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UNICEF GUINEA/M.MMAZBOUDI

USAID/GUINEA CDCS GENDER ANALYSIS

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ACRONYMS

ADS	Automated Directives Systems
AOR	Agreement officer representative
ASC	<i>Agents santé communautaires</i> (community health worker)
BSD	<i>Bureaux de Stratégies et Développement</i> (Strategy and Development Offices)
CBO	Community-based organization
CDCS	Country Development Cooperation Strategy
CEDAW	Convention on the Elimination of all Forms of Discrimination Against Women
CEFM	Child, early, and forced marriage
CENI	Independent National Electoral Commission
COR	Contracting officer representative
CSO	Civil society organizations
DHS	Demographic and Household Survey
DO	Development Objective
ECOWAS	Economic Community of West African States
EDS	<i>Enquête Démographique et de Santé</i> (Demographic and Health Survey)
EVD	Ebola Virus Disease
FAO	Food and Agricultural Organization
FGD	Focus group discussions
FGM/C	Female genital mutilation/cutting
FP	Family planning
FP/RH	Family planning and reproductive health
GDP	Gross domestic product
GEWE	Gender equality and women's empowerment
GFP	Gender Focal Point
GOG	Government of Guinea
GRB	Gender-responsive budgeting
HDI	Human Development Index
HIV/AIDS	Human immunodeficiency virus / Acquired immune deficiency syndrome
IP	Implementing partner
IPV	Intimate partner violence
IR	Intermediate Result
J2SR	Journey to Self-Reliance
MASPF	<i>Ministère des Affaires Sociales, de la Promotion Féminine et de l'Enfance</i> (Ministry of Social Affairs, Promotion of Women and Children)
MASPV	<i>Ministère de l'Action Sociales et des Personnes Vulnérables</i> (Ministry of Social Action and Vulnerable People)
MCH	Maternal and child health
MDAF	<i>Ministère des Droits et de l'Autonomisation des Femmes</i> (Ministry of Women's Rights and Empowerment)
MICS	Multiple Indicator Cluster Survey
MOH	Ministry of Health
NAP	National Adaptation Planning
OECD	Organization for Economic Cooperation and Development
OPROGEM	<i>Office National pour la Protection du Genre, de l'Enfance et Des Moeurs</i> (National Office for the Protection of Gender, Childhood, and Morals)
OSC	One-Stop Centers
RECOS	<i>Relais Communautaires</i> (Community Mobilizers)
RH	Reproductive health
SDG	Sustainable Development Goals

SOW	Scope of Work
SME	Small or medium enterprise
SRH	Sexual and reproductive health
SSA	Sub-Saharan Africa
STI	Sexually transmitted infection
TBA	Traditional birth attendant
TEC	Technical Evaluation Committee
TFR	Total fertility rate
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WEEE	Women's Entrepreneurship and Economic Empowerment
W-GDP	White House Women's Global Development and Prosperity Initiative

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EXECUTIVE SUMMARY

INTRODUCTION

The United States Agency for International Development (USAID)/Guinea contracted Banyan Global to undertake a countrywide gender analysis to inform the USAID/Guinea 2021–2025 Country Development Cooperation Strategy (CDCS) and gender integration in the mission’s programs, projects, and activities. This analysis identifies gender advances, constraints, and opportunities in Guinea along two mission development objectives (DO): (DO1) Increased capacity and commitment of the local health system for better health outcomes; and (DO2) Democratic and economic governance strengthened. This report addresses two cross-cutting themes: gender-based violence (GBV) prevention and response; and specific value chains where the private sector is well placed to empower women. It also addresses urban and rural inhabitants as key populations. It provides recommendations on women’s economic empowerment (WEE) and links the report’s recommendations to the USAID Journey to Self-Reliance (J2SR).

METHODOLOGY

Banyan Global prepared this report at the culmination of a multi-stage process that included a review of 88 secondary data sources in addition to several internal USAID documents. The research team collected primary data remotely by carrying out surveys and remote key stakeholder interviews. Over 60 external stakeholders responded to online surveys or completed remote interviews. The key findings and recommendations are presented below, with tags to highlight opportunities to address WEE and labels to highlight linkages to the USAID J2SR sub-dimensions.

GENDER ANALYSIS FINDINGS AND RECOMMENDATIONS

TABLE 1. GENDER ANALYSIS KEY FINDINGS AND RECOMMENDATIONS

FINDINGS	RECOMMENDATIONS
DO 1: Increased capacity and commitment of the local health system for better health outcomes	
J2SR Sub-Dimensions: Open and accountable government, inclusive development, government capacity, civil society capacity, and citizen capacity	
IR 1.1 Provision of quality Maternal Child Health (MCH), family planning/reproductive health (FP/RH), and malaria services assured	
<ul style="list-style-type: none">• Informal (and in some instances formal) payment schemes associated with health care limit women and men’s access to health services, with a disproportionate impact on women and adolescent girls.• Insufficient female medical personnel, in particular doctors and health center management, affects women’s use of health services.• Gender-sensitive services and infrastructure are virtually nonexistent.• The Guinean health system is marked by widespread unavailability of coordinated	<ul style="list-style-type: none">• Partner with civil society organizations (CSOs) for increased oversight of health center financial practices to mitigate the imposition of informal payment schemes that restrict access to important and state-sponsored health services.• Engage with relevant institutions to develop a strategy to increase the percentage of female health professionals in decision-making positions. Increase the percentage of female health professionals in decision-making positions by engaging with relevant institutions on strategic planning. Advocate for recruitment at decentralized levels, and regularly track women’s equality issues within the health workforce. WEE

and holistic GBV response services; health care providers lack capacity in the clinical management of GBV.	<ul style="list-style-type: none"> • Advocate and support institutionalized pre- and in-service training on the clinical management of GBV, for all health-care professionals.¹ • Invest in GBV-specific programming supporting (or piloting) one-stop centers (OSC). Seek opportunities to leverage the expertise and experience of active CSOs working in GBV prevention and response. • Incorporate gender into clinical audits and other efforts to monitor quality of care of MCH and FP/RH services, and gender-sensitivity of related infrastructure, services, and facilities.
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IR 1.2 Health-enhancing social norms established

<ul style="list-style-type: none"> • The attitudes of health care providers and managers impede access to, and quality of, gender-sensitive health services. Common attitudes include impolite and dictatorial staff and a general disrespect for those seeking care, especially in rural areas. • Gender roles, unequitable decision-making practices, and lack of household communication between men and women limit health-enhancing behaviors. These are not adequately addressed in program strategies (specifically in relation to power dynamics and influential individuals). • Pervasive norms around masculinity prevent men from practicing and supporting appropriate health-seeking behaviors specifically related to FP/RH. • Gender norms that tolerate and justify GBV contribute to high prevalence rates of GBV, especially Intimate Partner Violence (IPV). • The normative view that FGM/C is an important socio-cultural tradition, rather than a form of GBV or a violation of human rights, results in a high FGM/C prevalence rate—with devastating health impacts. • Measures to combat FGM/C rarely take a holistic approach or include a focus on social norm change. 	<ul style="list-style-type: none"> • Ensure that activity targeting does not inadvertently reinforce existing gender roles that negatively impact gender-equality and health outcomes. Approaches to promote health-enhancing norms should seek to transform norms about gender roles and responsibilities that over-burden women and girls with work related to MCH and FP/RH and that may inadvertently exclude men and boys. • Ensure inclusion of appropriately targeted Social Behavior Change Communication strategies that, for example, take into account power dynamics in polygamous households and the influence of elderly women and traditional leaders. • Empower girls and women economically through microfinance activities, enabling them to make healthy choices, increase their negotiating power, and enhance their efficacy and self-confidence. WEE • Use critical reflection as an effective strategy to enable peer educators to serve as change agents who can identify inequitable gender norms and understand how these norms influence people's health and health behavior, including related to female genital mutilation/cutting (FGM/C). • Promote strategies for male engagement (gender-equitable masculinities) to reduce gender-based inequities in health. • Integrate GBV prevention into all DOI programming through community mobilization and social norm interventions, including specifically programming that recognizes the need for tailored and holistic approaches to reduce FGM/C and child, early, and forced marriage (CEFM).²
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IR 1.3 Democratic norms and processes strengthened

<ul style="list-style-type: none"> • Limited participation of women at the highest levels of decision-making in the health sector affects health outcomes for women and girls. • Inclusive platforms for community engagement on health system governance that prioritize the voice of women and girls are rare. 	<ul style="list-style-type: none"> • Work with community-level structures (e.g., health committees) to improve inclusive community engagement opportunities for participatory consultations. • Integrate knowledge (and benefits) of gender-responsive budgeting (GRB) into interventions aimed at strengthening civil society and relevant institutions.³ • Promote coalitions of organizations working on GBV in support of a multi-sectoral, coordinated GBV response.
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¹ In accordance with EO 13950, USAID has put a hold on all upcoming training, seminars, and other related fora on diversity and inclusion pending an Agency and OPM review of the content of these programs (see Executive Order and OMB Guidance). It may also be helpful to review Agency Notices numbers 09214 and 10196. Mission staff reviewing these recommendations should seek guidance from Mission leadership prior to moving forward with any training events.

² Refer to note 1 above.

³ Refer to note 1 above.

- There is no line item or specific budget for gender-related priorities in health ministries.
- A vibrant and active civil society and independent media are undertaking GBV advocacy efforts and raising awareness in Guinea, albeit with limited funding and little experience in gender-transformative approaches aimed at norm change.

IR 1.4 Cross-cutting: Use of strategic information for decision-making increased

- The health system in Guinea has data analysis and visualization systems available, but it is not systematically using them to analyze and address gender gaps in health service access, use, and outcomes.
- There is little cross-ministerial collaboration for data-sharing related to gender equality and GBV prevention and response.
- There is a major gap in available research on the prevalence and drivers of GBV.
- Conduct trainings on the use of sex-disaggregated data to inform health systems decisions.⁴
- Participate in existing GBV coordination working groups to access information on existing programs/approaches to GBV prevention and response, and support convening relevant actors.⁵
- Finance a national study on the prevalence of GBV, its drivers, and context-appropriate strategies to combat it.
- Finance a study on FGM/C efforts in Guinea to identify what has worked in reducing its incidence in Guinea, in line with global evidence-based guidelines.

DO 2: Democratic and economic governance strengthened

J2SR Sub-Dimensions: Open and accountable government, inclusive development, economic policy, government capacity, civil society capacity, and citizen capacity

IR 2.1 Democratic norms and processes strengthened

- The biggest barriers to the effective participation and active leadership of women and girls in decision-making structures are: gender norms; restricted mobility, due to the need for spousal permission; time constraints; safety concerns; and illiteracy.
- Though there are a number of women's groups that are active in advocacy and political events, women report feeling unsafe at political demonstrations.
- Decentralization policy design and implementation have not been adequately responsive to the priorities and needs of women and girls in Guinea; the response of CSOs working in women's rights has been fragmented
- GBV survivors' limited awareness of their rights, gaps in GBV legislation, and weak enforcement of legal protections perpetuate impunity of perpetrators.
- Increase women's participation in decision-making structures by encouraging the creation of local government-led programs to train and build the capacity of women, by engaging strategically with potential "resistors," and by sharing evidence to make the business case for women in decision-making positions. **WEE**
- Invest in women's economic assets; enhance women's decision-making power through economic programs that increase women's access to property, land, livelihoods, other capital, and business opportunities. **WEE**
- Leverage the decentralization process to increase capacity for GRB and strategic planning (with a particular focus on GBV).
- Seek new partnerships with CSOs working in gender equality, especially for co-design of new projects.

IR 2.2 Conflict management and mitigation improved

- Traditional justice systems in Guinea reinforce the subordination of women to their husbands, due to the importance accorded to marriage (especially in regard to divorce and inheritance); women's participation in traditional justice bodies is weak and without decision-making power.
- Deliberately widen the lens of conflict mitigation to include GBV.
- Invest in women's economic assets, as there is a clear opportunity to enhance women's decision-making power through economic programs that increase women's access to property, land, livelihoods, other capital, and business opportunities. **WEE**

⁴ Refer to note 1 above.

⁵ Refer to note 1 above.

- Low capacity of authorities to resolve disputes related to GBV in an appropriate and fair manner deters survivors from receiving justice.
- Women are disproportionately affected by the environmental impacts of mining activities on local communities, but they are rarely consulted in remedial meetings and rarely lodge complaints.
- Provide technical assistance to peace process leaders to increase their capacity to meaningfully address gender issues, including GBV, mining-related conflicts, and equitable political participation and governance.⁶ **WEE**
- Support coalition building between active CSO groups engaged in conflict management and mitigation with women and youth.

IR 2.3 Sustainable economic opportunities increased

- Sexual harassment is a major reported barrier for women in the private sector.
 - Many women engage in *petite commerce* (small commercial activities), but structural factors—such as access to resources including financial services—limit their expansion.
 - Men in Guinea are viewed as the “farmers” and women as “farmer’s assistants” or laborers, which leads to gender-inequitable access to productive resources and advisory services.
 - Political interference in Guinea is a potential risk to small or medium enterprise (SME) owners generally, particularly to women entrepreneurs.
 - Certain agricultural value chains offer unique opportunities for women’s empowerment, but women remain limited by structural factors related to control of resources, social networks, and gender norms that dictate men’s control over revenue.
 - Support existing, successful women entrepreneurs to expand and to share successes with other women. **WEE**
 - Promote the business case for increased female leadership in firms by working with targeted actors in the private sector to encourage firms to recruit, identify, retain, and promote female employees into more leadership roles. **WEE**
 - Increase women’s access to financial services by encouraging financial institutions to allow for alternative collateral and group-based approaches to lending. **WEE**
 - Seek opportunities to invest in and promote the fruit drying, cashew, small fishery, and shea value chains, as these commodities have potential in women’s economic empowerment. **WEE**
- Develop co-design processes to engage women’s agricultural organizations that can speak to the needs and priorities of women entrepreneurs in the agricultural sector. **WEE**

I. INTRODUCTION

I.1 BACKGROUND

In line with the requirements in the United States Agency for International Development’s (USAID) Automated Directives System (ADS) 201.3.2.9 and ADS 205, USAID/Guinea contracted Banyan Global to undertake a countrywide gender analysis to inform its 2021–2025 Country Development Cooperation Strategy (CDCS). The gender analysis aligns with the USAID Gender Equality and Female Empowerment Policy, the U.S. Strategy to Prevent and Respond to Gender-Based Violence Globally, the USAID Policy Framework, the USAID Journey to Self-Reliance (J2SR), and the Women’s Entrepreneurship and Economic Empowerment (WEEE) Act of 2018.

I.2 PURPOSE OF THE USAID/GUINEA GENDER ANALYSIS

This gender analysis aims to provide data to enhance the integration of gender equality and women’s empowerment (GEWE) in the USAID/Guinea 2020–2025 CDCS. As shown in Table 2, the analysis addresses specific development objectives (DOs), USAID ADS 205 gender analysis domains, crosscutting themes, and key populations. (Refer also to the scope of work (SOW) in Annex A.)

⁶ Refer to note 1 above.

TABLE 2. KEY ELEMENTS OF THE GENDER ANALYSIS

DEVELOPMENT OBJECTIVES	USAID ADS 205 GENDER ANALYSIS DOMAINS	CROSSCUTTING THEMES & KEY POPULATIONS
<ul style="list-style-type: none"> • DO1: Increased capacity and commitment of the local health system for better health outcomes • DO2: Democratic and economic governance strengthened 	<ul style="list-style-type: none"> • Laws, policies, regulations, and institutional practices • Cultural norms and beliefs • Gender roles, responsibilities, and time use • Access to and control over assets and resources • Patterns of power and decision-making 	<ul style="list-style-type: none"> • Gender-based violence (GBV) prevention and response • Women's economic empowerment • Value chains well-placed to empower women

The analysis methodology comprised a desk review of secondary data as well as remote primary data collection. Despite challenges posed by the ongoing COVID-19 pandemic, over 60 key informants provided primary data via an online survey or remote interviews. The gender analysis findings and recommendations point to linkages by DO with the [USAID J2SR sub-dimensions](#) (shown in Figure 1).

They also point to opportunities for the mission to consider, related to both the 2018 WEEE Act and the White House's Women's Global Development and Prosperity Initiative (W-GDP) (indicated in this report by a **WEE** tag).

Section 2 of the report provides an overview of the country context and the gender landscape. Sections 3 and 4 present the gender analysis findings and recommendations, organized by USAID/Guinea DO. Section 5 presents recommendations related specifically to strengthening gender quality and women's empowerment within USAID/Guinea. Annex A is the gender analysis's SOW; Annex B provides the gender analysis methodology; Annex C lists the key documents consulted; Annex D presents the gender analysis interview guides; and Annex E lists key interviewees.

FIGURE 1. USAID J2SR SUB-DIMENSIONS



2. COUNTRY CONTEXT AND GENDER LANDSCAPE

2.1 GUINEA CONTEXT AND BACKGROUND

The Republic of Guinea (herein referred to as Guinea) is a low-income coastal West African country that shares a border with six other countries, four of which have experienced prolonged conflicts: Côte D'Ivoire, Guinea-Bissau, Liberia, and Sierra Leone. The majority of Guinea's population is Muslim (approximately 85 percent), followed by Christian (8 percent) and traditional religious practitioners (7 percent).¹ The official language is French, and there are several other national languages, including Loma, Susu, Peuhl, Malinké, Kpelle, and Kissi.²

Guinea has four natural geographical regions (Lower, Middle, Upper, and Forest Guinea), each with different climatic, hydrological, and ecological characteristics. It is further divided into seven administrative regions, in addition to the national capital of Conakry and its surrounding areas.³ Guinea's economy is mainly dependent on agriculture and mineral production. Guinea has significant but underexploited natural resource endowments, including the world's largest untapped iron-ore mine and about one-third of the world's bauxite reserves.⁴

As of 2018, Guinea's population is estimated at just over 12.4 million inhabitants.⁵ The urban population is 34.8 percent of the total population, and the population growth rate of Conakry is three times the national average, reflecting an increasing rural exodus. The majority of the population lives in rural areas, which have a higher concentration of women (62 percent) than men (56 percent).⁶ The youth population is growing rapidly: nearly half of the Guinean population is less than 15 years of age (48 percent), compared with just 4 percent of the population above age 65.⁷ Women's total fertility rate (TFR) declined slightly, from an average of 5.5 children in 1999 to 4.8 in 2018. However, early pregnancy remains high; nearly one-quarter of women aged 15–19 have already begun childbearing.⁸



Map of Guinea: administrative and ecological regions

Despite its potential, Guinea remains one of the poorest countries in Sub-Saharan Africa (SSA). The 2019 United Nations Human Development Report indicates that Guinea has a Human Development Index (HDI) score of 0.466, positioning it at 175 out of 189 countries.⁹ The HDI value for females in Guinea is 0.413 compared to 0.513 for males, resulting in a Gender Development Index of 0.806.¹⁰ The estimated 2018 Gross National Income (GNI) per capita for Guinea is \$2,211, with marked gender gaps: GNI per capita for women in Guinea is \$1,878, versus \$2,569 for men.¹¹ The most recent census of poverty levels

(2012) shows 55.2 percent of the population living in poverty.¹² Poverty is very unevenly distributed by region and gender. Multi-dimensional poverty affects rural inhabitants more than urban (89.3 percent compared to 18.6 percent).¹³ Due to the

COVID-19 pandemic, real gross domestic product (GDP) growth has decreased from 6.2 percent in 2018 to 3.2 percent in 2020.¹⁴

Guinea's overall education levels are lower than the SSA average, and gender gaps are wider. The 2018 Demographic and Household Survey (DHS) found that over 60 percent of women and 44 percent of men have received no formal education.¹⁵ Literacy rates in Guinea show similar patterns, with 53 percent of men literate compared to only 24 percent of women (age 15–49).¹⁶ Gender parity in school enrollment rates has improved, but fewer girls than boys make the transition to higher levels of education. These gaps are more severe in rural areas. The Human Capital Index estimates that a girl is expected to complete 6.2 years of school, while a boy is anticipated to complete 7.7 years.¹⁷

The 2020 World Economic Forum's Global Gender Gap report positions Guinea at 125 out of 153 countries.¹⁸ Guinea's 2019 rankings on gender gaps in economic participation and opportunity is low, while gender gaps in educational and political empowerment remain persistently high.¹⁹ Reports estimate that reducing gender inequality in Guinea could accelerate per capita GDP growth by up to 0.6 percentage points per year, or 10.2 percent overall by 2035.²⁰

Significant challenges persist, such as GBV—including harmful traditional practices like child, early and forced marriage (CEFM) and female genital mutilation/cutting (FGM/C). Sixty-three percent of women in Guinea have experienced domestic violence over the course of their lifetime;²¹ Ninety-seven percent of women and girls in Guinea have undergone FGM/C;²² 19 percent of all girls were married by age 15; and 51 percent were married by age 18.²³

2.2 GENDER EQUALITY OVERVIEW, BY ADS205 GENDER ANALYSIS DOMAIN

LAWS, POLICIES, REGULATIONS, AND INSTITUTIONAL PRACTICES

At the international level, Guinea has ratified several key international conventions on human rights and equality. In 1982, Guinea ratified the Convention on the Elimination of all forms of Discrimination Against Women (CEDAW);²⁴ more recently, the Government of Guinea (GOG) has committed to the Sustainable Development Goals (SDGs) to promote gender equality (Goal 5). Similarly, the GOG has made more important commitments to gender equality at the regional and sub-regional level.^{25, 26}

At the national level, revisions to Guinea's constitution in 2001 introduced the principles of non-discrimination and gender equality.²⁷ Article 8 of the constitution establishes equality between men and women as a fundamental right. Additionally, Articles 1 and 15 guarantee that men and women have equal access to non-land assets, and at the time of marriage, spouses can establish a contract specifying the division of ownership.²⁸ When women marry, they have the right to retain control over and use of assets that they own independently of their husbands. The GOG recently updated the constitution in 2020, and various draft versions of the constitution are currently in circulation. In the April 2020 version, the GOG expanded Article 8 to include the "physical integrity" of all genders, which prohibits GBV and FGM/C. It also expanded Article 23 to define the age of marriage as 18 and to prohibit forced marriage.²⁹

The national labor code prohibits gender discrimination in hiring as well as all forms of workplace harassment, including sexual harassment.³⁰ A draft Family Code (*Code des Personnes et de la Famille*) as

well as amendments to the Civil Code³¹ have been under preparation for several years but have not yet been adopted.

Statutory law, especially the Civil and Labor Codes, contains many discriminatory provisions, including on marriage, adultery, and polygamy.³² For example, the husband is defined as “the head of the family,” granting him the legal power to choose the place of residence for the family and the right to object to his wife exercising the profession of her choice. In cases of divorce, a woman has custody of children only until they are seven years of age.

