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THE PRIVATE HEALTH SECTOR IN WEST AFRICA: SIX MACRO-LEVEL ASSESSMENTS

November 2014

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SHOPS
Strengthening Health Outcomes *through* the Private Sector

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ACRONYMS

ABBEF	*Association Burkinabèe pour le Bien-Etre Familial*
ACMS	*Association Camerounaise pour le Marketing Social*
AFD	*Agence Française de Développement*
AGIR-PF	*Agir pour la Planification Familiale*
AIBEF	*Association Ivoirienne pour le Bien Etre Familial*
AIDS	Acquired Immune Deficiency Syndrome
AIDSETI	AIDS Empowerment and Treatment International
AIMAS	*Agence Ivoirienne de Marketing Social*
ANBEF	*Association Nigérienne pour le Bien Etre Familial*
ANIMAS SUTURA	*Association Nigérienne de Marketing Social*
AMPF	*Association Mauritanienne pour la Promotion de la Famille*
APROCLIB	Association of Private Clinics of Burkina Faso
ART	Antiretrovial Therapy
ARV	Antiretrovirals
ASMAGO	*Association Mauritanienne des Gynécologues et Obstétriciens*
AWARE	Action for West Africa Region (USAID-funded project)
BMCI	*Banque Mauritanienne pour le Commerce International*
BURCASO	*Conseil Burkinabè des ONGs, OBCs et Associations de Lutte contre les IST / VIH / Sida*
CAMEC	*Central d'Approvisionnement en Médicaments*
CAMEG	*Centrale d'Achat des Médicaments Essentiels et Génériques*
CAMNAFAW	Cameroon National Association for Family Welfare
CBF	Cameroon Business Forum
CD4	Cluster of Differentiation 4
CECI	*Coalition des Entreprises de Côte d'Ivoire*
CEDAV	*Centre de Dépistage Anonyme et Volontaire du VIH*
CENAME	*Centrale Nationale d'Approvisionement en Médicaments Essentiels*
CFA (or FCFA)	*Franc des colonies Françaises d'Afrique*
CHAI	Clinton Health Access Initiative
CIRBA	*Centre Intégré de Recherche Biologique*

CNAM	*Caisse Nationale d'Assurance Maladie*
CNLS	*Conseil National de Lutte contre le SIDA*
CNSPE	Coalition Nationale du Secteur Privé et des Entreprises contre le VIH-Sida et les IST, Burkina Faso
CNSS	*Caisse Nationale de Sécurité Sociale*
CRS	Catholic Relief Services
CS	Contraceptive Security
CSR	Corporate Social Responsibility
DANIDA	Danish International Development Agency
DFID	Department for International Development
DHS	Demographic and Health Surveys
DIPE	Directorate of Information, Planning and Evaluation
DPM	Directorate of Pharmacy and Medicines, Côte d'Ivoire
DSF	*Direction de la Santé Familiale* (Department of Family Health)
ECOWAS	Economic Community of West African States
FBO	Faith-Based Organizations
FHI360	Family Health International 360
FP	Family Planning
GDP	Gross Domestic Product
GICAM	*Groupement Interprofessionnel du Cameroun*
GIP-ESTHER	*Groupe d'Intérêt Public Ensemble pour une Solidarité Thérapeutique Hospitalière en Réseau*
GIZ	*Gesellschaft für Internationale Zusammenarbeit*
HANSHEP	Harnessing Non-state Actors for Better Health for the Poor
HCT	HIV Counseling and Testing
HDR	Human Development Report
HIV	Human Immunodeficiency Virus
IPC	*Initiative Privée et Communautaire de Lutte contre le VIH/SIDA*
IPPF	International Planned Parenthood Federation
IST	*Infections Sexuellement Transmissibles*
IUDs	Intrauterine Device
KfW	*Kreditanstalt für Wiederaufbau*
MARP	Most-At-Risk Population
MDG	Millenium Development Goals
MICS	Multiple Indicator Cluster Survey

MOH	Ministry Of Health
MSI	Marie Stopes International
MSM	Men who have Sex with Men
NGO	Nongovernmental Organization
NHA	National Health Accounts
OCEAC	*Organisation de Coordination pour la lutte contre les Endémies en Afrique Centrale*
PACTE-VIH	*Prévention et Prise en Charge du VIH/Sida en Afrique de l'Ouest*
PAMAC	*Programme d'Appui au Monde Associatif et Communautaire*
PEPFAR	United States President's Emergency Plan for AIDS Relief
PLHIV	People Living with HIV
PLWHA	People Living With HIV/AIDS
PMTCT	Prevention of Mother-To-Child Transmission of HIV
PNDS	*Plan National de Développement Sanitaire*
PNPEC	*Programme National de Prise en Charge Médicale des Personnes Vivant avec le VIH*
PNS	*Politique Nationale de Santé*
PPD	Public-Private Dialogue
PPPs	Public-Private Partnerships
PROMACO	*Programme de Marketing Social et de Communication pour la Santé*
PS	Private Sector
PSI	Population Services International
RHCS	Reproductive Health Commodity Security
RSB	*Renaissance Santé Bouaké*
RSE	*Responsabilité Sociale d'Entreprise*
SHOPS	Strengthening Health Outcomes through the Private Sector
SIDA	Syndrome d'Immunodéficience Acquise (AIDS)
SNIM	*Société Nationale Industrielle et Minière de Mauritanie*
STI	Sexually Transmitted Infection
SW	Sex Workers
SWAAS	Association des Femmes Africaines Face au SIDA
THE	Total Health Expenditure
TMA	Total Market Approach
UNAIDS	Joint United Nations Program on HIV/AIDS
UNDP	United Nations Development Program

UNFPA	United Nations Fund for Population Activities
UNICEF	United Nations Children's Fund
URCB	*Union des Religieux et Coutumiers du Burkina pour la Promotion de la Santé et du Développement*
USAID	United States Agency for International Development
USAID WA/RHO	USAID's West Africa Regional Health Office
VIH	*See HIV*
WAHO	West African Health Organization
WBG	World Bank Group
WHO	World Health Organization

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EXECUTIVE SUMMARY

Recognizing that the private health sector represents a key opportunity through which African countries can work to strengthen health indicators, the United States Agency for International Development West Africa Regional Health Office (USAID WA/RHO), asked the Strengthening Health Outcomes through the Private Sector (SHOPS) project to carry out macro-level assessments of the private health sector in six focus countries. The focus countries included four ECOWAS members — Burkina Faso, Côte d'Ivoire, Niger, and Togo — in addition to Cameroon and Mauritania. To complement and strengthen WA/RHO's 2012–2017 Family Planning Strategy and its 2012–2016 HIV/AIDS strategic plan, the objectives of the six-country assessment were set in the context of product and service delivery for FP as well as HIV and AIDS. Objectives included: 1) assessing the role of the private sector in the context of FP and HIV/AIDS; 2) determining the legal and regulatory framework governing the private sector with regard to FP and HIV/AIDS; 3) identifying key public-private partnerships and corporate social responsibility opportunities to expand FP and HIV/AIDS services; and 4) identifying local and international NGOs and commercial sector companies engaging in FP and HIV/AIDS activities. Outcomes of the macro assessments can be used by USAID West Africa as well as their FP and HIV/AIDS implementing partners to shape future activities.

To achieve these objectives, the assessment team began by compiling a review of both published and gray literature as well as available data from the most recent Demographic and Health Surveys (DHS), national health accounts, and international donor reports. Assessment teams interviewed over 150 key stakeholders between December 2013 and March 2014 to validate findings from the initial literature review, fill information gaps, and determine partnership opportunities. The assessment team then analyzed quantitative data and qualitative interview responses to synthesize key findings and draft recommendations. At a March 2014 meeting in Accra, Ghana, USAID implementing partners validated these findings and recommendations and offered suggestions for revising the final report which was completed in September 2014.

The results of the assessments provide real opportunities for private sector strengthening, especially in the areas of FP and HIV/AIDS. The key findings are listed in Table ES1.

TABLE ES-1: KEY FINDINGS FROM THE ASSESSMENT

Regional Themes	Finding
Health expenditures	**Out-of-pocket spending represents over 75 percent of private expenditures** in all six countries.
Scope of the private sector	**None of the focus country governments has an accurate picture of the scope of the private sector. Based on existing data, the private health sector appears much larger than anticipated**. In Cameroon and Côte d'Ivoire, for example, private facilities represent 44 and 52 percent of all health facilities, respectively.
	Within the private nonprofit sector in all six countries, IPPF and PSI affiliates are key stakeholders and are contracted by governments to provide FP and HIV services.

Regional Themes	Finding
	The informal sector is thriving in each of the six countries, but limited data are available beyond anecdotes. Lax regulations and difficult business procedures make it easy for unlicensed health businesses to flourish.
Enabling environment for private health practice HIV and FP service provision	**Regulation of the private health sector is weak.** The six countries share the following regulatory characteristics: poor enforcement of laws regarding non-compliant private health facilities; lack of incentives to develop private health facilities in rural areas; outdated, inadequate, and poorly enforced inspection standards; and poor private sector reporting, including disease surveillance.
	Private sector involvement in the national health strategy is weak, mostly due to lack of communication and agencies' lack of knowledge of the private sector. The six countries show varying levels of distrust between the public and private sectors.
	Where dialogue platforms for public-private interaction exist, they do not meet regularly and may not include the private for-profit health sector. Two exceptions are Burkina Faso and Côte d'Ivoire. Burkina Faso, with support from the World Bank Group, is developing a dialogue platform which includes the private health sector, though it is still at an early stage. In Côte d'Ivoire, with support from USAID Côte d'Ivoire, SHOPS is working with public and private stakeholders to amend a government decree to allow for a more representative dialogue platform.
	It is difficult to establish and operate a health business in the region. The six focus countries are at the bottom of the World Bank's Ease of Doing Business Report.
HIV and FP product and service provision	**The private sector varies as a major source for obtaining family planning methods**, ranging from just 5.4 percent of Nigeriens to over 50 percent of people in Togo, Côte d'Ivoire, and Cameroon.
	Private provision of HIV/AIDS services vary by country, by type of services, and by private provider category, but in general the for-profit sector is marginally involved. Mauritania and Niger have no registered private sector sites offering ART, while in Burkina Faso and Côte d'Ivoire the totals are in the single digits or low teens. The private nonprofit sector is much more involved in treatment, comprising 45 percent of all ART treatment in Togo and maintaining 65 sites in Côte d'Ivoire.
	Free or subsidized provision of many FP and HIV products limit the private sector's incentive to provide these products. In all six countries, HIV products are free. In Niger and Mauritania, there is also free provision of FP products, while in Burkina Faso, Togo, and Côte d'Ivoire these commodities are provided on a cost-recovery basis. In Cameroon, FP products are subsidized.
	Governments in all six countries tend to contract out for HIV services, and in some cases FP services, with local and international NGOs which in turn contract with community-based organizations. This is the case, for example, in Burkina Faso, Côte d'Ivoire, Niger, and Togo.
	Private providers in all six countries expressed an interest in expanding provision of FP and HIV services, provided that a clear regulatory environment exists that legally allows them to charge a fair price for their work.

Regional Themes	Finding
Corporate social responsibility (CSR)	**In general, CSR is not well developed in the region.** CSR initiatives exist mostly among the oil and mining companies as well as large-scale agricultural and brewery conglomerates. These activities focus more on HIV than FP.
	Each of the six countries has CSR organizations and business coalitions that can help USAID navigate the CSR landscape and connect with companies interested in health partnerships. For example, the *Coalition Nigérienne des Entreprises du Secteur Privé contre le Sida, la Tuberculose et le Paludisme* and the *Coalition des Entreprises de Côte d'Ivoire contre le Sida* both have multinational and donor members.
Partnerships	In general, **the region has a low number of PPPs** when compared to other areas such as East Africa. Among the six countries in this report, **most PPPs are focused on service contracts with NGOs** tied to community-based distribution of HIV and FP products and services. The government of Burkina Faso, with assistance of the IFC, is exploring management of the newly built Blaise Compaoré Hospital in Ouagadougou through a PPP (World Bank 2013a). Other PPPs among the six countries are primarily related to HIV, whether through agreements between governments and companies for procurement of ARVs or education campaigns. Across the region, **legislation regarding PPPs is incomplete, and no country has significant health-specific PPP activity**. While some countries have PPP policies (Burkina Faso, Côte d'Ivoire, and Cameroon), there are no private health sector policies or operational PPP Units in health among the focus countries. Côte d'Ivoire has a health focal point for PPPs, but it has not moved forward with any health projects.

Based on these findings, the assessment team has put forth the regional and country-specific recommendations and sub-recommendations outlined in Tables ES-2 and ES-3.

TABLE ES-2: REGIONAL RECOMMENDATIONS

Regional recommendation	Sub-recommendation
Improve the public-private landscape across the region through Ministry of Health collaboration with WAHO as catalyst, convener, and connector	Ministries of health in each country are key drivers of public-private collaboration, and they set the tone for partnerships in the country. Ministries of health, in collaboration with the West African Health Organization (WAHO) and with guidance from representatives of the East Africa Healthcare Federation, can **develop a regional private sector dialogue platform** in West Africa to advocate for private sector issues to governments. The West Africa Healthcare Federation's mandate would include developing standards across the region for private sector reporting and disease surveillance.
	WAHO could take the lead for a **cross-regional examination of how regulatory burdens inhibit more effective private sector engagement** in collaboration with USAID. private sector stakeholders across the six countries indicated this could help grow the private health sector.
	Since WAHO is a key stakeholder in FP and HIV/AIDS, it would be useful to **present the findings of this report and the companion report on mhealth to WAHO** as part of a one-day meeting.

Regional recommendation	Sub-recommendation
	In response to the changing donor environment, **WAHO can take the lead in assisting ministries of health with resource mobilization strategies to fill the funding gap for FP and HIV products and services**. By coordinating resource mobilization strategies, WAHO can encourage regional synergies.
Develop a total market approach to FP through contraceptive security committees	WAHO's current collaboration with KfW on contraceptive procurement includes a component related to the total market approach (TMA), yet government stakeholders interviewed had little understanding of TMA or desire to pursue it. USAID projects would do well to **work with countries on market segmentation activities which will also require capacity building of the public sector**.
	USAID West Africa projects can work to ensure that the private for-profit health sector is included in contraceptive security committees in each country. Of the six countries, only Niger currently includes the private for-profit health sector in its contraceptive security committee. SHOPS has found in other countries that this committee can be a catalytic vehicle for public-private collaboration. Contraceptive security committees can also serve as platforms to lobby for improved contraceptive logistics systems.
Increase access to family planning services through collaboration with MSI, IPPF, and PSI affiliates in focus countries	**Private provider networks (such as those run by MSI, PSI, and IPPF) including social franchises and clinic outreach programs offer the most direct way to increase access to family planning methods** in rural and urban areas. Building on their existing programs will help leverage scarce FP resources while gaining economies of scale.
Increase CSR opportunities within countries and regionally	The CSR landscape has changed, and multinationals are more selective and less willing to engage in CSR activities unrelated to their core business function. **Reach companies through CSR associations and business councils in each country,** such as the *Coalition des Entreprises de Côte d'Ivoire contre le Sida*, in order to preselect companies interested in partnerships in HIV and FP.
Develop and document PPPs within West Africa	While **mining companies** in the region are smaller than in other areas of Africa, they **offer the best opportunity for PPPs in health** among multinationals present in the region. Based on their geographic distribution and interest in health, IAMGOLD and Vale are possible partnership candidates. Integrating FP into HIV activities at mining company worksites is also recommended.
Increase learning within the region	**Document the scale and scope of the informal sector both for service provision and supply of health products**. Stakeholders interviewed in each country expressed interest in learning more about both unauthorized health facilities and illegal drug sellers. Such research would be a first step in determining how to improve their role in quality provision of FP and HIV products and services.
	There is increased focus among West African countries in infrastructure PPPs with PPP laws in several countries drafted to encourage investment promotion. However, there is a need to **show how to move from infrastructure-driven to health-outcomes-driven partnership strategies**. Guidance is needed on how this transition has been handled in other regions to help guide health PPP efforts in the six focus countries.

Regional recommendation	Sub-recommendation
	As part of the development of a regional private sector alliance, there is a need for a regional mechanism for sharing of information and experience through an online community of practice. **Examination and documentation of successful public-private initiatives** can also help move West African countries towards stronger private sector engagement in health.

TABLE ES-3: COUNTRY-SPECIFIC RECOMMENDATIONS

Recommendation	Sub-recommendation
Burkina Faso	
Improve policies and regulations regarding the private health sector	Despite reforms undertaken by the government of Burkina Faso to enhance private participation in the health sector, more efforts are needed to remove the constraints that hamper its growth. **Work with the WBG to improve the legal and regulatory environment, launch the private health sector federation, and improve enforcement of unlicensed clinics.**
Modify restrictions that impede growth of the private health sector	Private sector stakeholders expressed frustration that the health sector has to pay more tax than the education sector. Work is needed to **streamline import regulations and VAT exemptions**. USAID West Africa projects can design incentives for private providers to serve peri-urban areas with low access to health products and services to improve FP and HIV health outcomes.
Increase the role of FBOs in provision of HIV services to most-at-risk populations (MARPs)	In Burkina Faso, **FBOs have strong relationships with the Ministry of Health, but there is room for an increase in their role for key populations**. *Union des Religieux et Coutumiers du Burkina pour la Promotion de la Santé et du Développement* has existing contracts for HIV provision and could add additional activities for most-at-risk populations, such as safe sex messages and development of tailored counseling activities.
Cameroon	
Ensure greater access to FP services and products	To increase the coverage of FP services in rural areas, work with MOH to **supply FP products through community pharmacies,** in addition to the current provision of child health products.
Engage private providers to deliver HIV treatment.	USAID implementing partners can **work with the government of Cameroon to develop tax incentives and an enabling environment to encourage private providers to deliver HIV treatment**.
Work with the private sector to improve health outcomes	USAID implementing partners can **provide technical assistance to *Association Camerounaise pour le Marketing Social* to add HIV services to the ProFam family planning network in Yaoundé, Douala, and Bafousam.**
Develop PPP with a mining or agribusiness company	USAID implementing partners can **partner with mining companies and the Cameroon Business Coalition against AIDS for prevention and education campaigns**.

Recommendation	Sub-recommendation
Côte d'Ivoire	
Strengthen policies to bolster private sector participation in FP and HIV service delivery	The Reproductive Health Law, written in 2009, has yet to be signed into law. It would be useful to **work with the *Commission Paritaire*, an emerging public-private forum, to retool this law to include the private health sector in conjunction with the USAID-funded Futures Group-led Health Policy Project**.
Work with the private sector to promote and strengthen PPPs and CSR activities	**Work with Africa Center for Information and Development to provide HIV and FP services in mining companies** such as Newmont Overseas Exploration and Occidental Gold.
	The SHOPS project is currently conducting a pilot activity for private sector provision of ART services, partnering with the *Association des Cliniques Privées de Côte d'Ivoire*. **Integrating FP services into the pilot network of private HIV service providers** would leverage the network to expand the reach of private sector FP provision.
	Develop a health PPP with agribusiness companies in southern and southwestern Côte d'Ivoire, such as *Société des Caoutchoucs de Grand-Béréby*.
Mauritania	
Promote an enabling environment for the private sector at the national level and through PPPs	**Increase the role of the private sector in strategic documents** such as the national health development plan (*Plan National de Developpement Sanitaire*).
	Advocate with the government to prioritize PPPs to deliver FP and HIV services in order to strengthen the health system, particularly in conjunction with the Plan to Reposition FP 2014–2018.
Promote public sector strengthening of RH/FP rights and access	**Advocate for quick adoption of the Reproductive Health Law.**
	Improve access to quality FP services for remote populations through community-based distribution in partnership with the Association Mauritanienne de Planning Familiale.
Niger	
Invest in community-based FP and HIV activities through partnerships with local NGOs	**Support community-based FP extension services through partnerships with NGOs including the *Association Nigérienne pour le Bien Etre Familial* (ANBEF), ANIMAS SUTURA, and PSI.** These outreach services must focus FP messaging on girls and couples. An additional focus must be on pregnant women, ensuring that they can access antenatal care. **Focus on Adagez and Dosso,** the two regions with the highest unmet FP need.
	Work through community radio stations to disseminate FP messages aimed directly at men. More than television or newspaper, community radio appears to be the medium of choice for receiving information, especially among rural Nigeriens. Messaging must be aimed primarily at men as they hold power in traditional Nigerien culture.
	Partner with Society for Women and AIDS in Africa/Niger to support preventive HIV services for sex worker populations including promotion of female condom use.

Recommendation	Sub-recommendation
Engage the private commercial sector in improving health outcomes	**Support *Coalition Nationale des Entreprises de Lutte Contre le Sida, la Tuberculose et le Paludisme* (CNEP-STP) as a coordinating mechanism** for the private commercial sector. Work through CNEP-STP to **strengthen workplace health programs**.
	Work through Asusu's women's groups to disseminate FP messages at the community level. Asusu microfinance institution lends microcredit to a network of over 20,000 women's groups. USAID can utilize this network to incorporate FP messaging within regular meetings of the women's groups.
Togo	
Improve private sector reporting	**Train private sector facilities on reporting and M&E.** Training opportunities (both for NGOs and private providers) should be openly advertised through existing HIV and FP platforms, such as the *Plateforme des Organisations de la Société Civile contre le VIH/Sida* and the *Fédération nationale des ONG/Associations (FONGTO) de Lutte contre le VIH/Sida/IST et de Planification Familiale*.
Invest in community-based FP and HIV activities through partnerships with local NGOs	**Expand existing partnerships with community health workers and local health authorities,** coupled with strengthening the health information system based on the AWARE II model, developed with the NGO Adesco in three districts. Expand the pilot with local NGOs such as *Espoir Vie Togo* and *Aides Médicales et Charité*.
Develop partnerships between the corporate sector and the NGO sector in provision of HIV and FP services	**The International Labor Organization model for HIV prevention in the workplace could be implemented in Cameroon in partnership with the Association of Employers and the Chamber of Commerce**. The corporate sector could contract with NGOs for the provision of outreach programs that include FP and HIV.
Engage the private commercial sector	**Develop a dialogue platform that includes the private commercial sector** to improve health service allocation and allow for better reporting of health information data. Dialogue should also be reinforced between private pharmacies and the national AIDS program to deliver ART.

1. INTRODUCTION AND METHODOLOGY

1.1 BACKGROUND

The West Africa region is characterized by a confluence of economic and health development challenges. Approximately 150 million people live on less than the equivalent of $1.25 per day, with unemployment among youth especially high (Ford Foundation 2010). Poverty levels are compounded by severe health challenges. HIV/AIDS prevalence, although not as high as rates in eastern and southern Africa, is still higher than the global average in many countries, mainly due to the high prevalence in key populations such as men having sex with men (MSM) and sex workers (SW).[1] For example, in Togo, a 2011 study found that while HIV prevalence is 3.1 percent in the general population, it is 20 percent among MSM (Sow and Dia 2013b). In Burkina Faso, HIV prevalence among SWs ranged from 7.7 percent to 36.2 percent by district, which is significantly higher than the one percent prevalence found in the general population (Sow and Dia 2013a). Similarly, the HIV prevalence rate among the general population in Cameroon is estimated at 4.5 percent, while rates among MSM and SW are above 36 percent (CNLS-IST 2012b). Côte d'Ivoire likewise has an HIV prevalence rate among sex workers estimated at above 30 percent (Barnes et al. 2013) versus an estimated 3.7 percent in the general population (MEASURE DHS).

Various reports recognize progress made in the global AIDS response, but francophone Africa still lags behind. At a 2011 Francophonie Summit in Kinshasa, only about 40 percent of ART-eligible patients were on treatment in francophone sub-Saharan Africa, and no more than 15 percent of affected/eligible children accessed ARVs in Africa's francophone countries (Brisset 2013). In April 2014, three years after the Kinshasa conference, Médecins Sans Frontières reiterated that Western francophone Africa still lags behind in the AIDS response and called for adoption of the policies and practices that have advanced the response in Eastern and Southern Africa (Médecins Sans Frontières 2014).

Turning to family planning, West Africa records some of the highest fertility rates in the world (Table 1). Low contraceptive prevalence rates (less than 20 percent) and high levels of unmet need for family planning contribute to high levels of maternal and infant mortality.

[1] According to World Bank data, HIV prevalence is as high as 17.9 percent in South Africa and 7.2 percent in Uganda (World Bank 2014b).

TABLE 1: FERTILITY RATES BY COUNTRY

Country	Total Fertility Rate
Burkina	6.0
Côte d'Ivoire	5.0
Cameroon	5.1
Mauritania	4.8
Niger	7.6
Togo	4.7

Source: Population Reference Bureau 2013

1.2 DEVELOPMENT PARTNER CONTEXT

These health challenges have drawn the focus of the Economic Community of West African States (ECOWAS), a regional body of 15 countries focused on promoting economic integration across its members. In 1987, the 15 ECOWAS countries founded the West African Health Organization (WAHO) to promote attainment of the highest possible standard and protection of health of the peoples in the sub-region, by harmonizing the policies of member states, pooling resources, and cooperating to combat the health problems of the sub-region (West African Health Organization 2009). WAHO has developed strategies for combating HIV/AIDS and for reducing maternal and infant mortality rates across the West African region. Ministries of health in member countries have also developed country-specific health policies and programs to facilitate implementation of these regional plans. WAHO works to synchronize interventions and programs across the region by maintaining sustainable partnerships, strengthening capacity building, promoting cooperation, collecting and analyzing data, and disseminating key findings. WAHO implements several health activities such as a diagnostic survey of the private health sector, an eHealth strategy, collaboration with six local manufacturers on local production of anti-retrovirals (ARVs), and assistance to five laboratories in the region to provide quality control.

Another key stakeholder in the region, the West Africa Regional Health Office of USAID (USAID West Africa), operates in 21 countries with the mission of being a center of learning and leveraging. Its family planning-specific strategy for 2012–2017 focuses on increasing outreach to vulnerable populations and utilization of family planning services to reduce unmet need for contraception. This strategy aims to increase access to and use of quality family planning services, strengthen the enabling environment for family planning services, and improve contraceptive commodity security. Additionally, the WA/RHO works to prevent new HIV infections in key populations and in bridge groups to general populations. For those already infected with HIV or AIDS, the regional USAID office empowers local partners to improve care and support services.

USAID West Africa includes two regional flagship projects, *Agir pour la Planification Familiale* (AGIR-PF) for family planning and *Prévention et Prise en Charge du VIH/Sida en Afrique de l'Ouest* (PACTE-VIH) for HIV. Additionally, USAID West Africa works through the global USAID-funded Health Policy Project and DELIVER project within individual countries and across the region.

USAID West Africa launched AGIR-PF in July 2013. The program will expand women's access to and use of family planning in Burkina Faso, Côte d'Ivoire, Mauritania, Niger, and Togo. PACTE-VIH began in 2013 and operates in Burkina Faso and Togo to increase access to high-quality HIV prevention and care programs for the most-at-risk populations (MARP), improve the enabling environment for evidence-based public health interventions targeting MARP, improve the quality of HIV prevention interventions that focus on MARP, and increase access to quality and timely information focused on MARP interventions.

The family planning activities of WAHO, USAID West Africa, and host countries are directly influenced by commitments made in 2011 at the conference on Population, Development, and Family Planning in West Africa: An Urgency for Action. Representatives from Benin, Burkina Faso, Guinea, Mali, Mauritania, Niger, Senegal, Togo, and later Côte d'Ivoire arrived at a consensus known as the Ouagadougou Partnership to take concrete actions to increase the uptake of family planning in their respective countries. In addition to government officials, donors in attendance also agreed to provide unprecedented support in coordinating family planning efforts across the region. These countries have each developed a strategy to relaunch family planning activities and thereby reenergize efforts to increase contraceptive prevalence in each country and within the region.

1.3 METHODOLOGY

The assessment team used a mix of quantitative and qualitative methods to assess the role of the private sector in the areas of FP and HIV, determine the legal and regulatory framework governing the private sector, identify public-private partnership opportunities, and identify local and international NGOs and commercial enterprises engaged in FP and HIV/AIDS activities. Quantitative data from the most recent Demographic and Health Surveys, national health accounts, and numerous other databases and reports were utilized to understand contraceptive prevalence, unmet need for contraception, contraceptive method mix, source of family planning, HIV prevalence, as well as several other measures to quantify the size and role of the private health sector in each of the focus countries. Visits to each of the six focus countries with a total of over 150 stakeholder interviews revealed critical information regarding regulatory frameworks and public-private partnership opportunities. Combining quantitative and qualitative approaches allowed for validation, verification, and triangulation of private health sector data.

As Figure 1 shows, a private sector assessment (PSA) typically consists of five steps: plan, learn, analyze, share, and act. All five steps emphasize collaboration and engagement with local stakeholders in order to ensure accuracy and buy-in for the key findings and recommendations. Although PSAs often focus on one country and one health area, given USAID West Africa's regional focus, the current document is a multi-country macro-level PSA that includes both FP and HIV/AIDS components.

FIGURE 1: STEPS IN A PRIVATE HEALTH SECTOR ASSESSMENT



Step One: Plan

In preparation for the private health sector assessments, the SHOPS project finalized a scope of work with USAID West Africa in October 2013 and identified senior consultants and staff to conduct the six on-site assessments between December 2013 and March 2014. The assessment team was comprised of three international private sector experts from the SHOPS project and three West African senior health systems experts with significant experience in family planning and HIV.

In addition to the PSA activity in Burkina Faso, Cameroon, Côte d'Ivoire, Mauritania, Niger, and Togo, USAID West Africa requested that SHOPS conduct a regional scan of the telecommunications industry and health opportunities in the 15 ECOWAS countries plus Cameroon and Mauritania. Mobile health — i.e., using mobile technology to improve health outcomes — is addressed in a companion document to this report: mHealth in West Africa: A Landscape Report.

Step Two: Learn

To better understand the current political, economic, health, and social landscape in the six countries, the macro PSA team began with a background review that covered the most recent Demographic and Health Surveys (DHS) and national health accounts analysis as well as reports from WAHO, World Bank, International Monetary Fund, World Health Organization, UNFPA/UNDP, USAID, and U.S. Centers for Disease Control and Prevention. This first step provided a comprehensive picture of emerging issues within the private health sector and suggested key knowledge gaps to focus on during the in-country stakeholder interviews.

Following the literature review, the PSA team travelled to each country for one-week visits to conduct key stakeholder interviews and collect additional documentation (Table 2). Key stakeholders interviewed include members of the for-profit private sector, nonprofit private sector, public sector, and development partners. (Key stakeholders are defined in more detail in Section 1.5 Key Concepts.)

TABLE 2: MACRO ASSESSMENT FIELD VISIT SCHEDULE

Country	Travel Date
Burkina Faso	February 22 to March 2, 2014
Cameroon	December 8 to December 17, 2013
Côte d'Ivoire	January 13 to January 17, 2014/March 17 to 21, 2014
Mauritania	March 1 to March 10, 2014
Niger	January 11 to January 19, 2014
Togo	January 31 to February 10, 2014

Adapting a key informant interview guide (that has been fine-tuned by SHOPS through its previous private sector assessments), the macro assessment team met with a broad range of representatives from the public, private nonprofit, and private for-profit health sectors in each country. In total, the macro-PSA team interviewed more than 157 individuals from approximately 144 organizations, including government officials, donors present in the region, USAID implementing partners, professional and technical associations, private hospital and clinic networks and associations, faith-based organization and NGO representatives, industry representatives, banks and other commercial lenders, and private health care providers. A list of all stakeholders interviewed by sector and country is included as Annex A. The assessment team worked with local counterparts to select key stakeholders based on a number of criteria

including their role in the countries' health systems, the degree to which they represented their respective fields, and the size and scope of their work.

Step Three: Analyze

Analysis began while in-country. Through nightly debriefings, the PSA team shared information, vetted initial findings, and began to form actionable recommendations. After the data collection trips, SHOPS presented initial findings at USAID West Africa's Implementing Partners Meeting in March 2014, enabling the macro PSA team to validate the key findings with USAID implementing partners in the region including members of WAHO, AGIR-PF, PACTE-VIH, and DELIVER. In the process of drafting the report, the PSA team also followed up with local counterparts for additional information and clarification.

Step Four: Share

Based on the initial data analysis and stakeholder interviews, individual team members prepared their respective sections. The assessment team leader compiled a consolidated draft report which was shared with the entire macro-PSA team and SHOPS senior management for comments. The team then shared a second draft with a wider technical audience at a dissemination event in May 2014 in Accra that included members of the six countries' ministries of mealth, private sector representatives, WAHO, development partners, and USAID country offices.

Step Five: Act

The assessment team produced a final report that reflects the comments and concerns raised by local stakeholders. USAID implementing partners AGIR-PF and PACTE-VIH will be able to use the report recommendations to better leverage the private health sector in USAID-funded FP and HIV/AIDS activities.

1.4 GOALS OF MACRO-LEVEL ASSESSMENT ACTIVITY

The overall goal of the macro-level assessment activity was to develop strategies for better leveraging the private health sector in West Africa for FP, HIV, and AIDS to complement project activities of AGIR-PF and PACTE-VIH. Within that framework, there were five sub-goals:

- Assess the current role of the private sector in providing FP and HIV/AIDS commodities and services.
- Determine the legal and regulatory framework governing the private health sector, particularly with regard to FP and HIV/AIDS.
- Determine the current involvement of the private health sector in public-private partnerships as well as opportunities for private sector collaboration to expand coverage and reach with a particular focus on FP and HIV/AIDS.
- Determine the major local and international non-governmental organizations (NGOs) active in family planning and HIV/AIDS in the country as well as any companies with corporate social responsibility activities in those two health areas.
- Determine opportunities for partnership with the private sector.

1.5 KEY CONCEPTS

This section offers definitions of some key concepts used throughout the report.

Private Health Sector: The private health sector in West Africa is diverse, comprised of for-profit commercial entities as well as nonprofit organizations, such as nongovernmental organizations (NGOs) and faith-based organizations (FBOs) that provide health services, products, or information.

Private providers in West Africa deliver a range of health services and products in a wide variety of venues; a practice might operate in a single room in a provider's home or in a state-of-the-art clinic. Many larger companies, particularly those in mining and agriculture, offer health care through workplace clinics. Across the West Africa region, the private pharmaceutical sector is the largest subgroup of private providers. Among the nonprofit sector in the six focus countries, FBOs play an important role in providing essential services, particularly for underserved populations. Supporting these health care providers are ancillary services such as private laboratories and other diagnostic services.

Key Health Stakeholders: A key health stakeholder is an individual or group who can affect or is affected by an organization, strategy, or policy in health. Below is a list of key stakeholders interviewed as part of the macro-level private health sector assessment in the six focus countries. Annex A provides lists of stakeholders by country.

