development, “Guiné-Bissau - Inquérito aos Indicadores Múltiplos 2014: Relatório Final” (Guinea-Bissau Multiple Indicator Cluster Survey 2014: Final Report), MICS 5: Final Report, 2014, March 2016, pp. 135, 137 and 140.

²⁵ Médecins Sans Frontières, “Epidemics: Neglected Emergencies?”, October 2015, p. 10.

²⁶ Some NGOs, such as Plan International, Wellfound, SNV have also contributed to the total results and Médicos da Comunidade, ADPP, Nadel, Ordemar, CVGB and Battodem Gollem have worked in the regions to establish CLTS initiatives.

²⁷ PNDS II (see footnote 11), p. 16.

²⁸ World Health Assembly, WHA27.22 Admission of a new Member: Guinea-Bissau, Tenth plenary meeting, 16 May 1974.

widowhood, old age or other lack of livelihood in circumstances beyond his control.”

23. The right to health has been codified in several legally binding international and regional human rights treaties to which Guinea-Bissau is a party. Article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR) provides the cornerstone protection of the right to health in international law, as the States parties to the Covenant not only recognize “the right of everyone to the enjoyment of the highest attainable standard of physical and mental health”, but also recognize the need to take concrete steps to achieve the full realization of this right, including measures for: (i) the provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child; (ii) the improvement of all aspects of environmental and industrial hygiene; (iii) the prevention, treatment and control of epidemic, endemic, occupational and other diseases; and (iv) the creation of conditions which would assure to all medical service and medical attention in the event of sickness.²⁹

24. Additional right-to-health protections for marginalized groups are contained in group-specific international treaties, such as the International Convention on the Elimination of All Forms of Racial Discrimination ratified by Guinea-Bissau on 1 November 2010;³⁰ the Convention on the Elimination of All Forms of Discrimination against Women ratified by Guinea-Bissau on 23 August 1985;³¹ the Convention on the Rights of the Child ratified by Guinea-Bissau on 20 August 1990;³² and the Convention on the Rights of Persons with Disabilities ratified by Guinea-Bissau on 24 September 2014.³³ It should be noted that Guinea-Bissau has signed but not ratified the optional protocols to the International Covenant on Economic, Social and Cultural Rights (ICESCR), to the Convention on the Rights of the Child (CRC) and to the Convention on the Rights of Persons with Disabilities (CRPD) all relating to the competence of the respective treaty body to receive communications, as well as the International Convention on the Rights of Migrant Workers and Their Families, which also contains health-related provisions. Additional international human rights instruments contain protections relevant to the right to health in various situations, environments and processes, including armed conflict, development, the workplace and detention.

25. Moreover, far-reaching commitments relating to the right to health have been made in the outcome documents of numerous United Nations world conferences. Many refer to the right to health and health-related rights, as well as health issues. The Agenda 2030 on Sustainable Development is one of those key documents. Adopted unanimously by all United Nations Member States, the Agenda 2030 for Sustainable Development with its 17 Sustainable Development Goals and 169 targets, will shape the direction of global and national development policies until 2030.

26. The Agenda 2030 offers new entry points and opportunities for bridging the divide between human rights and development, including the right to health. For example, the Sustainable Development Goal 3 is to “ensure healthy lives and promote well-being for all at all ages”. The Agenda 2030 also recognizes the need for partnerships for development, including for the realization of the right to health. In this regard, the United Nations Charter (1945) already recognizes the importance of international cooperation in the health field (article 13 (1) (b)) and stresses that “with a view to the creation of conditions of stability and well-being, which are necessary for peaceful and friendly relations among nations (...) the United Nations shall promote (...) solutions of international economic, social, health and related problems” (article 55 (b)). Moreover, the Global Strategy for Women’s, Children’s and Adolescent’s Health (2016-2030) recognizes that “only a comprehensive human rights-based approach will overcome the varied and complex challenges facing women’s, children’s and adolescent’s health”. The Global Strategy, proposes as a roadmap to achieve the right to the highest attainable standard of health for every woman, child and adolescent, that countries and their partners simultaneously take action in nine interconnected and interdependent areas: country leadership; financing for health; health systems resilience; individual potential; community engagement; multisector action; humanitarian and fragile settings; research and

²⁹ International Covenant on Economic, Social and Cultural Rights (ICESCR), 1966, art.12 (2).

³⁰ Article 5 (e) (iv) of International Convention on the Elimination of All Forms of Racial Discrimination provides protections for racial and ethnic groups in relation to “the right to public health (and) medical care”.

³¹ The Convention on the Elimination of All Forms of Discrimination against Women contains several provisions for the protection of women’s right to health, in particular articles 11 (1) f, 12 and 14 (2) b.

³² The Convention on the Rights of the Child contains extensive provisions on the child’s right to health, including article 24, which is fully dedicated to the right to the health of the child, and articles 3 (3), 17, 23, 25, 32 and 28, which contain protections for particularly vulnerable groups of children. Articles 2, 3, 6 and 12 are also of the utmost importance in this context as they serve to guide the implementation of all rights recognized in the Convention.

³³ Articles 25 and 26 of the Convention on the Rights of Persons with Disabilities contain, respectively, a number of provisions on the right to health of persons with disabilities, and on health habilitation and rehabilitation services for these persons.

innovation; and accountability.³⁴

27. Guinea-Bissau has been a member of the African Union since 1973 and a State party to the African Charter on Human and Peoples' Rights since 1986. The right to "the best attainable state of physical and mental health" is recognized in article 16 of the African Charter, which requires States to take "necessary measures to protect the health of their people and to ensure that they receive medical attention when they are sick". In addition, since 2008, Guinea-Bissau has been a party to the African Charter on the Rights and Welfare of the Child, which recognizes that "every child shall have the right to enjoy the best attainable state of physical, mental and spiritual health". This includes the obligation for the State to "ensure the provision of adequate nutrition and safe drinking water", as well as "necessary medical assistance and health care" (article 14). It has also been a party to the Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa, which contains a number of provisions on women's rights to health and reproductive rights as well as on the elimination of harmful practices that endanger the health of women (articles 14 and 5 respectively).

28. The current Constitution of Guinea-Bissau (1994) highlights in article 15 that "public health aims to promote the physical and mental well-being of populations and their balanced insertion in the socio-ecological environment in which they live." It further states that public health "should be oriented towards prevention and aim at the progressive socialization of medicine and drug and medical sectors."

29. Although the Constitution does not refer explicitly to the right to health, article 29 notes that constitutional and legal procedures relating to fundamental rights have to be interpreted in harmony with the Universal Declaration of Human Rights, which recognizes the right to health in article 25. Furthermore, article 58 of the Constitution provides for the gradual creation of "necessary conditions for the full realization of the rights of a social and economic nature", which are recognized in the chapter on rights, freedoms, guarantees and fundamental duties.

A. National Legal and Policy Framework

30. The idea of adopting a National Law on Health was mooted between 2010 and 2011, but abandoned shortly after the coup d'état of 12 April 2012. Currently, there is no law outlining the core goods, services and facilities, and health-related rights that the population is entitled to, and thus, the Government should consider elaborating a framework law on the right to health.

31. The national legal framework on the right to health includes (i) Law No. 5/2007 on HIV/AIDS, which prohibits discrimination against people living with HIV/AIDS and preserves confidentiality; (ii) Law No. 11/2010 on Reproductive Health and Family Planning, which, *inter alia*, raised the minimum age for marriage to 18 years; (iii) Law No. 12/2011 on Prevention and Fight against Trafficking in Persons, particularly Women and Children, which incorporated most of the provisions of the Protocol to Prevent, Suppress and Punish Trafficking in Persons, Especially Women and Children, supplementing the United Nations Convention against Transnational Organized Crime; (iv) Law No. 14/2011 to Prevent, Fight and Suppress Female Genital Mutilation, which prohibits and criminalizes the practice of female genital mutilation. The inadequate level of implementation of these laws remains a matter of concern.

32. The National Health Development Plan for 2008-2017 aims at "ensuring quality care, accessible to all"³⁵ and integrates other policies and frameworks relevant to the realization of the right to health in Guinea-Bissau, such as (i) the National Plan of Human Resources for Health (2008-2017) and (ii) the Operational Plan for the Nationwide Transition on antenatal and maternal health (Known as POPEN, its Portuguese acronym). According to the PNDS II, the main priorities for the Ministry of Health (MINSAP) are (i) the Reproductive Health Programme, which includes maternal and child health, family planning, the expanded programme on immunization (Known as EPI), the strategy of integrated management of childhood illness, and nutrition; and (ii) the prevention of, and fight against, endemic diseases, which include the programmes to combat HIV/AIDS and Sexually Transmitted Infections (STI), malaria, leprosy, TB, onchocerciasis, other neglected diseases, and vision loss.

33. The factors that impeded the achievement of these goals under the 1998-2007 PNDS I, and which appear to have hampered the effective implementation of PNDS II, include the lack of infrastructure and essential equipment; a "constant" drain of health staff abroad, particularly during the civil war period (1998-1999), and the general lack of human resources within the system; governance instability; the absence of effective monitoring and supervision within the health care system; poor conditions of roads, and limited transport; and, increasing detrimental practices such as mismanagement of equipment, and the current lack of sustainability of the health

³⁴ The Global Strategy for Women's, Children's and Adolescents' Health (2016-2030), Every Woman Every Child Movement, 2015, p.43. Available at: <http://www.who.int/life-course/partners/global-strategy/en/>

³⁵ PNDS II (see footnote 11), p. 8.

care system.

34. Additional national policies and frameworks that are relevant for the protection of the right to health in the country include the 2017 National Malaria Campaign; the National Malaria Control Programme (2013-2017) as well as a number of past policies including: (i) the National Action Plan on Birth Registration (2010-2013);³⁶ (ii) the National Action Plan to Prevent Sexual Abuse and Exploitation (2011-2013); (iii) the National Action Plan to Combat Female Genital Mutilation (2010-2015); (iv) the National Gender Policy (2014); (v) Guinea-Bissau National Plan for Food Security (elaborated in 2008); (vi) the National Immunization Policy (elaborated in 2007) and the Injection Safety Policy (elaborated in 2003); (vii) the National Nutrition Policy (elaborated in 2014) and a (viii) a Blood Policy (approved by Council of Ministers in 2014).

B. The National Public Health System

35. The Ministry of Public Health (MINSAP) is part of the State Secretariat for the management of hospitals and the Government Department responsible for formulating, proposing, coordinating and executing the Government policies on health and the fight against epidemics. MINSAP includes a general secretariat; a general inspectorate of health activities; the National Institute of Public Health (INASA); the Office for the Central Purchase of Essential Medicaments (CECOME); 11 regional directorates for public health; and general directorates for the prevention and promotion of health, the administration of the health system, and the administration of health care institutions.

36. The health care administration system is ostensibly decentralized, with MINSAP assuming responsibility for central policy formulation and planning, as well as coordination of placement and payment of health care workers throughout the country. In each of the health sector regions, a health team formulates its own regional plan in consultation with MINSAP. The regional teams conduct a number of activities including financial management, procurement coordination, outreach and sensitization, and maintenance of facilities. However, regional health offices are severely under-resourced. Their activities are funded through a five per cent levy taken from health care posts within the relevant region (15 per cent levies are also taken from hospitals). The only funding received from MINSAP for regional activities is for specific programmes, such as vaccination campaigns.

37. Health remains a low priority for government expenditure. The proportion of the government budget spent on health is 5.18 per cent,³⁷ well below the commitment made by the Government in Abuja in April 2001, when African Union countries pledged to adopt a budgetary allocation of at least 15 per cent to improve the health sector. Government expenditure on health as a percentage of GDP remains at around 1 per cent.³⁸ Moreover, less than 1 per cent of the general budget of the State is currently allocated to women's and children's health,³⁹ despite the chronic vulnerability of these population groups. It must be noted that due to the political stalemate that has affected the country since August 2015, the health budgetary expenditure has stalled as the various governments appointed since then have not seen approved their respective programmes of government and national budgets in Parliament.

38. The vast majority of MINSAP funds are allotted to pay salaries of doctors, nurses and other health care technicians. The remainder of the system is funded by donors, and through patients' out-of-pocket payments, at rates that appear to be the highest in West Africa.⁴⁰ Patients generally pay a consultation fee at a health care facility,⁴¹ and also pay for goods such as drugs, and services including specific medical procedures. The majority of these out-of-pocket payments are used by administrators to maintain health care facilities and pay for health care goods.

39. There is a need to improve financial and administrative data collection and record keeping systems, as even in respect of use of central health care funds, there is no record of all health care expenditure, particularly the funds that are not used to pay staff salaries.⁴² The appointment of health care professionals to administrative posts within the health care system, both in government and other positions such as hospital directorships, is not systematically

³⁶ UNICEF is currently supporting a birth registration project funded through the Peacebuilding Fund.

³⁷ WHO, "2015 National Budget Allocation", Bissau, 2016.

³⁸ WHO, "Global Health Expenditure Atlas", Geneva, September 2014, p. 33; see also Human Development Report 2016 (see footnote 7), p. 229.

³⁹ Committee on the Rights of the Child, "Concluding observations on the combined second to fourth periodic reports of Guinea-Bissau, adopted by the Committee at its sixty-third session (27 May-14 June 2013)", CRC/C/GNB/CO/2-4, 8 July 2013, para. 16.

