Report

Malaria Matchbox in Guinea-Bissau
Study on vulnerability to malaria, rights' protection and barriers to access to health care

Guinea-Bissau, July 2019

INDEX

Acronyms and Abbreviations

AS	Área Sanitária (Sanitary Area)
ASC	Agente de Saúde Comunitária (Community Health Agent)
SAB	Bissau's Autonomous Sector
CCS	Conselho consultivo e de seguimento (Advisory and Follow-up Council)
CECOME	Central de Compras de Medicamentos Essenciais (Essential Medicines Purchasing Center)
CG-PNDS	Célula de Gestão do Plano Nacional de Desenvolvimento Sanitário (National Health Development Plan Management Cell)
CSLS	Célula Sectorial de Luta contra Sida (Sectorial Cell of Fight Against AIDS)
DENARP	Documento Estratégico Nacional para a Redução da Pobreza (National Poverty Reduction Strategy Document)
DRS	Direção Regional de Saúde (Regional Health Directorate)
ES	Estrutura sanitaria (Healthcare structure)
IEC/CBC	Education, Communication / Communication for Behavior Change
INASA	Instituto Nacional de Saúde Pública (National Institute of Public Health)
IPT	Intermittent Preventive Treatment
LLIN	Long Lasting Impregnated Nets
MICS	Multiple Indicator Cluster Survey
MINSAP	Ministry of Public Health
NGO	Non-governmental organization
PEN	Plano Estratégico Nacional (National Strategic Plan)
PM	Policy maker
PNC	Prenatal Consultation
PNDS	Plano Nacional de Desenvolvimento Sanitário (National Health Development Plan)
PNLP	Programa Nacional de Luta contra o Paludismo (National Malaria Control Programme)
PSB	Projeto de Saúde de Bandim (Bandim's Health Project)
SMC	Seasonal malaria chemoprevention
CS	Civil society
SP	Sulfadoxina-Pyrimetamina
QDT	Quick Diagnostic Test
UNDP	United Nations Development Programme
UNICEF	United Nations Children's Fund
WHO	World Health Organization

SUMMARY

The Malaria Matchbox tool by the Global Fund, was implemented in Guinea-Bissau with the goal to determine which specific populations and groups are particularly vulnerable to malaria; identify barriers to accessing malaria services and to draw up an effective intervention plan in order to reduce barriers to access, while **respecting human rights and gender.**

A qualitative study was thus carried out between May and June 2019 in Bissau's Autonomous Sector (SAB); Gabu's sector and the Buruntuma health area in Gabú region; Cacine´s sector in Tombali region; and Bolama and Bubaque Islands. Fifty-nine interviews were conducted with key informants representing health, education and environmental policy makers, representatives of civil society including national and international NGOs working in health, environment or human rights, rights of vulnerable groups and gender. Twenty-nine focus group discussions were conducted with beneficiaries from different categories: general population of different age groups, gender, people with disabilities, people living with HIV, community health workers and traditional healers.

The populations identified as being most at risk or vulnerable to malaria were children of both sexes, pregnant women and the elderly as is already known. They are vulnerable not only because of their biological characteristics, but also because they are dependent on the care of others and on women and gender issues.

In addition to these groups, other vulnerable groups have been identified, such as male and female young people aged 15-19 years, pregnant women, people with disabilities, fishermen, women of childbearing age, rural dwellers living far from health facilities (much beyond the 5 km recommended by WHO). In Gabu, Cacine and SAB respondents also considered Guinea Conakry's immigrant community, commonly known as "Nania" and "talibé" children [who study Quran at a Muslim school] in Gabu as vulnerable.

Vulnerabilities relate to cultural and traditional beliefs, such as seeking traditional treatment; gender issues related to the fact that women do not have decision-making power, which is exclusive to men/husbands. Pregnant women do not attend IPT1, for example, due to the fact that they do not attend antenatal appointments regularly because they prefer female service providers or due to challenging domestic occupations and income levels. Young pregnant girls, because they are minors, need the support of mentors.

The main barriers identified during the study include lack of access to adequate information and the considerable distances to health service facilities, lack of roads and public transport, increasing the cost of services for the population. The provision of services falls short of what is desired: lack of and the high cost of the services provided

1 Interminent preventive treatment: malaria preventive treatment of pregnant women with sulphadoxine 500 mg-pyrimethamine 25 mg from 16 weeks gestational age.

and supplies is noted, and some medical tests and medicines, even though free, end up being paid due to stock outs.

The poor quality and availability of human resources was an area identified by most informants, especially the lack of female service providers, the behavior of staff which is often characterized as insensitive, the practice of applying illegal charges for services that are free, absences from the workplace by health care privders that ultimately causes temporary closure of health centers, little preparation for care for users with special needs such as people with disabilities, LBGTQI and young girls.
Finally, institutional and governance weaknesses in the health care system, were considered very important. In particular, the inadequate implementation of laws, directives, policies and strategies, and especially the lack of monitoring of stakeholder accountability at all levels.

INTRODUTION

The Global Fund invests in programmes aimed at combating stigmatizing, discriminatory and punitive attitudes, practices, norms, policies and laws that impede people's access to health services, as well as protecting and promoting the realization of correlating human rights, such as the right not to suffer cruel, inhuman or degrading treatment and the right of appeal if rights are violated.

Malaria is a disease that disproportionately affects the most vulnerable populations. However, populations that are most affected or less able to access malaria prevention, diagnosis and treatment services vary, based on region or country and even at the local level, depending on the context of the disease. Human rights and gender-related vulnerabilities and barriers in access to services can undermine malaria prevention and control efforts, therefore removing these barriers is essential to ensuring that services are sustainable and benefit all those who need them.

In September 2016, as part of a collaborative project funded by the Global Fund and carried out by the International Public Health Advisor (IPHA), the Malaria Matchbox tool was designed to help countries a) identify specific groups and their characteristics (age, sex, gender, occupation, ethnic group, etc.) who are particularly vulnerable and / or excluded from malaria control services, b) the existing barriers that these groups encounter preventing them from accessing health care services and c) identify what needs to be in place to ensure malaria control. Ultimately, the tool will allow for the design of an effective and equitable intervention plan to reduce existing gender and human rights barriers, that impact programme effectiveness.

The Global Fund will support countries in implementing the tool box in order to improve the quality of malaria programmes by adopting a more human rights and gender equality approach to programming.

Capturing vulnerabilities across populations requires insight into different socio-economic categories - including gender, age, income level, ethnicity, household location (including rural / urban divide) - as well as context-based barriers due to gender or that

may deny rights to health care. Although biological circumstances and / or high vector exposure may contribute to high levels of incidence in certain groups, other characteristics - such as income, educational level, language, ethnic affinity, or geographical location of the household - may determine whether current care or not can adequately reach these groups or if they seek formal health care or not.

The Malaria Matchbox tool was implemented in Guinea-Bissau between March-July, 2019.

From the analysis of the situation based on a review of the previously available literature, it was found that despite the success achieved in reducing the prevalence of malaria parasitemia from 9.9% in 2012 to 0.7% in 2017 in children aged 6-59 months and 7.9% to 1.5% in children over the age of 5; the tendency of decreasing cases of disease and death in health structures over the years and the fact that 97% of households own at least one LLIN and approximately 92% of the population uses them, it is necessary to take into account the country's structural and operational barriers in order to achieve universal access as well as accelerate the implementation of comprehensive policies, multisectoral approaches and strengthening health systems to protect the most vulnerable – bearing in mind that universal access to health is a fundamental human right, and therefore should be accessible and equitably available.

Guinea-Bissau's Ministry of Health, through its National Malaria Control Program (PNLP) with the support of partners, notably the Global Fund to Fight Malaria, Tuberculosis and AIDS, has intensified action to combat malaria reinforcing long-used strategies such as early diagnosis and correct treatment, prevention through the use of Long-Lasting Impregnated Nets (LLIN), intermittent preventive treatment of pregnant women and seasonal chemoprophylaxis in children under the age of five.

The results of the desk situational analysis showed that, 66% of the population do not yet have access to services, ie they live beyond 5 km of the nearest Primary Health Care facility. Moreover, only 54% of the sanitary structures were considered in good condition; there is shortage of qualified human resources in the various fields and advanced degradation of the vast majority of health infrastructure, frequent stockouts and poor management were observed.