TABLE 3: LIST OF KEY STAKEHOLDERS INTERVIEWED

Commercial private sector	Nonprofit private sector	Public sector	Development partners
• Health care providers (e.g. doctors, nurses, midwives) • Health care facilities (e.g. hospitals, clinics, pharmacies) • Pharmaceutical distributors • Health insurance companies • Diagnostic services (e.g. laboratories) • Multinational companies (e.g. mining companies)	• NGOs engaged in health care delivery • Faith-based organizations • Professional and medical associations • Civil society organizations • Business coalitions • Corporate social responsibility NGOs	• Ministries of health, finance, public works, investment promotion departments • Professional councils and regulatory boards • Public hospitals • Central medical stores • Government commissions on HIV and AIDS • Government health dialogue platforms	• International donors (e.g. foundations, foreign national governments) • Multilateral organizations (e.g. UN, WHO, World Bank)

Public-Private Partnerships: A PPP in health is any formal collaboration between the public sector (at any level: national and local governments, international donor agencies, bilateral government donors) and the nonpublic sector (commercial and nonprofit, traditional healers, midwives, or herbalists) in order to jointly regulate, finance, or implement the delivery of health services, products, equipment, research, communications, or education (Barnes 2011).

2. REGIONAL OVERVIEW

The private sector is increasingly recognized globally as a key health partner in emerging markets. As demand for health services and products increases, stressing an already overburdened public health sector, the private health sector can help improve the efficiency of resources, alleviate the patient load at public facilities, and decrease wait times. The private health sector can also help governments address long-standing health challenges: private health networks can deliver services and drugs in areas not reached by ministries of health (MOHs), and also fill the supply gap for key health products.

Despite these potential benefits, private sector involvement in the national strategy of the six West African focus countries has not been optimized due to lack of communication between the two sectors, lack of knowledge of the scope of the private health sector, poor regulation of the sector, and poor private health sector reporting. Donor and government concerns about quality and affordability may have limited the role the private sector currently plays.

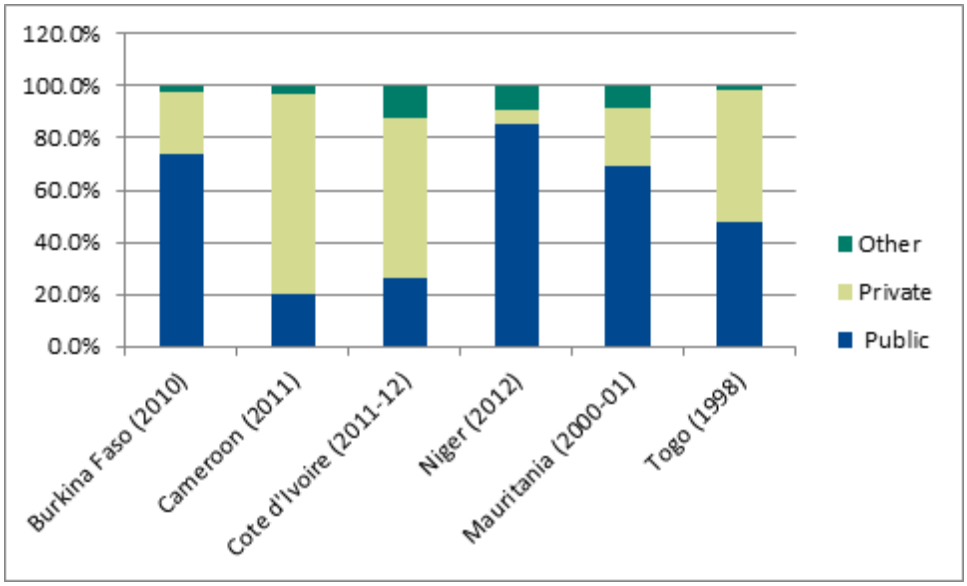
A closer look at the prospective role of the private health sector in West Africa is particularly important since HIV is no longer perceived as a global health emergency: funding has lost some of its political momentum with more funding cuts on the horizon. The following section describes the private health sector in the region and highlights key regional themes.

2.1 A REGIONAL LOOK AT THE PRIVATE HEALTH SECTOR

The private health sector in Francophone West Africa is diverse and complex, comprising a wide range of nonprofit and for-profit entities engaged in a number of health activities, especially service delivery, pharmaceutical dispensing, and laboratory diagnostics. In the six focus countries, nonprofits (faith-based organizations, charitable nonprofits, and community-based organizations) are primarily engaged in service delivery and supportive care with a more pronounced role in rural areas to deliver services to hard-to-reach populations. For-profit entities include a wide range of actors involved in a range of activities: delivering health services, wholesaling and distributing medical products and technology, training health workers, and providing private health financing. Although they can also be found in rural areas, for-profit facilities are heavily concentrated in urban areas in the six focus countries.

Research conducted for this report indicates that in the six focus countries, the private health sector is already playing a role in the provision of health products and services. Source of family planning by sector can be taken as an indicator of private sector involvement. Figure 2 shows that private provision of modern FP methods (through private medical and other private sources) ranges from a low of 5.4 percent in Niger to above 50 percent in Togo, Côte d'Ivoire, and Cameroon.

FIGURE 2: SOURCE OF MODERN FAMILY PLANNING METHODS IN SIX COUNTRIES

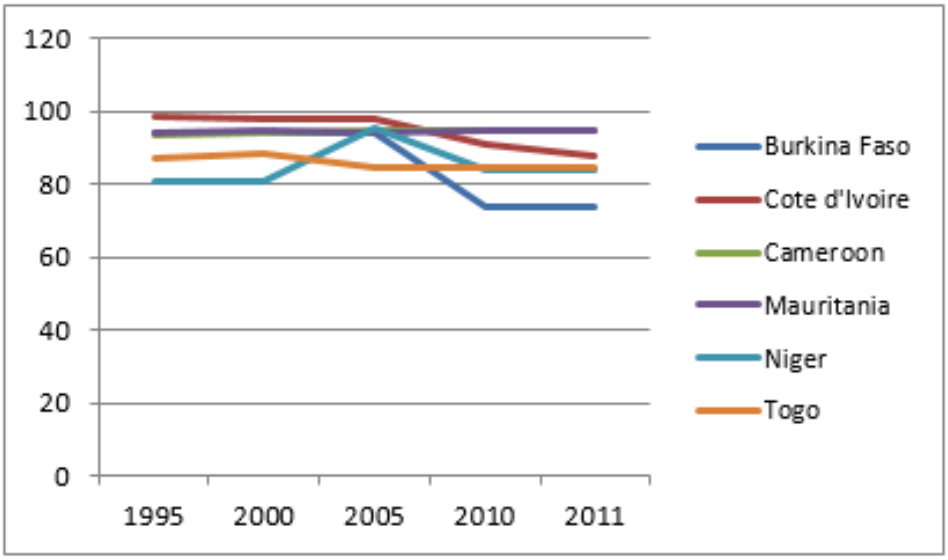


Source: Measure DHS.

For HIV/AIDS services, the private sector, particularly the nonprofit sector, plays a major role in HIV prevention and counseling and testing (HCT), as well as in caring for orphaned and vulnerable children (OVCs) in all six countries. In Togo, for example, in addition to contributing to HCT activities, private nonprofit entities carried out nearly all HIV prevention initiatives and cared for nearly all OVCs (CNLS-IST 2012b). In Burkina Faso, 62 percent of the 228,098 HIV tests conducted in 2011 were credited to the private nonprofit sector. Nonprofit entities also provided ART, though not at the same scale as HCT and prevention. The participation of the commercial sector in ART provision in all six countries is low due to the public sector's ART monopoly. In some countries the control of free ARV distribution is a problematic issue. In Côte d'Ivoire, only four commercial sites provide ART (Barnes et al. 2013); Niger also had only four sites in 2011; Burkina had seven in 2011 (UNAIDS 2012). Togo has eight workplace sites with a limited ART role; and informants in Mauritania identified the public sector as the sole official provider of ART. In Cameroon, the private commercial sector provided 14 percent of all ART sites in 2012, mainly through workplace programs. In Côte d'Ivoire, since a segment of the population prefers to use the private commercial sector for reasons of confidentiality and stigma avoidance (Barnes et al. 2013), the SHOPS project's pilot program seeks to increase ART commercial sites in Abidjan from four to 19 in 2014.

Another measure of the role of the private health sector is the amount of out-of-pocket spending, i.e., what consumers pay for health products and services. In all six focus countries, out-of-pocket expenditures account for over 75 percent of private expenditures on health (Figure 3). This finding suggests that individuals do not have other ways to pay for health care costs such as insurance, and therefore they make most of their payments for health care out of their own private funds. Even though the public sector in most of these countries provides services free of charge, these data indicate that people may be sourcing some of their health care in the private health sector. In some cases, a patient may receive a consultation in the public sector but then obtain auxiliary services like prescriptions or lab tests in the private sector.

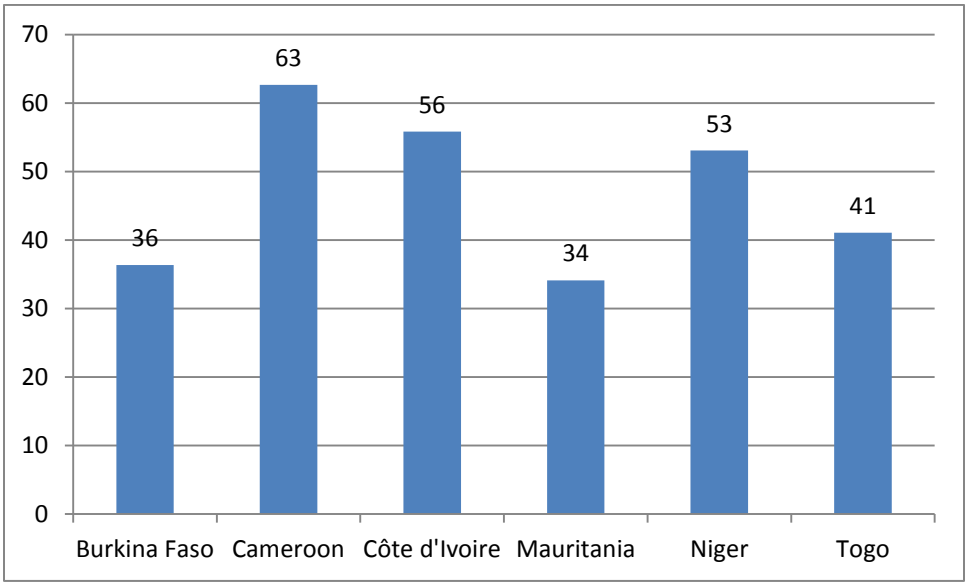
FIGURE 3: OUT-OF-POCKET EXPENDITURE AS PERCENT OF PRIVATE HEALTH EXPENDITURE (1995–2011)



Source: World Bank 2014

In 2012, household contribution as a percentage of total health expenditure among the six focus countries varied from 34 percent in Mauritania to 63 percent in Cameroon with Mauritania, Togo, and Burkina Faso below 50 percent and Niger, Côte d'Ivoire, and Cameroon above 50 percent (Figure 4).

FIGURE 4: OUT-OF-POCKET EXPENDITURE AS A PERCENT OF TOTAL HEALTH EXPENDITURE (2012)



Source: World Health Organization

2.2 KEY REGIONAL THEMES

West Africa is a region of extreme cultural, geographic, and religious diversity. Côte d'Ivoire alone is home to over 60 dialects (Nations Online 2013), and religious diversity is high as well. Even so, the countries in the region share a strong pro-natalist stance, and they record some of the highest birth rates in the world. Key themes among the six focus countries that emerged and that shape the private health landscape are discussed below. Country-specific information can be found in Section 3.

1. The private health sector is larger than expected.

In each of the six countries covered in this report, researchers found a growing private health sector that, though difficult to measure, was much larger than anticipated. In Cameroon, with the best-documented private health sector, of the 4,351 health facilities identified in the country in 2011, 2,428 (44 percent) are in the private sector (Cameroon Department of Human Resources 2011). In Côte d'Ivoire, a 2010 health facility survey conducted by the Directorate of Information, Planning and Evaluation found that private facilities represent 52 percent of all health facilities in the country (DIPE 2011). By volume, the private sector in Togo delivers more services than the public sector, especially in the category of ambulatory services (HiA 2010). In 2013, Burkina Faso had 361 registered private for-profit health sector establishments accounting for about 20 percent of the country's health facilities. For Niger, while exact numbers could not be found, the Order of Pharmacists, Doctors, and Dental Surgeons estimated during an interview that 900–1,000 private health professionals practice in the country. SHOPS consultants found a thriving private health sector in Mauritania as well.

Alongside the licensed private health sector is a thriving black market for FP and HIV products. In each of the six focus countries, the informal sector, while poorly documented, is estimated to be a dominant subsector. The informal sector includes unlicensed service providers and drug sellers as well as traditional healers called by various names. Lax regulations and difficult business procedures make it easy for illegal health businesses to flourish (see Table 7). These West African countries are also affected by porous borders with leakage of products from Nigeria, the largest economy in the region. Condoms and contraceptives of varying quality can be found outside registered health facilities, and the macro assessment team also found evidence of ARVs available through informal channels in Cameroon.

2. Contraceptive security committees are not operational.

Contraceptive security (CS) committees are useful vehicles to establish stronger public-private dialogue in FP. Yet the CS committees in the six focus countries are either not operational (Cameroon, Mauritania, Togo) or not inclusive of the private for-profit health sector (Côte d'Ivoire, and Burkina Faso). All USAID West Africa focus countries include the nonprofit private health sector, but Niger is the only country which has a CS committee including the private for-profit sector (Table 4). However, Niger's two committees related to CS include over 40 members which makes consensus difficult. Burkina Faso's contraceptive security committee has the strongest government leadership, but its first meeting was in March 2014, and it is too early to know whether it will continue.

TABLE 4: STATUS OF CONTRACEPTIVE SECURITY COMMITTEES BY SECTOR

Country	Functioning CS Committee?	Private For-Profit Sector Represented?
Burkina Faso	Yes, but just started meeting	No
Cameroon	No	No
Côte d'Ivoire	Yes	No
Mauritania	No	None
Niger	Yes	Yes
Togo	Not operational	No

Through the DELIVER project, efforts are underway to streamline and operationalize contraceptive security committees in the USAID West Africa priority countries. DELIVER, along with USAID implementing partners, has a unique opportunity to ensure that the private for-profit health sector is included in these revitalized contraceptive security committee efforts.

3. A total market approach is needed.

A key opportunity for USAID West Africa implementing partners is to use the revitalized contraceptive security committees to launch a total market approach (TMA) activity in FP. In a total market approach, stakeholders consider all sources of supply (public, nonprofit, and commercial sectors) to design strategies that efficiently serve all consumer segments, thereby increasing access to and sustainability of FP programs. Ideally, the government plays a leadership role in orienting different suppliers to different consumer segments by leveraging the comparative advantages of each source of supply. TMAs are developed with the knowledge that FP products and services are available to consumers through multiple channels and may be more or less appealing depending on where they are sold, how much they cost, how they are promoted, how discreetly they can be procured, and geographic proximity. Ideally, this process especially benefits the poor, as they gain increased access to a variety of free, subsidized, and low-cost products from all three sectors. WAHO, with financial support of KfW, has been implementing a regional reproductive health agenda that includes TMA; however, the study team found no evidence of TMA activities in five of the focus countries and only limited TMA activities in Côte d'Ivoire. USAID West Africa implementing partners, in collaboration with WAHO, can use the guidelines designed to support the TMA process for FP to conduct TMA exercises through the contraceptive security committees (Drake 2011).

TMA Exercise in Côte d'Ivoire

In 2010, AIMAS, the local social marketing organization in Côte d'Ivoire, organized a one-day workshop with technical support from Abt Associates to help the government play a greater role in coordinating different funding and implementing partners in reproductive health. Participants included the Ministry of Health's Division of Reproductive Health, the Ministry of HIV/AIDS, the United Nations Population Fund, the local affiliate of the International Planned Parenthood Federation, other local nongovernmental organizations, and commercial contraceptive suppliers. The objective was to promote a more coordinated approach to contraceptive programming, one that takes into account players from the public, private nonprofit, and private commercial sectors.

The meeting helped create opportunities to improve efficiency and sustainability through cost savings and better targeting of resources. The IPPF affiliate realized it could procure some of the Ministry of Health's excess supplies of injectables, instead of conducting its own international procurement. The Global Fund recipient realized that it needed to better coordinate condom distribution activities with the social marketing organizations: condom distribution and promotion activities were focused in the southern cities and towns with no organization providing similar efforts in northern towns. Such programming changes based on information from the workshop resulted in a better use of resources for contraceptive programming (Barnes et al. 2012).

In spite of plans to create working groups to exchange information on existing stocks, procurement plans, distribution strategies, and communications strategies, these groups have not materialized, indicating that technical assistance is needed to continue the TMA process in Côte d'Ivoire. USAID West Africa implementing partners, working through the convening power of contraceptive security committees, can implement TMA strategies to improve the efficiency of the FP marketplace and better distribute scarce resources.

4. The regulatory framework for the private health sector is weak.

For the six focus countries of this report, the regulatory framework for the private health sector is weak with no overall strategy to guide efforts to improve the private sector's role in the health system and resolve challenges. All six countries are affected by regulatory gaps: poor enforcement of laws regarding non-compliant private health facilities; lack of incentives to ease the installation of the private health sector in rural areas; outdated, inadequate, and poorly enforced inspection standards; and poor private sector reporting, including disease surveillance.

It is encouraging that several countries in the region mention the private sector in their relaunching family planning documents. However, none of the six focus countries has optimized the policy environment for the private health sector. Across the six focus countries, the policy environment does not adequately recognize the private sector, and this could discourage the growth of licensed private provision of services and create barriers to entry. At the same time, there is a high tolerance for unauthorized facilities due in part to the lack of funding for facility inspections.

WAHO's leadership may be needed for a regional push to develop private health strategies and standardize regulations for opening and inspecting private health facilities, similar to its success in promoting coordinated informed buying (CIB) (West African Health Organization 2011).

5. With varying degrees of public-private interaction in the health sector, there is room for improvement.

Creating linkages between the public and private sectors can help build an integrated sustainable health system. Dialogue platforms exist for public-private interaction in each country such as contraceptive security committees, technical working groups for PPPs, and public-private forums. By and large, these platforms either do not meet regularly or are not fulfilling their mandate of including all voices in the discussion, particularly the private for-profit health sector. In general, dialogue is stronger between the nonprofit and public sectors, often with the convening assistance of development partners. For example, since 2003, the FP Multisectoral Working Group in Mauritania has promoted an annual week-long FP campaign with strong private nonprofit participation — but no private for-profit members. The macro assessment team also found several sector-specific dialogue platforms in each country (composed of development partners, NGOs, or FBOs), with no opportunity for cross-sector dialogue. The SHOPS team heard from the private health providers interviewed for this report that governments, in their view, were paying lip service to the idea of cross-sectoral communication, but they did not feel their voice was adequately included in the national health dialogue.

6. The private sector is already providing FP and HIV services.

In the six West African focus countries, many FP and HIV products and services are guaranteed free of cost by the government. Nonetheless, the private nonprofit sector is a significant provider of FP and HIV/AIDS services in the six focus countries, mainly through contracting arrangements for service delivery. Major local actors in FP product and service delivery include the affiliates of International Planned Parenthood Federation (IPPF) and Population Services International (PSI) in each country, as well as international organizations such as Marie Stopes International (MSI). HIV/AIDS service delivery is provided through local and international NGOs who often contract in turn with regional community-based organizations.

For-profit private providers are also involved in HIV service provision, mainly through contracting arrangements with governments, although at a much lower level than NGOs and FBOs. During field visits, for-profit providers expressed interest in increasing provision of FP and HIV products and services, provided policies are in place to legally allow provision of these items, governed by clear enabling policies.

- Strong presence of social marketing and social franchise organizations

Each of the six focus countries hosts strong social marketing and social franchise organizations such as IPPF and PSI affiliates. Affiliates of IPPF and PSI with social marketing activities by country include:

- Burkina Faso: *Association Burkinabèe pour le Bien-Etre Familial* (ABBEF)—IPPF and *Programme de Marketing Social et de Communication pour la Santé* (PROMACO)—PSI
- Cameroon: Cameroon National Association for Family Welfare (CAMNAFAW)—IPPF and *Protection de la Famille* (Profam)—PSI
- Côte d'Ivoire: *Association Ivoirienne pour le Bien Etre Familial* (AIBEF)—IPPF and Agence *Ivoirienne de Marketing Social* (AIMAS)—PSI
- Mauritania: *Association Mauritanienne pour la Promotion de la Famille* (AMPF)—IPPF
- Niger: *Association Nigérienne pour le Bien Etre Familial* (ANBEF)—IPPF and the recently introduced PSI program, and
- Togo: *Association Togolaise pour le Bien Etre Familial* (ATBEF)—IPPF and Association Togolaise pour le Marketing Social(ATMS)/Pour une Meilleure Famille (POMEFA)—PSI

These organizations offer varying levels of FP services and products. For example, Profam in Cameroon is a network of over 100 private and faith-based clinics; AMPF in Mauritania manages five health centers and one mobile clinic, and ATMS/POMEFA in Togo comprises nine private and 70 public sector clinics (Viswanathan and Schatzkin 2013).

Beside IPPF and PSI, a number of international and local organizations are involved in social franchising and marketing of FP and HIV/AIDS services and products. MSI's footprint in West Africa is limited to Burkina Faso where it runs a social franchise program with three clinics and five mobile teams. The Foundation Ad Lucem in Cameroon is the second largest provider of medical services in Cameroon with a network of 10 hospitals and 18 health centers (*Fondation Médicale Ad Lucem Cameroun* 2005). The *Association Nigérienne de Marketing Social* (ANIMAS-SUTURA),[2] the largest national social marketing NGO in Niger, promotes FP education, operates two major warehouses in the country, and distributes condoms and pills in 563 villages. In Côte d'Ivoire, the SHOPS project is piloting a network of 15 commercial clinics to expand and improve the quality of HIV/AIDS services in the private sector.

7. Operating a health business in the region presents difficulties.

It is not easy doing business in West Africa, and the six focus countries of this report are near the bottom of the IFC's global ranking of ease of doing business (Table 5). The difficulty in opening and operating a business directly affects private health businesses. Private providers interviewed in the six focus countries reported that import restrictions and the favorable status of the central purchasing parastatal organization make importing difficult and time consuming. The lengthy registration process also hinders the growth of the private health sector. Table 5 also shows that many private businesses in the six focus countries don't pay taxes, indicating that the public sector needs to better capture the contributions of private businesses in each country.

TABLE 5: EASE OF DOING BUSINESS IN SIX FOCUS COUNTRIES (2013)

Country	Rank out of 189 Countries	Worst Categories
Burkina Faso	154	Paying Taxes (160), Trading Across Borders (174)
Cameroon	168	Enforcing Contracts (175), Paying Taxes (180)
Côte d'Ivoire	167	Trading Across Borders (165), Paying Taxes (173)
Mauritania	173	Paying Taxes (181), Resolving Insolvency (189)
Niger	176	Paying Taxes (162), Trading Across Borders (178)
Togo	157	Starting a Business (168), Paying Taxes (172)

Source: International Finance Corporation 2014a.

8. CSR activities are focused on a few key sectors.

In general, corporate social responsibility is not well developed in West Africa. There are relatively few multinationals in the region, although Cameroon, Niger, and Côte d'Ivoire have mining and oil installations which typically have well-developed CSR programs. With the decline in gold and iron ore prices, many mining companies have pulled out from Africa, and those that remain are not investing as much in social programs. Companies involved in the extractives industry in West Africa tend to be mid-level and smaller firms with limited interest in social programs and CSR. Annex C provides a list of major mining companies that are active in the six

[2] ANIMAS-SUTURA began with KfW funding.

countries covered in this report. Several oil companies present in West Africa have operations offshore and thus have less impetus for CSR activities since they are not visible in the country.

The recent Mining Health Initiative of Harnessing Non-State Actors for Better Health for the Poor (HANSHEP), funded by DFID, Rockefeller Foundation and IFC, developed case studies and good practice standards for mobilizing the mining industry to support the delivery of quality healthcare (HANSHEP 2014). This report can help guide USAID West Africa's implementing partners, although the case studies do not include these six focus countries. According to the International Council of Mining and Metals, mining companies in Africa that engage in regional-level health initiatives often implement them through the company foundation and may also involve an international NGO, UN agency, or bilateral donor (as for BHP Billiton's health activities in South Africa and Mozambique). Worksite health programs are also common, such as Newmont Ghana's Workplace program for HIV/AIDs and malaria (ICMM 2013). Given the sheer number of mining companies active in West Africa, a scoping study is needed to determine those that are most interested in working in FP and HIV/AIDS.

There are also CSR initiatives among large-scale agriculture companies in Côte d'Ivoire (cocoa and tea) and among breweries in Niger. Among local companies in the six focus countries, the western concept of CSR is still a nascent idea. Multinationals and their foundations in the region tend to be active in HIV, though much less so in FP.

Many companies engage in CSR activities they consider in strategic alignment with their core values, often focusing on a single area, such as environment, education, or labor rights. Among Francophone West African countries, Côte d'Ivoire is considered the most advanced in terms of CSR (RSE Senegal 2012). Examples of CSR activities in health among the six focus countries, mainly pertaining to HIV, can be seen in Table 6.

TABLE 6: CSR EXAMPLES IN FP AND HIV ACTIVITIES

Company	Country	Health Activity
Brasserie BB	Togo	Finances *Espoir Vie* work with OVC.
BMCI *(Banque Mauritanienne pour le Commerce International*)	Mauritania	Finances STOPSIDA activities with fishermen.
Total Foundation	Burkina Faso & Cameroon	Finances activities of NGOs for HIV activities with truck drivers.*
Anglo Gold	Ghana, Burkina Faso	Health program for dwellings around mining community. In Ghana, reduced malaria incidence by 73 percent in 2 years (Mining Health Initiative 2013).
Orange	Cameroon, region	My Healthline provides personalized advice on contraceptives, HIV, STIs, and sexuality (RSE et PED 2014). Orange also pledges to hire HIV+ staff in collaboration with Comité National de Lutte contre le Sida (CNLS), le Ministère de la Santé, and le Groupement Interprofessionnel du Cameroun (Gicam).
Olam	Côte d'Ivoire Cameroon	Agro giant Olam partnered with GIZ, EngenderHealth, and Action Health Incorporated to provide education and HIV testing and treatment in 7 countries, including Côte d'Ivoire and Cameroon. Olam invested $468,000 in activity in 2012 (Abidjan.net 2012).
SIFCA	Côte d'Ivoire	A company with palm oil, sugar, and rubber plantations in Côte d'Ivoire; sponsors health activities in the communities where

Company	Country	Health Activity
		they work (*L'Afrique s'éveille* 2011; SIFCA 2012).
AREVA	Niger	Largest open-pit uranium mine in West Africa provides free medical care for employees and families, and built two hospitals and a health observatory for monitoring worksite illnesses (Areva 2013).
Exxon Mobil, COTCO	Cameroon	The Cameroon Oil Transportation Company (COTCO), the company responsible for the Chad-Cameroon pipeline, has invested CFA 2.2 billion ($4.5 million) in projects fighting malaria, HIV/AIDS, and tuberculosis (Business in Cameroon 2014).
RandGold	Côte d'Ivoire	Distribution of condoms, free and confidential HIV testing (Randgold Resources Limited 2014).
Groupe Tedamoun	Mauritania	Community HIV campaign for fishermen, hairdressers, and students (RSE et PED).
GlaxoSmithKline Foundation	Cameroon	GSK Fondation France supports 12 health programs in Cameroon, including: HIV testing for 7,000 pregnant women a month in 25 health centers; modernization of hospital facilities and equipment; and provision of grants for HIV-related mother and child health activities.**
Groupe Industrial Promotion Services (IPS)	Burkina Faso, Côte d'Ivoire	Groupe Industrial Promotion Services (IPS), part of the Agha Khan Network and in collaboration with the Agha Khan Foundation, has created a system of mutuelles for workers, including HIV/AIDS (CFPMI 2007).

*http://www.burkinapmepmi.com/spip.php?article15532

**http://www.developingcountriesunit.gsk.com/Cameroon

There are nascent CSR organizations in most West Africa countries that can help USAID projects navigate the CSR landscape and connect with those companies interested in health partnerships. In general, the business coalitions against HIV/AIDS already include the companies most likely to be interested in HIV/AIDS activities and should thus be a focus of USAID West Africa implementing partners. Key CSR organizations by country are shown in Table 7.

TABLE 7: KEY CSR ORGANIZATIONS BY COUNTRY

Country	CSR Organization
Burkina Faso	RSE Burkina; l'ORCADE (NGO that works with IAMGOLD)
Cameroon	*Plateforme de Coordination des Entreprises Contre le VIH-Sida* (PCGE); *Groupement Inter-Patronal du Cameroon*; *La Coalition Nationale d'Entreprises* (CCA/SIDA) (Santé en Entreprise 2014)
Côte d'Ivoire	*La Commission Gouvernance Ethique et RSE de la Confédération Générale des Entreprises de Côte d'Ivoire* (CGECI)
Mauritania	*Coalition des Entreprises Mauritaniennes contre le VIH/SIDA*
Niger	*La Coalition Nigérienne des Entreprise* (*Santé en Entreprise* 2014); *Coalition Nigérienne des Entreprises du Secteur Privé contre le Sida, la Tuberculose et le Paludisme* (CNEP/STP)
Togo	*Commission Nationale des Droits de l'Homme* (CNDH), which focuses on CSR and human rights
Regional	*Club Santé Afrique*, a regional CSR organization

9. There are relatively few PPPs, compared to East Africa.

Public-private partnership (PPP) in the health sector has been promoted informally by West Africa governments since the colonial period, as governments recognized that they could not provide all the needed health and social welfare services without assistance from the private sector. Among the six countries in this report, most PPPs are focused on service contracts with NGOs tied to community-based distribution of HIV and FP products and services in specific regions. Other PPPs among the six countries are primarily related to HIV or malaria, such as through agreements between governments and companies for procurement of ARVs or education campaigns.

In recent years, with donor support, governments have been working towards creating a strong institutional environment to facilitate public-private collaboration. East African countries, through donor support, have developed PPP legislation and PPP-enabling policies, including a PPP office, often associated with the Ministry of Finance. In Kenya, Uganda, and Tanzania, the realization that PPPs in health have a different character than other types of PPPs led to establishment of a PPP strategy in health, as well as a health PPP unit at the MOH and a health PPP action plan to address key health gaps.

Countries in West Africa are not as far along the PPP continuum as their East African neighbors. In general, although governments have recently established PPP policies focused on large infrastructure projects, the broader enabling regulations have been slow to develop. None of the West African countries covered in this report has a health PPP strategy or a health PPP unit. Côte d'Ivoire is perhaps the most proactive on health PPPs, hosting a delegation of European investors in mid-2013 to explore PPPs for rehabilitation of public hospitals, university hospitals, and a cardiology center (Government of Côte d'Ivoire 2013). However, Côte d'Ivoire has yet to implement any health PPPs.

TABLE 8: PUBLIC-PRIVATE PARTNERSHIP POLICIES

Country	Private Health Sector Strategy	PPP Policy	PPP Department	Health PPP Focal Point	Health PPP Strategy
Burkina Faso		X	X		
Cameroon		X			
Côte d'Ivoire		X	X	X	
Mauritania			X		
Niger		X	X		
Togo		X	X		

3. COUNTRY SNAPSHOTS

The following section provides an overview of the private health sector landscape in Burkina Faso, Cameroon, Côte d'Ivoire, Mauritania, Niger, and Togo. Each country snapshot begins with a brief overview followed by a discussion of the dynamics of the private health sector, the enabling environment, trends in health financing, and the delivery of FP and HIV products and services through private channels in the country. Also included is an outline of the key public and private sector stakeholders in each country, existing corporate social responsibility activities, and public-private partnerships in health.

While these country snapshots cannot capture the full breadth of issues related to the private sector landscape, they serve as a macro-level view of key issues and themes in each country. Since the level of information available about the private health sector varies by country, it was not possible to provide the same types of information for each country.

3.1 BURKINA FASO

3.1.1 BACKGROUND

Burkina Faso, a landlocked country with 16.5 million inhabitants, has seen significant progress over the last several years (World Bank n.d.): maternal mortality decreased from 700 per 100,000 in 1990 to 300 per 100,000 in 2013, and under-five mortality decreased from 208 to 146 per 100,000 over the same period (Countdown 2013). The country has witnessed an annual average growth rate of over 5.5 percent between 2000 and 2012 (World Bank 2013b). However, it remains one of the world's poorest countries with a per capita income of $660 in 2012 (World Bank 2013b). The 2013 UNDP Human Development Index ranks it 183rd among 187 countries with comparable data (UNDP 2013).

The *Plan National de Développement Sanitaire* (PNDS), which set Burkina Faso's health priorities for the decade 2001–2010, was followed by the *Politique Nationale de Santé 2011–2020* (PNS) and by the PNDS 2011–2020. An important component of the new plan is the role of community health workers in the provision of health services at the district level. The PNS noted the following challenges in the country: poor governance, poor inter-sectoral collaboration, high maternal and child morbidity, poor health coverage, insufficient health products of uneven quality, a poorly-performing health information system, and insufficient financing of health coupled with poor resource allocation. The PNS calls for increased coordination with civil society and the private health sector, including results-based financing, development of public-private partnerships, expanded contracting, and a greater role for the private health sector in HIV/AIDS (Burkina Faso Ministry of Health 2011).

Burkina Faso's health landscape is characterized by a low contraceptive prevalence rate, particularly in rural areas. Nearly a quarter of all households across all wealth quintiles have unmet need for family planning. In 2010, 73 percent of modern users sourced their contraceptive methods from the public sector while 24 percent sourced their methods from the private sector. This marks a significant decrease since 2003 when 43 percent of modern users sourced those methods privately. The regional and country snapshots appended to this report graphically present Burkina Faso's health statistics.

The HIV prevalence rate has nearly halved, from 1.9 percent in 2003 to 1 percent in 2010. However, while 57 percent of urban pregnant women are counseled and tested, only 21 percent of rural women receive these services.

3.1.2 OVERVIEW OF THE PRIVATE HEALTH SECTOR

The health system in Burkina Faso is composed of both public and private actors. Public facilities provide primary, secondary, and tertiary care, and comprise 31 medical centers, 122 public clinics, 22 maternity hospitals, 42 ambulatory care centers, 9 regional health centers, and 3 university hospitals for specialized care. In addition, the army and the social security administration operate separate health facilities. The public sector provides many free health services: indigent care, care for malaria for pregnant women and children less than five years old, vaccination, tuberculosis and other contagious diseases, prenatal consultations, and anti-retrovirals. The government of Burkina Faso also subsidizes deliveries, contraceptives, and postnatal consultations. These free and subsidized health offerings have an impact on the types of services and products the private health sector can offer (Burkina Faso Ministry of Health 2011).

The private health sector has been an acknowledged component of the health system in Burkina Faso for over 20 years, beginning with reforms based on the Bamako Initiative in 1990 and the adoption of a hospital law in 1994 that established clear distinctions between the public and private sectors. The private sector's importance to the health system is discussed in the PNDS 2001-2010 as well as the PNDS 2011-2020 (World Bank 2012a). The government has also worked to integrate private sector traditional practitioners into the health system through a policy on traditional medicine (World Health Organization 2010).