⁴⁰ World Bank Development Indicators, April 2016.

⁴¹ Patients who do not have to pay a consultation fee include children under five, pregnant mothers, women giving birth, and patients aged 60 and over.

⁴² PNDS II (see footnote 11), p. 37.

recorded and publicized. Staff turnover is frequent, and Government authorities sometimes replace health care administrators' multiple times within a year.

40. The country's health system as a whole remains heavily dependent on donors. While efforts have been made to avoid duplication in service delivery and promote coordination, MINSAP is planning to create a management function within the Ministry to bring together all donor funds and better coordinate their activities. However, there are concerns around how this will function in practice. To address this dearth of coordination, donors funding the health sector created at the end of 2016 a health sector coordination group currently comprised of the World Bank, the Global Fund, the European Union, GAVI, WHO, UNICEF, UNDP, and MINSAP.

C. National Health Institutions

41. The National Institute of Public Health (*Instituto Nacional de Saúde Pública*, INASA), was created in 2011, and provides leadership in the field of public health. It brings together key components of the country's public health system including the National Public Health Laboratory, MINSAP's epidemiology unit, and the National School of Public Health, and the Bandim Health Project. INASA collaborates with various international donors, NGOs and national public health institutions to build its capacity to deliver key services. Despite frequent changes of government and ongoing political instability, INASA has enjoyed a relative independence from the Government, along with substantial donor support, which has enabled its continued operation.

42. As noted, INASA collaborates with a number of international donors, NGOs and national public health institutions to build its capacity to deliver key services. For example, close cooperation between INASA and the United States' Centre for Disease Control (CDC) provides a good model for collaborative work to overcome global health problems in disease surveillance and emergency preparedness, as illustrated during the Ebola outbreak in West Africa in 2016. The National Public Health Laboratory is now equipped to diagnose multi-drug resistant tuberculosis while in the past samples were sent to Senegal or Europe for analysis.

43. Efforts should be made to preserve the independence of INASA in respect of its core activities, and to clearly delineate the activities and authority of MINSAP and INASA. This is of particular importance in relation to decision-making concerning public health activities that may limit human rights, such as limitations on freedom of movement in the event of a declared epidemic. INASA could also consider more frequent publication and sharing of the data it holds, in order to further advance progress in health and ensure transparency. Its activities could be strengthened to further build up the national health information systems as a basis for evidence-based health policy, in close collaboration with MINSAP. The same could be done for CECOME, which although nominally autonomous, since 2015 has experienced two changes of the senior management group by MINSAP.

IV. The National Health Care System: A Human Rights-Based Approach

44. The national healthcare system is comprised of the public, government-run sector, including over 3,000 trained Community Health Workers, private providers, and traditional medicine practitioners. However, traditional healers represent the first line of health care. It should be noticed that it is only after consulting and spending money on traditional healers, and when health is not improved through these means that sick people, whose health has further deteriorated, reach out to the public or private health sector. Unfortunately MINSAP and international partners are not engaged with the first line of health care, which remains the domain of traditional healers.

45. There are minimal differences in quality of care between the public and private sectors, and many healthcare workers practice within both systems. Public facilities are classified into "Type A" (hospitals), "Type B" (healthcare clinics) and "Type C" (basic healthcare posts), differentiated by the level of staffing, healthcare goods and services provided. In addition, a number of facilities are run and primarily funded by NGOs in partnership with the government. This is the case of Cumura and Quinhamel hospitals, which are funded and managed by the Catholic Church, with medical staff supplied through an agreement with MINSAP.

46. A pre-condition for the materialization of the human right of everyone to health, is an effective, national health care system, which should take into consideration the underlying determinants of health, some of which are described in section II. It should be noted that while the right to health is an inclusive right, the determinants of health implicate systems, settings, factors and environments beyond the health sector, and thus, a human rights-based approach to health should be implemented by all sectors impacting on health and not exclusively by the health sector.

47. The formulation and implementation of national health strategies and plans of action should respect, *inter alia*, the principles of non-discrimination and people's participation. In particular, the right of individuals and groups to participate in decision-making processes, which may affect their development, must be an integral

component of any policy, programme or strategy developed to discharge governmental obligations under article 12 of the ICESCR. The effective provision of health services can only be assured if people's participation is secured by States.⁴³

48. Participation by the population of Guinea-Bissau in health care-related policymaking and institutions is limited. Stakeholders consistently noted that people are not accustomed to questioning the quality of care received, or to make complaints to hospital, regional or national administration regarding health care facilities, goods and services. Instead, the minority of those who can afford to do so seek care outside the country. Furthermore, there is no formal mechanism for individuals to take part in governmental decision-making, or review proposed laws or policies. Steering committees and governing bodies for areas touching on health, should make provisions for the participation of affected individuals or groups.

49. Moreover, national mechanisms should monitor both the human rights of patients and of healthcare professionals.⁴⁴ MINSAP's supervision and internal monitoring of compliance with human rights standards is limited, due to practical difficulties such as a lack of transport, fuel and adequate funding, and technical limitations, including lack of sufficiently trained personnel. Moreover, existing monitoring activities do not appear to incorporate human rights standards and the National Human Rights Commission⁴⁵ (*Comissão Nacional dos Direitos Humanos*, CNDH) does not have a mandate to receive complaints from the population or from healthcare professionals.⁴⁶

50. The Committee on Economic, Social and Cultural Rights (CESCR) observes that a health care system shall be available, accessible, acceptable and of good quality.⁴⁷ We shall refer hereinafter to each of these elements.

A. Availability

51. The CESCR has consistently emphasized that functioning public health and health-care facilities, goods and services, as well as programmes, have to be available in sufficient quantity within the State party.⁴⁸ This includes adequate numbers of health facilities, support services and medical and other professionals trained to provide these services. Hereinafter the report shall refer to availability of (1) health care infrastructure and (2) health care services.

1. Availability of health care infrastructure and goods

52. Availability of health care physical infrastructure is reasonable in Guinea-Bissau.⁴⁹ However, such facilities are insufficient to constitute genuine availability under the right to health. Availability requires genuine availability of health care infrastructure to all, including those in remote rural areas and, genuine functionality, in the form of trained medical and professional personnel receiving domestically competitive salaries and essential drugs.⁵⁰ In this regard, many health posts in the country are dysfunctional or semi-functional.

53. In 2014, the Special Rapporteur on extreme poverty noted that "most" regional health posts have no health care workers;⁵¹ this is not necessarily still the case in 2017, but it is not uncommon for health care workers to refuse to work in regional posts.

54. Where health posts are staffed, equipment, trained staff and drugs are frequently unavailable. For example, Guinea-Bissau sorely lacks radiological capacity, despite donations of computerized tomography scanners (CT scanners) from the Kingdom of Morocco, as staff are yet to be trained on the use of these machines. Similarly, one dialysis machine is available, but not yet use in the national reference hospital Simão Mendes also because of gaps in technical capacity.

⁴³ E/C.12/2000/4 (see footnote 1), para. 54.

⁴⁴ Report of the Special Rapporteur of the Commission on Human Rights on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Paul Hunt, submitted in accordance with Commission resolution 2005/24, A/60/348, 12 September 2005, p. 16.

⁴⁵ The CNDH is an inter-institutional body, which reports to the Ministry of Justice.

⁴⁶ OHCHR has provided legal advice to the Government of Guinea-Bissau to strengthen such Commission, particularly its independence (see "Report of the Secretary General: National institutions for the promotion and protection of human rights", A/HRC/27/39, 30 June 2014). However, the Statute of such body is not harmonized with the Principles relating to the Status of National Institutions (Paris Principles), adopted by General Assembly resolution 48/134 of 20 December 1993.

⁴⁷ E/C.12/2000/4 (see footnote 1), para. 12.

⁴⁸ *Ibid.*

⁴⁹ Information available at WHO indicates that in 2014, Guinea-Bissau had 96 health posts, 562 health centres, 437 district hospitals, no provincial hospitals and 525 regional hospitals. See WHO, Guinea-Bissau Country Indicators, Global Atlas of Medical Devices, 2014, available at http://www.who.int/medical_devices/countries/gnb.pdf (last accessed on 28 March 2017).

⁵⁰ E/C.12/2000/4 (see footnote 1), para. 12(a).

⁵¹ A/HRC/29/31/Add.1 (see footnote 17), paras. 5, 8 and 54.

55. Most Type B and C facilities lack electricity or water supplies. Health care workers in a number of “Type C” health posts described having to deliver babies by candlelight, without access to sterile water, which may have an impact on the mortality rates of newborns and their mothers. The condition of these facilities is often very poor due to a lack of funding for regular maintenance. Many of them are run-down and in urgent need of renovation. In the regions, housing for health care workers is essentially unavailable, as buildings are uninhabitable.

56. To address some of these deficits, MINSAP and UNICEF, together with the European Union and the Global Fund, developed an updated community health worker (CHWs) strategy (1 CHW to cover 50 households), with 16 key family practices, including EPI, nutrition, malaria, TB, and HIV. To date, over 3,000 CHWs have been trained, and equipped with basic supplies.

2. Availability of health care services

57. Adequate availability of health care services is highly dependent on there being sufficient human resources to deliver services. Guinea-Bissau’s lack of sufficient human resources for health is consistently cited as one of the biggest challenges the country faces in delivering quality care to its population. In 2014, there were 1.7 doctors per 10,000 people in Guinea-Bissau.⁵² Presently, there are only three pediatricians in the country, all expatriates, for a population of approximately 720,000 children under the age of 15.⁵³ There are only four obstetricians and around 34 skilled midwives in Guinea-Bissau, and only one anesthetist (an expatriate). The lack of specialists in anesthesiology is so severe that the surgery room of the maternity ward of Simão Mendes National Hospital, fully renovated and equipped in 2013, is not functional due to a lack of specialists in the country. Guinea-Bissau also faces a dearth of other key health sector personnel including demographers, epidemiologists, and health care managers and administrators. This massive shortage of health professionals in certain countries, particularly in sub-Saharan Africa, has been recognized as a serious right to health issue.⁵⁴

58. Two institutions in Guinea-Bissau currently train doctors. The Faculty of Medicine “Raul Dias Arguelles”, which was established by the Government of Cuba in 1986, trains the majority of Bissau-Guinean doctors. Since 1986, over 200 Bissau-Guinean doctors have been trained in collaboration with the Government of Cuba.⁵⁵ Jean Piaget University (private) also provides medical training in Bissau. This has improved the doctor/patient ratio in the country, which recently increased to 1.7 doctors per 10,000 people, compared to 0.7 doctors between 2004 and 2014.⁵⁶ However, there persists a significant and ongoing loss of doctors to higher-income countries. Guinea-Bissau’s increased capacity to produce medical graduates has not translated into improved specialty medical capacity. Additionally, most doctors live and work in urban areas, which does not benefit the approximate 50 per cent of the population that lives in rural areas.

59. There are no specialty training programmes in the country, a fact that significantly contributes to the “brain drain” of doctors overseas, as those who leave to complete specialty training often do not return. Presently, most of the limited selection of specialty medical services available in the country is delivered by a handful of committed local doctors, together with United Nations Volunteer (UNV) specialists.

60. Nurses are currently trained at Jean Piaget and at the Escola Nacional de Saude (ENS) (a public university), but not in sufficient numbers to meet the demand; there are currently 1,137 nurses in the country,⁵⁷ representing a rate of 6.4 nurses per 10,000 people; Guinea-Bissau is among the 28 per cent of countries reported to have less than 1 nursing/midwifery personnel per 1,000 population.⁵⁸

61. Availability of midwives is also very limited, as ENS stopped training midwives in 2005 and only restarted in 2013. The current unmet need for midwives is 79 per cent.⁵⁹ The fact that there was not a single educational facility producing midwives for eight years in a country with a high maternal mortality ratio, is alarming.⁶⁰ Steps are being taken to redress this; for instance, in April 2016, UNFPA, in partnership with ENS, implemented a six-month “training of trainers” in obstetrics for 50 practicing midwives. Additionally, a 12-month training course was held for 34 specialized nurses in anesthesiology to increase the availability of anesthesia throughout the

⁵² WHO, “Guinea-Bissau Cooperation Strategy”, Bissau, 2015.

⁵³ *Ibid.*

⁵⁴ A/60/348 (see footnote 44), p. 10.

⁵⁵ Peter Karibe Mendy and Richard A. Lobban Jr., *Historical Dictionary of the Republic of Guinea-Bissau*, 4th edition, 2013, p. 114.

⁵⁶ Guinea-Bissau Cooperation Strategy (see footnote 52).

⁵⁷ Carlos Sangreman, *Observando Direitos na Guiné-Bissau: Educação, Saúde, Habitação, Água, Energia, Saneamento, Justiça, Meios de Subsistência* (Observing Rights in Guinea-Bissau: Education, Health, Housing, Water, Energy, Sanitation, Justice, Means of Subsistence), Bissau, 2016, p. 76-77.

⁵⁸ WHO, “Density of nursing and midwifery personnel”, 2016.

⁵⁹ UNFPA, ICM & WHO, “The state of the world’s midwifery 2014: A universal pathway. A woman’s right to health”, p.108.