Despite the existence of some gender-sensitive legal frameworks in Guinea guaranteeing equitable treatment for men and boys and women and girls, traditional laws often supersede formal legal frameworks. The parallel existence of customary, religious, and statutory laws in Guinea creates confusion and often undermines women’s rights.³³ For example:

- National policies stipulate that widows are entitled to receive one-eighth of total inheritance; however, customary forms of levirate³⁴ and sororate³⁵ continue to be practiced, preventing women from receiving widow inheritance entitlements.
- Though Guinean land law grants equal rights to women and men, customary practices prohibit women from inheriting land. Instead, they are entitled to hold land only on a usufruct³⁶ basis, which authorizes them to work family-owned land and draw a wage.
- Divorce laws generally favor men in awarding custody and dividing communal assets. Legal testimony given by women also carries less weight than testimony by men, in accordance with Islamic and customary law.³⁷
- The labor code prohibits gender discrimination in hiring. However, traditional practices historically discriminate against women and sometimes take precedence over the law, particularly in rural areas.³⁸

At the institutional level, the GOG created the Ministry of Social Affairs and Gender Promotion (MASPFE) (*Le Ministère des Affaires Sociales, de la Promotion Féminine et de l’Enfance*) in 1996 to focus on issues related to gender equality.³⁹ The original Ministry had branches at every administrative level (national, prefectural, and mayoral). The MASPFE is comprised of three technical departments: *Direction Nationale de la Promotion Féminine et du Genre* (National Directorate for the Promotion of Women and Gender); *Direction Nationale de la Protection Sociale* (National Directorate for Social Protection); and *Direction Nationale de l’Enfance* (National Directorate of Children). The primary function of MASPFE is to oversee the implementation of the National Policy on Gender (which it created in 2011 and revised 2017) and the National Policy on Social Protection and Children. The MASPFE also has overseen the creation of gender units in ministerial departments and has established other relevant entities: a gender thematic group; a network of women Ministers and Parliamentarians; regional committee to combat GBV; a National Committee for the Abandonment of FGM/C; and CEDAW monitoring committees.⁴⁰ In May 2020, the MASPFE split into two new ministerial offices: The Ministry of Social Action and Vulnerable Persons (*Le Ministère de l’Action Sociales et des Personnes Vulnérables*) (MASPV) and the Ministry of Rights and Women’s Empowerment (*Le Ministère des Droits et de l’Autonomisation des Femmes*) (MDAF). The purpose of the split was to establish a clear division between social and child protection and women’s rights and empowerment. The split, however, has not yet been operationalized, and

confusion persists among GOG stakeholders about the division of responsibilities. This confusion has created concerns that there may be reductions in budget allocations for already inadequately funded GEWE initiatives.⁴¹

CULTURAL NORMS AND BELIEFS

As mentioned above, deeply rooted sociocultural norms and beliefs, embedded in customary and/or religious practices, often limit the full application of national legal and policy frameworks to advance gender equality.

Gender norms and beliefs in Guinea follow traditional and conservative patterns, which dictate rigid roles for women, men, boys, and girls. Cultural attitudes and beliefs construct “real men” to be heads of households—the breadwinners, and the ones who make decisions about household resource use and investments.⁴²

Gender norms about what it means to be a “real woman” are conflated with submissiveness, pride, dignity, taking care of the family, and domestic duties.⁴³ Notions of femininity and masculinity can limit women’s mobility and their ability to participate and take on leadership roles outside of the domestic sphere. For example, women often receive blame when the house is seen as unclean, children are unruly, food is ill-prepared (or food stocks mismanaged), household members are sick, and even when their husbands are not looking “smart” when they leave the house.⁴⁴ In the financial realm, social norms impact women’s control over income and expenditures. Guinean men may welcome women’s financial contributions; however, “some men . . . see their status as head of the household threatened by an economically powerful wife.”⁴⁵

In Guinea, marriage is considered a formal union of two families rather than a choice between a man and woman. The extent to which a young Guinean woman has a say in the choice of her husband depends on many factors. The most important is her ethnic, educational, and economic background and her family’s marriage tradition. High status is attached to men who have multiple young brides, and more than 42 percent of Guinean girls aged 15–19 are in polygamous unions.⁴⁶ Relatedly, the family unit or household in Guinea is large and often comprised of multiple generations. Individuals and families acquire social status and respect when they observe socio-cultural norms, and they typically do not deviate from these societal norms (thus risking ostracism). Older women are associated with more experience and wisdom and often uphold socio-cultural norms.

Rigid, underlying cultural norms and beliefs related to the roles and sexuality of women and girls in Guinea contributes to a culture of acceptance of various forms of GBV (refer to [IR 1.2 findings](#)). Examples of such beliefs include gender prescriptions that require: girls’ virginity before marriage;⁴⁷ women’s chastity and monogamy; women’s sexual availability to their partners;⁴⁸ and the production of legitimate male heirs.⁴⁹ Other norms include concerns about girls’ marriageability, social acceptance, and the fear of losing the protection of other women and the community, if a girl does not undergo FGM/C. This is reflected in the high prevalence of FGM/C in Guinea (95 percent of women ages 15–49).⁵⁰

Norms also contribute to the practice of CEFM and other forms of forced marriage, such as “levirate,” where a widow is obliged to marry her brother-in-law after the death of her husband.⁵¹ In most instances of levirate, a woman’s refusal to obey this custom deprives her custody of her children and the

right to remain in the marital home. More generally, customary beliefs and practices of inheritance (of land and property) almost always favor men/boys over women/girls, even in cases of widowhood.⁵²

GENDER ROLES, RESPONSIBILITIES, AND TIME USE

As mentioned above, there is a rigid division of roles and responsibilities between men and women in Guinea, dictated by socio-cultural norms and beliefs. For example, household chores (such as cooking, collecting fuel, and fetching water) and childcare are considered the sole responsibility of women and girls. Men are responsible for family finances, defined narrowly as being an economic provider (and with primary control over income use). Some factors, such as the labor emigration of men, have led to a rise of women as heads of household. In most cases, however, his male kin become the head of household if a woman's husband emigrates.

As a result of the unequitable division of labor, women are extremely overworked. For example, a study of women's time burden in Guinea found that women (aged 15 and up) spend an average of 22 hours per week on domestic tasks, including collection of wood and water, whereas men spend an average of four hours per week.⁵³ This unequitable division of household labor results in major "time poverty" for women and constrains women's ability to work outside the home, pursue education/training, or engage in social/leisure activities. On average, adult women spend 25 percent more time on unpaid work than adult men, and girls spend 34 percent more time on unpaid work than boys. This gap is even more pronounced for children who are enrolled in school, suggesting that it may be more difficult for girls to find the time to study, especially in rural areas.⁵⁴

Women's time burden creates substantial gender gaps in earnings and productivity, which can decrease women's bargaining power and voice, including their ability to negotiate productive work within the household. Guinean women also play a significant role in agricultural production. They are largely responsible for subsistence farming, whereas men participate largely in commercial agriculture (cash crops). When women contribute to the cultivation of male family members' cash crops, they are often not paid for that work. In several traditionally livestock-rearing communities, women receive cattle as a form of dowry.⁵⁵ The Quran assures women the right to control assets given as dowry. However, in general, all decisions about cattle, including the decision to slaughter or sell, are made by men. Relatedly, women (and children) are responsible for small household ruminants (sheep and goats primarily) and poultry.⁵⁶ However, if this work becomes especially lucrative (through higher production or selling price), men assume control over these commodities.⁵⁷

Women also make up most vendors in markets. Men who are active in selling in markets typically sell non-perishable goods.⁵⁸ Many market women buy the ingredients for meals with the money they earn that day, and are thus responsible for nourishing their families. Women thus play a critical role in household nutrition and food security, through their market activities, their role in subsistence food production, and their unpaid labor for their husband's commercial agricultural production.

The distribution of the domestic workload among women in polygamous households is determined by the hierarchy of co-wives. For example, younger wives often bear more of the workload than senior wives. Women in polygamous households ostensibly benefit from sharing the workload in chores and childcare, which may create an opportunity to participate in income-generating opportunities.

ACCESS TO AND CONTROL OVER ASSETS AND RESOURCES

Gender norms put women at a disadvantage in their access and capacity to use productive resources, such as land, agricultural inputs and services, financial services, and technologies.

Despite the important role women play in agricultural production (from land preparation to harvest), women have little control over any resources derived from the agricultural sector. Women have far less control over the acquisition of seed, fertilizer, and other agricultural inputs.⁵⁹ They are often not involved in decision-making concerning the division of land parcels and how household resources are invested to optimize land and labor productivity. A national study indicated that 78.5 percent of women consider themselves “supportive labor” on family farms controlled by men.⁶⁰ A 2016 USAID-funded survey found that few Guinean women have access to agricultural extension services to learn about more sustainable production practices. Lastly, few women have access to income or credit to purchase necessary machinery or inputs.⁶¹

Though Guinean land law grants equal rights to women and men, customary practices prohibit women from inheriting land.⁶² Instead, they are entitled to hold land only on a usufruct basis, which authorizes them to work family-owned land and draw a wage. Though land tenure is a major issue for both men and women, there are notable gender gaps. Only 5 percent of women own agricultural land, compared to 12 percent of men.⁶³ Only 3 percent of women own a house on their own, compared to 14 percent of men.⁶⁴

The Civil Code is gender-neutral with respect to legal rights to access financial services, including bank loans and other forms of credit.⁶⁵ The National Policy on Gender includes measures aimed at expanding women’s access to formal financial services, such as the establishment of a guarantee fund to allow women to more easily access credit. (IR 2.3 has more detail.)

The 2018 DHS found that men have bank accounts twice as often as women (8 percent for men versus 4 percent of women).⁶⁶ There is a significant urban-rural gap, with 9 percent of women in urban areas using a bank account versus 1 percent of rural women.⁶⁷ Research conducted by the World Bank Group in 2019 found a gender gap of 7.6 percent in financial account ownership in Guinea, with 27.3 percent of men having an account compared to 19.7 percent of women.⁶⁸ The same study found a significant gender gap in mobile money account ownership—men are nearly twice as likely to have mobile money accounts (at 17.6 percent compared to 9.9 percent). The DHS 2018 found that almost 30 percent of men use a phone for financial transactions, versus only 17 percent of women.⁶⁹

In terms of access to mobile technologies and information channels, 86 percent of men and 69 percent of women have a cell phone; 86 percent of urban women have phones, versus 59 percent of rural women.⁷⁰ The 2018 DHS found that only 15 percent of women used the internet in the last 12 months (compared to 32 percent of men).

PATTERNS OF POWER AND DECISION-MAKING

Significant gender gaps exist both at the household level and in national and decentralized governance structures with regard to patterns of power and decision-making. Women in Guinea are largely under-represented in the administrative decision-making positions. In 2020, only 16 of the 114 members of the National Assembly are women (14 percent), decreased from 17 women in 2019.⁷¹ There are only seven

women ministers, out of a total of 38. At the Independent National Electoral Commission (CENI), there are only four women and 17 men.⁷² According to the CENI, of the 29,669 candidates for councilor positions for all 342 constituencies, in the local elections on February 4, 2018, there were only 7,070 women (23.8 percent).⁷³ Despite the current law on parity, establishing a 50-percent quota for women on all electoral lists, only 25 women were elected to the National Assembly (19 percent).⁷⁴ This is in part because there is no accountability if parties fail to meet this requirement; even when the quota is respected, women are often not prioritized on their party's list, making their election less likely.⁷⁵ Women make up 17.6 percent of Supreme Court judges, 11 percent of the police sector, and 15 percent of the gendarmerie.⁷⁶ In the military, women occupy only 5.9 percent of posts, and they are completely absent in the hierarchy of the Defense and Security Forces.⁷⁷ The under-representation of women is even more pronounced in the decentralized administrative structures. As of 2020, women lead only two of the country's 33 prefectures, and there is only one woman governor out of a total of eight.⁷⁸ It is important to note, however, that the mere presence of women decision-makers does not necessarily make institutions more gender-sensitive.

According to the 2018 DHS, gender disparities are present at the household level in decision-making on the use of individual earnings. Ninety-one percent of men stated that they are the principal decision-makers about what to do with money they earn, versus 73 percent of women. Fourteen percent of couples make the decision together on the use of the woman's earnings, and 13.5 percent of women do not have any control over their income.⁷⁹ See findings for IR 1.3 and IR 2.1 for more on decision-making.

3. GENDER ANALYSIS FINDINGS AND RECOMMENDATIONS: DOI — INCREASED CAPACITY AND COMMITMENT OF THE LOCAL HEALTH SYSTEM FOR BETTER HEALTH OUTCOMES

IR 1.1: Provision of quality Maternal Child Health (MCH), Family Planning /Reproductive Health (FP/RH), and malaria services assured

IR 1.2: Health-enhancing social norms established

IR 1.3: Democratic norms and processes strengthened

IR 1.4: Cross-cutting: Use of strategic information for decision-making increased

TABLE 3. SNAPSHOT OF RELEVANT STATISTICS

- The maternal mortality rate in Guinea is among the highest in the world, at 679 for every 100,000 women in 2015.⁸⁰
- The median age at first marriage (women aged 25–40) is 18.5 years.⁸¹
- The median age at first sexual intercourse (women aged 25–40) is 16.6 years.⁸²
- The TFR is 4.8 children per female, and median age at first birth is 20 years.⁸³
- Over one-third of women reported having their first child before the age of 18. Four percent of women reported this occurring before the age of 15 (versus 0 percent for men).
- Only 11 percent of women are using modern contraception. Twenty-two percent of women aged 25–49 report unmet needs in FP.⁸⁴

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- Only 59 percent of women report having decision-making power in their own health care.⁸⁵
 - The rate of malnutrition among women is 11.2 percent, with 9.3 percent in urban areas and 12.8 percent in rural areas.⁸⁶
 - Roughly 1.5 percent of the population is human immunodeficiency virus (HIV) positive, with gender discrepancies in infection rates (1.6 percent for women compared to 1.3 percent for men).⁸⁷
 - Seventy-nine percent of households have access to improved water sources (98 percent in urban areas and 70 percent in rural areas). Over half of households use improved toilets (33 percent in rural areas versus 87 percent in urban areas).
 - Only 2 percent of men and women in Guinea are covered by medical insurance. This service is accessed primarily by the wealthiest Guineans.⁸⁸
 - Only 22 percent of women nationally take iron folic acid during pregnancy, 18 percent take deworming medicine, 24 percent take intermittent prophylactic treatment for malaria, and 28–39 percent sleep under insecticide-treated nets.⁸⁹
 - Around 10 percent of women have low body mass index (BMI), 18 percent of women 15–49 are overweight, and 8 percent are obese.⁹⁰
 - Sixty-three percent of women in Guinea have experienced domestic violence over the course of their life. 41 percent of these women have experienced domestic violence in the last 12 months.⁹¹
 - Thirty (30) percent of women have experienced some form of sexual violence since the age of 15. Roughly 68 percent of women have experienced some form of verbal or psychological violence since the age of 15.⁹²
 - Over half of all girls in Guinea are married before their 18th birthday, and 19 percent are married before the age of 15.⁹³ According to United Nations Children's Fund (UNICEF), Guinea has the eighth highest prevalence rate of child marriage in the world.⁹⁴
 - Guinea has the second highest rate of FGM/C in the world, at 97 percent.⁹⁵
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3.1 KEY FINDINGS: IR 1.1 PROVISION OF QUALITY MCH, FP/RH, AND MALARIA SERVICES ASSURED

Women's MCH and FP/RF needs are largely unmet. Guinea has among the highest maternal mortality rates in SSA, at 679 for every 100,000 women.⁹⁶ Approximately 28 percent of all female deaths in Guinea are maternal deaths, with the highest rate at 35.3 percent in the 20–24 age group.⁹⁷ Only 18 percent of women's needs for a traditional birth attendant (TBA) are being met.⁹⁸ The main determinants of high mortality rates are poor quality obstetric health services, a shortage of skilled birth attendants, high fertility rates, high rates of FGM/C, and early childbearing.⁹⁹

Nearly half of all women of reproductive age in Guinea are anemic, with the highest rates in the Faranah and Kankan regions, at 61 and 55 percent respectively. High rates of anemia are due to a combination of poor birth spacing (an estimated 13 percent of women give birth within 24 months of a previous birth),¹⁰⁰ a high prevalence of parasites, and a lack of access to or use of health supplies and services. The 2018 DHS found that approximately 81 percent of women aged 15–49 who had a live birth in the last five years received prenatal care from a qualified health professional (usually a nurse or a nurse-midwife).¹⁰¹ In 2018, 14 percent of women did not receive any prenatal care at all, which represents only a marginal improvement from 2005, when 17 percent did not receive such care.¹⁰² There is a major gap between rural and urban access to prenatal care (40 percent and 84 percent, respectively), due to the distance to health centers in rural areas. Thirty-seven percent of women reported receiving post-natal care, and 4 percent reported suffering from obstetric fistula.¹⁰³

The TFR in Guinea is 4.8 children per female, and the median age of first birth is 20. Over one-third of women reported having their first child before the age of 18 (4 percent before the age of 15). Sexual debut is much earlier for females than for males.¹⁰⁴ Fifteen percent of females (versus 6 percent of males) reported having sex for the first time before the age of 15.¹⁰⁵ Low access to sexual reproductive

health/family planning services, as well as high rates of CEFM, contribute to high rates of early childbearing. CEFM is discussed in greater detail in the next section, under IR 1.2.

Unequitable access to health centers and services has gendered impacts. In Guinea, access to health services in and outside the home, especially for rural populations, is limited by a lack of investment in and inadequate distribution of health infrastructure and personnel across the health care system. Gender-unequal norms further exacerbate these challenges. These include: limitations on women's physical mobility; norms requiring women to ask their husband for permission prior to leaving the home; and women's time burden related to household work.¹⁰⁶ Patterns of decision-making also play a role. The 2018 DHS found that only 59 percent of women aged 15–49 reported having sole decision-making authority over their own health care, while 28 percent reported joint decision-making over their own health care.

Informal (and in some instances formal) payment schemes associated with health care limit women and men's access to health services, with a disproportionate impact on women and adolescent girls.¹⁰⁷ In many instances, health care payment schemes (sometimes in-kind) are demanded for services that are state-mandated and therefore supposed to be free. One current USAID implementing partner (IP) found that for one of their current activities, 50 percent of women beneficiaries reported being asked to pay for childbirth services that should be free.¹⁰⁸ This further disproportionately impacts women because of their lower access to and control over household income. Moreover, many of the payment schemes are for MCH services unique to women. Studies from SSA countries show that even though many poor women may be exempt from fees, there is little incentive for providers to apply those exemptions as they too are constrained by restrictive economic and health service conditions.¹⁰⁹ A key stakeholder summarized the challenges: "These informal payments occur at every step of health care—from consultation to the laboratory—and really discourage the population from seeking care."¹¹⁰

Insufficient female medical personnel, in particular doctors and health center management, affects women's use of health services. Human resources, both formal and informal, are an integral part of any health system. The quality, commitment, and dedication of health care providers are critical to equitable health systems. The health care workforce in Guinea is insufficient to meet the health care needs of the country's population. This is due to decades of underinvestment in effective health human resource management, with limited public recruitment.¹¹¹

It is also because there are insufficient numbers of female medical personnel, in part because of gender inequalities in educational opportunities. Though women serve as nurses, nurse midwives, and TBAs, and in other informal health-related positions, there are few female health facility managers. There are also few female medical doctors, particularly in rural areas.¹¹² This is likely due, in part, to the GOG policy of taking gender into account in the deployment of staff by allowing married women to work in urban areas or near their husbands.¹¹³

Gender imbalances in high-level health center staff is particularly important in Guinea because socio-cultural and religious norms and practices stigmatize social and physical contact between female patients and male care providers.¹¹⁴ In Guinea, women are reluctant to consult male doctors, especially on issues related to sexual and reproductive health (SRH) and FP.¹¹⁵ This likely holds true for disclosure of issues related to GBV. For this and other reasons, women in Guinea prefer to use traditional care providers, even where other health care services are available.¹¹⁶

Stigmatization about sexual activity outside of marriage, and insufficient information, prevent adolescent girls from using available health facilities and services. Religious beliefs and social norms make sexuality in general taboo in Guinea.¹¹⁷ Norms that prohibit sexual intercourse outside of marriage often deter young unmarried women from seeking SRH and FP services, as they fear providers will stereotype them or treat them poorly (discussed more under IR 1.2).¹¹⁸ Women's ability to access health services is further limited by their limited control over household income and expenditures necessary for such visits. Lastly, women's use of FP services is influenced by social norms and power dynamics. For example, 51 percent of women and 77 percent of men think it is justifiable for a woman to procure condoms, and demand condom use, if she is aware that her husband/partner has a sexually transmitted infection (STI).¹¹⁹

Gender-sensitive services and infrastructure are virtually nonexistent. In Guinea, the health care system is not conducive to providing people-centered services that consider the different needs, experiences, and desires of men, women, and youth. For example, there is a lack of consistent age- and context-specific SRH services, and often those services inadvertently exclude men and boys.¹²⁰ Most health facilities lack essential commodities, equipment, and supplies to respond effectively to GBV. One study found that fewer than half of health facilities in Guinea offer postexposure prophylaxis against human immunodeficiency virus/acquired immune deficiency syndrome (HIV/AIDs).¹²¹ In addition, health stakeholders identified a need for increased management tools, such as registers, referral forms, and medico-legal forms.¹²²

The Guinean health system is marked by a widespread lack of coordinated and holistic GBV response services. In general terms, the health system in Guinea is not adequately equipped to respond to the country's high prevalence and incidence rates of GBV, including of FGM/C and CEFM. As in many countries in SSA, health, psychosocial, and protection systems in Guinea are stretched thin, and available services are not survivor-centered.¹²³ Systems do exist to respond to rape and other forms of GBV, but survivors encounter barriers including the cost of services, limitations in service quality, and a GBV referral pathway that is not yet fully coordinated.¹²⁴ Additionally, GBV standard operating procedures are not systematically disseminated or in use across health facilities in Guinea.¹²⁵ Many facilities fail to take important measures to protect the confidentiality of GBV survivors, such as keeping their files in locked filing cabinets and obtaining informed consent before sharing client data with providers at referral sites.¹²⁶ Lastly, the referral system for nonmedical services, such as legal assistance and social services, is very weak.¹²⁷

Health care providers in Guinea lack capacity in the clinical management of GBV. One study found that fewer than one-third (28 percent) of health care providers had ever received a training on GBV, and almost half (48 percent) could not name any laws relating to GBV.¹²⁸ International organizations are largely responsible for providing the trainings that have occurred, but these trainings are not continual or systematic. Furthermore, there are no GOG institutional mandates for GBV training of healthcare professionals despite the prevalence of GBV country-wide.¹²⁹ For example, GBV is not a topic covered in medical school, with the exception of brief modules on FGM/C.¹³⁰ Lack of training results in significant healthcare provider barriers to providing effective health care response to GBV, including:¹³¹

- Insufficient knowledge about causes, consequences, and dynamics of GBV

- Individual attitudes and misconceptions about GBV that may result in perceiving GBV as a private matter, or blaming the survivor for the violence¹³²
- Lack of clinical skills in responding to GBV, including lack of information about existing support services or appropriate professional contacts which could serve as a basis for referral
- Lack of intra-institutional GBV response service coordination, such as standardized protocols, documentation forms, or staff training on treating GBV survivors
- Uncertainties about legal obligations such as confidentiality rules or reporting obligations, and an absence of standard procedures, policies, and protocols

3.2 KEY RECOMMENDATIONS: IR 1.1 PROVISION OF QUALITY MCH, FP/RH, AND MALARIA SERVICES ASSURED

The following recommendations align with five USAID J2SR sub-dimensions: open and accountable government; inclusive development; government capacity; civil society capacity; and citizen capacity.

