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Draft country programme document**

The Republic of Guinea

Summary

The draft country programme document for the Republic of Guinea is presented to the Executive Board for discussion and comments. The Board is requested to approve the aggregate indicative budget of $44,710,000 from regular resources, subject to the availability of funds, and $57,000,000 from other resources, subject to the availability of specific-purpose contributions, for the period 2013-2017.

* E/ICEF/2012/9.

** In accordance with Executive Board decision 2006/19, the present document will be revised and posted on the UNICEF website, along with the results matrix, no later than six weeks after discussion of the draft CPD at the 2012 annual session of the Executive Board. The revised CPD will then be presented to the Executive Board for approval at the second regular session of 2012.

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Basic data[†] *(2010 unless otherwise stated)*	
Child population (millions, under 18 years)	4.9
U5MR (per 1,000 live births)	130
Underweight (% moderate and severe, 2008)	21
(% urban/rural, poorest/richest)	15/23, 24/19
Maternal mortality ratio (per 100,000 live births, 2008)	680[a]
Primary school enrolment/attendance (% net, male/female, 2009)	79/69[b]
Survival rate to last primary grade (%, male/female, 2008)	63
Use of improved drinking water sources (%)	74
Use of improved sanitation facilities (%)	18
Adult HIV prevalence rate (%, 15-49 years of age, male/female, 2009)	1.3
Child labour (%, 5-14 years of age, male/female, 2003)	25
Birth registration (%, under 5 years of age)	43
(%, male/female, urban/rural, poorest/richest)	44/42, 78/33, 21/83
GNI per capita (US$)	380
One-year-olds immunized against DPT3 (%)	57
One-year-olds immunized against measles (%)	51

[†] More comprehensive data on children and women are available at www.unicef.org.

[a] 980 deaths per 100,000 live births is the 2005 estimate developed by the Maternal Mortality Estimation Interagency Group (WHO, UNICEF, UNFPA and the World Bank, together with independent technical experts), adjusted for underreporting and misclassification of maternal deaths. For more information, see www.childinfo.org/maternal_ mortality.html.

[b] Survey data.

Summary of the situation of children and women

1. Guinea is marked by economic and social difficulties and ranked 156th out of 169 countries on the 2010 Human Development Index. Between 2006 and 2010, the average annual growth rate of gross domestic product was approximately 2.2 per cent, while the annual population growth rate was estimated at 3.1 per cent. The poverty rate climbed from 53 per cent in 2008 to just over 58 per cent in 2011. An analysis of regional disparities shows that the three poorest quintiles (approximately 60 per cent of the population) have a much lower quality of life than the other two quintiles.

2. The fall in foreign aid, mainly owing to the political instability of recent years, and the inequitable distribution of available resources, have led to a decline in the delivery of and access to basic social services for the poorest populations, especially those in rural areas, worsening the child well-being indicators.

3. In the health sector, although the under-5 mortality rate fell from 163 to 130 per 1,000 live births from 2005 to 2010, it remains very high. The trends analysis shows that the most progress has been made in child mortality, with less progress in infant mortality and very little progress in neonatal mortality. Sixty-eight per cent of children under the age of 5 die of three main causes: malaria, acute respiratory infections and diarrhoea.

4. Maternal mortality has risen to 680 per 100,000 live births from 528 per 100,000 live births in 1999, mainly owing to the low rate of births attended by qualified health personnel (48 per cent, 32 per cent of which are in rural areas and 84 per cent in urban areas). Furthermore, 80 per cent of maternal deaths are directly attributable to obstetric causes. Ninety-seven per cent of pregnant women in urban areas and 86 per cent in rural areas have access to at least one child protection network.

5. Thirty-four per cent of children under the age of 5 suffer from chronic malnutrition, 21 per cent of whom suffer from the severe variety; and wasting is most prevalent among children between 6 and 23 months of age, especially those between 6 and 11 months of age. These two types of malnutrition are directly or indirectly linked to poor breastfeeding practices, insufficient supplementation, food insecurity and constant exposure to pathogens without appropriate health care.

