Public Disclosure Authorized

Public Disclosure Authorized

Guinea Bissau: Qualitative Assessment of Demand Side Constraints to Access Maternal and Child Health Services

June 2019

Health Nutrition Population Global Practice

Africa Region

Document of the World Bank

Standard Disclaimer:

This volume is a product of the staff of the International Bank for Reconstruction and Development/ The World Bank. The findings, interpretations, and conclusions expressed in this paper do not necessarily reflect the views of the Executive Directors of The World Bank or the governments they represent. The World Bank does not guarantee the accuracy of the data included in this work. The boundaries, colors, denominations, and other information shown on any map in this work do not imply any judgment on the part of The World Bank concerning the legal status of any territory or the endorsement or acceptance of such boundaries.

Copyright Statement:

The material in this publication is copyrighted. Copying and/or transmitting portions or all of this work without permission may be a violation of applicable law. The International Bank for Reconstruction and Development/ The World Bank encourages dissemination of its work and will normally grant permission to reproduce portions of the work promptly.

For permission to photocopy or reprint any part of this work, please send a request with complete information to the Copyright Clearance Center, Inc., 222 Rosewood Drive, Danvers, MA 01923, USA, telephone 978-750-8400, fax 978-750-4470, http://www.copyright.com/.

All other queries on rights and licenses, including subsidiary rights, should be addressed to the Office of the Publisher, The World Bank, 1818 H Street NW, Washington, DC 20433, USA, fax 202-522-2422, e-mail pubrights@worldbank.org.

Acknowledgments

This report has been prepared by the World Bank Health, Nutrition and Population Global Practice (HNP GP). The report was led by Edson C. Araujo (TTL and Senior Economist, HNP GP). The core team included team included Clara Saraiva (Professor, University of Lisbon, World Bank consultant) and Alejandra Mia Garcia-Meza (Consultant, World Bank). The team received insightful comments and inputs from Christoph Herbst (Senior Health Specialist, GHN05) and Jaime Bayona (senior Health Specialist, GHNGE). The report was cleared by Gaston Sorgho (Practice Manager, GHN13) and Amadou Ba (Resident Representative, AFCF1).

Table of Contents

List of tables

List of figures

ACRONYMS

ANC	Ante-Natal Care
ASC	Agente de saúde comunitária /CHA Community Health Agent
EMI	Entreaide Médicale Internationale
FP	Family Planning
FGC	Feminine Genital Cutting
FGM	Feminine Genital Mutilation
HC	Health Center
HF	Health Facility
HRM	Human Resources Management
IUD	Intrauterine Device
KII	Key Informant Interview
MCH	Maternal and Child Health
MCHS	Maternal and Children Health Services
MDG	Millennium Development Goal
MINSAP	Ministry of Health-Guinea-Bissau
MMR	Maternity Mortality Rate
NMR	Neonatal Mortality Rate
PNC	Post-natal Care
PIMI	Programa Integrado para a Redução da Mortalidade Materno Infantil/ Integrated Program for the Reduction of MCMR.
RH	Reproductive Health
RMNCHS	Reproductive Maternal Newborn and Child Health Services
SBA	Skilled Birth Attendant
TBA	Traditional Birth Attendant
WASH	Water Sanitation and Hygiene
WB	World Bank

A-Executive summary

Objectives

The main objective of this research was to identify the main social and cultural constraints in accessing reproductive, maternal, newborn and child health Services (RMNCHS) in Guinea-Bissau, to effectively improve their access and use by women and children. Additionally, the research also explored aspects related to female genital cutting (FGC or FGM) and girls' access to information on reproductive health.

The demand barriers to improve access and coverage of quality of MCH services were previously listed as: (i) poor technical quality, (ii) poor responsiveness; (iii) high controversial costs; (iv) access/distance to health facilities; (v) use of traditional practices. These intertwine with supply side barriers such as: (i) weakness of training capacity; (ii) shortage of health professionals; (iii) inadequate referral system; (iv) weak supply chain (WB 2017).

Methodology

The research was based on a holistic approach, using qualitative methods, which included focus group discussions, in depth semi-structured interviews with key informants, informal interviews, conversations and participant observation. This approach helps to deal with the complexity of rural areas by emphasizing the complementarity of diverse contributions taken from different angles.

In each village/*tabanka* visited, five different focus-groups were organized: (i) adolescent and young unmarried women with no children; (ii) pregnant women and mothers of children under five; (i) fathers of children under five; (iv) grandmothers/elderly women; (v) Group of Community Health Agents (ASC). Individual interviews were held with key-informants: women having had their child born at a health facility; women identified as particularly vulnerable or with complicated problems; nurses working at the health center (community health nurses or nurses at minor health centers, when they exist); *matronas* (midwives) and *mindjeres garandi* (elderly women); *djambakóss* and other religious specialists.

Field research was carried out October 19th to November 4th 2017, covering eight villages (*tabankas*) in several regions of the country: Oio, Cacheu, Biombo, Gabú and Quinara. The *tabankas* chosen tried to show a balance between the ones with easier access to HC and the ones with very little or no access to HC.

Six major themes were selected to be researched, each subdivided into main sub-themes: (i) **use of health facilities** (ANC and delivery at home/HC, women´s secrets and men's, elderly women and the "kingdom of the health center"); (ii) **access to health facilitie**s (distance, transportation); (iii) **about the health center** (staff competence, payments/gratuities, possible improvements); (iv) **socio-cultural issues** (gender, religious-*matronas, djambakóss, mouros*); (v) **reproductive health and FGM** (family planning, *fanado*); (vi) **from the health staff**: ASCs (being an ASC, access to the health center, relationship with the HC and with the community, socio-cultural issues, reproductive health and FGM); (vii) **from the health staff**: nurses (being a nurse, access

to the health center, relationship with the community, socio-cultural issues, reproductive health and FGM).

In all the themes and subthemes organized the objective was to give voice to all the individuals interviewed either in FGDs or KII, and to carefully listen to actors involved in MNCH. FGDs and KII were recorded and notes were carefully taken. To achieve these goals, individuals from the demand side (pregnant women, mothers of small children, partners of pregnant women and fathers of small children, older women) were interviewed, as well as from the supply side (as ASCs, nurses, TBAs and traditional healers), since the relationship they have with the population is crucial to improve RMNCH

Results

Being able to have children is the major concern of women in Africa, and Guinea-Bissau is no exception. Women take care that they are able to get pregnant and to bear healthy children, as they are a major asset for the organization and strength of the lineage system. Women often hide their pregnancies during their early stages, to prevent curses and envies from others. This partly accounts for a low utilization of ANC in the first trimester of pregnancy. Still, they are aware of the benefits of ANC and of giving birth at the HC.

Nevertheless, the major constraint for women to come to ANC and deliver at the HC is the distance to the HC and the lack of transportation. Women in further away villages prefer to deliver at home with a TBA for "fear of delivering in the bush", on the way to the HC. In some villages women would have to walk 25 or even 30 km, which is impossible when one is pregnant.

Most women trust the staff at the health center, although there are complaints about poor treatment; other issues relate to the lack of transparency on what should be free and what has to be paid for. In all the studied communities, the population showed willingness to help in improving HC conditions, renewing old buildings, but also feel the state (and the Ministry of Health) must act in improving its contributions and services, by proving skilled staff, equipment and medicines.

In terms of socio-cultural issues, women were asked about their relationship with men, knowing that in most ethnic groups women tend to have to obey to men´s orders. The relationship implies not only the men but also other co-wives and the competition amongst them, where giving birth is a major issue. Even if women are willing to space their pregnancies they will avoid being left behind based on the number of children a co-wife may have.

The study assessed the role of the TBAs (*matronas*),as well as the position of other traditional healers, as the *djambakóss* (traditional healer among animist ethnic group), and the *mouro* (traditional diviner and healer among Muslim ethnic groups). All of these still have extremely important roles, particularly in areas where going to the HC is impossible, since they are the ones available in the *tabankas*, which individuals turn to in search of help for their ailments, even more so in the case of a pregnancy.

Young girls (and boys) were asked about reproductive health. They all showed willingness to engage in family planning. Nevertheless girls feel that, in spite of their positive discourse on this, the boys role on this is a minor one, as they will not care to use precautions during sexual intercourse. FGM continues to be a problem in Muslim ethnic

groups, and is a very delicate matter to discuss, as it has been officially forbidden. Women claim no one performs it in their communities, and they do it to their daughters at a younger age than before; younger girls and men are more willing to discuss the matter.

ASCs are the element of liaison with the community, and very important in the functioning of the referral system at the community level. All of the ASCs were extremely proud of their work and duties, and feel that by becoming an ASC they have also become important persons in the community. Conscious of the major problem of distance and access to the HCs, they ask for better work conditions (such as vehicles, but also flashlights, regular payments), which they think will not only improve their performance but will also help in being able to bring more people and especially pregnant women and children to the health centers.

Nurses deal directly with the women at the health centers. Although they may be often perceived as being "on the other side of the barricade", they are well positioned to corroborate the complaints individuals have. Many of these complaints are shared by both the population and the health staff: lack of physical conditions at the HCs, lack of proper equipment and medicines, shortage of skilled personnel, lack of proper training.

As far as the research completed, the demand and supply side barriers in accessing MNCHS previously identified have been confirmed. Some recommendations are suggested in the final part of this report. It is also recommended that this research should be continued in the areas not yet inquired—Bafatá, Tombali and especially the Bijagós regions, especially since the second phase of PIMI (PIMII) is now covering the whole country. It is important to access the results of such nationwide implementation, especially in regions, as the islands, where the difficulties listed were even more problematic, due to geographical isolation.

B-Background, Objectives, Methodology, Field Work Organization and Report Topics

1. Background

Guinea-Bissau is currently one of the countries most dependent upon international aid for the health sector. Health care is provided by the public health system, private operators, NGOs and civil society organizations, religious organizations and traditional medicine. A scenario with a multiplicity of nosological systems, where medical pluralism is the rule. Maternal and Child Health is one of the main concerns, and the one this research is focused on.

Guinea-Bissau has one of the highest maternal mortality rates in the world. According to the last Multi Indicators Cluster Survey (MICS) the maternal mortality rate (MMR) is estimated at 900 maternal deaths per 100,000 live births, one of the highest in the world.[1] The country did not achieve the Millennium Development Goal (MDG) for maternal health, set to lower MMR to 229 per 100,000 live births and is unlikely to achieve the Sustainable Development Goals (SDGs) target for 2030 with the current trend. Progress has been made to reduce child mortality, but both infant mortality rate (IMR) and under-five mortality rate (U5MR) remain among the highest rates in the world, 60 and 89 per 1,000 live births, respectively.[2]

The utilization of obstetric services by expecting mothers in Guinea-Bissau has been persistently low for several years. Only 45% of the deliveries take place in health facilities.[5] A recent assessment by a European Union funded project showed that out of every 100 women having at least one antenatal care visit only 37% delivered their babies in a health facility and only 38% of women had the standard four antenatal consultations.[3] Key contributing factors include: (i) on the supply side, an acute shortage of critical cadres and specialties (such as midwives, surgeons, obstetrician, and gynecologists), weak infrastructure, low availability of surgical services, and medicines. Moreover, obstetric care in most regions is provided by general nurses, most of whom are males; (ii) on the demand side, a set of issues have been pointed out as reasons to not utilize maternal health services, such as high costs (including costs of medicines), under the table payments, the perception of low quality of services, and socio-cultural factors.

Neonatal mortality rate (NMR), 35.8 per 1,000 live births, is higher than the average for West Africa and is strongly associated with birth spacing and birth order, indicating a lack of access to reproductive health services. The rate of NMR is comparable for any of the first six children born to a woman (approximately 36 per 1000 live births), but is 2.5 times higher for children born seventh or later in the birth order. This pattern is also true for birth spacing; children born less than two years after their previous sibling are almost twice as likely to die as if they were born at least three years after their previous sibling. These same patterns hold true for U5MR, currently at 89 per 1000 live births.[5] Only 16% of women aged 15-49 report using any contraceptive method, and the adolescent pregnancy rate is estimated at 28%.Given constraints in the access pointed out above, birth spacing and maternal knowledge seem to be more important factors influencing child health outcomes.

2. Current Status of MCH Services in Guinea-Bissau

The most relevant current initiative is the Programa Integrado para a Redução da Mortalidade Materno Infantil (PIMI). The PIMI project is funded by the European Union and implemented through a joint collaboration with Instituto Marquês de Valle Flor (IMVF), United Nations Children´s Fund (UNICEF) and Entreaide Médicale Internationale (EMI). The program involved also several NGOs, amongst them VIDA

[1] UNICEF, 2015. Multi Indicators Cluster Survey.
[2] World Development Indicators, 2016.
[3] European Union, 2016. Assessment of the *Programa Integrado para a Redução da Mortalidade Materno-Infantil* (PIMI). Bissau, Guinea-Bissau.

(Voluntariado Internacional para o Desenvolvimento em África), responsible for implementing community health programs in several regions. The first phase of PIMI (PIMI I), was implemented from June 2013 to November 2016, targeting the Oio, Farim, Cacheu and Biombo areas. The PIMI I program included the donation of free equipment and medicines and was complemented with the formation and capacity building of both health workers and Community Health Agents (ASCs) by several organizations and NGOs in the field. PIMI has been implemented side by side with other programs, such as H4+ (an initiative of collective leadership and collaborative effort by six agencies within the United Nations system -UNAIDS, UNFPA, UNICEF, UN Women, WHO and the World Bank) and E health.

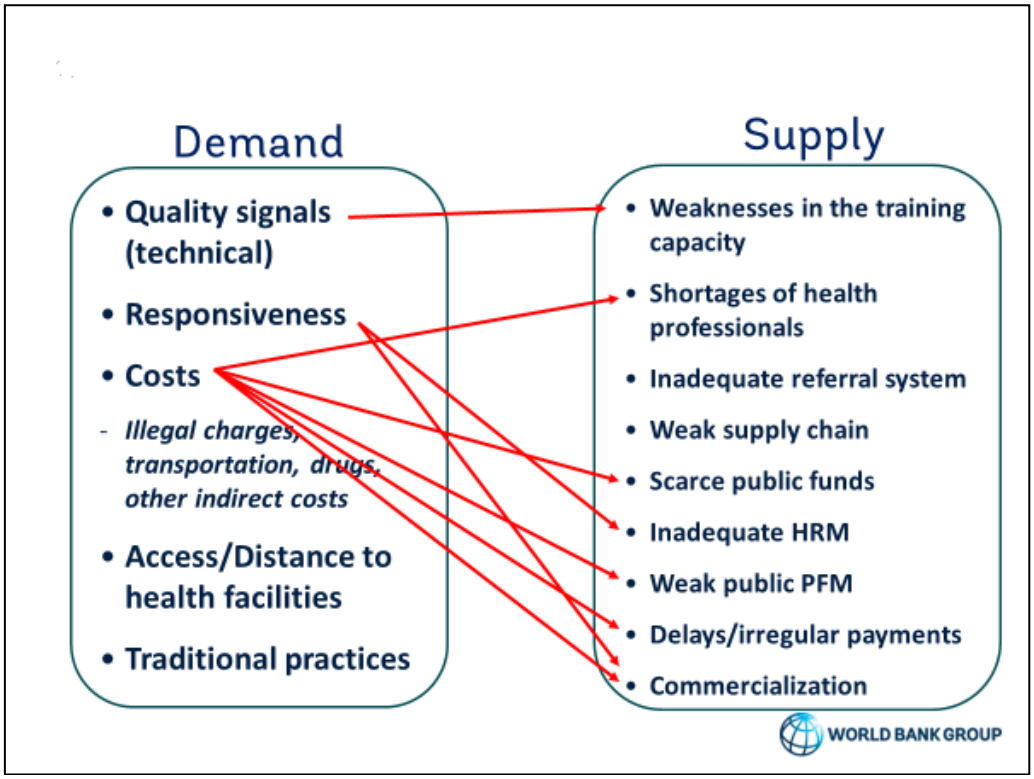
The second phase of PIMI (PIMI II) started in November 2017 and includes collaboration with the Cuban government (Cuban Medical Services). Despite all the improvements achieved by PIMI I, there has been no systematic assessment of its impact on the targeted population. There is some quantitative data available (for instance, the quantity of medicines given within the gratuity program, the number of pregnant women who did attend pre-natal care and gave birth in health facilities), but no follow-up research to measure the effect of such actions amongst the population (particularly women), how they perceive the program, what they feel about the improvements that the program might have brought them.