⁶⁰ See Chapter VI for further discussion.

country. Further, UNFPA and WHO, under the Global Health Partnership H6 (formerly H4+), together with United Nations Volunteers (UNV), have placed international specialists from different backgrounds (obstetricians-gynecologist, midwives, anesthesiologists, pediatricians) to work in chosen hospitals and simultaneously train local health care providers with a view to enhance local healthcare capacities.

62. In addition to the civil war, and the lack of specialty training, another key driver of the brain drain of health professionals is the lack of adequate remuneration. Doctors in the country are paid modestly, with salaries of approximately FCFA 150,000 per month (around USD 250), and mid-tier nurses and medical technicians earn around FCFA 90,000 monthly. Community Health Workers are paid approximately 7,500 FCFA per month. Recent political instability has caused significant disruptions in the disbursement of salaries,⁶¹ and many health care workers incur significant expenses in having to pay rent in regional areas due to poor quality of government-provided housing at health care facilities.

63. These conditions have periodically led health care professionals to strike which, on occasion, has reduced the availability of health care services to such an extent that violations of the right to life and health occurred. For example, between March and May in 2016, health workers went on strike demanding salary increases, payment of arrears and better working conditions, and the inclusion of new graduates in MINSAP payroll. During that period no arrangement was made for a core minimum number of workers to be available to ensure adequate provision of emergency medical care. Consequently, a total of 24 patients reportedly died; 14 at the national hospital, and 10 patients at the military hospital, whose personnel, while not on strike, was unable to cope with demand caused by the situation.⁶² In this case, the failure of both the State and providers of health care services to make adequate services available, directly violated the individual rights to life and to health.

64. Finally, the lack of availability of health care services often stems from a combination of a shortage of health care workers and health care goods. For example, there are no anatomical pathology services in Guinea-Bissau, due to a lack of trained pathologists and requisite equipment. Any diagnosis of cancer must be made through analysis of biopsies in Portugal. For similar reasons, dialysis, interventional cardiology, chemotherapy and radiotherapy are all unavailable in Guinea-Bissau.

B. Accessibility

65. Health facilities, goods and services have to be accessible to everyone without discrimination, within the jurisdiction of the State party. Accessibility has four overlapping dimensions: non-discrimination, physical accessibility, economic accessibility (affordability) and information accessibility.⁶³

1. Non-discrimination

66. Encouragingly, there does not appear to be any clear patterns of overt, *de jure* discrimination based on ethnicity in Guinea-Bissau, in relation to access to health care goods, services and facilities. Where ethnic disparities in mortality do exist, they generally appear to be a function of location.⁶⁴ However, gender-based discrimination remains a significant problem. The disproportionate burden of illness borne by women of childbearing combined with their specific needs for access to quality sexual and reproductive health care, means they have much greater exposure to the health system. Their needs merit extra attention and focused efforts by the State.

67. A human rights-based approach requires particular attention to people in situations of vulnerability. Moreover, women who seek an abortion tend to suffer multiple discrimination in access to health care services in view of the endemic levels of poverty in the country.⁶⁵ While the national law does not criminalize abortion as long as it is provided in medical facilities by a professional and with the consent of the pregnant woman,⁶⁶

⁶¹ “Report of the Secretary-General on developments in Guinea-Bissau and the activities of the United Nations Integrated Peacebuilding Office in Guinea-Bissau”, S/2017/111, 7 February 2017; and “Report of the Secretary-General on the progress made with regard to the stabilization and restoration of constitutional order in Guinea-Bissau”, S/2016/720, 16 August 2016.

⁶² According to information provided by the Director of Simão Mendes Hospital and the Clinic Director of the Military Hospital during a monitoring visit conducted by UNIOGBIS during the mentioned strike (see below for further information).

⁶³ E/C.12/2000/4 (see footnote 1), para. 12(b).

⁶⁴ See e.g. Maram Mane and ors, “Trends and determinants of mortality in women of reproductive age in rural Guinea-Bissau, West Africa – a cohort study” *BMC Women’s Health*, vol. 13, No. 48, December 2013.

⁶⁵ Committee on Economic, Social and Cultural Rights, “General Comment No. 22 (2016) on the right to sexual and reproductive health”, E/C.12/GC/22, 2 May 2016, paras. 30, 34 and 45.

⁶⁶ Article 112 of the Penal Code (Decree-Law No. 4/93, in *Suplemento ao B.O. No. 41*, 13 October 1993, provides that: “1. A person who causes abortion to a pregnant woman against or without her consent, while it would have been possible to obtain such consent, shall be punished with three years’ imprisonment. 2. A person who carries out abortion outside health care facilities or without having professional qualification to do so shall be punished with imprisonment of two to six years,

stakeholders highlighted that a major challenge for women's access to safe abortion are the charges levied for such services by health care professionals. Being unable to afford these fees, a significant proportion of women tend to resort to abortion services carried out by unqualified individuals and outside of health care facilities, with risk to their lives and health, risks too of being criminalized and of exposure to instances of gender-based and instances of multiple discrimination.

2. *Economic accessibility*

68. Economic accessibility may constitute the most pressing problem within the national health care system. The vast majority of patients and their families do not have the financial means to pay for health care goods, services and facilities. In both public and private facilities, out-of-pocket payments are rampant. In 2012, it was estimated that private household expenditure constituted 43 per cent of health care expenditure in Guinea-Bissau.⁶⁷ High rates of fee-for-service health care inevitably lead to financial strain for families, with depletion of savings or valuable assets, and potentially incurrance of significant debt or even bankruptcy. According to a World Bank Health Sector Review conducted in 2016, Guinea-Bissau has the highest out of pocket payment rates in West Africa.⁶⁸

69. The primary cause of this high incidence of out-of-pocket payments is the lack of government funding for health care goods, facilities and services. Only 5.18 per cent of the national budget is allocated for health care, and most of that is allocated to pay the salaries for public servants. As there are insufficient funds to pay for health care goods and facilities once salaries are paid, patients are required to make out-of-pocket payments to fund the operation of the health system. The State budgetary allocation for health is also insufficient to employ all health care workers, and therefore some practice in the private sector. Patients receive no co-contribution or rebate for payments to access these services. The average consultation fee in Guinea-Bissau is FCFA 750 (approximately USD 1.10).

70. Drugs procured through CECOME are sold through public facilities with a modest mark-up. For example, a standard course of generic amoxicillin costs around FCFA 700, if purchased through a hospital. If complex care is needed, costs mount up. Presently, at Simão Mendes Hospital, a diagnostic blood test cost around FCFA 1,000 to 3,000. The cost of a blood transfusion can be around FCFA 25,000 to 35,000, even though donations of blood are ostensibly free. Oxygen routinely costs FCFA 25,000. Where patients or their families cannot pay these fees, they generally either forego care, or may in some instances receive financial support from NGOs.

71. Steps are being taken to redress the burden that out-of-pocket payments place on the population. For instance, in the context of its efforts to reduce the extremely high maternal and child mortality rates, the Government has partnered with the United Nations and the European Union to deliver services for free for pregnant women and children under five. This policy has generally received favorable feedback to date, but some inconsistencies remain and impede access.⁶⁹

72. The 2014 government instituted free medical services and drugs for children, pregnant women and the elderly. Through donor and United Nations advocacy, on 25 May 2015, MINSAP instituted free malaria diagnosis and treatment for all.

3. *Physical accessibility*

73. Physical accessibility of health care facilities is affected by distance, poverty and a general lack of transport. Many health posts remain at a significant distance from the population they are to serve. During human rights monitoring and assessment visits undertaken in 2016, UNIOGBIS was informed that 52 per cent of people have to travel for over an hour to reach the closest health care facility, which is usually a "Type C" facility providing only the most basic health care interventions. Physical distance to "Type A" health care facilities also remains a significant problem, coupled with economic inaccessibility. In the event that patients require evacuation

regardless of the outcome. 3. A pregnant woman who consents to an abortion carried out in the circumstances described in the above paragraph shall be punished with the penalty prescribed therein, which shall be mitigated if the conduct is aimed at hiding a dishonourable situation." See also article 16(3) of Law No 11/2010 on Reproductive Health and Family Planning (in *B.O. No. 39*, 29 September 2010), which provides: "The voluntary termination of pregnancy is authorized in accordance with the law on abortion". Article 17 of this same law provides: "The Government and non-governmental organizations in this field are committed to work in benefit of the health of the woman, to address the consequences of clandestine abortions as a wider public health issue, and to promote a reduction of the cases of abortion by enlarging and improving the services that provide advice and education on family planning. 2. In all cases, women are entitled to access quality services to remedy complications resulting from abortion."

⁶⁷ Global Health Expenditure Atlas (see footnote 38), p. 33.

⁶⁸ World Bank Development Indicators, April 2016.

⁶⁹ See Chapter IV of this report.

to Bissau from regional health care facilities, transport is inconsistently available. Where ambulances are available, patients are required to pay for fuel, which can be prohibitively expensive for most families. For example, ambulance evacuation from Cacine (Tombali) to Bissau costs around FCFA 75,000—a little more than twice the minimum wage in the country. Through the European Union Integrated Mother and Child Health Programme (known as “PIMI”), medical evacuations for pregnant girls and women are funded.

74. Moreover, there is significant inter-regional variation in the average distance a patient needs to travel to access these facilities. For example, the average distance that an inhabitant of Bissau’s administrative region has to travel to secure pre-natal care is 2.1 kilometres, whereas in Gabú this distance is 5.2 kilometres, and in Quinara 10.8 kilometres.⁷⁰ There is minimal data on inter-ethnicity variation in terms of physical accessibility.

75. Some non-governmental and charitable organizations fund evacuations. For example, at Tite Hospital in Quinara, evacuations to Bissau by boat are funded by the Catholic mission in the region at a cost of FCFA 50,000. However, the sustainability of such support is questionable. The severest problems of physical access are experienced by residents of the Bijagos islands region, where, due to a lack of maritime transport, patients are often required to wait for several days to be evacuated to the mainland. The cost of maritime evacuations can exceed FCFA 100,000, depending on locality.

4. Information accessibility

76. Accessibility of health information is hampered due to extraordinary illiteracy rates (see section II.B). Significant attempts have been made to overcome this through widespread use of radio programmes to inform people regarding key public health messages. The role of community health workers has also been vital in increasing information accessibility, and it has been demonstrated that this resulted in improved health literacy within the population. For example, improved rates of vaccination and of attendance at antenatal care have been demonstrated in areas where community health workers have been involved.

C. Acceptability

77. All health facilities, goods and services must be provided in a manner respectful of medical ethics and culturally appropriate, *i.e.* respectful of the culture of individuals, minorities, peoples and communities, sensitive to gender and life-cycle requirements.⁷¹ In this regard, as a general rule, health care goods, services and facilities in Guinea-Bissau are acceptable to the population. However, the delivery of family planning information and services to the Islamic community, which constitutes approximately 50 per cent of the population, has proved challenging due to cultural practices and language barriers. Although half of all girls and women nationwide have undergone female genital mutilation, the practice is “nearly universal” amongst Muslims.⁷² Activities to decrease the rate of female genital mutilation within this community are yet to yield the expected outcomes.

D. Quality

78. Health facilities, goods and services must be scientifically and medically appropriate and of good quality (skilled medical personnel, scientifically approved and unexpired drugs and hospital equipment, safe and potable water, and adequate sanitation).⁷³ Poor quality of health services, even when those are available and accessible, can have a significant negative impact on morbidity and mortality.

79. The most challenging issue faced by Guinea-Bissau regarding quality concerns service delivery, in addition to the previously mentioned issues, relates to the health care workforce. Indicators that health care quality has historically been inadequate come from research conducted in Bissau, where high mortality rates amongst children were observed despite relatively high service availability, and good care-seeking behaviour on behalf of parents and caregivers. Since 1997, there is some indication that practices have improved. However, many challenges remain in the quality of health care provision, evidenced, among others, by the high rate of neonatal mortality that has failed to decline substantially over time.

80. Attention should also be paid to a significant “brain drain” of health care professionals as the cost of training health workers who eventually go working abroad (particularly in other lusophone countries) is borne by Guinea-Bissau and by donors, but it is never effectively repaid by “recipient” countries. This situation creates a professional deficit and deprives people in Guinea-Bissau of quality care.

81. Major areas of concern relate to (1) data to inform planning; (2) health care education; (3) health care practice and knowledge and capacity limitations.

⁷⁰ Carlos Sangreman, *Observando Direitos na Guiné-Bissau* (see footnote 57), p. 67.

⁷¹ E/C.12/2000/4 (see footnote 1), para. 12(c).

⁷² UNICEF, “Guinea-Bissau: Statistical Profile on Female Genital Mutilation”, Bissau, December 2013.

⁷³ E/C.12/2000/4 (see footnote 1), para. 12(d).

1. Data to inform planning

82. Until recently, the capacity for widespread collection of high-quality disaggregated data in Guinea-Bissau was limited, which has impeded the production of evidence-based policies.⁷⁴ In the past, high quality research, although often on a small scale, was predominately carried out by Bandim Health Project, funded by the Danish Government with technical support from the University of Copenhagen, as well as the National Laboratory for Public Health, the Department of Epidemiology and the *Instituto Nacional de Estudos e Pesquisas* (INEP).⁷⁵

83. It is encouraging that five Multiple Indicator Cluster Surveys (MICS) were conducted by the Ministry of Economy and Finance, in conjunction with UNICEF. The latest was produced in 2014, and significant increases in the quality of the collected data has been noted since the first MICS in 1995.