- **Increase the percentage of female health professionals in decision-making positions** by engaging with relevant institutions on strategic planning. **WEE**
 - Conduct a gender audit of current recruitment techniques, as well as policies on deployment to rural areas, to identify potential gender barriers. Support the GOG to develop strategies to address identified bottlenecks with respect to gender-sensitive recruitment practices.
 - Advocate for recruitment at decentralized levels. Top-down recruitment models are not conducive to retention of women, especially in rural areas.
 - Regularly track women's equality issues within the health workforce, such as equal pay, decent working conditions (including addressing sexual harassment), and representation in management and leadership. **WEE**
- **Partner with civil society organizations (CSOs) for increased oversight (accountability) of health center financial practices**, to mitigate the imposition of informal payment schemes that restrict access to important state-sponsored health services.
 - Consider community-based monitoring systems, such as community scoreboards, to measure progress in regard to financial practices. Link these efforts to IR 1.3.
 - Support women's organizations that are critical to ensuring that women have voice and agency and that are often at the forefront of identifying problems and experimenting with innovative solutions related to gender-responsive governance. **WEE**
- **Advocate for and support the institutionalization of pre- and in-service training** on the clinical management of GBV for all health-care professionals.
- **Require IPs to work with targeted health centers** to develop (or publicize) referral pathways, so that service providers can provide and monitor clinical referrals.

- **Invest in GBV-specific programming** to support (or pilot) one-stop centers (OSC). The OSC is an innovative, holistic, person-centered care model for GBV survivors, comprised of four pillars: medical, psychosocial, legal, and socio-economic care. **WEE**
 - Work with the *Coalition Nationale de Guinée pour les Droits et la Citoyenneté des Femmes* (Guinean National Coalition for Women's Rights and Citizenship) and the *Association Guinéenne des Assistantes Sociales* (Guinean Association of Social Assistants) for co-design initiatives, as they both have experience in Guinea implementing similar OSC models.
 - Engage with other local actors with experience in GBV prevention and response, including leaders of: *Club des Amis du Monde* (Friends of the World Club, CAM); Guinean Center of Training and Education for Development (CEGUIFED); Guinean Association for Rural Development and the Environment (GUIDRE); Association of Youth in the Service of Humanity (AJSH); and *Club des Jeunes Filles* (Young Girls Club).
- **Incorporate gender into clinical audits and other efforts to monitor the quality of MCH and FP/RH services** in targeted level-one health centers. This could take the form of a gender-sensitivity assessment tool, or gender audits of targeted health centers, evaluating issues related to gender-sensitive infrastructure, operating hours, services, and facilities.

3.3 KEY FINDINGS: IR 1.2 HEALTH-ENHANCING SOCIAL NORMS ESTABLISHED

The attitudes of health care providers and managers impede access to, and quality of, gender-sensitive health services. Health care centers are often riddled with poor service delivery, marked by long waiting periods, impolite and demanding staff, and a general disrespect for those seeking care, especially in rural areas. Health care providers (at health centers or hospitals) are often viewed as dictatorial and condescending.¹³³ There is a prevalent perception that health-related issues will not be kept confidential. Single mothers are particularly susceptible to stigma and stereotyped treatment, as are young or adolescent girls seeking FP services.¹³⁴ A 2017 study looking at the mistreatment of women during childbirth in Guinea suggested that women and healthcare providers believe that mistreatment is justifiable under certain circumstances, such as when women cry out or are noncompliant with providers' demands.¹³⁵ Incidents of GBV, particularly intimate partner violence (IPV), are rarely disclosed at health centers due to fear of judgement from medical providers.¹³⁶

Community-level development and health actors do not receive pre- or in-service gender-related training. Neither community health workers (*agent santé communautaires*, ASC) nor community mobilizers (*relais communautaires*, RECOS) receive gender-related training, specifically in relation to gender barriers and opportunities related to health-enhancing social norms. They receive no training on issues related to access to health care, or on how to respond to disclosure of GBV as it relates to their job responsibilities. This is a missed opportunity, as these actors are likely to be the first to learn about cases of GBV, as community-based health care workers.

Gender roles, unequitable decision-making practices, and lack of household communication between men and women limit health-enhancing behaviors. Gendered power dynamics regarding access to and control of resources—including income, patterns of decision-making, familial authority, perpetuation of social norms, and division of labor—affect health-related decision and behaviors. In Guinea, childcare, health, and nutrition are viewed as women's domain.¹³⁷

Though women may experience some autonomy within this domain (in deciding what to cook, etc.), they are still very much limited by inequitable decision-making practices that favor men. For example, men do not consult with their wife/wives on the allocation or use of household resources, including those needed for health-enhancing behaviors.¹³⁸ Male family members may override women's decisions regarding mosquito net use, or where and when to access treatment for MCH services, especially when financial resources are required. Unequal power between men and women also contributes to coerced sex, the spread of STIs and HIV/AIDs, and unintended pregnancies. In general, mothers-in-law are able to exert control over the behavior of new daughters-in-law, particularly in relation to household care and health-related behaviors.¹³⁹ Polygamous households also have hierarchies and related patterns of power and division of labor among co-wives; often, first wives are seen as the most powerful and can sometimes exploit or even abuse younger co-wives.¹⁴⁰ Traditional and religious leaders are similarly influential.¹⁴¹

Pervasive norms around masculinity prevent men from practicing and supporting appropriate health-seeking behaviors specifically related to FP/RH. Research has shown that inequitable gender norms influence how men interact with their partners, families, and children on a wide range of issues, including contraceptive use, GBV, domestic chores, parenting, and health-seeking behavior.¹⁴² For example, the sexual double standard that permits sexual freedom for men and demands sexual restraint from women influences health outcomes, specifically related to FP/RH and male engagement. Boys and men are often not held accountable for their sexual behavior or sexual violence; rape within marriage is invisible; and accepted narratives emphasize the need for men to maintain control over women's sexuality.¹⁴³ By distancing boys and men from the domain of SRH, society and health-care systems tend to excuse them from responsibility and reinforce the notion that FP/RH is a concern only for women.¹⁴⁴

Traditional and religious norms and beliefs correlate with unmet needs for FP. Despite progress in health policies and programs aimed to improve women's access to SRH care, the use of contraception remains low in Guinea. According to the 2018 DHS, only 10.9 percent of women aged 15–49 in a marital union used any modern contraception method. Of this same group, only 22 percent reported satisfaction in terms of FP needs. Men's dominance in household and community decision-making extends to women's ability to make decisions on issues related to FP/RH (refer to Section 2.2 on **Patterns of Power and Decision-Making**.) Among women who use contraception, 66 percent made the decision themselves.¹⁴⁵ In 20 percent of cases, women made the decision jointly with a husband/partner, and 15 percent of women said their husband/partner made the decision. Among women not using contraception, the role of the partner in decision-making was higher, at 20 percent.¹⁴⁶ Women in Guinea are not supposed to refuse sexual relations with their husbands; nearly 50 percent of women think violence against women is justified in this situation.¹⁴⁷ Lastly, traditional and religious norms that value large families, husbands with multiple wives, and women with multiple children inhibit use of FP.¹⁴⁸

Gender norms that tolerate and justify GBV contribute to high prevalence rates of GBV, especially IPV. The MASPFE and the United Nations Population Fund (UNFPA) together conducted the most recent prevalence study on GBV in Guinea (2017), which found 63 percent of women in Guinea had experienced domestic violence over the course of their lifetime. Forty-one percent of these women had experienced IPV in the last 12 months.¹⁴⁹ The rates of domestic violence were more pronounced in urban than in rural areas. GBV prevalence was more pronounced in the Faranah (33 percent), N'Zérékoré (33.1 percent), and Kankan (43 percent) regions.¹⁵⁰

The 2018 DHS found that 67 percent of women (and 55 percent of men) believe that a man beating his wife is acceptable under at least one condition, including for burning the food, arguing with him, leaving the house without telling him, neglecting the children, or refusing sexual intercourse.¹⁵¹ The low awareness of women and girls of their rights, as well as socio-cultural traditions, erroneous interpretations of religion, high levels of illiteracy, and polygamy, also contribute to the prevalence of IPV.¹⁵²

Socio-cultural norms, poverty, and low education levels drive persistently high rates of CEFM in Guinea, which have devastating impacts on MCH and education outcomes. Guinea has the eighth highest prevalence rate of CEFM in the world.¹⁵³ According to the 2016 Multiple Indicator Cluster Survey (MICS), 54.6 percent of women aged 20–49 were married before age 18. Twenty-one percent of women aged 15–49 were married before age 15. Child marriage, measured as marriage before 18, is prevalent across administrative regions for women aged 20–49: Labé (76 percent), Moyenne Guinée (72 percent), Kankan and Haute Guinée (69 percent), Mamou (68 percent), and Faranah (65 percent).¹⁵⁴ CEFM is more prevalent in rural areas and is particularly common among the Fulani, Malinke, and Susu ethnic groups as well as forested Guineans, where inherited traditions regarding the age at which a girl is considered ready for marriage are passed down through generations. Polygamy perpetuates CEFM as men with multiple young wives enjoy general high regard.¹⁵⁵ “It is extremely difficult to refuse a forced marriage in Guinean society,” as this constitutes a “challenge to parental authority,” which results in the girl being rejected by her family and forced to leave the family home.¹⁵⁶ CEFM in Guinea is sometimes justified so that large families do not have to cover the costs of raising their female children to adulthood.¹⁵⁷

Girls’ education levels, child marriage, and early childbearing are closely linked. Child marriage and early childbearing limit girl’s education attainment. Girls who marry or drop out of school early are more likely to experience poor health, have more children over their lifetime, and earn less income in adulthood.¹⁵⁸ They are also more at risk of experiencing IPV and not having decision-making authority within the household.¹⁵⁹ Girls’ education is, in turn, viewed as one of the best deterrents of CEFM: 63 percent of women with no education were married before the age of 18, compared to only 26 percent who had completed secondary education or higher.¹⁶⁰

The normative view that FGM/C is an important socio-cultural tradition, rather than a form of GBV or a violation of human rights, results in a high FGM/C prevalence rate—with devastating health impacts. There is almost universal prevalence of FGM/C in Guinea, with slight variations according to socio-demographic factors. Christians practice FGM/C less than Muslims (77.9 percent vs 97.1 percent).¹⁶¹ Some variations also exist among ethnic groups.¹⁶² FGM/C prevalence in urban areas is comparable to rural areas (94.8 versus 94.3 percent respectively), with the capital of Conakry having a prevalence of 95.6 percent.¹⁶³ The procedure usually takes place in the familial home, and the ceremony can include several girls to be cut at once.¹⁶⁴ It is usually performed by traditional practitioners. A 2017 UNFPA report on GBV found that nearly 20 percent of women who had undergone FGM/C experienced a number of health problems.¹⁶⁵ However, there is an increased involvement of medical staff in the practice, which may reduce health complications of such procedures but does little to eliminate the practice.¹⁶⁶

A 2019 ethnographic study on FGM/C in Guinea found that the most important reason for the practice in Guinea is respect for ancestral customs, followed by the objective of restraining women’s sexuality

(both before and during marriage) to safeguard the family's honor.¹⁶⁷ Submission to the sociocultural norm of FGM/C is reinforced by social pressure, as well as by stigmatization and ostracism in cases of non-compliance.¹⁶⁸ In such a context, it is virtually impossible to escape the practice without suffering negative social consequences. Current FGM/C research shows that the risk of being socially ostracized, excluded from community activities, and denied financial and practical support as well as marriage possibilities, can outweigh the health risks associated with the practice in certain communities.¹⁶⁹

Measures to combat FGM/C rarely take a holistic approach, or include a focus on social norm change. There has been limited progress to reduce the prevalence of FGM/C in Guinea, despite strong legal frameworks criminalizing it,¹⁷⁰ as well as numerous GOG-led awareness-raising and education campaigns and multi-sectoral coordination committees and national strategies advocating for its elimination.¹⁷¹ Though there has been some progress in reducing the prevalence of FGM/C among younger populations, programs supporting the abandonment of FGM/C have been largely ineffective in Guinea because they consist almost exclusively of “awareness-raising,”¹⁷² primarily focusing on negative health outcomes. Awareness-raising is largely ineffective because FGM/C is seen as part of an important traditional rite of initiation into adulthood for girls.¹⁷³ Furthermore, some GOG and CSO leaders feign interest in combatting FGM/C because “that was where the money is”—while in their own households “they are cutting their daughters.”¹⁷⁴ Little research exists in Guinea on the motivation and rationale for couples who chose to not submit their child to FGM/C, which could help inform prevention strategies.¹⁷⁵

Global lessons learned demonstrate that large-scale abandonment can only be expected when FGM/C is no longer an all-dominant social norm, and families can abandon the practice without the risk of stigmatization and exclusion.¹⁷⁶ Moreover, it is critical to adopt holistic and community-led approaches to FGM/C. They must include, but not be limited to: the engagement of community and religious leaders to speak out against FGM/C; targeted approaches with cutters and health-care professionals; and a favorable legal framework. There is also evidence of the importance of peer groups as part of a holistic approach.¹⁷⁷

Regional studies have shown that laws are necessary, but they require social legitimacy to be effective.¹⁷⁸ For example, law enforcement personnel may have limited knowledge about these laws or a conflict of interest, whereby they may continue to support the practice to uphold community traditions. Legal prohibitions of FGM/C may promote abandonment of the practice or may just drive it underground. The research highlights the need to find meaningful ways to address inherent conflicts between formal laws prohibiting FGM/C and local and regional religion and customs, which are also recognized as sources of law.¹⁷⁹

Programs to end harmful practices such as FGM/C, and programs to end IPV and other forms of GBV, are frequently designed and implemented separately. Research has found that

BOX 1. EMERGING EVIDENCE FOR FGM/C ABANDONMENT POLICY AND PROGRAMS

- Make targeted investments based on evidence about patterns of FGM/C and the specific locations where it is practiced
- Strengthen the capacity of health care and law enforcement professionals to address FGM/C effectively
- Strengthen linkages among the legal, educational, and health sectors, and develop multisectoral responses at decentralized levels
- Support local research capacity to ensure that FGM/C responses are informed by reliable evidence and tailored to the local context
- Focus abandonment efforts on family and community members who decide whether girls are cut, including fathers, health workers, traditional cutters, TBAs, and religious and community leaders

Population Council. 2020. Evidence to End FGM/C: Research to help Girls and Women Thrive: Reflections from 5 years of Research.

sometimes when FGM/C decreases in a community, it may be replaced by child marriage.¹⁸⁰ While tailored approaches are important, this can result in isolation of initiatives that would benefit from sharing of knowledge and good practices, and from strategic, coordinated efforts. Approaches to combat GBV in all its forms share common objectives related to changing social norms and empowering women and girls, and so can generate valuable discussion and debate that can lead to the adoption of holistic violence-prevention principles.¹⁸¹

3.4 KEY RECOMMENDATIONS: IR 1.2 HEALTH-ENHANCING SOCIAL NORMS ESTABLISHED

The following recommendations align with five USAID J2SR sub-dimensions: open and accountable government; inclusive development; government capacity; civil society capacity; and citizen capacity.

- **Ensure that activity targeting does not inadvertently reinforce existing gender roles that impact gender equality and health outcomes.** Approaches to promote health-enhancing norms should seek to transform norms about gender roles and responsibilities that over-burden women and girls with responsibilities for MCH and FP/RH and should avoid inadvertently excluding men and boys. Careful attention should be paid to ensure that these approaches create more equitable power dynamics. **WEE**
- **Ensure inclusion of appropriately targeted social and behavioral change communication strategies that employ evidence-based, gender-transformative approaches for promoting health-enhancing norms.**
 - Strategies should account for power dynamics in polygamous households and the influence of elderly women (i.e., mothers-in-law)¹⁸² and traditional and religious leaders.
 - Integrate behavior change modules (such as the Gender Action Learning System) to address women's time burden through the promotion of more equitable division of household labor. A case can be made for better financial and health outcomes when women have more free time for market and health-related activities.⁷
 - Adapt strategies to address gender barriers that accompany particular life stages (e.g., encouraging newly married couples to delay having their first child).
 - Involve and engage men as partners and clients, particularly in programs addressing MCH, FP/RH, and GBV, using approaches like EngenderHealth's **Men As Partners** approach, and Promundo's **Program P or Program H**.⁸
- **Empower girls and women economically through microfinance activities**, enabling them to make healthy choices, increase their negotiating power, and enhance their efficacy and self-

⁷ In accordance with EO 13950, USAID has put a hold on all upcoming training, seminars, and other related fora on diversity and inclusion pending an Agency and OPM review of the content of these programs (see Executive Order and OMB Guidance). It may also be helpful to review Agency Notices numbers 09214 and 10196. Mission staff reviewing these recommendations should seek guidance from Mission leadership prior to moving forward with any training events.

⁸ Refer to note 7.

confidence. **WEE**

- **Train peer educators in gender, communication, and negotiation skills** to reach underserved and difficult-to-reach groups, such as widows, adolescent girls, unwed young women (urban and rural), out-of-school young men and women, and out-of-work urban young men.
 - Use critical reflection as an effective strategy to enable peer educators to serve as change agents who can identify inequitable gender norms and can understand how these norms influence people’s health and health behavior, including related to FGM/C.⁹
- **Promote strategies for male engagement (gender-equitable masculinities) to reduce gender-based inequities in health.**¹⁸³
 - Approaches should integrate identified potential incentives that may help men change their behaviors (i.e., through understanding health and economic benefits from more gender-equitable behavior).
 - Prioritize strategies that seek to increase: men’s active and supportive involvement in MCH, FP/RH, and malaria programming; men’s support of women’s economic empowerment; and men as change agents to prevent and reduce incidence of GBV. **WEE**
 - Integrate “couples” modules, where wives are invited to participate in training/approaches that promote better communication, joint-planning, and decision-making. See for example the Gender Action Learning System (GALS), Husband Schools,¹⁸⁴ or approaches like the Responsible, Engaged and Loving (REAL) Fathers Initiative.¹⁸⁵ **WEE**
- **Integrate GBV prevention into all DOI programming through community mobilization and social norm interventions.** Prevention has the potential to significantly reduce morbidity and mortality, improve the health of women and girls, and reduce health, social and judicial-systems costs. Preventing GBV in the long term requires not only changing individual knowledge and behaviors, but also changing the norms that uphold the imbalance of power between women and men. (See Box 2.)
- **Recognize the need for tailored and holistic approaches to reduce FGM/C, while also prioritizing initiatives that seek synergies between approaches to combat FGM/C and other forms of GBV.** **WEE**
 - Explore replication of successful prevention interventions that have an impact on the reduction of both FGM/C and other forms of GBV, such as IPV (e.g., TOSTAN Community Empowerment Program). **WEE**
 - Work with communities to identify interventions that address common risk factors and common root causes of both FGM/C and GBV (including CEFM)—for example, girls’ education and women’s economic empowerment initiatives. **WEE**
- **Create minimum standards for GBV response and ensure that all mission activities integrate standards to promote across portfolios.** To ensure adequate adhesion to principles

⁹ Refer to note 7.

of “do no harm,” USAID/Guinea should develop minimum standards that specifically outline appropriate protocols for IPs and field-based partners to address disclosures of GBV, including CEFM and FGM/C.

- **Institutionalize training on the clinical management of GBV for ASCs and RECOs.** Like higher-level health care staff, ASCs and RECOs should receive pre- and in-service training on GBV.
- **Leverage existing youth platforms to increase awareness on gender-related issues in health.** USAID/Guinea should seek to leverage existing platforms, such as *centre d’écoute* and *santé scolaire* (listening and school health centers), as venues for training and critical reflection on harmful gender norms related specifically to GBV, including FGM/C and CEFM. These platforms have proven successful in raising awareness about COVID-19.

BOX 2. EFFECTIVE COMMUNITY MOBILIZATION ACTIVITIES

- Engage all members of the community (men, women, boys and girls), including separately, with dedicated and tailored approaches for each group
- Focus on transforming social norms, attitudes, and behaviors, by generating conversations and reflections on gender roles
- Organize regular events where participants are expected to remain engaged throughout the program
- Follow a Human Rights Framework (aimed at responding to the needs of all women and girls, including those facing intersecting forms of discrimination)

UN Spotlight Initiative Theory of Change Guidance

3.5 KEY FINDINGS: IR 1.3 DEMOCRATIC NORMS AND PROCESSES STRENGTHENED

Limited participation of women at the highest levels of decision-making in the health sector affects health outcomes for women and girls. Gender equity is imperative for the attainment of healthy lives and wellbeing of all and promoting gender equity in leadership in the health sector is an important part of this endeavor. Even though women play a substantial role in informal health care, including at the household and community levels, they are systematically excluded from engagement in planning and decision-making on resource allocation in Guinea’s health sector.¹⁸⁶ Socio-cultural barriers prevent women from studying health-related fields or entering political positions that may lead to decision-making power.¹⁸⁷ Not including women’s voices in health system governance results in policies that fail to account for the gendered dimensions of health.

Inclusive platforms for community engagement on health system governance that prioritize the voice of women and girls are rare. There are no formal fora to provide citizens (men, women, and young men/women) with the chance to inform health governance. Opportunities to influence health system governance at the community level is especially important for women, since they are underrepresented in decision-making positions at the higher levels. More generally, public opportunities to inform decision-making and priority-setting are necessary to foster confidence and trust in the health system and to ensure that services are people-centered. Community platforms also serve as an important accountability mechanism, where health policy makers and providers can engage with and answer to citizens, and where decisions can be shaped to reduce gender inequities in health. The current Ministry of Health (MOH) policy does not stipulate requirements for community engagement in health-related governance.¹⁸⁸

There is no line item or specific budget for gender-related priorities in health ministries. Generally, central finance and planning bodies in Guinea are not engaged with necessary gender human resources and training to ensure that sector budgets allocate resources for gender priorities.¹⁸⁹ The current MOH budget includes no budget line for gender-specific needs or initiatives.¹⁹⁰ This may be

because there is low prioritization of gender-related issues in Guinea's health policy, which dictates budget allocations in this sector. Until there is a national budget mandate to prioritize funding for gender programs in health initiatives, addressing gender issues will remain low on the MOH agenda. USAID/Guinea has had success, however, in advocating for specific budget allocations for issues related to FP; this experience can provide a model for advocating for increased gender-responsive budgeting (GRB) for other key health issues.