There is also little evidence on the role of cultural/religious practices on the access to MCH services in Guinea-Bissau. Within this sphere are, among others, gender related issues, issues of elderly hegemony (for instance, older women, *mindjeres garandis* and midwives, *matronas)* over the younger women, worldviews and conceptions of what is and what is not appropriate to do as far as female intimate health troubles are concerned, the use of traditional medicines and traditional practices by renowned traditional healers (*djambakóss*). These can only be assessed through qualitative-based research.
These issues are more prominent in certain areas of Guinea-Bissau. For example, the population in the Cacheu and Biombo areas (the majority being Manjako, Papel and Balanta) are mainly animists, whereas the Oio has a mixed population of Balantas and other ethnic groups (Christians, Animists and Muslims), and the Gabu/Bafatá areas have mainly Fula and Mandinga, who are Muslim. As it was referred to above, some of the identified constraints in having women come to the health centers are not only the accessibility problems, but also issues that relate to male hegemony, lack of independence over cash and economic means, but also many other that have to do with cultural and religious constraints. Many of them relate to the respect and emotional ties women have with other women in the *tabankas*, but also the power *mindjeres grarandis* (the older women) exert over young women. Young women rely on them and on the *matronas* (local midwives) to help them in problems related to their sexual health, pregnancy and delivery. Women value being able to give birth at home, in the *tabanka*, and *matronas* are keepers of secrets not to be made public (as questions regarding Feminine Genital Cutting). Besides these, *curandeiros*, *djambakóss* and *mouros* (and, in the Papel, Manjako and Bijagós regions also *balobeiros*) are also important characters in the *tabankas* everyday life. They are specialists individuals turn to in order to solve health problems, especially if health services and health professionals are not available and reachable. Their work includes magical actions, but reputable *djambakóss* have a wide knowledge of local herbs and plants that heal many ailments. It is very important to assess the impact of the work of such specialists upon MCH and their relationship with MCHS.

More recently (July 2017) the World Bank analytical work has identified key problems in the health systems' challenges, on the demand and supply sides, that compromise the access and coverage of MCH services. The constraints on the demand side include poor technical quality, poor responsiveness, high and controversial costs (illegal charges, transportation, drugs and other indirect costs), difficult access to health facilities and the use of traditional practices. On the supply sides there are problems related to weakness in the training capacity, shortage of health professionals, inadequate referral system, weak supply chain, scarce public funds, inadequate Human Resources Management (HRM), weak public PFM, delays and irregular payments, and commercialization.

The figure below lists demand and supply barriers to improve access and coverage of quality of MCH services:

Figure 1 Demand and Supply barriers to improve access and coverage of quality MCH services in Guinea-Bissau



Source: World Bank, 2017. 3. Objectives

The **main objective** of this research is to identify the main social and cultural constraints in accessing reproductive, maternal, newborn and child health Services (RMNCHS) in Guinea-Bissau, to effectively improve their access and use by women and children. Additionally, the research will also explore some aspects related to female genital cutting (FGC or FGM) and girls' access to information on reproductive health.

The **specific objectives** are:

- to further explore the identified demand-side challenges and supply-side challenges to RMNCHS

- to explore the connections among the several difficulties in RMNCHS and understand which play a stronger role in the different regions/sub-regions
- to research gender related issues, as male hegemony over women (especially over younger women and in Islamized zones, but also in other, as in many ethnic groups it is usual to have several co-wives)
- to research issues of elderly hegemony, which is strong in Guinea-Bissau in all the ethnic groups. Older women, *mindjeres garandis* often rule over the younger ones and the first wife keeps part of her authority over the younger co-wives throughout her life;
- to research the role of midwives, *matronas* and the relation pregnant women keep with them. It is important to note that many of them are also *fanatecas*, and thus responsible for FGM, which is kept secret outside the community.
- to research the roles of midwives, *matronas, mindjeres garandis,* and mother in-laws play in counseling young women in topics related to reproductive health, including the use of traditional and modern methods for contraception, family planning and birth spacing.
- to research the role of Agentes de Saude Comunitária (ASCs) during pregnancy, birth and post-natal care
- to research worldviews and conceptions of what is and what is not appropriate to do as far as female intimate health troubles are concerned
- to research the use of traditional medicines and traditional practices by renowned *djambakóss*.
- to understand the interaction such local healers (*matronas*, *djambakóss*) have (or do not have) with the health services and health professionals.
- to assess the knowledge of midwives, *matronas,* and *mindjeres garandis* about pregnancy risk factors and their relationship to healthcare seeking behavior.
- to assess what individuals (and especially the targeted population, women in reproductive age) feel about projects such as PIMI and other and what they feel needs improvement.
- to come up with possible solutions for improvement in access to MNCH, by finding out what exactly are the weaknesses, beyond the already identified ones, and how they can jointly be accessed and overcome.
- to identify possible incentives (both on the supply and the demand-side) that will help improve RMNCH.

4. Research hypotheses

- women believe pregnancy should not become public too early in the pregnancy, because it may cause envy (from other women, co-wives or other), and because there is always the danger of miscarriage and failure in carrying out the pregnancy.
- women prefer giving birth at home, they trust traditional midwives (*matronas* and *mindjer garandis*) more than they do (more or less) anonymous health workers at the health center.
- giving birth at home also shows bravery

- women trust other women more; in the *tabanka* giving birth is always a female affair; at the health center they may encounter a male nurse/doctor which might make them feel uncomfortable
- gender hegemony: women need men´s authorization to go to the health center
- health workers at health centers are often harsh in the way they treat the women, especially if they did not come for pre-natal consultations (interpersonal quality)
- women who had access and frequented primary (or upper) education are more willing to seek MNCHS
- reproductive health issues are also surrounded by secrecy, and there may be negative views on using contraceptive methods.
- FGM is often a problem related to secrecy in sexual/gendered-related bodily practices and believes*; Matronas* are sometimes also *fanatecas*, the women who perform FGM and who therefore do not wish their activities to become public.

5. Research

5.1. Methodology

The research was based on a holistic approach, using qualitative methods[4], which included focus group discussions, in depth semi-structured interviews with key informants, informal interviews, conversations and participant observation. This approach helps to deal with the complexity of rural areas by emphasizing the complementarity of diverse contributions taken from different angles. Pre-designed questionnaires tend to be insufficiently flexible to handle the complexity and variation observed in local livelihoods and the unintended ambiguities that often arise.

Due to the diversity of factors interfering with the problematic around people's health habits and the relation with their lifestyles, religious believes, social and gender relations, we consider that **Focus Groups Discussions** (FGD) and **participant observation** (interacting with the population in occasions outside the FGD, namely in walks through the *tabanka*) yield better results than a simple sample survey. Additionally, **in-depth interviews with key informants (Key Informants Interviews-KII)** also help to achieve a deeper understanding of constraints individuals feel when trying to assess health services.

Since rural areas have far more problems with accessibility to health services, it is important to conduct field work mainly in rural areas (keeping nevertheless in mind the connections and relationship with urban areas).

Table 1: Research approach, research dimensions and target population

[4] These methods are used in PRA (Participatory Rural Appraisal) and RRA (Rapid Rural Appraisal) approaches. PRA is an approach used in international development which aims to incorporate the knowledge and opinions of rural people in the planning and management of development projects and programs. RRA is a systematic but semi-structured activity out in the field by a multidisciplinary team and is designed to obtain information and to formulate hypotheses about life and problems present in rural areas.

Research approach	Dimensions	Population
Focus Group Discussions (FGD)	- FGD identify the main social and cultural constraints in accessing reproductive, maternal, newborn and children health in Guinea-Bissau	-young and adolescent women, not yet mothers - Pregnant women and mothers of children under five -fathers of children under five -grandmothers/elderly women -groups of ASC
Key Informants Interviews (KII)	-to explore further specific topics raised in the focus groups discussions	-*matronas* -*djambakóss* -nurses at health centers -women having given birth in health facility -women having given birth at home -women identified as particularly vulnerable -specific ASC
Walks-trough and participant observation	-to gather information and understand the general living conditions of the *tabanka*: working conditions, existence of health facilities, of primary schools, sanitary conditions, water and electricity supply	-all the population in the *tabanka*

5.2. Field work research

Data collection took place during a one day research period in a village/*tabanka*. **Focus group discussions** took place in each village/*tabanka* visited. In each of them, **five different focus-groups** were organized:

1) adolescent and young unmarried women with no children
2) pregnant women and mothers of children under five
3) fathers of children under five
4) grandmothers/elderly women
5) group of Community Health Agents (ASC) (in some villages)

Each group consisted of a minimum of four and a maximum of ten persons, to ensure proper interaction. In some *tabankas* it was possible to organize extra smaller FGD, with young boys and *matronas*, in order to cross-check information from other FGD.

Individual interviews were held with key-informants: women having had their child born at a health facility; women identified as particularly vulnerable or with complicated problems; nurses working at the health center (community health nurses or nurses at minor health centers, when they exist); *matronas* (midwives) and *mindjeres garandi* (elderly women); *djambakóss* and other religious specialists. In villages where it was not

possible to conduct FGD with ASC individual interviews were held with at least one ASC.

All the FGD and interviews were recorded and detailed notes taken. Field work was planned in collaboration with the health ministry in Guinea-Bissau (MINSAP), in cooperation with the Regional Health Directors, the health staff at the health centers and with the local NGOs.

5.3. Targeted areas

The field research was carried out October 19th to November 4th 2017, covering sample villages (*tabankas*) in several regions of the country: Oio, Cacheu, Biombo, Gabú and Quinara.

The initial idea was to compare and contrast regions where PIMI seems to have worked very well and access to MCHS was implemented and successful (such as the Cacheu and Biombo areas) with others where the PIMI project faced more difficulties (as in the Oio and Gabú areas) or was not implemented in its first phase (PIMI I) (as the Quinara-Buba areas). In order to collect data in each region two *tabankas* (villages) were selected, one having an HC (or one nearby, up to 5 km away) and one with very difficult access to the health center. This basic idea was followed in the field work, but, since there was not enough time to cover all the *tabankas* in some further away regions (as Gabú and Quinara), it was decided to put a heavier emphasis on villages (*tabankas*) with no health facilities or difficult to access. In the cases where research took place in a village with a health center focus group participants came from different villages served by that HC, some closer and some very distant. Table 2 outlines the targeted areas based on the above criteria and distances to HCs.

Table 2: Targeted areas

Region	Village	HC (in the village or nearby)	HC access conditions
Cacheu	Có	yes, in Có	
Cacheu	Pelundo	yes, in Pelundo	
Cacheu	Jéte	no	ca.12 km away; large river has to be crossed
Biombo	Ondame	yes, Ondame	
Biombo	Dorse	yes, Dorse	
Oio	Encheia	yes, Encheia	
Gabú	Pahamo	no	ca. 23 km away
Quinara	Buba	Yes, Buba	
Quinara	Dutadjara	no	ca. 25 km away

6. Report topics

Keeping in mind that the **main objective** of this research is to identify the main social and cultural constraints in accessing reproductive, maternal, newborn and child health

RMNCH Services in Guinea-Bissau, six major themes were selected, each subdivided into main sub-themes organized following the guidelines of scripts for the FGD (Focus Group Discussions) and KII (Key Informants Interviews) (see Table 4 and Annex 1 and 2).

1.Use of health facilities (ANC and delivery at home/HC)

2.Access to health facilities (distance, transportation)

3.About the health center (staff competence, payments/gratuities, possible improvements)

4.Socio-cultural issues (gender, religious-*matronas, djambakóss, mouros*)

5. Reproductive health and female genital cutting (FGM)

6. From the side of the health staff: ASCs

7. From the side of the health staff: nurses

In all the themes and subthemes organized for this research the objective was to **give voice** to all the individuals interviewed either in FGDs or KII. Keeping in mind that quantitative data gives the overall picture of the weaknesses and strengths of the situation, the objective in this research was to listen to the actors involved in MNCH. Therefore, not only the individuals from the demand side (pregnant women, mothers of small children, partners of pregnant women and fathers of small children, older women) were inquired, but also the ones from the supply side (as ASCs, nurses, TBAs and traditional healers), since the relationship these last ones have with the population is crucial to improve RMNCH.

Table 3 Themes and subthemes

1.Use of health facilities (ANC and delivery at home/HC)
Subthemes
1.1. ANC and delivery at home/HC
1.2. Women´s secrets and men
1.3. Elderly women and the "kingdom of the health center"
2. Access to health facilities (distance, transportation)
Subthemes
2.1. Distance, transportation
2.2. When you have to walk 30 km to reach the HC
3.About the health center (staff competence, payments/gratuities, possible improvements)
Subthemes
3.1. Staff competence and relationship
3.2. Payments/ gratuities
3.3. Possible improvements
4.Socio-cultural issues (gender, religious-*matronas, djambakóss, mouros*)
Subthemes
4.1. Sharing a man with *combossas*
4.2. Matronas
4.3. *Going to the djambakóss*
5. Reproductive health and female genital cutting (FGM)

Subthemes
5.1. Family planning
5.2. *Fanado*
6. From the side of the health staff: ASCs
Subthemes
6.1. Being an ASC
6.2. Access to the health center
6.3. Relationship with the health center and with the community
6. 4. Socio-cultural issues
6. 5. Reproductive health and FGM
7. From the side of the health staff: nurses
Subthemes
7.1. Being a nurse
7.2. Access to the health center
7.3. Relationship with the health center and with the community
7. 4. Socio-cultural issues
7. 5. Reproductive health and FGM

C-Data Report

1.Use of health facilities (ANC and delivery at home/HC)

Subthemes
1.1. ANC and delivery at home/HC
1.2. Women´s secrets and men
1.3. Elderly women and the "kingdom of the health center"

1.1. ANC and delivery at home/HC

Being able to have children is the major concern of women in Africa, and Guinea-Bissau is no exception. As such, all women take care that they are able to get pregnant and to bear healthy children. A healthy woman will spend a large part of her life pregnant, as birth spacing generally coincides with the breastfeeding period (one and a half to two years). Being a mother gives a woman personal pride and fulfillment, but, beyond that, it certifies that she is socially recognized as someone who contributes to the lineage reproduction and therefore to the well-being of the community. Children are indeed a major asset for the organization and strength of the lineage system. Tensions between lineages and within the family are frequent and many of these evolve around women and one of the most valuable assets they produce: children.