84. Since the establishment of INASA, and the Government's approval of a national statistics strategy in 2015, there are signs that the country's capacity to collect quality data is improving. Moreover, capacity-building through partnerships between international and local researchers, has led to the exploration of research topics closely related to national policy-making, for instance around the salaries of health care workers' or the quality of care, reflecting the important human rights principle of participation.⁷⁶ It is hoped that increased capacity within INASA will lead to more country-driven research, with the support of international partners.

85. The main challenges Guinea-Bissau still faces regarding data collection are the limited number of skilled researchers, and over dependence on foreign assistance.⁷⁷ Moreover, there is little data collected on several topics of emerging interest, including on non-communicable diseases, given the overwhelming focus on communicable diseases and maternal mortality as key drivers of morbidity and mortality to date.

2. Health care education

86. Education of health care professionals in Guinea-Bissau has mainly relied upon the cooperation of the Government of Cuba, mostly through medical teaching in Spanish at the Faculty of Medicine "Raul Dias Arguelles". The medical professional curricula at the tertiary level includes bioethics, but no formal human rights content is included or taught.

87. Under the right to health framework, medical professionals are both duty-bearers and rights-holders. It is therefore essential to raise their awareness about human rights. Poor working conditions and inadequate financial compensation are among the complex and interrelated factors that negatively impact compliance with human rights standards, as so it is the lack of targeted training in human rights. For health practitioners to be able to protect the right to health of their patients and, at the same time, to be knowledgeable about their own human rights,⁷⁸ human rights training must be integrated into the curricula of all health professionals.

88. Stakeholders noted that when cooperation with the Government of Cuba started, significantly increased funding from the Government of Cuba was available for teaching, and various medical specialists were routinely brought to Guinea-Bissau for that purpose. However, medical students informed UNIOGBIS that they are taught by a small number of doctors, and that core content in areas such as pediatrics and obstetrics is not regularly delivered by specialists. Furthermore, some stakeholders observed that there are challenges in receiving courses taught in Spanish. It was also highlighted that students receive textbooks in e-book format, which is impractical for many who do not have computers or have limited access to electricity. This is compounded by the fact that only two of the four clinical sites of the national medical school have computers for students' use.

89. *Ad-hoc* education is generally conducted on-site when new equipment or goods are delivered to health care facilities. However, there is no systematic oversight of continuing medical education for health care professionals and no programme or policy on continuing clinical education.⁷⁹ Stakeholders reported that, where *ad-hoc* training sessions are held, health care workers would generally not attend unless paid a *per diem*, which was described as a common issue throughout the public service. It was highlighted to UNIOGBIS that the misperception of formal training as a financial entitlement by some, appears to have undermined the concept of continuing education as a core professional responsibility. Moreover, there are no official, accredited, specialty training courses in the country, and there is a lack of specialty staff to supervise and conduct on-the-job training of junior medical staff through the apprenticeship model frequently utilized in medical education.

⁷⁴ United Nations Population Fund, "Country programme document for Guinea-Bissau", DP/FPA/CPD/GNB/6, 30 June 2015, para. 6.

⁷⁵ WHO, "World Health Report 2013", Geneva, 2013.

⁷⁶ Maarten O Kok and ors, "The emergence and current performance of a health research system: lessons from Guinea Bissau" *Health Research Policy and Systems*, vol. 10, No. 5, February 2012.

⁷⁷ World Health Report 2013 (see footnote 75), p. 101.

⁷⁸ A/60/348 (see footnote 44).

⁷⁹ Ongoing health care training following graduation for doctors, nurses and health care administrators.

90. Some initiatives have been undertaken to upskill certain practitioners to perform key specialized tasks. For example, in 2008, the Director of Catio Hospital, in Tombali region, undertook a month-long training course in Bissau with overseas-trained obstetricians, in order to be able to perform caesarean sections. Together with a nurse trained to administer basic anesthesia, this intervention allowed Catio Hospital to significantly increase its capacity to provide quality care. A number of family doctors throughout the country have received similar training, which led to a considerable improvement of access to emergency obstetric care. Similarly, UNFPA has brought expatriate specialists in urological surgery to Guinea-Bissau to run training programmes upskilling local medical doctors in surgery for treatment of obstetric fistula, a debilitating condition mainly caused by poor quality delivery or emergency obstetric care. Developing and implementing a programme or policy on continuing clinical education, will assist to replicate nationwide good initiatives, which otherwise may remain isolated.

3. *Health care practice and knowledge and capacity limitations*

91. Quality care is delivered through partnerships between MINSAP and charitable or private organizations, such as Cumura Hospital and Quinhamel Hospital, respectively operated by the Catholic and Evangelical Churches.⁸⁰ However, the long-term sustainability of these operations is not guaranteed, given their dependence on donor funds and administration by non-governmental personnel.

92. It must be noted that although many dedicated health care practitioners manage to treat people despite enormous obstacles, various factors appear to jeopardize quality care. For instance, the combination of absence of accommodation in remote areas, lack of specialty, continuing training, and absence of solid educational attainment amongst health care workers, limits the ability of many practitioners to provide high-quality care. This is exacerbated, at times, by the lack of supervision of medical professionals and the inappropriate use of already-limited resources. For example, a number of stakeholders informed UNIOGBIS that they had witnessed: the use of multiple antibiotics in a setting when one or two would suffice; frequent prescription of branded drugs where generics would be equally effective; and unnecessary performance of diagnostic blood tests. Such behaviours are common in settings where there is a lack of confidence or knowledge gaps amongst the health care cadre.

93. A lack of appropriately trained health care workers in the country, could be overcome through capacity-building to enable medical professionals to make appropriate treatment choices within available resources, usually through direct supervision by senior staff and on-the-job training using an apprenticeship model. One randomized controlled trial, run in Simão Mendes Hospital ten years ago, demonstrated that thorough training in the use of standardized guidelines, along with monitoring of compliance and payment of small financial incentives, reduced child mortality due to malaria by 50 per cent.⁸¹ This trial was initiated after free supply of drug kits for emergency management of severe and complicated malaria failed to significantly reduce mortality. This example shows that increased availability and accessibility of health care goods and services may not translate into improved outcomes without significant, corresponding increases in quality of service delivery. However, it demonstrates that such achievements are feasible in Guinea-Bissau.

94. When health care professionals unknowingly provide low-quality care, due to circumstances beyond their control, including lack of equipment, or gaps in capacity, this does not necessarily translate into violations of the right to health. Nevertheless, to fulfill its obligations to promote and protect the right to health, the State must take measures to address systemic quality issues⁸² and prevent professionals from deliberately taking actions that contravene patients' interests and may violate their rights.

V. **The Accountability Framework**

95. Accountability compels a State to explain what it is doing and why and how it is progressing, as expeditiously and effectively as possible, towards the realization of the right to health for all.⁸³ It also compels the State to take appropriate steps to ensure that the private sector and civil society are aware of, and consider the importance of, the right to health in pursuing their activities.⁸⁴

⁸⁰ PNDS II (see footnote 11).

⁸¹ Sidu Biai and Ors, "Reduced in-hospital mortality after improved management of children under 5 years admitted to hospital with malaria: randomised trial", *British Medical Journal*, vol. 337, September 2007.

⁸² Jonathan Cohen and Tamar Ezar, "Human rights in patient care: A theoretical and practical framework", *Health and Human Rights Journal*, vol. 15, No. 2, December 2013.

⁸³ "Implementation of General Assembly Resolution 60/251 of 15 March 2006 Entitled 'Human Rights Council': Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Paul Hunt", A/HRC/4/28, 17 January 2007, paras. 46 and 87.

⁸⁴ E/C.12/2000/4 (see footnote 1), para. 55.

96. International human rights law does not prescribe a formula for domestic mechanisms of accountability and redress, and the right to health can be realized and monitored through various mechanisms. However, at a minimum, all accountability mechanisms must be accessible, transparent and effective.

97. In Guinea-Bissau, MINSAP has recognized the “widespread impunity at all levels” of the national health system, noting that even when managers try to enforce technical and financial standards, they face a lack of support and inevitably become frustrated and demotivated.⁸⁵ Moreover, there appears to be a large deficit of accountability mechanisms in the health sector, as stakeholders highlighted there is no effective judicial or other mechanisms to consider complaints of health rights violations with the formal justice system not accessible for the majority of the population.⁸⁶ Although there is a law on medical negligence, there are no recorded cases being brought under it. This illustrates a large deficit of accountability mechanisms in the health sector.

98. Patients have very limited options to claim their rights if they are unable to access care due to inadequate availability of services, or lack the necessary financial resources to pay for healthcare goods and services. In cases of negligent or substandard care, patients generally only have the option of making a complaint through the health care facility, when complaint mechanisms exist. Such mechanisms have been established at Simão Mendes Hospital and at the National Military Hospital. However, in neither hospital is there a charter of patients’ rights, defining the freedoms and entitlements of patients. Although complaints mechanisms exist in some regional hospitals, patient charters are often lacking.

99. It is encouraging that a new, formal complaints mechanism is being established at the Simão Mendes Hospital, which will be operated by the Ministry of Justice, with oversight by the Attorney-General. However, there is no clarity regarding: the legal status of this institution (judicial, quasi-judicial or otherwise); the procedures it will apply (e.g. formal, legal / evidentiary procedures, with lawyers/advocates); and whether and which remedies will be available to complainants. Moreover, it is unclear whether patients of regional hospitals or local health posts will have formal or effective access to the complaints mechanism established through Simão Mendes Hospital. MINSAP, together with the Ministry of Justice, should ensure that a complaint mechanism is available to all citizens, and that the legal status of such mechanism, the courses of action complainants can utilize, and the remedies available, are clearly defined.

100. In addition to government oversight, there are a few mechanisms through which medical professionals can be held accountable for any misconduct. However, the professional associations of doctors and nurses in Guinea-Bissau have a very limited competence to regulate the activities of its members. Moreover, no patients’ rights organizations exist and, to date, no human rights organization has specifically focused on violations to the right to health, although doctors are becoming increasingly active within civil society. For example, the doctor’s union AGUIME is attempting to improve the governmental accountability deficit by pushing for transparent, merit-based appointments of senior healthcare administrators. This illustrates the need for civil society to have a stronger voice on the right to health, and to advocate for the ratification of the Optional Protocol on Economic, Social and Cultural Rights.

VI. Health-related Issues in-focus

101. Major issues of concern, having an important impact on the realization of the right to health in the country include: child and maternal mortality, sexual and reproductive rights, HIV/AIDS, tuberculosis, malaria, mental health and access to medicines.

⁸⁵ PNDS II (see footnote 11), p. 38

⁸⁶ “Report of the Special Rapporteur on the independence of judges and lawyers on her mission to Guinea-Bissau”, A/HRC/32/34/Add.1, 4 April 2016.

A. Child and Maternal Mortality⁸⁷

102. Although equality between men and women is secured in Article 25 of the Constitution, women frequently experience poorer health outcomes than men, particularly pregnant women. The maternal mortality ratio between 2007 and 2014 was 900 deaths per 100,000 live births, amongst the worst in the world.⁸⁸ In 2015, the maternal mortality ratio was of 549 deaths per 100,000 live births.⁸⁹ The leading cause of maternal deaths due to obstetric complications is hemorrhage, accounting for over 40 per cent of obstetric deaths, with other causes including postpartum infections, dystocia, hypertensive diseases of pregnancy, and complications of abortions.⁹⁰ The country is almost at the bottom in the world with respect to maternal health outcomes.

103. According to the MICS 5 report for Guinea-Bissau, only 45 per cent of births were attended by skilled personnel in 2013 and 2014.⁹¹ In 2016, the infant mortality rate was of 60.3 per 1,000 live births, and the under-five mortality rate was of 92.5 per 1,000 live births.⁹² The major causes of death for children under five are communicable diseases, particularly malaria, diarrheal diseases, and respiratory illnesses. Of deaths under five, many are amongst children in their first month of life: the neonatal mortality rate was 36 deaths per 1,000 live births from 2010 to 2014 according to the MICS 5 for Guinea-Bissau, and of 39.7 deaths per 1,000 live births in 2015 according to the World Bank.⁹³

104. More progress must be made on neonatal mortality, given its enormous contribution to the overall quantum of child deaths. Part of the solution lies in securing earlier presentations of women for delivery with skilled birth attendants, as delays in attending facilities significantly increase the risk to the neonate and to the mother. However, better neonatal pediatric care is also needed. With support from UNICEF, in 2016, the Government elaborated a comprehensive plan within Every Newborn Action Plan (ENAP) platform to tackle neonatal mortality. Considering the overall fragility of the system, including the lack of specialty pediatric capacity,⁹⁴ especially in neonatal services, such plan and platform will require significant donor support.