Ministry gender focal points (GFPs) have low capacity in terms of gender training; they often lack necessary authority to influence decisions on priority setting or budget allocation. The engagement of GFPs in each ministry has not so far been successful in increasing public servants' capacity to carry out gender-responsive planning and budgeting, or in increasing the gender-sensitivity of GOG policies across sectors. Ministries and departments usually designate as GFPs low-level officers, with little authority and unclear mandates. In many instances, women are assigned as GFPs because of their gender and not for their technical expertise.¹⁹¹ GFPs, including in the MOH, occupy less influential positions within the decision-making structures; they may struggle to engage with male-dominated political networks and high-level connections. In addition, GFPs are concentrated in national structures and are notably absent in decentralized GOG offices (regional and prefectural). In general, GFPs within health-related ministries are marginalized within their ministry's decision-making processes.¹⁹²

A vibrant and active civil society and independent media are undertaking GBV advocacy efforts and raising awareness in Guinea, albeit with limited funding and little experience in gender-transformative approaches aimed at norm change. Many CSOs focus on GBV prevention by raising awareness of the negative consequences related to FGM/C and CEFM. This is also seen in the media's increased attention to GBV in Guinea in the last five years, with a specific focus on sexual violence against minors. CSOs offer rich expertise and understanding of context that can be leveraged in future project design processes. Many of these organizations, however, are hindered by budget constraints that limit their interventions to awareness-raising or public advocacy campaigns. Many of them have little experience in social and behavioral change communication approaches that might address the gender-unequal norms that underpin GBV.

Few international organizations in Guinea are actively working in GBV, likely due to the lack of donor funds for GBV-specific projects. Tostan International, Plan International, UNFPA, and UNICEF currently have programming specifically related to GBV prevention and response. UNFPA co-leads the GBV prevention and response working group; Plan International works on several projects aiming to reduce GBV in schools; and Tostan International implements a community empowerment program for the abandonment of FGM/C.

Guinea's health policy has been slow to recognize the gendered dimensions of pandemics. During the Ebola Virus Disease (EVD) pandemic in 2014, an evaluation of *Médecins Sans Frontières* (Doctors Without Borders) EVD response in Guinea noted that awareness and education programs had limited impact because they lacked an understanding of local gender norms.¹⁹³ Pregnant women infected with EVD in Guinea faced a 90 percent chance of dying from the disease, compared to 75 percent for the general population.¹⁹⁴ Not recognizing the gender dynamics of outbreaks limits the effectiveness of response efforts and compounds existing inequalities.¹⁹⁵

Evidence suggests that COVID-19 will likely increase the incidence of GBV. During the EVD pandemic, data collected in GBV centers indicated that the number of GBV cases in Kankan was 1.4 times higher than that reported before the beginning of the epidemic.¹⁹⁶ Additionally, twice as many incidents of sexual violence were recorded in 2014 as in 2013.¹⁹⁷ Increases in GBV incidence during the COVID-19 pandemic are also likely to take place, due to pandemic-related stress and the breakdown of normal social support and protection systems. However, United Nations Development Programme (UNDP)’s COVID-19 Global Gender Response Tracker shows that none of the measures put in place by the GOG to respond to the ongoing pandemic are gender-sensitive.¹⁹⁸ Of particular note is their lack of acknowledgement of risks that increase GBV. Though current data is not readily available, there are anecdotal reports of increases in IPV from key informants working with survivors of GBV.¹⁹⁹

3.6 KEY RECOMMENDATIONS: IR 1.3 DEMOCRATIC NORMS AND PROCESSES STRENGTHENED

The following recommendations align with four USAID J2SR sub-dimensions: inclusive development; government capacity; civil society capacity; and citizen capacity.

- **Formulate gender-transformative policies and health professional regulations.** Such regulations at all levels of health governance would help support gender equality in the workplace, increase the number of women in leadership and decision-making roles, and ensure decent work conditions for all.²⁰⁰
- **Prioritize strategic partnerships with local CSOs to leverage their local and regional experience and their expertise in GBV prevention and response initiatives.**
 - Finance full mapping of local actors in GBV prevention and response, documenting their approaches and lessons learned to-date.
- **Encourage media reporting to cover issues and monitor budget allocations related to gender and GBV in the health sector.** Any engagement with media should seek to encourage a widening of GBV-related reporting and could include training on gender biases in reporting.
- **Promote coalitions of organizations working on GBV in support of a multi-sectoral, coordinated GBV response.** Networking and coalition-building can contribute to increasing efficiency in service provision. For instance, organizations may become partners for referring patients. Further, networks and coalitions provide a forum for exchanging knowledge and tools for partners to use in their work.
- **Work with community-level structures (e.g., health committees) to improve inclusive community engagement opportunities for participatory consultations.**
 - Encourage approaches such as community conversations (dialogue and critical reflection), targeting traditional and religious leaders, to promote understanding of the importance of women’s engagement and leadership in community-level decision-making processes. Support leaders in commitments to “small doable actions” that increase women’s active involvement.

- Adapt gender-equitable masculinities approaches (described under IR 1.2) to promote easing women's time burden, which is an obstacle to women's participation.
- **Integrate knowledge (and benefits) of GRB into interventions aimed to strengthen civil society and relevant institutions.** Consider working with CSOs to target the following institutions working in health: *Directions Administratives et Financières* (Administrative and Financial Departments); *Services Administratifs et Financiers* (Administration and Financial Offices); and the *Bureaux de Stratégies et Développement* (BSD, Strategy and Development Offices).

3.7 KEY FINDINGS: IR 1.4 CROSS-CUTTING: USE OF STRATEGIC INFORMATION FOR DECISION-MAKING INCREASED

The health system in Guinea has data analysis and visualization systems available, but it is not systematically using them to analyze and address gender gaps in health service access, use, and outcomes. The existence of data collection platforms is promising and offers a potential avenue for better understanding of gender-related gaps and opportunities in service access and use and health outcomes.

There is a major gap in terms of available research on the prevalence and drivers of GBV.

There have only been two published national studies on GBV in Guinea in the last 20 years. MASPFE, in partnership with various United Nations organizations (UNDP, UNFPA, UNICEF, and the World Health Organization), carried out the first national study on GBV in Guinea in 2009. The scope of the study was vast and included all types of GBV, including economic violence. It found that 92 percent of women aged 15–64 had experienced one form of GBV in their lifetime.²⁰¹ MASPFE with UNFPA carried out a second major study in 2017. Prevalence data on CEFM and FGM/C exists in UNICEF's Multiple Indicator Cluster Survey (MICS) (2016) and the DHS (2018); however, data on IPV prevalence is not available. Qualitative data highlighting the drivers of IPV is also unavailable.

There is little cross-ministerial collaboration for data-sharing related to gender equality and GBV prevention and response. GOG Ministry officials confirmed during data collection that cross-sectoral ministerial collaboration is very low in Guinea in general.²⁰² This means that when any sector-specific data is collected, it is rarely shared for a more integrated analysis, including analysis related to gender. GOG officials' responses indicate a siloed approach where gender-related issues are deemed outside the responsibilities of other sectoral ministries. The Ministerial split of the MASPFE in May 2020 has resulted in bureaucratic restructuring, with new roles and responsibilities that have yet to be communicated.

Coordinated data collection on all forms of GBV in Guinea is lacking. The primary system for data collection on the incidence of GBV is housed in the *Office National pour la Protection du Genre, de l'Enfance et Des Moeurs* (National Office for the Protection of Gender, Childhood, and Morals, OPROGEM) which is under the Guinean Ministry of Security and Civil Protection. This severely limits both the type and quantity of data on GBV, as the OPROGEM operates in the official judicial realm and implements primarily through the police—where survivors rarely turn, especially in rural areas. This data is not systematically shared with relevant stakeholders, including CSOs. Moreover, GBV data is not routinely collected at health centers. These bodies need to set up data systems that go beyond the internal recording needs of their offices to support a holistic and coordinated process to inform evidence based GBV prevention and response programming.

3.8 KEY RECOMMENDATIONS: IR 1.4 CROSS-CUTTING: USE OF STRATEGIC INFORMATION FOR DECISION-MAKING INCREASED

The following recommendations align with four USAID J2SR sub-dimensions: inclusive development; government capacity; civil society capacity; and citizen capacity.

- **Finance a national study on the prevalence of GBV, its drivers, and context-appropriate and culturally appropriate strategies to combat it.** The study might be co-financed with relevant GOG institutions and could help build capacity to adhere to ethical standards for GBV research. The study should focus specifically on the prevalence of various forms of GBV—with particular focus on IPV. Analysis should show regional trends as well as disaggregation by ethnicity, age, religion, and urban/rural populations. The study should seek to understand to what extent data on GBV is collected by health centers and the OPROGEM at the national and decentralized levels. Lastly, the study should include a thorough mapping of the various actors (including donors) working in GBV prevention and response, and any existing referral pathways.
- **Finance a study on FGM/C efforts in Guinea to identify what has worked in reducing its incidence.** The study should analyze regional variations of FGM/C and assess programming to address it using the guidelines to shape the assessment criteria (refer to Box 2). Most FGM/C studies in Guinea to date focus on what works to change attitudes and social norms. However, analysis is required to link how those changes in attitudes and social norms, as well as other variables, are connected to prevalence.²⁰³
- **Conduct trainings on the use of sex-disaggregated data** to inform health systems decisions. Training content should include modules on how to use data for advocacy (link to GRB mentioned in IR 1.3).
 - Support improvement to health information systems data collection on cases of IPV and FGM/C.
- **Enhance USAID participation in existing GBV coordination working groups** to access information on existing programs/ approaches to GBV prevention and response, and support convening relevant actors.

3.9 ASSUMPTIONS AND RISKS

- GOG willingness to consider reforms in human resources management to increase women's representation in decision-making, including in health centers
- GOG and other relevant institutions' willingness to commit to addressing gender inequities in health system, which shape health experiences across a range of issues and across life cycles
- Donors and international community commitment to addressing GBV (including CEFM and FGM/C) prevention and response in health systems strengthening programming
- Women and girls continued low access to necessary health services, as health system reform does not adequately address gender power relations and community norms

- Worsening GBV prevalence, due to low priority for prevention and response approaches, a lack of coordinated holistic services of health system, and persistent high levels of acceptance of GBV at community and individual levels (including CEFM and FGM/C)

3.10 ILLUSTRATIVE INDICATORS

TABLE 4. RECOMMENDED KEY ILLUSTRATIVE INDICATORS, BY INTERMEDIATE RESULT (IR)

INTERMEDIATE RESULT	RECOMMENDED ILLUSTRATIVE INDICATORS
IR 1.1: Provision of quality MCH, FP, RH, and malaria services assured	<ul style="list-style-type: none"> • Number of persons trained with USG assistance to advance outcomes consistent with gender equality or female empowerment through their roles in public or private sector institutions or organizations (USG 2020 F indicator: GNDR-8) • Number of legal instruments drafted, proposed, or adopted with USG assistance designed to improve prevention of or response to sexual and GBV at the national or sub-national level (USG 2020 F indicator: GNDR-5) • Number of people reached by a U.S. Government-funded intervention providing GBV services (such as health, legal, psychosocial counseling, shelters, or hotlines) (USG 2020 F indicator: GNDR-6) • Percentage of women in decision-making positions (health facility managers or doctors) in the health care system (urban/rural) (Custom indicator) • Percentage of health units with at least one service provider trained to care for and refer GBV survivors (Custom indicator: USAID WE3 TA Indicator)
IR 1.2: Health-enhancing social norms established	<ul style="list-style-type: none"> • Number of USG-assisted community health workers (CHWs) providing Family Planning (FP) information, referrals, and/or services during the year (USG F indicator) • Percentage of women (15–49) who make their own health decisions (Custom indicator: USAID WE3 TA Indicator) • Percentage of ever-partnered women and girls aged 15 years and older who experienced physical, sexual, or psychological violence by a current or former intimate partner in the previous 12 months, by form of violence and by age (Custom indicator: USAID WE3 TA Indicator) • Proportion of women aged 20–24 years who were married or in a union before age 15 and before age 18 (Custom indicator: USAID WE3 TA Indicator) • Proportion of girls and women aged 15–49 years who have undergone female genital mutilation/cutting (Custom indicator: USAID WE3 TA Indicator) • Percentage of people who believe that a husband/partner is justified in hitting or beating his wife in circumstances (Custom indicator: USAID WE3 TA Indicator)
IR 1.3: Democratic norms and processes strengthened	<ul style="list-style-type: none"> • Number of persons trained with USG assistance to advance outcomes consistent with gender equality or female empowerment through their roles in public or private sector institutions or organizations (USG 2020 F indicator: GNDR-8) • Number of USG-supported activities designed to promote or strengthen the civic participation of women (USG F Indicator)

	<ul style="list-style-type: none"> Extent to which a national (MOH) budget is broken down by gender, age, income, or region (Custom indicator: USAID WE3 TA Indicator)
IR 1.4: Cross-cutting: Use of strategic information for decision-making increased	<ul style="list-style-type: none"> Existence of designated mechanisms charged with gender analysis of health statistics (Custom indicator: USAID WE3 TA Indicator) Number of gender-sensitive health indicators to generate evidence that informs effective service delivery (Custom indicator) Percentage of trained practitioners who can effectively respond to gender issues in planning, implementation, and evaluation of health care provision and health research (Custom indicator)

4. GENDER ANALYSIS FINDINGS AND RECOMMENDATIONS: DO2 - DEMOCRATIC AND ECONOMIC GOVERNANCE STRENGTHENED

IR 2.1: Democratic norms and processes strengthened

IR 2.2: Conflict management and mitigation improved

IR 2.3: Sustainable economic opportunities increased

TABLE 5. SNAPSHOT OF RELEVANT STATISTICS

National level governance²⁰⁴

- Ministerial level: seven women ministers out of a total of 38-member government (18 percent)
- National Assembly: 16 women out of 114 representatives (14 percent)
- National Assembly Office: four women out of 14 members (29 percent)
- Supreme Court: five women out of 40 judges (12.5 percent)
- High Communication Authority: two women out of 11 Commissioners (18 percent)
- Economic and Social Council: 11 women out of 45 members (24 percent)
- Independent National Electoral Commission (CENI): four women out of 17 commissioners (23.5 percent)

Decentralized governance (prefects, sous-prefect, or regional governor)²⁰⁵

- Regional Governors: one woman out of eight governors (12.5 percent)
- Prefect: two women out of 33 members (6.1 percent)
- General Secretaries – Decentralization (*Secrétaire Général Chargé des Collectivités Décentralisées*, “Secretary General in Charge of Decentralized Collectivities”): 0 women out of 33 members (0 percent)
- General Secretaries – Administrative Affairs (*Secrétaire Général Chargé des Affaires Administratives*, “Secretary General in Charge of Administrative Affairs”): one woman out of 33 members (3 percent)
- Sous-prefect: six women out of 304 members (2 percent)
- General Secretaries – Urban/Rural communes (*Secrétaire Général des Communes Urbaines/Rurales*, “Secretary General of Urban/Rural Communes”): 6 women out of 38 members (15.8 percent)
- President of Special Delegations (*Présidentes des Délégations Spéciales*, “Presidents of Special Delegations”): 2 women out of 128 presidents (1.6 percent)

Economic Participation

- The female labor force participation rate in Guinea is one of the highest in SSA, at 66 percent. Men workers are mainly concentrated in agriculture (65 percent), services (9 percent), and retail sales (8 percent), while women in the labor force are mainly concentrated in agriculture (70 percent) and retail sales (20 percent).²⁰⁶
 - The unemployment rate for women (2.3 percent) is slightly lower than that of men (3.3 percent).²⁰⁷ For women, unemployment is more a rural than a urban phenomenon, with 4.6 percent of urban women unemployed compared to 27 percent of rural women.
 - Men are twice as likely to have bank accounts as women (8 percent for men versus 4 percent of women).²⁰⁸
 - Only 15 percent of workers in private firms in Guinea are women; a quarter of private firms did not have any female employees.²⁰⁹
 - According to the 2018 DHS, 86 percent of men and 69 percent of women have a cell phone. Among women, 86 percent of urban women have phones versus 59 percent of rural women. Only 15 percent of women had used the internet in the 12 months prior to the 2018 DHS (compared to 32 percent of men).²¹⁰
 - Only 9 percent of Guinean firms had a woman among their owners.²¹¹
 - Male-headed households in Guinea generally farm larger plots, use more farming inputs such as fertilizer and improved seeds, and are more likely to use irrigation. Yields of both legumes and cereals are much higher for male-headed households than female-headed households.²¹²
 - According to a 2014 study in mining areas, about 91.4 percent of men and 61.5 percent of women surveyed would like to have a job in the mine—overall, 74.4 percent of all genders combined.²¹³
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4.1 KEY FINDINGS: IR 2.1 DEMOCRATIC NORMS AND PROCESSES STRENGTHENED

The biggest barriers to the effective participation and active leadership of women and girls in decision-making structures are: gender norms, restricted mobility (due to women’s need for spousal permission to participate in activities outside the home), time constraints, safety concerns, and illiteracy.²¹⁴ Disproportionate rates of illiteracy and lack of political skills among women and girls are obstacles to women’s participation in decision-making structures. Despite this, there is great interest among women in more active engagement with decision-making structures. Their ability to act on that interest is limited by socio-cultural norms related to women needing to ask for permission from their spouse (or other male relative) prior to engaging in activities outside the home,²¹⁵ as well as time poverty due to childcare responsibilities.²¹⁶ As well, perceptions of the domain of politics (local and national) as a “dirty” and “unacceptable” sphere for women also limit their participation.²¹⁷ Men limit women’s participation in this domain as a form of “protection,” preferring to maintain “women’s engagement through consultations with her husband in the home.”²¹⁸

Women are underrepresented in political and electoral processes and, where present, their participation is often tokenized. Although women play a major role in Guinea’s local economies, they lack proportional political representation and adequate formal political input in decision-making processes at all levels.²¹⁹ Only 14 percent of parliamentarians and 16 percent of government ministers are women (refer to Section 2.2 on [Patterns of Power and Decision-Making](#)). Guinea’s political parties have few inclusive processes for policy platform development or for transparent candidate and leadership selection.²²⁰ Male and female youth and persons with disabilities are also largely excluded from political debates and decision-making processes.

When women are present at political events, the quality of their participation is limited primarily to “dancing, canvassing, and applauding the male party chiefs.”²²¹ The barriers for women’s active participation in decision-making structures are many. Structural barriers through discriminatory laws and institutional practices limit women’s opportunities to run for office and participate in democratic

processes (including lower-level customary governance structures). Socio-cultural norms and practices erode women's self-confidence, further inhibiting their active engagement in public life.²²²

Though there are a number of women's groups that are active in advocacy and political events, women report feeling unsafe at political demonstrations.²²³ Women's involvement in political protests in the past has sometimes resulted in violence.²²⁴ For example, on September 28, 2009 women's involvement in a peaceful protest against the military junta resulted in extreme violence, including rape (at least 109 cases of sexual violence documented).²²⁵ More than ten years after these crimes were committed, the trials for the perpetrators of the violence still have not taken place.²²⁶ This event continues to cast a shadow of fear for many women's groups active in political advocacy.²²⁷ There have also been reports of election-related GBV taking place during the 2020 elections, at the time of writing.²²⁸

Decentralization policy design and implementation have not been adequately responsive to the priorities and needs of women and girls in Guinea. Local governments in Guinea face constraints in delivering on their commitments, including: limited capacity to implement gender-responsive planning and budgeting; weak accountability mechanisms; and limited capacity to deliver gender-responsive services.²²⁹ The implementation of gender-equality commitments at the local level requires a concerted effort by national and local governments, civil society, and donor agencies. However, CSOs working on women's rights and governance are competing for the same funding, which impedes consensus building and leads to donor-driven agenda setting.²³⁰ This lack of consensus has resulted in fragmented contributions to decentralized policy design and implementation.

Low capacity of gender-specific ministries and GFPs across line ministries contributes to low levels of awareness on the importance of equitable participation and inclusive governance processes. One report found that, while the Guinean Directorate for Women and Gender Promotion comprises around 100 civil servants, very few of its staff have the capacity to deliver training on gender-responsive planning.²³¹ Many of the gender units have undefined roles and are ineffective and, in some cases, not operational.²³² This means that access to expertise and resources for integrating gender institutionally remains a challenge. GOG respondents report that, even when thematic focal points exist, they rarely undertake joint activities across ministries, resulting in siloed gender initiatives.²³³

Gender gaps in access to media have important implications for media-focused initiatives. Seventy-one percent of rural young women and 50 percent of rural young men have no access to media (compared to 23 and 24 percent of women and men in Conakry).²³⁴ Radio remains the most important source of information for the public, and the only one to reach the entire country. Radio call-in shows are popular, allowing citizens to express broad discontent with the government, and more broadly offering an opportunity for women to stay civically engaged and active.²³⁵ Still, only 30 percent of women and 42 percent of men listen regularly to radio overall, and in urban areas only 27 percent of women and 38 percent of men.²³⁶ Women also have more limited access to mobile phones, computers, and internet, and access is worsened by literacy gender gaps. An increase in online news websites reflects the growing demand for divergent views. However, gender gaps in internet use preclude women from equitable access, particularly in rural areas.²³⁷

GBV survivors' limited awareness of their rights, gaps in GBV legislation, and weak enforcement of legal protections perpetuate impunity of perpetrators. There is an

overwhelming consensus that survivors of GBV do not seek justice in part because they are not aware of their rights under the law, particularly on issues related to CEFM and FGM/C.²³⁸ When survivors do seek justice, moreover, gaps in legislation and weak enforcement mechanisms make justice improbable. Though Guinea was the first country to institute a law against FGM/C through the Penal Code, it still has no legislation criminalizing IPV. The Criminal Code also does not recognize the concept of spousal rape.²³⁹ Though charges for “wife-beating” can be filed under the Penal Code provisions on general assault,²⁴⁰ charges of this kind are rarely pursued due to fear of stigmatization and reprisal (discussed under IR 1.2) as well as a complicated judicial process.

In cases where incidence of GBV is disclosed, it is often “settled” informally. Despite high rates of GBV in Guinea, many survivors do not seek formal justice or assistance from support services. Guinean culture considers it unacceptable for a woman to file a complaint against her husband for violence.²⁴¹ Relatedly, social norms view issues of GBV (including CEFM and FGM/C) as “familial” and traditional issues rather than infringement on an individual’s rights.²⁴² As a result, Guineans often seek advice through informal channels, including with traditional leaders (e.g., the village chief), and only seek the police for “matters of a criminal nature.”²⁴³ Women who have the courage to report abuse to the police (in particular IPV) face even more violence at home and are ostracized from their communities for speaking out.²⁴⁴ The culture of secrecy, shame, and stigma around GBV results in low access to and use of support services for GBV survivors, including health care services.

4.2 KEY RECOMMENDATIONS IR 2.1 DEMOCRATIC NORMS AND PROCESSES STRENGTHENED

The following recommendations align with six USAID J2SR sub-dimensions: open and accountable government; inclusive development; economic policy; government capacity; civil society capacity; and citizen capacity.