Women often hide their pregnancy in the early stages because they fear envy from other women and the evil eye. Even if they let their husbands know that they are pregnant, they only make it public once the belly starts showing and they can no longer hide it. In the same logic, they will not go to the health center in the early pregnancy stages, to prevent it from becoming widely known. This contributes to starting ANC late.

Nevertheless, women acknowledge the advantages of ANC: they know it will help in preventing possible problems, as they often state: "they check your body, your body temperature, your belly and the baby, and give you medicines if needed" (FGD women). The most frequent problems that women mentioned are anemia and feeling weak (which they refer to as "low blood"), malaria, and, towards the end of pregnancy, making sure the baby is in the correct position. Pregnant women in general are conscious that it is important to prevent and treat malaria (as it is a major death cause, also in small children), and they mention that they use the Milda nets during distribution campaigns.

The main factor preventing women from coming early to ANC is accessing the health services. Most *tabankas* do not have HCs, the nearest one is too far away and there is no transportation available:

> We all try to come to the HC, but sometimes it is not possible. I only came when I already had a huge belly, because it was too far to come all the time (…) women should always go to ANC, because at the HC they can accompany the evolution of the baby and give medicines, in cases they are needed. But many times it is just impossible to come (FGD, women, Có).

Although women are aware that they are supposed to attend at least four ANCs, in practice it is hard for them to comply. Many only go one time, very often already in their late pregnancy, to make sure they receive the card that allows them to give birth at the

HC. Since it is mandatory to hold this ID card to use the health services and give birth there, women try to have it, even in only in late pregnancy stages.

Table 4: advantages and disadvantages of ANC

Advantages of ANC	Disadvantages of ANC
-you are followed by SBA from the beginning of your pregnancy on	-it is often hard to make it to the HC for ANC, especially if it is too far
-you are followed by SBA from the beginning of your pregnancy on	-sometimes you walk the long distance to the HC and then the nurse is not there; he/she is away in training or elsewhere
-you are followed by SBA from the beginning of your pregnancy on	-you make your pregnancy public
-health personnel can check if everything is ok with you and the fetus	-there is no privacy: everyone knows and this may cause envy and curses (evil eye) by others
-you receive your card	-sometimes there are no cards available and you feel disappointed as it is a reason why you came
-health personnel will not blame you for not coming to ANC when you come to give birth	-health personnel might still criticize if you did not come to all the required ANC
-it is free of charge	-you have costs to get there; most of the times the HC is far from the *tabanka*

They all stated that the moment they fear the most is **giving birth**, so their efforts go towards trying to be in a HC at that moment. If the HC is too far several strategies can be used. One of them is going to stay with relatives in a *tabanka* that has a HC once the delivery time approaches.

In their discourse all the different groups interviewed agree that **giving birth at the HC** is the best thing to do. The reasons for this are clear and relate to security: all women stated that at the health facility they will be attended to by a skilled technician who can help in case complications come up during labor. They are also conscious that if further problems arise or the staff/HC cannot respond to more complicate cases, being at the HC already helps in being transferred elsewhere, to a regional hospital or to Simão Mendes hospital in the capital. Most complications women have to do with insufficient contractions, a bad positioning of the baby, bleeding or other problems related to the parturient´s state of health.

> I gave birth at home and this is not good. I started bleeding , and the *mindjeres garandis* helped, they gave me a *mézinho di terra* to drink. I always gave birth at home, and I already have 3 children. But I only did it because the HC is too far away and there is no way to get there in time once labor starts (C. FGD, women, Jéte).

Giving birth at the HC also has negative sides: it is often very far and women run the risk of giving birth on the way, which they feel is even more dangerous than staying at home; when transportation to get to the HC is available the costs are high; there are costs at the HC (although PIMI has introduced gratuity it is not clear what is free); the fact that they are attended to by a male nurse; they may be left alone (whereas at home there are always women surrounding you) or be mistreated by the health personnel.

Coming to the health center
Summary FGD women, Có
V. came to the health center to deliver her baby, but there was no midwife and things got complicated. She had to be transferred to Cachungo. It was her 7th child. She has 4 girls and 3 boys. She says she does not want any more children, she wants to use the "sticker for the arm".

When labor starts and there is no time to reach the HC, women **give birth at home**, accompanied by other women and TBAs (*matronas*). They are the ones that are available. In remote *tabankas* they constitute the persons that pregnant women in labor turn to, as L. (Encheia) stated: "I gave birth at home. Labor started and there was no time to come to the HC".

Knowing that they can give birth at home because *matronas* and elderly women are there to help them makes women feel more secure, especially in areas where the HC is very far away. They feel they are amongst women, and giving birth is a "women´s affair", showing bravery, resilience and endurance to face hard moments.

Other problems relate to the desire to adhere to traditional ways of giving birth. Women traditionally walk or move to accelerate the delivery. They do not like to stay still in a bed while waiting for dilation to occur. This relates to the idea that women should remain active throughout pregnancy and that doing this will also help them in delivery. In fact, older women often mention such strategies as contributing to a good and fast delivery:

> When we were young and had our children, when we felt the delivery time was approaching we would always start pestling (*piloar*) , and this hurried delivery. (FGD, Older women, Pahamo).

They also prefer to squat to deliver, instead of lying in a marquise, as they have to at the health center. It is common to use the placenta for traditional ceremonies related to birth. After that the placenta must be buried within the household compound. This is the reason why, even when they deliver at the health center, women always ask for a bag to take the placenta home.

On the issue of having a male or female nurse taking care of them, most women said they would not mind having a male nurse, as long as he is skilled; others very clearly said they mind, and they would prefer not to have a male nurse "intruding in womens´affairs":

> I prefer a woman nurse, I feel embarrassed if it is a male nurse who is attending to the patients. I have always been attended to by a female nurse. In Cachungo once a male nurse came and I refused the consultation.(V. FGD women Có).

Younger girls who have not yet been pregnant are quite assertive when they say that when they get pregnant, they are sure they want to go the health center.

"Our worst fear is the delivery moment"
FGD summary, young girls, Dutadjara
These girls are between the ages of 12 and 18. None of them has children. The two older ones say God (Allah) has not yet given them that. None of them wants to give birth at home. They were very assertive about this, and answered with a straight "No!" to the question of whether they would like to give birth at home. They say the reason is because they think there may be complications, and so they prefer to have their babies at the HC. They feel they will have more support at the HC.A. says that when she gets pregnant she will go to a place closer to the HC, so that she can give birth there. She says women from this *tabanka* do this when they are pregnant and have relatives they can stay with in place where there is a HC. M., who is 13 years old, wants to give birth at the hospital "to have help"; she says there they give you *mézinho* to help you in delivery. Although none of them has ever been pregnant yet, their worst fear about pregnancy is the delivery moment.

Table 5: Advantages and Disadvantages of giving birth at home

Advantages of giving birth at home	Disadvantages of giving birth at home
-when labor comes, one is at home	
-one does not run the risk of giving birth on the way to the HC	
-you are in your home environment, surrounded by your family	
-one is surrounded by other women and giving birth is a women´s affair	-when things go wrong and problems arise there are no SBA
-there is privacy: only women are allowed	
-one can move as one wishes or squat	
-*matronas* will help you; they know what they are doing	-*matronas* cannot handle problems as heavy bleeding
-you have your baby there; the placenta is there, for the traditional ceremonies	-if there are problems with the cutting the umbilical cord they have to take the baby to the HC

Table 6: Advantages and Disadvantages of giving birth at the HC

Advantages of giving birth at the HC	Disadvantages of giving birth at the HC
-the health staff is there to support you	-the HC may be very far and delivery happens on the way there

-if there is a problem they can help you	-if birth occurs on the way there you may be in the middle of the bushes
-you are with SBA	-there is no privacy: other people enter the room where you are delivering
-you are with SBA	-they do not want your family to be there
-you are with SBA	-they may be very unpleasant to you
-you are with SBA	-it may be a male nurse, which makes you feel uncomfortable
-you are with SBA	-sometimes there is no SBA available or he/she is not able to help you and you are sent elsewhere
-giving birth there is free of charge	-it is not certain when it is free and when it is paid or how much you should pay
- it is supposed to be free	-but then you are charged for the sheets or the bed
-you get medicines for free	-it is not certain when it is free and when it is paid or how much you should pay
-they know how to *cortar o bico* (umbilical cord)	-*cortar o bico* is connected to traditional ways which SBA may not care about
-there is no risk of bleeding for the baby after the cut	-they have to ask to take the placenta home
-you are followed after the birth and so there are no risks of infections or bleeding after giving birth	
-you are sure your baby will also be checked to see if everything is fine with him/her	

1.2. Women´s secrets and men

Younger men claim that nowadays when they know that their wife is pregnant they instruct her to come to the health center, which is something their fathers did not do in the older days. Men have an important role in referring women to the health services. It is normally them who either take them themselves (on motorbikes) or call and pay for a taxi or another vehicle to bring them.

They feel their women should deliver in the health center, because if there are birth complications, they are already in the health center. Although they acknowledge that it is nicer for a woman to be attended by a female nurse, they feel it does not matter if it is

a **male or female nurse** taking care of the pregnant women, as long as they are competent: "what is important is that they are well treated".

In fact, their opinions split in two groups: the younger and more educated ones say that they do not mind, as long as the technician is competent. Older and especially older Muslim men state this is not right, and women should be accompanied only by women:

> During delivery only women are allowed to be present. Men cannot be there. It is the *matrona* who *corta o bico* (cuts the umbilical cord) and it is them who take care of these women´s things. Not us, men (FGD, men , Pahamo).

Men state that if delivery starts women have to give birth at home. They say "it is the destiny of God". They also explain that they do not accompany the wife´s pregnancy and they do not know if they are already in their last month of pregnancy. If they know and there is time for that, they can try to take them to the HC.

> N. and O. think it is bad to have a male *nurse* attending the women while in labor. When a woman is in labor all the family comes to the HC to give support. Men come but they cannot enter, only women are allowed. We think a HC cannot work without a female nurse. But it has been a long time since female nurses worked here. There was also a local *matrona* who used to come to this house (the old HC) and work there. It was a woman who had received training from the Ministry of Heath, but she left a long time ago. (FGD men , Jéte)

1.3.Elderly women and the "kingdom of the health center"

Elderly women and *matrona*s in general defend the same idea that giving birth at the HC is safer. They also discussed that giving birth nowadays is not like it used to be. Before women would not come to the health centers to deliver the babies. For most of them, many decades ago, when they had their children, there was no assistance or child vaccination. As they say:

> We are old and we know more. But nowadays "it is the kingdom of the health centers". We help the women giving birth at home. But if it gets complicated we have to bring them to the health center. Even if the birth takes place at home we bring the newborn to the health center to check about *corte di bico* (*matrona*, Encheia).

2. Access to health facilities (distance, transportation)

Subthemes
2.1. Distance, transportation
2.2. when you have to walk 30 km to reach the HC

2.1. Distance, transportation

Going to the health center for ANC and giving birth is valued as a "modern" stance and attitude towards the life people aim to have, but in general, they also know it is the ideal life, difficult to attain for most of them.

In all the *tabankas* the main constraint in seeking the health services were the problems in accessing such services. These concerns can be translated in two words: **roads and vehicles**. All the interviewed were unanimous in that in order to improve the health conditions they need transportation from the *tabankas* to the health centers.

In the regions where research was conducted, there are major differences concerning *tabankas* that have HCs in the *tabanka* or nearby (as in the Biombo region), and regions where the *tabankas* are far from any health center (as the Gabú and the Quinara-Buba regions). Since the number of HCs does not at all correspond to the number of *tabankas*, in most cases there is no HC in the village, and women have to walk. Some *tabankas* are more than 23 or even 25 km away. It takes people over 4 to 5 hours to get here. As a result, women do not come to ANC visits or to give birth.

Improving transportation to the HC
Summary FGD women Encheia
Women emphasized the need for transportation to bring them to the health center. For them, the best improvement they could have would be to have a car that would bring them to the health center. F. lives very far away, she has to cross the river to come to the HC; if there is no one to cross the river she cannot come. She would like it, if ASC had medicines with them to give them as it is very difficult for them to come to the HC.

In the further away *tabankas* people have to use bikes or motorcars, which is complicated when one is pregnant. Even if transportation exists, it is not readily available and it has high costs. Women very often do not have cash to pay for the transportation, and they depend upon men to be able to go to the HC.

> It is the men who provide for the money for women to go to the health center. Often, if women are not feeling well we will take them themselves to the health center with the motorbike. The health center has a motocar, but it is so far away for them to come and fetch the woman. And it not good for a pregnant woman; without an ambulance it is impossible to transport the pregnant women, especially during the rainy season. If women need to go to the hospital, we call for a cab from Gabú. We never call the ambulance; we have no contacts of the hospital, and it is not worth it. With the taxis, we already know them…and they know us (FGD, men, Pahamo).
>
> It is generally the men who give the women money to go to the HC and pay for the consultations. I did not go to consultation yesterday because my man only gave me 500 CFAs, which is not enough. Sometimes men say they do not have money and we have to pay themselves. (FGD, women, Dutadjara).
>
> Our wives gave birth here because the closest HC is too far. If we had a HC here or close by they would give birth there. The long distance to the HC here is a huge problem and prevents women from giving birth there, as they may die on their way there. (FGD, men, Dutadjara)

In cases as Jéte, Cacheu region, this becomes more complicated as one has to cross the river. The *tabanka* is 3 km away from the port. Then one needs to cross the river and, getting to the other side, there are still 9 km to the main road and 10 km to the Pelundo health center. In this island everything is done on foot. There are no cars and no motorbikes. If there is an emergency the ambulance comes to the port of Djita, but they

still have to walk to the island port, cross the river and then travel 10 km to get to the Pelundo HC or 12 km to Cachungo.

Distance and transportation to the HC
Interview summary with women (Encheia)
L. gave birth at home, with the *mindjeres garandis* and *matronas*. Labour started and she could not wait to come to the HC. J. lives in a *tabanka* 6 km away from this HC. It takes over an hour walking to get here, but if you are pregnant or in labor it takes much longer. (…) When they are in pain (as in labor pain) they cannot walk. For most of them who live far away it costs around 800CFA to go to Bissorã or 750 CFA to come to Encheia. Even so, most often there is no *toca-toca* (public transportation). There is only transportation in market days (*lumo*). They are willing to pay for transportation, when they have cash. They sometimes get the cash from the men; if the men do not provide it they have to use their own money, which they get from selling vegetables, fruits (bananas), cashew and fish in Bissorã or Bula.