Private health facilities in Burkina are categorized as either for-profit or nonprofit. Ninety percent of private facilities are located in the two largest cities, Ouagadougou and Bobo-Dioulasso (World Health Organization 2010). The government of Burkina Faso defines five types of private health establishments: health facilities, rehabilitation facilities and medical device establishments, diagnostic centers, medical teaching facilities, and pharmaceutical facilities.

Categories of Private Health Facilities in Burkina Faso (World Bank 2012a)

An inter-ministerial decree defines five types of private health establishments:

1) Health facilities, including hospitals, clinics, medical and dental offices, and birthing centers
2) Rehabilitation facilities and medical device establishments
3) Diagnostic centers, including medical imaging firms and laboratories
4) Medical teaching facilities, including both modern and traditional medicine
5) Pharmaceutical facilities, including pharmacies, pharmaceutical distributors and wholesalers, and pharmaceutical warehouses

3.1.2.1 FOR-PROFIT

Burkina Faso's 361 registered private for-profit health sector establishments accounted for about 20 percent of the country's health facilities in 2013. According to a study conducted by the Ministry of Health in 2005, 13 percent of the people seeking health care go to the private health sector. While the private health sector is used by people from every population group, utilization by the richest quintile, at 18 percent, is twice as high as by the poorest quintile, at 9 percent (World Bank 2012a).

A World Bank Study in 2010–2011 found that 70 percent of the country's private for-profit facilities are at the primary level of care, 11 percent are at the secondary level, and 19 percent are specialized services such as laboratories, dentists, or diagnostics services (World Bank 2012a). Medical centers and nursing offices are the most common types of private facilities (Table 9), and most private facilities are for-profit (Table 10).

TABLE 9: PRIVATE FACILITIES BY TYPE OF STRUCTURE (2012)

Type of Structure	Total
Clinic	40
Polyclinic	9
Medical center	482
Hospital	0
Medical office	17
Dental office	5
Nurses office	179
Birthing clinic	14
CPSP	36
Other	3
Total	361

Source: Burkina Faso Ministry of Health 2013

TABLE 10: PRIVATE FACILITIES BY CATEGORY (2012)

Status	Total
For-profit	261
Association	37
FBO (Muslim, Catholic, Protestant)	54
NGO	9
Total	361

Source: Burkina Faso Ministry of Health 2013

In 2010, private health establishments employed approximately 1,800 workers, of whom eight percent were doctors (143), 37 percent were nurses (669), 12 percent were midwives and birth attendants (216), and the rest were unskilled staff members (Burkina Faso Ministry of Health 2011). In the same year, there were 144 private pharmacies in the country and 500 private drug warehouses (Burkina Faso Ministry of Health 2011). Twenty-seven pharmacies were created in 2012 alone, according to the Bulletin of the *Ordre National des Pharmaciens du Burkina Faso* (National Order of Pharmacists of Burkina Faso 2013). According to the *Carte Sanitaire*, only the cities of Ouagadougou and Bobo-Dioulasso have more than 20 pharmacies each (Government of Burkina Faso).

A 2012 study found a wide spectrum of pricing for services in the private health sector (World Bank 2012a):

- Medical consultation: CFA 4,200–6,000 ($8.94–$12.77)[3]
- Normal delivery: CFA 64,900, ranging from 36,000 to 83,750 ($76.60–$178.19)
- Caesarian: CFA 235,600, ranging from 210,000 to 261,000 ($446.81–$555.32)
- Chest x-ray: CFA 7,400, ranging from 6,300 to 8,500 ($13.40-$18.09)
- Day of hospitalization: ranging from CFA 10,000 to 18,000 ($21.28–$38.30)

3.1.2.2 NONPROFIT

According to legislation, the private nonprofit sector in Burkina Faso includes associations, faith-based organizations, and foundations that are allowed to provide health services under certain conditions and are governed by the same laws as those of public facilities (Consultant Group International 2005). Burkina Faso's very active nonprofit private sector, financed primarily by donors, is characterized by significant contracting with the government for HIV and (to a lesser extent) RH services. For example, the following organizations all contract with the government for HIV/AIDS services and prevention, working through community organizations in each geographic area: *l'Union des Religieux et Coutumiers du Burkina pour la Promotion de la Santé et du Développement* (URCB); AIDS Empowerment and Treatment International (AIDSETI); *Conseil Burkinabè des ONGs, OBCs et Associations de Lutte contre les IST / VIH / Sida* (BURCASO); *Initiative Privée et Communautaire de lutte contre le VIH/SIDA* (IPC); *Programme d'Appui au Monde Associatif et Communautaire de Lutte contre le VIH, TB et le Paludisme* (PAMAC); and PROMACO. For FP, other organizations are active. *L'Association Burkinabè pour le Bien Etre Familial* (ABBEF), the Burkinabé affiliate of IPPF, provides a comprehensive mix of RH services and supplies through its four branches and two clinics in collaboration with the government of Burkina Faso, local NGOs, and funding from the Danish International Development Agency (DANIDA), EU, UNICEF, and the United Nations Fund for Population Activities (UNFPA). MSI has three clinics, five mobile teams (currently adding six teams in the Resilence Zone), and seven midwives on mobile outreach; MSI launched a social franchise in 2010.

Donor nations and organizations working through local and international NGOs include: the Netherlands, Belgium, Norway, Japan, the European Union, France, Germany, Denmark, Taiwan, the African Development Bank, the Islamic Development Bank, UNICEF, UNFPA, and USAID (Table 13). UNFPA is the largest donor of RH/FP funding, supporting the government of Burkina Faso in its provision efforts. Several USAID-supported FP and HIV projects have recently ended including Action for West Africa Region (AWARE) II (TASC 3 IQC led by Management Sciences for Health) which built on AWARE I to provide technical support to public and private entities in West Africa. AWARE II included Burkina Faso in FP/RH, HIV/AIDS, and

[3] Exchange rate in 2012 was CFA 470 to $1.00.

maternal and child health (MCH). USAID also supported the RESPOND project (2010–2012), led by EngenderHealth, to improve family planning programs and increase access to FP methods (EngenderHealth 2014; Futures Group).

The World Bank Group is currently working with the ministry of health and private sector associations on a legal and regulatory review and on establishment of a federation of private health sector actors (International Finance Corporation 2011).

TABLE 11: MAJOR ACTORS IN HEALTH SECTOR IN BURKINA FASO

	NGOs, FBOs, and Civil Society	Development Partners
International	MSI, Engenderhealth, Pop Council FHI 360, John Snow Inc., Catholic Relief Services	Global Fund, UNFPA, WAHO, World Bank Group, WHO, UNAIDS, GIZ/KFW
Local	ABBEF, PAMAC, *Association Don Carlo pour les Orphelins* (ADCO), UCB, AIDSETI, *Association SOS/ Sida*, Association of Private Clinics of Burkina Faso (APROCLIB), BURCASO, IPC, *Recherche Action, Kasabati*, *Association African Solidarité* (AAS), Yeredon, *Association des Jeunes pour le Développement de la Région de Bittou* (AJDRB), *Responsabilité Espoir Vie Solidarité* (REVS+), Alternative Burkina, *Actions des Entreprises contre le VIH-Sida au Burkina* (AECV-B), *Coalition Nationale du Secteur Privé et des Entreprises contre le VIH-Sida et les IST* (CNSPE)	

Specific donor interventions related to HIV/AIDS include: Global Fund financing of HIV programs; MSM interventions supported by a consortium of Sidaction, *Fondation de France*, and *Solidarités Sida*; UNFPA funding for sex workers; and a program of GIP ESTHER[4] on key populations (PACTE VIH 2013).

There are several private sector organizations focused on corporate social responsibility and HIV in Burkina Faso, but none focusing specifically on family planning. HIV organizations include *Actions des entreprises contre le VIH-Sida au Burkina* (AECV-B) serving as an exchange platform for member companies including local companies and multinationals.[5] A national coalition, the *Coalition Nationale du Secteur Privé et des Entreprises contre le VIH-Sida et les IST* (CNSPE), brings together a wide range of actors including private sector HIV committees in large companies; SMES; the informal sector; unions; and associations of workers living with HIV and AIDS. Another HIV-specific private sector association, *Sida-ENTREPRISES*, includes mainly multinationals, such as Accor, CFAO, Imperial Tobacco, and Total.

Two organizations that are particularly active within the private health sector have become useful collaborators for USAID's FP and HIV activities.

[4] The Groupe d'intérêt public Ensemble pour une Solidarité Thérapeutique Hospitalière en Réseau (GIP Esther) is a French NGO focused on PLHA and active in 17 countries. See http://www.vih.org/reseau/gip-esther.

[5] Members include CFAO, SNTB, SDV, SOBUGAZ, MABUCIG, TOTAL Burkina, SGBB, Banque Internationale du Commerce, de l'Industrie et de l'Artisanat du Burkina (BICIA-B), SOFITEL OUAGA 2000, Mercure Silmandé, Gras Savoye, AGF Burkina, SONABEL, SITARAIL, Bank of Africa (BOA), SOGEA-SATOM, and CIP DENK PHARMA.

***L'Association Professionnelle des Cliniques et Polycliniques Privées du Burkina* (APROCLIB):** As one of the private sector leaders in Burkina Faso, APROCLIB has 60 members of which 10 provide HIV services. Apparently none provide FP products or services. In February 2013, APROCLIB hosted a forum on taxes and the private health sector with participation of the ministries of economy and finance which highlighted private provider discontent with the treatment of health structures for tax purposes including VAT exemptions and the rate of withholding tax on certain private health professionals.

***Fédération des Associations Professionnelles de la Santé Privée du Burkina* (FASPB)**: FASPB was created in 2013 with the technical assistance of the World Bank Group to unite the voices of the private health sector and to serve as a platform for advocacy and regulatory change. Its initial efforts are focused on bringing unauthorized facilities into compliance and on "putting order in our own house," as President (Dr.) Jean-Baptiste Ouedraogo explained at the launch event (Paré 2013).

3.1.2.3 DISTRIBUTION

Burkina Faso has no local pharmaceutical manufacturing apart from three companies that produce herbal medicines: Phytofla, Gamet, and Phytosallus (World Health Organization 2010). The importation of medicines is conducted by the *Centrale d'Achats des Médicaments Essentiels Génériques et des Consommables Médicaux* (CAMEG) as well as eight private wholesalers: *la Coopération Pharmaceutique et de Distribution* (COPHADIS); LABOREX/Burkina; *Distribution Pharmaceutique du Burkina Faso* (DPBF); Multi M; Pharmaplus; ISDA; COPHARMED; and Pharma International (Burkina Faso Ministry of Health 2011; World Health Organization 2010).

CAMEG, the nonprofit central procurement and distribution agency that supplies public health facilities, represents 48 percent of the total market value of sales. CAMEG, created in 1992 (Decree N°92-127/SAN-ASF), supplies generic drugs and sources mainly from Asia. It procures products other than contraceptives, manages a large central warehouse, and has seven "*agences commerciales*" in the country. In 2010, CAMEG supplied 63 district warehouses, three Centres Hospitalier Universitaires and nine Centres Hospitalier Régionals, in addition to private health structures and company clinics (Kagone et al. 2005). CAMEG circulates international requests for proposals based on a pre-qualified list of suppliers (Veervoort 2012).

The MOH logistics system is the largest in the country. There are three other major networks: MSI, the IPPF affiliate, ABBEF; and PROMACO which is affiliated with PSI. PROMACO and ABBEF receive some products from the MOH logistics system but also import directly. Most donors of ARVs provide these products to the country through CAMEG.

3.1.3 ENABLING ENVIRONMENT

Burkina Faso's regulation of the private health sector began in 1990 with authorization of private health facilities, and it continued with specification of conditions for private providers in 2000 and pharmacists in 2003 (Table 12). The current *Plan National de Développement Sanitaire* (PNDS) for Burkina Faso 2011-2020 acknowledges the role of the private sector and includes specific interventions aimed at increasing its contribution for each of the plan's key strategies.

TABLE 12: IMPORTANT HEALTH LAWS, DECREES, AND STRATEGIES IN BURKINA FASO

No.	Date	Law/ Decree/ Directive
N/A	2011	Plan National de Développement Sanitaire 2011-2020
N/A	2005	Guaranteeing the universal right and access to free reproductive health services, including FP services and contraception
20003-148	2003	National Pharmaceutical Legislation allowing private products in the market and legalizing private pharmaceutical practice
2001/284	2002	Establishment of a permanent technical committee between the public and private health sectors
2000-457	2000	Conditions of private for-profit health sector profession
Kiti AN-VIII-066	1990	Conditions for authorization of establishment of a private for-profit health facilities, defines the private health sector including for-profit and nonprofit entities

In addition to the above legislation, other laws impacting the private health sector include the investment code, import-related legislation, and laws relating to unfair competition (Consultant Group International 2005).

The government of Burkina Faso has pledged support for family planning, most recently through its Repositioning Family Planning Strategy, as part of the Ouagadougou Partnership (see below). In 2012, at the Family Planning Summit in London, the first lady of Burkina Faso announced the government's support of family planning through a dedicated budget line item, the authorization of new products such as Depo-provera Uniject, and partnerships with the private sector (Government of Burkina Faso 2013). This builds on a reproductive health law from 2005 that states, "The right to reproductive health is a fundamental right guaranteed to each human being during her or his entire life, in all situations and in all places" and that "couples and individuals decide freely and responsibly the number of children they have as well as the spacing of their birth" (Amnesty International 2009). For condoms, there are few if any applicable policies, regulations, or controls that would impact its management. For other contraceptives, the policies, regulations, and controls that affect all medications would logically apply to them as well. The two main laws applicable to all medications are the Public Health Code (1994) and Regulations on Advertisement in Burkina Faso (2002) which includes a ban on advertising branded health products.

Burkina Faso has recently completed its Repositioning of Family Planning Strategy as a component of the Ouagadougou Partnership's resolve to increase the extremely low rate of contraceptive use in Francophone Africa. The Strategy highlighted the following major challenges that influence use of family planning in the country: the need for demand creation; low product availability and access to family planning services; and the need for monitoring and evaluation activities. The Strategy's goal is to address these challenges and increase contraceptive prevalence to 25 percent for married women by 2015 — an increase of 5 percent from the 2010 figure — primarily working through community-based distribution, advocacy to

religious and community leaders, and mass media campaigns (Government of Burkina Faso 2013).

3.1.3.1 GAPS

Several policy gaps remain, including enabling legislation and protocols governing the private health sector, developing a more rigorous approach for the registration of medications, and preventing drugs from less-regulated ECOWAS countries from flooding the market. While the ease of doing business in Burkina Faso has improved, it remains difficult and time-consuming to open a health business in the country.

3.1.3.2 PUBLIC-PRIVATE DIALOGUE

Burkina Faso has been working on improving public-private dialogue (PPD) for over 10 years, and the country has established several public-private dialogue platforms. It is arguably the front runner in the region in the PPD domain. Since 2006, the Ministry of Health has conducted an annual review of the health sector at a national meeting held to validate the findings of a technical committee which is composed of public sector representatives, the donor community, implementing partners, and other key stakeholders. It is unclear whether the private health sector is included (Burkina Faso Ministry of Health 2014). There is also a *Commission technique permanente de concertation* attached to the secretary general's office (World Bank 2012a). Other specialized dialogue platforms include: a Contraceptive Security Committee; a Committee for the Relaunch of Family Planning (which has now become the *Comité de Suivi du Plan*); a donor group called SR-VIH Comité which meets monthly; and an NGO platform that unites around 20 FP and HIV NGOs and meets bi-monthly. The *Direction Générale des Etablissements Sanitaires et la Reglementation* has a committee on public-private cooperation created by ministerial decree that meets three times per year. A key focus is the fight against illegal private sector facilities.

In principle, the Contraceptive Security Committee meets bi-annually and is supported by UNFPA. However, it does not appear to be a strong platform for multisectoral discourse. The *Comité de Suivi du Plan* does not include private for-profit participation, although that subsector did have some input into the strategic plan. Similarly, the other committees mentioned above lack multisectoral participation. Dialogue between the public and private sectors focuses almost exclusively on the public and nonprofit private sectors.

To date, Burkina Faso has no private health sector strategy, no health PPP policy, no health PPP department, and very few PPPs apart from the significant contracting out that occurs between the public and the nonprofit private sector. There is a health PPP focal point, however, and efforts are underway to determine how the private health sector might cover surgery referrals when public sector hospitals are unable to provide care.

3.1.4 TRENDS IN HEALTH FINANCE

In 2009, households financed 37 percent of total health expenditures in Burkina Faso, while the government funded 35 percent and donors and NGOs financed 26 percent. Companies and parastatals financed 2 percent over the same time period. The public sector's share of national health expenditures increased from 31 percent in 2008 to 35 percent in 2009 (World Bank 2012).

There is currently no national health insurance in Burkina Faso. Approximately 4 percent of the population has private health insurance covered through employers (World Bank 2012a). Three years ago, the government began work on establishing mandatory health insurance for salaried workers and voluntary health insurance for non-salaried workers in both the formal and informal sectors. In discussions with key stakeholders, concern was expressed over the MOH's wish to nationalize health insurance and to close down the private health insurance companies. This would result in a loss of jobs and most likely a smaller basket of services covered than would be offered through the private sector.

Currently, private health insurance consists of "mutuelles" and company-based health insurance. Mutuelles are community organizations that pool risk for health-related expenses. The mutuelle movement began in Burkina in the 1960s and exploded in 1992 after the Bamako Initiative. In 2010, there were 180 mutuelles (*Burkina Faso Ministère de la Fonction Publique, du Travail et de la Sécurité Sociale* 2012). These mutuelles have been supported by WHO, Dutch Aid, French AID, and UNICEF.

Private companies offer health insurance to workers to complement coverage provided by social security. Such insurance is managed either by the company itself or through one of six private health insurance companies: *Société Nationale d'Assurance et de Réassurance*, *Alliance Générale des Professionnels*, *Union des assurances du Burkina Faso*, *Générale des assurances*, or *Colina assurance* and *Raynal assurance*. (*Burkina Faso Ministère de la Fonction Publique, du Travail et de la Sécurité Sociale* 2012.)

3.1.5 DELIVERY OF FP AND HIV SERVICES THROUGH PUBLIC AND PRIVATE CHANNELS

There is a heavy reliance on the government of Burkina Faso for supply of FP commodities and services. The government has been working on strengthening RH commodity security and has developed a contraceptive/RH security strategy (2006–2015). The goals of this strategy are "to transition away from donor-funded contraception procurement; to ensure continuous financing for FP products; to improve the quality of family planning services for clients; to improve contraceptive logistics management; to develop effective actions to promote modern contraceptive use; and to guarantee coordination" (Reproductive Health Supplies Coalition (a); Deliver 2010). The government has increased its RH/FP budget line from $1,167,251 in 2006 to $4,497,407 in 2010, including both commodities and capacity development (UNFPA 2011). The Department of Family Health leads this process with financial assistance from UNFPA and in collaboration with IPPF, PROMACO (PSI's local social marketing organization), MSI, CAMEG, and USAID. Challenges remain in terms of low demand for contraceptives and their relatively high cost (Reproductive Health Supplies Coalition (b).

As mentioned, the Ministry of Health has an extensive contracting-out program with local and international NGOs for the provision of HIV and FP services. These arrangements are widely seen as successful and necessary to increase access. For example, BURCASO receives funding from the MOH and in turn contracts with 52 community-based organizations for provision of HIV services. URCB has a similar arrangement. The Ministry of Health also has

contracts with 10 of the 60 members of the Association of Private Clinics of Burkina Faso (APROCLIB) to provide services for people living with HIV (PLHIV) including screening tests, ARV treatment, and transmission of data by quarter. While required to provide HIV products free of charge, private providers are allowed to charge a small fee for service provision.

However, for family planning, the Direction of Family Health indicated that in order to receive free family planning products, private for-profit entities must agree to provide free FP products *and* services. Under this requirement, few private for-profit providers in fact offer FP products and services to their patients. MSI and ABBEF provide injectables, IUDs, condoms, pills, and implants through their clinics. Unlike public sector facilities which usually charge separately for gloves, injections, and other add-ons, the MSI and ABBEF clinics provide the service, product, associated equipment all for one subsidized price.

3.1.5.1 FAMILY PLANNING

The public sector offers condoms, oral contraceptives, IUDS, injectables, and implants at public sector facilities. MSI and ABBEF also offer these products at their private clinics. Wholesalers/importers supply both generic and specialty drugs. According to the World Bank Group's Private Health Sector Assessment, the retail prices of medicines are set identically in the for-profit and nonprofit segments by adding to the purchase price an ad valorem margin. However, the prices charged by for-profits are three times higher than nonprofits. (World Bank 2012a.) Independent importers tend to import globally based on market opportunities, but their profit margin is small (World Bank 2012a).

Alongside the formal drug market is a thriving illicit drug market in which Asian and Nigerian products dominate. These products impact private providers in particular due to price competition. There are also safety issues related to the quality of these products (Kagone et al. 2005).

Among the private sector, there is widespread resentment about CAMEG's preferential treatment. CAMEG has an inherent advantage over other wholesalers because all public establishments buy from CAMEG. Also, private wholesalers pay taxes while CAMEG is exempted (Kagone et al. 2005). In February 2013, APROCLIB, in collaboration with the World Bank Group, organized a meeting on taxes in the private health sector. Results of the meeting included the recognition (1) that the private health sector faces the same import requirements as importers of non-medical products which tends to limit its growth and (2) that no policy vehicle allows payment for referrals from the public to the private sector.

Key players in reproductive health commodity security are: the Department of Family Health (DSF), which has overall stewardship and leads all processes; UNFPA, currently the principal donor; IPPF; PROMACO; MSI; and CAMEG. USAID has also been active, especially in the Reproductive Health Supplies Coalition, an international voluntary partnership of 200 organizations focused on choice, access, and use of affordable high-quality reproductive health supplies in low- and middle-income countries (Reproductive Health Supplies Coalition (a)).

3.1.5.2 HIV AND AIDS

As a low prevalence country for HIV, Burkina Faso does not receive significant Global Fund money for HIV programs, and the funds received are concentrated mainly in testing and counseling. Testing in Burkina Faso is voluntary and confidential and is mostly carried out by community-based organizations. The National Strategic Framework for HIV/AIDS for 2006–2010 includes the provision of ARVs and the treatment of opportunistic infections. Treatment is provided with support from the World Bank Multi-Country HIV/AIDS Program for Africa and Treatment Acceleration Project, the French project ESTHER (*Ensemble pour une Solidarité*

Thérapeutique Hospitalière En Réseau), the Italian Cooperation, the French Cooperation, the Global Fund, the Red Cross/Red Crescent, and *Médecins Sans Frontières* (World Health Organization 2005). In 2011, 293 individuals were on ART in seven private clinics that participated in treatment (Global AIDS Response Progress Reporting 2012). Treatment non-adherence rates are lower in private facilities at 4.8, 5.2, and 5.4 percent (in FBOs, for-profit, and for-profit facilities respectively), compared to 11.6 percent in public centers (Global AIDS Response Progress Reporting 2012).

The private sector, particularly nonprofit entities, plays a significant role in HIV counselling and testing, providing 71 percent of all HIV testing in 2011 (62 percent nonprofit and 9 percent for-profit) (Global AIDS Response Progress Reporting 2012).

Procurement of ARVs and supply chain management in Burkina Faso is handled by CAMEG. The William J. Clinton Foundation is supporting negotiation of lower prices for ARVs. WHO supports the development of national guidelines, training activities, and support for testing and counseling. International partners that support the delivery of ARVs include the World Bank, the Red Cross, *Médecins Sans Frontières*, and ESTHER. USAID, the Dutch Cooperation, and the Belgian Cooperation support prevention programs.

At the *Secrétariat Permanent du Conseil National de Lutte Contre le SIDA* (SP/CNLS), a permanent committee is being created for high-risk populations. This committee and its six subcommittees (including one on MSM and one on sex workers), will provide recommendations to improve interventions with key groups.

3.1.6 PUBLIC-PRIVATE PARTNERSHIPS

While dialogue between the public and private sectors in Burkina Faso has received donor support over the past 10 years, there is still much work to do. In May 2013, the National Assembly adopted legislation governing PPPs focused on larger infrastructure projects (*Agence de Presse Labor* 2013). According to stakeholder interviews, in early 2014 the government of Burkina Faso, in collaboration with the IFC, began exploring a PPP for management of the newly built Blaise Compaoré Hospital in Ouagadougou.

Public-private partnerships in health through contracting relationships with NGOs are well developed, particularly for HIV services. Other types of public-private partnership are poorly developed. The MOH has identified the following areas for health PPPs: care, equipment, human resources, and maintenance (Sanou). In February 2014, the Health in Africa Initiative of the World Bank Group affirmed its interest in working with the government of Burkina Faso on PPPs (Bayiri.com 2014). Table 13 shows a sample of current PPPs in the country.

TABLE 13: PUBLIC-PRIVATE PARTNERSHIPS IN HEALTH IN BURKINA FASO

Private entity	Public entity	Description
Burkaso, UPC, PAMAC, IPC, etc.	MOH	NGOs contract with the public sector for provision of HIV services
TOTAL	MOH	TOTAL Foundation provides ARTs and Behavior Change Communication for truck drivers
Major commercial businesses	MOH	Anecdotally, major private companies in Burkina Faso generally have workplace health programs that have PPPs with the MOH
AROCLIB	MOH	Contracting arrangement of 10 member clinics to provide HIV case management (screening tests, ARV treatment, transmission of data by quarter)
PROMACO	MOH	Social marketing for HIV and FP

3.2 CAMEROON

3.2.1 BACKGROUND

Cameroon is a Central African lower-middle income country with a population estimated at 21.7 million (as of 2012) and a per capita gross national income of $1,170 (World Bank 2012c). According to the World Bank's Doing Business report, Cameroon ranks 168 out of 189 countries, after slipping six places since the 2013 report (International Finance Corporation 2014b). In the UNDP's 2013 Human Development Report (HDR), Cameroon ranks 150th out of 187 nations and is in the bottom 15 for the Gender Inequality Index—an index which takes into account reproductive health by measuring maternal mortality and adolescent fertility rates. Maternal mortality rate has worsened over the years, increasing from 669 per 100,000 live births in 2004 to 782 in 2011 (Egal 2013). This rate is significantly above the sub-Saharan Africa average of 475 per 100,000 live births as reported by the HDR report, despite multiple government policies and international commitments that make family planning one of the nation's strategic priorities. According to the Population Reference Bureau, total fertility rate in Cameroon was 5.1 in 2013. The private non-profit health sector provides a significant share of FP services, mostly with funding from donors.

Donors also fund most of the HIV/AIDS programs in Cameroon. An estimated 600,000 individuals, of whom 50 percent are female, are HIV-positive; the HIV prevalence rate among the general population was 4.5 percent in 2012 (UNAIDS 2012). The HIV prevalence rate is much higher among sex workers and MSM, at 36.7 and 37.2 percent respectively (CNLS 2012). Cameroon faces a significant gap in ART coverage: the 105,563 individuals on ART in 2011 (increased from 89,455 in 2010) represented only 49 percent of eligible HIV-positive patients, despite the national free ARV policy (UNAIDS 2012).

The government of Cameroon has shown increased commitment to HIV/AIDS response and has increased financial support for AIDS programs. The private nonprofit sector is a recognized partner in the national AIDS response, participating in policy document development, resource mobilization, and the HIV/AIDS continuum of care.

3.2.2 OVERVIEW OF THE PRIVATE HEALTH SECTOR

The Cameroonian health sector is divided into three sub-sectors:

- The public sub-sector, including all health facilities attached to the Ministry of Health and other ministerial departments
- The private sub-sector, comprised of nonprofit (faith- and community-based) facilities and for-profit facilities
- The traditional medicine sub-sector, for which significant efforts are currently underway to integrate into the health system

In 2012, there were 681,948 patient visits to private for-profit health facilities and over 1.7 million patient visits to private faith-based facilities (UNAIDS 2012). These figures indicate that in 2012, 49 percent of all hospital admissions in Cameroon were for private facilities. The most-attended private health facilities are faith-based (Table 14). The Littoral and Center regions registered the highest private health facility admissions.

TABLE 14: CAMEROON HOSPITAL ATTENDANCE (2012)

Region	Public health facilities (district hospitals, CMAs[6], & health centers)	Faith-based health facilities (hospitals & health centers)	Private for-profit health facilities (hospitals, clinics & health centers)
Adamawa	179,213	66,217	0
East	159,570	122,382	13,541
North West	262,997	331,602	25,101
South	75,426	23,497	22,522
South West	194,648	207,549	136,702
Center	345,463	388,373	203,832
Far North	612,028	55,628	41,552
North	452,443	56,607	27,277
Littoral	284,865	503,254	211,421
TOTAL	2,566,653	1,755,109	681,948
COMBINED TOTAL	**5,003,710**		

Source: Ministry of Health data obtained through stakeholder interviews

Of the 4,351 health facilities identified in Cameroon in 2011 through a Ministry of Health census, 2,428 (44 percent) were in the private sector. The same census found that 30 percent of the 22,194 health personnel active in Cameroon in 2011 practiced in the private sector. Table 15 shows the public-private breakdown by health worker category.

TABLE 15: PUBLIC-PRIVATE HEALTH WORKER DISTRIBUTION

Qualification	Public	Private
Doctors, generalists	1,132	288
Doctors, specialists	339	83
Dentists	39	19
Nurses	13,084	5,870
Pharmacists	55	107
Pharmacy technicians	900	278
TOTAL	15,549	6,645

Source: Ministry of Health data obtained through stakeholder interviews

[6] CMA: *Centre Médical d'Arrondissement*

As reported in 2014 by the National Public Radio and Inter Press Service, Cameroon has a large illegal private health sector that serves the needs of a significant number of Cameroonians who cannot afford the overcrowded public sector (Nfor 2014; NPR 2014). According to these sources, the cost of unauthorized private care is substantially lower than in the public sector. Given the illegal nature of these private clinics, it is impossible to determine what proportion of Cameroonians they serve.

3.2.2.1 FOR-PROFIT

In 2011, 28 percent of all hospital attendance in the private sector took place in the for-profit sector. The majority of health facilities (57 percent) are for-profit entities, as are 35 percent of private health workers (Cameroon Department of Human Resources 2011).

The private health sector is also a provider of HIV/AIDS services. In 2012, 6 percent and 14 percent of all ARV sites were in the faith-based and for-profit sectors respectively.

A large number of for-profit health facilities operate illegally, including private medical training institutions, clinics, and unlicensed drug sellers. In January 2014, the Cameroonian government took steps to close over 524 medical training institutions and 600 private clinics that operated without accreditation or authorization (Nfor 2014). An unknown number of illegal drug sellers operate on the streets and in various markets. According to one health worker in Yaoundé, 60 percent of all the patients they see in the clinic have taken illegally sold drugs (Nfor 2013).

3.2.2.2 NONPROFIT

The majority (72 percent) of hospital attendance in the private sector was recorded in the nonprofit sector, where 43 percent of all private health facilities are found (Cameroon Department of Human Resources 2011). The nonprofit sector accounts for about 65 percent of all private sector health workers. Most of these health workers (almost 56 percent) practice in the faith-based facilities.

The private health sector, particularly the nonprofit sector, plays a key role in the provision of FP services. In part, the role of the private sector stems from the fact that the government entity in charge of ensuring the availability, supply, and accessibility of contraceptive products, National Essential Drugs Supply Center (CENAME), is rarely involved in contraceptives management. A number of HIV/AIDS services are also provided in the nonprofit sector. In 2012, 6.2 percent of all ARV sites were in the faith-based sectors. The key nonprofit organizations and their development partners are shown in Table 16.

TABLE 16: KEY HEALTH STAKEHOLDERS IN CAMEROON

	NGO, FBO, Civil Society	Development Partners
International	PSI, CRS, CHAI/CLINTON	USAID West Africa, UNFPA, UNAIDS, GIZ
Local	*Association Camerounaise pour le Marketing Social* (ACMS), Cameroon National Association for Family Welfare (CAMNAFAW), Ad Lucem Foundation, *Centre Médical la Cathedrale*, MTN Foundation, Alternatives Cameroon	

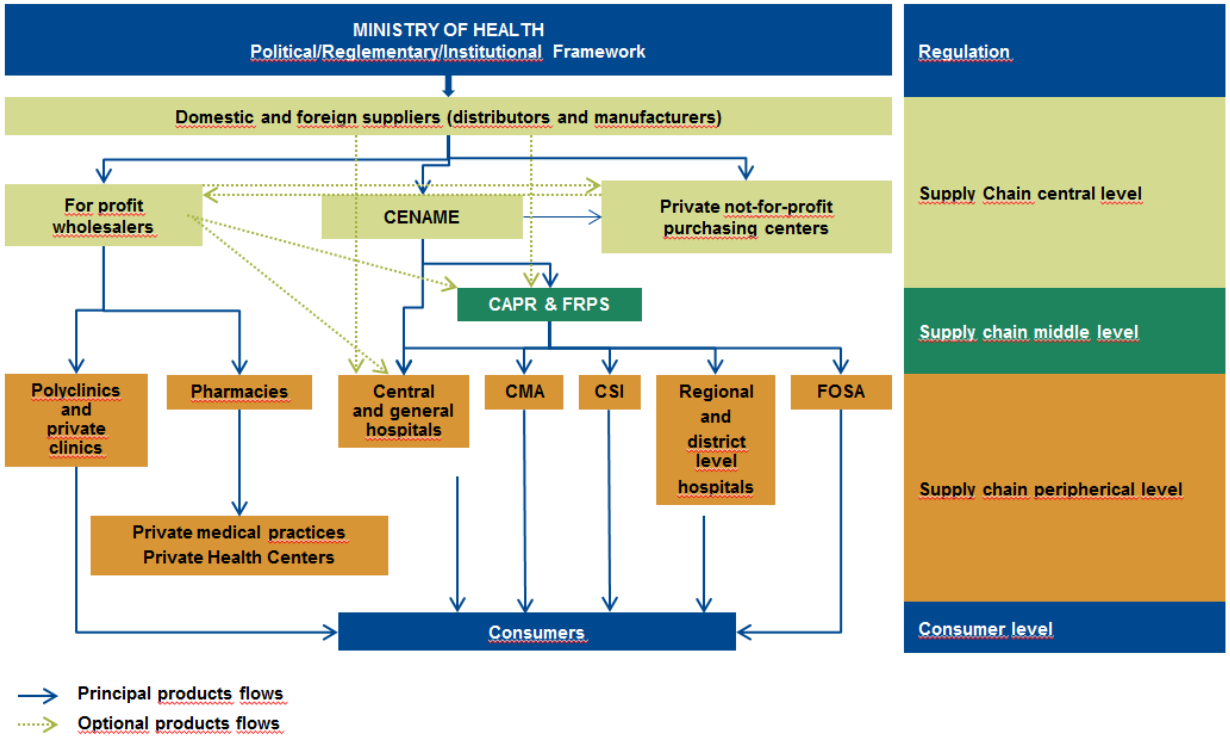
A number of civil society organizations are active in Cameroon advocating for improvements in the health sector.