The main factor decreasing demand for health services include costs (44%) – which was higher in the regions of Cacheu (58%), SAB (51%) and Gabu (51%) – while distance appeared as the second factor (11%) (*World Bank 2016*).
In addition to children under five and pregnant women as the most identified vulnerable group, recent studies have observed the 5-14 and 15-24 age group as affected, in addition to males.

OBJECTIVES AND EXPECTED RESULTS

Overall Objectives:

1. To support Guinea-Bissau in identifying the barriers encountered by people in the most vulnerable situations with regard to access to malaria prevention, diagnosis and treatment services
2. To enable the integration of interventions taking into account Human Rights and Gender, complemented by the information obtained through the literature review.

The specific objectives were to:

⇒ Identify the most-at-risk populations or groups of individuals as well as the most vulnerable groups in relation to effective malaria prevention and treatment, considering routine data disaggregated by age, sex, income, social status and and loation.
⇒ Identify key social, economic and cultural factors that negatively influence the use and effectiveness of malaria prevention programmes and access to primary health services by different population groups
⇒ Develop an action plan that will address the identified barriers in order to amplify existing interventions.

The deliverbles of the assignment were to:

⇒ Develop a situational analysis report of the findings of the study hihglighting the most at risk populations; main factors and barriers that influence the decision not to use malaria control programmes; and develop recommendations for action

METHODOLOGY

STUDY DESIGN, LOCATION AND PARTICIPANTS

This study was fundamentally qualitative in nature, given the nature of the intended data, which aims at understanding perceptions, motivations and barriers related to accessing malaria control interventions, in the context of Human Rights and Gender.

The geographical scope of the study included national level, as well as in depth data collection in five of the 11 health regions, namely: the Autonomous Sector of Bissau involving both the central level, the health areas of Bairro Militar, Antula and Quelelé and the regions of Gabu (Gabu sector and Buruntuma sanitary area), Tombali (Cacine Sector), Bijagós (Bubaque and Bolama sector).

Based on the Malaria Machbox quesionnaires, Key informant interview (KII) guides and Focus group discussion (FGD) guidelines were developed. The questionnaire and interviews guidelines in Portuguese were applied in the most relevant language for each participant and the focus group discussions were conducted in Creole, but the transcriptions were written in Portuguese.

Consent forms were issued to all inteviewees. All interviews were recorded with the consent of the participants for greater fidelity to their words and later transcribed. On average, the interviews lasted about an hour and a half.

Semi-structured interviews were conducted with key informants, applying the Malaria Matchbox tool questionnaires to the group of government and civil society actors, according to the type of structure and level of involvement in health, social and human rights and gender promotion programmes.

Focus group discussions were also held with beneficiaries of the health programmes, with an average of five participants per group using interview guidelines to guide the discussions. These groups were approached separately in four categories: men, women, young boys, young girls. Young people were defined as people aged between 15 and 20 years old. The groups of men and women were interviewed separately and according to the following age groups: 21 - 35 years, 36 - 50 years and over 50 years. This grouping bears in mind the social status and intrinsic specificities of the group, allowing participants to openly express their point of view – since, although the issue of malaria is not considered a sensitive topic, issues related to barriers and the fulfillment of human rights can be.

Participants were selected through intentional sampling, ie participants with characteristics and potential to provide rich, relevant and diverse data relevant to the research. The conversations took place in their respective communities or workplace, in a space, allowing for participants' privacy and comfort.

Nine interviewers and six supervisors were trained for three days on the following topics: Malaria MatchboxTool; Human Rights (concepts and protection mechanisms); Human Rights and Right to Health; Protocol for the Malaria Matchbox Guinea-Bissau study; Methodology and techniques for collecting information; and Code of conduct for interviewers. The tool was also pre-tested at the Simão Mendes Maternity Hospital, the Family Health Directorate, the PNLP and the Ministry of Public Health and Social Cohesion.

Field data collection was conducted from 28 May to 12 June at the central level structures in Bissau and regional SAB, Gabu, Tombali (Cacine), Bolama and Bijagós (Bubaque) structures. The data collected and the results were shared for validation to the interviewers and the Advisory and Follow-up Committee (CCS).

DATA PROCESSING AND ANALYSIS

The analysis and interpretation of recorded and transcribed data was done by stages using the main component method. Researchers first became familiar with the data, which was coded and the main themes are identified while feedback on the findings was shared.

ETHICAL CONSIDERATIONS

The survey protocol was approved by the National Health Ethics Committee (Reference: 026 / CNES / INASA / 2019). Prior to inclusion to the study, participants were asked to give written consent after receiving explanations on the reasons and objectives of the survey and the procedures. In focus groups, oral consent was recorded. For persons under 18 years of age, in addition to the consent of their legal guardians, consent was also requested from themselves. All interaction with the participants were performed in settings ensuring privacy and confidentiality of the data collected. The interviews were transcribed anonymously and only the main investigators had access to the records after data collection was completed.

MANAGEMENT AND OVERSIGHT

The study was led by the CCM and the National Malaria Control Program. The Bandim Health Project provided in country technical support and international consultants provided further guidance and quality assurance.
An Advisory and Follow-up Committee (CCS) set up for this purpose and made up of six representatives from the CCM, the current Principal Recipient of GF Malaria, i.e. UNDP, CG-PNDS, PNLP, the National Institute of Public Health (INASA) and the Institute of Women and Children provided oversight and follow up. To ensure national consensus and understanding of the study protocol as well as the Malaria Matchbox tool, the CCS reviewed and approved all instruments, planned work and supervised data collection in the field.

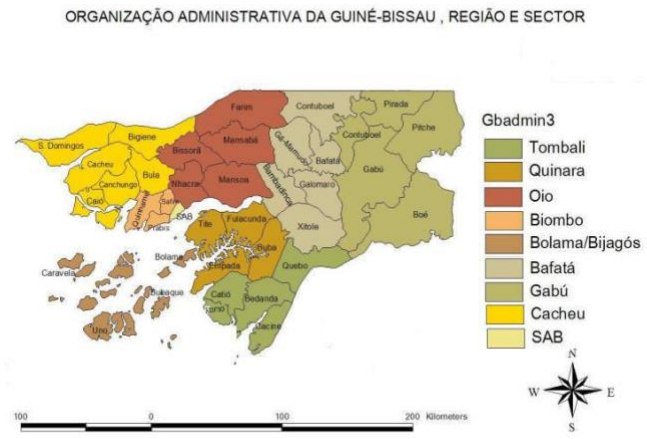
RESULTS

Field data collection was conducted from 28 May to 12 June at the central level structures in Bissau and regional SAB, Gabu, Tombali (Cacine), Bolama and Bijagós (Bubaque) structures. The data collected and the results were shared for validation to the interviewers and CCS.

FEATURES OF STUDY'S LOCATIONS

Guinea-Bissau, situated on the coast of West Africa, between Senegal, Guinea Conakry and the Atlantic Ocean, extends over an area of 36 125 km2, of which only 27 700 km2 is an emerged surface due to the country's low altitude relative to sea level. Only 78% of the territory is continental and the rest constituted by islands; the tides penetrate 150 km inland, partially or totally cutting off access to some areas during parts of the year.

Figure 1. Guinea-Bissau Map, administrative sectors



Source: MEPIR, INE: Census 2009.

Sector Autonomous of Bissau: Situated on the Geba River estuary on the Atlantic coast, Bissau is Guinea-Bissau's administrative and political capital. With an area of 78 km² in 2009 it comprises a population of 365,097 inhabitants, representing 25% of the total population of the country and more than 64% of the urban population.[2]. It is mostly inhabited by the Balanta (28%), Fula (18%), Pepel (16%) and Mandinga (%) ethnic groups. In terms of religion the majority is Christian (40%), Muslims account for 34% and animists 7,9%.
SAB has the highest concentration of administrative institutions, partners and service delivery structures. In the health sector, SAB is distinguished by having a regional health directorate and 10 additional administrative health areas offering primary health care.

Region of Gabu: Located to the east of the country, bordering Guinea-Conakry and Senegal, Gabu's sector is 2123 km² and is administratively divided into five sectors: Madina de Boé, Gabu, Pirada, Pitche and Sonaco. It has a population of 205,608 (14%), predominantly inhabited by Fula (80%) and Mandinga (14%) ethnic groups and the majority of the population are muslims[3]. In the health sector it is organized in 19 administrative health areas and has a regional hospital located in the city of Gabú, sector of Gabú.