2.2. When you have to walk 30 km to reach the HC

In the worst cases (Pahamo, Gabú region; Dutadjara, Buba region; Jéte, Cacheu region) the nearest health centers are more than 25 km away. When there are rivers to cross one has to *camba* (cross the river), using small canoes cut out from a tree´s trunk. During the rainy season, it is not possible to cross in the fragile canoes and one has to go around to a point where the river can be crossed, which turns the 25 km to an even longer distance of 35 km or more. In the regions of Gabú and Buba many *tabankas* are more than 20 or 30 km away from the nearest health center:

> The biggest problem here for pregnant women is that most *tabankas* have no HC and no easy access to them. Many of them are 20 or 30 km away from the nearest HC; the roads are bad or inexistent. We only have one ambulance, and the roads are very bad. Djassam and Nhala have no road at all .(Nurse, director, Buba HC)

> We have no health center nearby. All six of us gave birth at home, but the health center only brings advantages (…) When the delivery moment came they called the *matrona*. There are about four in the *tabanka*.There are some women that go closer to the health center when the delivery time approaches, for instance, in the last month of pregnancy. They do this to be close to the health center, so that they are sure they are there went the time comes. They go and live with relatives in the *tabanka* that has an health center.(FGD Women, Pahamo).

Four to five hours walking
FGD summary, Pahamo
In this *tabanka* there is no health center. They go to the one in Candjadude, about 16 km away. If they leave early in the morning (before sunrise) they get there around noon; it takes them about 4/5 hours walking. They try to go to pre-natal consultations, but they do not deliver at the health facilities because there is no transportation. There are motorcars, but these are not adequate for pregnant women. There is not even a public transportation service (*toca-toca*), so they need to know someone in Gabú who

can come and fetch them. Even if they call the hospital in Gabú they do not send an ambulance. The only way to go is with a taxi. They say they never even tried to call the hospital, because they know it is useless. Their husbands also do not contact the ambulance, because it is useless. It should be the men contacting the ambulance, but they do not do it. They only call the taxis.

3. About the health center (staff competence, payments/gratuities, possible improvements)

Subthemes
3.1. Staff competence and relationship
3.2. Payments/ gratuities
3.3. Possible improvements

3.1. Staff competence and relationship

The reason women go to ANC and give birth at the HC is to feel secure that if problems arise they are attended to and eventually transported elsewhere, if their case gets to be too complicated. In order for this to happen, the referral system has to work. The referral system starts with the work of the ASCs, which are supposed to report complicated pregnancies and women who are likely to have birth complications.

The willingness to come to the HC, either to attend ANC or give birth very much depends on the trust and relationship women have with the health staff at the HC. Normally, such relationship is built during the pregnancy period, if women come to ANC, or is already existent, from previous pregnancies and child care, as when the mothers bring their small children to vaccination.

In most of the cases both women and their partners stated they trust the health staff. But in some places there were complaints about women being mistreated and insulted by the health staff. A bad relationship can also result from personal or family conflicts (more common within the *tabanka*, that is, in cases the HC is in the *tabanka* the woman lives in), or start with what are apparently small issues, as when women forget to bring their health card, or one is not given to them.

How small problems become big issues
Interview summary vulnerable woman, Có
E. is 19 years old; it is her first pregnancy. She is in her sixth month of pregnancy. Her boyfriend, who lives with another woman and has children with her, wanted her to do an abortion. She did not accept to be a *combossa* with his other wife either, and left him. She now lives with her mother. She says she started coming to the health center in her fourth month. They took blood samples and sent them to Bissau. She always comes for consultations (ANC), but she is given no card. She thinks she cannot have the normal pregnant consultations and the nurses do not pay attention to her because she has no card. This is the third time she comes here, and "still they do not give me a card". She wants to give birth at the health center, but she does not know if this will be possible due to the fact that she has no card.

3.2. Payments/gratuities

Before women used to pay for the health services. In the last few years, with programs such as PIMI and E saúde most health services for pregnant women and children up to 5 years of age became free, in the regions where such programs were implemented. In many of the health centers visited there were posters in the doors or walls explaining (in kriol), which services pregnant women do not have to pay. Still, many people are illiterate and, even if they can read, many details remain confusing for them. It is most often not clear for the women which services they should pay for and which should be free of charge.

> When C. (a young nurse that used to work there, now doing training at IMV, Bissau) was here consultations and medicines were free. Now, it is very confusing…we do not know what we have to pay for and what should be free (FGD women, Encheia).

The same happens with men. They are aware that pregnant women have free consultations and free medicines, but do not know the exact details. In several health centers women are charged for bed or bed sheets. Although medicines for pregnant women and children are supposed to be available free of charge under the mentioned PIMI and E sáude programs, the health centers often run out of them. They also have to pay if there are not medicines available at the health center and they have to buy them in the pharmacy.

Besides that, there is no consistency across health centers. In some people pay, in others they do not. Some health center will charge for the bed or the sheets, knowing that giving birth is supposed to be free of charge.

What are we paying for?
Interview summary, woman, Có
Here, I normally pay 4000/5000 CFA for the bed, depending on the days. I do not care if I am attended to by a male or a female nurse, as long as it is a skilled technician. Often the health personnel despise the patients (women and children) because they think people should pay, otherwise they do not attend to them. But I do not know which services we are entitled to have for free.

In regions where there are several health centers, as in Biombo, it is interesting to note that women are willing to pay to have better services. For instance, in Ondame there are three health centers: the state one, the Catholic church one, and the protestant church one. It is a good example to show that if the conditions are there (accessibility, good conditions at the health center) women will go to the health services and will pay for the services.

> I prefer the private church HC, since they have plenty of maternity rooms, and I pay 2000 CFA for a bed. The medicines cost around 1750/2000 CFA, in a normal situation (that is, without complications). The public one is for free, but the church one is much cleaner and nicer. It is organized, and one feels really taken care of over there (FGD women, Ondame).

3.3. Possible improvements

Besides the basic and most relevant problems of **accessing** the health center (distance, bad roads and no vehicles), there are other issues that people refer to and that they think could improve the quality of health services:

- Infrastructural improvements:
    - Buildings are in poor shape and most health centers have very small space; they have no room for women to be interned and stay there if there are complications and it is dangerous for her to return home.
    - Water and electricity (many health centers have no running water; some still have no electricity, although many of them received solar panels within the last two years)
    - Scarcity of basic equipment (i.e. reanimation kits for newborns)
- Medicine availability
- Clarity on costs. Some HCs will charge for the bed or the sheets; others will charge for the consultation; others do not charge at all.
- Shortage of health professionals. People complain that some technicians that were at the HC before went away to Bissau or elsewhere to do training or training supervision and never came back: "health staff should be augmented and never diminished, which often happens" (FGD women, Có).
- Recycling training, further capacitation for health professionals in order to improve their professional knowledge, skills and performance. This would make women feel more at ease, as they would feel they are in the hands of SBA (skilled birth attendants)

On the community side, men stated that the community should raise awareness of the importance of coming to the health center; they also emphasize the importance of improving hygiene conditions and constructing toilets and other basic equipment. In most of the *tabankas* the men said they (the community) would help with the labor force if someone provides building materials (in the cases the HC does not exist) or repair the buildings, the equipment and the health staff. Such is the case of Jéte, the *tabanka* in an island in the Cacheu region, referred to above, where the majority of the population is Balanta.

In this *tabanka* there was a "Unidade de saúde base", from the *tuga* time (Portuguese colonial period), which was deactivated. They say a nurse was there until later on, but she was very mean to the women; she would not help them with delivery, she was cruel and disagreeable, etc. The building is now falling apart and nurse W. uses it to implement children vaccination and check on the pregnant women.

The nurse normally comes once a month, sometimes every 3 months, especially during the rainy season. He is now alone, since his colleague went to Bissau to do training and he does not always have the time to come here. The people in the community repeated several times how much they would like to have a health center in the *tabanka*. Since the walls and ceiling of the old building are still standing, they say they can contribute with material and local labor to reconstruct it. There is a women´s and men´s

association in the island, so they claim they could organize themselves in order to achieve this.

Table 7: complaints and improvement suggestions

Complaints (women and men)	Possible improvements
Degraded buildings, falling apart	Renew building with community help
Not enough space; women cannot stay when they have problems during pregnancy and are sent home	Enlarge the health facilities
No running water	Repair pipes or install them
No electricity	Repair solar panels or install them
Lack of equipment	Receive more equipment
Lack of laboratory for clinical tests	Receive laboratory
Lack of medicines	Receive more medicines
Not clear what one has to pay	posters with itemized prices; radio announcements
Need for more staff	More staff; skilled technicians, midwives
Need for staff recycling training	Further and periodical training of health staff
Need for vehicles (ambulance) directly attached to the HC	Receive vehicles

4.Socio-cultural issues (gender, religious, *matronas, djambakóss, mouros*)

Subthemes
4.1. Sharing a man with *combossas*
4.2. *Matronas*
4.3. *Going to the djambakóss*

4.1.Sharing a man with *combossas*

Becoming pregnant is a main goal for any woman in Guinea-Bissau. Conscious of infant and children high mortality rate, they want to have several children. They also want to make sure they have daughters, as they are traditionally known to take care of their elderly parents much more than boys. Not to be able to have children is a cause for distress and pain.

Womens infertility
Summary FGD Pahamo
S. is 23 years old and never gave birth. She says they call her S. which means trash, but her real name is M. (She says this smiling, even laughing, but it is obvious she is in pain). She is the only child, her mother had successive abortions. When she was born "she was named S. so that no one could care about her" (meaning, to avoid envy…). She already went to the *mouro* and he promised she will become pregnant. He gave her a pot with koranic writings with water for her to bath in. But he never gave her *mézinho*. *Matronas* never gave her anything either. Neither the *mouro* nor

the *matronas* ever sent her to the health center because they thought they could not heal her.

A woman who cannot get pregnant, has successive abortions or is not capable of carrying her pregnancies to term is stigmatized and ostracized by the other women, and especially by men. The same may happen if a woman uses contraceptive methods to avoid pregnancy or tries to space the pregnancies.

Going to the HC with the mother-in-law
Summary FGD, women, Dutadjara
L. says she wants to stop having children, as she already has 6. She is wondering what she can do, and says she wants to go to the HC to use contraception and have no more children. She says she can choose to tell her man or keep it to herself. Some of them manage to space their pregnancies. A. has one 4 year old child and only now she is once again pregnant. She wants to have a total of 4 or 5 children. She tells that for four years she would not get pregnant and her husband accused her of having IUD or something else to prevent pregnancy. He sent his own mother with her to the HC to make sure she had not done it.

All women (no matter which ethnic group they belong to) would prefer not to have a co-wife (*combossa*), but they know that if they do not beget children they will be overtaken by the *combossa*, and that means they will lose the husband´s attention, as "men always prefer the newest wives".

When men get another co-wife (*combossa*), most of the times the old one will be put aside. Since men´s evaluation of the woman´s role as far as creating a family is vital, it is also to their husbands (or the father of the child) that women first tell about their pregnancy.

Most men want *combossas*. The usual in most ethnic groups is for a man to have two to three wives, depending on his social and economic status. The men also inherit their brother´s wives, in case he dies. For instance, in one of the villages the chief had three wives, two died, but then he inherited two from his deceased brother.

> If we do not want children the man can decide to get a second wife. I have a *combossa*, who has 7 children. God will dictate what happens to me and my *combossa*. But if I do not want more children he will find another woman who wants to have them, (M, FGD women, Dutadjara)

Elderly women emphasized that livelihoods were different when they were young. Women used to become pregnant when they were 20 or older. The proximity between the two sexes was not as easy and marriages were normally arranged for by the families. Even after the marriage there was the tradition of women "making it hard" for men to sleep in the same bed with them. As a result, they feel women would start their sexual life later than nowadays. Still, they also state nowadays younger women have a lot more autonomy, as they often do not obey to men.

4.2. *Matronas*

In many cases women are followed throughout their pregnancy by TBAs (*matrona*s), especially when the delivery time approaches. They are known to help in many ways. They can help in turning the baby, if they feel the baby is in a bad birth position; they help in accelerating birth ("There are *matronas* that have a "hot hand", they pass their hand over the woman´s belly and she gives birth, almost without noticing…"); and they can also help by giving other traditional medicines. Most often women go to them during pregnancy; some go just when labor starts: "there are women who come for *mézinhos* during pregnancy, and others just for the delivery moment" (*matrona*, Pahamo). In any case, they are respected as individuals who are connoisseurs of the secrets of traditional medicine.

> All the women that delivered with my help, I cut the *bico* (umbilical cord) at home and then later on bring the mother and the child to the health center to be vaccinated. (…) There are *doenças di terra* and *doenças di hospital*. Yellow fever is *di terra*, and can be healed with traditional medicines. There are problems during pregnancy that we can handle, as lowering the woman´s body temperature. If such problems are not attended to they can become big problems during the delivery process. Sometimes pregnant women accumulate liquids inside their bellies; in such cases we give *mézinho* so that the liquid diminishes and the woman can give birth. If we cannot help we instruct the woman to go to the health center. (S. FGDs older women Có)

Another positive aspect of using the *matronas* services is that women feel they are free of charge; even if they decide to give them a retribution for their work (in cash or in goods), they do not feel pressured to do so, so they feel it is, in a symbolic sense, free.

> When we use the services of the *matrona* there is no fixed fee, we pay what and how we want. The *matrona* takes care of the pregnant women from the beginning to the end of pregnancy. They provide mainly traditional medicines, made out of plants. They have medicines for the pregnancy period and also for the delivery moment.

Being a *matrona*
Interview summary *matrona*, Tor
H. is a *matrona*, she is 48 years old, and she learned everything from her stepmother. Here, in Biombo, there are several HC. Nevertheless, women also come to her to give birth. She is from Bissa, but came to Tor to inherit. There are people that come all the way from Bisa to consult her. She has helped many women give birth. She started doing this when she was still a *badjuda*. She received training in Quinhamel before they had ASCs. The community chose her to come for the training. She only accepts normal deliveries; if she sees there are problems she sends the woman to the HC. No one ever died at her hands. For her, although she thinks it is better to give birth at the health center, there are also advantages of giving birth at home. If the pregnant woman comes to her already in labor she stays with her; otherwise, she sends her to the HC. She thinks the HC is better because if birth occurs at home and the woman starts bleeding there is nothing she can do, and at the hospital they can. She uses the traditional medicine. If the woman is bleeding she uses lemon, water and salt and gives to the woman to drink. If there is no *mofunesa* (curse) the bleeding stops. If the bleeding is very bad, with the help of the ASCs she sends the woman to the hospital. Dorse has an ambulance, and so does Quinhamel. The same happens when the

delivery gets complicated. She thinks ASCs really help. Before, people would not even consider coming to the HC. Now, with ASCs, they come to the HC.

Older women who have been *matronas* all their lives understand things have to change and women should go to the health centers, because it is safer for them. Still, they recognize their work as important to the community and that their knowledge should be passed on to the new generations.