- **Cameroon Medical Council (CMC),** created in 1958, oversees and advocates for the medical profession throughout Cameroon. For private doctors, the CMC helps members with required processes and permissions related to opening and maintaining a health facility and helps doctors manage conflicts and risks in the provision of health care.
- **National Pharmaceutical Society**, founded in 1980, oversees and advocates for the pharmaceutical profession in Cameroon and assists private pharmacists in navigating different administrative procedures.
- **The Cameroon Business Coalition against HIV/AIDS, TB and Malaria (CCA≠SIDA)** was launched in March 2006 to elevate the private business response to the HIV/AIDS epidemic from a company-level to a national platform. Some of CCA≠SIDA's goals include the dissemination of HIV-related news among businesses, improving workplace provision of HIV/AIDS care, and mobilizing financing for AIDS programs.
- **The Employers' Group of Cameroon** (GICAM, *Groupement inter patronal du Cameroun*), is involved in public-private partnerships with the MOH and has been the driving force behind CCA≠SIDA.
- **Cameroonian network of PLHIV (RECAP+),** created in 2000, is a network of 46 nonprofit PLHIV organizations that operates in 10 provinces of Cameroon. Its main objective is to improve the welfare of PLHIV, working at the center of the response to HIV in Cameroon. The association has led campaigns on continuum of care and adoption of laws on rights and responsibilities of PLHIV. It is involved in training of PLHIV on HIV-related topics and AIDS care and conducts income generating activities that sustain its mission.
- **Cameroon Business Forum (CBF)** advocates for dialogue between the public and private sectors. It falls under the authority of the prime minister and is supported by the private sector and technical and financial partners. From January 2009 to December 2011, the IFC operated the CBF's technical secretariat. The Forum holds a full meeting once a year, but technical and monitoring committees meet several times a year.

3.2.2.3 DISTRIBUTION

Cameroon has a national system of essential drug procurement (*Système National d'Approvisionnement en Médicaments Essentiels*, or SYNAME) which includes all the facilities, procedures, and distributions channels that have been put in place to provide essential drugs in Cameroon (Figure 5). The system includes both public and private entities at all levels with the exception of the regulatory function which is overseen by the public sector. Public and private sector entities are active in both the procurement and distribution of FP and HIV/AIDS products. The for-profit pharmaceutical sector is comprised of 8 manufacturers, 23 wholesalers, and 388 pharmacies (Ministry of Public Health 2013). The official pharmaceutical market was estimated at CFA 110 billion ($234 million). Of that amount, 68 percent is generated in the private for-profit sector compared to 14 percent in the private nonprofit sector and 18 percent in the public sector (Ministry of Public Health 2013).

FIGURE 5: PHARMACEUTICAL SUPPLY CHAIN (CAMEROON)



CAPR: Centre d'Approvisionnement Pharmaceutique Régional; FRPS: Fond Régional pour la Promotion de la Santé; CMA: Centre Médical d'Arrondissement; CSI: Centre de Santé Intégré; FOSA: Formation Sanitaire

Source: Egal and Kapahou 2013.

As of 2013, Cameroon has 379 accredited pharmacies which translates to one accredited pharmacy per 57,000 Cameroonians. The ratio is better in urban areas but worse in regions such as Etranger (where there was not a single private pharmacy in 2011) or the East and South with just two private pharmacies each (Cameroon Department of Human Resources 2011). There are no lower structures in the supply chain that are licensed to sell health products.

3.2.2.3.1 DRUG SELLERS

Alongside the authorized medical channels there is a thriving black market of unlicensed and unauthorized drug sellers, called "*pharmacies du gazon*," "*pharmacies en plein air*," or "*vendeurs ambulantes de medicaments*." A 1999 study by the Department of Statistics and National Treasury at the Ministry of Economy and Finance (the only study available on this topic) found that 45 percent of these unauthorized pharmaceuticals originated in Nigeria, 15 percent from large pharmaceutical companies, 11 percent as free samples, and 29 percent from non-identified sources (Cameroon-Info.Net 2008).

According to several individuals interviewed, this illegal supply chain is known to public officials; it prospers due to a long porous border with Nigeria and proximity to other conflict zones. Article 16 of Law N°90/035 (August 10, 1990) specifies sanctions for unlicensed drug sales including a fine of CFA 500,000–2,000,000 ($1,064-$4,255) and/or imprisonment of six days to six months. Sweeps of illegal pharmaceuticals occur sporadically: in 2008 two tons of illegal pharmaceutical products were destroyed, and in 2011-2012 Operation COBRA destroyed, by some accounts,

5,000 tons (Investir au Cameroun 2012). However, the assessment team found no current or ongoing government operation to close down drug sellers. A Ministry of Health subcommittee of the National Pharmacy Committee, called the *Sous Commission sur la Vente Illicite de médicaments*, has been established to review this issue, but it is not currently operational.

Unlicensed drug sellers are suppliers of FP products, including contraceptives, injectables, and condoms. ART products are less well-represented, although there are reports of ARTs for sale by drug sellers starting at CFA 2,500 ($5.32) (Cameroon-Info.Net 2012). There appears to be no reliable information on the size of the illegal drug market or its geographic distribution, client motivations, products offered, or supply chain. All informants interviewed in Cameroon from both the public and private sectors reported that an in-depth study of drug sellers is sorely needed.

Two key stakeholders interviewed for this study felt that "*Pharmacies Communautaires*" which are overseen by villages and stocked by health centers and NGOs could be a useful avenue to increase access to FP products (but not ART). Another option mentioned was changing the law to allow pharmacists to dispense in locations where they are not physically onsite.

3.2.3 ENABLING ENVIRONMENT

The legal environment in Cameroon is favorable to the growth of the private health sector, and most legal documents recognize both public and private providers. The assessment team did, however, learn through key informant interviews that HIV/AIDS nonprofit organizations providing services to MSM face challenges. Cameroon civil society which participated in the development of the 2011–2015 National Strategic Plan continues to stimulate debate around the MSM issue.

For FP services, the Family Health Directorate (DSF in the Ministry of Health), and particularly the Reproductive Health Sub-Directorate, is responsible for the elaboration, implementation, and oversight of all reproductive health policies across the public and private health sectors. The DSF collaborates with pharmaceutical regulatory bodies. These regulatory bodies allow nonprofit private sector entities to access contraceptive stocks from CENAME, the national supplier of drugs and essential health products. While for-profit pharmaceutical retailers also obtain supplies from CENAME for a pre-established list of drugs, contraceptives are not on the list. Key laws, regulations, and decrees that affect the private health sector are summarized in Table 17.

TABLE 17: KEY HEALTH LAWS, REGULATIONS, AND DECREES IN CAMEROON

No.	Date	Law/decree/directive
N/A	2010	2011-2015 National Strategic Plan for the Fight against AIDS: the plan was developed working with the private sector as a key partner. Identifying and operationalizing PPPs are specified in one of the pillars but not currently operationalized.
2006/012	2006	General law on PPP contracts, not specific to health.
0334/MSP/CAB	2002	Decision reorganizing the national malaria response; it applies to both the public and private sector.
366/D/MSP/CAB	2002	Decision creating a mixed national AIDS, TB, and malaria response coordinating committee.
92-265	1992	Revises a 1990 law regulating the medical doctor profession. Private practice is allowed under the approval of the *Ordre des Médecins*. Foreign doctors can only practice in private facilities if their country of origin has a convention with Cameroon.
90-035	1990	Law regulating pharmacist profession: it allows private practice by Cameroonians but generally prohibits foreign private pharmacists.
84-009	1984	Law governing the nurse, midwife, and medical technician professions: it fixes conditions for private practice and prohibits dual-practice.

3.2.4 TRENDS IN HEALTH FINANCE

Cameroon allocates 5 percent of its national budget to health, a figure far below the 15 percent Abuja target (Egal 2013). Private resources account for 70.37 percent of total health expenditures (THE) (Table 18). Of these private resources, 94.48 percent come from out of pocket spending, a figure higher than for other West African countries with comparable per capita health expenditures. Only an estimated 3–5 percent of Cameroonians have health insurance coverage, and health insurance plans do not cover family planning products.

TABLE 18: HEALTH EXPENDITURES AND SOURCES (2011)

Health Expenditure Indicator	Amount/Percent
Total health expenditure (THE) per capita	$68.00
Private health expenditure as percent of THE	70.37%
Out-of-pocket expenditures as percent of private health expenditures	94.48%
External (foreign) resources as percent of THE	13.18%
Total public health expenditures as percent of THE	16.45%

Source: World Bank 2012

International donors and organizations finance most FP and HIV/AIDS activities; these include PEPFAR, Global Fund, GIZ, UNFPA, UNAIDS, USAID, and IPFF. The government's verbal commitment to family planning is evident in policy discussions and reports, but financial commitment has not followed. In 2013, the government of Cameroon earmarked CFA 100 million ($212,766) to the procurement of family planning products and reserved CFA 65 million ($138,298) for contraceptives. However, these funds had to be reallocated to other priorities during the year, leaving the financing of family planning products to donor and private funding, as has been the case since 2010. Table 19 shows the sources of financing for family planning stakeholders.

TABLE 19: FINANCING SOURCES FOR FAMILY PLANNING STAKEHOLDERS

Financing source	FP Agent
Private/Own funds	*Association Camerounaise pour le Marketing Social* (ACMS), Cameroon National Association for Family Welfare (CAMNAFAW), Cameroon Baptist Convention Health Services (CBCHS), Diagnostic Distribution, GIZ, LABOREX, UBIPHARM, MOH, UNFPA
Own funds and Heavily Indebted Poor Countries (HIPC) funds	*Comité National de Lutte contre le Sida du Cameroun* (CNLS)
KfW	Organization for the Coordination of the Fight Against Endemic Diseases in Central Africa (OCEAC)

Source: Egal and Kapahou 2013

UNFPA has declared Cameroon one of its priority countries for FP which in principle guarantees UNFPA funding for FP until 2020. This funding should cover the national FP funding gap.

For HIV and AIDS, there are partnerships such as the convention between the Confederation of Private Insurers and UNAIDS to finance HIV/AIDS services that leverage local resources for health financing. The government of Cameroon has also entered into a partnership with the Employers' Group of Cameroon (GICAM) to establish a private fund for ARV procurement. As shown in Table 20, donors provide the majority of the funding for the Cameroonian AIDS response, followed by public and then private funds.

TABLE 20: FUNDING FOR HIV/AIDS BY SOURCE (2011)

Source	Amount (CFA in millions)	Percent
Public funds	6,838	22
Private funds	4,215	14
International/donor funds	19,435	64
TOTAL	30,488	100

Source: National AIDS Control Committee Central Technical Group (2012)

3.2.5 DELIVERY OF FP AND HIV SERVICES THROUGH PUBLIC AND PRIVATE CHANNELS

Both FP and HIV/AIDS services are available in private facilities in Cameroon. While the private sector performs slightly better than the public sector in terms of health worker FP knowledge, the general coverage of FP services remains very low throughout the country (Ndeboc 2011). The 2011 Report on the Evaluation of Family Planning Services in Cameroon concluded that only 10 percent of health facilities (public and private combined) had technically competent staff to provide a full range of FP services; 23 percent of all facilities in Cameroon had no competent personnel to provide any modern family planning methods or had information about them.

The Cameroonian Strategic Plan for the Fight Against AIDS recognizes that more efforts are needed in the public and private sectors to cover unmet need for products and services, particularly in peri-urban and rural areas. According to the strategic plan, 61 percent of condom needs are unmet, and 51 percent of PLHIV eligible for ART are not on treatment, despite contracting-out efforts to increase the availability of products and services through the private health nonprofit and for-profit sectors (National AIDS Control Committee Central Technical Group 2010).

3.2.5.1 FAMILY PLANNING

In Cameroon, access to health, including services for reproductive health, is a right recognized for each citizen. Since 1980, multiple strategic documents and national commissions and health plans established are a testimony to a national commitment to reproductive health. Despite these government efforts, family planning challenges persist. The maternal mortality rate remained high at 782 deaths/100,000 live births in 2011, actually increasing from 2004. The total fertility rate is 5.1 children per woman while the contraceptive prevalence rate is just 24 percent (16 percent for modern methods and 8 percent for traditional methods) (Ndeboc 2011). One in four married women no longer wants to have children while one-third of married women would like to space births by a minimum of two years. In total, 62 percent of married women are potential candidates for family planning services. In the face of this unmet need, there is a funding gap from both government and donors and a lack of qualified human resources for FP services. There is also a geographic imbalance in provision of FP services and products. Additionally, there are cultural and religious barriers to accessing family planning services. Unlike other countries in this report, Cameroon is not part of the Ouagadougou partnership and thus does not have a focus on relaunching family planning and committing to a specific increase in the contraceptive prevalence rate.

While all FP methods are available in Cameroon, there is a preference for long-acting and permanent methods such as IUDs according to maternal health program managers and social marketing personnel. According to the latest DHS, 20 percent of modern contraceptive users go to public facilities, 27 percent go to the private medical sector, and 50 percent use private non-medical sources, such as shops, markets, parents, or friends (MEASURE DHS).

The private sector is actively engaged in the provision of FP and reproductive health services, particularly through the Profam social franchise — a network of *the Association Camerounaise pour le Marketing Social* (ACMS) and a PSI affiliate, with over 100 private and faith-based clinics. Clinics are admitted to Profam after verification that they provide quality services, employ qualified personnel, and undergo regular control and supervision. The Profam network conducts regular social mobilization campaigns toward targeted populations using social marketing techniques.

In addition to Profam, the Cameroon National Association for Family Welfare (CAMNAFAW), an IPPF affiliate, also provides FP/RH services in its network of private clinics and conducts social mobilization campaigns. The IPPF typically supplies CAMNAFAW with FP products, and UNFPA has provided supplies during stock-outs.

Some clients procure their FP products from private pharmacies where prices are typically higher. For-profit clinics do not offer FP services.

A 2011 Report on the Evaluation of Family Planning Services in Cameroon concluded, "Looking at the average availability of trained personnel per category of health unit and per FP method...the private and faith-based health units evaluated had better coverage than the public health units" (Table 21). The Clinton Health Access Initiative (CHAI) with support from PEPFAR, GIZ, UNFPA, and the government of Cameroon has created a database of human resources for provision of FP services. The goal is to determine the training needs to fill the current gap in FP services provision. CHAI works closely with ACMS and CAMNAFAW.

TABLE 21: DISTRIBUTION OF PERSONNEL TRAINED ON FP METHODS IN CAMEROON

Type of training	Total Number and Average Trained Personnel Found in FP Clinics, by Category							
	Public		Private For-Profit		Faith-Based		TOTAL	
	Total	Trained per site	Total	Trained per site	Total	Trained per site	Total	Trained per site
IUD insertion/ removal	44	0.47	7	0.58	11	0.61	62	0.50
Norplant insertion	41	0.44	8	0.67	10	0.56	59	0.48
Norplant removal	34	0.36	8	0.67	10	0.56	52	0.42
Voluntary Surgical Contraception (CCV)	4	0.04	0	0	0	0	4	0.03

Source: Ndeboc 2011

There is no local capacity for production of family planning products in Cameroon. The largest importer and supplier of FP products is UNFPA which has supplied health facilities for many years. However, as shown in Table 22, different suppliers dominate a given type of contraceptive. There is a gap for some methods, particularly in rural areas. According to informants, a recent ministerial decision mandated that all FP products go through the CENAME network for distribution to public and private sector facilities. Since UNFPA-provided FP products were free, this new mandate will limit the accessibility of these products since CENAME will charge an 11 percent handling fee that will be passed onto consumers. Table 24 shows contraceptive supplies imported by major donors, NGOs, and pharmacies.

TABLE 22: CONTRACEPTIVE IMPORTS BY KEY STAKEHOLDERS (2010–2013)

Contraceptive type		Total quantity (in thousands)				
		UNFPA	OCEAC	ACMS	CAMNAFAW	UBIPHARM
Short-acting methods	Condoms	16,843	147,143	92,239	1,480	1,428
	Pills	3,101	0	50	34	25
	Injectables	1,118	0	30	13	3
Long-acting methods	Implants	46	0	15.5	1.4	0
	IUDs	136.5	0	99.4	4	0
Emergency contraceptives	Morning after pill	0	0	0	12.4	11.5

Source: Egal and Kapahou 2013

For the private sector, there is an alternative supply chain for the distribution of FP products. Private networks such as *Fondation Ad Lucem* are authorized either to order directly from CENAME or to import products independently in accordance with national laws. Faith-based clinics have their own central drug supply store and manage their own supply chain and distribution of family planning products.

3.2.5.2 HIV AND AIDS

Many private sector entities are active in the HIV/AIDS response. These include the ACMS/PSI social franchise; faith-based networks; NGOs; and for-profit companies such as Exxon Mobil, construction companies, insurance companies, telephone companies, and the Confederation of Cameroonian Enterprises. According to assessment informants, Exxon Mobil has an annual budget of $500,000 for employee HIV/AIDS services. The assessment team also learned in interviews that on average, private pharmacies supply about 10 million condoms on the Cameroonian market. When added to the amount of condoms brought into the country through UNFPA and social marketing organizations, ACMS estimates there remains a supply gap of about 20 to 25 million condoms a year.

Through USAID and/or Global Fund support, several nonprofit private sector entities (Care International, CAMNAFAW, CRS, Femme Active, etc.) are engaged in care and support of vulnerable populations such as MSM, sex workers, and orphans. Care and support of MSM remains controversial, entailing legal and programmatic challenges to the organizations involved.

Some public-private collaboration exists in the HIV response. Many private for-profit clinics refer their HIV and hepatitis clients to public clinics/hospitals, and the Confederation of Private Enterprises has a convention with the government for the distribution and procurement of ARVs.

3.2.6 PUBLIC-PRIVATE PARTNERSHIPS

Cameroon passed a general law on PPP contracts in 2006. However, the law is poorly implemented (Cameroon-Info.Net 2008).

In the health sector, several PPPs exist in Cameroon involving some of the major telecom, extractive, and insurance companies. For example, with total ARV needs for the 2013–2017 period estimated at CFA 146 billion ($303 million) and an anticipated gap of CFA 58 billion ($120 million), employers in Cameroon are acutely aware that universal access to ARVs is threatened (Ebongue 2014). To begin leveraging private sector resources, the Employers' Group of Cameroon (GICAM) signed a public-private partnership with the MOH to establish a fund for ARVs. This private fund will be used for the procurement of ARVs from vetted suppliers. Table 23 provides examples of health PPPs in Cameroon.

TABLE 23: PUBLIC-PRIVATE HEALTH PARTNERSHIPS IN CAMEROON

Private entity	Public entity	Description
GICAM	MOH	Since the free ARV policy is threatened by a financial shortfall anticipated to amount to CFA 58 billion, GICAM established a private fund for the procurement of ARVs. The fund is a beginning for a national resource mobilization campaign to fill the gap and ensure free ARVs to at least 80 percent of Cameroonian PLHIVs by 2017.
ACMS	Public facilities	Social franchise for FP and HIV services: The PROFAM network integrates comprehensive HIV services (VCT, PMTCT, ART) and FP services in over 100 public and private facilities.
AD LUCEM	Public facilities	Social franchise for FP and HIV services through Ad Lucem-MOH partnership. Ad Lucem Foundation facilities reach some of the remotest areas of Cameroon where public service are scarce.
CAMNAFAW	MOH	In the delivery of FP and HIV/AIDS services, CAMNAFAW partners with the MOH at the national and local levels.

3.3 CÔTE D'IVOIRE

3.3.1 BACKGROUND

Côte d'Ivoire is the third most populous country in West Africa with 22.4 million inhabitants (Central Intelligence Agency 2014a). Abidjan, the economic capital, is home to approximately one-fourth of the country's population. Following the end of a decade-long civil war in 2011, Côte d'Ivoire is making great strides in economic recovery with a GDP growth of 9.8 percent and an inflation rate of 3.6 percent in 2012 (World Bank 2014a).

Still, challenges remain. From 2005 to 2012, Côte d'Ivoire's maternal mortality rate increased from 543 to 614 deaths per 100,000 live births. Total Fertility Rate (TFR) is five children per woman. Despite government and donor efforts, the national reproductive health and family planning program faces funding shortages, stock insecurity, commodity distribution and community mobilization challenges, questionable quality of services, and insufficient capacity to deliver services. According to the 2012 DHS, unmet need for FP stood above 30 percent for the two lowest wealth quintiles and at 27 and 20 percent for the fourth and fifth quintiles respectively.

A national commitment to improving access to reproductive health services is evidenced by an emphasis on the integration of FP/RH services and a desire to reposition family planning as part of the Ouagadougou Partnership. Nationally, a coordination program for FP/RH has been established: FP/RH policies and strategies have been adopted, and contraceptive security has a line in the national budget. Important progress has been made, including: the validation of a roadmap for the reduction of maternal, neonatal, and child mortality; the adoption of the National RH Policy, the 2009-2013 Strategic RH Plan, and the National Advocacy Strategy to Reposition FP; the implementation of the Campaign to Reduce Maternal Mortality (CARMA); the introduction of the contraceptive implant with the support of UNFPA in 2007; and introduction of an emergency contraceptive by *Agence Ivoirienne de Marketing Social* (AIMAS) in 2008.

Due to over 30 years of national and donor commitment, the HIV prevalence rate has been steadily decreasing from over 10 percent in the 1990s (Barnes et al. 2013) to 4.7 percent in 2005 (AIDS Indicator Survey 2005), to 3.7 percent in 2012 (DHS 2013). At the same time, ART service delivery improved from 2,473 people on ART in 2003 to 51,820 in 2008 and 89,410 in 2011 (MSHP 2008 and MSLS 2012) thanks to PEPFAR and Global Fund support. However, in 2011, the unmet need for ART was estimated at 140,000 people.[7] In 2009, 450,000 people lived with HIV, and 36,000 died of HIV (*Conseil National de Lutte contre le Sida* 2011).

Efforts to curtail the AIDS epidemic were first concentrated in the public sector and only later included nonprofit and civil society organizations. In 2001, the government created a strong National Program of Medical Care for people living with HIV/AIDS (PLWHA) — the *Programme National de Prise en Charge médicale des personnes vivant avec le VIH* (PNPEC) — thereby keeping treatment within its control and selectively accrediting ART providers. With the expansion of PNPEC, the for-profit health sector has generally stayed out of AIDS treatment.

[7] UNGASS 2011 estimates that 230,000 people living with HIV have a CD4 count greater than 350 and of these, only 89,410 in 2011 were undergoing antiretroviral therapy. We have rounded this to 90,000 to allow for additional patients on ART and to convey the fact that these are broad estimates, leaving a total of 140,000 people with unmet need.

3.3.2 OVERVIEW OF THE PRIVATE HEALTH SECTOR

Côte d'Ivoire's private health sector is divided into four subsectors: for-profit; nonprofit (including faith-based organizations and associations); social protection (including workplace-based clinics, "*mutuelles*," and insurance); and traditional medicine. Decree No. 96-877 (October 1996) defines and regulates the private health sector; however, given fiscal constraints, the Ministry of Health has limited capacity for engaging and regulating the private health sector. Table 24 shows the number and types of private facilities between 2008 and 2010. Of interest is the decrease in clinics and general medicine and OB/GYNs, along with a significant increase in nursing centers.

TABLE 24: TYPES OF FACILITIES (2008–2010)

Private Health Facilities	Number	
	2008	2010
Polyclinics	15	13
Clinics	182	136
Nursing centers	556	964
General medicine and OB/GYN offices	227	114
Dental offices	Not surveyed	101
Laboratories	11	20
Radiology centers	4	4
Chinese clinics	36	67
Ambulatory care centers	Not surveyed	4
Hemodialysis centers	Not surveyed	1
Osteopathy centers	Not surveyed	2
Miscellaneous care units (counseling centers, homeopathic offices, etc.)	Not surveyed	147
Workplace health centers	463	463
Total	**1,494**	**2,036**

Source: DIPE 2011

As of 2006, there was a concentration of private facilities in urban areas, particularly in Abidjan. With the exception of the region of Worodougou, other regions of the country have at least one private facility.

3.3.2.1 FOR-PROFIT

A 2010 health facility survey conducted by the Directorate of Information, Planning and Evaluation (DIPE) found that private facilities represent 52 percent of all health facilities in Côte d'Ivoire, 49.5 percent private for-profit and just under 2.5 percent nonprofit/faith-based (Table 25). Of the 2,036 private health facilities surveyed, only 27 percent were authorized by the government (DIPE 2011). Dual practice is common, as is unauthorized care by lower echelon providers such as nurses.

TABLE 25: SUMMARY OF PUBLIC AND PRIVATE HEALTH FACILITIES (2010)

Type of Facility	Number	Percent
Public sector health facilities, 2009–2010	1,887	45.63
Semi-public facilities and institutions	11	0.27
Public health sector administrative services, 2009–2010	102	2.47
Authorized private health facilities (2009)	554	13.40
Unauthorized private health facilities	1,482	35.84
Private faith- and community-based health facilities	99	2.39
Total	**4,135**	**100**

Source: DIPE 2011.

3.3.2.2 NONPROFIT

Private nonprofit health facilities were established in Côte d'Ivoire long before the emergence of AIDS. The majority of these facilities are faith-based (Christian) hospitals and clinics. More recently, some secular NGOs have established small clinics or consultation offices to respond to an expanding need for health care beyond the existing capacity of the public sector.

The key international organizations are PSI, Engenderhealth, and FHI 360 supported by funding partners USAID, *Agence Française de Développement* (AFD), UNFPA, and UNAIDS. Many civil society organizations, varying in size and scope, play an advocacy role in the Ivorian health sector including professional provider associations, networks of PLHIV, and local coalitions of commercial sector businesses (Table 26).

TABLE 26: NONPROFIT ORGANIZATIONS AND MAJOR FUNDING PARTNERS

	Organizations	Development Partners
International	PSI, Engenderhealth, FHI 360	USAID, AFD, UNFPA, ONUSIDA
Local	AIMAS, *Association Ivoirienne pour le Bien Etre familial* (AIBEF), *Coalition des Entreprises de Côte d'Ivoire* (CECI), *Association des Cliniques Privées de Côte d'Ivoire* (ACP-CI), *Association des Sociétés d'Assurance en Côte d'Ivoire* (ASACI), SYNAMEPCI, *Espace Confiance and Alternative Côte d'Ivoire* (ACI), Ivorian Network of PLWHA (RIP+), Council of Organizations for the Fight against AIDS in Ivory Coast (COSCI), ACONDA	

The most active nonprofit organizations are highlighted below.

- ***Association des Cliniques Privées de Côte d'Ivoire*** **(ACPCI) and Syndicate of Private Doctors of Ivory Coast (SYNAMEPCI)** are two private professional associations that lobby the government for more favorable policies and better enforcement of laws governing the health sector, especially to counter the uncontrolled growth of illicit health providers. ACPCI, created in 1991, has over 50 member clinics accounting for 80 percent of private sector services in Côte d'Ivoire.
- **Coalition of Ivorian Businesses against HIV/AIDS (CECI)** is a nonprofit association of private businesses and their representative associations committed to fight HIV/AIDS, TB, and malaria. CECI acts as the interface linking the public sector, private businesses, providers, and donors. The coalition conducts training for personnel, provides AIDS-related information, organizes conferences, and conducts awareness campaigns among member businesses.
- **Council of Organizations for the Fight against AIDS in Ivory Coast (COSCI) and Ivorian Network of PLWHA (RIP+)** are umbrella organizations created to improve professional standards among AIDS-focused NGOs as well as to advocate on behalf of civil society and their members. Both organizations have received donor funding to conduct trainings with member NGOs in capacity building, data reporting, and management.

3.3.2.3 DISTRIBUTION

Côte d'Ivoire also has a growing pharmaceutical manufacturing sector that meets Good Manufacturing Practices (GMP) standards. In the next four to five years, drug manufacturers hope to increase their share of supply from four to 30 percent of national drug consumption. Currently, *Côte d'Ivoire Pharmacie* (CIPHARM) and other manufacturers produce Cotrimoxazole for PNPEC, and they are interested in producing drugs for HIV and AIDS including ARVs.

Key informants reported that the private health sector has in many ways been able to maximize efficiencies in stock procurement and distribution, albeit for lower volumes and largely for urban distribution.

3.3.3 ENABLING ENVIRONMENT

A 2013 private sector assessment found that "weak governance of the private health sector — for-profit and nonprofit — is a significant threat preventing the private sector from playing a greater role in delivering quality services to the Ivoirian population in general and for HIV/AIDS in particular" (Barnes et al. 2013). The assessment noted an adversarial relationship between the public and private health sectors. Compared to other countries with similar levels of development, Côte d'Ivoire has a low level of positive engagement with the private health sector.

Laws regarding the private health sector are summarized in Table 27.

TABLE 27: KEY HEALTH LAWS, DECREES, AND STRATEGIES IN CÔTE D'IVOIRE

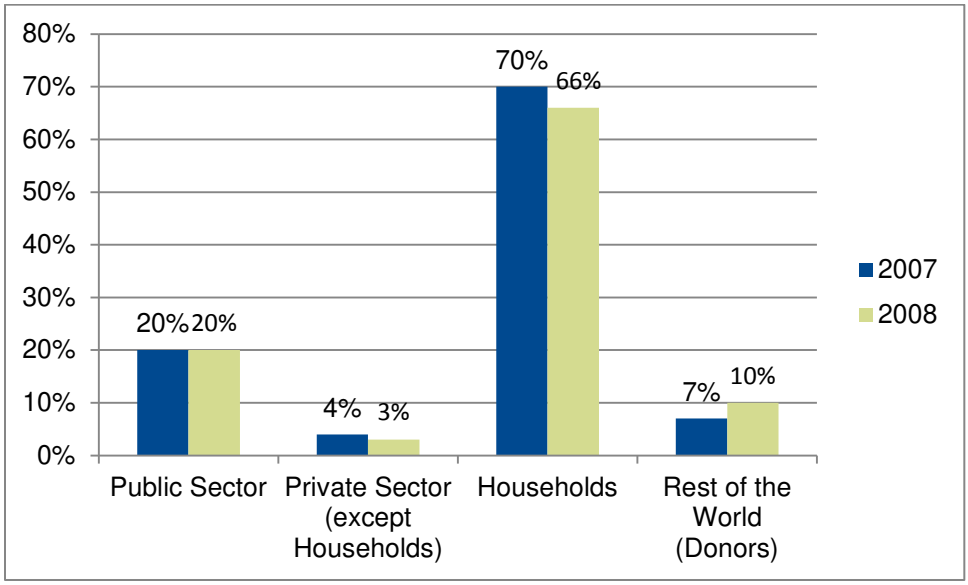
No.	Date	Law/decree/directive
214	2007	Creation, organization, and operation of the joint commission of Côte d'Ivoire's private providers
300	2006	Tasks of the Directorate of Professions and Health Care Facilities (DEPS), the entity charged with overseeing the private sector
2004-498	2004	Decree establishing a National Fund for the Fight Against AIDS (private sector was invited to contribute and be part of the fund)
02/98/CM/UEMOA	1998	Directive fixing standard value added tax rates for all West African Economic and Monetary Union countries and exonerating health products and services, including in private health clinics from value- added tax
98-473	1998	Decree regulating drug commercials and pharmacy advertisements
96-878	1996	Decree establishing authorization and matriculation of private health facilities professionals
96-877	1996	Decree on classification, definition, and organization of private health facilities
390 MIC/MPSPAS	1995	Establishes rates for certain services in private health facilities
94-667	1994	Decree establishing drug procurement procedures and prices

Source: SHOPS unpublished research (2014)

3.3.4 TRENDS IN HEALTH FINANCE

The 2008 national health accounts (NHA) analysis shows that the total health expenditure (THE) in 2008 was CFA 613,406,905,505 ($1.3 billion), with an annual per capita expenditure of CFA 29,827 or $66 (*Ministère de la Santé et de l'Hygiène Publique* 2010). This figure is comparable to health spending in other lower income countries but is below the sub-Saharan African average of $84 per capita health spending (Trading Economics 2013). At 66 percent (down from 70 percent in 2007), the share of total health spending from households is still relatively high, given that Côte d'Ivoire formerly had a policy of state provision of health care. As shown in Figure 6, the slight lessening of the household burden from 2007 to 2008 came from external funding, since the public sector's contribution did not change and the private sector's dropped by one percentage point. Ninety-six percent of household health expenditures are borne by households themselves, indicating an extremely high level of out-of-pocket payments and a very low level of prepayments and risk pooling. According to the same NHA analysis, *Mutuelle Générale des Fonctionnaires et Agents de l'Etat de Côte d'Ivoire*, the largest mutuelle in the country, accounts for only 1.8 percent of household spending on health.

FIGURE 6: SHARE OF TOTAL HEALTH SPENDING (CÔTE D'IVOIRE, 2007–2008)



Source: MSHP 2010.

For HIV and AIDS, 88 percent of total spending in 2008 came from donors and international nonprofits (Table 28). Household spending on HIV/AIDS was low, at 3 percent — comparable to the level of overall private health spending (2006 to 2008, including households) at 3.77 percent. According to the same report, the vast majority of HIV/AIDS spending is managed by the public sector with a significant share (21 percent) spent on drug purchases (*Ministère de la Santé et de l'Hygiène Publique* 2010).

TABLE 28: HIV/AIDS EXPENSES BY SOURCE OF FUNDING (2008)

Financing Source	Amount (CFA in millions)	% THE/HIV
Ministry of Economy and Finance	4,725	7
Other public funds	41	0
Employers	412	1
Households	189	3
National NGOs	350	1
Other private funds	75	0
Multilateral donors	6,689	10
Bilateral donors	49,806	77
International nonprofits	651	1
THE/HIV	63,938	100

Source: MSHP 2010.

3.3.5 DELIVERY OF FP AND HIV SERVICES IN PUBLIC AND PRIVATE CHANNELS

Côte d'Ivoire has a large number of diverse service delivery facilities distributed widely throughout the country. Considering its size, Côte d'Ivoire has a fairly broad range of specialist care.

3.3.5.1 FAMILY PLANNING

The private health sector is a very active provider of family planning services in Côte d'Ivoire, including the *Agence Ivoirienne de Marketing Social* (AIMAS) and the *Association Ivoirienne pour le Bien être familial* (AIBEF), as well as private wholesalers and pharmacies. The sector is supported by key international partners: UNFPA, KFW, IPPF, AFD (in the framework of the Debt Reduction-Development Contract (C2D), and USAID.

In 2014, AIMAS (with KfW and AFD funding) launched a social franchising program for contraceptives in Abidjan, Yamoussoukro, San-Pédro, and Daloa. The program includes private and public health centers. Previously, through an agreement with VIVO Energy (formerly SHELL), AIMAS implemented a youth center within the SHELL institute of Yamoussoukro to provide youth FP/RH outreach services. In Abidjan and other cities across the country, AIMAS strengthened the capacity of ten NGOs that provide integrated HIV/FP services. These NGOs are implementing outreach programs to their respective communities.

AIBEF (the IPPF affiliate in Côte d'Ivoire) offers clinical services in its six centers as well as in more than 150 publicly operated centers. The organization also provides FP outreach services through its private clinic network. AIBEF receives contraceptive products through IPPF and, in cases of stock-outs, from UNFPA. AIBEF also provides FP outreach services to private companies and FP services to their personnel (and dependents). Other local partners in FP involved in advocacy and community mobilization are *Association de Soutien à l'Autopromotion Sanitaire et Urbaine* (ASAPSU) and *Renaissance Santé Bouaké* (RSB).