Tombali Region, Cacine Sector: Situated to the south of the country bordering Guinea Conakry, Tombali has an area of 3736 km², with 91089 inhabitants (6.3%)[4]. It is administratively divided into five sectors: Catió, Komo, Cacine, Bedanda and Quebo. Inhabited predominantly by Balanta (47%) and Fula (21%) ethnic groups, the population belonging to the Felupe and Saracolé ethnic groups corresponds to less than 1%, and most of the population are practitioners of Islam 43%, followed by animist 24% and Christian 15%. The Cacine sector has an area of 613 km2 where there are two sanitary areas: Cacine and Sanconha. The region's headquarters of Tombali is located in Catió.

[2] Instituto Nacional de Estatística, 2009, III RGPH, "Características da População", MEPIR
[3] Instituto Nacional de Estatística, 2009, III RGPH, "Características da População", MEPIR
[4] Instituto Nacional de Estatística, 2009, III RGPH, "Características da População", MEPIR

Region of Bolama / Bijagós: Situated to the south of the Bijagos archipelago, the Bolama sector consists of islands with a surface area of 451 km² and 10 206 inhabitants. It is inhabited predominantly by Bijagos ethnic groups (64%), mostly Christians (30.7%), followed by animists (25%) and Muslims (15%). Located southwest of the Bijagos Archipelago, the island of Bubaque has 1013 km² with 4299 inhabitants, mostly ethnic Bijagos (64%), practitioners of Christianity (31%) followed by animists ((25%) and Muslims (12%).

SAMPLE DESCRIPTION

59 interviews were conducted with key informants representing a total of 24 health, education and environmental policy makers, 30 civil society representatives which included national and international NGOs working in the field of health, environment and human rights, rights of vulnerable groups and gender.

Table 1. Interviews planned and conducted with key informants

Key informant category	Region					
	Bissau	Gabu	Tombali / Cacine	Bijagós / Bubaque	Bolama	Total
Policy makers	**11**	**4**	**3**	**3**	**3**	**24**
Ministry of Health	6	1	1	1	1	10
Ministry of Education	1	1	1	1	1	5
Ministry of the Environment	1	0	0	0	0	1
Health care facilities (hospital, health center)	3	2	1	1	1	8
Civil Society	**16**	**7**	**2**	**3**	**2**	**30**
National NGO working in health	3	0	0	0	2	5
National NGO working in the environmental field	1	0	0	1	0	2
National organizations involved in promoting the rights of vulnerable groups	5	5	0	0	0	10
International NGO	7	2	2	2	0	13
International partners	**5**	**0**	**0**	**0**	**0**	**5**
Multilateral	2	0	0	0	0	2
Specialized in human rights or gender	3	0	0	0	0	3
Total	**32**	**11**	**5**	**6**	**5**	**59**

A total of 29 focus group discussions were held with different categories, such as: the general population representing different age groups, gender, people with disabilities, people living with HIV, community health workers and traditional healers, these last two playing a dual role as both beneficiaries as well as service provider.

The interviews were performed in SAB (DRS and CS of Bairro Militar), in the region of Gabu (Gabu Sector and Buruntuma Sector), Tombali Region (Cacine Sector), Bolama Island, Bubaque Island and Bissau Autonomous Sector in different locations according to NGO offices and public sector facilities. Focus group discussions were held in the Military District, the Quelelé District and the Antula District.

Table 2. Focus group discussion with beneficiaries

Category of Participants	Region					
	BAS	Gabú	Tombali / Cacine	Bijagós / Bubaque	Bolama	Total
General population	**6**	**4**	**4**	**4**	**4**	**22**
Young women (15-20 years old)	1	1	1	1	1	5
Young men (15-20 years old)	1	1	1	1	1	5
Women (21-35 years old)	1	1	1	1	0	4
Women (36-50 years old)	1	0	0	0	1	2
Men (21-35 years old)	1	0	0	0	1	2
Men (36-50 years old)	1	1	1	1	0	4
Disable people	**1**	**0**	**0**	**0**	**0**	**1**
PvVIH	**2**	**0**	**0**	**0**	**0**	**2**
Male	1	0	0	0	0	1
Female	1	0	0	0	0	1
Community Health Agents (ASC)	**0**	**1**	**1**	**1**	**0**	**3**
Healers	**0**	**1**	**0**	**0**	**0**	**1**
Total	**9**	**6**	**5**	**5**	**4**	**29**

IDENTIFICATION OF POPULATIONS AND GROUPS OF HIGHER RISK AND MOST VULNERABLE

Overall, the populations identified during the survey as those most at risk and vulnerable to malaria were a) children of both sexes, b) pregnant women and c) the elderly. These groups had previously been identified as vulnerable groups in the national Malaria Plan. In addition to these groups, young men and women aged 15-19, people living with disabilities, fishermen, adult women, people living in rural areas far from health facilities (much more than 5 km recommended by WHO) were also identified as vulnerable to malaria.

In Gabu, Cacine and SAB, the Guinea Conakry immigrant community, commonly known as “Nania” and also the Talibé[5] children in Gabu were considered vulnerable.

[5] Talibé children are children who are sent by their families to study the Quran with teachers who find themselves in situations of vulnerability linked to deprivation, begging in the streets and the underlying philosophy of austerity

Children under 5 years of age, combined with their biological characteristics, depend on the care of their mother or others. The children are exposed while playing at night, and many caregiver may not seek health care on time. Due to cultural beliefs, they may first seek traditional treatment that may not address the malaria symptoms. Furthermore, mothers, who are the primary caregivers, do not have the power to make decisions on when and where to take their children for health services, even if they have the money to do so, as they need the permission of their husbands.

The study found that pregnant women do not take the ITP if they do not attend prenatal appointments regularly, as they do not use what is available to them. The preference for female service providers for antenatal consultations and even for other services was quite evident, especially in Gabu. Pregnant women, and women in general, still face gender related barriers, as they depend on permission from their husbands. Children and adolescents aged 10 to 14 and young women aged 15 to 18, also face barriers to access because they are minors and need the support of caregivers to travel to consultations.

The elderly were vulnerable due to the fact that they have weaker immunity, and they depend on others to receive health information or to seek health services, and often are financially dependent on their families.

Young people between the ages of 15 and 19 get malaria because they do not want to sleep under the mosquito net, as they say it is uncomfortable or causes itching or allergies; they are, also, exposed to risks outside the home in djumbai (gathering) at night, fleeing the heat, or watching television or the computer, on the bancadas (groups of friends and neighbors meeting for several hours of conversation) of young people and when they are participating in cultural rituals such as boys' fanado (ritual for circumcision and education of traditional citizenship). On the other hand, it was also said that since the results of the diagnosis commonly identifies malaria as the disease, they choose to self-medicate.

People living in rural areas far from health facilities are most affected by lack of access to public health information, distance and difficulties due to the lack of roads and of public transportation and the cost for these, as most of the rual population are poor.

Geographical location and environmental factors are determinants of malaria risk, such as populations living on the many islands off the coast. For example, fishermen residing on these islands or temporary camps on the islands are unable to protect themselves nor do they have access to treatment when they get ill.

Other factor identified include living in areas that are breeding ground for mosquitos, such as wetlands, near standing water, neighborhoods near rubbish dumps, with poor sanitation and abandoned degraded housing. The type of housing contributes to the vulnerability of the population to malaria, as they often are poorly constructed houses, with no windows or doors, no roofs and no ventilation.

Guinea Conakry immigrants are not accessing the preventive, diagnostic and treatment measures provided by public health services due to a number of factors, which include cultural factors and refusal of health interventions such as vaccination. As other women in other regions, Guine Conakry women are also affected, since women in this community only seek health center services when authorized by their husbands, they and their children are affected and do not receive intermittent preventive treatment during pregnancy. These women, the few who use public health services, only accept to be attended by female health providers.

In addition, prisoners were also identified as being vulnerable to malaria. Despite being provided with LLIN[6] for prevention distributed among prisons during mass distribution campaigns every three years, most of the time the prisoners do not use the LLINs. In some prisons, mosquito nets are used to commit suicide and therefore not provided, and in others there are not enough LLIN for the overcrowded cells.