6. Mother-to-child transmission of HIV is prevalent in urban and economically vibrant areas. The national HIV seroprevalence rate is 1.5 per cent, while the rate among pregnant women cared for by child protection networks rose from 2.5 per cent in 2008 to 3 per cent in 2010. Eighty per cent of people living with HIV in rural areas have no access to care.

7. Direct and indirect costs and low rates of preschool enrolment limit the chances of access to school. Retention and primary school completion rates remain low, especially for girls and vulnerable children. Fewer than 50 per cent of children start school at the required age (7 years) and one in five children of school age finish primary school at the required age (12 years). The gross completion rate for girls (44 per cent) is 12 points lower than that for boys, probably owing to the combined effects of late entry into school, harmful sociocultural practices and early pregnancies. More than one in four women (26 per cent) between 15 and 19 years of age are already mothers.

8. As a result of low enrolment and the drop out rate (8 per cent on average: 13.2 per cent for girls and 6 per cent for boys in 2011), the number of adolescents who are unenrolled or have dropped out is estimated at 915,846, including 567,733 girls (62 per cent). Exclusion from education, along with youth unemployment, cause frustration among adolescents and make them vulnerable, thus creating another challenge for peacebuilding.

9. Early pregnancies aggravate illiteracy among young girls and increase their chances of dying during childbirth. The average number of births per 1,000 young women between 15 and 19 years of age is 154 across the country, 104 in urban areas and 187 in rural areas. The number of adolescent girls who have begun their reproductive lives is higher in the poorest quintile (39 per cent) than in the richest quintile (20 per cent). This early fertility among young girls is apparently largely due to early involvement in sexual activity and family poverty.

10. Female genital mutilation/cutting affects approximately 9 out of 10 women between 15 and 19 years of age (90 per cent), exposing young women to high risks of morbidity and mortality. The practice affects all social segments of society, regardless of educational level, religion and milieu. Initiation rites and preparation of young girls for their future role as wives are the reasons cited for its perpetuation.

11. The birth registration rate is low (43 per cent) and varies considerably: 59 per cent of rural births are not registered, compared to 23 per cent in urban areas, while

37 per cent of births for the richest quintiles are not registered, compared to 66 per cent for the poorest quintiles. Low birth registration is the result of the long distances to registry offices, the cost of birth certificates, and illiteracy among most parents, especially mothers.

12. Overall, these numbers hide disparities between Conakry and the other regions of Guinea. For example, the gross primary-school completion rate for girls in Conakry is 94 per cent, compared to 26 per cent in Nzérékoré in the south of the country. The infant and child mortality rate in Conakry is 9.2 per cent, compared to 20.4 per cent in rural areas. Basic social services for populations in sub-prefectures outside Conakry are non-functional and of poor quality. When functional services do exist, the level of poverty in the communities prevents them from gaining access to them.

13. In terms of the supply and demand of services, the worsening situation of children and women is the result of (a) underinvestment in basic social services, which deepens disparities; (b) inadequate facilities that do not provide quality services; and (c) social norms, behaviours and family practices. These factors, together with outdated and unreliable data, undermine child survival and growth, and help to keep child and mother well-being high.

14. The Government of Guinea submitted its initial report to the Committee on the Rights of the Child in 1999; its second report, submitted in 2008, will not be discussed until June 2012, highlighting the ineffective follow-up to the Committee's recommendations.

15. The country is engaged in and has reached the completion point of the Highly Indebted Poor Countries Initiative; that achievement and the investments expected in the mining sector represent potential sources of financial resources for the Government.