For-profit private clinics do not currently offer family planning services, although they provide antenatal, postnatal, and delivery services to a significant segment of the population. Thus, the Association of Private Clinics of Côte d'Ivoire could serve as a gateway for the integration of FP services in the private sector.

Contraceptives are accessible and available in the private pharmaceutical sector. They are delivered to private pharmacies as well as warehouses for public distribution by three pharmaceutical wholesalers: Laborex, DPCI, and Copharmed. These wholesalers receive products (pills, condoms, and injectables) either from their foreign suppliers or from local pharmaceutical companies (CIPHARM and LPCI).

Distribution of contraceptives is subject to drug regulation by the Directorate of Pharmacy and Medicines (DPM), requiring registration and prior authorization before launching a new product in the market. Regulations also restrict advertising, fix prices, and impose a mandatory drug circuit for public and private providers.

There is a black market for drugs, including contraceptives. These drug sellers are primarily found in Adjamé-Roxy as well as in markets in towns that were besieged during the long conflict period. The DPM has begun an awareness campaign to dismantle this black market (Assoumou 2013).

3.3.5.2 HIV/AIDS

The scale-up of the national treatment program by PNPEC and its partners has made HIV/AIDS services widely, if unevenly, accessible throughout the country. The system used by PNPEC to establish and supervise treatment centers is generally good with encouraging progress in getting more PLWHA on treatment. PNPEC has also established a consistent process for accrediting treatment centers by ensuring service providers and laboratories receive regular monitoring visits. PNPEC also offers training to providers at accredited treatment locations to ensure that facilities maintain their quality level.

Prior to PEPFAR and to the creation of PNPEC, many PLWHA were treated in the private commercial sector. As there was no standardization of protocols, a variety of treatment regimens was used with the attendant risk of increased drug resistance. By 2010, however, the public sector had the majority of sites providing HIV/AIDS services (Table 29). These services include HCT and ART in addition to prevention of mother-to-child transmission (PMTCT), as well as care and support for PLWHA and OVC. Many NGOs/FBOs that were created to fight AIDS through both prevention and psychosocial support have more recently evolved into service delivery organizations providing testing, treatment, and support for PLWHA. Some of these nonprofit facilities offer a full range of HIV/AIDS services from counseling and testing to PMTCT and ART. Many of these service providers have received significant support and training through partnerships with Alliance, ACONDA, Elizabeth Glaser Pediatric AIDS Foundation, Ariel Glaser Pediatric AIDS Foundation, Family Health International 360 (FHI360), and others, supported by PEPFAR or Global Fund financing.

TABLE 29: NUMBER OF SITES PROVIDING HIV/AIDS SERVICES BY SECTOR (2010)

Type of Facility	CT	PMTCT	ART	Lab with CD4
Public	641	559	387	106
NGO	15	6	5	10
Community-based	63	31	33	8
Private for-profit	4	2	4	2
Faith-based	25	20	27	7
Workplace	19	11	12	5
TOTAL	767	629	468	138

Source: Barnes et al. 2013

In the commercial sector, only four private clinics provide ART in addition to a number of workplace clinics that provide HIV/AIDS services including ART and prevention programs. Since January 2014, the SHOPS project has been implementing a pilot intervention involving 15 clinics to expand ART services among commercial providers. An estimated 126 private facilities currently offer counseling and testing, though this is likely underestimated; many private facilities in fact procure rapid HIV tests and offer HCT services without systematically reporting their testing data to public sector authorities or PNPEC. Moreover, private facility referral of clinically identified HIV/AIDS patients to public sources of care — typically at late stage presentation — is rarely captured as part of national data and disease surveillance.

Although PNPEC's system for accrediting treatment centers is generally strong, it is limited to public sector and NGO facilities. If the government so chose, PNPEC could easily expand its accreditation to more private facilities, in addition to the four currently recognized. While the existing supply of treatment centers would seem to be adequate for the number of people receiving ART, using for-profit clinics would help pay the cost of operating the treatment centers. For-profit clinics might be able to cover their fixed costs and therefore require less public funding

per patient treated. Moreover, the national treatment program may be missing some patients who need treatment but who do not want to be treated in a public sector or NGO facility due to concerns about confidentiality, stigma, or quality of public services.

3.3.6 PUBLIC-PRIVATE PARTNERSHIPS

Côte d'Ivoire was a PPP pioneer in West Africa with the first PPP project for water supply in the early 1960s (World Bank 2012b). The country has recently focused on securing European partners for PPPs to rehabilitate public and university hospitals, but no health PPPs have been signed to date (Government of Côte d'Ivoire 2013). The country does not have a formal health PPP policy, and formal engagement of the private sector remains quite limited. Only a few partnerships fall under a strict definition of PPPs, and some others are still nascent.

TABLE 30: PUBLIC-PRIVATE PARTNERSHIPS IN HEALTH IN CÔTE D'IVOIRE

Private entity	Public entity	Description
Coalition des Entreprises de Côte d'Ivoire	MOH	Association provides HIV services (HCT, mobilization) in work places
Centre Intégré de Recherches Biocliniques d'Abidjan (CIRBA)	MOH	Provision of HIV/AIDS services (HCT, PMTCT, ART) through partnership with MOH
Various parastatals and private banks	MOH	HIV prevention, training on HIV to parastatals and private banks
MTN/ARIEL	MOH	Telecommunications company partners with *la Fondation Ariel Glaser pour la Lutte contre le Sida Pédiatrique en Côte d'Ivoire* on HIV prevention and training on pediatric ART
AIMAS/VIVO Energy	MOH	Energy company partners with social marketing organization on Yamoussoukro youth center, mobilization campaign, and training on FP and HIV
CMS WALE, RSB, CTC Yamoussoukro	MOH	HIV services (awareness campaigns, HCT, PMTCT, ART, lab services)
PSI/Côte d'Ivoire, agro-industrial companies, extractive industries, public works companies	MOH	PSI/Côte d'Ivoire partners with large employers on HIV and FP awareness campaigns
AIBEF/Aconda/CIRBA/Private clinics	Public universities	Partnership among NGOs, private clinics, and a university research center with official dual-practice agreements whereby doctors practice in private entities, since universities have excess doctors

3.4 MAURITANIA

3.4.1 BACKGROUND

Mauritania boasts the third largest land area of West African nations. Located in the Sahel, its relatively small population of 3.4 million is concentrated in a narrow strip along the Senegal River (the country's southern border) or along the coast of the North Atlantic Ocean, to the west (Central Intelligence Agency 2014b). Approximately one-fourth of all inhabitants live in the capital city of Nouakchott (Central Intelligence Agency 2014b). The country's population is expected to double by 2050 (Population Reference Bureau 2013), reflecting the large proportion of young people as well as a high fertility rate of 4.8 (Population Reference Bureau 2013). Mauritania's GDP has grown rapidly — at 7.6 percent in 2012 — thanks to vigorous economic reforms and budding oil and mineral industries. However, the World Bank projects economic growth lagging behind sub-Saharan Africa by 2014 (World Bank 2014d). Administratively, the country is divided into 13 *Wilayas* (regions), 55 *Moughataas* (departments), and 218 municipalities, of which Nouakchott comprises nine.

3.4.2 OVERVIEW OF THE PRIVATE HEALTH SECTOR

A relatively new law (Decree No. 90/2011/PM of 2011) established the Ministry of Health and its administrative structure. The legislation was accompanied by recent increases in government spending on health. The large private health sector, however, remains largely unregulated despite governing legislation, resulting in inadequate quality assurance. Moreover, no forum exists for communication between the public sector and the private for-profit sector. In contrast, the private nonprofit sector, which includes NGOs and associations, is actively involved in all aspects of public health, including the promotion of maternal and child health and the fight against HIV and malaria.

Although the private sector continues to grow, geographic distribution of medical facilities is uneven: one in four people live more than five kilometers from a health facility (Africa Health Workforce Observatory 2009). FP/RH services are concentrated in the main urban areas with higher populations and are less available in rural locations. The country's largest cities, Nouakchott and Nouadhibou, together host the following private facilities: 15 medical and surgical clinics; 47 medical consulting offices; 37 dental offices; 15 primary healthcare stations; 118 pharmacies; and 280 shops that sell pharmaceutical products (Maiga 2012). All told, private health facilities employ 90 percent of the qualified health professionals in Mauritania (Africa Health Workforce Observatory 2009).

3.4.2.1 FOR-PROFIT

The private for-profit sector in Mauritania remains very weakly integrated into the national health system. Despite the existence of legislation governing both the nonprofit and the for-profit sectors, authorities struggle to enforce the laws. According to key stakeholder interviews, an estimated 80 percent of private clinics operate without government authorization or oversight. The few cases of interaction between the public sector and the private for-profit sector involve irregular ad hoc exchanges of health information.

From informal interviews conducted in-country by the assessment team, it appears that dual practice is widespread, with the majority of public providers also working in private sector clinics and medical practices. The absence of regulation of dual practice results in an inequitable distribution of service time between the public and private sectors, often to the detriment of the public sector. Currently, there is no public-private platform to encourage dialogue around dual practice or other issues.

3.4.2.2 NONPROFIT

- **The Association of Ulemas and Scholars of Mauritania,** founded in 1993 as part of a larger regional West African network, promotes awareness of HIV/AIDS issues within the religious community by referring to the Koran, emphasizing the need to support people living with HIV, and combating rumors related to the disease. A stakeholder pointed to existing PPPs with the Ministry of Health and the Ministry of Social Action and welcomed further partnerships between the public and private sector. "We have something that you don't have, and you have something that we don't have, so we must work hand-in-hand," the informant said. Such partnerships might address issues such as enhancing adherence to medical protocols, challenging the stigmatization of those with AIDS, and increasing resources for awareness outreach.
- **National Order of Doctors, Pharmacists and Dental Surgeons,** currently under the direction of President Ahmed Zeyne, was created to uphold core values and ethics in Mauritania's health profession. Formerly operating exclusively in Nouakchott, the association has recently designated representatives in other districts at the local level. The council is planning to conduct a country-wide census of medical practices to generate an overview of the health sector in Mauritania.

The private nonprofit sector is largely composed of NGOs and health associations, such as *Santé Sans Frontière*, Stop Sida, Caritas Mauritania, Society for Women and Aids in Africa (SWAA), *Association Mauritanienne pour la Promotion de la Famille* (AMPF), and SOS Pairs Educateurs. These organizations have substantially increased demand for health services, especially in the areas of reproductive health, family planning, HIV services, child healthcare, prevention of female genital mutilation, and malaria treatment and prevention. Health service delivery is frequently through community health centers and mobile clinics designed to reach patients who would otherwise be unable to access treatment.

There are also many networks focused on diverse health areas. The Alpha Network (*Réseau Alpha*), working closely with Santé Sans Frontière, is composed of grassroots-level organizations in municipalities as well as community health workers within five kilometers of urban centers. A large number zof government-contracted community health workers are placed within NGOs, including *Santé Sans Frontière*, AMPF, and Caritas Health Center.

Most of these NGOs depend on donor funding. A handful of them are working towards financial self-sufficiency, including *Santé Sans Frontière* which is able to fund 35 percent of its annual operating costs. There are also several medical associations active in the country, including the three profiled below.

The Association of Private Clinics of Mauritania, with 13 member clinics, has existed for ten years at a relatively low level of activity. Without a platform for communication with the public sector, the quality of medical services, drugs, and devices remains a main concern for the association. The association also points to the legal vacuum regarding dual practice that allows public doctors to move to the more profitable private sector.

3.4.2.3 DISTRIBUTION

There are two drug supply systems in Mauritania. The public sector works through the drug supply center, *Centrale d'Approvisionnement en Médicaments* (CAMEC), which supplies all public facilities with essential drugs and medical consumables. The private sector is serviced by private wholesalers. Because the government of Mauritania grants CAMEC a monopoly on the importation of antibiotics, psychotropic drugs, anesthetics, and insulin, wholesalers and private clinics are required to source those products from CAMEC. UNFPA provides the family planning

products that are stocked and distributed by CAMEC. HIV products are procured, stocked, and distributed by the Sectorial Committee to Fight HIV.

The pharmaceutical sector includes 118 pharmacies and 280 pharmaceutical repositories. Following liberalization measures in the early 1980s, many nonprofessionals have been allowed to integrate into the sector. CAMEC is currently being decentralized with regional agencies being created. Several challenges inhibit CAMEC's efficiency, such as a lack of strong logistical coordination, low capacity of stakeholders, and its inability to guarantee a constant supply of products.

Much like the public sector and CAMEC, the private sector also faces a number of challenges. The majority of private pharmacies are owned by non-professionals, and many or most do not adhere to legal requirements. The supply chain is fragile, and stock-outs are common. In general, the lack of regulation causes concern about the quality of medicines on the market. (Mauritania Ministry of Health 2011.)

3.4.3 ENABLING ENVIRONMENT

There is a general distrust of the commercial health sector within the public health sector, and the private health sector is rarely engaged in government policy formulation. Consumers who are financially able to seek medical treatment outside of the country are encouraged to do so. While new laws have been passed to better control clinics and pharmacies, regulation is weak, policies are rarely enforced, and little information is exchanged between the private and public health sectors.

The Mauritanian government implemented its first family planning program between 1988 and 1998; a second initiative, the National Reproductive Health Program, was launched in 1999. These initiatives have created a favorable environment, encouraging the creation of a number of professional associations and NGOs which have integrated family planning into their activities: the *Association des Sages-Femmes de Mauritanie* (ASFM); the IPPF affiliate, AMPF; *Association Mauritanienne des Gynécologues et Obstétriciens* (ASMAGO); *Réseau des Maires pour la Santé de la Reproduction* (Mayors' Association for Reproductive Health); and *Réseau des Parlementaires Mauritaniens pour la Population et le Développement* (Network of Parliamentarians for Population and Development) (Maiga 2012).

Despite the work of the National Reproductive Health Program, Mauritania has no specific policies focusing exclusively on family planning. Instead, family planning is treated as part of a larger reproductive health strategy, as in the strategic plan established for 2011–2015 (Mauritania Ministry of Health 2011). These strategic plans on health are jointly funded by the Government, UNFPA, Spanish Cooperation, *Agence Française de Développement*, and WHO (Maiga 2012). Challenges remain, and FP services are often inadequate due to staffing and equipment shortages, low use of long-term contraceptive methods, a lack of private sector involvement, and limited implementation of innovative strategies (Maiga 2012).

The Ministry of Health has noted the need for collaboration between the private (nonprofit) sector and other service providers to increase access to family planning services (Mauritania Ministry of Health 2011). Accordingly, the MOH has reduced some of the barriers to creating NGOs; it provides some contraceptives to NGOs for free, as well as funding for FP outreach. Since 2003, the FP Multisectoral Working Group has promoted an annual week-long FP outreach campaign with strong private nonprofit participation.

However, gaps remain regarding collaboration with the private sector. Although private organizations must be accredited by the government to provide services, there is no monitoring and no data reporting to the Ministry of Health. Moreover, civil society organizations and private providers are not included in MOH training opportunities.

3.4.4 TRENDS IN HEALTH FINANCE

Government commitment to health financing in Mauritania is low, with only 5 percent of the total budget allocated for healthcare expenditures —far below the 15 percent recommended by the Abuja conference (World Health Organization 2011a). The public sector sector relies heavily on international donors for financing. While the private nonprofit sector is also largely dependent on the donor community, some NGOs have implemented creative financing strategies including partnerships with large corporations such as TASIAST (a gold mine operated by Kinross Gold) and *Société Nationale Industrielle et Minière de Mauritanie*. Examples of partners contributing to funding for FP are listed in Table 31.

Table 31: Partners Contributing Funding to Family planning

Name of Partner	Financial Contributions In US Dollars)			Activity or Program Area
	2010	2011	2012	
Government Budget	12,027	12,027	12,027	FP promotion of weekly campaigns
UNFPA/ Program Funds	350,000	350,000	350,000	Institutional capacity development; training in technology and counseling; advocacy; behavior change communication; community health services; contraceptive procurement; training in logistics management software; medical equipment procurement; support for supervision
UNFPA/ Contraceptive Procurement	359,884	321,850	350,000	Contraceptive procurement and security
AMPF/IPPF	78,000	65,000	65,000	FP information and service delivery; contraceptive procurement from IPPF and UNFPA

Source: Maiga and Lo 2012.

Between 2009 and 2011, out-of-pocket health expenditure as a percentage of private expenditure on health remained constant at 94.5 percent (World Bank 2014e). The 6 percent covered by insurance is paid by the following entities: government (55 percent), households (26 percent), employers (17 percent), the National Center of Social Security (CNSS) (1 percent), and private insurance (1 percent) (Ould Mohamed El Moctar). The range of services covered is limited, and family planning is not included in most insurance plans.

Risk-pooling mechanisms such as *mutuelles* are rare in Mauritania, but one successful mutual health insurance scheme operates in partnership with Caritas on the outskirts of Nouakchott. This *mutuelle* covers a range of reproductive health services: consultations and drugs (100 percent reimbursed); lab analyses (75 percent reimbursed); delivery (75 percent reimbursed); a package for women referred to the hospital during childbirth ($19); and caesarian sections (100 percent reimbursed). Several facilities have signed on with the *mutuelle* to treat patients,

including one hospital, three health centers, and five health posts. With high out-of-pocket health expenses and low uptake of *mutuelle* health insurance, Mauritania has an opportunity to increase the number of insured people by establishing a network of local *mutuelles*.

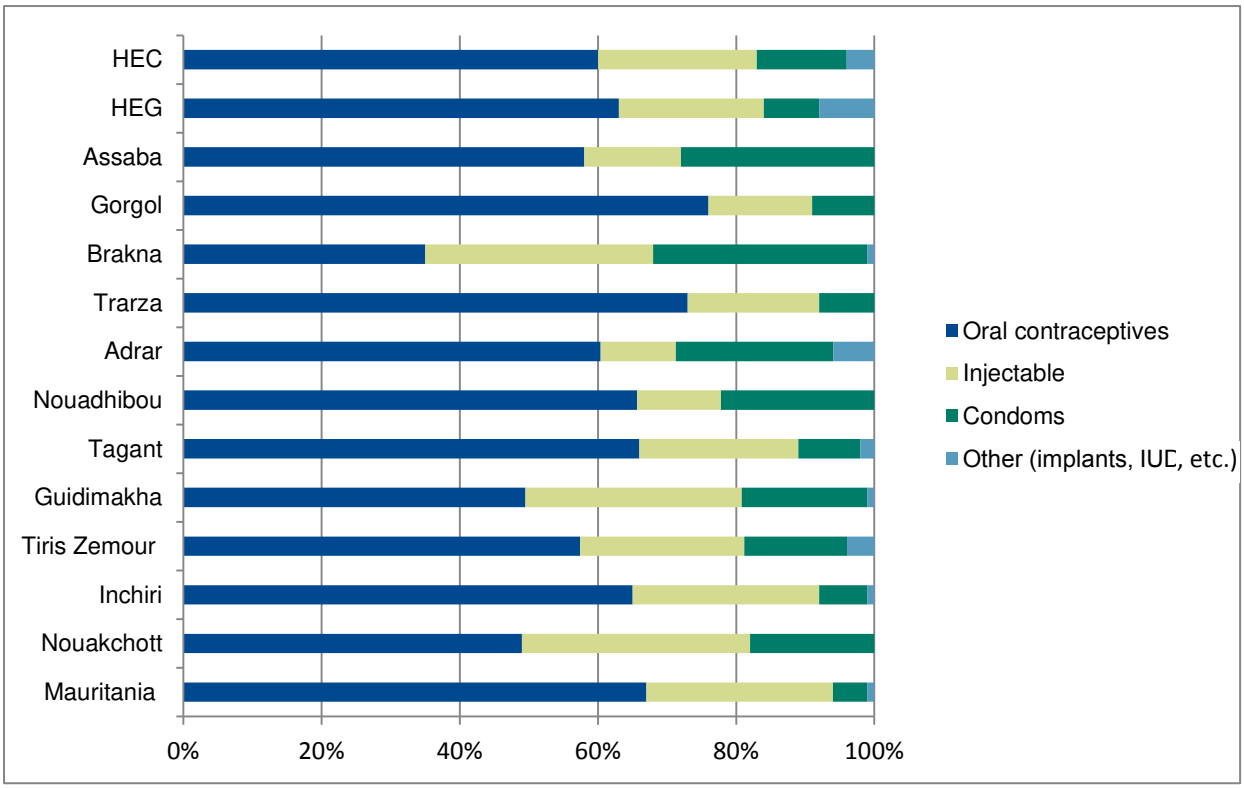
3.4.5 DELIVERY OF FP AND HIV SERVICES IN PUBLIC AND PRIVATE CHANNELS

Mauritania's service delivery of FP and HIV services through private channels is still nascent as seen in the following sections.

3.4.5.1 FAMILY PLANNING

Contraceptive prevalence, at an unchanged level since 2000, does not exceed 9.3 percent for all methods or 8 percent for modern methods. The most popular modern method is oral contraception (5.7 percent), followed by IUDs (1.3 percent) and injectables (0.4 percent) (Meddeb 2009). The modern method mix by region is shown in Figure 7.

FIGURE 7: MODERN CONTRACEPTIVE METHOD MIX BY REGION (MAURITANIA)



Source: Maiga and Lo 2012

In the public sector, the *Programme National de SR/PF* (PNSR) is the body in charge of RH/FP programs, and it coordinates activities with the Directorate for Planning, Coordination, and Health Information and the Directorate for Finances. The main partners providing funds and technical assistance to reposition family planning are UNFPA, the French Development Agency (AFD), the Spanish Agency for International Cooperation, and WHO.

The government's commitment to respond to rapid population growth through family planning is expressed in some key strategic documents, including: the National Policy Statement on Population, enacted in 1995; the 2005 Strategic Framework for Economic Growth; the Strategic

Framework for Poverty Reduction; the Framework for Accelerating the Achievement of the MDGs (March 2012); the PNDS 2011–2020; and the Strategic Plan for HR products security (PSSPSR).

Following the Ouagadougou conference, Mauritania drafted a plan to reposition family planning for 2014–2018. This plan pledges to increase the contraceptive prevalence rate to 18.5 percent in 2018 by addressing the challenges of supply and demand of FP services in the country. Survey data indicate that 48.6 percent of women of childbearing age have the desire to space or limit births (Mauritania Ministry of Health 2011).

The FP activities of both the public and private nonprofit sectors are focused on supply strengthening, demand creation, and policy advocacy. One local NGO, AMPF, manages five health centers and one mobile clinic, all in urban areas. The clinics provide pre- and post-natal consultations, gynecological consultations, testing and treatment for HIV and other STIs, counseling services, and immunizations.

UNFPA is the only provider of contraception and condoms for the government of Mauritania. Advocacy efforts have successfully encouraged the government to reserve a family planning budgetary line item for 2014 of approximately $516,000. In 2005, a ministerial decree created a reproductive health committee which has been inactive; however, a sub-committee for contraceptive security is currently being created.

3.4.5.2 HIV AND AIDS

Mauritania's HIV prevalence rate is relatively low at 0.7 percent, but the rate is higher among MSM and SW. UNAIDS, a key partner in the fight against HIV, has provided support in producing policy and reference documents for HIV/AIDS: Strategic Plan 2008–2015; Monitoring and Evaluation Plan; Strategic Document on Elimination of Mother to Child Transmission; and Mauritanian Strategy on Case Management. UNAIDS has also advocated for higher resource mobilization for HIV activities and services within the state budget, increased to 1,000,000 Euros ($1,358,910) in 2013.

HIV care is currently provided by the public sector only at the secondary and tertiary care levels. The government offers a free supply of ART as well as other HIV reagents. Counseling and testing are provided by both the public and nonprofit sectors. The nonprofit sector provides mobile services for areas farther than 5 kilometers from a health center and in urban and periurban settings through either fixed health centers or mobile units.

Informal interviews revealed that the private for-profit sector was used mostly by wealthier people for counseling and testing as well as treatment; however, the difficulty of contacting these wealthier users makes this hard to quantify. During the assessment, a representative from the government's National Council to Fight AIDS (CNLS) expressed willingness to work on a strategy to increase the role of the private for-profit sector in HIV services.

Stigma and discrimination against people living with HIV remains strong in Mauritania. The Ulema and Scholars network cooperates with government, partners, and NGOs to develop outreach actions within the Muslim community focused on changing behaviors and transcending barriers to HIV, reproductive health, and child health services, in order to decrease the burden of religious considerations on health.

3.4.6 PUBLIC-PRIVATE PARTNERSHIPS

Partnerships between the public and private sectors (particularly the for-profit sector) face recurring communication and dialogue problems. The Directorate of Hospital Medicine (*Direction de la Médecine Hospitalière*) manages PPPs but lacks the necessary funding and influence to monitor the private sector and partnerships. Current PPPs, in most cases focused on the public sector and NGOs, are listed in Table 32. The assessment team noted that these technical and financial partners are working toward a stronger partnership between the public and private health sectors which will depend on a corresponding level of commitment at the MOH.

TABLE 32: CURRENT HEALTH PPPS IN MAURITANIA

Focus	Actors	Health Areas
Service delivery and care to vulnerable populations	MOH – *Santé Sans Frontière*	MOH contracts with NGO for health products, health information, HIV testing, RH/FP service delivery, and nutrition
Mobile outreach	*Santé Sans Frontière* – Kinross Gold	Mining company sponsors mobile health clinic with HIV focus
HIV/AIDS outreach	Stop Sida – *Banque Mauritanienne pour le Commerce International* (BMCI)	Bank partners with NGO to finance certain HIV-related activities
HIV testing for fishermen	Stop Sida– Employers	Employers partner with Stop SIDA to offer HIV testing for fishermen
Service delivery and care to populations	*Association Mauritanienne pour la Promotion de la Famille* – MOH	MOH contract with AMPF for provision of FP products by PNSR and occasional participation in trainings
Service delivery and care to populations	*Association Mauritanienne pour la Promotion de la Famille – Association Mauritanienne des Gynécologues et Obstétriciens*	Partnership between NGO and provider association for capacity building
Service delivery and care to populations	CARITAS – MOH	Training of PMTCT agents with outreach work financed by PNLS and MOH
Communication	Total – MOH	Total partners with MOH for World AIDS Day and HIV outreach
Streamlining of information collection forms	ASCOMA – CNAM	Insurance company ASCOMA developed a single fee reimbursement form, cost recovery at the national health insurance fund (CNAM)

3.5 NIGER

3.5.1 BACKGROUND

Niger is a landlocked country bordered by seven countries in West Africa. The capital, Niamey, is located in the southwestern corner along the Niger River, far removed from the desert that comprises 55 percent of the country. Outside of the capital, the quality of roads and other infrastructure is low. This presents formidable logistical challenges, especially with regard to transport of medical products and accessibility to health services.

In 2010, Niger had a fertility rate of 7.6 children per women , the highest in the world (Population Reference Bureau 2013). Since 2006, all FP and HIV products and services are guaranteed free of cost by the government.

With Niger's relatively low HIV prevalence rate (0.4 percent), the country is typically excluded from major donor aid which is often focused on countries with high prevalence rates. Among sex workers, however, HIV prevalence is extremely high at 24 percent (UNAIDS 2013a).

3.5.2 OVERVIEW OF THE PRIVATE HEALTH SECTOR

The private health sector in Niger consists of a small NGO and faith-based sector and a growing for-profit commercial sector. Relative to neighboring countries, the private health sector in Niger is small, underdeveloped, and concentrated almost exclusively in the capital city of Niamey. Private practice in Niger is by and large formal: 80 percent of private health providers are registered with the local regulatory body, a prerequisite for formal licensing and operation in the country.

3.5.2.1 FOR-PROFIT

Since the liberalization of Niger in 1986, followed by a 1997 law authorizing private health practice, the commercial private health sector has grown steadily in size. Within the capital, a handful of major polyclinics cater to expats and the wealthiest Nigeriens; large- and medium-sized clinics are found throughout the city center. Well-stocked private pharmacies dominate Niamey's drug sector and are 20 times as numerous as public dispensaries in the capital. Outside of Niamey and other major cities (such as Maradi), the private commercial health sector is virtually nonexistent. There are 16 private pharmaceutical wholesalers, of which IBPHARM, LABOREX, and SAPHAR are the largest. There is also a well-established informal market for pharmaceutical drugs throughout the country. Table 33 indicates the size of the commercial private health sector in Niger.

TABLE 33: NIGER: PRIVATE HEALTH SECTOR OVERVIEW

Type of Facility or Provider	Number
Number of private pharmacies in Niamey	**85**
Number of private pharmacies outside of Niamey	17
Total private pharmacies	102
Number of private physicians, pharmacists, and dental surgeons registered with the local regulatory body	750
Estimated total number of private health providers	900-1,000

3.5.2.2 NONPROFIT

While a handful of local NGOs is active in the Nigerien health sector, only one network of private clinics exists with just three health centers (in Niamey, Tillabery, and Dossou). This network is operated by the Nigerien Association for the Wellbeing of the Family (ANBEF), the IPPF affiliate in Niger. PSI opened an office in Niger in late 2013. A local NGO, *Mieux Vivre avec le Sida* (MVS), opened a Voluntary and Anonymous Center for Testing (CEDAV) which currently serves as a quasi-public HIV testing facility in Niamey. ANIMAS-SUTURA, a local social marketing NGO, operates major drug warehouses in Niamey and Maradi. The French mining conglomerate AREVA owns two hospitals in the Arlit region which it operates with company-paid doctors and staff. SIM, an American faith-based NGO, heavily supports two hospitals: the Danja hospital in Maradi district and Galmi Hopsital in Zinder district. Table 34 shows the organization of the private and public health sectors.

TABLE 34: ORGANIZATION OF THE HEALTH SECTOR IN NIGER

	Public	Private
Products	ONPPC* Popular pharmacies (44)	Commercial pharmacies (102) Private wholesalers (16 total; 3 major)
Services	National and district level hospitals; stand-alone maternities; Centre Integré de Santé; *Centre de Dépistage Anonyme et Volontaire* (CEDAV)	Commercial medical practices; dental practices ANBEF (3 centers) AREVA-run hospitals (2) SIM-supported hospitals (2)

* The National Office of Pharmaceutical and Chemical Products

3.5.2.3 DISTRIBUTION

Niger has no domestic pharmaceutical production. All procurement and distribution of drugs and pharmaceutical products must pass through the government-run National Office of Pharmaceutical and Chemical Products (ONPPC) which has three depots in Niamey, Tahoua, and Zinder. New drugs must be reviewed and approved by the Ministry of Health's Directorate of Pharmacy. Major funders of the ONPPC include the government of Niger, the Global Fund, the World Bank, and UNFPA. Private commercial pharmacies must request supplies from ONPPC; orders are typically filled within a few hours or by the next business day for generics but can take up to a month for specialty items. The three major wholesalers, IBPHARM, LABOREX, and SAPHAR, procure their products through ONPPC and distribute at wholesale prices to pharmacies, clinics, and NGOs. All private and public pharmacies charge a 35 percent markup, including on FP products. However, local NGOs (such as ANBEF and ANIMAS-SUTURA) are major distributors of family planning methods, especially condoms and oral pills, procured from countries such as India and Malaysia.

3.5.3 ENABLING ENVIRONMENT

Specific laws declaring universal rights and free access to reproductive health, including FP and HIV treatment have existed since 2006 and 2007 respectively; these services continue to be offered free of charge to the population at large. Following the Ouagadougou Regional Conference on Family Planning in 2011, the MOH adopted a 2013–2020 plan for scaling up FP services. The plan is ambitious, especially on integration of PMTCT services and increased distribution of contraceptives at the community level.

In large cities, access to FP services is common and available free of charge through both private and public practitioners. In rural areas, however, local marabous discourage the use of FP, and religious beliefs can contradict efforts to increase uptake of FP.

In general, the political environment in the MOH favors increasing health coverage and improving access through legislation and national strategies. MOH officials were found to be knowledgeable and articulate about existing gaps and barriers, recognizing the role of cultural and religious factors. Table 35 shows the most pertinent health sector laws and decrees passed in Niger in the last three decades. However, implementation of policies may be inconsistent.

TABLE 35: KEY HEALTH LAWS, DECREES, AND STRATEGIES IN NIGER

No.	Date	Law/decree/directive
N/A	November 2013	National guidelines on distribution and conservation of health products; Details of a quality assurance plan for health products and services
N/A	2013	Official Family Planning strategy 2013–2020
2010-54	September 2010	Defines the roles and responsibilities of local elected officials in the management of health services
2007-08	April 2007	Law guaranteeing free access and free services for HIV testing, support, and confidentiality of results, and ARV therapy for those affected with HIV
2006-16	May 2006	Guarantees the universal right and access to free reproductive health services, including FP services and contraception
97-002/ 301	January 1997	National Pharmaceutical Legislation allowing private products in the market and legalizing private pharmaceutical practice
88-31/ 88-205	June 1988	Creation of a national order of doctors, pharmacists, and dental surgeons; effective legalization of private medical practice in Niger

Although an MOH directorate oversees private sector practice, dialogue between the private health sector and the government appeared to be non-existent, with no official dialogue forums.

3.5.3.1 CIVIL SOCIETY ORGANIZATIONS

A handful of civil society organizations advocates for improvements in health, including professional provider associations and local coalitions of commercial sector businesses.

- **The Order of Doctors, Pharmacists, and Dental Surgeons** is responsible for coordinating all aspects of the registration process. Despite limited capacity, it currently enrolls 80 percent of private sector practitioners. The Order appears to be the only sanctioned regulatory body monitoring private health practice in Niger. There are plans to divide it into three separate orders for doctors, pharmacists, and dental surgeons.
- **The Association of Private Pharmacists** is run by a private pharmacist who convenes meetings at his pharmacy. Lacking a physical space, the Association collects minimal dues from member pharmacies. Aside from the semi-regular meetings, the organization does not appear to have other activities beyond informing its members of trainings such as those organized by the Niger Chamber of Commerce. While private provider associations have traditionally played an important role in organizing and building the capacity of providers, the Association of Private Pharmacists is currently limited in its scope of activity.
- **The Business Coalition against HIV/AIDS, TB, and Malaria (CNEP-STP)** has 58 dues-paying members totaling approximately 10,000 employees with an estimated 50,000 dependents. Its members are some of the biggest private multinationals in Niger, including

Nestle, Bank of Africa, Oil Libya, Orange, Areva, and Sefa Motors, as well as public sector entities such as the *Caisse Nationale de Sécurité Sociale* (Social Security Institute), *Société d'Electricité* (state-run electricity utility company), SONIDEP (petrol), and *Société Nationale d'Eau* (the state-run water company). Recently, CNEP-STP has begun to expand its focus to encompass all aspects of wellbeing. If properly funded, CNEP-STP represents a key opportunity to improve health outcomes in Niger.