In the case of people with disabilities, it is noted that the lack of ramps or handrails for wheelchair users in sanitary facilities, the inadequacy of public transport that becomes more expensive than usual, and communication difficulties are factors that inhibit the use of health services. In short, health facilities are not suitable for access to care with regard to physical conditions as well as human resources with competence and training to care for people with disabilities.

People living with HIV and LGBTQI suffer from stigmatization or self-stigmatization and end up not seeking services or preferring to seek services from the mobile clinics of the NGO that specifically targets these groups. It is important to report that there is no official data regarding LBTQI populations.

BARRIERS THAT LIMIT ACCESS TO MALARIA RELATED INFORMATION, PREVENTION, DIAGNOSIS AND TREATMENT

FACTORS RELATED TO HEALTH SERVICES' SUPPLY

Health coverage and organization of health services

Lack of access to health services is primarily due to the physical factors resulting from the long distances between communities and the health structure. An example highlighted in the interviews with policy makers, is the distance from Boé Health Center which is about 30 / 40km from the community. Poor roads, combined with inadequate or infrequent means of transport (eg ambulance, raft in Tchetche, public transport, interconnection between islands in Bijagós and Bolama), makes it difficult or impossible even for a local to travel within rural areas. In Cacine there was also mention of the difficulties with river crossing during the rainy season, the lack of public transport for

[6] Long lasting insecticidal treated net: factory treated nets with insecticide, whose effect against vectors lasts for around three years.

the movement of people from distant tabancas to the health center, especially when these transports are forced to pay the police. According to the interviewees (policy makers), the extension of the continental territory and the many remote and disperse villages are factors that hinder access to health services.

The supply of quality services is affected by the state of health infrastructure degradation, lack of equipment and constant stockouts of medicines and supplies in general. Malaria medicines are no exception either, although service providers have reported that this has not occurred lately.

> *"Medicines sometimes, the amount that is supplied in a health facility, cannot match the period that is sent and ends, those who have possibilities end up looking differently, those who have less conditions end up having difficulty continuing treatment"* (CECOMES).

One of the key data collection questions included whether health facilties had the medicine Coartem in stock. During field data collection, it was confirmed that Coartem existed in the health facilities. One of the regions set up a system in which health centers in need (when the quantities are not enough or drugs are out of date) can request from others who still have the medicine in stock. It was also noted that the entities involved in the process already have a plan and initiatives underway to address this situation.

Quality of care

Health facilities still lack human resources, both in terms of quantity and quality. Availability and the unequal distribution of health workers across the country is due to the difficulties in retaining staff in remoter regions and areas far from the capital. There is also lack of materials and fully functional equipment or laboratories, contributing even more to the demotivation of health staff. Other factors also impact on the availability of health workers, including their absence when they are required to attend trainings or when conducting specific activities such as public health campaigns. A recent development observed involves the prolonged absences by health care providers, to attend undergraduate courses in Bissau while still remaining as health officials.

Another aspect highly cited by PM, CS and all focus groups, has to do with the attitude of health professionals related to the rights of users and beneficiaries of health services. A negative approach such as shouting at the patient, disregarding their complaints, having no patience and being judgmental, are more than enough to make the patient feel injured and refuse to seek health services. Another issue identified was the illegal charges for services made by health professionals in health facilities.
It should also be noted that many health managers believe, in the context of malaria, that:

> *"There are no excluded populations. All populations have the same rights when seeking health services. "*
> *"People not covered by malaria program in Bijagos Islands are few at the Bijagos region level because all the people who have been diagnosed and found to have malaria will be offered medicine, which many sometimes makes people*

untreated if there is a drug stock out , but all people have drug coverage offered for the program "

However, this statement contradicts the opinion of users who perceive that those with higher economic status are better served than poorer people, that people are served according to their appearance *"si bu mara fixe"* (GF), economic status or relevant position in the community, and if there is a relationship of familiarity and friendship with the health professional.
It was also considered that people with disabilities, people living with HIV and foreigners are victims of discrimination and rely more on traditional treatment with healers, djambacus and also ASCs. The absence of confidentiality is also a barrier that demonstrates the poor quality of care and it is also why LGBTQ do not resort to the health center, but prefer to seek health care through the mobile clinic promoted by the NGO ENDA.

"Health caregivers learn very early at universities about the code of ethics in the exercise of their health functions. It turns out that many of them do not respect these principles in their workplaces. Unethical behaviors in health facilities contribute to the reduction of number of people seeking services at health facilities to treat their health problems and may also generate distrust from patient to comply with the treatment prescribed by the technician who has treated him differently. This type of behavior is more frequent among female providers" (PM)

Wrong or inadequate diagnosis by the health professionals were reported: some health professionals treat some cases of fever as malaria without confirmtion by QDT or other laboratory test as reccomended, or some doctors and nurses may not follow the guidelines of the National Malaria Control Program or engange in malpractice. Medicine bought in the streets may be expired or banned..

There appears to be a large deficit of accountability mechanisms in the health sector/ , Stakeholders highlighted that there is no effective judicial or other mechanisms to consider complaints of health rights violations, due to the fact that the formal justice system is not accessible for the majority of the population. Although there is a law on medical negligence, there are no recorded cases being brought under it.

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 meither of the hospitals 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.

FACTORS RELATED TO SERVICE DEMAND

Cultural beliefs and traditional practice

Local or traditional beliefs, perceptions and practices are elements of a cultural pattern wich moves with daily life, meaning that after created the pattern, the practice gains temporality and becomes recurrently evoked as a historical practice. and assumes legitimacy by resorting to cultural issues to justify certain cultural practices: *"because in our culture it is like this"* or *"because in our culture it is like this"* (Govint, 2017, p.64,65). In this sense, access or no access to malaria care and services is also linked to cultural beliefs, perceptions and practices.

A large part of the population uses traditional treatment, and there is no habit of the Guinea-Bissau's population to routinely seek formal health services (CS), especially in cases of emergency. However, applying illegal charges for services mean that the population does not have access to diagnosis, care and treatment (CS).

> "People from the Muslim religion, for example, interpret malaria as "*disease of the week*" since the symptoms appear intermittently, i.e. they appear and disappear making the person feel an apparent improvement. To treat this disease they usually use "*faroba."* (CS).

Some traditional and cultural beliefs and interpretations can cause harm not only the individual, but also the community:

> "Beliefs can indeed influence demand. But there are other prejudices in which the disease, if not caused by God, is caused by a spell. These interpretations happen more frequentfly within the Balanta and Papel ethnic groups. Traditional beliefs are another factor, many believe that if their ancestors never sought medical care and did not suffer from it, it will be no different with them either "(SCP).

Recourse to the use of traditional medicines administered by healers is apparently cheaper and financially "advantageous" due to the more flexible payment options available to them, unlike going to a health center where people without money are not received (GF) while a healer can be paid in kind.

Certain cultural practices based on traditional beliefs and perceptions hinder access to health care services. Communities seek the services of the traditional healer, *djambacus*, murus, or iran to treat diseases, including malaria and other fevers because these practices have been used to for generations and because it is cheaper to go to the healer and other traditional and spiritual practioners. The demand for health centers or the hospital often occurs at late stages of the disease progression. These different interpretations affect the demand for services, in the sense that if someone consumes the *faroba*, *padja santo, padja di algadon*, plants among others, and feel well or healed, the person believes that they do not need to go to the doctor:

Gender and the role of women in the community

The dynamics of power relations within the household with regard to gender is also an element that can enable us to understand who makes decisions regarding the demand

for and access to malaria services and how women and children are affected by these factors.

In general, the role of women in Guinea Bissau's society is relegated to the background: she is a domestic, caregiver, and "well behaved". She has little freedom to participate in public spaces. With regard to her health, the woman has no power over her body, culturally and religiously her body belongs to her husband. It is in this sense that the man is unanimously identified as the decision-maker in his role as head of household, husband, father, uncle, brother, grandfather, "*homi garandi*".

The dynamics of decision-making in the household influences vulnerability to malaria. For example, in the case of pregnant women who attend PNC only at a very late stag en te preganancy, and therefore do not attend IPT or appear later, at the 9th month they have anemia or give birth at home:

> "Once we met a woman who was about to give birth, but just because her mother-in-law said she could not go to the hospital in the absence of her husband, one of our colleagues immediately put her in the car and we immediately drove to the hospital as soon as we left from the car she gave birth "(CS).