Key results and lessons learned from previous cooperation (2007-2012)

Key results

16. During the previous cycle, UNICEF support for regular campaigns led to a decrease in the number of cases of yellow fever and neonatal tetanus, though 15 districts are still considered "high risk" for the latter. There were two reported cases of poliomyelitis in Guinea in 2011. With regard to routine immunization, however, the situation has worsened for all antigens, with the exception of the tuberculosis and yellow fever vaccines. The ratio of initial contact in primary curative consultations per child and per year rose from 0.37 per cent in 2007 to 0.57 per cent in 2009 and 2010, which helped to increase three prenatal consultations coverage from 80 per cent to 82 per cent and primary curative consultations coverage from 0.2 to 0.3 contact per capita per year between 2009 and 2010. The rate of births attended by trained health workers rose from 48 per cent in 2007 to 61 per cent in 2011.

17. Children's nutrition improved in general. The overall prevalence of malnutrition dropped from 8 per cent in 2007 to 5 per cent in 2011, that of chronic malnutrition fell from 40 per cent to 34 per cent, and that of underweight children declined from 21 per cent to 16 per cent. On the other hand, the rate of exclusive breastfeeding dropped from 56 per cent to 17 per cent as a result of decreased support from the Government and its partners for its promotion.

18. UNICEF helped to expand geographic coverage of prevention of mother-to-child transmission, which rose from 6.5 per cent in 2006 to 28 per cent in 2011. The proportion of HIV-positive pregnant women who benefited from prenatal consultations and received antiretroviral treatment for the prevention of mother-to-child transmission increased from 6.6 per cent in 2006 to 26 per cent in 2010, and 9 per cent of children born to HIV-positive mothers received antiretroviral treatment.

19. The incidence of cholera, which previously exceeded 8,000 cases, resulting in 310 deaths in 2007, dropped to zero cases in 2010 and only two cases in 2011 (with no deaths). UNICEF contributed to its decrease by promoting the use of chlorine and latrines. The community-led total sanitation initiative and potable water supply led to a 77 per cent decrease in the rates of diarrhoea and water-borne diseases in areas receiving support.

20. First-year gross and net enrolment ratios have improved. The gross enrolment ratio rose from 77 per cent to 82 per cent (74 per cent to 76 per cent among girls) from 2007 to 2010, while the net enrolment ratio rose from 35 per cent to 44 per cent (34 per cent to 41 per cent among girls). However, the completion rate declined from 59 per cent (49 per cent among girls) to 57 per cent (45 per cent among girls). Gender parity, progress towards universal primary-school completion and the quality of education remain of major concern. UNICEF played an important role in the implementation of the Sectoral Programme for Education.

21. The rate of birth registration has increased, and the care provided to child victims of abuse has improved. As a result of joint efforts, birth registration rose from 28 per cent to 43 per cent from 2005 to 2010. The community child protection system is gradually being built up through the establishment of over 200 local protection committees. The legal framework has been strengthened through various measures, including the adoption of 11 pieces of legislation implementing the Child Code and the signing and publication of five decrees banning and punishing cutting/female genital mutilation.

Lessons learned

22. A strategic vision and long-term plan have been established for the education sector, with the support of technical and financial partners, including UNICEF. The strategic vision and plan incorporate the equity dimension and identify priority measures in the area of basic education. The education sector has a mechanism for functional coordination between its technical and financial partners, as well as between those partners and the Government. This should enable it to mobilize the necessary funds and to coordinate responses to needs within the sector. This strategy will be replicated in the health sector.

23. The programme's decentralization strategy helped to strengthen the link between the decision-making and operational levels of Government and the sub-prefectures. The strategy made it possible to work directly with communities and to closely monitor the measures taken and expenses incurred. It should be noted that community-based measures are more effective and can be scaled up more easily when decentralized authorities are involved in the planning, implementation and follow-up of activities. This decentralization will also make it possible to more effectively support community-based integrated activities and to strengthen local follow-up systems, which are indispensable for the continued elimination of bottlenecks and barriers that reduce the impact of measures taken to benefit children.

24. The progress achieved as a result of the community-led total sanitation initiative (a 77 per cent decrease in cases of diarrhoea) shows that a combination of home-water treatment and total sanitation efforts undertaken by the communities themselves, which purchase chlorine and build their own latrines without external assistance, can result in a dramatic decrease in diarrhoea-related diseases and helminth infections.