- **Increase women’s participation in decision-making structures: WEE**
 - Encourage the creation of local government-led programs to train and build the capacity of women to participate in local governance. Such programs should take into consideration differences in women’s income, access to employment, literacy, education level, and time use, to overcome barriers to women’s participation in local governance. **WEE**
 - Engage strategically with men and potential “resistors” to build and share evidence to make the business case for women in decision-making positions.
 - Integrate functional literacy initiatives into DO2 programming with modules on confidence, leadership, public speaking, etc. In cases where this is not possible, USAID/Guinea should seek to implement activities in areas where literacy programming is available and actively seek synergies with these existing programs.
- **Invest in women’s economic assets.** There is a clear opportunity to provide support to enhance women’s decision-making power in economic programs that increase women’s access to property, land, livelihoods, other capital, and business opportunities. Existing initiatives can be adapted so they not only help achieve women’s economic empowerment but also enhance women’s role in decision-making in relevant structures. **WEE**

- **Support capacity building of line ministries on gender integration (beyond GFPs)**
 - Create platforms for expert CSOs to engage with GOG ministries regarding strategies and agendas related to GEWE and GBV prevention and response.
 - Create platforms that allow for the national gender machinery to engage with “high-profile” ministries (e.g., Ministries of Health and Ministry of Justice) to support building the strategic relationships and partnerships necessary for advocacy and influence.
- **Connect government and CSOs to address GBV.** Foster relationships between local governments and CSOs working to end GBV, to increase communication and better position these CSOs to inform and advocate on GBV issues.
- **Leverage the decentralization process to increase capacity for GRB and strategic planning** (with a particular focus on GBV). Decentralized processes offer an excellent opportunity for advocating for GRB—particularly in budgeting for needs related to GBV prevention and response.
 - Build the capacity of CSOs to engage in GRB initiatives, and monitor government-led budget processes.
- **Support elected women officials**, including through the *Réseau des Femmes Elues Locales d’Afrique* – *Guinée* (Network of Locally Elected Women of Africa) and *Forum des Femmes Parlementaires de Guinée* (Forum of Women Parliamentarians of Guinea). Continue to support elected women officials, linking them with one another for networking/professional support as well as for potential youth-related initiatives, as inspiring mentors.
 - Invest in political apprenticeships and networking opportunities for interested young women.
- **Seek new partnerships with CSOs working in gender equality**, especially for co-design of new projects.
 - Invest in women’s organizations and movements, providing opportunities for them to define their own agendas while informing USAID priorities regarding civil society engagement and gender equality. **WEE**
- **Map media coverage, preference, and access in rural areas** to understand access to the various media forms and gender gaps.

4.3 KEY FINDINGS: IR 2.2 CONFLICT MANAGEMENT AND MITIGATION IMPROVED

Formal peacebuilding processes, including those focused on natural resource management, do not adequately include women. Common conflicts in Guinea include ethno-political conflicts, natural resource disputes (over land), and union or labor-related conflicts. In all instances, women are disproportionately impacted but rarely consulted.²⁴⁵ Reported reasons for this low level of engagement include: socio-cultural stereotypes of women as victims; a strict division of labor between men and women in the public and private spheres; low levels of political will to include women in the process; and women’s fear of physical violence (particularly for involvement in politicalized conflict).

Traditional justice systems in Guinea reinforce the subordination of women to their husbands and limit equitable women’s participation and decision-making. Traditional justice in Guinea is an ensemble of conflict-management practices, centered on dialogue and reconciliation. These practices are deeply rooted in the customs of the different communities in the country.²⁴⁶ Traditional justice actors include traditional or religious leaders, village chiefs, and elders—all predominantly men. Occasionally, older women are consulted in conflict resolution, but they do not hold the same decision-making authority as men. Inheritance and divorce are key issues with significant impact for women that are often resolved through traditional systems.²⁴⁷ Marriage disputes are often mediated by informal authorities in the community, leading to situations where women are pressured to accept inequitable settlements proposed by their families and community elders.

Low capacity of authorities to resolve disputes related to GBV in an appropriate and fair manner deters survivors from receiving justice. GBV survivors frequently do not seek help from the police or other authorities because they perceive the police to be reluctant to intervene (particularly in cases of IPV) and because the prosecution of GBV perpetrators is rare.²⁴⁸ Survivors and their families are reluctant to report crimes also because they fear that the police will ask them to pay for the investigation.²⁴⁹ If a woman survivor files a complaint, her family frequently orders her to withdraw the complaint and resolve the matter informally.²⁵⁰ Women who do not withdraw complaints are very likely to end up divorced, which puts them in a dire economic position and risks losing custody of their children and any acquired assets.²⁵¹ Additionally, challenges among actors in the legal system—including low levels of awareness of existing legislation, lack of capacity to apply that legislation, corruption, and low resources for relevant actors. Where GBV survivors pursue informal resolution processes, the outcomes similarly often favor men, especially in rural areas, and frequently result in women returning to their abusers.

Women bear a disproportionate share of the environmental burden that mining activities impose on local communities, but they are rarely consulted in remedial meetings and rarely lodge complaints. Despite their lack of formal engagement with mining companies, women are disproportionately affected by their activities—the loss of land due to mining, reduced water access, and concerns over health.²⁵² Moreover, women’s unequitable participation in village governance (see [IR 1.2 findings](#) above) impedes women from lodging complaints related to mining.²⁵³ One informant said, “It’s rare for women to lodge complaints against a mining company,” even though they are disproportionately impacted.²⁵⁴ A 2018 Human Rights Watch report on mining in Guinea found that mining companies reported that they make sure to include women in community meetings, but women themselves said they are not often aware of meetings with mining companies; when they do participate, social norms make it difficult for them to speak frankly in front of their husbands or male elders.²⁵⁵

CSOs working with women in this area are concentrated in urban areas. There are several local and regional NGOs working in conflict resolution and peacebuilding and many of them have strong representation of women. However, these groups are concentrated in Conakry, and their involvement in conflict resolution processes seems to be primarily at the national and regional levels.

4.4 KEY RECOMMENDATIONS: IR 2.2 CONFLICT MANAGEMENT AND MITIGATION IMPROVED

The following recommendations align with three USAID J2SR sub-dimensions: inclusive development; civil society capacity; and citizen capacity.

- **Deliberately widen the lens of conflict mitigation to include GBV.** Any activities focused on conflict mitigation should include specific, targeted activities for GBV prevention, mitigation, and response. It could also include targeted approaches to increasing awareness of the rights of women/girls under the law as well as the role of local authorities as duty bearers.
- **Build gender capacity of peace negotiators.** Provide technical assistance to peace process leaders, both men and women, to increase their capacity to meaningfully address gender issues—including GBV, access to healthcare (under DOI), mining-related conflicts, economic development, and equitable political participation and governance—within the ensuing framework and agreements.¹⁰ **WEE**
- **Conduct mapping of existing CSOs working in conflict mitigation and management.** Where the pool is small, seek partnership with new CSOs that show dedication to high participation.
 - Require USAID partners to engage CSOs with good representation and leadership of women in the design of conflict resolution and peacebuilding projects.
- **Support coalition building between active CSO groups engaged with women and youth in conflict management and mitigation.**
 - Establish effective networking systems between women’s groups. **WEE**
 - Facilitate establishing clear goals and effective lobbying and advocacy campaigns.
- **Support the documentation of success stories related to women’s participation in conflict mitigation.** USAID/Guinea should document best practices in engaging women in conflict management in its portfolio. Documentation should include best practices and lessons learned.

4.5 KEY FINDINGS: IR 2.3 SUSTAINABLE ECONOMIC OPPORTUNITIES INCREASED

There is near gender parity in labor-force participation levels in Guinea, but wage gaps as well as formal business activities favor men. In contrast to other countries with similar GDP per capita, Guinea has achieved parity in its female-to-male ratio of labor force participation.²⁵⁶ Women are less likely, however, to join the formal labor force and to work for pay, and they do not have access to the same work opportunities as men. Even when they do, they are more likely to work part-time or in the informal sector.²⁵⁷ Women are also paid less for the same jobs. The World Bank (2019) found the raw gender earnings gap was 38 percent (favoring men) in 2018.²⁵⁸ It also found that female participation in the formal private sector is particularly low. Furthermore, only 9 percent of Guinean firms included a woman among the owners.²⁵⁹ Women make up only 15 percent of the formal, private sector workforce; one-quarter of firms did not have any female employees.²⁶⁰

¹⁰ In accordance with EO 13950, USAID has put a hold on all upcoming training, seminars, and other related fora on diversity and inclusion pending an Agency and OPM review of the content of these programs (see Executive Order and OMB Guidance). It may also be helpful to review Agency Notices numbers 09214 and 10196. Mission staff reviewing these recommendations should seek guidance from Mission leadership prior to moving forward with any training events.

Sexual harassment is a major reported barrier for women in the private sector.²⁶¹ Sexual harassment is prohibited by the Labor Code, but the Ministry of Labor has not documented any cases of sexual harassment, despite researchers' reports of its prevalence.²⁶² Reports show that urban women working in the formal sector often experience sexual harassment.²⁶³ Women seldom formally report sexual harassment due to fear of retaliation, including loss of job or demotion.²⁶⁴

Many women engage in *petite commerce* (small commercial activities), but structural factors—such as access to resources including financial services—limit their expansion.

Women are actively involved in various income-generating activities, specifically including soap making and fabric dying. However, most women do not have access to financial services, including credit—especially in rural areas. Only 9.3 percent of urban women aged 15–49 have a bank account, versus 15 percent of urban men; in rural areas, this percentage falls to 0.7 percent for women and 3.3 percent for men.²⁶⁵ Barriers include:

- Women's lack of knowledge about the procedures for accessing financial services²⁶⁶
- Loan procedures or conditions set by commercial banks that in effect exclude women, such as collateral requirements (e.g., land) to obtain credit
- Stringent proof of identity requirements for opening a bank account that tend to exclude women and youth²⁶⁷

A 2019 study on women and youth financial inclusion found that 37 percent of all respondents cited identity documents and administrative issues as a major barrier to opening a bank account. Another 30 percent were deterred by transaction costs on banking platforms.²⁶⁸

As a result of these barriers, women often resort to informal credit systems, such as tontines, where women are the majority of participants.²⁶⁹ A notable exception is Guinea's *Mutuelles Financières des Femmes Africaines* (African Women's Financial Mutuals), a women-run micro-bank in partnership with Afriland First Bank. These institutions, primarily in urban settings, target low-income women.²⁷⁰

Stereotypes of women who run their own businesses, as well as perceptions of “acceptable” roles for women, limit women's ability to succeed in business activities.

Women who own their own businesses are reportedly viewed as “*insoumis*” (rebellious), unruly and insubordinate.²⁷¹ Their success and income is perceived as an insult to gender norms that dictate women should not be autonomous or powerful earners in the household.

Political interference in Guinea is a potential risk to small or medium enterprise (SME) owners generally, particularly to women entrepreneurs. Women and men reportedly experience political interference in private business endeavors when their political participation is viewed as contradictory to those in power. Women in particular face bureaucratic hurdles, extra fees, and other obstacles because of their involvement in politics.²⁷²

Men in Guinea are viewed as the “farmers” and women as “farmer's assistants” or laborers, which leads to gender-inequitable access to productive resources and advisory services. A USAID study on gender and farming practices in Guinea found fewer men than women farmers across various agroecological zones, reflecting male migration from rural areas to urban centers and to work in the mining industry.²⁷³ Women participate at all levels and perform almost all functions,

in agricultural and livestock value chains.²⁷⁴ Women are also primarily responsible for producing food for household consumption, yet are limited to small parcels of land to do so.²⁷⁵ Despite this, men are regarded as “farmers” and women as “*mains d’oeuvre*” (laborers).²⁷⁶ This classification leads to an unequitable provision of agricultural extension services, technical training, and inputs, which in turn widens the agricultural production gender gap (described in Box 3). Similarly, women rarely have control over income from agricultural production, especially from cash crops (i.e., cola nut and coffee).

Box 3. WOMEN AS FARMERS

A study conducted in 2019 by the World Bank in Guinea found that male-headed households generally farm larger plots, use more farming inputs such as fertilizer and improved seeds, and are more likely to use irrigation. They also found that yields of both legumes and cereals are much higher for male-headed households than female-headed households. The same World Bank study found that female-headed households produce 8 percent less than male-headed agricultural households.

Guinea: The Economic Benefits of a Gender Inclusive Society. 2019. Washington, D.C. World Bank Group.

Limitations on women’s productive activities and on their control over economic resources restrict their benefits from agricultural work as well as their growth as agricultural entrepreneurs. Deep-seated gender inequalities in both informal and formal institutions mean that women and men engage under different and often inequitable terms in agricultural value chains.²⁷⁷ This is most evident in the types of activities they engage in and the control they have over the benefits of participation, within and across value chains. Though this varies slightly depending on the crop, women play a prominent role in agricultural post-harvest transformation and commercialization—generally ensuring that certain products move from areas of local surplus to deficit markets.²⁷⁸ Women are reportedly interested in expanding their work in these areas to grow their businesses. Structural and relational barriers—such as limited access to markets, mobility constraints, lack of formal market information, and norms that limit women’s business relationships with men—impede the growth of woman-owned enterprises in this area.²⁷⁹

Women are well represented among agricultural cooperative members but remain underrepresented in leadership positions. In Guinea, women are underrepresented in research and development firms as well as in Agricultural Extension and Advisory services.²⁸⁰ The *Conseil National des Organizations Paysannes de Guinée-Conakry* (National Council of Farmer Organizations of Guinea-Conakry) comprises 22 agricultural federations, 18,000 grassroots producer associations (POs) from all administrative zones, and over 500,000 members; 52 percent of its members are women.²⁸¹ However, despite the Council’s concerted efforts, only six of the 22 federations have female presidents. Approximately 30 of the 18,000 *groupements* (producer associations) have female presidents.

Few women are employed formally in mining, despite their interest, though they are active in the “*entourage*” of mining activities. According to a 2014 study in Guinean mining areas, about 91.4 percent of men and 61.5 percent of women surveyed would like to have a job in a local mine.²⁸² Despite this, women are primarily engaged in informal work on mining sites, such as food services, transportation of water or other materials,²⁸³ or laundry for on-site workers.²⁸⁴ These roles present risks to women’s safety. Moreover, transactional sex, prostitution, and a practice known as *foudoukoudouni* (short-term marriage)²⁸⁵ are common in mining communities.²⁸⁶

4.6 KEY RECOMMENDATIONS: IR 2.3 SUSTAINABLE ECONOMIC OPPORTUNITIES INCREASED

The following recommendations align with five USAID J2SR sub-dimensions: inclusive development; economic policy; civil society capacity; citizen capacity; and capacity of the economy.

- **Support existing successful women entrepreneurs to expand and share successes with other women.**
 - Research the successful women entrepreneurs (especially in agriculture sector) to understand key factors and characteristics that lead to success (i.e., positive deviants). **WEE**
 - Promote the formation of women’s entrepreneur associations and women’s branches of chambers of commerce at the decentralized level. Support them to reach out to remote rural women producers and entrepreneurs to help bring them into formal-sector value chains and markets. **WEE**
- **Work with SME-owners to understand the benefits of inclusive business practices, the business case for gender equality.** For example, support the development of SME business plans to include services tailored to the needs of rural women, thus increasing services to this group while opening new avenues for expanded business.
- **Promote the business case for increased female leadership in firms by working with targeted actors in the private sector to encourage firms to recruit, identify, retain, and promote female employees into more leadership roles. WEE**
 - Support firms to develop recruitment strategies that help them attract and retain female talent—through job fairs, head-hunting, internship programs, on-job training, mentorship opportunities, and developing clear career growth trajectories. **WEE**
 - Provide support to targeted firms to develop and implement policies on sexual harassment.
- **Increase women’s access to financial services. WEE**
 - Encourage financial institutions to allow for alternative collateral and group-based approaches to lending to upscale innovative delivery mechanisms (mobile money). **WEE**
 - Invite financial service providers to present in person, at cooperatives, POs, and other groups where women are concentrated, to explain available financial services, procedures, and requirements. **WEE**
 - Implement microfinance programs that integrate functional and financial literacy, business and entrepreneurship training, and eventual graduation to formal finance and credit products. **WEE**
- **Seek to transform harmful gender norms and power relations in agricultural value chains, by working with agricultural POs or cooperatives.**
 - Specific initiatives to increase women’s participation in value chain work should be accompanied by interventions that promote reflection on power dynamics, including the benefits of equitable division of resources and benefits.
 - Target capacity-building initiatives at those steps of the value chain where women are particularly present (e.g., transformation and commercialization of agricultural products); organize women at these steps for collective action. Two promising approaches to consider are the [Gender Action](#)

Learning Systems (GALS) and International Fund for Agricultural Development’s Household Methodologies.¹¹ **WEE**

- Seek opportunities to invest in and promote the fruit drying, cashew, small fishery, and shea value chains, as areas of potential participation and profits for women—if designed with intentional gender outcomes. All these opportunities should include approaches to ensure that women benefit equitably from revenues (as described in the above recommendations). **WEE**
- **Develop co-design processes** to engage women’s agricultural organizations that can speak to the needs and priorities of women entrepreneurs in the agricultural sector. **WEE**
- **Make deliberate connections with GBV prevention:** economic empowerment for women presents both an opportunity to reduce risk to GBV and, in some cases, a risk to backlash of GBV in response to power shifts. **WEE**
- **Seek collaboration with the Women in Mining Africa Index** to better understand the potential for inclusion of women in the mining sector in Guinea, as well as other gender-related risks and opportunities.

4.7 ASSUMPTIONS AND RISKS

- The 2019 Law on Parity is applied and enforced for national and local elections, as well as for any elected position in public institutions. When the quota is respected, women are placed in high-ranking positions on their party’s list.
- Government officials will focus pre- and post-election on carrying out their functions as duty bearers, especially as it relates to GEWE.
- Legislative election processes in Guinea are free, fair, and transparent and do not create opportunities for violence, conflict, or civil unrest.
- Independent media does not inadvertently perpetuate harmful gender norms, especially related to GBV.
- Programming regarding civil society strengthening accounts for the unique risks and dangers to female activists and civil society members, including political violence.
- Prominent women’s organizations are adequately representative of diverse groups of women.
- Consensus building includes equitable participation of women’s groups (and others who are underrepresented).

¹¹ In accordance with EO 13950, USAID has put a hold on all upcoming training, seminars, and other related fora on diversity and inclusion pending an Agency and OPM review of the content of these programs (see Executive Order and OMB Guidance). It may also be helpful to review Agency Notices numbers 09214 and 10196. Mission staff reviewing these recommendations should seek guidance from Mission leadership prior to moving forward with any training events.

- Women's (and women's groups) active participation in conflict management efforts, especially in the political space, does not increase risk to GBV or invite political interference in entrepreneurship endeavors.
- Entrepreneurship initiatives do not exacerbate risk to GBV for women and girls.

4.8 ILLUSTRATIVE INDICATORS

TABLE 6. RECOMMENDED KEY ILLUSTRATIVE INDICATORS, BY IR

INTERMEDIATE RESULT	RECOMMENDED ILLUSTRATIVE INDICATORS
IR 2.1: Democratic norms and processes strengthened	<p>Number of USG-assisted political parties implementing initiatives to increase the number of candidates or members who are women, youth, and from marginalized groups (USG F indicator)</p> <p>Number of persons trained with USG assistance to advance outcomes consistent with gender equality or female empowerment through their roles in public or private sector institutions or organizations, by sex (USG F indicator)</p> <p>Number of USG-supported activities designed to promote or strengthen the civic participation of women (USG F indicator)</p> <p>Extent to which a national budget is broken down by gender, age, income, or region (Custom indicator: USAID WE3 TA Indicator)</p> <p>Number of women's rights groups (DR.4.2–1b CSO capacity development; Custom indicator: USAID WE3 TA Indicator)</p>
IR 2.2 Conflict management and mitigation improved	<p>Number of local women participating in a substantive role or position in a peacebuilding process supported with USG assistance (USG F Indicator: GNDR-10)</p> <p>Number of training and capacity-building activities conducted with USG assistance that are designed to promote the participation of women or the integration of gender perspectives in security sector institutions or activities (USG F indicator: GNDR-9)</p> <p>Percentage of male and female village or custom court magistrates trained in GBV, gender equality, and women's rights in property and family law (Custom indicator)</p>
IR 2.3 Sustainable economic opportunities increased	<p>Percentage of female participants in USG-assisted programs designed to increase access to productive economic resources (assets, credit, income, or employment) (USG F indicator: GNDR-2)</p> <p>Percentage of participants reporting increased agreement with the concept that males and females should have equal access to social, economic, and political resources and opportunities (USG F indicator: GNDR-4)</p> <p>Percentage of women reporting decision-making power related to agricultural production and business (Custom indicator: USAID WE3 TA indicator)</p> <p>Percentage of firms that report female participation in ownership and top management (Custom indicator: USAID WE3 TA)</p> <p>Number of financial services and products specifically designed to meet the needs of rural women (Custom indicator)</p> <p>Percentage growth of women-run enterprises, measured by profits, capital, number of employees, etc. (Custom indicator: USAID WE3 TA indicator)</p> <p>Percentage change in visibility and position of women in high value sub-sectors and value chains (Custom indicator: USAID WE3 TA indicator)</p>

5. USAID/GUINEA INSTITUTIONAL FRAMEWORK ON GENDER EQUALITY AND THE SOCIAL INCLUSION OF VULNERABLE GROUPS

The following findings are from KIIs with USAID staff, supplemented by a review of key documents.

5.1 USAID/GUINEA POLICY AND PRACTICE ON GENDER EQUALITY

- The Mission has a GFP; however, the GFP has full-time responsibilities under the DO2 portfolio, whose job description does not formally recognize gender-related tasks.
- Various staff confirmed that there is a USAID/Guinea Gender Mission Order, but no one could speak to its specific contents, and the research team was unable to locate it.
- The Mission has a Gender and Youth Working Group, but the group is largely inactive and meets sporadically. The working group is not guided by written terms of reference. Some staff feel they do not have the support of their supervisors to attend such meetings regularly or to dedicate time to gender- and youth-related initiatives that are not strictly in their SOW.
- Technical Evaluation Committees (TECs) do not have clear guidance on how to evaluate the quality of gender integration as a part of their scoring of proposals.
- Gender analyses are not included in Project Appraisal Documents (PADs) in a manner that goes beyond standard boiler-plate language and that identifies key gender gaps and opportunities in relation to PAD objectives. PADs do mention the mission's 2012 CDCS gender analysis generally but resulting strategies do not include approaches to address those findings beyond targets set for women's participation. There are no explicit mitigation strategies in relation to GBV prevention and response.
- Activities have not conducted their own gender analysis. IPs reported that this was not a requirement of the donor and they do not have sufficient funds to complete such an exercise.
- There are no current gender advisors supporting current USAID-funded IP activities. Some IPs mentioned good support from HQ technical staff, and others mentioned designated GFPs. Despite this, IPs have some excellent experience and insights regarding gender integration.
- Generally, USAID/Guinea staff agree that gender integration is an important component of all sectors, but they struggle with insufficient bandwidth to achieve integration in a substantive way. Certain staff reported frustration with trying to address gender equality in a concrete manner.
- Certain staff reported gendered internal practices and conduct that lead them to believe that attitudes and beliefs may hinder gender integration in programs and operations.
- The Mission does not have gender integration tools for activity-level gender strategies.
- The Mission does not currently have indicators measuring any gender impact.
- GBV prevention and response programming does not take place in DOI or DO2.