3.5.4 TRENDS IN HEALTH FINANCE

Out-of-pocket health expenditures in Niger have declined from 95 percent of private health expenditure in 2005 to 84 percent in 2011 (World Bank 2013b). This decline goes along with an increase in external sources of health finance, from 11 percent of THE in 1996 to 28 percent in 2011 (World Health Organization 2014; World Health Organization). Government expenditure on health reached a peak of 16 percent of THE in 2006, leveling off at around 11 percent in the period from 2008 to 2011.

A 2010 survey by the HLSP Institute, a global health policy knowledge center, estimated the breakdown of sources of overall (public and private) health financing: 40 percent out-of-pocket, 26 percent public, 26 percent donor aid, and 7 percent privately risk-pooled (insurance). Public facilities impose user fees, accounting for up to nine percent of public revenues; nevertheless, the survey concluded that fee exemptions for children, civil servants, HIV and TB patients, and the poor were very effective (Witter 2010). Additionally, caesarean sections and care for children under five have been provided free of charge since 2006 and 2007 respectively (UHC Forward). However, the government has had trouble generating sufficient income to fund these subsidies (IRIN 2010).

The number of rural mutual health organizations has increased from two in 2000 to 17 in 2008, but out-of-pocket expenses remain high. Little has been accomplished to pool healthcare risks, and less than 1 percent of the population was covered by these developing mutual health organizations in 2008 (World Health Organization 2014b). Benefit packages are moreover limited to the healthcare services available at integrated health centers.

3.5.5 DELIVERY OF FP AND HIV SERVICES THROUGH PUBLIC AND PRIVATE CHANNELS

In the 1980s and 1990s, family planning was seen in Niger as a necessary and important part of an integrated health regime. In the past decade, however, the country has seen a marked trend toward denouncing FP services. Opponents of FP claim that FP methods as well as vaccinations sterilize women and accuse the government of trying to stop women from reproducing. Promotion of FP methods in some areas has become controversial, especially in the provinces of Zinder, Tahouwa, and Maradi, along the border with Nigeria. Both opponents and proponents of FP use community radio as an important medium to disseminate their messages.

FP services such as counseling, insertions, removals, and injections are delivered regularly in public and private facilities in Niger. The Directorate of Mother and Child Health (DSME) at the Ministry of Health is responsible for ensuring availability of and access to FP methods throughout the country, as well as monitoring, supervision, and evaluation of all FP services. Anecdotal evidence suggests that the DSME has inadequate capacity to meet these responsibilities.

Since 2006, provision of all FP services and products is guaranteed free by law in public sector clinics. Private sector clinics offer the same FP services as the public sector, usually fee-based.

However, private facilities may also offer free services. Clinic Magoli, a major private polyclinic in Niamey, reportedly provides FP services to clients who cannot afford to pay. AREVA-run hospitals in Arlit offer a comprehensive range of FP products and services at their maternal and child health centers, from pre-natal care through two years after birth; all products and services are provided free of charge to AREVA employees, families of employees, and the community.

Several local NGOs are active in the provision of FP services. ANBEF, the largest, supports public sector facilities by training and qualifying health workers and by operating a cold-chain warehouse. ANBEF carries out periodic supervision of both public and private clinics and provides free FP communication materials (such as posters and pamphlets) to private and public facilities. ANBEF's trainings are carried out at the community level through local *Centre Integré de Santé*. SWAA, a national NGO, integrates FP education into community-based condom distribution activities and until mid-2013 provided female condoms and information to sex workers.

ANIMAS-SUTURA, the largest national social marketing NGO, operates two warehouses in Niamey and Maradi; it distributes its Foula condom and Sutura pill brands in 563 villages using 360 community agents. These activities, implemented in Tillabery, Tahoua, and Maradi districts, focus on roadside hotels, cyber cafes, and restaurants. The organization advertises its products in daily radio episodes broadcast by 70 local radio stations (50 community-based and 20 private). It operates three mobile health vehicles which promote FP education through film. ANIMAS-SUTURA supports MOH trainings of community agents, focusing on the Sutura brand oral pill.

A handful of major international NGOs operates in the FP sector in Niger. PSI arrived in late 2013 and plans to launch a UNFPA-funded female condom distribution program in 2014, focusing on the districts of Tahoua, Dossou, and Tillabery. MSI began work in late 2013. Catholic Relief Services (CRS) promotes traditional methods of contraception such as abstinence and fidelity alongside condom distribution in its community-based programs.

3.5.5.1 FAMILY PLANNING

Most major FP products are available in Niger at public and private health clinics, while pharmacies only stock condoms and oral pills. Public sector pharmacies, also known as popular pharmacies, carry the Foula brand condom and Sutura brand pill; private pharmacies carry two additional major condom brands, Maxim and Presa, as well as up to five oral pill brands. According to the DSME, the pill is the method most preferred by women.

Prior to 2006, the private sector dominated the market for FP products, especially condoms and oral pills. With free access to FP products mandated in 2006 and with competition from a robust informal market in pharmaceutical products, the private sector's market share of FP products has dropped in recent years.

The government of Niger has a line item in its annual budget for purchase of FP products. These resources go into a "common fund" managed by the Global Fund; contraceptives are purchased from the common fund, transferred to the ONPPC, and distributed to public and private clinics and pharmacies. UNFPA and WAHO are additional contributors to the common fund, with WAHO responsible for all aspects of the pharmaceutical supply and cold chain.

ANBEF distributes condoms, pills, injectables, IUDs, and implants[8] both through public facilities and through its three networked clinics. Through its community-based trainings for young girls, SWAA distributes male condoms; until mid-2013, it distributed female condoms to sex workers

[8] Implanon and NOVEX; Jadelle implants are reported to have recently disappeared from the market.

as part of a UNFPA-funded HIV and AIDS prevention program. ANIMAS-SUTURA imports, distributes, and subsidizes Foula condoms which have a 95 percent market share and Sutura oral pills with a 17 percent market share. Family planning products available in the private sector and their prices are listed in Table 36.

TABLE 36: FP PRODUCTS AVAILABLE IN THE PRIVATE SECTOR IN NIGER

Method	Brand Name	Price in CFA	Notes
Oral Pill	Sutura	300/3mos.	Imported and subsidized by ANIMAS-SUTURA.
	Microval	3,210/3mos.	Found only in private pharmacies
	Stediril	3,260/3mos.	Found only in private pharmacies
	Minidril	4,525/3mos.	Found only in private pharmacies
	Trinordial	3,280/3mos.	Found only in private pharmacies
	Adepal		Stock-out
Masculine Condom	Foula	300/3pc.	Imported and subsidized by ANIMAS-SUTURA.
	Presa	400/3pc.	Found only in private pharmacies
	Manix	1,200/3pc.	Found only in private pharmacies
IUD		1,000/ea.	
Implant	Jadelle	3,100/ea.	Heavily subsidized from original price of CFA 15,000 ($31). Reported as stocked out by ANBEF in early 2014
Emergency Contraceptive	Norlevo	3,500/ea.	Found in stock in one private pharmacy
Injectable	Depo Provera	N/A	Information not available

3.5.5.2 HIV/AIDS

Most HIV/AIDS service delivery is provided by the public sector. Ambulatory Treatment Centers (CTA) are the only locations in Niger where patients can receive HIV/AIDS treatment, particularly ART. There are only a handful of CTAs in Niger, which are concentrated in the urban areas; patients must be referred by public or private clinics before accessing treatment. The private sector's role in HIV/AIDS service delivery is limited to testing. Major private clinics and CEDAV in Niamey and other urban centers such as Maradi have the capacity to carry out HIV tests. By law, HIV testing and treatment is free in Niger, and doctors at private clinics are contracted by the government to test patients for referral to a CTA. No private pharmacies or facilities were found that currently dispense ARVs or carry out HIV/AIDS treatment services, with the exception of the two AREVA-run hospitals in Arlit. These hospitals purchase ARVs from ONPPC and administer ART therapy to AREVA employees, family members, and community members. In 2011, four commercial sector facilities were reported to provide ART (UNAIDS 2012).

NGOs' HIV/AIDS programming focuses mainly on sex worker populations which are found mostly along the highways between major cities. While the national HIV prevalence rate hovers between 0.4 and 0.7 percent, sex workers — with rates estimated at 24 percent —are considered the most at-risk population for contracting HIV. Since 2012, the World Bank has supported HIV/AIDS projects in all eight districts of Niger, focusing on sex workers and

partnering with ANIMAS-SUTURA as well as the Belgian NGO, Songes, to conduct education and testing and to give support to regional CTAs.

SWAA focuses its HIV/AIDS programming on educating young girls in middle and high school as well as local Muslim tribal leaders. It also educates the leaders of prostitution rings on preventing HIV/AIDS and promoting the use of female condoms by sex workers. According to SWAA, 62 percent of female sex workers used female condoms while the project was in operation. However, after UNFPA funding for the project ended in mid-2013, female condoms became unavailable on the market.

MVS has some activities related to HIV/AIDS interventions, including opening the CEDAV facility in Niamey. The major private sector enterprises in Niger, from mining to telecommunications to oil, have substantial workplace HIV programs for employees and their families. In Arlit, AREVA-run hospitals mandate monthly HIV testing of employees, and the facilities offer their services to the surrounding community.

Niger's new 2013–2020 plan for reproductive health puts special emphasis on reduction of mother-to-child transmission of HIV. The Global Fund (supported by the World Bank, UNICEF, and WHO) implements free provision of PMTCT services in public facilities, from pre-natal counseling up to childbirth. No additional support is given after the birth.

ARVs are currently supplied by a joint program of the Global Fund and WAHO through 2015. ARVs are transferred through ONPPC to the Intersectoral Committee for the Fight Against AIDS (CILS), which coordinates distribution of ARVs to CTAs and other hospitals. Reactives for HIV tests are also procured within this system. While the availability of ARVs appears to not be a major concern, frequent stock-outs of reactives for HIV testing limits the public and private sectors' ability to carry out HIV tests. Further, the availability of ART at only select CTAs located in urban areas means that a large portion of the population is unable to access high quality HIV treatment, due to the high cost of traveling large distances. As CTAs do not typically have sufficient capacity to store stock of ARVs beyond three months and do not accurately forecast their ARV stock needs, stock-outs of ARVs and reactives in areas outside of Niamey is common.

The major actors in Niger's health sector are listed by organization type in Table 37.

TABLE 37: MAJOR ACTORS IN THE HEALTH SECTOR IN NIGER

	NGO, FBO, Civil Society	Development Partners
International	CRS, PSI, MSI, JSI, Plan, CARE, Save the Children, EngenderHealth, Samaritan's Purse	Global Fund, UNFPA, UNICEF UNAIDS, World Bank, European Union, WHO, WAHO, AFD, Spain, GIZ/KfW, CTB, Netherlands, JICA, Swiss
Local	ANBEF, SWAA, ANIMAS-SUTURA, MVS, CNEP/STP, *Association des Pharmaciens Privés*, *Ordre National des médecins*, Niger Dental Association/*Association des Chirurgiens-Dentistes du Niger*, *Réseau-RSE*	

3.5.6 PUBLIC-PRIVATE PARTNERSHIPS

While Niger's PPP laws date from 2011, a March 2014 decree improves the PPP law and its implementation (Government of Niger 2014). The focus of PPPs has been on the areas of energy, water, communication, and transportation (Office National d'Edition et de Presse), but a few health public-private partnerships were documented (Table 38).

TABLE 38: PUBLIC-PRIVATE PARTNERSHIPS IN HEALTH IN NIGER

Private entity	Public entity	Location	Description
AREVA (commercial corporation)	MOH/CILS	Arlit town (Agadez); Niamey	CILS provides support to AREVA to procure ARVs and reactives for HIV testing. AREVA provides all health services to Arlit population for free. In Niamey, AREVA subsidizes materials for several laboratories.
Private providers	MOH	Countrywide	Doctors at private clinics are contracted by the government to test patients, after which they are referred to CTAs.
SIM (FBO)	MOH	Maradi and Zinder	SIM operates two hospitals in Maradi (Danja) and Zinder (Galmi) in partnership with MOH.
Private pharmacies	MOH	Countrywide	Through funding from the Global Fund, the MOH heavily subsidizes malaria test kits in public and private pharmacies across the country.
Major commercial businesses	MOH	Countrywide	Reportedly, major private companies in Niger have workplace health programs that have PPPs with the MOH.

3.6 TOGO

3.6.1 BACKGROUND

Bordered by Ghana, Burkina Faso, Benin, and the Atlantic Ocean, Togo is a small West African country of approximately 6.6 million people (World Bank 2014f). Only 39 percent of Togo's population lives in urban areas, a slight increase from 35 percent in 2005. Seventy-one percent of Togo's urban population lives in the capital city of Lomé (World Bank 2014f). Just under half of Togo's population is under the age of 15 (Population Reference Bureau 2013). With a gross national income of $900 per capita in 2013 (World Bank 2014c), Togo is one of the poorest countries in the world. The economy of Togo is largely based on agriculture, mining, and transit trade. The country's main port, Lomé, is the only deep water port in West Africa, making it an important first point of contact for goods to enter markets in the surrounding countries of Ghana, Burkina Faso, and Benin (Lecerf et al. 2009). Political instability led to civil conflict throughout the 1990s and early 2000s, but following legislative elections in 2007, the European Commission resumed its relationship with the Togolese government (Lecerf et al. 2009). In 2008, the World Bank and International Finance Corporation also began reinvesting in Togo and forgave millions of dollars in debt (U.S. Department of State 2013).

While overall contraceptive prevalence has remained low in Togo, the proportion of modern method users is relatively high compared to traditional methods which suggests that health workers' outreach efforts to educate people about modern FP methods have been somewhat effective. A 2010 Multiple Indicator Cluster Survey (MICS) reported that 15 percent of women of

reproductive age are currently using a method of family planning, including 13 percent using modern methods and 2 percent traditional methods. Total fertility rate remains high in Togo with five births per woman in 2012 (World Bank 2014c). The most popular modern methods in Togo are injectables, used by 6 percent of women of reproductive age, followed by condoms, oral contraceptives (OC), and implants. According to an interview with the Direction de la Santé Familiale, 37 percent of married women wish to space or limit future births but do not currently have access to family planning methods.

HIV prevalence in Togo has been stable at 3.2 percent since 2006. Regional disparities in prevalence exist: the highest prevalence, 6.8 percent, is in Lomé. Generally, HIV prevalence is greater in urban areas than in rural areas, and the disease disproportionally affects women (CNLS-IST 2012b). Over 60 percent of the adults living with HIV are women, and the prevalence among women ages 15 to 24 is 2.4 percent, compared to 0.6 percent among men in that age range (CNLS-IST 2012b). While the disease prevalence has remained stable over the last eight years, stigma still exists against PLHIV, and the fear of discrimination often discourages PLHIV from seeking certain types of services.

3.6.2 OVERVIEW OF THE PRIVATE HEALTH SECTOR

The Togolese health sector consists of a number of actors (Table 39) including for-profit, nonprofit, and government facilities as well as pharmacies and medical distributors. In addition, a number of multilateral and bilateral donor organizations support the health system alongside the national NGOs that provide an oversight role.

TABLE 39: MAJOR ACTORS IN THE HEALTH SECTOR IN TOGO

	NGO, FBO, Civil Society	Development Partners
International	Caritas, PSI, EngenderHealth	Global Fund, UNAIDS, UNFPA, UNDP, World Bank, WHO, AFD
Local	ATBEF (IPPF), Aides Médicales et Charité, *Association pour la Santé de la Mère, du Nouveau-né et de l'Enfant* (ASMENE), *Appui au Développement et à la Santé Communautaire* (ADESCO*), Espoir Vie Togo*, *Ordre des Médecins*, *Ordre des Pharmaciens*	

Approximately one-third of all registered health providers in Togo are currently working in the private sector, making it an important partner in the delivery of health services. Moreover, the private for-profit sector employs 75 percent of doctors and over 92 percent of pharmacists (IHP+ 2011). Accredited private sector facilities include nine private hospitals, sixteen private clinics, and 251 private practices (Government of Togo 2012). The private sector delivers a greater volume of services than the public sector, especially in the category of ambulatory services (HiA 2010). Within the private sector, the nonprofit subsector has the most active delivery channel for HIV prevention and care, as well as for family planning services. The pharmaceutical sector is heavily concentrated in Lomé, with only 18 authorized pharmacies operating outside the capital (Table 40). Overall, coordination between the public and private health sectors is still nascent, in part due to fragmentation within the private sector as well as a lack of government oversight.

TABLE 40: TOGO: PRIVATE HEALTH SECTOR OVERVIEW, 2013

Type of Facility or Provider	Number
Private pharmacies in Togo	180*
Private pharmacies in Lomé	162*
Private pharmacies outside of Lomé	18*
Private physicians registered with the local regulatory body	200**
Private health providers in Togo (estimated)	2,000**

Source:
* Interview with the *Ordre des Pharmaciens* 2014.
** Interview with the *Ordre des Médecins* 2014.

3.6.2.1 FOR-PROFIT

During the 1980s, providers began operating for-profit medical practices alongside the public sector which offered free services to all citizens. Following the reform of the Togolese health system in that decade, the private sector began to increase its presence, mainly in and around Lomé. It is estimated that the wealthiest Togolese use private facilities because of a perception that they provide a higher quality of care and use more advanced equipment.

The *Direction des Etablissements de Soin* (DES), the body responsible for providing licenses to medical facilities, estimates that about half of the health facilities working in Lomé operate without a license. In addition, some that apply for or receive accreditation eventually disappear from government records because of poor communication between the regulatory authority and the private providers.

According to the *Ordre National des Médecins*, there is no systematic registration of providers with the national medical council; it is estimated that only 40 percent of medical doctors are formally registered.

3.6.2.2 NONPROFIT

The nonprofit sector in Togo is diverse and plays an important role in the provision of HIV and family planning services. Local and international nongovernmental organizations are active in every region of the country, and they operate numerous clinics and health centers. Like for-profit health facilities, nonprofit facilities are also obligated to obtain accreditation from the Ministry of Health and to report to MOH at the local level. While the nonprofit sector is organized into multiple organizations and platforms, communication between these entities and the MOH is still nascent and irregular (Government of Togo 2012).

Though overall coordination between the non-profit and public sectors has been rudimentary, the two sectors have in fact successfully coordinated to address the HIV epidemic, as discussed below. The nonprofit sector has provided not only HIV prevention services but also care, advocacy, and psychosocial support, and has reached at-risk populations such as SW and MSM.

Two professional provider associations focus on advocacy for improvements in health:

The *Ordre des Médecins*, independent since 1963, has responsibility for coordinating provider registration, enforcing the deontology code, and managing a pension for retired members. Although registration is mandatory for all providers, currently only 921 doctors are registered

(including 200 from the private sector) — or about 40 percent of the total estimated number of providers. The Order has a division of about 70 private sector providers, the "Association des Médecins Privés." The Order is currently working closely with the public sector to set up PPPs to optimize use of resources in both sectors. This collaboration enables private providers to practice in the public sector and public sector providers to access the equipment of the private sector. As a strong proponent of better integration of the private medical sector, the Order is a key player in the extension of these PPPs.

The *Ordre des Pharmaciens*, created in 2006, is a relatively new organization. The Order regulates pharmacy practice and works with the government, although not as closely as with private drug wholesalers. Meeting with the assessment team, the deputy director indicated that it was important to work with the government (particularly with the pharmacy directorate) to increase the number of inspectors. He also pointed to the need for a better geographic distribution of pharmacists which is currently poor as 162 out of 180 pharmacies are located in the capital.

3.6.2.3 DISTRIBUTION

The commodity distribution system in Togo is centralized at the national level. Togo is completely dependent on foreign imports, having no domestic pharmaceutical production. FP commodities are procured through the government's *Direction de la Santé Familiale* (DSF) and through private wholesalers. ARVs have been distributed freely through the government supply chain since 2008, and there is virtually no private procurement of those medicines.

All procurements and pharmaceutical products at the Ministry level must pass through the government-affiliated Essential Medicines and Generic Drugs Purchasing Central (CAMEG). Accredited pharmacies, public and for-profit, request supplies from CAMEG through a voucher system which ensures traceability of the supply chain.

Contraceptives, however, come through a different route. The main storage facility for contraceptive products is located within the CAMEG compound in Lomé, but FP products that are imported by the *Direction de la Santé Familiale* (DSF) are distributed directly to public facilities without transiting through CAMEG. FP products are also imported by private wholesalers and distributed directly to for-profit pharmacies for retail. In addition, local NGOs such as the *Association Togolaise pour le Bien Etre Familial* (ATBEF) and the *Association Togolaise de Marketing Social* (ATMS, an affiliate of PSI) are major distributors of family planning methods.

Of the five large private wholesalers in Togo, four are for-profit,[9] and one is a wholesaler that works directly with the faith-based sector and with the *Organisation de la Charité pour un Développement Intégra*l (OCDI/Caritas Togo).

The president of the *Ordre des Pharmaciens* reported that, while a black market for pharmaceutical products exists, informal drug selling activities have decreased in the past years due to increased police scrutiny and systematic destruction of illegal stocks.

[9] SOTOMED, GTPHARM, UNIFACT, and SOCOPHARM.

3.6.3 ENABLING ENVIRONMENT

The general environment in Togo is favorable to the participation of the private sector in the health system. After a 15-year suspension, international organizations reestablished relationships with Togo in 2007, restoring a stable environment in the country (CNP Togo). The Togolese health system is shaped by a series of laws and decrees, including some that recognize the participation of the private health sector and the importance of public-private partnerships (Table 43). Through the DES, the Ministry of Health is responsible for accrediting health facilities and ensuring adequate coverage, quality of services, and epidemiological reporting. Accreditation, which must be renewed every five years, is mandatory for both private nonprofit and private for-profit facilities.

The policy environment is favorable to national-level family planning efforts (see Table 41).

TABLE 41: KEY HEATH LAWS, DECREES, AND STRATEGIES IN TOGO

Date	Law/decree/directive
2013–2017	Repositioning Family Planning Plan focuses on strengthening coordination among government, civil society, and communities
2012–2015	*Plan National de Développement Sanitaire* (National Health Development Plan): governs regular accreditation of health facilities
2010	*Charte des Petites et Moyennes Entreprises et Industries* (PME/PMI) *du Togo*: eases government contracts and outsourcing of public services to the private sector
2010	Accelerated Campaign for the Reduction of Maternal Mortality (CARMMA): some FP services would be free of charge; in partnership with FP NGOs
May 2009	*Code de la Santé* (National Health Code): takes responsibility for organization of the health sector, including development of the public and private sectors
2008-2012	National Strategy for Securing Reproductive Health Products: discusses procurement of antiretroviral medicines
2008	Roadmap to Reduce Maternal, Infant, and Child Mortality in Togo calls for increased resources dedicated to FP
2007	Reproductive Health Law: all citizens have the right to access services, information, and education on reproductive health
2006	Reduce Alive: advocacy document that stimulates policy dialogue and strategic planning
1998	National Population Policy

Following a national forum in 2008, a platform to coordinate civil society organizations was created in 2009 and supported for three and a half years by UNDP. The platform allowed for the emergence of a more organized nonprofit private sector, permitting NGOs to leverage funding sources. The platform, *Plateforme des Organisations de la Société Civile Impliquées dans la Riposte au VIH Sida au Togo*, currently consists of 166 organizations with a national coordinating body. According to a UNDP report, about 300 people from 70 nonprofit organizations have been trained in activities relating to the fight against HIV (Yina 2011).

Two government entities have leadership of the fight against HIV and AIDS: the National AIDS-IST Program (PNLS, *Programme National de Lutte contre le Sida*), and the National AIDS Council (CNLS, *Conseil National de Lutte contre le Sida*). Both entities interact with actors from the public sector and the private sector (including doctors, businessmen, traditional leaders, religious leaders, and NGOs). CNLS focuses on prevention, advocacy and outreach while PNLS

organizes the delivery of services to PLHIV. Currently, the national response is slated to be decentralized, and CNLS has regional offices. However, a lack of personnel has reportedly hindered the decentralization effort.

In spite of laws that encourage public-private coordination and partnerships, the most recent PNDS acknowledges that the collaboration framework set forth in an earlier plan is not operational and that the contracting policy has been used infrequently over the past 10 years (IHP+ 2011). At the provider level, the Code of Conduct of Civil Servants prohibits public medical doctors from working in the private sector, making partnerships more difficult.

3.6.4 TRENDS IN HEALTH FINANCE

The 2008 NHA data for Togo indicate that over CFA 70 billion ($146 million) was spent on health, representing about 6.9 percent of GDP. The PNDS highlights that the budget allocated to the Ministry of Health represented only 6 percent of the total government spending for 2008, well below the 15 percent agreed on at the Abuja Declaration. The 2008 NHA estimated that 51 percent of all health-related spending was out-of-pocket (Government of Togo 2012). The World Bank indicates that 84.6 percent of all private health expenditures were out of pocket (World Bank 2014e).

Private insurance is available through several companies, including *Groupement Togolais d'Assurances*, *Groupe NSIA*, *Fédérale d'Assurance du Togo*, and *Groupe COLINA*; however, financing through these structures is still marginal. A law ratified in 2011 (no. 2011-003) mandating health coverage of civil servants spurred the creation of the *Institut National d'Assurance Maladie* (INAM) in March 2012. The plan covers 80 percent of costs for all services, including consultation, hospitalization, drugs, medical tests, and radiology; the employee pays the remaining 20 percent. For some services, the scheme covers 100 percent of costs. The government is planning to extend the program to the rest of the population.

3.6.5 DELIVERY OF FP AND HIV SERVICES THROUGH PUBLIC AND PRIVATE CHANNELS

3.6.5.1 FAMILY PLANNING

Historically, the nonprofit sector has played a much more significant role than the for-profit sector in the delivery of family planning products and services in Togo. The largest nonprofit contributor to family planning services is ATBEF, the IPPF affiliate in Togo, with five clinics and a fleet of mobile clinics. Services delivered through ATBEF represent approximately 19 percent of couple-years of protection, although the organization runs only 3 percent of the country's facilities. PSI–TOGO (ATMS) is a social marketing organization that operates through 79 facilities (70 public and 9 private) to distribute FP products: an oral contraceptive (Confiance); an injectable contraceptive (Depo-Provera); and condoms (Protector Plus and Rebel male condoms and Protectiv female condoms). PSI/Togo estimates that its work helped to prevent 22,000 unwanted pregnancies in 2007 (PSI).

While NGOs have been successful in delivering family planning services, monitoring has been a challenge since the MOH does not have a system for accrediting NGOs in FP. Interviews at the DSF revealed that the government can more readily keep track of the organizations that have contracts with the DSF than those with other funding sources.

Most contraceptive methods are supplied by ATBEF and ATMS as well as multilateral stakeholders such as the UNFPA. The most common methods used by Togolese women are male condoms followed by injectables and pills. The government created a Contraceptive

Product Security Committee in 2006, and there is a line item for the purchase of family planning products, but there is still a relatively high level of contraceptive insecurity at the national level. Although the Contraceptive Product Security Committee estimated that it would need two billion CFA ($4.1 million) to purchase an adequate supply of contraceptives in 2012, the budget line item was only 30 million CFA ($62,241).

3.6.5.2 HIV AND AIDS

The private nonprofit health sector has historically been the main provider of HIV testing and counseling, treatment, and psycho-social support for PLHIV, providing support at the grassroots level. Since 2001, the government has assumed leadership of the national response through the creation of PNLS (the National AIDS-IST Program) and CNLS (the National AIDS Council). However, the nonprofit sector remains the leader in addressing at-risk populations, including members of the lesbian, gay, and bisexual community, sex workers, and orphaned and vulnerable children. In 2009, 36 civil society organizations were accredited by the PNLS, treating an estimated 45 percent of the PLHIV under ART in 2011. While for-profit providers are not a main source of HIV services, there may be advantages in encouraging greater provision of HIV services by private providers, including the perception that they offer better quality of care and more privacy for PLHIV.

Through workplace programs, the private sector has played a small role in delivering HIV care and services. A joint project by the United States Department of Labor and the International Labor Organization (ILO) has been implemented with eight local companies to strengthen HIV prevention and care in the workplace.

Since 2008, ART has been distributed without charge as part of the government's response to HIV and AIDS. In 2012, 68 distribution sites were licensed by the PNLS. ARTs have historically been centrally purchased by the PNLS through CAMEG and distributed through the MOH. Stock-outs of ART throughout the system seem to be a recurrent concern. Since 2011, the PNLS has worked toward decentralization of HIV product procurement and distribution, creating regional management committees to work jointly with CAMEG and the PNLS in supply chain management. (*Programme National de Lutte Contre le Sida et les IST* 2012.)

The National AIDS Program 2012 annual report indicates that most of the ART treatment sites send reports on time, allowing monitoring of the supply chain (*Programme National de Lutte Contre le Sida et les IST* 2012). However, sites differ greatly in terms of availability of ARTs and HIV test reagents. The report shows that while ARV and PMTCT products were available at all sites in 2012 (at 100 percent and 97 percent availability respectively), only 71 percent of sites had CD4 test reagents available throughout 2012, and only 30 percent of sites had supplies to conduct Voluntary Counseling and Testing (VCT).

3.6.6 PUBLIC-PRIVATE PARTNERSHIPS

Table 42 provides examples of PPPs in Togo.

TABLE 42: PUBLIC-PRIVATE PARTNERSHIPS IN HEALTH IN TOGO

Private entity	Public entity	Description
Caritas Togo (nurses and doctors)	MOH–*Centre Médicosocial UTB Circulaire/ Centre Médicosocial Nyekonakpoe*	MOH contracts with Caritas Togo for delivery of services in specific health centers
Various NGOs + private health centers	MOH	Through funding from the Global Fund, the MOH "places" (and pays) ministry personnel at the facility level to facilitate reporting and ensure government overview of the health sector
Private pharmacies	MOH	Through funding from the Global Fund, the MOH heavily subsidizes malaria test kits in public and private pharmacies across the country

4. CONCLUSION AND RECOMMENDATIONS

4.1 CONCLUSIONS

The six West African countries in this macro-assessment report present considerable diversity in terms of economic and social development, unmet RH/FP need, level of HIV delivery in the private sector, and market maturity. Yet, countries in the region share characteristics that are unique to this part of the world, particularly with respect to reproductive behavior, private sector growth, and health sector reforms. This report presents crosscutting findings about the role of the private health sector in the region while pointing out various limiting or encouraging factors in specific countries. Finally, the paper recommends strategies to leverage the contribution of the private sector through appropriate policies and partnerships in FP and HIV/AIDS to guide USAID project activities.

Across West Africa, governments are recognizing the opportunities that arise from partnering with the private health sector. Considering the limitations on public health budgets in the region and the reality of current out-of-pocket spending flowing to the private health sector, it is time to consider the private sector in Francophone Africa as a true ally in the effort to improve health outcomes in the region.

4.2 RECOMMENDATIONS

Based on these findings, the assessment team has put forth the following regional and country-specific recommendations and sub-recommendations.

4.2.1 REGIONAL RECOMMENDATIONS

1. **Improve the public-private landscape across the region through ministry of health collaboration with WAHO as catalyst, convener, and connector.**

Ministries of health in each country are key drivers of public-private collaboration, and they set the tone for partnerships in the country. Ministries of health, in collaboration with the West African Health Organization and with guidance from representatives of the East Africa Healthcare Federation, could develop a regional private sector alliance in West Africa that can advocate for private sector issues to governments. WAHO could work with this newly formed West African private sector alliance to develop standards across the region for private sector engagement, reporting, and disease surveillance.

In response to the changing donor environment, WAHO can take the lead in assisting countries with resource mobilization strategies to fill the funding gap for FP and HIV products and services. By coordinating resource mobilization strategies, WAHO can encourage regional synergies. With WAHO's leadership and convening power, it would be useful to develop private health sector strategies in each focus country to increase the private sector's role in health care delivery.

WAHO could take the lead for a cross-regional examination of how regulatory burdens inhibit more effective private sector engagement in collaboration with USAID. Private sector stakeholders across the six countries indicated this could help increase the growth of the private health sector.

Since WAHO is a key stakeholder in FP and HIV/AIDS, it would be useful to present the findings of this report and the companion report on mHealth to WAHO as part of a one-day meeting.

2. Develop total market approaches to FP using contraceptive security committees.

WAHO's current collaboration with KfW on contraceptive procurement includes a component related to the total market approach, yet government stakeholders interviewed had little understanding of TMA or desire to pursue it. USAID projects would do well to work with countries on market segmentation activities which will also require capacity building of the public sector.

USAID West Africa projects can work to ensure that the private for-profit health sector is included in contraceptive security committees in each country. Of the six countries, only Niger currently includes the private for-profit health sector in its contraceptive security committee. SHOPS has found in other countries that this committee can be a catalytic vehicle for public-private collaboration. Contraceptive security committees can also serve as platforms to lobby for improved contraceptive logistics systems.

The Ouagadougou Partnership, launched in 2011 at the Regional Conference on Population, Development and Family Planning, consists of nine Francophone country governments in West Africa that are committed to reaching at least one million new users of family planning methods by 2015. Focus countries of this report have each developed strategies to re-launch family planning. Building on the momentum of the Ouagadougou Partnership, USAID West Africa projects can work with contraceptive security committees to conduct a market segmentation exercise and develop a total market approach in each country. WAHO's role can be regional coordination of total market approach efforts in West Africa.

3. Increase access to family planning services through collaboration with MSI, IPPF, and PSI affiliates in focus countries.

Private provider networks (such as those run by MSI, PSI, and IPPF) including social franchises and clinic outreach programs offer the most direct way to increase access to family planning methods in rural and urban areas. Building on their existing programs will help leverage scarce FP resources while gaining economies of scale.

4. Increase CSR opportunities within countries and regionally.

The CSR landscape has changed, and multinationals are more selective and less willing to engage in CSR activities unrelated to their core business function. It is important to reach companies through CSR associations and business councils in each country such as the *Coalition des Entreprises de Côte d'Ivoire contre le Sida* which helps pre-select companies interested in partnerships in HIV and FP.

5. Develop PPPs with mining companies in West Africa.

While mining companies in the region are smaller than in other parts of Africa, they offer the best opportunity for PPPs in health among multinationals present in the region. These companies could integrate FP into existing HIV activities at their worksites. Based on their geographic distribution and interest in health, IAMGOLD and Vale are possible partnership candidates. HANSHEP's Mining Health Initiative offers useful guidance for developing community health programs with mining companies. Since none of its case study examples are

in West Africa, it would be useful to conduct research to better understand the role mining companies play in FP and HIV in the region.

6. Increase learning within the region

Stakeholders interviewed in each country expressed interest in learning more about both unauthorized health facilities and illegal drug sellers. Such research to document the scale and scope of the informal sector in service provision and supply of health products would be a first step in determining how to improve their role in quality provision of FP and HIV.

There is increased focus among West African countries in infrastructure PPPs with PPP laws in several countries drafted to encourage investment promotion. However, there is a need to show how to move from infrastructure-driven to health-outcomes-driven partnership strategies. Guidance is needed on how this transition has been handled in other regions to help inform health PPP efforts in the six focus countries.

As part of the development of a regional private sector alliance, there is a need for a regional mechanism for sharing of information and experience through an online community of practice. Examination and documentation of successful public-private initiatives can also help move West African countries toward stronger private sector engagement in health.