105. Four cornerstone interventions have been recognized as necessary to help reduce maternal mortality and/or child mortality at the point of care, all of which are inconsistently available: family planning; skilled birth attendance; effective referral networks; and emergency obstetric care. Important progress has been made through vaccination coverage, as well as through data collection and other interventions to improve maternal mortality and antenatal care, including the use of community health workers. However, efforts need to be strengthened to address the key drivers of maternal and child deaths in the country, which are: (1) the insufficient availability of skilled birth attendants, leading to poor quality care; (2) the insufficient accessibility of key health care goods (including life-saving commodities), services and facilities; and (3) cultural norms discouraging women from attending health care facilities for delivery.

1. Vaccination Coverage

106. Despite ongoing political instability, high vaccination coverage has proved effective in combating child mortality over the last decade. Cooperation between MINSAP and key donors and/or programmes including the United Nations Children's Fund (UNICEF), GAVI, and the World Health Organization (WHO), along with key non-government organizations and other actors, has contributed to raise coverage rates of vaccinations to over 80 per cent. Rotavirus and pneumococcal vaccinations have recently been introduced into the routine vaccination schedule; a welcome development, given the burden of respiratory and diarrheal diseases in the country amongst

⁸⁷ For more information, see the series of Reflection Guides prepared by OHCHR, UNFPA, WHO, the Partnership for Maternal, Newborn and Child Health, and the FXB Center for Health and Human Rights of Harvard University, which provide advice to different groups of stakeholders on the application of rights based approaches to maternal and child health, available at <http://www.ohchr.org/EN/Issues/Women/WRGS/Pages/MaternalAndChildHealth.aspx> (last accessed on 29 March 2017). See also the OHCHR technical guidance documents on "Preventable maternal mortality and morbidity and human rights", available at <http://www.ohchr.org/Documents/Issues/Women/WRGS/Health/ReportMaternalMortality.pdf> (last accessed on 29 March 2017), and on "Mortality among children under five years of age as a human rights concern", available at <http://www.ohchr.org/Documents/Issues/Women/WRGS/Health/StudyMortalityAmongChildren.pdf> (last accessed on 29 March 2017).

⁸⁸ MICS 5 (see footnote 20), p. 2; and World Bank Data, available at <http://data.worldbank.org/> (last accessed on 26 March 2017).

⁸⁹ Human Development Report 2016 (see footnote 7), p. 216.

⁹⁰ MICS 5 (see footnote 20), p. 2; and World Bank Data (see footnote 88).

⁹¹ MICS 5 (see footnote 20), p. 10.

⁹² Human Development Report 2016 (see footnote 7), p. 229. According to MICS 5 for Guinea-Bissau (see footnote 20), from 2010 to 2014, the infant mortality rate was of 55 and the under-five mortality rate was of 89, per 1,000 live births (p. 2).

⁹³ MICS 5 (see footnote 20), p. 2; and World Bank Data (see footnote 88).

⁹⁴ See MICS 5 (see footnote 20) for further information.

children. In the first quarter of 2017, MINSAP, with the support of UNICEF, will launch an equity study on immunization, to identify programme bottlenecks and pockets of population that remain unserved.

107. According to UNICEF, although vaccination campaigns have been consistently reaching high coverage rates, routine immunization has been on decline over the last three years, with no more than 49.3 per cent fully immunized children before their first birthday in 2016. Reversing this trend will require more resources. Shifting the current vaccination aid-dependence paradigm to a government-owned paradigm whereby the State shall assume gradually the expenses of vaccinations and include them systematically in the State budget is one of the most pressing challenges ahead.

2. Community health programme

108. There has been a community-approach in the delivery of basic interventions through community health workers and outreach services to complement the relatively weak primary health care system. Initial evaluations have suggested that UNICEF's delivery of 16 essential family practices by community health agents in nine regions has had positive results. Up to March 2017 the programme continued to be scaled up and 3,600 out of 4,500 planned Community Health Workers have been trained using the Integrated Community Case Management (iCCM) platform and retained in service. These 16 essential practices included promotion of good childhood nutrition, basic treatment of infectious diseases such as diarrhea, malaria and pneumonia, and household hygiene. However, the impact of this programme on mortality is not yet known.

109. These community-based activities are important, particularly in relation to sensitization, but they need to be reinforced to continue the downward trend in child mortality that has been observed since the 1990s, with additional activities to simultaneously strengthen key health system activities as a whole. It will be important to carefully monitor the efficacy of the various community health agent/worker programmes in respect of child survival.

3. Improvements in Antenatal care and Maternal Mortality data collection

110. It is encouraging that both access to, and quality of, antenatal care appear to be improving. Between 2010 and 2014, 92.4 per cent of women attended at least one antenatal care visit, with 64.9 per cent of women attending at least four visits.⁹⁵ Around three-quarters of antenatal visits included key interventions, such as blood pressure monitoring, and blood and urine testing, indicating improvements in quality of care delivered.⁹⁶

111. Increased attendance at antenatal visits also allows for detection of high-risk pregnancies, which can prompt early transfer for more specialized treatment or care at the "House of Mothers" (*Casa das Maes*) facility, where women from remote villages can stay in the days prior to giving birth. The number of facilities that offer basic obstetric care is also increasing. Seven out of 11 hospitals now offer comprehensive obstetric and neonatal care, and 95 per cent of facilities offer the obstetric and neonatal minimum package of care, compared to only up from 75 per cent in 2008.⁹⁷ However, it seems that these improvements have not had a significant impact on maternal death rates. One key reason for this appears to be a lack of access to high-quality care at the point of delivery. Other public health drivers, such as increased risk of maternal hemorrhage posed by iron deficiency anemia, are difficult to quantify due to inadequate data collection.

112. Data collection on maternal deaths has improved, with the implementation of a MINSAP decree of 16 March 2015, calling for compulsory notification of maternal deaths or "near miss" cases within 24 hours of a sentinel event. Several health professionals have received training in reporting, and all facilities are now apparently notifying maternal deaths, even if some difficulties remain. The decree also created national and regional maternal deaths review committees. The country is yet to develop a detailed national strategy or guidelines on maternal deaths surveillance and response (MDSR) to implement and reinforce the decree.

4. Insufficient availability of skilled birth attendants, leading to poor quality care

113. Few births in the country are attended by qualified health practitioners. Only 45 per cent of women aged 15-49 with a live birth in the previous years obtained professional assistance with their birth.⁹⁸ Failure to reduce the maternal mortality ratio may be caused by a limited quality of care, and too few midwives in the country to meet the demand (presently only 139 midwives in the entire country). Although a number of nursing and auxiliary staff has been trained to deliver basic obstetric care, the quality of care delivered is highly variable. Despite efforts made under the Global Health Partnership H6,⁹⁹ many health posts lack staff trained in obstetric

⁹⁵ *Idem*, p. 10.

⁹⁶ *Ibid.*

⁹⁷ DP/FPA/CPD/GNB/6 (see footnote 74), para. 8.

⁹⁸ MICS 5 (see footnote 20), p. 10.

⁹⁹ See *supra* paragraph 61.

care.

114. Where women do seek assistance during the partum period, the poor quality care they receive often results in inadequate outcomes. The poor quality of care available does not seem to stem from a lack of key obstetric medications. Every hospital visited in the course of preparing this report, including those that were not given prior notice of visits, had sufficient stocks of the thirteen United Nations-specified life-saving commodities for women and children, supplied by UNFPA.

115. Instead, the poor quality seemingly stems from the lack of experienced human resources described above, along with very limited availability of emergency obstetric care. Caesarean sections are now available in seven regions, but emergency health care for other obstetric complications and for the management of complications arising from abortion is effectively only available in Bissau, given that the country's two obstetricians are based there. These limitations in availability of high-quality emergency obstetric care are a key factor driving high maternal mortality in the country.

5. Insufficient accessibility of key health care goods, services and facilities

116. Economic accessibility has indeed been improved by the Government's policy of services being provided free for pregnant women. However, problems persist. Many diagnostic tests, medical interventions and drugs are not funded through the programme, which creates uncertainty and potential vulnerability for women attending health care services. For example, a pregnant woman generally will not be charged a consultation fee, or a fee to undergo a rapid diagnostic test for HIV or malaria, but they may have to pay for other medications, or for intravenous fluids, which may discourage their future attendance. Some women also end up paying for services to which they are technically entitled, either due to a lack of knowledge of the Government's policy, or other reasons such as inadequate negotiating power.

117. Physical accessibility is also constrained by a general lack of transport, along with its limited affordability. Intra-regional transport, between *tabancas* and health posts, or regional hospitals, is an enormous challenge in some regions. In addition to some regular and motorized boat ambulances, UNFPA provided 38 small moto-ambulances to many health care centres throughout Guinea-Bissau, but these vehicles cannot negotiate many of the unsealed roads in the country's remotest areas, leaving many *tabancas* without transport. It is encouraging that construction of surgical centres is being planned in Buba and in the Bijagós region by UNFPA, but in the absence of adequate specialists, accessibility will nevertheless remain limited.

6. Cultural norms discouraging women from attending healthcare facilities for deliver

118. Many women have a strong cultural preference for home-based delivery of children, or may delay seeking care due to community pressure, and then cannot access a skilled birth attendant in time to deliver safely. But this is not true of all women, and steps must be taken to address the economic and physical accessibility limitations listed above for those that do wish to attend.

119. It is promising that community health workers, through both regional MINSAP officers and non-governmental organizations, are undertaking vital sensitization work to encourage women to deliver institutionally. However, experience in other low-income countries has shown that without improvement in the quality of care, increasing numbers of institutional deliveries does not translate into reduced maternal mortality rates.

120. It is not appropriate to point exclusively to women's reluctance to attend, or delays in their attendance at health care institutions for delivery of their children, as a key driver of maternal mortality. It is also important to recognize the problems associated with the quality of those institutions, and that these quality concerns discourage women from attending health care facilities for delivery, even more strongly than do cultural factors.

121. Positive responses to improved quality of care have been seen throughout the country. For example, it is anecdotally reported in Bafatá hospital that significantly more patients are presenting to the pediatric unit from around the country, likely due to the presence of internationally-trained staff in *Medecins Sans Frontieres'* pediatric unit in the hospital. Concerted efforts to improve quality of maternal health may also result in similar increases in demand.

B. Sexual and Reproductive Rights

122. Concerns related to sexual and reproductive rights, which are also considered as drivers of poor maternal health, include: lack of women's agency in their own reproductive health as reflected too in the third party consent requirement; low rates of contraceptive utilization; adolescent pregnancy; female genital mutilation; early, forced and child marriage; sexual violence and human trafficking.

1. Lack of women's agency in their own reproductive health

123. Although the law of Guinea-Bissau provides that all individuals are equal with regard to their right to reproductive health and cannot be deprived of their right or discriminated on grounds of gender or marital status,¹⁰⁰ progress in achieving good maternal health is limited by constraints upon women's agency. In some parts of the country, women are prevented from making choices concerning their own reproductive health. For example, nearly every health care centre visited by UNIIOGBIS had documented cases of women being brought by their husbands to have contraceptive implants or intrauterine devices removed, because they had been placed without the husband's consent. Similar phenomena are witnessed in relation to birth spacing, access to abortion, and sexual interaction, including within marriage. There is a clear need for ongoing sensitization of men, women and health care workers in this regard. UNFPA has created five "Men's clubs" to try to engage men in discussions around reproductive health rights including family planning, and the eradication of gender-based violence, including Female Genital Mutilation (FGM) but to date these efforts have not been evaluated or implemented at scale.

2. Low contraceptive utilization

124. There is a substantial lack of access to modern and effective methods of contraception in Guinea-Bissau. Contraceptive use was low in 2014, at 16 per cent amongst women of childbearing age, and the birth rate among adolescents was high, at 106 per 1,000 women aged 15 to 19.¹⁰¹ The unmet need for contraception was at around 22 per cent.¹⁰²

125. Although cultural factors such as desirability of childbearing, contribute to a low demand for contraceptives, this is not the only cause for the low prevalence of contraceptive use, as given the opportunity, women reportedly receive educational messages positively and many seek out modern forms of contraception. UNFPA provides contraceptives for free. However, stock-outs occur frequently throughout the country, with approximately 50 per cent of health centres presently experiencing this.¹⁰³ In addition, some health care facilities do not stock contraceptives at all, without clear justification. In Bafatá hospital, contraceptives are not available in the maternity suite, and must be accessed at the nearby health post instead, which is an unnecessary deterrent for women who have just given birth and wish to use contraceptives to space their pregnancies.

3. Adolescent pregnancy and early, forced and child marriage

126. According to MICS 5 for Guinea-Bissau, in 2014, 28.3 per cent of women had at least one live birth before the age of 18, and the adolescent birth rate was 106 live births per 1,000 women aged 15-19.¹⁰⁴ In 2015, the adolescent birth rate was of 89.5 according to the Human Development Report 2016,¹⁰⁵ and of 87.5292 according to the World Bank.¹⁰⁶ These high rates of adolescent pregnancy generally go hand-in-hand with sexual violence, insufficient access to health care goods, services and facilities, and the presence of early, child and forced marriages. Presently, seven per cent of girls are married before the age of 15, despite the Act on Reproductive Health, sets the minimum age of marriage at 18.