The *tugas* time: the old and the new ways
Interview summary, *matrona*, Jéte
R. is a *mindjer garandi*, previously a *matrona*. She is over 80 years old, and she says she already helped women to deliver in the *tugas* time, and even before. But in that (*tugas*) time if things got complicated an helicopter would come. There were military barracks here and a car *(indemoco)* that crossed the river in the low tide. The military were here because this was a strategic point to attack Cachungo and Biombo.There was also radio, for communications. When asked if she thinks it was worse or better in the *tugas* time, she thinks it is better now, because there are cars. The helicopter would only come if it was available. So, now it is a bit better. She had 2 children, but one died. She is F. grandmother (*dona*).She thinks it is better if women give birth at the HC. She used to help women, and she was not paid for that. She no longer assists in childbirth, she says she is too old and no longer has strength. She also thinks women should be trained to assist others in delivery. She never trained anyone but has taught some things to her grand-daughter F. F. confirms she has already done it. She was not paid for that, but she thinks one should pay, as they also pay in the hospital. She herself had two deliveries in Bissau. When she saw delivery time was approaching she went to Bissau and waited there for the birth moment. For her second child she went to Bula, because her husband has a house in Bula.

4.3. Going to the *djambakóss*

Since HC and medical services in general are not easily reachable, women turn to traditional medicine to try to solve their maternity problems, as well as other health issues. In this case, and besides the *matronas*, the main agents are the *djambakóss.* For the ethnic groups that follow the traditional animist religions the *djambakóss* is an important person, and the one people first turn to when they have health problems. For Muslims, the *mouro* has approximately the same role. *Matronas* (TBAs) exist in all the regions and *tabankas*.

The *djambakóss* can help with contraception or infertility ("they put a cord around the woman´s belly, in different ways") or, also in cases of infertility, by giving them traditional medicine (*mézinho*) to become pregnant. This is made out of plant roots and leaves, and can either be drunk or used to be bathed in.

One of the advantages of going to the traditional healers is that women do not pay the higher costs of the health center. The payment is low compared to the HC (for instance, 100 CFA compared to 2000 CFA at the HC). Many times they do not receive money but in kind donations, with goods that people have in their households, such as *cana*, chicken, goats.

Going to the *djambakóss*

Summary FGD women Có
U. spent over 200.000 CFA to become pregnant. She consulted a *djambakóss* Macanha, and was able to become pregnant. He gave her traditional medicine, some roots from a plant, to be boiled in water. Although she is a Muslim, she says *mouros* are not good to solve such problems. During her pregnancy she continued to go to the *djambakóss* to control her body temperature (he always gave her more *mézinhos*). The *mézinho* was drunk by her and her husband. Nevertheless, she also came to the health center for regular consultations. She paid for *torna-boka* when her daughter was born. Her daughter is two years old, and in the meanwhile she has not returned to the *djambakóss* to become pregnant again. For her, the main problem in the health center is that there is not a proper midwife to attend to the pregnant women, especially in delivery. N. also went to a *djmbakóss*, Manjako, and also solved the problem. She used to abort each time she would become pregnant. He touched her belly, took some blood, and gave her a *mézinho* made from plant roots. Nowadays she has 6 children.

The *djambakóss* can also help women during pregnancy:

> When you go to a *djmbakóss*, he/she will explain to the pregnant woman what is going on with her and her child; for instance, he might feel she has a stone inside her belly, and will free the woman of such ailment just by touching the woman´s belly…(FGD women, Encheia).

The older women stress the differences between the time when they were young and now:

> Before, women used to go to the *djambakóss*; he/she would touch their belly and tell them if the child was in a good position, or if the woman and/or child had been cursed by conflicts within the family, etc. Even if a child was crying one would go to the *djambakóss*. Now, pregnant women are abandoning the *djambakóss* and preferring to come to the HC. (FGD, older women, Encheia)

> When we were young people would just go to the *djambakóss*. If a woman could not get pregnant he would give her some medicine. Even nowadays the *djambakóss* can turn a baby inside the mothers belly if the baby is in a bad position. The medicine they give is basically made out of plants roots. But now people should also go to the HCs. *Matronas* and *djambakóss* can only give *mézinho*, they cannot do clinical analysis or ultra-sounds, that can only be done at a HC. My daughters are all in Bissau so and they go to the health centers or to the hospital in Bissau (V. FGD older women, Có)

People go to both, and use the services of traditional healers in combination with the medical services at the health centers. Health staff often complains that women first go to the *djambakóss* to try to solve problems in pregnancy or children´s health, and they end up coming to the health services too late to be able to be treated. Following the same logic, if they come to the health services and are treated and cured, they will say it was the *djambakóss*, as they also (and frequently first) went there:

> A woman did fertility treatment here, but nevertheless thinks it was the *djambakóss* who made her become pregnant. She had a lot of vaginal infections before she got pregnant, and was treated for that here at the health center (…) Ethnic groups such as Mancanha and Manjako love the *djambakóss*. For instance, a few weeks ago we had the case of a child who had malaria and that we treated…but people believe it was the *djambakóss* who healed the child.

> Only now people start giving value to medical treatment. In Cassisse, last year, a child died, because they did not bring her to the HC. Before yesterday another child came and we treated her and she is fine now (nurses, Có).

Djambakóss, just like *matronas*, state the difference between *doenças di terra* and *doenças di hospital*. They feel they are able to treat the first ones, but not the *doenças di hospital*, which must be handled at the health facilities. Problems such as the ones due to curses or the evil eye must be treated by the *djambakóss*. Serious health problems that may occur during pregnancy or in delivery are for them clearly *doenças di hospital*, and must be handled there. They also often state their willingness to work together with the health services and the health personnel.

Doenças di terra and *doenças di hospital*
Interview summary, *djambakóss*, Jéte
M. says that when there is a situation of affliction it happens that the *djambakóss* comes, and it is ok, it is a situation of affliction. Although it is a woman´s thing, and they should indeed help each other, if a woman feels she has the "evil eye" she goes to the *djambakóss*. Otherwise, for other things they can go to the HC. The *djambakóss* can help in putting the baby in the right position, but it is his wife who helps in delivery. When a woman comes to him with a lot of problems and he sees he cannot help he can send her to the HC. There was a woman he sent there (she went to Cachungo), but it was a still-born. As soon as he arrived to her place he immediately saw he could not help her. It has happened other times that he sees he cannot treat the problem and sends the women straight to the health center.

5. Reproductive health and female genital cutting (FGM)

Subthemes
5.1. Family planning
2.2. *Fanado*

5.1. Family planning

The focus groups where the issues of reproductive health and contraception were more widely and openly discussed were the young women´s FGD, between the age of 12 and 18 years of age. Most of them have heard about contraceptive methods, from their teachers in school. Most of them never came to the health center to talk about this or ask for contraceptives, except the older girls (over 16 years of age). They also believe girls should only go to the HC to seek contraceptive methods when they become 18. Most of them say they will choose a contraceptive method, when time comes: either Jadelle, Intrauterine Device (IUD) or Depo-provera (and intramuscular injection).

They also are aware that family planning has both advantages and disadvantages and that "family planning" can also be to help women getting pregnant. This was not

touched upon in the family planning sessions they attended though projects that came and talked to them about such issues.

> I know Ginera (a contraceptive method) is good for women who have children; the ones that never had children will not want to take it, as they want to become pregnant. I think family planning is not good for women who never had children or have successive abortions, because we all want to have children.(C. FGD young women, Ondame).

> I think contraception is both a female and a male subject. I do talk to my boyfriend about this, but the fact is that the boys do not want to use condoms. Sometimes we are able to convince our boyfriends to use it, other times no. I think women know more about contraception than men. They are more careless as they do not get pregnant. Often they have several girlfriends and transmit STD. (M. FGD, Young girls, Ondame)

Contraception is an issue that shows inequality between men and women. All the men interviewed, regardless of age, state that contraception is an affair that must be handled by both men and women, together. Nevertheless, focus group discussions with young girls showed that the concern is mainly a female one, as boys are often careless, even if theoretically they feel the responsibility should be shared between men and women.

Women who already have children tend to want to have more, although they sometimes attend sessions on family planning. There are also regional differences. From the information gathered from the population and the health staff, Biombo, for instance, is a region where (Papel) women do use some contraception. In mostly Muslim areas family planning is almost inexistent, as people think that they have to follow "Allah´s wishes".

Men with a higher education level and who are better off economically seem to reflect more on issues of contraception and birth spacing.

> In the old days women were given in marriage to a man and they had to accept all the men wanted. Nowadays it is different. Family planning concerns both men and women. The *namoro* (courtship) is a phase to prepare for marriage. In this sense, such things should be discussed during this period. Just getting along well is not enough for a good marriage.(FGD men Có).

Their discourse also reflects the constant tension between the consciousness that one should engage in family planning to be "modern", and the traditional values that make women have children without spacing the births. They point out two main reasons for this: the value of having children to help in the household work and to be a company for when you are older; and the ambition that young women have to have an officially committed relationship with a man, once they think he is "a good catch". Becoming pregnant is a way to make sure the man will not be able to leave the relationship entirely.

> In my opinion, having more or less children does depend on education and on the social and economic level. People want more children so that they can work on the fields, in agriculture. Having children is not a solution; you need a job, to have children in a responsible way. If my son is sick I cannot ask my father for help. It should be me in charge (F. FGD, men, Có)

> Things have to be planned together. Often women cheat: they take money from us to have DIU and then they do not do it, because they want to cheat on men and get pregnant. It is important to have a house, work and money before marrying and having children, but the *badjudas* often do not care about this. They go after a man who looks

> good and seems to have a good social position. I only decided to have a family after he got a job. (R. FGD men, Có)

Birth spacing
Summary FGD men Encheia
The birth of subsequent children, without birth spacing is bad; one of the bad things is that later on there is not enough economical means to provide education to all their offspring. They state that they agree with the use of contraceptives, but the fact is that women always want to have many children. They all state that they only have one wife and do not desire a second one, but traditionally it is not like that, and their fathers all had at least two wives.

Young boys interviewed think reproductive health must be a joint responsibility, both by boys and girls. Their opinion is in exact contrast with the opinion of the older men, who think they alone should control women's fertility. Their stance has to do not only with age differences, but also with religious reasons, as we can see in the different excerpts from interviews with younger men in Biombo (where the majority follows traditional animist religions) and with older men in the Buba region (in a *tabanka* where the majority is Mandinga or Beafada and Muslim).

> In school we were taught to prevent STD by using condoms. Sexual intercourse must take place using protection (condom). I always use it and talk with the other boys about this. Some men take interest in that, other times it is more the women. Sometimes the boys want to use condoms and the girls do not care, and vice-versa., but it only works with the efforts of both.(M. FGD young men, Ondame)

> If women are oriented to prevent further pregnancies at the HC or elsewhere, they must inform the husband. Even if they want or have to act according to the recommendations of the HC for medical reasons, they must tell their husbands (FGD men, Dutajara).

Older women are conscious that things have changed, and that nowadays women are more free to plan their pregnancies. But regional and religious differences can also be observed here, with a much more conservative position in regions where Islam predominates (as in the Gabú and Buba areas).

> In the old days, women had no access to contraception methods; anyway, they were not worried about that, all they wanted was to have children. If a woman could not get pregnant she would try anything, go everywhere to solve the problem. Nowadays, there are women who never get pregnant because they use contraceptive methods. Young women nowadays decide whether they want to have children (or not). (FGD Older women, Pahamo)

Life that God has given humans cannot take away
FGD summary older women, Dutadjara
These women are all over 70 years old, *mindjeres garandis.* They say they work for women to get pregnant. According to their religion (Islam) one cannot use abortive products. If women want to abort they tell them to go to the HC: "life that God gave

humans cannot take away.”They do not agree that young women use contraceptive methods. They think people, and women especially, have to grow old accompanied, with children around. Being old is difficult, and ones need the younger ones. They would not like to be alone.

5.2. *Fanado*

Most ethnic groups in Guinea-Bissau have initiation ceremonies named in kriol *fanado*. But *fanado´*s ceremonies can include or exclude body mutilation. It is more common for male *fanado* to include male circumcision. In most groups female *fanado* does not imply body cutting, but in the Muslim groups it normally involves some type of feminine genital cutting (FGC). This was widely and openly practiced up to some decades ago. Since it became forbidden by the state the prohibition is widely advertised through the public radio, and people became aware that they can have problems if they admit to doing it to their children or grandchildren.

As a result, it has become a taboo subject, very hard to discuss with people. Almost everyone states that they do not do it, and describe it as a “thing of the past”. The facts are that FGC (or FGM) is still widely practiced, but now in girls at a very early age, just a few years old. In the same line of reasoning everyone says there are no longer *fanatecas* in the *tabankas*: they say they all have died or moved away. Nevertheless, it was possible to discuss this issue in several of the focus groups, especially with the younger women.

Fanado
Interview summary, woman, Có
U. is a Muslim woman, 28 years old, and she had *fanado* when she was eight years old. She was stitched and then later on unstitched for her marriage. She says she has a “open uterus” (???) , but she does not know if *fanado* was the reason for that. She does not want her daughter (who is now 2 years old) to be submitted to *fanado*. If her husband makes her do it, it will be his solely responsibility. She comments that she is Fula and Fula men have a lot of authority on such matters (“men have a lot of *força*”-strength).

Most of the young girls in Pahamo (Gabú), between ages 12 and 15, said they went through *fanado*, but they were very young, and therefore they do not remember. A wide discussion arose between the ones that defended their future daughters should also have FGC and the others who were against it. The ones in favor stated that it is a tradition and it should be respected.

Women in the Pahamo FGD (all Mandinga, all Muslims) said their mothers underwent *fanado*, but they themselves and their daughters no longer do it. They mentioned that everyone knows that it is forbidden now, they hear it on the radio, and their husbands know about this as well.

Pro and against Female *fanado*
FGD summary men, Pahamo
Discussion arose in the men FGD on the advantages and disadvantages of *fanado*. Three of them want their daughters to undergo *fanado*. They state “it is a tradition,

the elderly always did it and we have to do the same". M states all his daughters did it, just as the men also have masculine *fanado*. They have heard in the radio about the problems due to *fanado*, but they do not agree with what is said in the radio. M and A are against *fanado*. A says he learned about the bad consequences of *fanado* through the action of Torstan (NGO); he participated in an awareness campaign. M (the one who worked in Cape Verde and is therefore called "the capeverdian") says he thinks FMG diminishes the female capacities, and there should only be male *fanado*. A says people have to gather and reflect upon what is negative for health. Individuals have to take responsibility in what they do and it is necessary to raise public awareness. He thinks more radio programs are necessary in order to do this.

6. From the side of the health staff: ASCs

Subthemes
6.1. Being an ASC
6.2. Access to the health center
6.3. Relationship with the health center and with the community
6. 4. Socio-cultural issues
6. 5. Reproductive health and FGM

6.1. Being an ASC

The health system in Guinea-Bissau is organized according to three levels (central, regional, local). The local level includes the health centers serving the different sanitary regions and *tabankas*. The health centers serve many *tabankas* and although the system of advanced strategy[5] does exist, to assist *tabankas* further away than 5 km, it is impossible for the nurses to cover the whole population. The ASCs are the link to the community and act as key elements in the referral system at the local level.