5.2 RECOMMENDATIONS FOR USAID/GUINEA

- Hire a full-time gender advisor, positioned in the mission's Program Office. This staff member could oversee the revitalization of the Mission Gender Order, ensure that the gender technical working group is functional and effective, and provide support to TECs in terms of gender scoring.
- Plan for the inclusion of gender analyses in PAD documents, highlighting the sector-specific gender gaps.
- Include clear, specific gender integration criteria in all solicitation of new activities. For example, require: dedicated LOE or budget for gender-related activities; LOE for a gender advisor or focal point (including required expertise); partnerships with women's organizations; and key gender gaps to be addressed in Activity strategy.
- Provide guidance to Contracting Officer Representative (COR)/Agreement Officer Representative (AOR) on evaluating IPs work plans as well as Activity, Monitoring, Evaluation, and Learning Plans (AMELPS) to insure adequate gender integration.
- Increase the number of USAID IPs that include indicators and reporting on levels of participation of women and men—in public life, leadership roles, decision-making, and access to and control over resources.
- Ensure that IPs complete required activity-level gender analysis and gender (integration) strategies as deliverables during project start-up. Ensure budget allocations for gender actions.
- Create a community of practice of IPs' GFPs/gender advisors to encourage lessons learned in relation to current activity implementation.
- Organize trainings for all USAID staff (not just technical/programming) on unconscious bias and gender and diversity.
- Devise minimum requirements for GBV response and prevention, outlining guidance for GBV monitoring and mitigation within non-GBV-focused sectoral programming. This would include guidance regarding the specific actions to take when and if incidents of GBV occur (or are disclosed) during program implementation. Ensure that minimum requirements are outlined in activity solicitation documents.
- Conduct a gender audit of the mission staff's attitudes, beliefs, and perceptions as well as operations in relation to procurement.

ANNEX A: SCOPE OF WORK

I. OBJECTIVE

Following the USAID ADS 201 and ADS205 and the U.S. Women's Entrepreneurship and Economic Empowerment (WEEE) Act that requires gender analysis be performed at all levels of USAID's work in every sector, the Mission will undertake a gender analysis to identify the country-level gender equality and women's empowerment advances, issues, inequalities, constraints, and opportunities.

USAID/Guinea is preparing to develop a new 2020-2024 Country Development Cooperation Strategy (CDCS) for Guinea. The current CDCS is valid from May 2015 to December 2020. USAID/Guinea requires a gender analysis to inform the development of a new CDCS, centered on the Journey to Self-Reliance principles. The findings and recommendations of the gender analysis will also guide USAID/Guinea in reflecting gender equality and female empowerment commitment in its CDCS Goal, Development Objectives, and Intermediate and Sub-Intermediate Results, and in better incorporating it into project design and implementation, and Collaboration, Learning and Adapting (CLA). The key stakeholders and the primary audience for the analysis results, will be USAID/Guinea and USAID/Washington. At the same time, an approved version of the analysis will be accessible publicly to all interested parties in the development community and beyond.

The gender analysis will focus on the following three key sectors: Health, Democracy and Governance (D&G), and Economic Growth. Economic Growth comprises of the following three sub-sectors – Energy, Agriculture, and Environment. The gender analysis will also focus on the following as cross-cutting themes – Gender-Based Violence (GBV) and specific value chains where the private sector is well-placed to empower women. The gender analysis will include urban and rural residents as a key population.

2. BACKGROUND

In Guinea, women are most affected by gender inequalities due to factors such as patriarchal and cultural stereotypes, interpretation of the holy Quran religious texts according to men's whims and positions, subordination of women in public decision-making and accountability within the structures. There are limited rights of land ownership and production, GBV, inequitable access to skilled jobs and managerial positions and limited access to health services. While close to 77 percent of girls attend primary school, only 25 percent of secondary school age girls are attending. This dramatic difference is largely due to teen girls dropping out to help at home or because of child marriage.

USAID/Guinea Previous Gender Analyses

USAID/Guinea carried out a gender analysis in 2012. The analysis focused on the topics of: Democracy and Governance; Growth and Economic Environment; Initiative for Global Health; Education; and integration of gender equality in the formulation of mission results. The following are the 2012 gender analysis' main findings:

- Despite the assertion of equality between men and women before the law and the rights of women, in practice, the legal provisions are often circumvented or violated.
- Women are the first victims of violence and political turmoil that marked the country in the past, especially in 2006, 2007, 2009 and in between the two rounds of presidential elections in 2010.

- Gender inequalities, at the expense of women, are particularly sensitive in the four focus areas of USAID Guinea in 2012, namely governance and democracy, growth, health and education.
- Economically, women are most affected by the context of widespread poverty because they are the poorest of the poor. Women are the most vulnerable, and have the least capacity and resources (such as credit, technology, farmlands) that enable them to assert their rights and interests. In general, the more high tech, the more capital intensive the activity is, and the more significant the income it generates, the more it is largely dominated by men.
- In the field of health, despite some progress for nearly two decades, the health situation in Guinea remained very poor in 2012. Although women's life expectancy at birth was 59.6 years against 56.6 years for men, Guinean women suffer from a major deficit in the field of health because of limited access to health services and social support network. For example, more than 60% of deliveries were not assisted and infant mortality affected 163 per 1000 births in 2012.
- In the field of education, despite some significant progress, illiteracy was still very high in 2012, affecting more than the majority of the Guinean population, which is an impediment to progress in many other areas such as health, rural development or democracy.
- The main factors that hinder progress in sectors such as agriculture, health, natural resource management or education, are issues related to the performance of public administration.
- Government policies emphasize the need to implement measures to promote women's participation in politics and decision-making bodies to correct inequalities between men and women in these areas. However, despite the assertion of political will in these policy documents and speeches, the recommended follow-up actions are hardly visible in the reality on the ground.

The gender analysis gave the following nine recommendations:

1. Support the establishment of a National Observatory on Gender.
2. Promote gender topics in the media.
3. Revitalize and strengthen 'Gender' loci in the key ministries.
4. Create "Gender" focal points in CSOs.
5. Expand and strengthen the monitoring committees of the Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW).
6. Extend the actions of "Faisons Ensemble Project" to all regions of Guinea with a greater focus on growth sectors (AGR, microfinance) and taking gender into better account.
7. Continue, strengthen and coordinate the actions of Engender Health and GHI, based on Village Committees for the Mother and Child Protection in both cases.
8. Pursue and strengthen the actions of the RESPOND Project.
9. Resume and expand the School Project (EP) initiative by incorporating lessons learned from PACEEQ, Government of Children and Promoting Active Pedagogies projects.

It was also recommended that Gender Strategic Plan of USAID / Guinea should contribute to achieving the Millennium Development Goals (MDGs) to be achieved by 2015, based on the Poverty Reduction Strategy. To achieve this goal, USAID / Guinea could use outcome and impact indicators that will combine the indicators used by the Guinean government in different areas and indicators standardized by the USG foreign assistance.

USAID Relevant Policies

Gender equality and female empowerment are core development objectives, fundamental for the realization of human rights and key to effective and sustainable development outcomes. Promoting gender equality and advancing the status of all women and girls around the world is vital to achieving U.S. foreign policy and development objectives. Since 2012, USAID adopted several comprehensive and interlinked policies and strategies to reduce gender inequality and to enable girls and women to realize their rights, determine their life outcomes, influence decision-making and become change agents in households, communities, and societies.

These policies and strategies include: The Gender Equality and Female Empowerment (GEFE) Policy; 2018 WEEE Act¹², The Women Peace and Security Act¹³; the U.S. Strategy to Prevent and Respond to Gender-Based Violence Globally; USG Strategy to Empower Adolescent Girls Globally; the USAID Vision for Ending Child Marriage and Meeting the Needs of Married Children; Youth Policy; Women Global Development and Prosperity Initiative (W-GDP)¹⁴; the USAID Disability Policy, the USAID Lesbian, Gay, Bisexual, Trans, and/or Intersex Vision for Action and the USAID Counter-Trafficking in Persons Policy. Together, these laws, policies and strategies provide guidance on pursuing more effective, evidence-based investments in gender equality and female empowerment and incorporating these efforts into our core development programming. Automated Directive System (ADS) 205 explains how to implement these new policies and strategies across USAID's program cycle. USAID's 2019 Policy Framework's vision in the J2SR recognizes that self-reliant systems are inclusive and open to a wide array of individuals and groups, especially women, youth, and marginalized or vulnerable populations, and these systems benefit when all individuals participate in them.

3. OBJECTIVES AND PURPOSE

The goal of USAID/Guinea country level gender analysis is to identify the macro level gender equality and women's empowerment advances issues, inequalities, constraints, and opportunities, and provide specific recommendations on how USAID/Guinea can achieve greater gender integration, including emphasizing outcomes for women/girls roles at all levels on its strategic planning across different sectors in facilitation of Guinea's Journey to Self-Reliance. The gender analysis will inform the CDCS on how to improve/ensure women's leadership and meaningful participation in USAID programs/activities; ensure women/girls (or men/boys) equal benefit; meet the differential needs of women/girls (men/boys); reduce identified gender gaps; do no harm (identify and mitigate unintended negative consequences from USAID programming); and provide recommendations on how GEWE approach can improve CDCS implementation/outcomes/success

¹² <https://www.congress.gov/bill/115th-congress/senate-bill/3247/text>

¹³ <https://www.congress.gov/bill/115th-congress/senate-bill/1141>

¹⁴ <https://www.whitehouse.gov/wgdp/>

The analysis will address the key tasks as follows:

1. Analyze and present findings and recommendations on gender equality and women's empowerment advances and gaps in Guinea in all of USAID/Guinea's sectors listed above. GBV prevention and response, and specific value chains where the private sector is well-placed to empower women will be key cross-cutting priority focus areas addressed under all sectors. Key populations will include urban and rural residents.
2. Identify opportunities (programmatic and partnerships) for gender and women's empowerment to be integrated into USAID/Guinea's CDCS and programming. This will include the identification of opportunities to leverage knowledge and data collected by other key players in Guinea, including but not limited to the private sector, civil society, academia, think tanks, and other key donor partners.

The analysis must gather data and information on the following domains from the [ADS205](#):

- **Laws, Policies, Regulations, and Institutional Practices that influence the context in which men and women act and make decisions:** The gender analysis should identify the extent to which laws, policies, regulations, and institutional practices contain explicit gender biases (e.g., explicit provisions that treat males and females differently; laws and regulations that criminalize and/or restrict individuals on the basis of their gender identity or expression) or implicit gender biases (e.g., the different impacts of laws, policies, regulations, and practices on men and women because of different social arrangements and economic behavior). The analysis should also identify when key gender-related legislation (e.g., laws on non-discrimination, gender equality, GBV sexual harassment) is absent, or when it is honored in the breach, as is the case with female genital cutting and a number of other practices that are technically illegal but continue to be practiced widely and with impunity.

For the purpose of this analysis:

- Laws include formal statutory laws.
 - Policies and regulations include formal and informal rules and procedures adopted by public institutions for making decisions and taking public action.
 - Institutional practices can be formal or informal and include behaviors or norms related to human resources (hiring and firing), professional conduct (workplace harassment), safety and security, provision of services, and the like.
- **Cultural Norms and Beliefs:** This domain should analyze cultural norms and beliefs (often expressed as gender stereotypes) on appropriate qualities, life goals, and aspirations for males and females. These norms and beliefs likely differ by region and ethnic group, so it is important to sufficiently represent nuance and variation when it is present. Gender norms and beliefs are influenced by perceptions of gender identity and expression and are often supported by and embedded in laws, policies, and institutional practices. They influence how females and males behave in different domains. Special attention should be paid to the collective conception of appropriate female sexuality and how this relates to female genital cutting. Women's right to access land and heritage should also be addressed.
 - **Gender Roles, Responsibilities, and Time Use:** The gender analysis should assess what males and females (of all ages) do in the spheres of productive (market) economic activity and

reproductive (non-market) activity, including roles, responsibilities, and time use during paid work, unpaid work (including care and other work in the home), religious observation, and community service to get an accurate portrait of how people lead their lives and to anticipate potential constraints to participation in development projects. Decision power regarding choice of partner, age at marriage, polygamy, pregnancy, and childrearing should be a prominent area of analysis.

- **Access to and Control over Assets and Resources:** This component of gender analysis should examine whether females and males own and/or have access to and the capacity to use productive resources – assets (land, housing), income, social benefits (social insurance, pensions), public services (health, water), technology – and information necessary to be a fully active and productive participant in society. Analysis of this domain may also include an examination of how a society's acceptance (or lack thereof) of individuals' gender identity and/or expression, marital status, and presence or lack of female genital cutting may influence their ability to access and control resources.
- **Patterns of Power and Decision-making:** This domain of gender analysis should assess power analysis of patriarchy in Guinea; the ability of women and men to decide, influence, and exercise control over material, human, intellectual, and financial resources, in the family, community, and country. It also includes the capacity to vote and run for office at all levels of government. Analyses should examine to what extent males and females are represented in senior level decision-making positions and exercise voice in decisions made by public, private, and civil society organizations. Issues of power often cross-cut the other domains of gender analysis as well.

4. METHODOLOGY

Data Gathering Methods

The Gender Analysis should comprise a combination of primary and secondary data collection.

Secondary data collection should include the analysis of data from multiple sources, including country-level gender analysis performed by the government and other donors or academics as well as:

- Sub national or sectoral gender analyses;
- Official national and subnational data and statistics;
- Relevant public data from USAID datasets, projects and activities;
- Guinea Demographic and Health Survey, including available datasets of the survey;
- Technical reports related to economic growth, trade, finance, workforce development; W-GDP Pillars; GBV (IPV, domestic violence, Workplace, FGM, CEFM, SGBV); Women/girls and Governance (J2SR); Private sector engagement (how it impacts gender issues, needs, service, etc.); Resilience
- Periodic reports to the United Nations (UN) human rights committees; and

- Shadow reports and reports by UN and regional intergovernmental organizations, non-governmental organizations (NGOs), World Bank's Women, Business and the Law report and implementers.

Primary data collection should include key informant interviews and focus group discussions (FGDs) with relevant stakeholders. The analysis team must consult with a wide variety of key stakeholders who are aware of the local context and can provide unpublished information. These stakeholders include, but are not limited to: local academic institutions, think tanks, civil society organizations, private sector companies serving a predominantly female clientele, doctors and other representatives of the public health system, government officials at national and sub national levels, USAID Implementing Partners, Gender Development Partners Group, program beneficiaries, USAID/Guinea staff.

Given that all international and domestic travel is currently prohibited for both USAID staff and implementing partners, the gender analysis team will conduct the primary data collection remotely. In place of in-person interviews and meetings for the KII's and FGD's, the research team will carry out phone calls and video conferences. The Team Leader will manage the national consultants remotely. To the greatest extent possible, the Team Leader will participate in interviews via phone or video conference. Interviews can be recorded where the Team Leader cannot participate. The team will need to utilize various applications¹⁵ to both record interviews and set up international phone calls and/or video conferences. If possible, Mission sector and CDCS DO team members can be included in the stakeholder calls to engage technical and DO staff in the gender analysis.

The gender analysis team can also utilize various online survey tools, such as three specifically tailored surveys, differentiated between key stakeholders such as implementing partners and CDCS design teams, focused on health, democracy and governance, and economic growth. The online surveys can be disseminated prior to data collection to identify key gaps in programming and better inform the KIIs and FGDs. These survey(s) can strengthen the qualitative data, and the quantitative data to a lesser degree.

Descriptive Statistics in Gender Analysis

Should the Contractor collect quantitative data, statistics disaggregated by sex and age should be collected and reported separately in different categories (male or female; age cohorts of 0-9; 10-14; 15-19; 20-24) or fashioned into ratios or absolute or relative gaps to show the status of females relative to males. Indicators pertaining to either males or females only should also be included, for instance, those measuring progress toward women's participation and leadership.

The Gender Analysis should reflect the intersection of sex with other characteristics such as age, marital status, excised vs. non-excised status, income, ethnicity, geographic location, or other socially relevant category as appropriate, in education, health, political participation, economic activity and earnings, time use, violence, and other relevant domains.

¹⁵ Examples of applications include Voice Notes, GoToMeeting, and VoiceRecord. The gender analysis team will use various technologies available in place of in-person interviews.

5. DELIVERABLES/TASKS REQUIRED

All written documentation for submission by the Contractor to USAID/Guinea must be in English, while the final analysis document will have Executive Summaries in both English and French. The Contractor must provide the following deliverables:

1. Inception Report: The Contractor shall submit their Inception Report (including the brief literature review, proposed methodology, work plan/schedule, and list of key contacts) to be concurred by the USAID/Guinea Activity Manager and approved by the Contracting Officer's Representative (COR). The data collection instruments and proposed list of interviewees shall be submitted no less than one week prior to primary data collection. USAID/Guinea should provide necessary documents (including project descriptions and scopes of works of current activities) and interview suggestions with relevant contact information to assist the Consultants.
2. Kick-off meetings on day one of the data collection with relevant USAID/Guinea staff including technical teams, DO team leaders to include an in-brief on the desk review, methodology, and timeline.
3. Consult with USAID technical teams on principal gender issues they would like examined within their sectors. This could include lines of questions, data, and recommended local information resources within their sectors (local NGOs and CSOs). The Consultant team can determine the best interactive methodology to consult with all sector teams (such as a theory of change mapping exercise). As possible, Mission technical/sector staff will be encouraged to join the Consultants during their field-based stakeholder and focus group meetings.
4. Revised Inception Report: Updated methodology and work plan/schedule before data collection.
5. Lead discussions with USAID/Guinea sectors and project teams to review findings, develop recommendations with direct input and buy-in from the USAID/Guinea staff.
6. Lead and develop a consultative workshop with project teams and other USAID staff to discuss and refine the draft theory of change and the gender action plan for USAID/Guinea. The gender action plan will make clear propositions of strategic choices that USAID/Guinea Mission should undertake in gender.
7. Mission-wide out-brief presentation/discussion and findings for each technical area, based on the gender analysis, including initial key findings from stakeholder interviews, conclusions and recommendation consultative workshop with USAID/Guinea teams and meetings with USAID partners and other donors, as well as initial conclusions, and of topline recommendations for gender integration in USAID/Guinea programming. Presentation must be held on the last day of the data collection, and materials will be due one business day before the out-brief.
8. The preliminary draft report that includes a country gender index must be submitted electronically to USAID/Guinea within five weeks after the completion of the data collection. The Mission will provide written comments to the Consultant electronically within five working days of receipt.
9. The Final Draft Report incorporating USAID/Guinea comments shall be submitted to USAID/Guinea no later than five working days after receiving the above comments. Should a second revision be necessary, the Mission will provide any additional written comments electronically within ten working days of the receipt of the revised draft and the Contractor shall submit a Final Report no later than five working days after receiving the above comments.

The following table presents the tentative timeline for the submission of deliverables. The due dates will be defined after the dates for Gender Analysis dates are finalized.

Deliverable	Timeframe	Due Date
Deliverable 1: Inception Report:	June 22 – July 17, 2020	July 17, 2020
Deliverable 2: Revised Inception Report	July 20 - 24, 2020	July 24, 2020
Deliverable 3: Kick-off meeting with relevant USAID/Guinea staff	N/A	July 27, 2020
Deliverable 4: Primary Data Collection	July 27 – August 21, 2020	August 21, 2020
Mission-wide out-brief presentation/discussion of the gender analysis	N/A	August 21, 2020
Deliverable 5: Draft Gender Analysis Report	August 24 – September 25, 2020	September 25, 2020
Deliverable 6: Final Gender Analysis Report	October 5-16, 2020	October 16, 2020

6. TEAM COMPOSITION

The contractor shall propose a team consisting of both international and local consultants to perform the gender analysis. The team should all speak fluent French, and at least one member of the team should speak each of Susu, Malinke, and Pulaar. The recommended composition of the team is the following:

Team Leader/Senior Gender Expert (international experience)

The team leader must have at least 10 years of international experience in gender analysis in the development areas of democracy and governance, health and education, economic growth, trade, private sector engagement and environment. S/he must have a master's degree in sociology or anthropology or a relevant social science field, and demonstrated experience working in solely French-speaking settings.

The team leader must have leadership skills, be able to lead meetings, coordinate, and gather different points of view of members of the team, draft initial document with conclusions and recommendations, and prepare the report and presentations. The team leader must be familiar with public policies

addressing gender and social inclusion gaps, GBV, disability, and gender agendas and programs of USAID. S/he must have experience in qualitative research and statistical data analysis.

Senior Gender Expert (national)

The National Senior Gender Expert must have at least ten years of experience working in development, research and/or evaluations in the gender analysis area. The consultant must have a Master's degree or equivalent in economics, public policy, development, or other related field.

The national Senior Gender Expert must have leadership skills, be able to lead meetings, coordinate, and gather different points of view of members of the team, draft initial document with conclusions and recommendations, and prepare the report and presentations. S/he must have experience in qualitative research and statistical data analysis.

This expert must be familiar with public policies addressing gender and social inclusion gaps, GBV, disability, and gender agendas and programs of the main development agencies in Guinea. S/he must have contacts with academia, think tanks, government institutions and NGOs in order to be able to set up the expert interviews and focus groups.

Gender Expert (national)

The National Gender Expert must have at least five years of experience working in development, research and/or evaluations preferably in the gender analysis area. The consultant must have a Bachelor's Degree (Master's Degree is highly desirable) or equivalent in economics, public policy, development, or other related field. S/he must have experience in qualitative research and statistical data analysis.

This expert must be familiar with public policies addressing gender and social inclusion gaps, GBV, disability, and gender agendas and programs of the main development agencies in Guinea. S/he must have contacts with academia, think tanks, government institutions and NGOs in order to be able to set up the expert interviews and focus groups.

7. ANALYSIS MANAGEMENT

The Contractor shall be responsible for the administrative support and logistics required to fulfill this task. These shall include all travel arrangements, appointment scheduling, secretarial services, report preparation services, printing, duplicating, and translation services.

USAID/Guinea will assist the Contractor in obtaining any additional program documents and contacts necessary to fulfill the task. The COR and/or alternate and Activity Manager at USAID/Guinea will provide strategic direction and guidance throughout the analytical process, including the development of the final work plan, any data collection tools, and gender analysis report outline, approach, and content. It is expected that some USAID/Guinea staff with different expertise will be involved with the gender analysis process. The primary focal point for the gender analysis will be Binta Ann as primary contact, based at USAID/Guinea.

8. FINAL REPORT AND SUPPORTING DATA

8.1 The Gender Analysis Report

The findings of the gender analysis must be reflected in a written report. The Gender Analysis final report should not exceed 35 pages, excluding cover page, table of contents, and annexes/attachments.