The country programme, 2013-2017

Summary budget table

	(In thousands of United States dollars)		
Programme components	*Regular resources*	*Other resources*	*Total*
Child and maternal health	9 128	18 372	27 500
Nutrition	3 427	12 073	15 500
Children and HIV/AIDS	3 427	6 083	11 575
Water, hygiene and sanitation	3 427	7 073	10 500
Quality basic education	4 927	11 573	16 500
Child protection	3 431	3 708	7 139
Social policies, advocacy, monitoring and evaluation	2 877	3 823	6 700
Cross-sectoral	5 496	2 865	8 361
Total	**36 140**	**65 570**	**103 775**

Preparation process

25. In preparing the new country programme, the office initiated several meetings, including a strategic moment of reflection with senior officials, which had a positive impact on the discussions about equity. Priority and strategic courses of action for reaching the most disadvantaged children were identified. The situation of women and children was also analysed, in cooperation with all decentralized offices and the central office, non-governmental organizations (NGOs) and the Children's Parliament.

26. The upcoming programme fits into the general framework of the United Nations Development Assistance Framework (UNDAF), the five-year plan and the Poverty Reduction Strategy Paper (PRSP). UNICEF co-chaired the programme harmonization group of the United Nations country team and the UNDAF "Basic Social Services" workshop, in line with the PRSP and the five-year plan. The UNDAF results matrices are fully aligned with the priorities identified following the situational analysis.

Programme components, results and strategies

27. The country programme is in line with the objectives of the PRSP and focuses in particular on the most vulnerable and disadvantaged children. Its goal is to help reduce the under-5 mortality rate by 25 per cent, increase the primary-school completion rate by 20 per cent and protect children in a more equitable and sustainable manner. It

will also help to create an environment where children can exercise their right to participate in decision-making on matters that affect their lives.

28. While developing the areas of action of the main strategies described below, the programme will ensure that each intermediate result of the different components incorporates the notion of behavioural change, in order to encourage the adoption of essential family practices in all sub-prefectures exhibiting major disparities. Over time, this cross-sectoral strategy is designed to achieve the following specific result: ensuring that communities and vulnerable and marginalized groups in particular participate in the establishment of social norms that promote children's health and development by reinforcing the adoption of essential family practices and the use of basic social services, with special focus on vaccination campaigns. The partnership with religious leaders and the media will be strengthened for the purposes of advocacy, promotion of essential family practices, and participation of young people in the development process.

29. The programme will be built around three main strategies for reaching the most disadvantaged children: (a) influencing the political dialogue in order to strengthen programmes and investments that promote accessible, equitable and quality basic social services; (b) strengthening the management system between the central level and the sub-prefectures; and (c) strengthening and improving the delivery and use of services at the community level, as well as the adoption of key norms and behaviours in areas with the highest inequality indicators.

30. **Child and maternal health**. This programme component will focus on: (a) increasing national resources for the financing of high-impact measures to reduce maternal and infant mortality; (b) generating, on a regular basis, reliable data that provide information on the effectiveness of high-impact curative, preventive and promotional measures; and (c) ensuring that quality health services are available and used, especially by women and children under the age of 5, in the most disadvantaged areas owing to poor geographical access and dearth of measures.

31. This component will aim to speed up implementation of effective strategies for child survival and development. UNICEF will help to develop the new national health development plan and the programming, budgeting, implementation and coordination mechanisms established by the Government in cooperation with its technical and financial partners. Focus will be placed on strengthening the expanded routine immunization programme with support for renewal and management of the cold chain, improving data reliability, implementing the "reaching every district" strategy, introducing new vaccines to prevent pneumonia and diarrhoea, and taking robust action to eradicate poliomyelitis and measles. Integrated management of neonatal and childhood illnesses and promotion of essential family practices will remain key strategies for combating the most deadly illnesses.