All of the ASCs were extremely proud of their work and duties, and feel that by becoming an ASC they have also become important persons in the community: "in the beginning people would not talk a lot with us, but things have changed". As such, they want to make sure their work has visibility; asking for t-shirts and badges that identify them as such. Besides the fact that such identification items assure them an easy and priority service in any health center or hospital, the main reason relates to the symbolic value attached to their role and the pride they feel, directly related to the social/community recognition:

> In this type of work, we have no schedules. We may have to get up in the middle of the night to attend to someone who needs us. If the health center had an ambulance available, we could call when needed and the ambulance would come for the sick person. (ASCs FGD, Encheia)

[5] Advanced Strategy (*estratégia avançada*) refers to the temporary displacement of a team from a HC to assist a *tabanka* far from the health center, where it is difficult for people to come. The health personnel may come for just one day or several days, bringing medicines and equipment.

Their work is based on direct contact with the population and referring sick people to the health center. Most of the ASC feel that their job is mainly to inform the population, raise awareness and mobilize the population to come to the health center:

> I became an ASC to support and help the HC, so that health services reach all the children (and other people), in order to reduce child mortality. Before there were ASC there was a high level of mother and child mortality; we work to raise awareness in the community so that they come to the HC. Because we live in the communities we are able to do this. (S. ASCs FGD, Dorse)

> Before there were higher mother and child mortality rates. There were a lot of financial problems, people had no money, which was bad. It was hard to make people come to the HC, we had to talk to them four or five times about this before they came. In the last few years PIMI helped a lot, especially those who had no money to pay for consultations, because it became free of charge for pregnant women and small children. I am always trying to convince people to come to the HC; people often lie, they say they will come (or came) but they do not.(J. ASCs FGD, Dorse)

They are also entitled to give people some medicines: paracetamol, salts, medicines for diarrhea, betadine. This sometimes creates some problems, as people start asking for medicines all the time and do not understand that they can only give them and administer very simple medicines.

> We need to have more medicines, there are not enough, there are always people asking for medicines. If they do not have them to give to them they get very upset and a bad climate is created, which cannot be, since our work is based on a good human relationship with the people. ASCs get medicines from the health center and NGO Vida. We have not received any medicines for the past 8 month, so we have to tell people we do not have them. (S. ASCs FGD, Dorse).

This corroborates what the population feels, when they complain that ASCs should be able to give out more medicines, due to the distance that many *tabankas* have to the health center and pharmacies. This would also prevent people from buying fake or out of date medicines from Djilas in street markets.

> We think that the ASCs should be able to provide and administer a wider range of medicines, since many *tabankas* are too far away from the health center for people to come there just to receive proper medication. If there was transportation that could be done, that is, even if ASC does not know which medicines to administer, people could come to the HC to seek proper care. (FGD women Encheia).

Just as with the nurses, the ASCs worst nightmare is that people die while they are trying to take care of them and solve their problems. Some cases were reported, both by the population interviewed and the health personnel, as, when they happen, such cases stay in the people´s memories for a long time.

When the referral system fails
Interview ASC Pahamo
A. has been an ASC for 11 years. He can only recall the death of the pregnant woman about 7 months ago. He saw that things were getting complicated and he sent her to

the health center. Unfortunately when she got there there were no nurses, they were all away in training. The health center was full and she stayed with relatives. The relatives went to the health center to report on the pregnant relative. The ASC went to the house and saw how bad the woman was, so he asked for the nurse to go there, but he/she never went. The woman died in the home of her relatives. A. says he will never again refer someone to the health center, it is better to send them straight to the hospital in Gabú. In their training the ASC are told they should always refer the cases to the health center, but it does not work. The health center is too far away anyway and does not work. If a woman is having problems he calls the hospital in Gabú directly, identifying the problem and asking for an ambulance to come. He thinks he will have no problems doing this because everyone and all the colleagues ASCs saw what happened, that in the health center they are not well attended to.

The problems ASCs listed relate to poor access to the health center; no transportation; shortage of medicine supplies; lack of proper equipment to do their work; poor monetary incentives, with often delayed payments; lack of proper information as far as on-going or future projects go (for instance, they were not aware, in October 2017, that PIMI II was going to start soon). Other problems have to do with gender discrimination and lack of training.

Gender discrimination relates to the fact that mainly boys attend school, and so women never reach even the 4th grade, which is compulsory to become an ASC (as will be discussed in section 6.4).

6.2. Access to the health center

The main problem they feel is a main constraint to their work is the lack of transportation and the hard conditions to reach the health center. During the rainy season, when it becomes impossible to cross certain rivers, some have to walk over 25 km.

> UNICEF gives us bikes, but then we have no way to repair them, no way to arrange for spare parts; the same happens in the case of motorbike, we have no way to fix them…they all work for a while, but with the bad roads and the rainy seasons, they end up falling apart. (ASCs FGD, Encheia)

> I have repaired my bike several times, spent my own money, but it breaks again. We work a lot and receive very little. Often the people in the communities think ASCs are very well paid, which is not true (J. ASCs FGD, Dorse)

Such access constraints are very hard for them, but they are conscious that they are even harder (or impossible) to overcome for a pregnant woman or any sick person that they may realize they need to take to the health center. They feel that even if a pregnant woman wants to come and deliver at the health center, most often this is impossible, because if the woman starts the delivery process and is too far away from the health center, she cannot make it there, without transportation.

Ambulances are available in some regional hospitals, but often the process is long and does not act in time to solve the problems.

> We need several things to improve the working conditions. Now, it is very complicated. When there are problems I calls W and W contacts Cachungo. We take the patient in a

> doolie and cross the river; it is very complicated. The ambulance has to come from Canchungo. Once it happened that the woman gave birth at the port, because it took too long to get there. The child died. (ASC, Jéte)

They are paid 7.500 CFA a month, but since last November (November 2016) that they receive no payment. They are paid at the health center. Most of them say they continue to work as ASC, in spite of the lack in payments: "our work has to continue….even if we are not paid, we continue…" (ASCs FGD Encheia)

They also claim the need for items that they feel that should be considered essential and therefore provided by the Ministry of Health: flashlights to work at night, rubber boots to walk during the rainy season and protect them against snake bites, weighing scales to weigh pregnant women, infants and children.

6.3. Relationship with the health center and with the community

They all reported a good relationship with the health center and the health center personnel, and reiterate the health staff concerns with the lack of proper working conditions at the health center. This seems to be confirmed by the opinion most nurses have of the ASCs:

> ASC refer people to the HC, they help a lot. They have not been paid for two years now. As a result, even when we implement the advanced strategy for vaccination, people do not come, because the ASCs are not functioning. Many of them are not working because they are not paid for. Some continue to do their work, but it is hard, without being paid… (nurses, Có).

ASCs feel that the community could engage in a number of activities to raise awareness in individuals concerning the importance of attending the health services and improve the overall sanitary conditions.

What can the community do to improve the health services?
ASCs FGD Encheia
-organize periodic meetings to raise awareness in individuals on the importance of creating and attending other public services, such as school and church
-people must become aware of the importance of bodily hygiene
-latrines should be build, as many health problems derive from a lack of hygiene and open air defecation
-people must become aware of the importance of eating well

6.4. Socio-cultural issues

All the ASCs are supposed to have basic education, 4th grade, and be able to read and write. Such rule, although felt as fair, raises inequalities on whom can become an ASC, as traditionally males were more oriented towards going to school to try to achieve better jobs. A woman´s main role would be to have children to help in the house and agriculture/fishing tasks. As a result, the percentage of female ASCs is very small compared to male. In the several ASCs FGDs only one female ASC participated, in Dorse. For instance, in Encheia, 19 ASCs turned up for the discussion; they were all males. Several of the *matronas* interviewed expressed the wish to receive training and become ASCs, but without the basic education they cannot do it.

> I am a *matrona*; I received training in Quinhamel before they had ASCs. At that time, the community was inquired to know whom they wanted to choose to go for training. I was chosen.(…) I would like to become an ASC, but I cannot, because one has to have studied up to the 4th grade. Women are not recruited because of their low schooling, which is very unfair. (H. , *matrona*, Tor)

Their concern with raising awareness in the community extends to aspects of gender differences and traditional medicine. Since one of their main tasks relates to maternal and children health, they stated that they try to raise awareness in men of the need to take women and children to the health facilities:

> We work to raise awareness in men that they should not spend so much money in *cana* and should instead give it to their pregnant women so that they use it to come to the health center. (ASCs FGD, Encheia)

> They claim they have good relationships with the local TBAs and *djambakóss*. They work together with them and feel they understand the use of ASCs and the fact that things are changing and people tend to use the health services a lot more than in the "old days". They also think it would be good to involve them more in the relationship with the health centers.We do not accept to take people to the *djambakóss*. Older people believed more in the powers of the *djambakóss* than in going to the health centers; but that is changing, and pregnant women now prefer to come to the health center than going to the *djambakóss"*. (ASCs FGD Encheia)

In the FGDs with the ASCs one topic that was widely discussed was the decision to first go to the *djambakóss*. In reality, people go to both *djambakóss* and the health center. They feel their role as ASC is to alert people to come directly to the HC when they have health problems, but they cannot antagonize the traditional healers. They are conscious that they cannot eradicate *djambakóss* or other traditional healers and they have to work with them.

> The Papel have *djambakóss, curandeiro, balobeiro*, etc. It is better to work with them and not against them….and here we have no problems with the *djambakóss*. But people always go first to the *djambakóss* to see what is the matter and the ASCs have to convince people to come to the HC. It is one of our roles (ASCs FGD Dorse).

> It is very important to have ASCs who can refer people to the HC. Such a case happened just last week, as a pregnant woman with pre-eclampsia that was being treated by a *djambakóss* was brought here by an ASC. It is important that the ASC develop a good relationship with *mindjeres garandis, matronas and djambakóss*. The *matronas*

> do not have the ambulance phone number. There is a good collaboration between *mindjeres garandis* and *matronas*. But the ASC can also intervene, if he/she sees things are not well with what the *matrona* is doing. And they do intervene, but for that there has to be a good relationship with them.(nurse, Dorse)

6.5. Reproductive health and female genital cutting (FGM)

When asked if they talk to people about contraception and STD, they say they do, but it is a complicated subject, as people do not pay much attention. It is especially more difficult for male ASCs to touch upon such subjects with girls and women; they think it would be easier if they had more female colleagues ASCs.
They claim young women are talked into that also because they feel their mothers will help them with the children, when, in fact, it is the mothers themselves that mostly take care of young children. Women, especially the older ones, always talk about the need for more children for the lineage (*djorsom*).

> Women here always have a lot of children, it is a long tradition. My grandmother had eight children and died of childbirth in her last baby. (S. ASCs FGD, Dorse).

> When we try to make men aware of the need to use protection during sexual intercourse they do not care, and say it has to be "flesh to flesh", and that "one does not eat banana with the peel". When we advise people not to have children too early it is very difficult, as everyone wants to have them, as they do not want to stay behind the colleagues who are in the same age group (*mandjuadade*) and already have them. (ASCs FGD, Dorse).

7. From the side of the health staff: nurses

Subthemes
7.1. Being a nurse
7.2. Access to the health center
7.3. Relationship with the community
7. 4. Socio-cultural issues
7. 5. Reproductive health and FGM

7.1. Being a nurse

Most nurses are not from the region they work in. Their work often entails long distances from family and friends, which, in spite of receiving a house in the vicinity of the HC, is hard. They feel gratified by helping the population.

> We feel gratified when we deliver a baby and everything goes well. It is very hard when there are stillborn or when things go wrong with the mother and we feel powerless to help (nurse, Có)

They also need to create a good relationship with ASCs, since they are the liaison with the population, especially for *tabankas* that are very far from the HC. Some nurses mentioned that it would be better if all the ASCs had proper training, because that directly reflects on the way they work with the HC and with the nurses.

All the nurses say their goal is to have women deliver at the health center. Older ones, with many years of practice in several regions of Guinea-Bissau and very much aware of the reality they face, say that giving birth can take place at home, especially when it happens very fast and there is no time to reach the HC.

Being in touch with women, in their daily routine, they are able to judge what women feel are advantages and disadvantages of giving birth at home or at the health center.

Women´s opinion on the advantages of giving birth at home, according to the nurses
Summary interviews with nurses
-idea that women that give birth at home are brave enough to do it
-pride of giving birth at home
-secrets connected to women: giving birth is not a men´s business
-it must be women giving support to other women
-at home, they do not run the risk of being helped by a man
-if one comes to the hospital one pays, at home it is free. *Matronas* are not paid in cash, they accept offers.

Women´s opinion on the disadvantages and misconceptions of giving birth at the HC, according to the nurses
Summary interviews with nurses
-the child is immediately registered and the register is free of charge
-medicines are free and there are also other gifts for the child
-plenty of women do not know they will not be charged at the HC (there is a lot of illiteracy).
-being attended to by specialized personnel

The nurses think that giving birth at home has no advantages; it can only bring problems, because a lot of women die, since people in the *tabankas* are not trained.

> *Matronas* do not know everything, often they cannot handle problems that arise. One of the problems is that they cannot *cortar o bico* or reanimate the newborn. Another problem is that the cutting objects to cut the umbilical cord, etc., are not suitable nor disinfected but, on the contrary, very dirty. Often oyster shells are used, just as knifes that have been used to cut fish. But the medical services should work with the TBAs and not against them. In many far away regions they are the only asset women have. *Matronas* can be instructed and trained to refer pregnant women to the HC. If they do it, we will have much safer deliveries (nurse, Buba HC)

Very often the *matronas* come to the health centers with the newborn to check if everything is in order with the umbilical cord cutting. They use dirty knifes and that can lead to infections. The other problem is that they cut the umbilical cord not 3 cm from the belly button, but too close (less than 3cm) and that can lead to extreme bleeding that will kill the baby. They also use threads that are not strong enough and this may also provoke hemorrhage.

7.2. Access to the Health center

They are aware that the biggest constraint for women and children to come to the health center and use their services is the distance between the *tabanka* and the health center, and the fact that in most cases there is no transportation. They feel that if they themselves often feel isolated in the *tabankas* where they live (where the health center is placed) due to the distances and the lack of suitable accessibility, it is clear that it must be much harder for the patients.

> The main problem in assisting pregnant women is that they come for consultation very late in pregnancy, since the distances are very long ones, and they have no way to get here. As a consequence, most deliveries (around 90%) take place at home. In 2016 we had an average of 10 deliveries per month. This year, 2017, there has been less. (Interviews, nurses, Có)

7.3. Relationship with the community

Most of the nurses feel they are competent and that their competence is acknowledged by the community. Once again, it is more so with the older ones, who have been in the health center long enough to create a relationship of trust and reliability with the population: "they trust me more than they trust the *djambakóss* or the *balobeiro*" (nurse Dorse).

Normally they are not placed where they would like to be; they feel this also affects their relationship with the community. They feel that if they have good working conditions it compensates for being away from the family and not being able to choose where they are placed at.

They think that their relationship with the community reflects not only what they do but also the conditions of the health center. In a way, if they feel proud of the HC they take care of it; they will keep it in a good condition and this will also pass on to their patients. And this may result in also engaging the community to help, as was the case in Pelundo.

> This health center was reconstructed with the help of the community. Everything was falling apart and, with nurse C. (IMVF) we reunited all the men at the mosque and mobilized the community to do it. NGO Vida also helped. Even so, there is still many needed improvements. For instance, here are only three beds; when we have more patients we have to send them to Cachungo, because there is no space here (nurse, Pelundo).