The report must be written in English and should include the following sections:

- **Executive summary (2 pages):** Synthesizes main findings, recommendations, and lessons learned. Does not include new information not available in the report. This must be a stand-alone document.
- **Introduction (1 page):** Clearly specifies the purpose of the analysis/assessment, the use of findings, the decisions for which evidence is being provided, and audiences of the report. The analysis/assessment topics of interest are articulated to the purpose; questions regarding lessons learned are included in this section.
- **Country Context and Gender Landscape (2-4 pages):** This section provides the country context and background of gender equality in Guinea by ADS205 Domains.
- **Gender Analysis Findings and Recommendations structured according to the two development objectives. (up to 20 pages):** This is the main section of the report. It will include detailed key gender analysis findings and recommendations structured around the two draft CDCS results framework development objectives and corresponding intermediate results. The findings must be clearly supported by multiple evidence sources referenced in the text, increasing its credibility. To the extent possible, evidence should be presented by using graphs and tables, and any other form that facilitates the readers' understanding of the text. Recommendations must be concise, specific, practical, and relevant to decision-making and the achievement of results on behalf of key stakeholders (including USAID), as appropriate.
- **USAID/Guinea Institutional Framework on Gender Equality and Social Inclusion of Vulnerable Groups (2-3) pages maximum):** This section will address, but not be limited to, the following questions – 1) a mission gender or inclusive development adviser position? 2) a gender/inclusive development mission order? 3) a mission Gender or Inclusive Development Adviser position? 4) Gender/Inclusive Development Mission Order? 5) Internal Mission Gender or Inclusive Development Working Group? 6) Gender integration in procurement criteria? 7) Gender analysis for PADs, activities? 8) USAID activity-level gender integration strategy template (Quality? Incorporated into program, including Monitoring Evaluation and Learning Strategy?) 9) Project Gender Indicators (Do they exist? What do they measure? Is what they mission sufficient?
- **Appendices** must include: a) SOW of the analysis b) methodology and limitations c) reference list d) interview guide e) list of key interviewees. Other appendices may be added as applicable.

8.2 Interview notes and resource documents

The Contractor must provide summaries of all key meetings, workshops, discussions, and any data collection exercises conducted in the course of the analysis. These summaries must be submitted to USAID/Guinea Activity Manager, along with copies of any background documents and reports gathered in the course of the assessment. All information must be provided in an electronic format, organized and fully documented for use.

8.3 Datasets

Should the Contractor use quantitative data, all datasets generated during the performance of the assessment must be submitted in a machine-readable, non-proprietary format and excluding any personally identifiable information, with supporting documentation describing the dataset, such as code books, data dictionaries, data gathering tools, notes on data quality, and explanations of redactions. All datasets created during the performance of the task order must be submitted to the Development Data Library per open data requirements found in ADS 579, USAID Development Data, and per the instructions outlined in ADS 302mas (302.3.5.22). The Contractor must submit the Dataset and supporting documentation within thirty (30) calendar days after the Dataset is first used to produce an Intellectual Work or is of sufficient quality to produce an Intellectual Work.

8.4 Submission to the Development Experience Clearinghouse

The final approved report (or a sanitized version of it) must be a public document to be submitted to the Development Experience Clearinghouse (www.dec.org) (DEC) following the required Office of GenDev format. The contractor must make the final gender analysis report publicly available through the DEC within 30 calendar days of final approval of the formatted report.

8.5 Task Order Packaging and Marking

Task Order packaging and marking shall be performed in accordance with Section D of Advancing the Gender Integration Technical Assistance II Task Order: 47QRAA18D00CM.

8.6 Branding and Marking

The Contractor shall comply with the requirements of the policy directives and required procedures outlined in USAID Automated Directive System (ADS) 320.3.2 “Branding and Marking in USAID Direct Contracts” (version from January 8, 2007) at <https://www.usaid.gov/ads/policy/300/320>; and USAID “Standard Graphic Manual” available at: <http://www.usaid.gov/branding/gsm>, or any successor branding policy.

ANNEX B: METHODOLOGY AND LIMITATIONS

INCEPTION REPORT

The research team prepared an inception report from July 21 to August 14, 2020, which included a desk review of the secondary data sources specified in Annex C. The purpose of the desk review was to identify the major GEWE advances, gaps, and opportunities in Guinea as a whole, with a focus on the two DOs that were the main units of analysis for the USAID/Guinea 2020–2025 CDCS. Based on the desk review findings, the research team designed the methodology and work plan, which includes a research matrix (Table B1 below) that connects the research questions to potential sources of secondary data and the instruments to use for collecting the data (Annex D). It also included question guides tailored to each data-collection method, as well as a list of key stakeholders to consult during primary data collection.

At the outset of the assignment, the gender analysis was primarily focused on the three key sectors of health, democracy and governance, and economic growth. The Inception Report used these three key sectors as the primary unit of analysis. As the start of the assignment was delayed by several months, and the USAID/Guinea mission had a draft CDCS results framework at the time of completing the Inception Report, the data collection turned its focus to the DOs and IRs of USAID/Guinea's draft results framework as the primary unit of analysis. This was done to ensure that the CDCS results framework design teams had the most relevant and up-to-date recommendations that could be easily integrated into their framework and programming.

TABLE B1. GUIDING RESEARCH THEMES FOR THE GENDER ANALYSIS

RESEARCH THEME	DATA REQUIRED	TOOLS AND SOURCE OF INFORMATION
Current gender gaps and gender advances between females and males in targeted groups, regarding USAID key priority intervention areas and J2SR domains	<ul style="list-style-type: none"> Current gender gaps in Health, Democracy and Governance, and Economic Growth (as aligned with CDCS Results frameworks) Barriers to equitable participation for women/girls and men/boys in USAID/Guinea programming activities Gender gaps, in relevant sectors, for both urban and rural populations Capacity gaps (including institutional) in terms of ability to address gender gaps across key sectors 	<ul style="list-style-type: none"> Literature review <ul style="list-style-type: none"> National statistics and databases (INE), research reports, global indexes, USAID's studies Research reports, USAID and others donor's studies, national reports to international mechanisms (CEDAW, International Labor Organization Conventions, SDG's, etc.) GOG studies National laws, regulations and policies, gender equality policies and instruments at national and local level Online surveys: USAID/Guinea staff Semi-structured interviews (by DO)

		<ul style="list-style-type: none"> ○ USAID/Guinea partners ○ Relevant stakeholders (CSOs, NGOs, research institutes, community-based project stakeholders, etc.) ○ GOG officials
<p>Opportunities for greater gender integration, including opportunities¹⁶ to reduce existing gender gaps (or leverage GEWE opportunities) in targeted sectors (Health, Democracy and Governance, and Economic Growth) and to ensure equitable participation in and benefit from USAID/Guinea's Activities</p>	<ul style="list-style-type: none"> • Programmatic and institutional opportunities to (1) reduce gender gaps in Health, Democracy and Governance, and Economic Growth sectors and (2) ensure equitable participation in and benefit from USAID/Guinea programming • Opportunities to promote women's leaderships and meaningful participation in decision-making structures at all levels • Identification of value-chains with potential to increase women's empowerment outcomes • Opportunities to leverage knowledge, expertise, and data of relevant key players working toward GEWE in key sectors 	<ul style="list-style-type: none"> • Literature review: National statistics and data bases (INE), research reports, global indexes, USAID's studies. USAID and others donor's studies, national reports to international mechanisms (CEDAW, ILO Conventions, SDG's, DSOs, etc.). National laws, regulations and policies, gender equality policies and instruments at national and local level. • Semi-structured interviews (by DO): USAID/Guinea partners, relevant stakeholders (CSOs, NGOs, research institutes, community-based project stakeholders. etc.), and GOG officials.
Gender-Based Violence (GBV)	<ul style="list-style-type: none"> • Current trends in GBV in Guinea (including harmful practices such as FGM/C and CEFM) • Opportunities to integrate GBV prevention and response into USAID/Guinea's programming portfolio • Capacity needs of IPs to address GBV in programming across sectors • Identification of minimum programmatic standards to ensure that all USAID/Guinea's activities align with principles of "Do No Harm" in relation to GBV 	<ul style="list-style-type: none"> • Literature review: National statistics and data bases (INE), research reports, global indexes, USAID's studies. USAID and others donor's studies, national reports to international mechanisms (CEDAW, ILO Conventions, SDG's, DSOs, etc.). National laws, regulations and policies, gender equality policies and instruments at national and local level. • Semi-structured interviews (by DO): USAID/Guinea partners, relevant stakeholders (CSOs, NGOs, research institutes, community-based project stakeholders. etc.), and GOG officials.

¹⁶ Opportunities focus both on programming and partnerships.

PRIMARY DATA COLLECTION

The research team collected in-country primary data between August 24 and September 28, 2020. Due to the COVID-19 pandemic, all primary data was collected remotely through virtual interviews, phone calls, and online surveys.

The research team conducted a total of eight online surveys for external stakeholders. For DOI, the team designed three surveys: one for current implementing partners, one for GOG health stakeholders, and one for all other stakeholders. For DO2, there were four surveys: (1) for IPs focused on democracy and governance; (2) for IPs working in agriculture (value chains) and economic growth; (3) for all other democracy and governance stakeholders (including GOG and media); and (4) for all other agriculture (value chains) and economic growth stakeholders. The last online survey was for gender-specific stakeholders, including CSOs and GOG officials working in GEWE and GBV prevention and response.

PRESENTATION OF PRELIMINARY FINDINGS AND RECOMMENDATIONS

Toward the end of the in-country data collection, the research team gave a remote presentation of the preliminary findings and recommendations of the gender analysis to USAID/Guinea staff. The purpose of the presentation was to validate and expand upon the preliminary findings and recommendations.

DATA ANALYSIS AND INTERPRETATION AND REPORT PREPARATION

The research was very successful in conducting remote, primary data collection with very high completion rates among external stakeholders. In total, the research team collected over 60 online survey responses. The research team analyzed and interpreted the primary data collected and delivered the draft gender analysis report to USAID/Guinea on November 2, 2020. The research team delivered the final gender analysis report to USAID/Guinea on November 23, 2020, incorporating the previous USAID/Guinea feedback (on the draft report).

PROTECTION OF INFORMANT INFORMATION

The research team obtained free and prior informed consent both at the organizational level and from all research participants, which included taking the following steps at the beginning of all semi-structured interviews and focus groups:

- An explanation of the purposes of the research, how long it will take, and the procedures to be followed
- A description of any risks to the person participating (if relevant)
- A description of any expected benefits to the person participating, or to their community, as a result of participating
- A statement describing whether the data will be anonymous or stored confidentially
- Contact details if they have questions or concerns regarding the research
- A statement that participation is voluntary, that refusal to participate will involve no penalty, and that the subject may stop participating at any time
- For interviews with individuals and/or groups at risk, the research team did not record personally identifying information of respondents, omitting the names, ages, organizations, and even times and dates of interviews.

LIMITATIONS OF THE GENDER ANALYSIS

Due to COVID-19, most of the data collection was carried out via online surveys. This presented several challenges related to data quality and survey response rates. When deemed necessary, the research team would follow up with phone interviews for additional information or data point clarification.

Almost no GOG staff were in their offices or responding to email regularly, because they have generally been mobilized for the 2020 presidential elections. This resulted in a lower number of GOG survey respondents than anticipated.

In addition, the team requested an official USAID letter to be sent to all IPs and GOG stakeholder offices so that research could follow appropriate and context-specific protocols. The electronic letter was sent out approximately 10 days late, however, and in one instance with incorrect survey links. The hard letter was sent out nearly three weeks late. These challenges caused delays in the gender analysis process.

Lastly, the online survey for USAID staff was not successful. Only one USAID staff member filled out the survey. This presents a major limitation in findings related to USAID institutional practices and procedures, which the research team attempted to rectify with telephone interviews and document review.

ANNEX C: REFERENCE LIST

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ANNEX D: INTERVIEW GUIDES FOR THE GENDER ANALYSIS

Please note the following are survey guides, in English, targeting the various stakeholders. Survey guides in French are not included in this document for the sake of brevity.

I. USAID/GUINEA institutional practices tools

TOOL I.A: USAID/GUINEA STAFF ONLINE SURVEY

We are conducting a gender analysis to inform the USAID/Guinea 2020-2025 Country Development Cooperation Strategy. This analysis focuses on identifying key gender-related trends that advance and/or exacerbate key outcomes for women, men, girls, and boys in Guinea. It also will help identify successful strategies, approaches, and lessons learned that can be used to strengthen USAID/Guinea activities. The Analysis is focusing on areas of health, democracy and governance, and economic growth, with a cross-sectoral look at Gender-Based violence (GBV) programming and value chains to empower women.

For this analysis, we are conducting online surveys and interviews with USAID staff, implementing partners, and key stakeholders. Findings from all interviews will contribute to a report that will be finalized in November and made publicly available on the USAID website.

Your participation in this interview is completely voluntary. You can choose not to respond to a particular question or stop completing the survey at any time. There are no right or wrong answers. Please feel free to give your honest opinion and experiences and as much information as you can in response to the questions.

Everything you share with us will remain anonymous but not confidential. This means that we may share quotes or stories, but your name will not be tied to them. No personal information will be disclosed in any setting. Your participation will take approximately 15-25 minutes.¹⁷

1. What office do you work in?
 - Health
 - Democracy and Governance
 - Economic Growth
 - Program Office
2. To what extent have gender analyses informed the current Project Appraisal Documents (PAD) or activity designs at your mission?
 - To a Great Extent
 - Somewhat
 - Very Little
 - Not at All

Comment:

¹⁷ If conducting interview please make sure to ask permission to record (where relevant): Because the research team is primarily working remotely, we would like to ask your permission to record this interview. Recordings will be used for data entry and coding and the recording will not be shared outside of the research team. We can also do the interview without recording if you prefer. Do you agree to be recorded?

3. In your opinion, what are the obstacles to incorporating a gender analysis into project appraisal documents (PADs) or activity designs? (check all that apply)
- ☐ Lack of financial resources
 - ☐ Lack of time
 - ☐ Lack of staff or in-country capacity for gender analysis
 - ☐ Limited availability of secondary data on gender
 - ☐ Seen as unimportant to objectives of the project
 - ☐ Other [please specify]

Comment:

4. How often do implementing partners carry out post-award gender analyses and develop gender strategies to inform the activities in your office's portfolio?
- ☐ Always
 - ☐ Very Frequently
 - ☐ Occasionally
 - ☐ Rarely
 - ☐ Very Rarely
 - ☐ Never

Comment:

5. What are the main constraints your office faces to ensure that implementing partners integrate gender equality in a concrete and effective way?
- ☐ Low capacity of IPs to integrate gender into implementation
 - ☐ Not seen as important for the objectives of the project
 - ☐ Lack of support from senior management
 - ☐ Lack of financial resources for gender integration
 - ☐ Low organizational priority for gender issues
 - ☐ Other [please specify]

Comment:

5b. Any suggestions on what USAID could do to support IPs to overcome these constraints?

6. Are gender questions or criteria included in USAID/Guinea's acquisition and assistance procedures (e.g., Annual Program Statements, RFAs, and RFPs)?
- ☐ Always
 - ☐ Very Frequently
 - ☐ Occasionally
 - ☐ Rarely
 - ☐ Very Rarely
 - ☐ Never
 - ☐ Other [please specify]

Comment:

7. Is attention to gender integration and/or gender equality in activity design and staffing a factor in USAID's selection of implementing partners?

- Always
- Very Frequently
- Occasionally
- Rarely
- Very Rarely
- Never
- Other [please specify]

Comment:

8. If you had to cite three main results that your office has produced or is producing (through the programs it manages, and during the current CDCS) for addressing gender equality and women's empowerment, what would they be?
9. What areas do you think USAID should prioritize in its CDCS in regard to your portfolio/sector related to gender equality and female empowerment?
10. Any other comments and/or recommendations for USAID/Guinea's CDCS gender analysis?

TOOL I.B: USAID/GUINEA – PROGRAM OFFICE / GENDER FOCAL POINT / INTERVIEW

1. Does the mission have a gender or inclusive development mission order? How often is its effectiveness reviewed?
2. Does the mission have a dedicated gender advisor, or a gender Point of Contact (POC)? How is this person most frequently used?
3. Does the mission have a gender or inclusive development working group? How does it function? What purpose does it serve? What are its greatest advances and challenges in this regard?
4. What type of support does the mission provide to its partners to integrate gender equality and women's empowerment or to facilitate cross-partner learning in this domain?
5. In your opinion, do USAID/Guinea's project appraisal documents and activity designs adequately address gender equality and women's empowerment? Why or why not? What are the challenges in this regard? Opportunities?
6. Is gender equality and women's empowerment integrated into the selection criteria for new awards? In your experience, do technical evaluation committee (TEC) members take the time to establish a shared understanding of expectations for gender integration in new applications?
7. What reporting or planning tools do CORs/AORs use to ensure that their partners adequately address gender equality and women's empowerment? Good practices or challenges to cite? (i.e. mandatory content for quarterly reports, Activity, Monitoring, Evaluation, and Learning Plans, work plans, gender action plans, etc.)
8. Once the new CDCS is complete, what steps will the mission undertake to ensure that gender equality and women's empowerment will be incorporated into the Performance Management Plan (PMP)?

9. What other institutional measures are needed (if any) to support mission staff or partners to integrate gender equality and women's empowerment?

10. Is there anything else you want to add or ask about that we didn't discuss in the interview?

II. Development Objective I Health tools

TOOL II.A. USAID/GUINEA DOI (HEALTH) GOVERNMENT OF GUINEA (GOG) INTERVIEW GUIDE

INTERVIEW DATE:

START & FINISH TIME:

NAME, CONTACT & TITLE OF INTERVIEWEE:

INSITUATION/ORGANIZATION:

REGION:

We are conducting a gender analysis to inform the USAID/Guinea 2020-2025 Country Development Cooperation Strategy. This analysis focuses on identifying key gender-related trends that advance and/or exacerbate key outcomes for women, men, girls, and boys in Guinea. It also will help identify successful strategies, approaches, and lessons learned that can be used to strengthen USAID/Guinea activities. The Analysis is focusing on areas of health, democracy and governance, economic growth, with a cross-sectoral look at Gender-Based violence (GBV) programming and value chains to empower women.

For this analysis, we are conducting online surveys and interviews with USAID staff, implementing partners, and key stakeholders. Findings from all interviews will contribute to a report that will be finalized in November and made publicly available on the USAID website.

Your participation in this interview is completely voluntary. You can choose not to respond to a particular question or stop completing the survey at any time. There are no right or wrong answers. Please feel free to give your honest opinion and experiences and as much information as you can in response to the questions.

Everything you share with us will remain anonymous but not confidential. This means that we may share quotes or stories, but your name will not be tied to them. No personal information will be disclosed in any setting. Your participation will take approximately one hour.¹⁸

¹⁸ If conducting interview please makes sure to ask permission to record (where relevant): Because the research team is primarily working remotely, we would like to ask your permission to record this interview. Recordings will be used for data entry and coding and the recording will not be shared outside of the research team. We can also do the interview without recording if you prefer. Do you agree to be recorded?

1. Please tell me briefly about your work and how it relates to gender equality and female empowerment.
 - a) Is this an important and relevant aspect of your work? Why or why not?
2. What resources, tools and/or guidance does your Ministry/Unit/Department have related to gender equality and women's empowerment?
 - a) Gender Focal Points (*If speaking to one of the GFPs ask them about their work in that capacity and what support they've received to fulfill that role including any training*)
 - b) Gender policy/guidance documents? Inclusion of gender-related objectives in Ministerial policies?
3. In your view, what are the main challenges in your work/sector/Ministry/Office in terms of working on gender equality and female empowerment?
4. What supports or hinders gender equality in health systems management and performance in Guinea?
5. What are the key gender-related issues in Guinea that impede the health system from providing quality health services (including Maternal Child Health, Reproductive Health, and Malaria)?
6. How is gender equality and women's empowerment promoted in health governance at the national and local levels?
7. What is the local capacity of health system *and* health service providers to respond to Gender-Based Violence?
8. How do health data collection and management systems support the collection of sex-disaggregated data?
9. How do you and other health sector actors use the data to inform their decision-making?
10. What key performance indicators should be included to measure gender equality in health system management?
11. What opportunities and challenges exist in increasing the number of female health providers?
12. How does your ministry, unit, or department make decisions about what health issues to prioritize for funding in your region?

[Probe to see if/how the different needs of women/girls, men/boys are taken into account.]
13. Please describe how your ministry, unit, or department collects and uses health data. How do you get information about specific groups that access the health system?

[Probe for different ways they disaggregate and use the data.]
14. Is there anything else you want to add or ask about that we didn't discuss in the interview?

TOOL II.B. USAID/GUINEA DOI (HEALTH) ONLINE SURVEY / INTERVIEW GUIDE (IMPLEMENTING PARTNERS, CSOS, NGOS, RESEARCH INSTITUTES, ETC.)

INTERVIEW DATE:

START & FINISH TIME:

NAME, CONTACT & TITLE OF INTERVIEWEE:

INSITUATION/ORGANIZATION:

REGION:

We are conducting a gender analysis to inform the USAID/Guinea 2020-2025 Country Development Cooperation Strategy. This analysis focuses on identifying key gender-related trends that advance and/or exacerbate key outcomes for women, men, girls, and boys in Guinea. It also will help identify successful strategies, approaches, and lessons learned that can be used to strengthen USAID/Guinea activities. The Analysis is focusing on areas of health, democracy and governance, economic growth, with a cross-sectoral look and Gender-Based violence (GBV) programming and value chains to empower women.

For this analysis, we are conducting online surveys and interviews with USAID staff, implementing partners, and key stakeholders. Findings from all interviews will contribute to a report that will be finalized in November and made publicly available on the USAID website.

Your participation in this interview is completely voluntary. You can choose not to respond to a particular question or stop completing the survey at any time. There are no right or wrong answers. Please feel free to give your honest opinion and experiences and as much information as you can in response to the questions.

Everything you share with us will remain anonymous but not confidential. This means that we may share quotes or stories, but your name will not be tied to them. No personal information will be disclosed in any setting. Your participation will take approximately 30-60 minutes.¹⁹

1. Please describe in general terms what is the focus and the scope of your organization/project. What is your role?
2. What supports or hinders gender equality in health systems management and performance in Guinea?
3. What are the key gender-related issues in Guinea that impede the health system from providing quality health services (including Maternal Child Health, Reproductive Health, and Malaria)?

¹⁹ If conducting interview please makes sure to ask permission to record (where relevant): Because the research team is primarily working remotely, we would like to ask your permission to record this interview. Recordings will be used for data entry and coding and the recording will not be shared outside of the research team. We can also do the interview without recording if you prefer. Do you agree to be recorded?

4. What are the barriers for men and women to accessing these services? Is this different for rural and urban populations?
5. What are some existing social norms that prevent or restrict health-enhancing behaviors for men and women? Are these different for rural and urban populations?
6. Which health providers' attitudes and behaviors positively or negatively affect the provision of maternal child health and reproductive health services?
7. How is gender equality and women's empowerment promoted in health governance at the national and local levels?
8. What decision-making and leadership opportunities do women have in the health sector at the national and decentralized levels? What about at the community level?
9. How do you and other health sector actors use the health data and management systems to support decision-making in support of the health of women and girls, and men and boys?
10. What is the local capacity of health system *and* health service providers to respond to Gender-Based Violence?
11. What indicators should be included in key performance indicators to measure gender equality in health system management?
12. Is there anything else you want to add or ask about that we didn't discuss in the interview?

Please only respond if you are a current implementing partner to a USAID-funded project:

13. If you could re-design the project or design a new project today, what recommendations do you have for increasing gender impact (reducing gender gaps and promoting female empowerment)?
14. At the strategic level, what do you think USAID should prioritize in the health sector in terms of gender equality and women's empowerment?