32. **Nutrition**. This programme component will focus on combating chronic malnutrition. It will ensure that: (a) increased financial support is provided for the promotion of exclusive breastfeeding and supplementary feeding, in order to reduce malnutrition rates; (b) statistical data on nutrition are generated in real time and used in political and programmatic decision-making; and (c) families living in the most disadvantaged areas adopt behaviours that foster good nutrition among children under the age of 5 and that children suffering from acute malnutrition receive quality care. In this connection, this component will place special emphasis on the introduction of appropriate supplementary feeding, micronutrient

supplementation, distribution of fortified foods, and promotion of diversification in foods consumed by communities. Management of severe acute malnutrition will be strengthened with the establishment of quality therapeutic centres and good data management for appropriate provision of therapeutic foods. The strategies used will consist of stakeholder and institutional capacity-building, community-based care and prevention, supplementation, and communication for development.

33. **Children and HIV/AIDS**. This programme component will help to reduce the spread of HIV infection among children and improve access to antiretroviral treatment for infected children. It will aim to scale up the strategy for eliminating mother-to-child transmission. It will ensure that: (a) the political, programmatic and budgetary dialogue is strengthened and that it helps to speed up the prevention and management of HIV/AIDS among children; (b) reliable data for monitoring the implementation and impact of measures are available; and (c) HIV-positive pregnant women receive antiretroviral treatment in order to reduce the risk of mother-to-child transmission, and that HIV-positive children receive adequate care. The major actions taken will include improved treatment of HIV-positive mothers, early diagnosis, treatment and care of infants exposed to HIV, and primary prevention and care for children made vulnerable by HIV.

34. **Water, hygiene and sanitation**. This programme component will develop activities integrated with health and education to help reduce mortality and drop out rates among primary school girls. The water, hygiene and sanitation component aims to achieve two main results: (a) stronger political, programmatic and budgetary dialogue in order to identify cost-effective measures that would help to improve the environment and reduce the incidence of water-borne diseases; and (b) equitable access to drinking water and sanitation services for communities, schools and health-care centres in disadvantaged areas. The component will focus on methods of time-of-use water chlorination and purification in order to reduce the incidence of diarrhoea.

35. **Quality basic education**. This programme component will focus on increasing primary-school completion rates among girls and children of vulnerable groups in the most disadvantaged regions. The results sought are that: (a) the Sectoral Programme for Education is updated and its funding increased in order to improve the quality of education and the rate of completion of primary school by all girls and the most vulnerable children; (b) coordination of the implementation of the Sectoral Programme for Education is effective at both the central and the decentralized levels and is supported by reliable and timely statistical data; and (c) the quality and success of learning are improved for all children, particularly girls from disadvantaged areas. The main measures include the promotion of community-based basic preschooling in order to encourage children to start school at the required age (6 years); and the implementation of innovative activities (tutoring by older girls of younger girls and those who are at risk of dropping out, monitoring of learning, classes for overage children), in order to reduce the drop out rate, improve the success rate and ensure accelerated education for children not enrolled in school or those who have dropped out. Emphasis will be placed on promoting and implementing the child-friendly schools model, with a focus on the scaling up of active teaching, improvement of the environment and participation of children in school life and management.

36. **Child protection**. This programme component will focus on the establishment of birth registration mechanisms and involvement of children in all actions that

affect them. Particular attention will be paid to elaborating a social protection policy for the most disadvantaged children, in cooperation with several partners. Specific programmatic measures will be taken to fill gaps and overcome challenges faced by adolescents, in order to improve their living conditions, promote opportunities, and foster peacebuilding, with special focus on the socioprofessional reintegration of at-risk adolescents. The results sought are that: (a) programmes and budgets that benefit the most vulnerable children are strengthened; (b) a management system between the central level and the sub-prefectures for monitoring child registration is established and information on violence against children is generated regularly and used in decision-making; and (c) children and young people receive a multisectoral response and are reintegrated, and families adopt behaviours that foster child registration and a reduction of female genital mutilation/cutting and early pregnancy. All these results will be achieved with the implementation of a stronger child protection system.