127. The high adolescent pregnancy rate is also a by-product of girls receiving significantly less education than boys, although educational attainment rates are poor for both genders.¹⁰⁷ The high pregnancy rate is also due to an almost complete lack of quality sexual and reproductive health education country-wide, as mentioned above. Furthermore, while a significant proportion of women of childbearing age lack access to safe abortion because they cannot afford it, women of adolescent age are disproportionately affected. Risks of early pregnancy, particularly in relation to intrapartum complications such as obstetric fistula, are significant and must be addressed in a comprehensive fashion.

128. Through the Peer Education Model, UNFPA has been working with the Youth to improve reproductive health and sexual and reproductive rights, including through training. This included the National Youth Training Workshop for the promotion of reproductive health rights, which took place in Bissau, in August 2016, bringing 140 youth representatives from different regions of the country.

¹⁰⁰ Law No. 11/2010 on Reproductive Health and Family Planning, published in *B.O.* No. 39, 29 September 2010, Article 3.

¹⁰¹ MICS 5 (see footnote 20), p. 9. See also World Bank Data (see footnote 88).

¹⁰² DP/FPA/CPD/GNB/6 (see footnote 74), para. 2.

¹⁰³ *Idem*, see table on pp. 6-7.

¹⁰⁴ MICS 5 (see footnote 20), p. 9.

¹⁰⁵ Human Development Report 2016 (see footnote 7), p. 216.

¹⁰⁶ World Bank Data (see footnote 88).

¹⁰⁷ Carlos Sangreman, *Observando Direitos na Guiné-Bissau* (see footnote 57).

4. Female genital mutilation

129. Law No. 14/2011, to Prevent, Fight and Suppress Female Genital Mutilation, criminalizes FGM. However, the prevalence of this practice stands at around 45 per cent, with about half of women aged between 45 and 49 and almost half of the women aged between 15 and 19 having been subjected to female genital mutilation, which also has negative effects on maternal health.¹⁰⁸ Significant barriers to the eradication of FGM remain. Efforts to further decrease this practice have been met with community resistance, although a number of communities have publicly abandoned the practice.

130. A number of prosecutions successfully proceeded in 2016 under the law banning FGM. However, the application of penalties has likely prompted practitioners and families to conceal the practice, rather than stop it altogether. Moreover, certain interventions have reportedly generated perverse incentives. For example, when traditional practitioners are compensated for ceasing to perform FGM, this may encourage other practitioners to claim they perform it in order to obtain compensation. Upon payment of compensation, the practice often restarts. In this connection, UNFPA and UNICEF are implementing a joint programme to promote the public abandonment of FGM by the communities.

C. HIV/AIDS

131. Acquired Immunodeficiency Syndrome (AIDS) is a disease caused by the human immunodeficiency virus (HIV). This virus attacks the patient's immune system, more precisely the lymphocytes, and causes a change in the defense mechanism of the body, causing the very frequently emergence of diseases. AIDS can be transmitted through sexual intercourse, contact with blood contaminated by transfusion or sharing of syringes, for example, and from mother to baby during pregnancy, childbirth or breastfeeding.¹⁰⁹

132. According to the National AIDS Secretariat, Guinea-Bissau is one of the few countries with incidence of both types of human immunodeficiency virus, HIV1 and HIV2, with prevalence rates tending to be higher in HIV1-positive cases. HIV prevalence amongst people aged 15-49 year olds is 3.7 per cent; young women are nearly twice as likely to be HIV positive as young men, with sex workers and pregnant women recording prevalence rates of 8.9 per cent and 5 per cent, respectively.¹¹⁰

133. The high rate of HIV amongst pregnant women in particular may reflect a "silent epidemic" of HIV. As pregnant women are entitled to free health care, they are significantly more likely than the remainder of the population to have been tested for HIV, and therefore infection rates amongst this group may more accurately reflect the actual prevalence of the illness. Positively, however, 83 per cent of women are recorded as having received anti-retrovirals to prevent mother-to-child transmission of HIV in 2014.¹¹¹ The 2016 Guinea-Bissau National AIDS Response Report recorded 2,392 mothers in need of care of prevent mother-to-child transmission. Of these, 1,571 mothers benefited from care in 2015, representing a coverage of 67,8 per cent.¹¹²

D. Tuberculosis

134. Tuberculosis is widespread, with 369 cases per 100,000 people reported in 2014 (377 cases per 100,000 in 2015).¹¹³ The Raoul Follereau Hospital, a Bissau-based institution, is a health institution that provides

¹⁰⁸ Africa Human Development Report 2016 (see footnote 16), p. 44.

¹⁰⁹ See generally, WHO, "HIV/AIDS Fact sheet", updated November 2016, available at <http://www.who.int/mediacentre/factsheets/fs360/en/> (last accessed on 28 March 2017)

¹¹⁰ DP/FPA/CPD/GNB/6 (see footnote 74), para. 3. In the course of the field visits and contacts undertaken for this report, in the north of the country, in São Domingos sector (Cacheu region), Mario Julio Mango, responsible for the health area of this locality, advised that the HIV prevalence rate in the sector is worrisome. "The 2015 outpatient and emergency data showed that of the 432 tested, 138 people are HIV-positive and in the 630 women tested in antenatal consultations, 30 are HIV-positive." In Bafatá region, cases have also been increasing mainly among women and young people. The information was disclosed by the head of control and outpatient treatment and general medical doctor of the Bafatá region, Dr. Élio Ernesto Dias. "In the active row we have 2,659 cases, including deaths and transfers, but I currently have 715 people in active treatment throughout the eastern province, of whom 191 are men, and more than 400 are women." For the President of the Association of People Living with HIV/AIDS, Pedro Mandica, the biggest challenge of an HIV positive person in the Bissau-Guinean society is not to have the support of other colleagues in their self-esteem and motivation. He appeal to husbands to accompany their wives to hospital and not to abandon them, as has been the case in Guinea-Bissau.

¹¹¹ WHO Global Health Observatory, available at http://www.who.int/gho/countries/gnb/country_profiles/en/ (last accessed on 28 March 2017)

¹¹² *Ibid.*

¹¹³ WHO, "Global Tuberculosis Report", 2016.

a comprehensive health care service to patients suffering from tuberculosis.¹¹⁴ It is an example of good practice in promoting economic accessibility of quality health care goods, facilities and services for a vulnerable group of people.

135. The 120-bed Bissau hospital provides in-patient and ambulatory care services. Those admitted to the facility for up to two months are given free medical treatment, for both tuberculosis and other co-morbidities, and are followed up in the community through an ambulatory care unit. Patients are further supplied with five healthy meals per day, in recognition of the fact that improvement in health, particularly recovery from tuberculosis, cannot occur in the absence of adequate nutritional intake. A small school is also incorporated into the site so that children with tuberculosis are educated during their lengthy treatment. Patients are encouraged to participate in gardening on-site, where vegetables are grown to prepare the meals of patients. Additionally, after the initial in-hospital period of TB treatment, patients are provided with monthly nutrition kits in order to increase adherence to treatment, so as to prevent multi-drug resistant TB, which is a growing problem in the country. Those kits are funded by the Global Fund (via UNDP and MINSAP) and by the European Union (via the World Food Programme).

E. Malaria

136. Malaria is widespread in the country and deaths due to malaria have steadily declined over the last decade.¹¹⁵ Between 2012 and 2014, malaria prevalence in representative surveyed areas of the country declined by 90 per cent amongst children aged six to 59 months, and by 83 per cent among individuals older than five.¹¹⁶ A decline in incidence was actually beginning to be observed prior to the implementation of many interventions, but concerted State and donor efforts have reduced malaria morbidity and mortality significantly. In particular, consistent donor support, including from the Global Fund, especially in relation to universal roll-outs of Insecticide-Treated Bed Nets (ITNs), has led to more than four out of five people sleeping under ITNs nightly.¹¹⁷

137. In March 2017, MINSAP with Global Fund support launched a Universal Campaign of ITNs, and by the end of May it is to launch a national distribution of mosquito nets. Other preventive measures, such as removal of stagnant water, have contributed to improve the situation. Significant issues of over-diagnosis and unwarranted treatment of malaria may now exist in Guinea-Bissau.¹¹⁸ Although treatment protocols have been updated to reflect the lowered prevalence of malaria in the country, anecdotal reports suggest that these protocols are not necessarily followed in a number of facilities. Accordingly, an increased emphasis on education, rational use of antimalarial medicine and widespread availability of diagnostic tests will likely be required. Consequently, malaria still remains the top cause of death in the country, and is considerably higher in Guinea-Bissau compared to neighboring West African countries. The contribution of Community Health Workers towards early detection and prompt treatment initiation is a key element in overall efforts to reduce malaria-related complications, including life-threatening complications.

F. Mental Health

138. Article 12 of the ICESCR recognizes that enjoyment of the highest attainable standard of mental health, alongside physical health, is central to the realization of the right to health. This requires the creation of conditions assuring equal and timely access to appropriate mental health treatment and care. According to the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, mental health goes beyond the mere absence of a mental impairment and includes “good emotional and social well-being, healthy non-violent relations between individuals and groups, with mutual trust of, tolerance of and respect for the dignity of every person”.¹¹⁹ The Special Rapporteur stressed that mental and physical health

¹¹⁴ It should be noted that Raoul Follereau Hospital does not currently have capacity to house and treat patients with multi-drug resistant tuberculosis (MDRTB), because of the risk of cross-infection between patients. This poses a significant public health threat, as these patients are managed in the community.

¹¹⁵ The last assessment on malaria transmission was carried out in 2014.

¹¹⁶ Amabelia Rodrigues and Ors, “Evaluation of the 2014 Long Lasting Insecticide Treated Net distribution campaign impact”, INASA, Bissau, 2015.

¹¹⁷ *Ibid.*

¹¹⁸ Amabelia Rodrigues and Ors, “Changing pattern of malaria in Bissau, Guinea Bissau”, *Tropical Medicine & International Health*, vol. 13, No. 3, March 2008.

¹¹⁹ “Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Dainius Pūras”, Human Rights Council, Twenty-ninth session, A/HRC/29/33, 2 April 2015, para. 77.

are equally important for the full realization of the right to health (principle of parity).¹²⁰ Moreover, OHCHR in its 2017 report on mental health and human rights identifies major challenges faced by users of health services, including persons with mental conditions and with psychological disabilities and identifies the need to improve the quality of mental health services globally, to put an end to involuntary treatment and institutionalization, and to create an appropriate legal and policy environment for the realization of their human rights.¹²¹

139. Guinea-Bissau must take progressive steps towards the full realization of the right to health that also create the conditions to ensure that appropriate and sufficient mental health care and treatment are available.¹²² As observed by the Committee on Economic, Social and Cultural Rights, the obligation of States to *fulfill* the right to health includes the obligation to promote and support the establishment of institutions that provide mental health services, which should be equitably distributed throughout the country.¹²³ Moreover, as a State party to the Convention on the Rights of Persons with Disabilities, which it ratified on 24 September 2014, Guinea-Bissau must adopt a human rights-based approach to disability. This approach requires the adoption of the relevant legislation and policies to ensure, for instance, that all persons with disabilities are treated without discrimination, have the right to exercise legal capacity as well as free and informed consent with regard to medical treatment, and are not subjected to forced institutionalization.¹²⁴

140. Guinea-Bissau lacks appropriate legislation protecting the rights of people with psychosocial disabilities, and the provision of mental health care in the country remains substantially inadequate to address the population's burden of mental illness. Even where such services are available, the quality is often poor, partly due to the lack of prioritization of mental health concerns within the overall health system. Many issues regarding the provision of mental health-care services in Guinea-Bissau are of concern. The major issues leading to deficiencies in the treatment of those with mental illness include grossly inadequate physical and human resources for service provision; lack of institutions that provide training for aspiring psychiatrists; high levels of stigma towards both mental health-care workers and patients; and lack of a comprehensive legislative framework to address mental health care.

141. Two mental health centres are operational in Guinea-Bissau. On 22 February and 1 March 2017, the Human Rights Section of UNIOGBIS visited the Mental Health Centre in *Enterramento*, Bissau and the *Quinhamel* Mental Centre, and was able to verify that they are understaffed and ill-equipped, both in terms of physical outfitting and financial resources. This is an obstacle for the Mental Centres to cope with their patient load. At the time of the visit, the *Quinhamel's* Mental Health Centre had 65 patients admitted, 11 of which were women. The service was free of charge for children under five, expectant mothers and the elderly (over 60 years old) although patients paid a daily fee of 1,000 FCFA. No financial support is provided to the two Mental Health Centres, and internal revenue charges for the consultation only are used to buy consumable items. The Centre has no electricity, no piped water, and only four beds were available. Most patients were obliged to sleep on the floor. Some walls were cracked and there was evidence of water leaks. Medical consultation was provided by a single worker who was not a qualified psychiatrist and had benefited from only a vocational training course.

142. After 18 years of interruption, the Mental Health Centre in Bissau reopened on 10 August 2016 thanks to the support from the European Union. The Centre was destroyed during the 1998 civil war, and the medical services were temporarily rendered at the "3 de Agosto" Hospital in Bissau. The Mental Health Centre in Bissau is a State-owned institution that was inaugurated in 1984, with the capacity to admit 60 patients. At that time, patients were accorded free care, including food, clothes and medicines. It now has 36 beds, and is divided into four sectors: psychiatry, general medicine, psychology and social assistance. Due to lack of funding, the main activities are limited to diagnostics and the issuance of prescriptions. The Centre has no psychiatrist or detoxification specialist. It also lacks equipment for Computed Axial Tomography, electroencephalograms and Magnetic Resonance Imaging (MRI) scanning.