"What is wrong here?" A sample case
Interview summary, nurses, Có
In this HC:
-there is no running water; there is a water deposit but it does not work
-they did not use to have electricity; since 2015 they have it, through the solar panels, but they often break down, as they need maintenance.
-there is a shortage of medicines, which started even before PIMI finished
-malaria tests also finished
-there is a big problem with medicine supply: when medicines get to Bula they stay there, and never get to Có. The boxes say Bula/Có and everything stays in Có (Bula

and Có are part of the same sanitary region of Cacheu, which has its headquarters in Cachungo).
-they never received the anti-malaria nets (Milda)
-they never received the reanimation kits
-salaries and incentives have been paid, but they are very low. The incentive is a percentage (30%) of the medical acts, so it depends also on the quantity of patients.

Health staff identified similar constraints from the supply side as users of the health system declared on the demand side.

Table 8: Supply-side constraints: health staff at HC

Access to the health center:
Accessibility be improved: there is an urgent need to improve the access conditions to the health center.
Roads need repairs. In Biombo, for instance, in spite of being so close to Bissau the road is in bad condition, and it is not a paved road. It is 53 km from Dorse to Bissau.
Need for ambulances or other transportation
Conditions at the health center:
Water and electricity
Space for women to be interned
Need for more health centers
Shortage of health staff:
Staff shortages
Replacement of staff that leaves for training
Need for training:
Need for mentoring and supervision by an SBA
Need for technical and recycling training
Shortage of supplies
Lack of equipment (some HC never received reanimation kits for the newborn)
Lack of medication availability
Not enough positive economic incentives
Delays in payment
Delay in performance-based incentives (PBI) are not regularly paid, and many have not received the “isolation subsidy”

All of these listed problems match the ones listed by the population. Both the community (demand side) and the health staff (supply side) feel that there is not an efficient management nor dedication by the Ministry of Health. The project E saúde brought medicines for the pregnant women for a month. They say on the radio that there are medicines, but they finished and the population does not understand that. The medicine against malaria also finished. MSF (Médicins sans frontières) has malaria medicines, but they will expire now without even having been delivered. There is a huge problem of lack of coordination by the Ministery (nurse Buba HC).

7. 4. Reproductive health and female genital cutting (FGM)

At the health centers nurses reported that women nowadays use contraceptive methods, and go to the HC for that. *Matronas* have no *mézinho* for contraception. *Djambakóss* do have them, they put a cord around the woman´s belly. At the health center, they use what is available, the implant Jadelle, Depo-Provera intramuscular shot or IUD. The use of contraceptives also varies according to the different regions. For instance, in Biombo, where the Papel are the predominant ethnic group, the health center in Dorse reports receiving about 50 to 60 Jadelle kits per month and they use them all. On the contrary, in predominantly Mandinga areas, as in the Gabú area, people say it is against "God´s will" to use contraceptive methods. When women do it, it involves secrecy from women and men.

Women do not talk to the health staff about FGC. Most people know it is now forbidden, and they can have problems if they do it or talk about the *fanatecas*. They also know that women perform it nowadays to their daughters at a very early age, so that they do not remember later on and do not talk about it.

Discussion, preliminary conclusions and recommendations

The main challenges to MCH in Guinea-Bissau previously identified (World Bank 2017) included the low level of pre-natal visits, the high level of home deliveries, the illegal and indirect costs that users are charged for, the perception by the population of the low quality of the services, the inoperation of the referral system, the shortage of health personnel and the low surgical capacity.

This study reveals that all these hold true. But it also reveals how important it is to listen to the people, the users, in order to understand why some tentative improvements are not working well, and some are. There are regional differences, but also variations that relate to socio-cultural factors, as religious and gender differences, multiple marriages, the use of traditional healers, etc.

Several studies conducted in Gambia (Alvesson and Dibba 2014), Ghana (Rinsworth et al 2015), Cameroon (De Allegri et al 2017), Rwanda (Rusa and Fritsche s.d.), analyze various aspects of the difficulties in having women and children assessing health services, and point out some problems that are common to Guinea-Bissau and that dialogue with the present report.

The Gambia report (Alvesson and Dibba 2014), focuses on women´s position in society and their role in production, consumption and reproduction and gender relations. It shows how women, even when pregnant, carry a heavier load of work than men, and how issues of women´s empowerment and their behavior during pregnancy are linked to ethnicity and religion. The piece on Ghana illustrates how, in spite of attempts to increase the use of the health facilities, the role of TBSs cannot be ruled out, as they are better placed to conduct deliveries in rural isolated communities (Rinsworth et al 2015). The Cameroon (De Allegri et al 2017), and Rwanda (Rusa and Fritsche s.d.) reports focus on Performance-based Financing in Health, revealing its positive and negative aspects.

Some of the research done in Guinea-Bissau (Garcia 2014; Acta Obstretrica e Ginceológica Portuguesa. Mortalidade nos PALOP. s.d; Afonso e Carvalho 2013; Einarsdóttir 2011; Baldursdóttir 2018) adresses issues that are researched in this study. Garcia´s work focuses specifically on sociocultural determinants of health in pregnant women in the Gabu region, which are valid for the different regions in the country and showing how determinant they are, when trying to understand attitudes of women towards MCH. In a research concerning the functioning of informal female community based aid systems, Aline Afonso and Clara Carvalho (2013) show how female *mandjuandadi* (the traditional age groups) and *abota* work as systems of support in areas where the state and other intervenients fail.

Einarsdóttir´s (2011) work focuses on assessing the results of the Bamako Initiative, and shows how problems of low and delayed payments of health staff cause discontent and corruption, (such as illegal charges). It also discusses how high prices of medicines exclude the lower income users from assessing the benefits, and appeals to a higher level of involvement of the state and MINSA in providing the means for the HC to function properly. The high and illegal prices for medicines and consultations at the HC, the improper way users are often treated at the HCs, the bad roads and lack of transportation are pointed out as reasons for the failure of the Bamako Initiative. The study stresses the need for gratuity in MCH, especially in deliveries, something that is currently been done

under the PIMI project. It points out the need for improvement in the road situation and in ambulance availability, so that women and children may reach the health facilities; in order to avoid illegal charges it recommends the implementation of a service where the users may file their complaints.

Although dated from 2011, Einarsdóttir´s work identifies these above mentioned problems that hold true still eight years after, and compromise the success of MCH. It is added to this that there was a general lack of information in the communities and an overall lack of economic means to use the health services, leading to a higher use of traditional healers, cheaper and available *in loco*. This study recommended the implementation of free MCH and the adoption of clear rules for charges, to avoid illegal costs, and the involvement of the government, and of the communities, so that information circulates and the system works.
Such conclusions and recommendations are valid for the findings in the present report.

In general, women are willing to attend ANC and give birth in the HC if the conditions are there. Basic conditions mean access to the HC, so that one does not run the risk of giving birth in the bush. This is the first main identified problem: there are not enough roads in Guinea-Bissau, and there are not enough means of transportation.

People must feel they can trust the HC and the health staff. In order for this to happen, health facilities have to be improved and provided with SBA, equipment and available medicines.

Gratuity rules have to be clear and transparent to everyone. Radio is one of the best ways to spread the news and keep the users informed on their rights, what they have to pay and what should be provided for free.

Besides investing in accessible and functional HC there should also be investment in the relationship with and training of TBAs and traditional healers; they are the ones that are *in loco* when everything else fails. Although the emphasis now is on forming and providing SBA, the role of TBAs and local healers cannot be downplayed. Improvements should be done with them, not without them.

There are differences in willingness to use MCHS and engage in reproductive health and family planning practices depending on the regions and the religions practiced by the different ethnic groups in Guinea-Bissau. These have to be kept in mind in any attempt to improve MCHS. FGM is still a reality, especially among Muslim populations. Since it is a complicated issue and people are aware that is forbidden by law, only through a long-term field work and a trust relationship with the population can such issues be properly addressed.

Changing behavior patterns and mind sets, both in women and men, takes a long time. This holds true for willingness to use the health services, as in issues concerning Reproductive health and FGM. It cannot be done with 2 or 3 years projects. It has to be done with the population and through community organization. Local ASCs are a key element for this.

One of the main steps to improve the willingness to attend MCHS is to implement a good dialogue with the local *matronas* and *djambakóss*, so that they also advise women to attend the services. It is important to raise awareness of care providers (*matronas* and

djambakóss) that there are many problems they cannot solve and which may lead to women and infant/children death if not taken care of properly by the medical services/attendants. It is also vital to raise the awareness of women to the same problem, so that they invest in attending MCHS.

Due to the trust people seem to place upon the ASC it would be recommended to invest in their capacitation and training, as well as in their personal gratification. This can be done by improving their salaries and offering them better work conditions.

The same holds true for health personnel as nurses who work in HCs, especially the ones that live very far from their families.

Finally, it is recommended that this research should be continued in the areas not yet inquired—Bafatá, Tombali and especially the Bijagós regions. Phase I of the PIMI program covered the Oio, Farim, Cacheu and Biombo areas. The second phase of PIMI (PIMII) started in November 2017, and covers the whole country. It is important to access the results of such nationwide implementation, especially in regions, as the islands, where the difficulties listed were even more problematic, due to geographical isolation. Therefore, it is recommended that a qualitative research be carried in these regions, as soon as possible, to identify the improvements and drawbacks perceived by the users of the health facilities and programs.

E-References

Afonso, A. and Carvalho, C. 2013 Adversidade e imaginação: dinâmicas de suporte social entre as mulheres na Guiné-Bissau, in C. Carvalho (org) *Mulheres no Mercado da Saúde. Apoio Social em Angola, Moçambique, Guiné-Bissau e Niger*, Lisboa, Almedina.

Alvesson, H. and Dibba, M. 2014 *Women´s Roles in Production, Consumption and Reproduction. A Case Study in the Gambia*.

Baldursdóttir, S. 2018 *The Alma Ata Declaration: Implementation of Community Health Care in Guinea-Bissau*., PhD thesis, University of Iceland.

Carvalho, C. 2013 "Introdução", in C. Carvalho (org) *Mulheres no Mercado da Saúde. Apoio Social em Angola, Moçambique, Guiné-Bissau e Niger*, Lisboa, Almedina.

Comaroff, J. & Comaroff, J.L. 1999 Occult Economies and the Violence of Abstraction: Notes from the South African Postcolony. *American Ethnologist*. 26 (2), 279-303.

De Allegri, M, et al *2017 Qualitative Research to Explain and Unpack Quantitative Findings from a Performance-Based Financing Pilot in Cameroon*, World Bank.

Dilger, H. 2007 Healing the wounds of modernity: Community, salvation and care in a neopentecostal church in Dar Es Salaam, Tanzania , *Journal of Religion in Africa*, 37, 59-83.

Einarsdóttir, J. 2011 *Avaliação da Iniciativa de Bamako na Guiné-Bissau: "Sem dinheiro estás morto!"*, PNDS/MINSA, WB.

European Union, 2016. Assessment of the *Programa Integrado para a Redução da Mortalidade Materno-Infantil* (PIMI). Bissau, Guinea-Bissau.

Garcia, E. 2014 *Determinantes socioculturais na saúde das grávidas na região de Gabú. "Análise da influência dos hábitos, dinâmicas sociais e culturais das mulheres em idade fértil, durante o processo pré-natal e parto"* AIFO.

Horbst, V., Gerrets, R, Schirripa, P. 2017 "Revisiting Medical pluralism", *L´Uomo*, n1(2017) , pp 7-26.

Pfeiffer, J. 2003 International NGOs and primary health care in Mozambique: the need for a new model of collaboration. *Social Science &Medicine*, 56 (4), 725-738.

Rishworth, A. Et al 2016 "I was on the way to the hospital but delivered in the bush": Maternal health in Ghana´s Upper West Region in the context of a traditional birth attendants´ ban, *Social Sciene & Medicine*: 48 (2016) 8-17.

Rusa, L. , Fritscge, G. *Rwanda:Perfomed-Based Finance in Health. Emerging Good Practice in Managing for Development Results: Sourcebook*, second edition. http://www.mfdr.org/sourcebook/2ndEdition/SourceBook_2E_17_Sept_07_EN.pdf

Silva, M. et al. S.d. "Maternal mortality in Portuguese speaking-African countries (PALOP)", *Acta Obstétrica e Ginecológica Portuguesa*.

Thaddeus S, Maine D. Too far to walk: maternal mortality in context. *Soc Sci Med* 1994; 38: 1091-1110

UNICEF, 2015. *Multi Indicators Cluster Survey*

WB 2017 *Strengthening Maternal and Child Health Service delivery in Guinea-Bissau. Identification Mission*.

World Development Indicators, 2016.

Annex 1

A-Scripts for focus group discussions

1.Focus group discussions with young women (*badjudas*)/young men

2. Focus group discussions with pregnant women and mothers of children under five

3. Focus group discussions with men with pregnant partners and fathers of children under five

4. Focus group discussions with grandmothers/elderly women (*mindjeres garandis*)

5. Focus groups discussion with ASC

Notes:

-Always start by explaining what the project is about and stress the fact that their responses/discussions will be kept anonymous

-After that, always ask for (informed) oral consent to record discussions and collect visual material (photos, videos)

1.Focus group discussions with young women (*badjudas*)

(inquire names, age, education level and religion for each one of the FGD participant)

1.1. Reproductive health

-what age do girls start a sexual active life?

-Do you do any type of contraception?

-Do you use traditional contraceptive methods?

-How did you get to know about contraception methods?

-who talked with you about contraception methods?

-did you ever go to a health center to find out about contraceptive methods?

-which do you think are the benefits of traditional contraceptive methods?

-which do you think are the benefits of contraceptive medicines available at the health center?

-do you think contraception is a female or male business?

-do you generally talk with your male friends or boyfriends about contraception?

-do you talk with your older female relatives about contraception?

-whom do you turn to to solve STD or reproductive problems? (*mindjeres garandis, matronas*)

-do you ever go to the *djambakóss/mouro* to solve STD?

-would you go to a health facility to solve STD?

1.2.Imagine you are pregnant…

-which are your worst fears concerning your pregnancy?

-whom would you tell first of all?

-when would tell them and make pregnancy public?

-would you go to a health center straight away? Why or why not?

-do you think one should follow pre-natal consultancies at the health center all way through pregnancy? Why? Why not?

-what are the difficulties you expect to encounter at health centers?

- what are the benefits you expect to encounter at health centers ?

-Would you like to give birth at home? Why?

-Would you trust a *mindjer garandi* to help you? Why?

1.3. On female genital cutting (FGM)

-Have you had FGM? When? Who performed it?

- Have you undergone the female cutting (*fanado*)? When?

- Was the cutting performed by a traditional practitioner (*fanateca*)?

- What type of cutting was performed?

- Do you think female cutting should continue? Why or why not?

- Do you think female cutting can be harmful to your health, namely during pregnancy and delivery?

-Do you think female cutting can be harmful to your baby's health?

-Would you submit your daughter to the female cutting (*fanado*)? Why or why not?

2.Focus group discussions with pregnant women and mothers of children under five

(inquire names, age, number of children, religion for each one of the FGD participant)

2.1. Use of health facilities (ANC and delivery at home/HC)

-which are your worst fears concerning your pregnancy?