In some areas of the country a woman can only go to the doctor when accompanied:

> *"in the northern area another component called "nandju" means that a woman only goes to the doctor accompanied by an elderly woman".*

However, in other cirumstances, women are more empowered to take decision on health realted matters, such as in Bissau. In the capital, where people are more exposed, it is understood that because of their economic activities, women have a little more autonomy and, because they are more concerned with health issues that concern everyone in the household, it is considered that she also makes health related decisions (SP).

In the Balanta ethnic group, the informants say that decisions are taken together and when this is not the case, the woman takes the risk and turns to health services (PD). We can consider that, in the case of the Balanta ethnic group, because it is in a way a horizontal society that is governed by rules but does not have a "boss", this positively impacts women's participation in decision making dynamics.

In terms of organizational culture, Bijagós society is considered matriarchal, with power being exercised by women, especially mothers – giving birth gives women the highest status in the family hierarchy. They have the power to decide how ceremonies are performed, what rituals, for what purposes, at what time. In this sense, when asked about who within the household makes decisions that affect the demand, access and use of health services, most stakeholders reply that they are women / mothers, that the responsibility of their children lies with them and that they have decision making power over domestic issues:

> *"With regard to going to the hospital, women make the decision to go to the hospital more than men, because here in Bijagós the son belongs to his mother"*

"For bijagos, women have more power to decide, in bijagos culture the woman is the one who has the most power to decide, if she has a child and cannot afford or a position, the sisters take care of that child, because the child belongs to the mother "(PM)
"Women participate in everything that has to do with the health of their children, she is the one who gives birth and the child belongs to her: "no mame ka na sinta ku si fidju doente i ka lebal hospital, son si falta di dinheru "(GF).

The level of education was also mentioned as an important factor to influencing the access to malaria and other health care and treatment services, that is, the more educated the head of household, the more open they might be to encourage the use of health services by their wives (CS).

Still, with regard to women's participation in decision making within the household, opinions differ between policy makers who consider that women are perceived as more concerned with health and children, making decisions and taking children to the health center, even if their husbands are violent. Civil society informants,however, consider that when it comes to economic power, as men have more power, women have no voice, their participation in decision-making is limited, and if she is informed about free services she may take the risk and go to seek those services.

Regarding gender issues, epeciaally in the case of the LGBTQI community compared to straight women and men, it is important to know which is the first place they seek to diagnose and treat malaria. Due to prejudice and lack of confidentiality on the part of health service providers, it is perceived that the LGBTQI community does not primarily seek services and information from the hospital, but rather pharmacies. Generally, men, women and young people both boys and girls seek services at health centers, however, it appears that more women and youth from peripheral areas go to healers or *djambacus* for "*ialsa mon*" (CS).

Gender issues permeate women's health issues (sexual and reproductive health and access to different services), as women are in a subordinate situation. Their decision-making and negotiating power regarding their own health is limited or simply non-existent in the communities, from the east (PM, CS), exposing them to greater vulnerability and greater risk of disease transmission (STI, HIV), situations such as unplanned pregnancy or other forms of violence that affect their health. Within the household, it is the man who makes decisions that affect access, the use of health care and treatment. If the husband is not present, then, the father, the older brother, the uncle, and in the absence of these male family figures, it would fall to the mother-in-law, to make the decisions. In some cases, the "*djarga*" of the village also influences decision making.

In situations in which the wife has to be hospitalized and the husband is not present, the older brother chooses not to decide, leaving the decision exclusively to the husband, since the latter will bear the financial expenses of the hospitalization (PM). When it comes to financial matters, often, even if the woman has some savings from her selling *coscous, fidjos moni, futi*, among others, and her husband does not have equal means,

she can only go to health services based on his permission, thus limiting her freedom and her decision about the health of her body.

A clear example given in one of the interviews and demonstrating this inequality of power in gender relations is that of the Sintchaussumane community. In this community, an income generating initiative that had been started was not continued as the men in the community blocked the process by claiming that, due to the fact that the women in their community now had financial autonomy, they were no longer obedient and would undermine the power of men within their families and communities.

Due to cultural and religious dynamics, women in communities from the eastern part of the country, prefer to be attended by female health providers, however, the majority of the health care providers in Gabu are male.. In Beli community, for example, women end up giving birth at home.

Direct and indirect costs related to the use of health services

Lack of financial means is a major barrier in accessing health services for young people (girl / boy) and adults (man / woman) who have no money (because they do not work or because they are dependent on others). Many communities are excluded frm health services due to illicit charges by health facilities, and lack of funds for transport required to reach the health facilities. (PM / CS / GF).

Young people are more affected by this, as other vulnerable populations (pregnant women, children under 5 years old and elderly aged 60 years and over) have the right to free health care services,

> *"Children from 5 to 14 years pay 100 to 200 francs for the medical act"*

Diagnosis and treatment are free, but when there are medicine stock outs, beneficiaries are advised to go to pharmacies to buy what should have been free of charge:

> *"Malaria analysis and treatment is not paid for. There are medicines available, but if it is out of stock, the patient is forced to go away " (GFH)*

There are systems in the communities which involves raising funds for health coverages – called the abota systems or mutuality systems. These are managed and made available when a member of the community needs care. These funds are used to pay for fuel for ambulance and motorcycles to transport the patient or a pregnant woman in labor (Sonaco / Dara, and to pay for the services provided on site.

Financial barriers identified that undermine access to health services, are overall limited financial conditions, the cost of transportation for travel (added to indirect individual costs), illicit charges, the cost of services, misinformation on free services, and cost for medicine purchase. Despite the Malaria Control Malaria Programme's policy on free user fees, cases of illegal charges were mentioned in some focus groups:

> *"At the hospital (health center) X everything has to paid, even adhesive. In some places, they take drugs from hospitals to sell at pharmacies outside. "*

Others confirmed the existance of free services by saying that all that is related to malaria is free, however, due to medicine stock outs, the user is obliged to go to the pharmacy where they have to pay:

> *"Analysis, treatment is all free" / Na tudu kau kusa di malaria ta patido, farmacia é ta pati ma bu tem ku leba resultado di analise "/" At CTA everything is offered to PLWHA when they don't have to send to Aida who give medicines according the result of the analysis and the prescription signed or document signed by the Social Worker for needy cases" (DGF)*

The order establishing the free treatment of malaria states that *"free early diagnosis malaria through thick drop, the rapid test and the treatment of simple malaria with the drug Artemether - Lumefantrine (Coartem) in all public health facilities"* for all age groups. Treatment of severe malaria and other types of treatment are not covered by this.

There is a partnership model between the Ministry of Public Health and some NGOs that financially cover some health related costs to increase specific beneficiary population's access to health services. Examples of these are: Transport arrangements for children <5 years old and pregnant women who are unable to access health facilities are provided by PIMI; Instituto Marquês Vale-Flor provides free care and drugs to pregnant women; AIDA provides free medicines to needy families and EMI subsidizes medical services. Populations that fall outside these schemes are people >15 years old. Some community health mutual initiatives were also cited, one example being the project supported bythe NGO Vida, in Suzana.

The challenge is whether this type of health care or financial coverage is equitably provided as NGOs normally operate in limited geographical locations. For example, the organization AIDA only works in Bissau in collaboration with the Users Office of Simão Mendes National Hospital. They have a social worker who assesses the conditions of patients who present themselves as vulnerable, make home visits to confirm their situation and start receiving free services.

Level of education and access to information

The level of education is an important factor in the understanding of and the motivation to use the services provided. According to the 2009 census conducted by the National Statistics Institute, approximately 52% of the population aged 6 and older is literate, that is, can read and write. Of these, 58% of males are literate against 42% of females. Between different ethnicities the differences are significant with the lowest literacy ratio found among the Fula (41%) and the Mandinga (39%) (Figure 2).

Figure 2. Literacy among the population of 6 years and older by ethnicity.

Source: National Statistics Institute, III RGPH, "Características da População", MEPIR 2009.