III. Development Objective 2 Democracy, Rights and Governance (DRG) tools

TOOL III. USAID/GUINEA DO2 KEY STAKEHOLDER SURVEY / INTERVIEW GUIDE (CSO, NGOS, IMPLEMENTING PARTNERS, RELEVANT GOG OFFICIALS)

INTERVIEW DATE:

START & FINISH TIME:

NAME, CONTACT & TITLE OF INTERVIEWEE:

INSITUATION/ORGANIZATION:

REGION:

We are conducting a gender analysis to inform the USAID/Guinea 2020-2025 Country Development Cooperation Strategy. This analysis focuses on identifying key gender-related trends that advance and/or exacerbate key outcomes for women, men, girls, and boys in Guinea. It also will help identify successful strategies, approaches, and lessons learned that can be used to strengthen USAID/Guinea activities. The Analysis is focusing on areas of health, democracy and governance, economic growth, with a cross-sectoral look at Gender-Based violence (GBV) programming and value chains to empower women.

For this analysis, we are conducting online surveys and interviews with USAID staff, implementing partners, and key stakeholders. Findings from all interviews will contribute to a report that will be finalized in November and made publicly available on the USAID website.

Your participation in this interview is completely voluntary. You can choose not to respond to a particular question or stop completing the survey at any time. There are no right or wrong answers. Please feel free to give your honest opinion and experiences and as much information as you can in response to the questions.

Everything you share with us will remain anonymous but not confidential. This means that we may share quotes or stories, but your name will not be tied to them. No personal information will be disclosed in any setting. Your participation will take approximately 30-60 minutes.²⁰

1. Please describe in general terms what is the focus and the scope of your organization/institution or project. What is your role?
2. What is the status of women's participation in politics, civil society, including community-based organizations, trade unions, farmers associations/producer organizations, and trade/business and professional associations?

²⁰ If conducting interview please makes sure to ask permission to record (where relevant): Because the research team is primarily working remotely, we would like to ask your permission to record this interview. Recordings will be used for data entry and coding and the recording will not be shared outside of the research team. We can also do the interview without recording if you prefer. Do you agree to be recorded?

3. What types of organizations tend to have the highest levels of female leadership?
4. What are the most common barriers and constraints to women's participation in politics, civil society and civil society organizations?
5. What formal or informal barriers exist that prevent women from participating in decision-making at the local level?
6. Within traditional justice or governance systems, are women represented in leadership positions?
7. What role does the media play in furthering reporting on issues with a focus on gender equality?
8. What mechanisms and legislation, if any, are in place for citizen consultation and input in local planning and budgeting processes, and around the provision and delivery of public services? Are these accessible to all members of the community? Why or why not?
9. What mandates or responsibilities exist at the local level for gender-responsive budgeting (GRB)? How do local governments engage in gender-responsive or participatory budgeting?
10. How are women and female youth represented as leaders and/or participants in peacebuilding and conflict-resolution mechanisms and initiatives?
 - a. What are some opportunities to increase women's participation in existing peacebuilding and conflict resolution processes?
11. What are the biggest policy and institutional level barriers in terms of responding to and preventing GBV?
 - a. What is the capacity of the relevant local authorities (traditional health providers, health, police, etc.) to respond to disclosure of GBV?
 - b. Do GBV survivors often seek justice through formal channels? Why or why not?
 - c. Are perpetrators of GBV often convicted or punished? Why or why not?
12. What key performance indicators should be included to measure gender equality in democracy and governance processes?
13. Is there anything else you want to add or ask about that we didn't discuss in the interview?

Please only respond to the remainder questions if you are a current implementing partner for a USAID-funded project:

14. If you could re-design the project or design a new project today, what recommendations do you have for increasing gender impact (reducing gender gaps and promoting female empowerment)?
15. At the strategic level, what do you think USAID should prioritize in the Democracy, Rights, and Governance sector in terms of gender equality and women's empowerment?

IV. Development Objective 2 (IR2.3) Private sector and economic growth tools

TOOL IV: PRIVATE SECTOR AND ECONOMIC GROWTH – KEY STAKEHOLDER SURVEY / INTERVIEW GUIDE (CSO, CBOs, NGOs, IMPLEMENTING PARTNERS, RELEVANT GOG OFFICIALS, ETC.)

INTERVIEW DATE:

START & FINISH TIME:

NAME, CONTACT & TITLE OF INTERVIEWEE:

INSITUATION/ORGANIZATION:

REGION:

We are conducting a gender analysis to inform the USAID/Guinea 2020-2025 Country Development Cooperation Strategy. This analysis focuses on identifying key gender-related trends that advance and/or exacerbate key outcomes for women, men, girls, and boys in Guinea. It also will help identify successful strategies, approaches, and lessons learned that can be used to strengthen USAID/Guinea activities. The Analysis is focusing on areas of health, democracy and governance, economic growth, with a cross-sectoral look at Gender-Based violence (GBV) programming and value chains to empower women.

For this analysis, we are conducting online surveys and interviews with USAID staff, implementing partners, and key stakeholders. Findings from all interviews will contribute to a report that will be finalized in November and made publicly available on the USAID website.

Your participation in this interview is completely voluntary. You can choose not to respond to a particular question or stop completing the survey at any time. There are no right or wrong answers. Please feel free to give your honest opinion and experiences and as much information as you can in response to the questions.

Everything you share with us will remain anonymous but not confidential. This means that we may share quotes or stories, but your name will not be tied to them. No personal information will be disclosed in any setting. Your participation will take approximately 30-60 minutes.

1. Please describe in general terms what is the focus and the scope of your organization/institution or project. What is your role?
2. What are the most common women-led enterprises in Guinea?
3. What are some of the challenges that women face in running their own enterprise? (*Probe: What hurdles do women have to overcome in order to become entrepreneurs? Socio-cultural barriers? Etc.*)
4. How do community members view women who run/own their own enterprises?
5. What barriers exist to women's access to private sector work? Do these barriers differ for rural versus urban women? How?

6. What are the differences, if any, in the ways that women and men access inputs (including credit) necessary for enterprise growth and entrepreneurship?
7. In which value chains are women particularly active in Guinea?
 - a. At what step of the chain are women particularly active?
 - b. Do they typically have control over revenue from the value chain? Why or why not?
 - c. *If not mentioned ask specifically about women's role in the cashew value chain.*
8. What value chains do you believe are strategically placed to empower women?
 - a. What are potential measures for improving women's access to employment opportunities in those value chains?
9. To what extent are women engaged in mining activities in Guinea?
 - a. Are women interested in working in the mining sector, generally?
 - b. Are there gender-related risks to women employed in the mining sector? What are they?
10. Do initiatives exist to increase women's leadership and participation in networks, cooperatives, or business associations? How have or can these initiatives affect women's engagement in private sector growth?
11. Are there active women's business associations in Guinea? If so, what key issues have they prioritized over the past five years?
12. What role do women and men play in energy sector governance at the national and sub-national levels? What are opportunities to strengthen their roles in this area?
13. What key performance indicators should be included to measure gender equality in economic growth?
14. Is there anything else you want to add or ask about that we didn't discuss in the interview?

Please only respond to the remainder questions if you are a current implementing partner to a USAID-funded project:

15. If you could re-design the project or design a new project today, what recommendations do you have for increasing gender impact (reducing gender gaps and promoting female empowerment)?
16. At the strategic level, what do you think USAID should prioritize in the Democracy, Rights, and Governance sector in terms of gender equality and women's empowerment?

V. GOG gender-related ministry stakeholders tools

TOOL V. INTERVIEW GUIDE FOR GOG'S OPROGEM, MASPV, OR MDAF

INTERVIEW DATE:

START & FINISH TIME:

NAME, CONTACT & TITLE OF INTERVIEWEE:

MINISTRY:

REGION:

We are conducting a gender analysis to inform the USAID/Guinea 2020-2025 Country Development Cooperation Strategy. This analysis focuses on identifying key gender-related trends that advance and/or exacerbate key outcomes for women, men, girls, and boys in Guinea. It also will help identify successful strategies, approaches, and lessons learned that can be used to strengthen USAID/Guinea activities. The Analysis is focusing on areas of health, democracy and governance, economic growth, with a cross-sectoral look at Gender-Based violence (GBV) programming and value chains to empower women.

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Your participation in this interview is completely voluntary. You can choose not to respond to a particular question or stop completing the survey at any time. There are no right or wrong answers. Please feel free to give your honest opinion and experiences and as much information as you can in response to the questions.

Everything you share with us will remain anonymous but not confidential. This means that we may share quotes or stories, but your name will not be tied to them. No personal information will be disclosed in any setting. Your participation will take approximately 30-60 minutes.

1. Please describe the mandate of your Ministry/unit/office. *If speaking with MASPV or MDAF ask about the new division of labor and transition period since their creation.*
2. How do you collaborate with other line ministries?
 - a. Do you have the opportunity to influence other sectoral ministry policies/plans and programs to improve gender integration?
 - b. What are the challenges in doing so?
2. What is your Ministry/Unit/Office's priorities in the following sectors:
 - a. Health?
 - b. Democracy and governance?
 - c. Economic growth and private sector engagement?
3. What specific work are you doing in Gender-Based Violence prevention and response programming.?

4. What are the biggest policy and institutional level barriers at the Government level in terms of responding to and preventing Gender-Based Violence?
5. What is the minimum package you think development actors/donors should adopt in terms of implementing in context where Gender-Based Violence is so high?
 - a. What are steps they should take to ensure an approach that ensure “do no harm”?
6. What is the status of women’s participation in civil society, including community-based organizations, trade unions, farmers associations/producer organizations, and trade/business and professional associations?
7. What types of organizations tend to have the highest levels of female leadership?
8. How does your Ministry/Unit/Office engage with civil society?
 - a. Are their particularly active groups that you suggest we speak with?
9. What formal or informal barriers exist that prevent women from participating in decision-making?
 - a. What type of work does your Ministry/Unit/Office do to help women participate effectively in decision-making structures?
10. How are women represented as leaders and/or participants in peacebuilding and conflict-resolution mechanisms and initiatives?
 - a. What type of work does your Ministry/Unit/Office do to help women participate effectively in peacebuilding and conflict-resolution mechanisms and initiatives?
11. What are some of the challenges that women face in running their own businesses? (*Probe: What hurdles do women have to overcome in order to become entrepreneurs? Socio-cultural barriers? Etc.*)
12. Which enterprises are well placed to empower women? Why?
13. Is there anything else you want to add or ask about that we didn’t discuss in the interview?

ANNEX E: LIST OF KEY INTERVIEWEES

ORGANIZATION	KEY STAKEHOLDER	POSITION
Agricultural Cooperative and Animal Production (CAPA)	Abdourahamane Diallo	President
Catholic Relief Services	Jonas Mamady Kamano	Project Manager
Chemonics	Dr Youssoufa Lo	Technical Advisor
Chemonics	Cheikh Sidiya Gassama	Country Director
Coalition of Women and Girls in Guinea	Mackalé Traoré	President
Coalition of Women Leaders of Guinea (COFFEL)	Fatou Baldé	President
Confederation of Farmers Organizations of Guinea	Andega Gilbert	Head of programs
Cultivating New Frontiers in Agriculture (CNFA)	Abou Gagara	Title not provided
Federation of planters of the fruit value chain in Lower Guinea	Moussa Camara	President
Femmes de l'UFDG	Hadja Maïmouna Diallo	Vice president
FHI 360	Susan Jay	Project Manager
Food and Agriculture Organization (FAO)	Dr. Racine N'Diaye	Country team leader
GiZ	Marie Chesany	Development Advisor
Guinean Association for Combat Violence against Women	Kébé Guilavogui	President
Guinean Association of Women for Equity and Governance (AGUIFPEG)	Mariama Ciré Keita	President
Guinean National Coalition for Women's Rights and Citizenship	Binta Nabé	President
Guinee360 (media outlet)	Abdourahamane Diallo	Journalist
International Federation of the Red Cross (IFRC)	Dr. Yuma Taido	Originator
International Organization on Migration (IOM)	M. Berete	Titled not provided
Johns Hopkins (Breakthrough Action)	Issiaga A Daffe	Chief of Party
Kaloum Commune	Camara Aminata Touré	Mayor
Ministry of Agriculture	Nathalie Konana	Gender Focal Point
Ministry of Decentralization	Aminata Sylla	Gender Focal Point

Ministry of Energy and Mines	Nounkoumba Cisse	Gender Focal Point
Ministry of Fisheries	Sidki Keita	Head of the Aquaculture Agency
Ministry of Health	Manty Bamba	Gender Focal Point
Ministry of Health: Family Health and Nutrition	Madina Rachid	Deputy Director
Ministry of Social Affairs and Gender Promotion (MASPFE)	Akoye Hector Guilavogui	Title not provided
National Democratic Institute	Paul Amegakpo	Resident Director
National Directorate of Gender and Equity (MDAF)	Ramatoulaye Condé	National Director
(Organization not provided)	Gbolou Toupou	Agricultural. Extension Agent
Private Entreprise « Fatou et Kadidja EFK »	Fatoumata Cissoko	Entrepreneur
Private Enterprise - « YARABI SARL »	Fatoumata Nabe	Entrepreneur
Radio Télévision Guinéenne (RTG) (media outlet)	Marie Sidibe	Journalist
RTI International, Stop Palu+	Dr Aissata Fofana	Chief of Party
Search for Common Ground	Aminata Tounkara	Project Manager
Strategy and Development Offices (BSD): Agriculture	Jean Luc Faber	Director (interim)
Strategy and Development Offices (BSD): Decentralization	El Hadj Badra Conde	Director
Strategy and Development Offices (BSD): Health	Abdoulaye Kaba	Director
Strategy and Development Offices (BSD): Mines	Aboubacar Kourouma	Director
Strategy and Development Offices (BSD): Ministry of Energy	Dr Mohamed Dounu	Director
Strategy and Development Offices (BSD): Ministry of Environment	Mamadou Bailo Sidibe	Director
Strategy and Development Offices (BSD): Social Action	El Bafode Keita	Director
Technical Secretary for Gender in Higher Education	Aissatou M'bara Diallo	Director
TOSTAN International	Mouctar Oulare	National Coordinator of Guinea
UNDP	Safiatou Kaba	Gender Focal Point
UNICEF	Dr. Pierre Ngom	Resident Representative

United Action for Integrated Development in Guinea (AUDIG)	Mamadou Toure	President
University of Sonofiaa	Kadiatou Lamarana Bah	Professor
USAID	Binta Ann	Gender and Youth Advisor
USAID	Gregory Vaughan	Economic Growth and Agriculture Officer
USAID	Maladho Balde	Democracy and Governance Specialist
USAID	Mamadou Bah	Monitoring and Evaluation Specialist
USAID	Mark Koenig	Democracy and Governance Officer
USAID	Pierre Balamou	Public Health Specialist
WAFRICA	Fatou Hann	President
Winrock International: Farmer-to-Farmer	Ibrahima Diallo	Country Director
Women-Girls without Borders	Cecile Sossouadouno	President
World Bank	(Name not provided)	Health Specialist

ENDNOTES

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- ¹ Institut National de la Statistique and ICF. 2019. *Enquête Démographique et de Santé (EDS) en Guinée 2018*. Conakry, Guinée, and Rockville, Maryland, United States of America.
- ² Central Intelligence Agency. 2019. “The World FactBook – Africa: Guinea.”
- ³ The administrative regions include: Nzérékoré, Kankan, Kindia, Boké, Labé, Faranah, and Mamou.
- ⁴ Central Intelligence Agency. 2019. “The World FactBook – Africa: Guinea.”
- ⁵ Ibid.
- ⁶ Institut National de la Statistique and ICF. 2019. *Enquête Démographique et de Santé (EDS) en Guinée 2018*. Conakry, Guinée, and Rockville, Maryland, United States of America.
- ⁷ Ibid.
- ⁸ TFR decreases from 34 percent in 2012. There are also regional differences in fertility rates, ranging from 3.6 (Conakry) to nearly 7.0 (Kankan). Ibid.
- ⁹ UNDP. 2019. *Human Development Report 2019*. New York: UNDP.
- ¹⁰ Unfortunately, the Gender Inequality Index was not calculated because of missing data for key indicators. Ibid.
- ¹¹ Ibid.
- ¹² Institut National de la Statistique. 2012. “Base de Données.” République de Guinée.
- ¹³ UNDP. 2019. *Human Development Report 2019*. New York: UNDP.
- ¹⁴ World Bank. 2019. *The World Bank in Guinea*. Washington, DC: World Bank Group. Accessed July 31, 2020.
- ¹⁵ These gaps become work in rural areas where 73 percent of rural women have received no education versus 38 percent of women in urban areas (57 percent versus 23 percent for men in rural/urban). Institut National de la Statistique and ICF. 2019. *Enquête Démographique et de Santé (EDS) en Guinée 2018*. Conakry, Guinée, and Rockville, Maryland, United States of America.
- ¹⁶ Ibid.
- ¹⁷ Wodon, Quentin, Doerte Doemeland, Sebastian M. Essl, Yele Maweki Batana, Luc Razafimandimby, Aly Sanoh, Olivier Bégué, et al. 2018. *Disrupting the Gender Divide in Mali, Chad, Niger, and Guinea. Special Topic in the 2018 AFCW3 Economic Update*. Washington, DC: World Bank Group. Accessed July 24, 2020.
- ¹⁸ World Economic Forum. 2020. *Global Gender Gap Report*.
- ¹⁹ 68 and 13 percent respectively, For all sub-indexes, the highest possible score is 1 (gender parity) and the lowest possible score is 0 (imparity). Ibid.
- ²⁰ Wodon, Quentin, Doerte Doemeland, Sebastian M. Essl, Yele Maweki Batana, Luc Razafimandimby, Aly Sanoh, Olivier Bégué, et al. 2018. *Disrupting the Gender Divide in Mali, Chad, Niger, and Guinea. Special Topic in the 2018 AFCW3 Economic Update*. Washington, DC: World Bank Group. Accessed July 24, 2020.
- ²¹ UNFPA. 2017. *Enquête Nationale sur les Violences Basées sur le Genre en Guinée*.
- ²² 28toomany. 2018. *Guinea: The Law and FMG*. 28toomany.
- ²³ Institut National de la Statistique. 2017. *Enquête par Grappes à Indicateurs Multiples (MICS, 2016), Rapport Final*. Conakry, Guinée.
- ²⁴ Wodon, Quentin, Doerte Doemeland, Sebastian M. Essl, Yele Maweki Batana, Luc Razafimandimby, Aly Sanoh, Olivier Bégué, et al. 2018. *Disrupting the Gender Divide in Mali, Chad, Niger, and Guinea. Special Topic in the 2018 AFCW3 Economic Update*. Washington, DC: World Bank Group. Accessed July 24, 2020.
- ²⁵ Including 1) the African Charter on Human and Peoples’ Rights on the Rights of Women in Africa; 2) the Draft Supplementary Act on Equality of Rights between Women and Men for Sustainable Development within the Economic Community of West African States (ECOWAS) Region; 3) the Draft ECOWAS Action Plan on Gender and Trade, and the Draft ECOWAS Gender and Migration Framework and Action Plan; and 4) the Common Gender Policy of the West African Economic and Monetary Union adopted in March 2016.
- ²⁶ République de Guinée. 2017. *Politique Nationale Genre Révisée*.
- ²⁷ OECD. 2019. *Social Institutions and Gender Index (SIGI) 2019 Global Report: Transforming Challenges into Opportunities*. Social Institutions and Gender Index. OECD Publishing, Paris.
- ²⁸ Ibid.
- ²⁹ République de Guinée. 2020. *Journal Officiel de la République Constitution*. 4eme République. Numéro Spécial du Secrétariat Général du Gouvernement 14 Avril 2020.

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- ³⁰ OECD. 2019. *Social Institutions and Gender Index (SIGI) 2019 Global Report: Transforming Challenges into Opportunities*. Social Institutions and Gender Index. OECD Publishing, Paris.
- ³¹ Ibid.
- ³² Ibid.
- ³³ Ibid.
- ³⁴ The custom of marriage by a man with his brother's widow, such marriage required in Biblical law if the deceased was childless.
- ³⁵ Subsequent or concurrent marriage with a wife's sister.
- ³⁶ Derives from civil law. The right of enjoying all the advantages derivable from the use of something that belongs to another, as far as it is compatible with the substance of the thing not being destroyed or injured.
- ³⁷ OECD. 2019. *Social Institutions and Gender Index (SIGI) 2019 Global Report: Transforming Challenges into Opportunities*. Social Institutions and Gender Index. OECD Publishing, Paris.
- ³⁸ Ibid.
- ³⁹ République de Guinée. 2017. *Politique Nationale Genre Révisée*.
- ⁴⁰ République de Guinée. 2019. *Rapport National sur l'Évaluation de la Mise en œuvre du Programme d'Action de Beijing+25*.
- ⁴¹ Key Stakeholder Interview/Survey, August 2020.
- ⁴² Ministère de l'Action Sociale, de la Promotion Féminine et de l'Enfance. 2015. *Situation Globale des Inégalités du Genre et de la Vulnérabilité en Guinée pour le Plan de Relance de Développement post Ébola*.
- ⁴³ Ammann, Carole. 2016. "'Women Must Not Become Lions': Social Roles of Muslim Women in Kankan, Guinea." *JENdA: A Journal of Culture and African Women Studies*.
- ⁴⁴ Ibid.
- ⁴⁵ Ibid.
- ⁴⁶ Institut National de la Statistique and ICF. 2019. *Enquête Démographique et de Santé (EDS) en Guinée 2018*. Conakry, Guinée, and Rockville, Maryland, United States of America.
- ⁴⁷ Odeku, Kola, Symphorosa Rembe, and Joel Anwo. 2009. "Female Genital Mutilation: A Human Rights perspective." *Journal of Psychology in Africa* 19(1): 55-61.
- ⁴⁸ Fourcroy, Jean L. 2006. "Customs, Culture, and Tradition—What Role do they Play in a Woman's Sexuality?" *The Journal of Sexual Medicine* 3(6): 954-959.
- ⁴⁹ Khosla, Rajat, Joya Banerjee, Doris Chou, Lale Say, and Susana T. Fried. 2017. "Gender Equality and Human Rights Approaches to Female Genital Mutilation: A Review of International Human Rights Norms and Standards." *Reprod Health* 14(59).
- ⁵⁰ Institut National de la Statistique and ICF. 2019. *Enquête Démographique et de Santé (EDS) en Guinée 2018*. Conakry, Guinée, and Rockville, Maryland, United States of America.
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²⁸¹ Key Stakeholder Interview/Survey, August 2020.

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²⁸³ One study found that 80 percent of profit from washing gold from lateritic soil carried out by women in Guinea goes to male intermediary buyers. Eftimie, A., K. Heller, J. Strongman, J. Hinton, K. Lahiri-Dutt, and N. Mutemeri, 2012. *Gender Dimensions of Artisanal and Small-scale Mining: A Rapid Assessment Toolkit*. Washington, DC: World Bank Group.

²⁸⁴ Key Stakeholder Interview/Survey, August 2020.

²⁸⁵ This is an informal contractual relationship between a man and women, for a specified duration (usually the entire mining season) with certain rights and responsibilities mirroring those of traditional marriage.

²⁸⁶ Key Stakeholder Interview/Survey, August 2020.