-when you understood you were pregnant, whom did you tell first of all?

-did you go to a health center straight away? Why or why not?

-do you think one should follow pre-natal consultancies at the health center all way through pregnancy? Why? Why not?

-do you go there for prenatal consultations? How often?

-Did you/will you like to give birth at home? Why?

-Did you/will you like to give birth at health center? Why?

-do you take your children to the health center? How often?

-what are the difficulties/problems you expect to encounter at health centers?

-which are the benefits you think you will get from going to the health center?

-how do you think the communities could help in improving the health services?

-what do you think the state should do to improve the health services?

2.2. Access to health facilities (distance, transportation)

-how far is the health center?

-how would you rate the access to health services (easy, difficult or very difficult?)

-how do you get there?

-if you have to take transportation, how much do you pay?

-how do you think the communities could help in improving the access to health services?

-what do you think the state should do to improve the access to the health services?

-would you go to health practitioners if they come to you?

2.3. About the health center (staff competence, payments/gratuities, possible improvements)

-what do you feel towards health personnel? Do you think they are enough and available?

- do you feel they are competent?

-Do you think they are experts?

-do you think medicines provided are enough?

-do you pay for the health center medicines? How do you pay for those?

-do you pay for the health staff services? How do you pay for those?

-do you mind if you have a male nurse taking care of you?

-how do you think the services at the health center could be improved?

2.4.Socio-cultural issues (gender, religious-*matronas, djambakóss, mouros*)

-who decides to go to the health facilities?

-who pays for transportation?

-should women obey men?

-would you consult a *matrona* while pregnant?

-would you go to the *djambakuss/marabout* if you have problems during pregnancy? Why?

2.5. Reproductive health and female genital cutting (FGM)

- Have you undergone the female cutting (*fanado*)? When?

- Was the cutting performed by a traditional practitioner (*fanateca*)?

- What type of cutting was performed?

- Do you think female cutting should continue? Why or why not?

- Do you think female cutting can be harmful to your health and your baby's health?

- Has your daughter undergone the cutting? Why or why not? When?

- Will you submit your daughter to the cutting? Why or why not?

2. Focus group discussions with men with pregnant partners and fathers of children under five

(inquire names, age, number of children, number of wives, religion for each one of the FGD participant)

3.1. Use of health facilities (ANC and delivery at home/HC)

-which are your worst fears concerning your partners pregnancy?

-did you advise your partner to go to a health center straight away? Why or why not?

-do you think one should follow pre-natal consultancies at the health center all way through pregnancy? Why? Why not?

-do you advise your partner to go to a health center for prenatal consultations? How often?

-would you like your partner to give birth at home? Why?

-do you take your children to the health center? How often?

-what are the difficulties/problems you expect to encounter at health centers?

-which are the benefits you think you will get from going to the health center?

-how do you think the communities could help in improving the health services?

-what do you think the state should do to improve the health services?

3.2. Access to health facilities (distance, transportation)

-how far is the health center?

-how would you rate the access to health services (easy, difficult or very difficult?

-how do you get there?

-if you have to take transportation, how much do you pay?

-how do you think the communities could help in improving the access to health services?

-what do you think the state should do to improve the access to the health services?

-would you go to health practitioners and take your partner and children there if they come to you?

3.3. About the health center (staff competence, payments/gratuities, possible improvements)

-what do you feel towards health personnel? Do you think they are enough and available?

- do you feel they are competent?

-Do you think they are experts?

-do you think medicines provided are enough?

-do you pay for the health center medicines? How do you pay for those?

-do you pay for the health staff services? How do you pay for those?

-do you mind if you have a male nurse taking care of your female partner and children?

-how do you think the services at the health center could be improved?

3.4.Socio-cultural issues (gender, religious-*matronas, djambakóss, mouros*)

-who decides to go to the health facilities?

-who pays for transportation?

-should women obey men?

-would you advise your partner to consult a *matrona* while pregnant?

-would you advise your partner to go to the *djambakuss/mouro* if she has problems during pregnancy? Why?

3.5. Reproductive health and female genital cutting (FGM)

- Has your wife undergone the female cutting (*fanado*)?

- Do you think female cutting should continue? Why or why not?

- Do you think female cutting can be harmful to your wife's health and your baby's health, namely during pregnancy and delivery?

- Has your daughter undergone the cutting? Why or why not? When?

- Will you submit your daughter to the cutting? Why or why not?

4. Focus group discussions with grandmothers/elderly women (*mindjeres garandis*)

(inquire names, age, number of children, religion for each one of the FGD participant)

4.1. Use of health facilities (ANC and delivery at home/HC)

-which are your worst fears concerning your daughters/daughter-in law pregnancy?

-would you advise them to go to a health center straight away? Why or why not?

-do you think one should follow pre-natal consultancies at the health center all way through pregnancy? Why? Why not?

-would you advise a woman to go to a health center for prenatal consultations? How often?

-did you ever go to a health facility when you were pregnant?

-did you give birth at home or at a health facility?

-would you like your daughter/daughter in law to give birth at home? Why?

-do you take your grandchildren to the health center? How often?

-what are the difficulties/problems you expect to encounter at health centers?

-which are the benefits you think you will get from going to the health center?

-how do you think the communities could help in improving the health services?

-what do you think the state should do to improve the health services?

4.2. Access to health facilities (distance, transportation)

-how far is the health center?

-how would you rate the acess to health services (easy, difficult or very difficult?)

-how do you get there?

-if you have to take transportation, how much do you pay?

-how do you think the communities could help in improving the access to health services?

-what do you think the state should do to improve the access to the health services?

-would you go to health practitioners and take your grandchildren there if they come to you?

-do you bring your grandchildren to the HC?

4.3. About the health center (staff competence, payments/gratuities, possible improvements)

-what do you feel towards health personnel? Do you think they are enough and available?

- do you feel they are competent?

-Do you think they are experts?

-do you think medicines provided are enough?

-do you pay for the health center medicines? How do you pay for those?

-do you pay for the health staff services? How do you pay for those?

-do you mind if you have a male nurse taking care of your daughter/daughter in law and children?

-how do you think the services at the health center could be improved?

4.4.Socio-cultural issues (gender, religious-*matronas, djambakóss, mouros*)

-who decides to go to the health facilities?

-who pays for transportation?

-should women obey men?

-would you advise your daughter/daughter in law to consult a *matrona* while pregnant?

-would you advise your daughter/daughter in law to go to the *djambakóss/mouro* if they have problems during pregnancy? Why?

4.5. Reproductive health and female genital cutting (FGM)

-Have you had FGM? When? Who performed it?

- Have you undergone the female cutting (*fanado*)? When?

- Was the cutting performed by a traditional practitioner (*fanateca*)?

- What type of cutting was performed?

- Do you think female cutting should continue? Why or why not?

- Do you think female cutting can be harmful to a woman´s health, namely during pregnancy and delivery?

-Do you think female cutting can be harmful to a baby's health?

-Would you submit your granddaughter to the female cutting (*fanado*)? Why or why not?

5. Focus groups discussion with ASC

5.1.Being an ASC

-when did you become ASC?

-why did you become an ASC?

-what are the aspects you enjoy most about being an ASC?

-What are the aspects you dislike about being an ASC?

-what are the major difficulties of your work?

-what would help you most in your work?

-Do you feel accepted by the community?

-Which aspects do you feel are most rewarding in being an ASC?

-What do you feel about the monetary incentives you receive? How much are you paid?

5.2. Access to the health Center (distance, transportation)

-how far is the health center from the *tabanka* where you live/work?

-how would you rate the acess to health services (easy, difficult or very difficult?)

-how do you get there?

-if you have to take transportation, how much do you pay?

-what is your relationship with the HC personnel?

-how do you think the communities could help in improving the access to health services?

-what do you think the state should do to improve the access to the health services?

-would you go to health practitioners and take your partner and children there if they come to you?

5.3. About the HC and relationship with staff (competence, possible improvements)

-what do you feel towards health personnel? Do you think they are enough and available?

- do you feel they are competent?

-do you think they are experts?

-do you think medicines provided are enough?

-what is your relationship with the HC personnel?

-how do you think the services at the health center could be improved?

5.4.Socio-cultural issues (gender, religious-*matronas, djambakóss, mouros*)

-who decides to go to the health facilities?

-who pays for transportation?

-should women obey men?

-do women in your community consult a *matrona* while pregnant?

-do women in your community consult go to the *djambakóss/mouro* if they have problems during pregnancy? Do you talk to them about these options?

-what is your relationship with the *matronas* and *djambkóss/mouro* in your community?

5.5. Reproductive health and female genital cutting (FGM)

-do you talk to people about family planning and STD?

-how do they respond to such questions?

-do you feel people practice any type of family planning?

-do people talk to you about FGM?

-are there *fanatecas* in your community? Do women use their services?

Annex 2

B-Script for keynote informant interviews

1. Health personnel- nurses, ASCs, health administration

2. *Matronas, djambakóss, mouros*

3. Women in specific vulnerable situations

1. Health personnel-nurses, etc.

1.1. Being a nurse

-when did you become a nurse? Why did you decide to do it?

-since when do you work in this post?

-how is your relationship with the community?

-how is your relationship with ASC?

-what are the main problems you encounter as a health professional?

-how do you think your work could be improved?

1.2.Access to health facilities (distance, transportation)

-how far is the health center from the *tabankas*?

-how would you rate the general population acess to health services (easy, difficult or very difficult?)

-how do they get here?

-how do you think the communities could help in improving the access to health services?

-what do you think the state should do to improve the access to the health services?

1.3.About the health center (staff competence, payments/gratuities, possible improvements)

-what do you think that the population feels towards the health personnel? -do you think they feel you are competent?

-do you think medicines you provide are enough?

-do people pay for the health center medicines?

-do people pay for the health staff services?

-do you think women mind if they have a male nurse taking care of them?

-how do you think the services at the health center could be improved?

1.4.Socio-cultural issues (gender, religious-*matronas, djambakóss, mouros*)

-who decides to go to the health facilities?

-who pays for transportation?

-should women obey men?

-do women in your community consult a *matrona* while pregnant?

-do women in your community consult go to the *djambakuss/mouro* if they have problems during pregnancy? Do you talk to them about these options?

-what is your relationship with the *matronas* and *djambkóss/mouro* in your community?

1.5. Reproductive health and female genital cutting (FGM)

-do you talk to people about family planning and STD?

-how do they respond to such questions?

-do you feel people practice any type of family planning?

-do people talk to you about FGM?

-are there *fanatecas* in your community? Do women use their services?

2. Matronas, djambakóss, mouros

2.1. Being a *matrona, djambakóss, mouro*

-when did you become a *matrona, djambakóss, mouro*? Why did you decide to do it?

-since when did you start helping women to give birth?

-how did you learn to do it?

-what do you generally do to help them?

-what are the aspects you enjoy most about being a *matrona, djambakóss, mouro?*

-What are the aspects you dislike about being a *matrona, djambakóss, mouro?*

-do you think people (and especially pregnant women and children) should come to you and not to the HC? Why?

-how do you think your work could be improved?

-what are the major difficulties of your work?

-how is your relationship with the community?

-how is your relationship with ASC?

-how is your relationship with the HC?

-What would help you most in your work?

-Do you feel accepted by the community?

-Do you get paid for your services?

2.2.Access to the health Center (distance, transportation)

-how far is the health center from the *tabanka* where you live/work?

-how would you rate the acess to health services (easy, difficult or very difficult?)

-how do you get there?

-if you have to take transportation, how much do you pay?

-what is your relationship with the HC personnel?

-how do you think the communities could help in improving the access to health services?

-what do you think the state should do to improve the access to the health services?

-would you go to health practitioners and take your partner and children there?

2.3.About the HC and relationship with staff (competence, possible improvements)

-do you think people (and especially pregnant women and children) should go to the HC? Why?

-what do you feel towards health personnel? Do you think they are enough and available?

- do you feel they are competent?

-do you think they are experts?

-do you think medicines provided are enough?

-what is your relationship with the HC personnel?

-how do you think the services at the health center could be improved?

2.4.Socio-cultural issues (gender, religious-*matronas, djambakóss, mouros*)
-who decides to go to the health facilities?

-who pays for transportation?

-should women obey men?

-do women in your community consult you as *matrona* while pregnant?

-do women in your community come to you as *djambakóss/mouro* if they have problems during pregnancy? Do you talk to them about these options?

-what is your relationship with the other *matronas* and *djambakóss/mouro* in your community?

2.5. Reproductive health and female genital cutting (FGM)
-do you talk to people about family planning and STD?

-how do they respond to such questions?

-do you feel people practice any type of family planning?

-do people talk to you about FGM?

-did you ever perform FGM?

-do you know if there are people performing it in your community?

-are there *fanatecas* in your community? Do women use their services?

-what is your relationship with the *fanatecas*?

- Do you think female cutting should continue? Why or why not?

- Do you think female cutting can be harmful to a woman´s health, namely during pregnancy and delivery?

-Do you think female cutting can be harmful to a baby's health?

-Would you submit your granddaughter to the female cutting (*fanado*)? Why or why not?

3. Women with specific vulnerable situations

3.1.Use of health facilities (ANC and delivery at home/HC)

-which are your worst fears concerning your pregnancy?

-when you understood you were pregnant, whom did you tell first of all?

-did you go to a health center straight away? Why or why not?

-do you think one should follow pre-natal consultancies at the health center all way through pregnancy? Why? Why not?

-do you go there for prenatal consultations? How often?

-Did you/will you like to give birth at home? Why?

-do you take your children to the health center? How often?

-what are the difficulties/problems you expect to encounter at health centers?

-which are the benefits you think you will get from going to the health center?

-how do you think the communities could help in improving the health services?

-what do you think the state should do to improve the health services?

3.2.Access to health facilities (distance, transportation)

-how far is the health center?

-how would you rate the acess to health services (easy, difficult or very difficult?)

-how do you get there?

-if you have to take transportation, how much do you pay?

-how do you think the communities could help in improving the access to health services?

-what do you think the state should do to improve the access to the health services?

-would you go to health practitioners if they come to you?

3.3.About the health center (staff competence, payments/gratuities, possible improvements)

-what do you feel towards health personnel? Do you think they are enough and available?

- do you feel they are competent?

-Do you think they are experts?

-do you think medicines provided are enough?

-do you pay for the health center medicines? How do you pay for those?

-do you pay for the health staff services? How do you pay for those?

-do you mind if you have a male nurse taking care of you?

-how do you think the services at the health center could be improved?

3.4.Socio-cultural issues (gender, religious-*matronas, djambakóss, mouros*)

-who decides to go to the health facilities?

-who pays for transportation?

-should women obey men?

-would you consult a *matrona* while pregnant?

-would you go to the *djambakuss/marabout* if you have problems during pregnancy? Why?

2.5. Reproductive health and female genital cutting (FGM)

- Have you undergone the female cutting (*fanado*)? When?
- Was the cutting performed by a traditional practitioner (*fanateca*)?
- What type of cutting was performed?
- Do you think female cutting should continue? Why or why not?
- Do you think female cutting can be harmful to your health and your baby's health?
- Has your daughter undergone the cutting? Why or why not? When?
- Will you submit your daughter to the cutting? Why or why not?