It should be noted here that according to the MICS5, in the eastern part of the country (Bafatá and Gabu), the situation of access and retention in the education system is alarming: only 26% of young girls (15-24 years) in the whole region are literate, contrasting with 41% of young men of the same age and locality.
The way in which information is communicated and transmitted is very important when dealing with health, especially in relation to major diseases such as HIV, TB, and Malaria. The language of communication was also a factor pointed out as prevention communication between the user and the health professional. Community members find it difficult if the health service provider does not speak their local language, and is not of the same ethnicity, which can facilitate the best approach in terms of understanding (PD, FG).
There are Community Health Agents who provide information and raise awareness among the community about various diseases, especially malaria, so people are exposed to regular information about malaria through different media, be it radios, djumbais, awareness campaigns and in the health facilities themselves. The general perception is that the population that has the most access to information is women, since they are those who participate more in the health interventions and other campaign and strategies targeting issues affecting their children.

It is important that information is transmitted in a language better understood by the majority of people, such as Creole or preferably in the local language (Fula / Mandiga). The most widely spoken language in the country is Creole, with approximately 60.4% of the population speaking Creole, while only 27% speak Portuguese.

It is also important that the information be clear and understandable, adapted to different groups and audiences. There is need to provide clear information on the fact that malaria services are free. Many people do not have this information and often do not go to health services because they think they will have to pay. It was also identified

that some groups, especially women, do not have access to radios for information and the majority do not have access to newspapers. Men and young boys are the ones who listen to the radio the most. Community Health Agents throughout the country are another medium through which the population / community has access to information. Other mediums mentioned were television, posters, health centers and hospitals, schools, *djumbais* and interpersonal awareness.

There is limited information that is accessible for people with different types of disabilities – i.e. hearing and visual impairment, verbal challenges etc.

Professional Activities and Occupations

The performance of some activities, in particular those related to the gender-based distribution of roles and responsibilities that men, women, boys and girls perform during certain times of the year, increase vulnerability to malaria. These were identified by women to be horticultural activities carried out by women, the informal activities of street vendors, fishermen, night watchmen, bolanha work (more women), cashew harvesting (women) and children guarding the cows in the field. However, some consider that the performance of these activities varies by ethnicity:

> *"It varies from ethnicity to ethnicity, for example in the Beafadas men engage in work on the plateau, grow rice, cassava, maize and other products. Women and girls engage in rice work, the rice fields are infested with mosquitoes making them the most affected. Boys are in the least vulnerable social category "(PM).*

The weight of productive and reproductive work, also taking into account the gender aspect (men, women, boys, girls), is a determinant that hinders access to health services, as we consider that women spend more hours working not only in the countryside (agriculture, horticulture) but also in the household, they have little time or less availability to access health services or routine medical care, and only do so when they are in a state of illness (PM).

Lack of access to safe drinking water causes girls and women to travel long distances in the morning or afternoon to collect drinking water, exposing themselves to risk and further aggravating the physical work assigned to women.

CONCLUSION

The analysis of the findings of this study led to the conclusion that, in addition to populations normally targeted by PNLP, such as children and pregnant women, other groups also face a high risk and are vulnerable to malaria.

Particular mention was made **of young boys and girls (10-14, 15-19**), **young pregnant women (15-19), people with disabilities**, **fishermen**, **rural dwellers far from health facilities (well beyond the 5 km recommended by WHO**), **the female immigrant community from Guinea Conakry** and the **talibés children**.

Vulnerabilities related to cultural and traditional beliefs, such as seeking traditional treatment, as well as gender issues related to the fact that women do not have decision-making power over theirs and their children's health needs and are dependent on their husbands, were significantly cited.

The main barriers identified were access to adequate public health information and services, the distances to health facilities and increasing the cost of services. The provision of services falls short of what is required, the lack of human resources in quantity and quality, disruptions of tests and medicines, cost of medical services and supplies, informal charges and lack of functioning supervisory structures, reporting and accountability were noted.

Plan

RELEVANCE

In 2017, the World Health Organization (WHO) recorded the biggest setback for malaria control in recent years, estimating that there have been 5 million more cases than in the previous year. The fight against malaria is at a critical point, and after a decade of success against the disease, progress has stalled. Every year, half a million people still die from malaria, most of them children under five. The African continent suffers more than 90% of the incidence of the disease. Malaria funding from traditional sources has stagnated and the political will to find a solution has been hampered by tight budgets and other priorities. Communities most affected by the disease do not always have the tools or knowledge to protect themselves from the disease and therefore a new booster is needed to revive the fight against malaria.

As part of the study using the Malaria Matchbox tool, the following barriers that prevent access to malaria prevention, diagnosis and treatment services were identified related to:

Health system factors - Inadequate health infrastructure, limited geographical access to health services, inadequate quality of services and human resources available, lack of skilled professionals, lack of equipment and supplies, limited health management capacity, and inadequate coordination among public health facilities.

Factors not related to health system – Limited capacity of community health workers to address severe malaria issues, social cultural beliefs and practices, and gender inequality and limited health care demand behaviors.

The **rights-based approach** is a conceptual framework that integrates the norms and principles of the international human rights system into development policies, programmes and processes as well as humanitarian actors. Therefore, **it focuses on procedures and outcomes**, which principles are the participation and empowerment of individuals and communities to promote change and enable them to exercise their rights

and fulfill their obligations, as well as to **identify rights holders** (women, girls, boys and men) and **duty bearers** (the State), and **seeks to strengthen the capacity of rights holders to claim their rights**, as well as those with **responsibility to fulfill those rights**. It therefore requires a change in attitude in the way we work and for the population in question: **they are no longer viewed as beneficiaries but as rights holders**.

The rights-based approach also requires national health rights **legislation** aligned with international human rights instruments and is fundamentally reflected in the principle of participation and empowerment of people and communities to promote change and enable them to exercise their rights and fulfill their obligations.

This approach is based on the understanding that **putting people at the center of the operational decision-making process** and developing protection strategies in partnership with the indivuals will guarantee they are better protected, their ability to identify, develop and maintain solutions will be strengthened and available resources will be used more wisely. The main objective is to ensure the right of the community to participate in decisions that affect their lives, as well as to be informed about the transparency of actions implemented in the communities.

Integrating a human rights approach as well as gender equity in health is intended to ensure that **all Guineans everywhere** can benefit from quality health services **whenever** and **wherever** they need them, without fear of impoverishment. This is what constitutes Universal Health Coverage, which implies the guarantee of gender equality in all actions.

The human rights approach requires policies, programmes and activities to be based on international legal standards. Community members and leaders must examine their roles as rights holders and bearers of responsibility, as well as review, along with all stakeholders, the obstacles to the exercise of these responsibilities and the means to overcome them.

VISION AND APPROACHES TO THE PLAN: RESPECT, PROTECT AND IMPLEMENT THE HUMAN RIGHT TO HEALTH IN GENERAL AND MALARIA IN PARTICULAR

Health from a human rights perspective provides a framework on the accountability of countries and the international community for what has been done and what needs to be done for population's health. The extension of integration of human rights into policy making, the analysis of social and physical health conditions and the provision of health care indicates a positive movement towards the realization of the human right to health.

The obligation to respect the human right to health means that the state cannot interfere or violate this right. **Protecting the right to health** means that the state must prevent non-state actors from interfering in any way with the enjoyment of human rights. The **implementation of the right to health** means that the state must be proactive in ensuring access to health care.

In response to these priorities, a strategy has been devised to accelerate the reduction of morbidity and mortality due to malaria, with priority being given to the synergy of the

different programmes and ongoing initiatives in the fields of Community Health, Malaria, Human Rights and Gender Equity promotion.