143. The provision of health care services in the community is beneficial to the treatment and recovery of patients as it enables them to retain employment and to remain close to their families and support network.¹²⁵ However, in Guinea-Bissau there is insufficient effort to provide mental health care in the community setting. The lack of support within communities for individuals suffering from mental illness constitutes an obstacle to their

¹²⁰ *Idem*, para. 82.

¹²¹ Report of the United Nations High Commissioner for Human Rights, "Mental health and human rights", A/HRC/34/32, 31 January 2017.

¹²² ICESCR (see footnote 29), art. 12(2)(d); and E/C.12/2000/4 (see footnote 1), paras. 12(a) and 17.

¹²³ E/C.12/2000/4 (see footnote 1), para. 36.

¹²⁴ A/HRC/34/32 (see footnote 121), paras. 22–23, 25–26 and 29.

¹²⁵ *Idem*, para. 54.

integration into society and the labour force.

144. The Directors of the mental health institutions highlighted concerns about the recruitment and retention of health professionals. Psychiatric-related health-care work tends to be stigmatized and such work is not adequately remunerated. As in the rest of the health sector, the mental health sector is affected by the lack of resources to retain health care professionals and by the “brain drain”. It is especially important that the Government create incentive structures and infrastructure that not only de-stigmatize and promote mental health work in Guinea-Bissau, but also retain health care professionals. While coverage will inevitably remain limited due to resource constraints, current deficits fall far below the minimum accessibility and availability requirements of the right to health.

145. Language barriers also limit the access to mental health care because the patient’s ability to communicate symptoms is critical to the diagnosis. It is estimated that over 20 languages are spoken throughout the country, and there are significantly more local dialects. This presents significant obstacles to access, especially for the rural poor and ethnic minorities. The Government, with the assistance of the international community, should spare no efforts to ensure the availability of staff conversant in local languages and dialects or interpreters at medical facilities.

146. Stigma surrounding mental illness often leads to the ill-treatment of people with mental illnesses, particularly in non-urban areas, and thus presents a significant barrier to families and communities seeking appropriate care for affected individuals, in addition to the physical and linguistic obstacles that those in more remote areas of the country face.

G. Access to Medicines and the Right to Health

147. With a view to ensuring the realization of the right to health, the State has the responsibility to ensure that medicines are available, accessible, culturally acceptable and of good quality.¹²⁶ An adequate supply of essential medicines, on WHO’s List of Essential Medicines, should also be available. Moreover, under its main obligation to protect the right to health, the State is required to prevent third parties from interfering with the realization of this right. Thus, the State should adopt legislation or other measures to ensure that private actors conform with human rights standards when providing health care or other services (such as regulating the composition of food products); control the marketing of medical equipment and medicines by private actors; and ensure that privatization does not constitute a threat to the availability, accessibility, acceptability and quality of health care facilities, goods and services.

148. CECOME, the Government-run, centralized procurement system for health care goods, procures medications, and distributes them to its regional branches, from which they are subsequently dispensed to health care facilities. However, CECOME functions inconsistently. Facilities that rely on supplies from CECOME note that they are generally able to obtain necessary drugs, but that stock-outs do occur. When this happens, those facilities are compelled to buy medications privately at large mark-ups with the challenge of uncertainty around pharmaceutical quality or, of temporarily discontinue supplying patients with these drugs. Theoretically, significant economic benefits should come from bulk procurement through a centralized system.¹²⁷ However, a number of hospitals individually procure and import drugs from abroad rather than through CECOME, due to the challenges they face in dealing with it. Moreover, certain health care facilities reported being able to obtain better prices for medications through direct dealings with suppliers. Due to the fragilities of CECOME, international partners undertake procurement through their own systems. This is the case of programmes funded by the Global Fund, which procures through UNDP; the European Union, which procures MCH and essential drugs via IMVF and EMI; and UNICEF, UNFPA, and WHO have their own procurement mechanisms. CECOME is primarily used for storage. Moreover, due to the state of its facilities, regional insurance companies do not insure the drugs, equipment, supplies stored at CECOME. With a view to address these challenges, UNDP with Global Fund resources is providing long term international technical assistance to CECOME, and both organizations are in discussions to build a new modern warehouse by the first quarter of 2018.

149. Various stakeholders reported that people buy medicines informally, ignoring that unauthorized medicines or those without quality control; expired; or stored without benefit of appropriate conditions or appropriate transportation controls, can be dangerous, and even life-threatening. The scale and impact of the sale of counterfeit medicines, label counterfeiting, medicines smuggling, the lack of control on medicines that are expired or the sale of medicines without prescription, is yet to be measured in the country. This is a major issue of public health to which the general public needs to be sensitized. A scoping study to determine its dimension and

¹²⁶ E/C.12/2000/4 (see footnote 1), para. 12.

¹²⁷ Such benefits include cheaper purchase prices and less use of technical staff for logistics.

devise proposals for the way forward is urgently required.

150. Encouragingly, availability of a number of medications, especially vaccines, has increased with concerted donor efforts to improve the cold chain throughout Guinea-Bissau, which means that drugs and vaccines are now much less likely to expire or become ineffective due to inadequate storage. UNFPA supplies key lifesaving reproductive health commodities (such as oxytocin), a wide range of contraceptives and female and male condoms free of charge,¹²⁸ and availability of medicines to treat HIV, TB and malaria is also generally good, thanks to Global Fund support, through the UNDP. However, during visits conducted in 2016, UNIOGBIS was informed that for the entirety of July 2016, Coartem 18 and 24, drugs used to treat malaria, were unavailable at the national reference hospital, Simão Mendes. The reason for this supply disruption was unclear. This was especially concerning given the increased incidence of malaria cases occurring at that time and highlights also the need to enhance accountability mechanisms.

151. Stock-outs of other vital health care goods, such as medicines, equipment, and basic laboratory supplies such as reagents, are common, because their supply is unpredictable. None of these goods are manufactured locally, so the country is entirely dependent on imports. The impact of drug unavailability on the right to health can be direct and severe. A number of documented cases of Stevens-Johnson syndrome, an often fatal dermatological condition, were recorded amongst patients living with HIV in Guinea-Bissau who were required to switch from efavirenz to nevirapine following stock-outs of efavirenz;¹²⁹ an outcome that could have been entirely avoided with sufficient availability.

VII. Activities of UNIOGBIS Human Rights component in relation to the right to health

152. In the discharge of its mandated activities,¹³⁰ the Human Rights Section of UNIOGBIS has undertaken a number of human rights monitoring and assessment missions' country-wide and consultations with stakeholders to collect information on the situation of economic, social and cultural rights in the country, including the right to health.

153. Assessment missions undertaken between January 2016 and March 2017 indicate that the highest constraints to ensure the fulfillment of the highest standard attainable of physical and mental health are faced by the Southern region, which includes the provinces of Tombali, Quinara and Bolama-Bijagos. Such constraints are compounded by its geographic, social and political isolation from the capital.

154. During a monitoring and assessment mission undertaken to the Southern region between 25 March and 17 April 2016, health authorities at regional and local levels indicated that a total of 36 health facilities served the three provinces. Tombali has a Regional Hospital based in Catió, and 15 health centres that provide medical care to 91,089 people distributed throughout eight health areas. According to information provided by regional health authorities, the Southern Province has a total of 182 health workers, including doctors, nurses, midwives, assistant nurses, as well as laboratory, pharmacy and ophthalmology technicians; 54 medical personnel including three medical doctors work in the sanitary region of Bijagós, which according to local authorities has a population of over 20,000 people and is composed of 11 of islands. This is equivalent to one doctor per 7,316 people, while WHO considers acceptable a ratio of one doctor for 1,000 people, or slightly above.¹³¹

155. Major concerns include the lack of appropriate access to basic health care; insufficient health personnel and poor infrastructure; difficult geographical access due to bad road conditions; and, scarce land and maritime means of public transportation. UNIOGBIS was informed that the average distance that a patient travels to reach a health centre is between 15 and 25 kilometers. Personnel at the hospital affirmed that the number of functioning ambulances was insufficient, and their fuel costs generally borne by the beneficiaries, most of whom lived below the poverty line. Mortality rates are reportedly high because of difficulties in accessing health services,

¹²⁸ UNFPA, Lifesaving Maternal Commodities, Bissau.

¹²⁹ Sanne Jespersen and ors, "Challenges facing HIV treatment in Guinea-Bissau: the benefits of international research collaborations", *Bulletin of the World Health Organization*, vol. 92, 2014, p. 911.

¹³⁰ Pursuant to United Nations Security Council Resolution Res.2343 of 23 February 2017, UNIOGBIS and the Special Representative will continue to lead international efforts in the provision of support to the Government of Guinea-Bissau in: (a) strengthening democratic institutions and enhancing the capacity of State organs to function effectively and constitutionally; (b) establishing effective and efficient law enforcement and criminal justice and penitentiary systems, capable of maintaining public security and combating impunity, while respecting human rights and fundamental freedoms; (c) Assisting national authorities in the promotion and protection of human rights as well as undertaking human rights monitoring and reporting activities.

¹³¹ See Density of physicians, Global Health Observatory Data, 2017, available at http://www.who.int/gho/health_workforce/physicians_density/en/ (consulted on 11 March 2017).

delays in supplying medicines to health centres, and widespread use of home treatments. With the exception of Bubaque, there is no pharmacy on the Bijagos islands.

156. Furthermore, the existence of only one financial agency in the Southern Province forces the majority of State employees, including health workers, to travel every month to Bissau in order to receive their salaries. This incurs travel costs, and leads to a systematic and prolonged absence of health workers from their duty stations. There is also a lack of information about health risks and available mechanisms for disease prevention, which negatively impacts, among others, the rights to health and to life. Public health services should be empowered to provide such information to the local population. In the second quarter of 2017, UNIOGBIS shall conduct an integrated mission to Bubaque, *inter alia*, to assess progress made in the promotion and protection of human rights, including the right to health.

157. During the first semester of 2016, the Human Rights Section of UNIOGBIS monitored nation-wide health sector strikes, which negatively impacted the right to health and the right to life. United Nations agencies, such as UNICEF and WHO, also assessed the situation, as did civil society organizations and other partners, such as the European Union. Some partners, including WHO and UNICEF provided support to the Government to ensure the continuity of basic services. On 7 April 2016, in Bissau, UNIOGBIS met the president of the committee representing the three Health Technicians Unions and the Director of the country's main medical facility, the Simão Mendes Hospital. In Bafata, UNIOGBIS visited the Regional Hospital and also met its Director. Following negotiations between the strike committee and the President of the Republic, the strike was suspended on 23 May 2016.

158. During a UNIOGBIS human rights monitoring and assessment visit undertaken to the Simão Mendes Hospital on 21 February 2017, the Hospital Director raised concerns about the acute lack of medical equipment and of qualified technicians and noted that the maternity ward continued to operate with great difficulties. He indicated that food was being provided only to those most in need and did not take into consideration dietary restrictions. This is a great concern including because the hospital is the national centre of reference. The administration of the hospital informed UNIOGBIS that 1.5 billion francs FCFA was required to ensure the regular functioning of the hospital and to provide adequate standards of health, which would correspond to a monthly expense of 125,000,000 FCFA, while the hospital budgetary expenses are of about 20,000,000 FCFA per month and its internal revenue is approximately 16,000,000 FCFA.

159. UNIOGBIS conducted regular visits to prison and detention facilities with a view to monitoring and assessing the human rights situation of individuals deprived of liberty, including the fulfillment of their right to health. Between January 2016 and February 2017, a total of 34 detention facilities were visited. These included the Bafatá Prison¹³² (intended for convicts); the Mansoa Prison¹³³ (intended for people under pre-trial detention), and the Judiciary Police Detention Centre in Bissau¹³⁴ (intended for people under police custody), all under the control and oversight of the Ministry of Justice. These also included the Airbase Detention Facility in Bissalanca,¹³⁵ under the control and oversight of the Ministry of Defense, which holds people under custody and in pre-trial detention, as well as detainees sentenced by military courts. Regular visits were also undertaken to the Public Order Police detention cells under the oversight and control of the Ministry of Internal Administration in Bissau¹³⁶ and in the regions of Bafatá,¹³⁷ Buba,¹³⁸ Gabú,¹³⁹ Tombali, Quínara and Bolama/Bijagós islands.¹⁴⁰ Following the monitoring visits, the Human Rights Section of UNIOGBIS advised national authorities responsible for prison administration, to take measures to improve detention conditions and uphold the human rights of persons deprived of liberty, including their right to health. Overcrowding appeared to be systemic. The Human Rights Section also identified additional capacity building needs for prison guards, including on the treatment and human rights of detainees. The Human Rights Section also provided human rights training to targeted groups, such as Senior Police Officers who, in topical meetings, raised concerns about hygiene and sanitation conditions in the Bafatá prison and the detention

¹³² UNIOGBIS HRS visits on 17 February, 1 and 17 August, 22 September, 14 December 2016 and 31 January 2017.