4.2.2 COUNTRY-SPECIFIC RECOMMENDATIONS

In addition to regional recommendations that WAHO and USAID West Africa projects can undertake, there are country-specific recommendations to help guide future FP and HIV/AIDS activities in the six focus countries.

4.2.2.1 BURKINA FASO RECOMMENDATIONS

1. Improve policies and regulations regarding the private health sector.

Despite reforms undertaken by the government of Burkina Faso to enhance private sector participation in the health sector, there are still constraints that limit private providers' growth. The World Bank Group has been active across the continent in efforts to remove barriers to the private health sector. USAID West Africa can partner with them on efforts in Burkina Faso to strengthen the legal and regulatory environment, coordinate the private health sector federation, and improve enforcement of unlicensed clinics.

2. Modify restrictions that impede the growth of the private health sector.

Private sector stakeholders expressed frustration that the health sector has to pay more tax than the education sector. Work is needed to streamline import regulations and value-added tax exemptions. USAID West Africa projects can design incentives for private providers to serve peri-urban areas with low access to health products and services to improve FP and HIV health outcomes.

3. Increase the role of FBOs in provision of HIV services to MARPs.

In Burkina Faso, FBOs have strong relationships with the Ministry of Health, but there is room for an increase in their role for key populations. *Union des Religieux et Coutumiers du Burkina pour la Promotion de la Santé et du Développement* has existing contracts for HIV provision and could add additional activities for most-at-risk populations, such as safe sex messages and development of tailored counseling activities.

4.2.2.2 CAMEROON RECOMMENDATIONS

1. Ensure greater access to FP services and products.

Cameroon's access to FP services is concentrated in urban areas. To increase the coverage of these services in rural areas, USAID West Africa implementing partners can work with the Ministry of Health to supply FP products through community pharmacies. Currently, only child health products are provided through community pharmacies.

2. Encourage private providers to deliver HIV treatment.

Cameroon's private sector is poorly represented in the provision of HIV treatment. USAID implementing partners can work with the government of Cameroon to develop tax incentives and an enabling environment to encourage private providers to deliver HIV treatment.

3. Work with the private sector to improve health outcomes.

Existing donor-funded activities would benefit from expansion of scale. For example, USAID implementing partners can provide technical assistance to the *Association Camerounaise pour le Marketing Social* to add HIV services to the ProFam family planning network in Bafousam, Douala, and Yaoundé.

4. Develop a PPP with a mining or agribusiness company.

Cameroon has a strong mining sector with multinational companies that have existing health activities. USAID implementing partners can collaborate with mining companies and the Cameroon Business Coalition against AIDS for prevention and education campaigns.

4.2.2.3 CÔTE D'IVOIRE RECOMMENDATIONS

1. Strengthen policies to bolster private sector participation in FP and HIV service delivery.

The country's Reproductive Health Law, written five years ago, has yet to be signed into law. It would be useful to work with Commission Paritaire, an emerging public-private forum, to revise this law to include the private health sector in conjunction with the USAID-funded Futures Group-led Health Policy Project.

2. Work with the private sector to promote and strengthen PPPs and CSR activities.

USAID West Africa implementing partners can work with the Africa Center for Information and Development to provide HIV and FP services in mining companies such as Newmont Overseas Exploration and Occidental Gold.

Another opportunity for USAID West Africa implementing partners is to work with *Association des Cliniques Privées de Côte d'Ivoire* to integrate FP services into the SHOPS-sponsored pilot network of private HIV service providers. Large agribusiness companies in southern and southwestern Côte d'Ivoire such as *Société des Caoutchoucs de Grand-Béréby* serve as potential partners for a health PPP.

4.2.2.4 MAURITANIA RECOMMENDATIONS

1. Promote an enabling environment for the private sector at the national level and through PPPs.

Mauritania's policy documents have limited mention of the private health sector, particularly for HIV and FP. Implementing partners can increase the role of the private sector in strategic documents such as the National Health Development Plan *(Plan National de Développement Sanitaire*). Implementing partners can also advocate with the government to prioritize PPPs to deliver FP and HIV services in conjunction with the Plan to Reposition FP 2014–2018.

2. Promote public sector strengthening of reproductive health/FP rights and access

USAID West Africa implementing partners can advocate for quick adoption of the Reproductive Health Law and also promote access to quality FP services for remote populations through community-based distribution in partnership with the *Association Mauritanienne de Planning Familiale*.

4.2.2.5 NIGER RECOMMENDATIONS

1. Invest in community-based FP and HIV activities through partnerships with local NGOs

USAID West Africa implementing partners can support community-based FP extension services through partnerships with ANBEF, ANIMAS SUTURA, PSI, and other local NGOs. Community-based outreach is essential in Niger where only 49 percent of the population has health coverage. These outreach services must focus FP messaging on girls and couples. An additional focus must be on antenatal care visits for pregnant women. It is important to focus on Agadez and Dosso, the two regions with the highest unmet FP need.

Opportunities exist to work through community radio stations to disseminate FP messages aimed directly at men who hold power in traditional Nigerien culture. More than television or newspaper, community radio appears to be the medium of choice for receiving information among rural Nigeriens.

While Niger has a relatively low prevalence of HIV, sex worker populations are the most vulnerable with high prevalence rates. USAID West Africa implementing partners can partner with the Nigerien chapter of Society for Women and AIDS in Africa to support preventive HIV services for sex worker populations, including promotion of female condom use.

2. Engage the private commercial sector in improving health outcomes.

USAID West Africa can support the *Coalition Nationale des Entreprises de Lutte Contre le Sida, la Tuberculose et le Paludisme* (CNEP-STP) as a coordinating mechanism for the private commercial sector. The organization has an energetic and ambitious director with a clear vision to work as a coordinating base for large enterprises in Niger to improve health outcomes.

Another opportunity to engage the private commercial sector is to work through Asusu's women's groups to disseminate FP messages at the community level. Asusu microfinance institution lends microcredit to a network of more than 20,000 women's groups. USAID can use this network to incorporate FP messaging at regular meetings of the women's groups.

4.2.2.6 TOGO RECOMMENDATIONS

1. Improve private sector reporting.

There is a need to train private sector facilities on reporting, monitoring ,and evaluation. Training opportunities (for NGOs and private providers) should be openly advertised through existing HIV and FP forums, such as *Plateforme des Organisations de la Société Civile contre le VIH/Sida* and *Fédération nationale des ONG/Associations de lutte contre le VIH/SIDA/IST et de planification familiale*).

2. Engage the private commercial sector.

Stronger discussion platforms that include the private commercial sector should be developed. While focusing on MOH leadership, such mechanisms would improve resource allocation and allow for better reporting of health information data. Dialogue should also be reinforced between private pharmacies and the National AIDS program to deliver ART.

3. Invest in community-based FP and HIV activities through partnerships with local NGOs.

Community-based activities are well-established in Togo, and USAID West Africa implementing partners can expand existing partnerships with community health workers and local health authorities based on the AWARE II model developed with the NGO Adesco in three districts. Local NGOs such as *Espoir Vie Togo* and *Aides Médicales et Charité* are well-positioned to partner on these activities.

4. Develop partnerships between the corporate and NGO sectors for the provision of HIV and FP services.

The International Labor Organization model for HIV prevention in the workplace could be implemented in Cameroon in partnership with the Association of Employers and the Chamber of Commerce. The corporate sector could contract with NGOs for the provision of outreach programs that include FP and HIV.

ANNEX A: STAKEHOLDER VISITS BY COUNTRY

The following list shows the key stakeholders that the macro assessment teams met in each country. A separate deliverable to USAID West Africa is a list of NGOs providing family planning and HIV/AIDS products and services for each of the six focus countries of the report. This list has been provided separately to USAID West Africa.

LIST OF PARTICIPANTS

Organization	Name	Title
Burkina Faso		
Catholic Relief Services	Moussa Dominique Bangre	Country Representative
PACTE-VIH	Dr. Joseph Aimee Bidiga	Coordinator
Population Council	Kabore Gisele	Project Coordinator
Marie Stopes International (MSI)	Nicolette Van Duursen	Country Director
Programme d'Appui au Monde Associatif et Communautaire de Lutte contre le VIH/SIDA (PAMAC)	Lougue Marcel Koudio	Coordinator
ABBEF *Association Burkinabèe pour le Bien-Etre Familial*	Boureihiman, Ouedraogo	Executive Director
Initiative Privée et communautaire Contre le VIH/Sida au Burkina Faso	Dr. Genevieve Onadja	Director
Association des Promoteurs des Cliniques Privees du Burkina (APROCLIB)	Dr. Diedon Alain, Hien	Principal Doctor at Notre Dame de la Compassion
Initiative Privée et Communautaire de Lutte contre le VIH/Sida au Burkina Faso	Dieudonne Bassonon	Director
Conseil Burkinabè des Organisations de Lutte contre le Sida (BURCASO)	Ousmane Ouedraogo	National Coordinator
Conseil National du Patronat Burkinabè	Philomene Yameogo	General Secretary
Ordre des Médecins du Burkina	Pr. Ali Niakara,	President
PROMACO	Simplice Seraphin Toe	Executive Director
	Nobila Kabore	M&E Director
Direction Générale de la Santé Familiale	Dr. Djeneba Sanon Ouedraogo	Secretary General
Ministère de la Santé	Dr. Amedee Prosper Djiguemde	Secretary General
John Snow, Incorporated	Parfait Nyuito Komlan Edah	Country Director
Association Burkinabè Raoul Follereau	Adama Jacques Ouandaogo	President

Organization	Name	Title
Cameroon		
MTN	Marie Germaine Ndzie	Stakeholders Manager
GIZ	Dr. Dieter Kocher	Principal Technical Adivsor
Catholic Relief Services	Lori Kunze	
Fondation Médicale Ad Lucem	Dr. Ngotte-Ntondo Josiane Dr. Bidjogo Atangana	Head of Medical Division
Direction de la Pharmacie du Médicament et des Laboratoires (DPML	Dr. Lekpa Karnaud	Supply Chain director
	Tetang Fouelefack	Deputy Director
	Xavier Lancelot	App Programmer
Ministère de la Santé, Directeur de la Santé Familiale	Pr. Robinson E. Mbu	Director
Ministère de la Santé, Programme National Multisectoriel de Lutte contre la Mortalité Maternelle, Néonatale et Infanto Juvénile	Dr Martina Baye	Technical Advisor
Ministère des Télécommunications	Jean Paul Richard	ITC Director
Ministère de la Santé, Santé Maternelle et Infantile	Dr. M'batye	Director
Ministère de la Santé, Direction des Ressources Humaines	Pr. Samuel Kingue	HR Director
Cameroon National Association for Family Welfare (CAMNAFAW)	Paul Dieudonne Desire Atangana Ondobo	Program Director
CHAI	Katherine W. Kalaris	Family Planning Program Manager
PSI Cameroon (*Association Camerounaise pour le Marketing Social* (ACMS))	Auguste Kpognon	Executive Director
	Dr. Jean Christian Youmba	Family Health Division
	Lea Monda	ProFam coordinator
	Jean Pythagore Biyik	Senior Coordinator
	Annie Michele Mvogo	HIV Division
UNFPA	Dr. Sharif Egal	Medical and Technical Division
UNAIDS Cameroon	Dr. Amadou Moctar Mbaye	Country Coordinator
CAMNAFAW (IPPF affiliate) and their clinic at Mimboman	Mr. Atangana	
Ordre National des Médecins du Cameroun	Dr. Josiane Ngotte-Ntondo	Medical and Technical Division
Centre Medical la Cathédrale	Dr. Michele Tagni Sartre	Director

Organization	Name	Title
Côte d'Ivoire		
PNSR (*Programme National de SR/PF*)	Dr Eliane ABBE	Former Director
	Dr. Kouakou Virgine	Director
	Dr Alexis Kouadio	Training Director
	M ZeregbeToh	Technical Advisor
CECI *Coalition des Entreprises de CI*	Paul Angenor Koffi	Executive Secretary
NPSP *Nouvelle Pharmacie de la Santé Publique*	Dir. Kristel KODO	Assistant Director
AIBEF *Association Ivoirienne de Bien-être Familial* (IPPF)	Florent KEI	Executive Director
DEPS *Direction des Etablissements et Professions Sanitaires*	Dr. Benjamin Nabala	Director
ACPCI *Association des Cliniques Privées de CI*	Dr. Joseph Boguifo	President
	Dr. Dacoury	Executive Secretary
ASACI *Association des sociétés d'Assurance de CI*	M Ambroise KONAN	Technical Advisor
Engender Health (Agir PF)	Dr. Kamelan	Director
SYNAMEPCI *Syndicat des Médecins Privés*	Dr. Sidick Bakayoko	President
Agence Française de Développement	Sonia Amalric	Program Manager
AIMAS : *Agence Ivoirienne de Marketing Social*	Koudou Lazare M GOUSSOU	Executive Director
FHI360	Marthe AHUI	Technical Advisor
ACID	Sanogo SEKOU	Director
USAID	Christina CHAPPELL	Health Director
PNPEC	Dr. ABO KOUAME	Director
DIPE	Dr. Pongathier	Director
Mauritania		
AECID (Mauritania) - *Agence Espagnole pour la Coopération Internationale au Développement*	Francisco Sancho Lopez	Coordinator
USAID	Linda Rae Gregory	Country Program Manager
WVI - Vision Mondiale Internationale (Mauritania)	Jean Gavriel Carvalho d'Alvarenga	Director of Operations
Caritas (Mauritanie)	Abdoulaye Samba Bâ	
Stop Sida (Mauritania)	M. Diawara Mahamadour	Program Manager
SWAA International - Society for Women and Aids in Africa (Mauritania)	Sana Adebass	Program Manager

Organization	Name	Title
Santé Sans Frontières	Dr. Cire Ly	President
ONUSIDA - *Programme Commun des Nations Unies contre le VIH/SIDA* (Mauritania)	Dr. El Hadj Ould Abdallahi	Country Coordinator
FNUAP - *Fonds des Nations Unies pour la Population* (Mauritania)	Bocar M'Baye	HIV Program Assistant
AMPF	Brahim Ould Ahmedou	Executive Director
PNSR	Dr. Mahfoud Ould Boye	Coordinator MOH/PNRS
Association des Ulemas et Erudits de Mauritanie	Ademine Ould Saleck	Imam, Nouakchott Mosque
Centrale d'Achats des Médicaments Essentiels et des Consommables Médicaux (CAMEC)	Dr. Ahmed Mohamed Ahmed	Commercial Director
Secretariat Exécutif National de Lutte contre le SIDA (CNLS)	Mohamed Lemine Ould Mreizig	Office Manager
Mauritanie Android	Moustapha Ould Yacoub	Founder
Regulatory Authority	Ahmed Ould Mohamedou	Communication Department Manager
Chinguitel	Mohamed Ould Ahmed Salem	Director of Public Companies Department
ASCOMA Courtage d'Assurances et de Réassurances	Mohamed Sadegh	Commercial director
AGIR-PF	Dr. Racine Kane	Country Representative
Association des Cliniques Privées de Mauritanie	Dr. Tolba MD Abderahmane	General Secretary
Matell	Mamoudou Ba, Chef du Service Marketing	Marketing Department Manager
UNICEF	Dr. Mamadou Ndiaye	Nutrition Manager
Ministry of Health, Hospital Medicine Management	Dr. Ba Mamadou S.	Director
PNSR	Jean Gavriel Carvalho d'Alvarenga	Director of Operations
Association des Ulemas et Erudits de Mauritanie	Abdoulaye Samba Bâ	
Centrale d'Achats des Médicaments Essentiels et des Consommables Médicaux (CAMEC)	M. Diawara Mahamadour	Program Manager
Secretariat Exécutif National de Lutte contre le SIDA (CNLS)	Sana Adebass, Responsable dans le cadre de la lutte contre le VIH	HIV Program Manager
Mauritanie Android	Dr. Cire Ly	President
Regulatory Authority	Dr. El Hadj Ould Abdallahi	Country Coordinator

Organization	Name	Title
Niger		
AREVA/SOMAIR	Toure Mariama Galadima	Sustainable Development/Sponsorship
AFD - Agence Française de Développement (Niger)	Sonia AMALRIC	Program Manager
CRS (Niger) - Catholic Relief Services	Dr. Ibrahim Ousmane	Coordinator
Samaritan's Purse	Alan Bobbett	Country Director
Direction de la Santé de Mère et de l'Enfant (DSME)	Dr. Ibrahim Souley	Director
Ministère de la Santé - Direction de la Pharmacie, des Laboratoires, et de la Médicine Traditionnelle	Dr. Messan Halimatou Allassane	Director
SWAA International - Society for Women and Aids in Africa (Niger)	Djatatou OUASSA	President
PSI Niger	Leger Royet	Country Representative
EngenderHealth	Dr. Fatima Moussa	Director of AGIR-PF
Banque Mondiale (Niger)	Djibrilla Karamoku	Sr. Health Specialist
Délégation de l'Union Européenne (Niger)	Nadia Cannata	
ANBEF - *Association Nigérienne pour le Bien-Etre Familial* (Niger)	Dr. Zagui Sani	Executive Director
ASUSU Microfinance Bank	Reki Moussa Hassane	Director
Polyclinique MAGORI	Dr. Ali ADA	Director
Pharmacie Maison Economique	Aichatou Nayama Kere	Deputy Director
Pharmacie Rond Point	Mohamed ISSA	Associate
Soni Ali Ber – Public Pharmacy	Bouraima Jackoumah	
Direction de la Pharmacie, des Laboratoires et la Médecine Traditionnelle (DPHL/MT)	Dr. Messan Hallimatou Allassane	Director
ANIMAS-SUTURA	Robert Eiger	Senior Advisor
	Nicolas de Metz	Consultant
Association des Pharmaciens Privés	Moustapha Diallo	State Pharmacist
Coordination Intersectorielle de Lutte contre les IST/VIH/SIDA (CILS)	Dr. Zeinabou Alhousseini M.	National Coordinator
La Coalition Nigérienne des Entreprises du Secteur Privé contre les IST/VIH/Sida, la Tuberculose, et le Paludisme (CNEP/STP)	Abdou Wahabou Amadou Issofou	Executive Director
Conseil National de l'Ordre des Médecins, Pharmaciens, et Chirurgiens-Dentistes	Dr. Almoustapha Illo	President

Organization	Name	Title
AREVA/SOMAIR	Toure Mariama Galadima	
AFD - *Agence Française de Développement* (Niger)	Sonia AMALRIC	Program Manager
CRS (Niger) - Catholic Relief Services	Dr. Ibrahim Ousmane	Coordinator
Samaritan's Purse	Alan Bobbett	National Director
Direction de la santé de la mère et de l'enfant (DSME)	Dr. Ibrahim Souley	Director
Ministère de la Santé - Direction de la Pharmacie, des Laboratoires, et de Médicine Traditionnelle	Dr. Messan Halimatou Allassane	Director
SWAA International - Society for Women and Aids in Africa (Niger)	Djatatou OUASSA	President
PSI Niger	Leger Royet	Country Representative
EngenderHealth	Dr. Fatima Moussa	Director of AGIR-PF
Togo		
USAID	Lukas Jackson	Development Projects Special Assistant
	Chantal Afoutou	Self-Help and Democracy and Human Rights Programs Coordinator
Aides Médicales et Charité (NGO)	Assagba Rahimatou	M&E director
Afrique Arc en Ciel (NGO)	Yves Kugbe	Program Manager
Moov Togo	Joseph Desiré Eliaka	Mobile Money Program Manager
Association pour la Santé de la Mère, du Nouveau-Né et de l'Enfant (ASMENE) (NGO)	Komi Agbéko Tsolenyanu	Executive Director
CCM Togo – Global Fund	Akou Pignandi	National Coordinator
Ministry of Health, Management of Global Funds Projects	Dr. Antoinette Eya D. Awaga	Coordinator
EngenderHealth	Dr. Eloi Ayamenou Amegan	Country Manager
Conseil National de Lutte contre le Sida et les IST (National AIDS Council)	Damien K. Amoussou	Deputy National Coordinator
CARITAS Togo	M. Emmanuel Planté	Project Manager
Agence Française de Développement	Lucie Vigier	Program Manager
AGIR (NGO)	Ayoko Mawuenam Koudoyor – Kangni	NGO Coordinator
Plan National de Lutte contre le Sida	Assetina Singo Tokofaï	Coordinator
PSI Togo / ATMS	Dr. Charles Dodzro	Program Manager
Association Togolaise pour le Bien Etre Familial (ATBEF)	Kossi Ahadji	Program Manager

Organization	Name	Title
CILSIDA (NGO)	Apoté Zekpa	Director
Clinique Biasa	Moise Fiadjoe	Director
UNDP	Jean François Some	HIV Program Specialist
UNAIDS	Tamir O. Sall	Country Director
ASPROFEM (NGO)	Odette Fagnon	Coordinator
Centrale d'Achat des Médicaments Essentiels et Génériques (CAMEG)	Komi Sefenu Takpa	Supply Chain Coordinator
Chambre de Commerce et d'Industrie	Rose Koudjome	Global Fund, Private Sector Representative
Appui au Développement et à la Santé Communautaire (ADESCO) (NGO)	Didier Nakpane Tante Kodjo	Director
Direction de la Santé Familiale	Dr. N'Tapi Kassouta	Director
UNFPA	Guy C. Ahialegbedzi	Assistant to the RH/HIV Program
Medical Society (*Ordre des Médecins*)	Komi Patrice Balo	Deputy Director
Pharmacists Society (*Ordre des Pharmaciens*)	Laté J.P. Lawson-Drackey	Deputy Director
Employers Association (*Patronat*)	Kékéli Klutse	Program Manager
	Mensa Yawo Kogbetse	Executive Director
Espoir Vie Togo	Jule Kokouvi Tchalla	M&E director
Forces en Action pour le Mieux-Etre de la Mère et de l'Enfant (NGO)	Dometo Sodji	Director/President of the Platform of CSO against HIV
Direction des Etablissements de Soin	Dr. Amivi Afefa M. Bibiane Baba	Director

ANNEX B: GOVERNMENT POLICIES TOWARD THE PRIVATE HEALTH SECTOR

In addition to the specific policies relating to the private health sector by country found in the body of the report, this annex provides a general overview by country of policies and strategies regarding the private health sector and gaps that need to be addressed. Information found in this section is synthesized from stakeholder conversations, legislative texts, and country-specific legal materials listed in the bibliography.

BURKINA FASO

Strategy for Private Health Sector

- PHS is included in the overall health sector policy via PNDS (national health plan)
- Government collaboration with the PHS includes contracting, local coordination, and annual dialogue
- Data collection is mandatory, but sanctions and facility closures are unenforced
- Compared to the region, PHS regulatory framework is strong
- Drug prices are regulated somewhat
- Facility inspections are fair and transparent but infrequent
- There are currently talks of a universal health insurance system
- There are subsidies available for the poor

Government Policies Regarding FP & HIV/AIDS

- Free care and treatment package to people living with HIV/AIDS
- There are antidiscrimination laws protecting people living with HIV (lodging, education, work, employment, health and social protection)
- Government highlights importance of considering MSM in the country's response to HIV
- There is legislation to guide programs geared towards sex workers, but it needs to be updated

Dialogue and Partnership

- PPP not well-defined, and actors are not coordinated
- Despite dialogue mechanisms, PHS is poorly represented and undervalued
- Large for-profit clinics are not reporting data, and when PHS data is reported, it is consolidated with public data to improve public indicators.

- Enforcement of regulation is inadequate, but it is applied fairly across all sectors
- While dual practice may be forbidden, many public physicians work in the PHS
- There are no incentives to encourage professionals to work in underserved areas
- Low insurance coverage and limited policy toward indigents

Gaps

- PPP not well-defined, and actors are not coordinated
- Despite the existence of dialogue mechanisms, PHS is poorly represented and undervalued
- Large for-profit clinics are not reporting data, and when PHS data is reported, it is consolidated with public data to improve public indicators.
- Enforcement of regulation is inadequate, but it is applied fairly across all sectors
- While dual practice may be forbidden, many public physicians work in the PHS
- There are no incentives to encourage professionals to work in underserved areas
- Low insurance coverage and limited policy toward indigents
- Many unemployed health workers with high number of medical students

CAMEROON

Strategy for Private Health Sector

- No specific strategy for the PHS
- Government contracts with the not for profit PHS and has contracting committee
- New laws in preparation for health insurance

Government Policies Regarding FP & HIV/AIDS

- Private providers can obtain free HIV drugs at subsidized price through the national purchasing agency and can sell the drugs with a profit margin.

Gaps

- No information exchange between sectors
- No dialogue platform
- Registration process is long and complex (two-step system of creating and opening a facility)
- Carte sanitaire outdated
- No incentives to ease the installation of the PHS in rural areas
- Rules on drug & health service pricing out of date and never enforced
- Inspection standards are outdated and inadequate

- Law forbids public and private physicians in the same association

CÔTE D'IVOIRE

Strategy for Private Health Sector

- PHS excluded from National Health Strategic Plan
- Nonprofit and FBO sector is better integrated into national health policy than private for profit sector
- PHS is included in disease surveillance during epidemic outbreaks
- No law specific to public health and the status of NGOs
- Professional associations, especially ACPCI, are the main communicators with the MOH
- There are standardized rules to own and operate a PHS facility
- It is mandatory to have health insurance through the 2001 law "AMU-*Assurance Maladie Universelle*," but there is no legal implementation

Government Policies Regarding FP & HIV/AIDS

- Free care and treatment packages to people living with HIV/AIDS

Gaps

- No significant PPP policy
- No mechanism for dialogue between the private and public sector
- No inclusion of PFP sector in health information systems
- No regular MOH verification of PHS practitioners
- Enforcement of health regulation is ineffective
- No enforcement of drug prices
- PHS facility inspections are not fair or transparent
- No incentives encouraging health professionals to work in underserved areas
- No regular inspections of pharmacies or health centers

MAURITANIA

Strategy for Private Health Sector

- A significant level of distrust hinders relations with the PHS, particularly regarding their commercial motives
- Current three-year plan was prepared without the involvement of the PHS
- New law on pharmacies has prompted more inspections and closures

- Inspections are fair and transparent, but closures are unenforced
- Mandatory insurance only for some public servants

Government Policies Regarding FP & HIV/AIDS

- Free care and treatment packages to people living with HIV/AIDS

Gaps

- No formal mechanism for dialogue
- Significant distrust between consumers and the health system leads many citizens to seek healthcare outside the country
- No consumer complaint mechanism
- The PHS is not involved in information exchange and reporting (including disease surveillance)
- Regulation and enforcement is poor
- No regulation on health service prices in the PHS
- No financing contracts of any kind
- Lack of training with few schools and low level of cooperation within the country
- No M&E process

NIGER

Strategy for Private Health Sector

- The PHS is included in dialogue, but there is little translation into action
- A well-functioning disease surveillance program is in place
- Inspection standards are the same for all facilities, and the process is fair; however, few inspections are performed
- Since 2007 Niger has been working on a national contracting strategy
- Most contracting is done with NGOs and FBOs
- No government financing toward the PHS
- Health insurance is not mandatory
- A new regulation on community-based insurance is in preparation
- There is a policy of free care for infants under five and pregnant women

Government Policies Regarding FP & HIV/AIDS

- Free care and treatment package to people living with HIV/AIDS

Gaps

- PHS is not well included in data collection except disease surveillance
- Regulation of the PHS is unenforced
- There is a need for M&E tools and broader communication of the regulatory framework
- The price of medical services is not regulated
- Law on dual practice is unclear

TOGO

Strategy for Private Health Sector

- New public health law (2009)
- PHS excluded from national health goals
- Nonprofit PHS is easily included in information exchange, but for-profit PHS is not
- Nonprofit PHS is more included in disease surveillance than the for-profit PHS
- The government sets medication prices
- Inspections are fair, transparent, and rigorous according to public sector actors, but PHS actors disagree
- Health insurance is not mandatory, and there is no government-run insurance scheme

Government Policies Regarding FP & HIV/AIDS

- Free care and treatment package to people living with HIV/AIDS

Gaps

- No formal mechanism of dialogue between public and private health sectors
- Implementation of regulation is ineffective
- Dual practice is not allowed but happens in practice
- Inspections of private health facilities rarely occur
- Financing contracts are uncommon

ANNEX C: MINING COMPANIES ACTIVE IN FOCUS COUNTRIES OF THE REPORT

The following list provides the names of mining companies active in each focus country.

LIST OF MINING COMPANIES ACTIVE IN EACH FOCUS COUNTRY

Country	Company
Burkina Faso	Essakane Sa, Semafo, Somita, Kalsaka Mining, Bmc, Ampella Mining Gold, Bissa Gold, Nantou Mining Sa, Orezone Inc Sarl, Ampella Mining, Gryphon Minerals, Goldbelt Resources, Mana Minerals, High River Gold Mines, Kiaka Gold, Gep Mines, Jilbey Burkina Sarl
Cameroon	Yan Chang Logone Development Company Sa, Glencore Exploration Cameroon Ltd, Kosmos Energy Cameroon Inc, Rodeo Development Ltd, Murphy Cameroon, Noble Energy Cameroon Ltd, Euroil Ltd, Mobil Producing Cameroon Limited Inc, Addax Petroleum Cameroon Ltd, Pecten Cameroun Company, Total Exploration Production Cameroun, Perenco Oil & Gas Cameroon Ltd, Perenco Cameroon, Nhc-Operation, Nhc Mandate, Cotco, Geovic Cameroon Plc, Razel, Cimencam, Cnk Mining
Côte d'Ivoire	Sodemi, Lgl-Equigold, Societe Des Mines D'ity (Smi), Yaoure Mining (Cluff Mining), Tongon, Boundoukou Manganese (Ex Taurian), Carem (Ex Biptfop), Cominor, Etruscan Resources, Golden Oriole, Golden Star Exploration, Jofema Mineral Resources, New African Business Corporation, Newmont Overseas Exploration, Occidental Gold, Randgold Resources, Rockstone Gold, Somici, Tata Steel, Td Continental
Mauritania	Societe Nationale Industrielle Et Miniere (Snim), Mauritanian Copper Mines (Mcm), Tasiast, Agrineq, Amssega Exploration, Arvg Specialty Mines (Pvt), Atlantic Metals, Aura Energy, Bofal Indo Mining Company, Bsa, Bumi Mauritanie, Caracal Gold, Cifc, Curve Capital Ventures, Drake Resources, Durman International Group, Earthstone Rm, El Aouj Mining Company, Elite Earth Minerals And Metals, Energie Atlantique, Es Minerals, Forte Energy, Generale Miniere Mauritanienne, Ghazal Minerals, Global Mauritania Mining, Groupe Azizi, Karfahane Co, Lusitania, Mauritania Energy Minerals, Mauritanian Minerals Company (Mmc), Mauritanian Mining Resources, Mauritania Ventures, Mauritanian Resources, Mineralis, Mining Resources, Negoce International Mining, Orecorp Mauritania, Pacific Andes Resources Development, Peak Metals, Sahara Minerals, Shield Mining, Shield Mining Saboussiri, Silvrex, Societe Mas, Somaso, Sonko Lowenthal, Sphere Mauritania, Tafoli Minerals, Taj-Africa, Tamagot Bumi, Tayssir Resources, Thl Mauritania Gold, Wadi Al Rawda, Wafa Mining, Wirami Entiti Mauritania

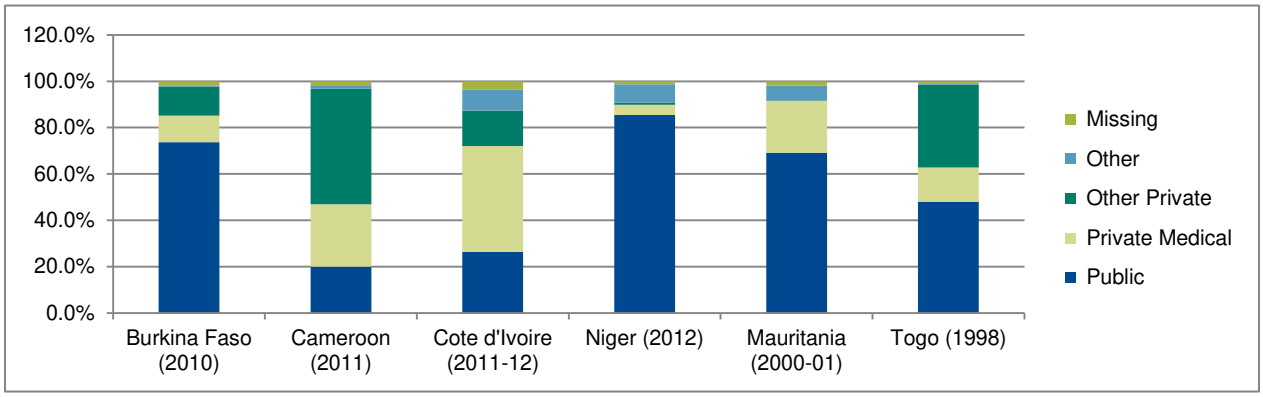
Country	Company
Niger	African Uranium Sarl, Agadez Ltd, Agmdc, Ali Tindano, Alou Abdoul Azibou, Amadou Biry Boulkadri, Amidou Ouaboa, Areva Nc Niger, Atelec, Boubacar Mohamed, Boureima Kiri, Caracal Gold Burkina, Cgc, Cnpc International Niger, Cnpc International Tenere, Cnpc Niger Petroleum, Cominak, Compagnie Geo Ingeniereie, Cooper Minerals, Delta Exploration, Demi Tiguiani, El Hadj Sadou Yacouba, El Hadji Abdoulaye Amadou, El Hadji Tahirou Hassane Et Fres, Ent Fayida Et Freres, Ets Mamane Eka, Ets Micmoun, Ets Nadia Gold Shop, Faria Asia Group Niger, Garba Maliki, Atomic Fuel Corporation, Global Uranium Ltd, Goviex Niger Holding, Gpe Sanecom/Asps, Gradoua Sa, Groupement Aiki, Groupement Alheri, Groupement Entreprise Atp/Sg/Ti, Groupement Expl Gypse, Groupement Gomni, Groupement Tabi Bene, Groupement Tebonse, Groupement Wafakay, Harouna Issa, Illiassou Djibrila, Imouraren Sa, Indo Energy Limited Adm, Island Arc Exploration, Issoufou Amadou, Issoufou Mahaman Moustapha, Jinxing Miniere, Lawan Hassan, Le Commerce Et, Mahamadou Bello, Mahamoudou Sihanri, Middle Island Resources, Mild Mining Ltd, Mining Business Corporation, Mohamed Ould Oumadah, Mohan Export India, Moumouni Gado, Moussa Ayouba, Niger Mining Services, Niger Resources Inc, Niger Uranium Sa, Nouvelle Cimenterie Du Niger, Ok Groupement D'entreprises, Ousseini Seydou, Rissa Mahamad, Sahel Lab Sa, Saidou Yahaya, Samaila Abouzedi, Sambo Namountoungou, Savadogo Mamoudou, Semafo Niger Sa, Semmous Lion Mining Ltd, Sgtp, Sipex Bvi/Sonatrach, Societe Des Mines Du Liptako, Snc Malbaza, Somair, Somina, Somini, Sonichar, Sopamin Sa, Soraz, Souley Halidou, Souley Mazankorai, Ste Anglo Energy, Ste Cruff Africa Associates Uk, Ste Des Ciments Du Niger, Ste D'exploitation De Manganese, Ste Indigo Exploration, Ste Jarra Mining, Ste Kemet Group Op South Afr, Ste Pamicor Limited Dtd Skm, Ste Predictive Discovery Sarl, Ste Prevail Gold Niger, Ste Snca, Ste Vestigo Resources, Taurian Resources Pvt Ltd, Trendfield Gold Mining, Uranium International Ltd, Yarga Amidou, Yaya Bizo, Younous Adam
Togo	Eni Togo, Snpt, West African Cement, Mm Mining, Scantogo Mines Sa, Pomar Togo Sa, Voltic, Brasserie Bb Lome Sa, Horizon Oxygene Clever Sarl, Societe Togolaise Des Eaux, Soltrans, Wafex, Togo Rail, Togo Carriere, Colas Afrique, Encotra, Les Aigles, Cemat Industrie/Inova, Ebomaf, Etoile Du Golfe, Satem Sarlu, Togolaise Des Grands Caous, Granu Togo G&B African Resources

Source: Extractive Industries Transparency Initiative, http://eiti.org/countries
Accessed: 3 April 2014.