37. **Social policies, advocacy, monitoring and evaluation**. This programme component will support the review of national policies, development of strategies and strengthening of the capacities of key Government institutions, in order to ensure that allocations and measures take into account the poorest populations in an equitable and sustainable manner, with a view towards peacebuilding. It will also focus on the collection and dissemination of disaggregated data (by sex, group and geography), in order to show the impact of services on the most disadvantaged children. Considering that the data available is outdated, focus will be placed on conducting a number of surveys and studies, such as the multiple indicator cluster survey/fourth population and health survey. The results sought are that: (a) the Government adopts a pro-poor and equitable programme and budget at the national level and a plan that puts the child at the centre of national development processes and reduces inequalities; and (b) mechanisms and systems for the collection of data and monitoring of social indicators are functional and equity-sensitive. An equity monitoring and evaluation framework is developed to take stock of the removal of barriers and bottlenecks that limit the improvement of living conditions for children and women.

38. UNICEF will coordinate the partners' response in nutrition, water-sanitation and education in times of crisis and humanitarian emergencies, such as floods, social disturbance and conflicts in neighbouring countries, which could undermine the achievement of the programme's expected results. The necessary measures will be taken to mitigate and evaluate these risks on an annual basis and adjust the programme strategies accordingly.

Relationship to national priorities and the United Nations Development Assistance Framework

39. The programme will contribute directly to the achievement of the objectives of UNDAF, which comprises three strategic segments: (i) promotion of good governance; (ii) acceleration of growth and promotion of employment and income opportunities for all; and (iii) reduction of vulnerability and improvement of living conditions. The various components of the country programme fall under the third segment, with some sub-categories of the protection programme in the second segment.

Relationship to international priorities

40. The strategic objectives of UNDAF in the Republic of Guinea draw inspiration from the Millennium Declaration and the Millennium Development Goals. The design, strategies and expected results of the 2013-2017 UNICEF programme were also guided by the Convention on the Rights of the Child, the African Charter of the Rights and Welfare of the Child, the Convention on the Elimination of All Forms of Discrimination against Women, A world fit for children, the Paris Declaration on Aid Effectiveness, the Accra Agenda for Action and the Hyogo Framework for Action. The programme contributes to the medium-term strategic plan of UNICEF and to the document entitled "Unite for Children, Unite against AIDS".

Major partnerships

41. The Government remains the priority partner of UNICEF, but UNICEF will also continue to cooperate with the Global Fund to Fight AIDS, Tuberculosis and Malaria, the International Health Partnership, the Global Alliance for Vaccines and Immunization, and the Global Partnership for Education. Stronger cooperation will be forged with such partners as the World Bank, the European Union, the African Development Bank, the Inter-American Development Bank, the United States Agency for International Development, Germany, France, Japan and the National Committees. UNICEF will continue to cooperate with non-governmental and faith-based organizations, which provide substantial support for basic social services and for vulnerable members of the community. Strategic partnerships will be pursued with international NGOs and agencies of the United Nations system as part of UNDAF, in order to scale up high-impact actions that benefit the most disadvantaged children.

Monitoring, evaluation and programme management

42. The Ministry of International Cooperation and the Ministry of Planning, mainly through its Central Coordination Unit, will coordinate the cooperation programme. A five-year plan of action and annual plans of action will be developed in cooperation with the relevant ministries.

43. UNICEF will continue to work in close cooperation with the statistics departments of key partner ministries in establishing data-collection mechanisms, in an effort to generate timely, quality official statistics disseminated at the central level for decision-making. A series of surveys and studies has been planned to take stock of the situation of children and the progress made, including progress towards achieving the Millennium Development Goals. The surveys and studies identified will be included in the office's monitoring and evaluation plan. UNICEF will also strengthen monitoring activities through its decentralized offices. A mid-point programme review will be conducted in 2015.