¹³³ UNIOGBIS HRS visits on 21-23 June 2016 and 31 January 2017.

¹³⁴ UNIOGBIS HRS visits on 8 February, 22 and 27 April, 14 June, 7 September, 16-18 October, and 10 November 2016.

¹³⁵ UNIOGBIS HRS visit on 10 February 2016.

¹³⁶ UNIOGBIS HRS visit on 8-9 September 2016.

¹³⁷ UNIOGBIS HRS visit on 17 August 2016.

¹³⁸ UNIOGBIS HRS visit on 22 September 2016.

¹³⁹ UNIOGBIS HRS visits on 17 August, 7 September, 28 September 2016.

¹⁴⁰ UNIOGBIS HRS visit on 14-18 March 2016.

cells.¹⁴¹

160. The monitoring visits of UNIOGBIS and additional information it received from various stakeholders revealed that many of the challenges associated with dire detention conditions are due to the financial constraints of the State. On this basis, and as a follow-up to the recommendations made in 2015 through the Universal Periodic Review (UPR), UNIOGBIS, signed a Grant Agreement with the Bissau-Guinean Human Rights League, on 7 December 2016, providing them with financial support to refurbish/rehabilitate the following correctional facilities: Judiciary Police Detention Centre in Bissau, Public Order Police cell of in Bissau (Known as Second Police Station);¹⁴² Bafatá and Mansoa Prison, and Public Order Police cells in Bafatá and Gabú. The project was finalized in March 2017, and the new structures are expected to be inaugurated in April 2017, at the same occasion of the dissemination by UNIOGBIS of a guide on the rights of persons deprived of liberty, which addresses among other issues, the minimum standards of health and sanitation detainees are entitled to.

VIII. Conclusions and recommendations

161. The full realization of the right to health in Guinea-Bissau is contingent upon the availability of adequate, equitable and sustainable financing for health, at the domestic and international levels, including within the framework of the Agenda 2030 and its goals 3 and 17. Despite the multifold barriers it faces, Guinea-Bissau, with the assistance of the international community, has continued to make progress towards the respect, protection and fulfillment of the highest attainable standard of physical and mental health. A number of achievements and good practices illustrate the commitment of the State and other stakeholders to the realization of the right to health. These include practices that demonstrably enhance individual or group enjoyment of one or more elements of the right to health, or that pay particular attention to vulnerable groups, including those living in poverty.

162. However, the full realization of the right to health in the country is hampered by serious multiple obstacles. This includes aspects related to the underlying determinants of health, such as endemic poverty; deficits in access to food, education, safe drinking water and sanitation; limited and inadequate infrastructure as well as other outstanding challenges to the availability, accessibility, acceptability and quality of the health care system. There is also a continuous need to address a number of shortcomings so as to promote and enhance accountability for, participation in and monitoring of the public health system.

163. In light of the findings and conclusions of this report, it is recommended that the Government of Guinea-Bissau continue to take steps to address the major challenges in the National Health Care System, including with regards to the availability of health care infrastructure, goods and services; economic, physical and information accessibility; and to improve data collection to better inform health planning. Health care education, among other things, requires particular attention including through addressing gaps in health care knowledge and practice, as well as human resource capacity limitations. In this connection, it is further recommended to the State to:

- Improve the quality and availability of pediatric and maternal care, particularly neonatal care.
- Create an accreditation mechanism to ensure that all healthcare professionals in the country, including doctors, nurses, midwives, and other healthcare technicians, meet minimum appropriate standards in terms of education, quality of practice and ethical conduct upon graduation from tertiary education.
- Ensure the regular supervision and oversight of healthcare professionals to ensure continued compliance with high-quality standards of care, including clinical protocols.
- Take measures to ensure that mental health care facilities are available throughout the country, with the appropriate level of resources, qualified professionals and relevant equipment.
- Provide input and oversight of self-regulatory activities where health professionals opt to self-regulate through a professional association or another form of organization, to ensure that minimum standards of quality care are delivered, and that healthcare professionals failing to meet those standards are suitably sanctioned by the professional organization.

¹⁴¹ These concerns were raised between 22 and 25 August 2016 in the context of a human rights training provided to 29 Senior Police Officers, including six women, members of the Public Order Police (POP), National Guard (GN), and Prison Guards, from Gabú and Bafatá.

¹⁴² Information gathered through monitoring and assessment visits to detention facilities indicated that the Judiciary Police Detention Centre (known as the Second Police Station) was the most critical situation. Besides being overcrowded, cells had no minimum conditions of hygiene and sanitation, and the accommodation is not reasonable or appropriate as most inmates sleep directly on cemented floor, without mattresses or mats. Further, those held under custody did not have access to food provided by State, nor access to legal counsel, or medical and pharmaceutical aid.

- Ensure access to medical facilities, including by providing high-speed boats for medical evacuation from the Bijagos Islands to the main continental land and adequate numbers of ambulances, and equipment to health centres.
- Ensure access to doctors in all regions of the country, including by deploying at least one medical doctor on the Bijagós islands of Uno and Formosa, and ensure adequate numbers of medical specialists are available within the country at any given time to: (a) train current medical students; and (b) upskill doctors in the country that are already qualified, so that higher quality care can be delivered while Guinea-Bissau builds its specialty training capacity. The presence of specialists in mental health nursing and midwifery should also be secured.
- Produce and disseminate a “life-saving awareness programme” for rural communities on health risks prevention, nutrition and crop diversification.
- Secure funding to train urgently more midwives through ENS, and to fund payment of their salaries once they enter the workforce.

164. The State should take further steps to ratify the optional protocols to the International Covenant on Economic, Social and Cultural Rights (ICESCR), to the Convention on the Rights of the Child (CRC) and to the Convention on the Rights of Persons with Disabilities (CRPD) all relating to the competence of the respective treaty body to receive individual communications, including on the right to health. It is also recommended that the State ratifies the Protocol to the African Charter on Human and Peoples’ Rights on the Establishment of the African Court on Human and Peoples’ Rights, to secure access to alternative mechanisms through which citizens can lodge complaints in the event of health-related human rights violations.

165. The State should continue to make progress towards the implementation of the recommendations related to the right to health made in the context of the 2015 Universal Periodic Review of Guinea-Bissau,¹⁴³ namely by:

- Exploring ways of providing adequate allocation of human, financial and technical resources to the health sector so as to ensure access to quality health services.
- Enhancing efforts to reduce infant and maternal mortality (e.g. taking preventive measures; improving the coverage and quality of routine immunization programmes, and conducting periodical vaccination campaigns, as well as formulating a comprehensive plan and strategy for maternal and child health, including for neonatal health).
- Increasing the health budget allocation to the recommended minimum of 15 per cent of GDP, in line with commitments under the Abuja Declaration, in order to counter the alarming maternal and under-five mortality and morbidity rates, including high neonatal mortality.
- Taking all necessary measures to reduce the number of HIV/AIDS infections by means of enhancing national education programmes, and increase efforts to ensure the availability and access to antiretroviral treatment drugs.

166. The State should also continue to take steps to implement the recommendations made to Guinea-Bissau on the realization of the right to health by other international human rights mechanisms, such as the Special Rapporteur on extreme poverty and human rights,¹⁴⁴ the Committee on the Rights of the Child,¹⁴⁵ and the Committee on the Elimination of Discrimination against Women.¹⁴⁶ In line with the recommendations of the Committee on the Rights of the Child, the State should ratify the African Charter on the Rights and Welfare of the Child, among others, to create a comprehensive child rights policy and a strategy for its implementation, including the protection of the right to health of all children in Guinea-Bissau. The National Commission on Human Rights should monitor the status of implementation of all recommendations made by international human rights mechanisms.

167. With a view to strengthen the legal, policy and institutional framework impacting on the right to health, it is recommended that the State:

¹⁴³ “Report of the Working Group on the Universal Periodic Review”, A/HRC/29/12, 13 April 2015, and “Views on conclusions and/or recommendations, voluntary commitments and replies presented by the State under review”, A/HRC/29/12/Add.1, 24 June 2015.

¹⁴⁴ A/HRC/29/31/Add.1 (see footnote 17).

¹⁴⁵ CRC/C/GNB/CO/2-4 (see footnote 39); Committee on the Rights of the Child, General Comment No. 15 (2013) on the right of the child to the enjoyment of the highest attainable standard of health, CRC/C/GC/15, 17 April 2013; and General Comment No. 3 (2003) on HIV/AIDS and the rights of the child, CRC/GC/2003/3, 17 March 2003.

¹⁴⁶ “Concluding observations of the Committee on the Elimination of Discrimination against Women”, CEDAW/C/GNB/CO/6, 7 August 2009.

- Ensure the inclusion of all determinants of health (e.g. social determinants of health as well as the structural and administrative barriers), in policymaking and planning to ensure the realization of the right to health in Guinea-Bissau. In particular, the State should develop a plan through which all health posts and *tabancas* are progressively provided with access to safe and potable water, sanitation facilities, electricity, and other key services.
- Take steps to ensure consistent adherence to the Maternal Deaths Surveillance and Response (MDSR) decree, which should inform policy decisions and strategies to systematically address all causes of maternal deaths throughout the country.
- Adopt legislation and policies concerning sexual and reproductive health and rights, to ensure reliable access by all individuals to contraceptives, abortion services and post-abortion care that are safe, affordable and effective.
- Refrain from any political interference with medical administration, including ending politically-motivated appointments and establish a system of periodical external auditing of the health expenditures.
- Develop a Patient Rights Charter grounded in human rights law and international standards for use of all health care facilities throughout the country.
- Establish a national mechanism through which patients and other actors can file complaints in case of mistreatment within the healthcare sector;
- Ensure the responsibilities and activities of MINSAP and INASA are clearly defined, and confirm the extent of each body's authority to take actions in the furtherance of public health efforts that may limit human rights, i.e. in the event of an epidemic.
- Ensure that persons deprived of liberty have access to health care, among others, by ensuring the implementation of the United Nations Standard Minimum Rules for the Treatment of Prisoners (the Nelson Mandela Rules), adopted by the United Nations General Assembly on 17 December 2015¹⁴⁷ and of national legislation on the treatment of prisoners (Decree 12/2011 of 3 February 2011).
- Incorporate human rights training into medical, nursing and other healthcare curricula, along with bioethics and professional ethics training, including the OHCHR Technical Guidance on a Human rights based approach to prevent maternal and child mortality, and facilitate access to specialty training for healthcare professionals.
-
- Adopt legislation to protect the rights of persons with psychosocial disabilities in line with the Convention on the Rights of Persons with Disabilities.

168. It is also recommended:

To national civil society organizations

- Seek assistance from the United Nations and other actors to build capacity to advocate for the protection, promotion and fulfilment of the right to health, and engage in advocacy efforts to help ensure that a Uniform Patients' Rights Charter is available nationwide and that accountability tools, such as complaints mechanisms, are fully implemented, functioning, available and utilized by all citizens.
- Advocate before national authorities for the adoption of international instruments, which will allow the submission of complains on violations to the right to health, such as the Optional Protocol to the ICESCR.

To the United Nations Country Team

- Support the State in the formulation and distribution of standardized clinical protocols/guidelines to healthcare facilities throughout the country, to harmonize practice and assist healthcare professionals in providing good-quality care. Training in the use of these protocols should also be provided to healthcare workers, to ensure effective implementation.
- Support the State in the dissemination of the Technical Guidance documents on a human right-based approach to the prevention of maternal and child mortality and in efforts to incorporate human rights training into medical, nursing and other healthcare curricula, along with bioethics and professional ethics training.
- Encourage and assist the Government to develop awareness raising programmes with respect to mental illness and engage in other activities to reduce stigma and discrimination surrounding mental health.
- Advocate for, and support the State in the development of a health care policy, that clearly defines the subgroups of the population that are entitled to free and/or subsidized healthcare goods, services and

¹⁴⁷ See United Nations General Assembly Resolution entitled "United Nations Standard Minimum Rules for the Treatment of Prisoners (the Nelson Mandela Rules)", A/RES/70/175, 8 January 2016.

facilities, and in the formulation of a complementary plan to progressively extend the coverage of free/subsidized care to subsequent population subgroups in the future, with a view to securing universal health coverage for the population, in line with the Sustainable Development Goal 3.

- Ensure continued support to the vaccination campaigns and encourage the Government to measure and report vaccination rates beyond one year of life, either up until two years of age, or later if necessary, to ensure that no child is left behind in obtaining their full complement of vaccinations under the Epidemiology and Prevention of Vaccine Preventable Diseases (EPV).
- Encourage the State to continue to evaluate the efforts of community health agents and workers, and ensure adequate supervision, oversight and continued education of these workers, to ensure quality service provision.
- Encourage and support efforts to measure the current dimension and impact of the sale of counterfeit medicines, label counterfeiting, medicines smuggling, as well as the lack of control on medicines that are expired, and the sale of medicines without prescription, as well as in effort to address those challenges and to sensitize the general public on this important issue of public health relevance.

To the donor community

- Continue to support Guinea-Bissau in its efforts towards the full realization of the right to health, including in the framework of the Agenda 2030 and its goals 3 and 17, among others, regarding maternal and neonatal mortality, access to medicines, and the improvement of the National Health Care System.