GUIDING PRINCIPLES

The strategy of this plan was guided by the following leading principles:

i) **Universal Coverage**: takes into account the need to ensure that all citizens at risk can use the promotive, curative, rehabilitative health services they needs, have access to information, protection, diagnosis and treatment available, with sustainability, quality and low cost.
ii) Aligned with human rights based approach that every person has the right to the highest attainable standard of health and health service provision should take into consideration the human rights of all
iii) **Multi-sectoral approach**: it is key to the success of the strategy to be implemented and implies intra and inter-sectoral collaboration. It is important to create awareness of the multi-sectoral malaria control in other sectors (Agriculture, Environment, Public Constrution, Education, Communication, Private Sector, Civil Society and Cooperation Partners, among others).
iv) **The community-based approach**: requires understanding, cooperation and coordination at all levels, including management, programming, protection, community services, technical services and information. In implementing the community-based approach, it is important to identify, recognize and understand changes among roles and power relations between women and men, between youth and old and between majority and minority groups, as well as working with leaders and all community members to ensure respect for rights and equality. This will help ensure that interventions do not weaken community structures that can be sources of protection and support.
v) **Gender:** implies equitable access by all groups to health services that are appropriate, respectful.
vi) **Non-disriminatory/Inclusive and respectful of multiple perspectives** - committed to considerations of age, gender, ability, ethnic, cultural, religious, economic and other factors that might influence the access to health and service provision.
vii) **Complementarity and synergy**: the elaborated strategy takes into account the ongoing initiatives of the different partners

TARGET GROUPS:

The elaborated strategy aims **to reinforce ongoing interventions and add value**, by ensuring syniergies between the MoH and their key partenrs, therefore the proposed activities will have the following target groups:

Strengthening capacities	Beneficiaries of social protection services	Beneficiaries of prevention, diagnosis and treatment services

▪ Health staff ▪ ASC	▪ Teens and young girls from 10 to 14, from 15 to 19 years old ▪ People with disabilities ▪ General population	▪ Teens and young boys during circumcision ceremony ▪ Teens and young girls from 10 to 14, from 15 to 19 years old ▪ Young pregnant girls aged 15-19 ▪ Prisoners ▪ Fishermen ▪ Cattle herdsmen ▪ Farmers ▪ People with disabilities

OVERALL GOAL:

⇒ Improve malaria prevention, diagnosis and treatment services for vulnerable groups, taking into account the human rights approach and ensuring gender equity

EXPECTED RESULTS:

1. An enabling environment for the access to malaria prevention, diagnosis and treatment services is promoted and in place

2. Malaria related information is availabile, appropriate and accessible to vulnerable groups

3. Malaria services targeted by vulnerable groups is increased

4. Quality of health services provided is improved

5. Institutional capacity in monitoring Human Rigths in health services, including malaria program , is strengthened

ACTIVITIES:

Expected Outcome 1: An enabling environment for the access to malaria prevention, diagnosis and treatment services is promoted and in place:

To ensure compliance with the commitments made by the Government of Guinea Bissau, it is urgent to update national policies taking into account the Human Rights approach and gender equity. It should be noted that although there is a National Health Policy approved by a Committee set up for this purpose, to date the PNS needs political approval, therefore it is not enforced.

Activities:

1.1. Review the National Health Policy in the context of Human Rights and Gender Equity

1.2. Advocate for the approval of the revised national Health Policy

Expected Outcome 2: Malaria related information is availabile, appropriate and accessible to vulnerable groups

Activities:

2.1 Develop and validate an integrated communication plan (malaria, HIV / AIDS and TB), guidelines and instruments taking into account the different target groups identified

2.2 Implement the communication plan through the media, community leaders, traditional healers, religious leaders, CHW and new technologies.

Expected Outcome 3: Malaria services targeted by vulnerable groups is increased

Activities:

3.1. Operationalize the existing advanced strategy in place and integrate simple malaria prevention, diagnosis and treatment services

3.2. Integrate malaria prevention, diagnosis and treatment services by NGOs that are implementing community health and environment programs

3.3. Review and update Community Health Agents responsibilities and scope of work in line with community profile and specific needs

3.4. Train 60 female CHW in malaria diagnosis and treatement (simple malaria)

Expected Outcome 4: Quality of health services provided to vulnerable groups is improved

Activities:

4.1.Incorporate human rights training into medical and nursing healthcare curricula

4.2. Integrate all aspects of Human Rights into current Green Line

4.3.Establish a national mechanism through which patients and other actors can file complaints in case of mistreatment within the healthcare sector

4.4. Conduct patiants quality health services perception study

Expected Outcome 5: Institutional capacity in monitoring Human Rigths in health services, including malaria program, is strengthened

Activities

5.1 Update and dissemenate health information collection sheets, disaggregated by age according to WHO guidelines (10-14; 15-19; 20-24)

5.2. Develop an oversight guidelines for healthcare provision

5.3. Train General Health Inspectorate (GHI) team on the oversight guidelines

5.4. Conduct oversight of healthcare professionals to ensure continued compliance with high-quality standards of care, including clinical protocols, by the General Health Inspectorate

INSTITUTIONAL FRAMEWORK: COORDINATION, IMPLEMENTATION AND MONITORING

Coordination, concertation, decision and supervision structure

This operational plan has a multisectoral character and needs the involvement of all sectors of society. Coordination of the implementation of the operational plan will be carried out by the Ministry of Health, through the PNDS Management cell. The main objective of the Ministry of Health will be to coordinate the activities of the partners involved in the implementation of the strategy,and in consultation with the Institute of Women and Children to ensure strategic partnerships between all Government and civil society actors to improve the integration of services to be made available, as well as create and strengthen synergies and partnerships.

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 government 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.

The national mechanisms should monitor both the human rights of patients and of healthcare professionals. 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 Commission (Comissão Nacional dos Direitos Humanos, CNDH) does not have a mandate to receive complaints from the population or from healthcare professionals.

The **Guinea-Bissau Comission of Human Rights** may be considered as the institution charged for following up the implementation of this strategy.

Executing Partners:

Prevention	Care and treatment	Protection	Follow up	Research
▪ Community, religious and political leaders ▪ Community Health Agents ▪ NGOs implementing	▪ Health centers ▪ Specialized NGOs	▪ CAJ	▪ CCM ▪ National Human Rigths Commission	▪ INASA ▪ PSB

activities of promotion and protection of the right to health ▪ Social Communication and new information technologies				

Budget:

Resultados esperados	Actividades	Orçamento (USD)
1.Promovido ambiente favorável para garantir o acesso aos serviços de prevenção, diagnóstico e tratamento do Paludismo	1.1.Rever a Política Nacional de Saúde tendo em consideração Direitos Humanos e equidade de género	3800
	1.2. Advocay para a aprovação no Conselho de Ministro da PNS	
2. Informações sobre prevenção, diagnostico e tratamento do paludismo disponíveis, apropriados e acessíveis aos grupos vulneráveis	2.1. Elaborar e validar o plano integrado de comunicação (paludismo, VIH/SIDA e TB), os guiões e instrumentos tendo em consideração os diferentes grupos alvos identificados	83000
	2.2. Implementar o plano de comunicação através dos mídias, líderes comunitários, religiosos, ASC e novas tecnologias de informação	
3. Aumentado a procura dos serviços de diagnostico e tratamento do paludismo pelos grupos vulneráveis.	3.1. Operacionalizar a estratégia avançada e integrar os serviços de prevenção, diagnóstico e tratamento do paludismo simples	10700
	3.2 Rever e atualizar as responsabilidades dos ASC tendo em consideração as necessidades das comunidades assim como o perfil das comunidades	
	3.3. Formar 60 agentes de saúde comunitária do sexo feminino no diagnóstico e tratamento do paludismo simples	
4. A qualidade dos serviços de saúde prestados aos grupos vulneráveis melhorada	4.1Introduzir formação sobre Direitos Humanos no curriculum de formação dos profissionais de saúde	20500
	4.2.Integrar todos os aspetos de DH à Linha verde da Farmácia (188) existente	
	4.3. Estabelecer um mecanismo nacional que permita que os pacientes e outros atores possam apresentar queixas em caso de mau tratamento e discriminação nas estruturas de saúde, publica e privada	
	4.4.Realizar estudos de perceção sobre a qualidade dos utentes e prestadores de serviço	
	5.1.Atualizar e reproduzir as fichas de recolha de informações sanitárias com as idades	27700

5. Reforçada a capacidade Institucional na monitorização dos Direitos Humanos nos serviços de saúde	desagregadas de acordo com as orientações OMS (10-14; 15-19; 20-24)	
	5.2.Elaborar guião de controlo de qualidade da prestação dos serviços de saúde	
	5.3.Formar equipa da Inspeção Geral de Saúde na utilização do guião	
	5.4.Realizar auditorias organizacionais dos serviços de saúde prestados assim como dos prestadores de saúde a diferentes níveis pela Inspeção Geral de Saúde	
	Total	**145700**

Table 3. Summary of identified barriers:

Policies / Strategies	Accessibility to structures	Accessibility to services	Quality of services	Protection	Management and Coordination
Weakness in oversight of international agreements, policies and strategies	The Health Map of some regions has not yet reached national geographical coverage in terms of Health Structures, taking into account the WHO recommendation on accessibility	Low education level of girls / women	Physical condition of structures and equipment	Absence of defense and protection mechanism of users and health professionals	Poor coordination and synergies
Need to elaborate the National Human Resources Development Plan that takes into account the specific and individual needs of users	Health facilities do not meet conditions / are not adapted (human resources and physical structures) for users with motor, hearing, visual, mental and or communication disabilities.	Inadequate information	Profile of health technicians	Lack of defense and protection mechanism for female adolescents	Unavailability of data sufficiently disaggregated by sex / age in DHIS2
Validation of the National Health Policy	Opening hours of health facilities are not adapted to the needs of adolescents and youth	Prevention strategies not suitable for certain target groups (fishermen, prisoners, farmers, women sellers in the *lumos*)	Information quality	Ineffective performance of the General Health Inspectorate	No data analysis by sanitary area
Need for clarification of policy decisions in the health sector	Transport unavailability (islands: emergency evacuation)	Decision making power of girls and women Some social and professional activities	Non-compliance with National Diagnostic and Treatment Policy recommendations	Lack of mechanisms that promote the responsibility of health professionals	Data deficiency at community level
Cost Recovery Policy vs. bilateral financing agreements that promote the free provision of some disease services and treatments	Transport cost (travel)	Money availability forgirls and women	Stock breaks of tests and some medications	Absence of enforcement of laws and policies that promote the Right to Health	Insufficient resources for regional oversight
		Cultural beliefs and practices related to customs		Organizations and institutions promoting Human Rights focused on the Right to Political Participation	

RECOMMENDATIONS FROM PARTICIPANTS TO ADDRESS BARRIERS TO ACCESS TO INFORMATIONS AND SERVICES:

Proposals and / or solutions was presented by policy-makers, implementers and focus groups to address the identified barriers mainly concerning aspects of human resources governance; improvement of quality of service provision; access to health care and medicines and improving access to information. Some of the participants' recommendations may not be feasible or may be less relevant.

Human Resources Improvement:

- Invest in quality training for health care providers, including technical knowledge as well as human rights and gender
- Update law on placement of public health officials and ensure better management of human resources placements
- Respect the criteria for allocation of health care staff
- Call for competion on technical posts
- Define clear policies for retention and / or allocation of human resources across different health regions and areas
- Implement incentive policies and motivation for health professionals such as the building of accommodation for them
- Apply ethical and professional sanctions for those who violate the professional code of conduct
- Recruit psychologists in health centers to listen to patients before they be seen by doctors
- Recruit interpreters for the hearing and speech impaired

Information Improvement:

- Training on health communication in the Creole language
- Behavior change awareness campaigns, radio health education programs
- Strengthen awareness campaigns mainly in Creole and local languages and in local / mother tongues
- Strengthen specific awareness campaigns for people with disabilities
- Television advertisements accompanied by sign language for the hearing impaired
- Training local youth to raise awareness as activists

Improve access to drugs:

- Improve drugs management by CECOMES
- Strengthen drugs surveillance in health facilities
- Improve drug control and its availability
- Greater and better control of drug expiration date

Improve governance:

- Clarify which services are free or turn all malaria-related services free for the entire population.

- Push health inspection to control drugs sales and health workers behaviors
- Implement full free health services for the entire population,
- Involve NGOs operating on health in the decision making
- Respect Conventions and Treaties on Mobility of Persons with Disabilities
- Reduce consultations prices

Improve the quality of services:

- Build or improve health facilities
- Equip all health facilities
- Improve health infrastructure, including disabled people's access
- More services and treatment rigor taking into account health policy / programme
- Patients follow-up
- Improve ASC subsidy / incentive, ASC capacity building
- Include healers in treatment practices
- Mobile Consultation Brigade for faraway places
- Provide higher quality LLIN, bigger and with softer cloth

Other general recommendations:

- Improvement of roads and structures and conditions of access, transportation
- Better qualified and less corrupt traffic police
- Supply of drinking water
- Promote literacy classes
- Advocate for health in OGE
- Improve coordination / dialogue within the health system
- Ensure electrical energy supply to sanitary structures, hygiene of sanitary structures
- Promote youth employment (Government)
- Community common areas cleanup campaigns

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ANNEXES

TABLE 4. SUMMARY OF MOST AFFECTED AND VULNERABLE POPULATIONS OR GROUPS TO MALARIA

Population or group	**Factors influencing vulnerability**
Children <5 years old of both sexes	- Biologically weaker - They are dependent and poorly cared for - are exposed at night playing in the street - Cultural: seek traditional treatments, healers, and only after health services; - Gender: Women care for them and they depend on decisions made by men.
Pregnant women of all ages	- Biologically weaker - Gender: dependence and submission of women to men; have no decision-making power over their own health - Lack of female service providers demotivates seeking prenatal consultation
Young boys (10-14 years old)	- Are dependent and exposed to carelessness by caregivers - Exposure outside the home: *Djumbai* at night due to heat or watching TV / movie on computer (all except small children) - Cultural rituals like the boys' excision - Sleep on the street due to heat or commuting (farmers, cattle herders) - May not use health services if unaccompanied
Young girls (10-14 years old)	- Are dependent and exposed to carelessness by caregivers - Exposure outside the home: *Djumbai* at night due to heat or watching TV / movie on computer (all except small children)

Population or group	Factors influencing vulnerability
	- Gender: Household tasks such as fetching water from distant locations and at risky times of day, less access to information as they are less in school and have less time to participate in awareness raising activities.
Young girls (15-19 years old)	- Exposure outside the home: *Djumbai* at night due to heat or watching TV / movie on computer (all except small children) - Sleep on the street due to heat or commuting (farmers, cattle herders) - May not use health services unaccompanied - Gender: Household tasks such as fetching water from distant locations and at risky times of day, less access to information as they are less in school and have less time to participate in awareness raising activities.
Young boys (15-19 years old)	-Don't want to use LLIN because they find it uncomfortable or have itching or allergy. - Believe they are not vulnerable to malaria - Exposure outside the home: *Djumbai* at night due to heat or watching TV / movie on computer (all except small children) - Cultural rituals like the boys' excision - Sleep on the street due to heat or commuting (farmers, cattle herders)
Women of childbearing age	- Gender: dependence and submission of women to men; they have no decision-making power over their own health; have less access to information because they are less literate; have less time to take care of own health - Workload: They have household and family income responsibilities for their children's basic needs, including exposure outside the home, street vending at night, etc. - Lack of female service providers demotivates seeking prenatal consultation services

Population or group	Factors influencing vulnerability
	- Cultural: first seek traditional treatments, healers and only then health services
Elderly people	- Biologically weak -Dependency: lack of financial means and need to be accompanied
Inhabitants of remote rural areas	- Distance to health facilities - Road shortages and lack of transportation and their cost - Have less information
Fishermen	-Difficulties in access and use of both prevention and treatment in island camps -Sleep on the street due to heat or commuting (farmers, cattle herders)
Night guards	- Due to their outdoor work, they are exposed without adequate protection
Prisoners	- Due to the use of LLIN for suicide or inability to use due to crowding of detainees in a cell
Persons with disability	- Dependence: poor financial conditions, need to be accompanied - Health Structure unable for people with disability (ramps, handrails) - Stigma and self-stigma - Children with severe disabilities are hidden from people and not taken to health services
PLWHA	- Stigma and self-stigma
LGBTQ	- Stigma and self-stigma - Fear of discrimination by healthcare providers

Population or group	Factors influencing vulnerability
Socioeconomic and housing conditions	- Financial conditions to cover transportation and treatment - Housing near wetlands (rice fields, etc.) - Still water and trash nearby - Direct and indirect health costs
Guinea Conakry immigrants, referred to as *"Nanias"*	- Cultural habits and traditions, refuse interventions and do not seek health services - Women and their children only use the services if husbands authorize
Talibés children	- Are not sufficiently cared for and oriented - Spend the day begging

Note: A major barrier to access to health services in general and malaria in particular that cuts across populations and groups is institutional and governance weaknesses, coupled with insufficient accountability in the implementation of policies, strategies and inefficient legislation and regulation.

DATA SHEET

Título do projeto:	Malaria matchbox
Local do estudo:	Guiné-Bissau, Regiões de SAB, Gabú, Bijagós e Tombali
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