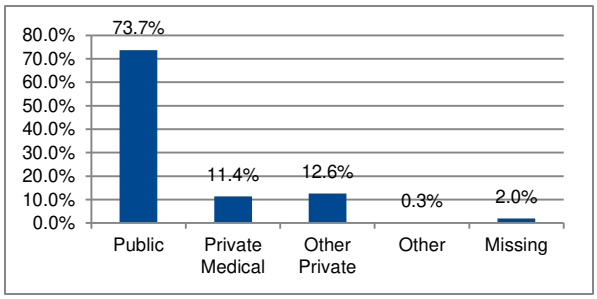
ANNEX D: REGIONAL AND COUNTRY SNAPSHOTS

The following country snapshots highlight trends in source of supply for modern contraception regionally as well as country-specific contraceptive prevalence rates, unmet need for family planning, HIV prevalence, and pregnant women counseled and tested for HIV. Data for these graphs was compiled from the most recent Demographic and Health Surveys, UNAIDS HIV statistics, and MICS.

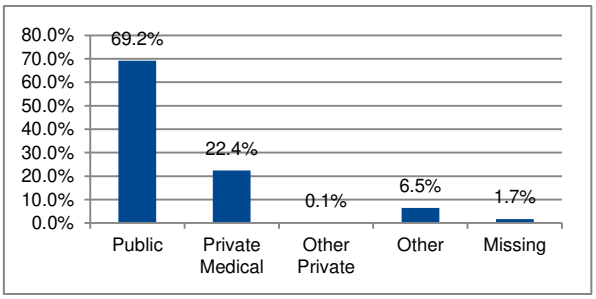
FIGURE D1: REGIONAL SOURCE OF MODERN FAMILY PLANNING SNAPSHOT



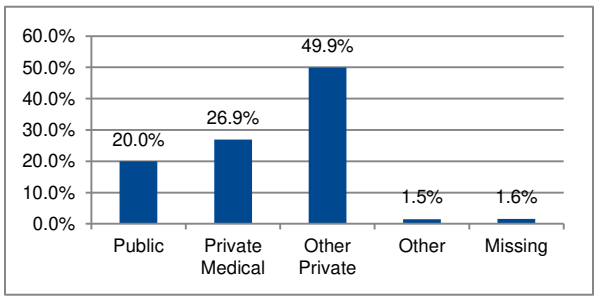
Burkina Faso 2010



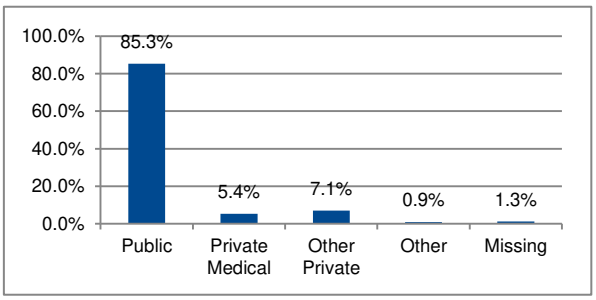
Mauritania 2000-01



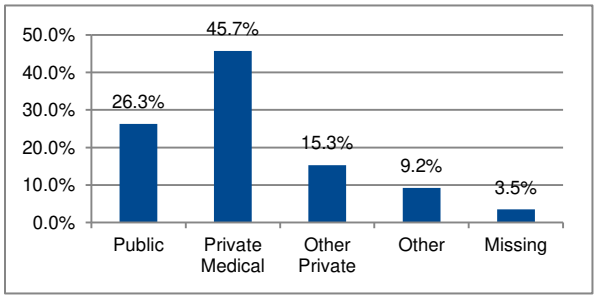
Cameroon 2011



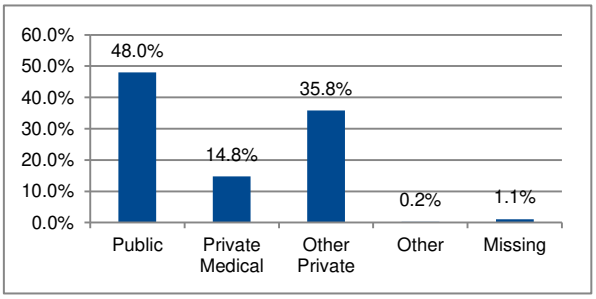
Niger 2012



Côte d'Ivoire 2011-12



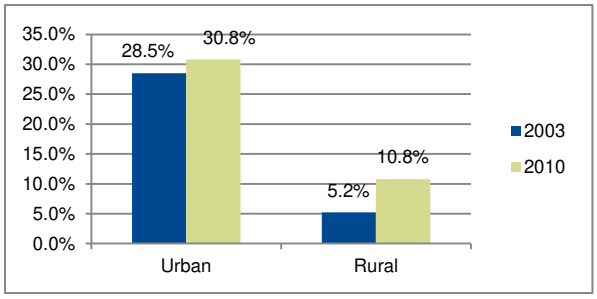
Togo 1998



Source: (MEASURE DHS)

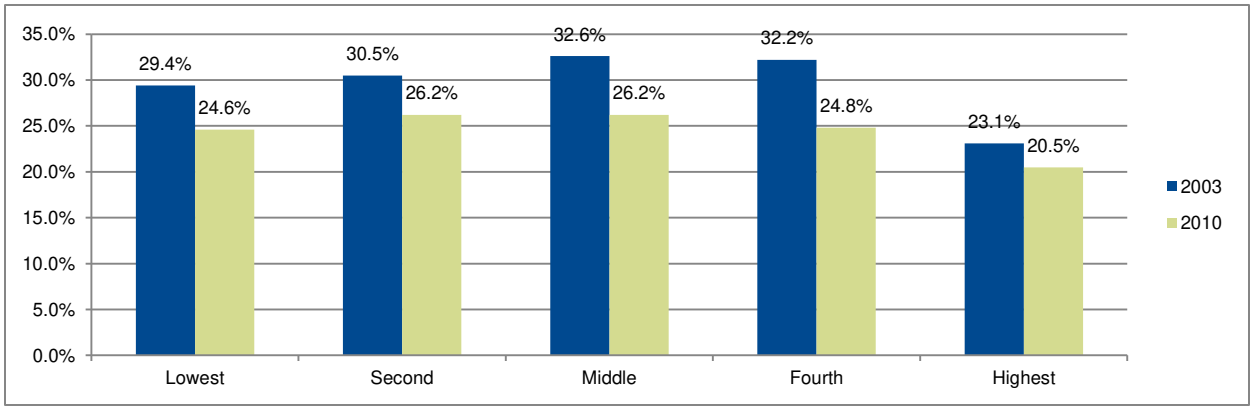
FIGURE D2: BURKINA FASO SNAPSHOT

Contraceptive Prevalence Rate: Any Modern Method by Location

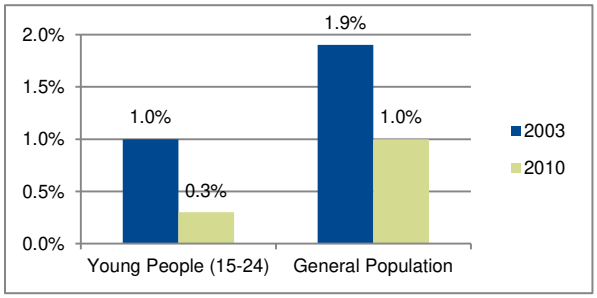




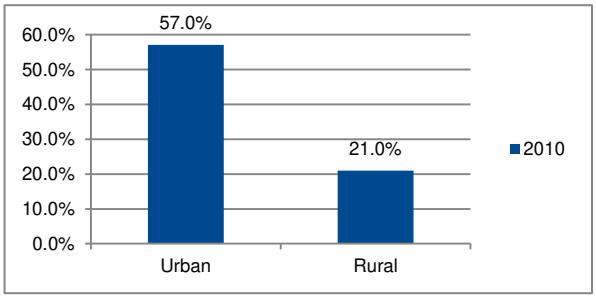
Unmet Need for Family Planning by Household Wealth Index



HIV Prevalence Rate: Total of Young and General Populations, Both Sexes Combined



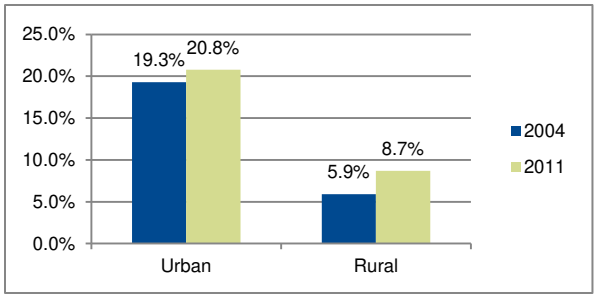
Pregnant Women Counseled and Tested by Location



Source :MEASURE DHS; Rosenberg 2014

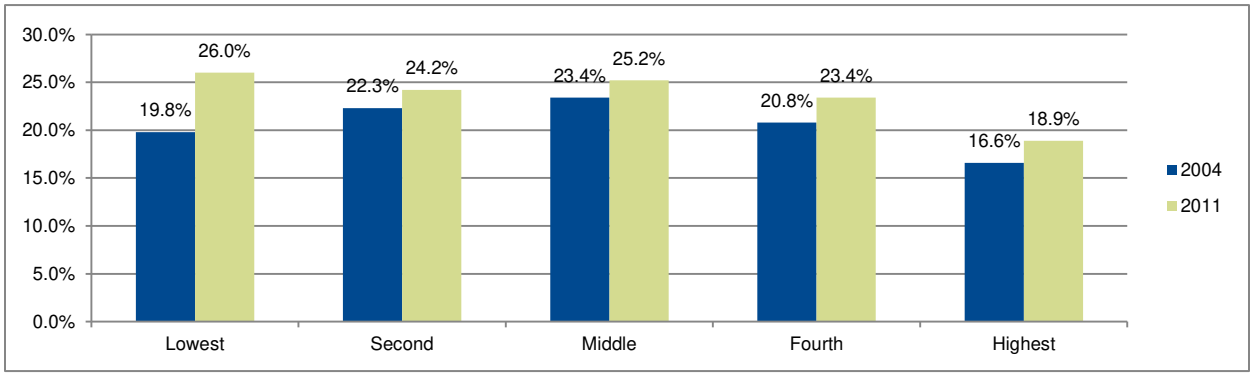
FIGURE D3: CAMEROON SNAPSHOT

Contraceptive Prevalence Rate: Any Modern Method by Location

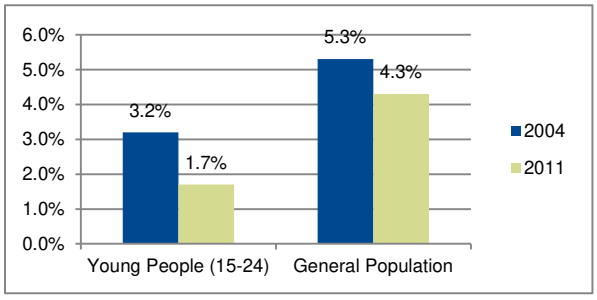




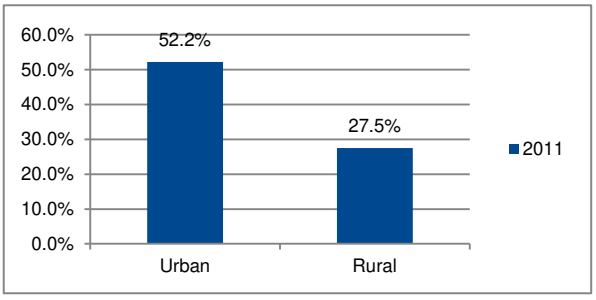
Unmet Need for Family Planning by Household Wealth Index



HIV Prevalence Rate: Total of Young and General Populations, Both Sexes Combined



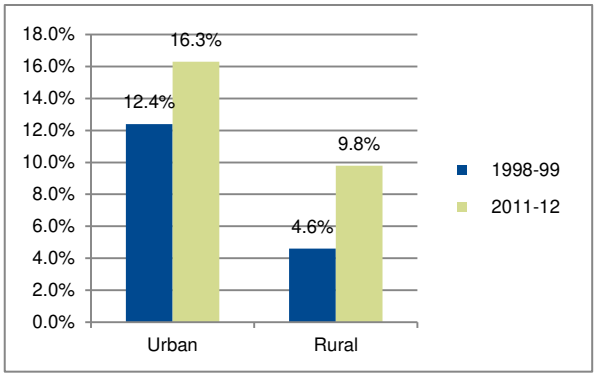
Pregnant Women Counseled and Tested by Location



Source: MEASURE DHS; Rosenberg 2014

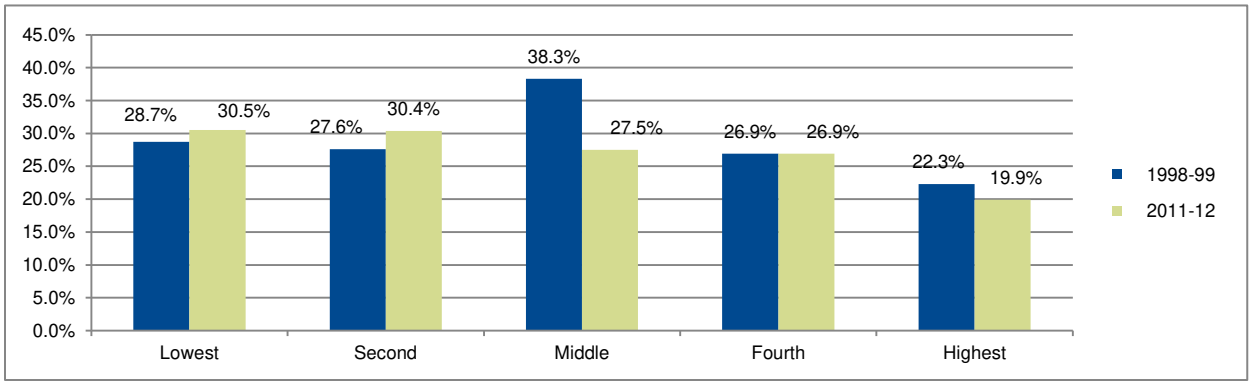
FIGURE D4: CÔTE D'IVOIRE SNAPSHOT

Contraceptive Prevalence Rate: Any Modern Method by Location

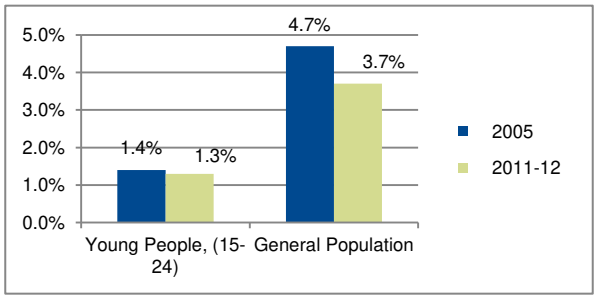




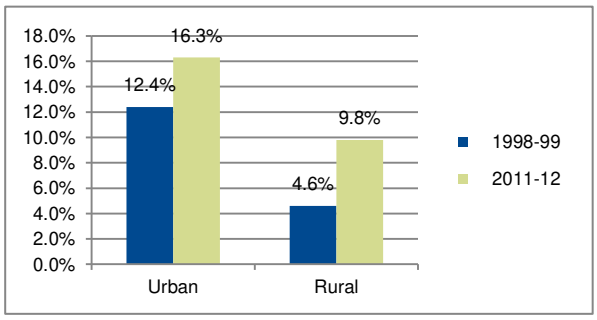
Unmet Need for Family Planning by Household Wealth Index



HIV Prevalence Rate: Total of Young and General Populations, Both Sexes Combined



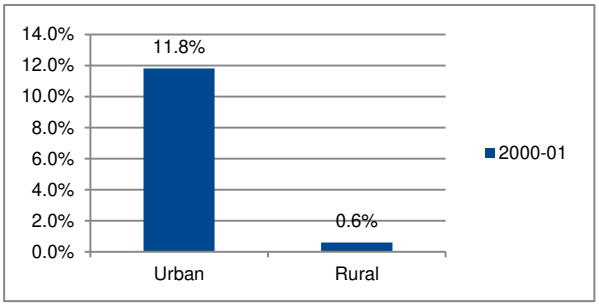
Pregnant Women Counseled and Tested by Location

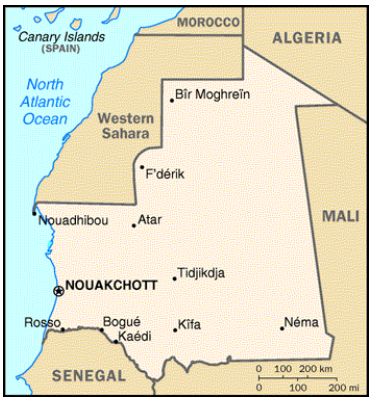


Source: MEASURE DHS; Rosenberg 2014

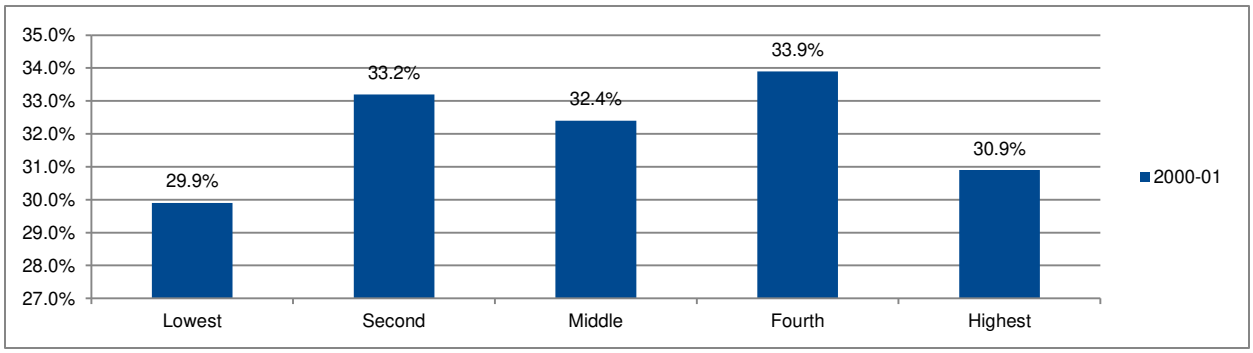
FIGURE D5: MAURITANIA SNAPSHOT

Unmet Need for Family Planning by Household Wealth Index

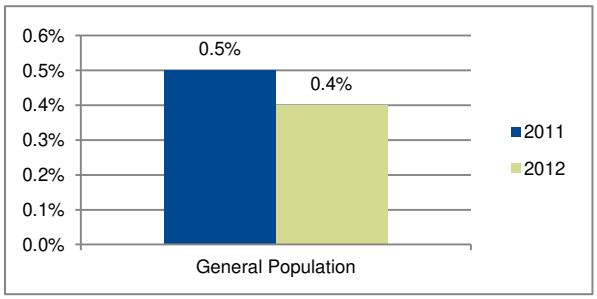




Contraceptive Prevalence Rate: Any Modern Method by Location



HIV Prevalence Rate: Total of Young and General Populations, Both Sexes Combined



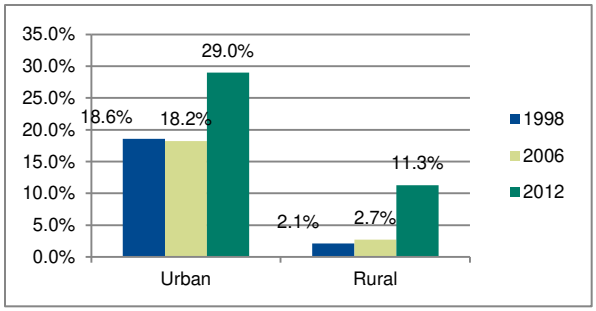
Source: MEASURE DHS; Rosenberg 2014; UNAIDS 2013

[10]

[10] No data is available for pregnant women tested and counseled by location

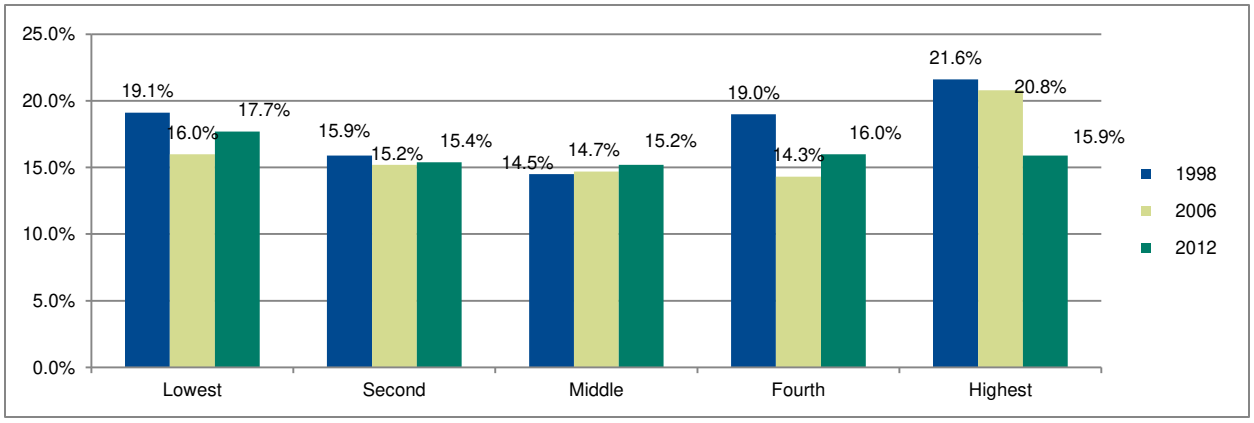
FIGURE D6: NIGER SNAPSHOT

Contraceptive Prevalence Rate: Any Modern Method by Location

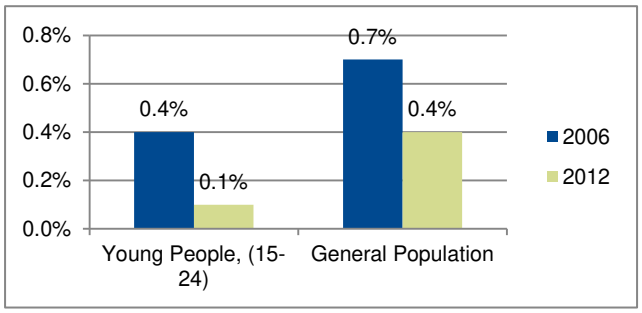




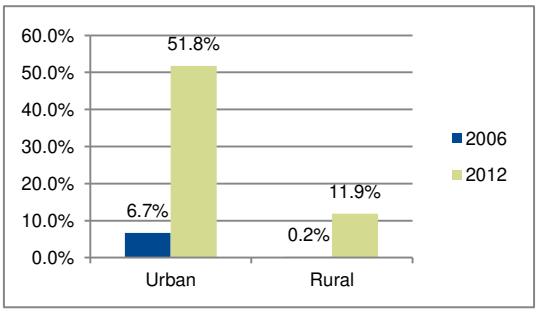
Unmet Need for Family Planning by Household Wealth Index



HIV Prevalence Rate: Total of Young and General Populations, Both Sexes Combined



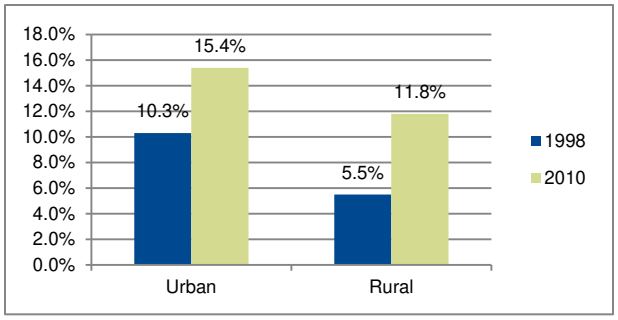
Pregnant Women Counseled and Tested by Location



Source : Institut National de la Statistique 2013; MEASURE DHS; Rosenberg 2014

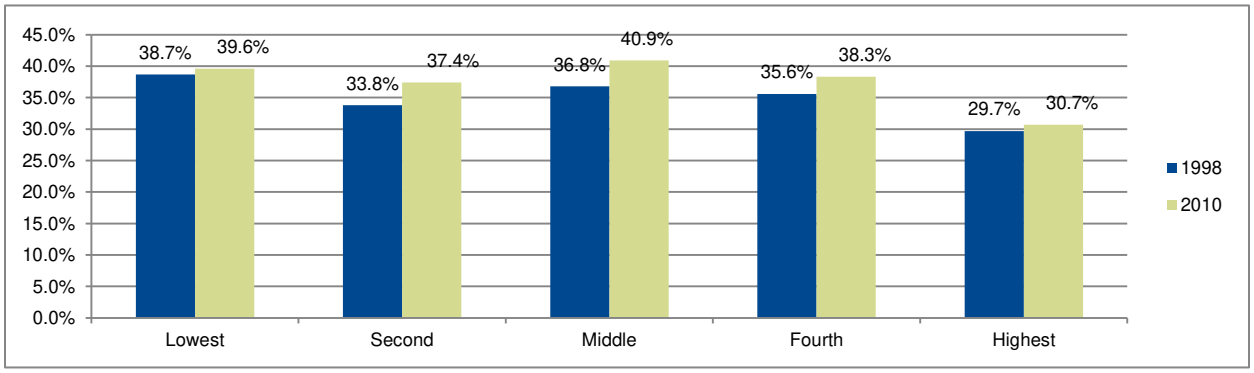
FIGURE D7: TOGO SNAPSHOT

Contraceptive Prevalence Rate: Any Modern Method by Location

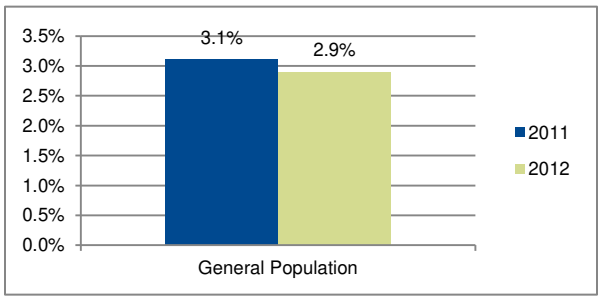




Unmet Need for Family Planning by Household Wealth Index



HIV Prevalence Rate: Total of Young and General Populations, Both Sexes Combined



Source: MEASURE DHS; MICS 2012; Rosenberg 2014; UNAIDS 2013

[11]

[11] No data is available for pregnant women tested and counseled by location

ANNEX E: BIBLIOGRAPHY

Abidjan.net. 2012. "Les Efforts d'Olam et leurs Partenaires dans la Lutte Contre le VIH/Sida Profitent à Plus de 234 000 Personnes en Afrique Rurale." <http://news.abidjan.net/h/446857.html>. Accessed April 9, 2014.

Africa Health Workforce Observatory. 2009. *Human Resources for Health Country Profile – Mauritania*. <http://www.hrh-observatory.afro.who.int/images/Document_Centre/mauritania_country_profile.pdf>. Accessed April 11, 2014.

Agence de Presse Labor. 2013. "Une loi sur le partenariat public-privé au Burkina Faso." <http://www.laborpresse.net/une-loi-sur-le-partenariat-public-prive-au-burkina-faso/#sthash.RwYKgFex.dpuf>. Accessed April 9, 2014.

Amnesty International. 2009. *Giving Life, Risking Death: Maternal Mortality in Burkina Faso*. London, England: Amnesty International Secretariat.

Areva. 2013. *Areva and Niger: A Strong Partnership*. Niamey, Niger. <http://niger.areva.com/niger/liblocal/docs/Presentation_AREVA%20et%20le%20Niger%20-%20Mars%202013VA.pdf>. Accessed April 9, 2014.

Assoumou, Didier. 2013. "Lutte contre les médicaments de rue: Le marché Adjamé-Roxy bientôt fermé." Abidjan.net. <http://news.abidjan.net/h/473298.html>. Accessed April 11, 2014.

Barnes, Jeffrey. 2011. *Designing Public-Private Partnerships in Health*. Bethesda, MD: Strengthening Health Outcomes through the Private Sector Project, Abt Associates Inc.

Barnes, Jeffrey, Janet Vail, and Dawn Crosby. 2012. *Total Market Initiatives for Reproductive Health*. Bethesda, MD: Strengthening Health Outcomes through the Private Sector Project, Abt Associates.

Barnes, Jeffrey, Desiré Boko, Mamadou Koné, Alphonse Kouakou, Thierry Uwamahoro, and James White. 2013. *Ivory Coast Private Health Sector Assessment*. Bethesda, MD: Strengthening Health Outcomes through the Private Sector Project, Abt Associates Inc.

Bayiri.com. 2014. *Banque Mondiale Prône le Partenariat Public-Privé dans la santé a Africallia 2014*. <http://bayiri.com/economie/la-banque-mondiale-prone-le-partenariat-public-prive-dans-la-sante-a-africallia-2014.html>. Accessed April 9, 2014.

Brisset, Claire. "Francophone Africa Fights AIDS." *Le Monde Diplomatique*. <http://mondediplo.com/2013/06/14suppaids>. Accessed May 9, 2014.

Burkina Faso Ministère de la Fonction Publique, du Travail et de la Sécurité Sociale. 2012. *Définition d'un Cadre Juridique pour l'Assurance Maladie au Burkina Faso*. <http://www.who.int/providingforhealth/countries/2012_06_11_SP_AMBF-Rapport_provisoire_Cadrage_juridique.pdf>. Accessed April 9, 2014.

Burkina Faso Ministry of Health. 2011. *Plan national de développement sanitaire 2011–2020*. <http://www.sante.gov.bf/files/Politiques_sanitaires/PNDS2011-2020_version1.pdf>. Accessed April 2, 2014.

_____. 2013. *Répertoire 2012 des Etablissements Sanitaires Privés de Soins du Burkina Faso.*

_____. 2014. *Revue technique 2013 du secteur de la santé: validation du rapport du comité technique*. <http://www.sante.gov.bf/index.php/le-ministere/organisation/233-revue-technique-2013-du-secteur-de-la-santevalidation-du-rapport-du-comite-technique>. Accessed April 2, 2014.

Business in Cameroon. 2014. *Cameroon: Exxon Mobil and COTCO Have Invested 2.2 Billion FCfa in Health in the Last 10 Years*. Yaounde, Cameroon. <http://www.businessincameroon.com/rse/1801-4587-cameroon-exxon-mobil-and-cotco-have-invested-2-2-billion-fcfa-in-health-in-the-last-10-years>. Accessed April 9, 2014.

Cameroon Department of Human Resources. 2011. *Recensement General des Personnels du Secteur de la Sante du Cameroun*. <http://cm-minsante-drh.com/site/images/stories/Rapport_general_du_recensement01_12_2011_misenforme_FINAL05122001.pdf>. Accessed April 11, 2014.

Cameroon-Info.Net. 2008. *Médicaments: L'ordonnance se fait toujours dans la rue*. Yaounde, Cameroon. <http://www.cameroon-info.net/stories/0,22865,@,medicaments-l-ordonnance-se-fait-toujours-dans-la-rue.html>. Accessed April 11, 2014.

_____. 2012. *Santé Publique: Gazon, un hôpital à ciel ouvert en plein cœur de Douala - Des injections préparées en plein air!* Yaounde, Cameroon. http://www.cameroon-info.net/stories/0,39427,@,sante-publique-gazon-un-hopital-a-ciel-ouvert-en-plein-c-ur-de-douala-des-inject.html>. Accessed April 11, 2014.

Central Intelligence Agency. 2014a. *The World Factbook: Côte d'Ivoire*. <https://www.cia.gov/library/publications/the-world-factbook/geos/iv.html>. Accessed April 11, 2014.

_____. 2014b. *The World Factbook:* Mauritania. <https://www.cia.gov/library/publications/the-world-factbook/geos/mr.html>. Accessed April 11, 2014.

CFPMI. 2007. *Développement Durable et Secteur Privé au Sénégal*. <http://www.rsesenegal.com/portail/main.php?page=showactu&type=1&id=1570>. Accessed April 9, 2014.

CNLS-IST (Conseil National de Lutte Contre le Sida et les Infections Sexuellement Transmissibles). 2012a. *Politique Nationale de Lutte Contre le VIH et le Sida au Togo: Vison 2020*. Lomé, Togo. <http://countryoffice.unfpa.org/togo/drive/PolitiqueNationaledeluttecontrelesidaauTogo_Vision2020.pdf>. Accessed April 15, 2014.

_____. 2012b. *Rapport de Progres sur la Riposte au Sida au Togo (GARP 2012)*. Lomé, Togo. <http://www.unaids.org/en/dataanalysis/knowyourresponse/countryprogressreports/2012countries/ce_TG_Narrative_Report%5b1%5d.pdf>. Accessed May 9, 2014.

CNP Togo. *Togo Guide: Doing Business and Investing in Togo within the Framework of OHADA Legislation*. <http://acpbusinessclimate.org/pseef/Documents/Togo_guide_en.pdf>. Accessed April 15, 2014.

Conférence Internationale des Ordres de Pharmaciens Francophones. Togo. <http://www.ciopf.org/Fiches-des-pays/Togo>. Accessed April 15, 2014.

Conseil National de Lutte Contre le Sida (CNLS). 2011. *Plan Stratégique National de Lutte contre l'Infection à VIH, le SIDA et les IST 2011–2015*. Abidjan, Côte d'Ivoire: CNLS.

Consultant Group International. 2005. *Etude sur le potentiel du développement du secteur prive sanitaire du Burkina Faso*. <http://www.sante.gov.bf/phocadownload/Publications_statistiques/Enquetes/13.pdf>. Accessed May 9,2014.

Countdown. 2013. *Countdown to 2015: Maternal, Newborn, and Child Survival: Burkina Faso*. <http://www.countdown2015mnch.org/documents/2013Report/Burkina_Faso_Accountability_profile_2013.pdf>. Accessed April 2, 2014.

DELIVER. 2007. *West Africa: Final Regional Report*. Arlington, VA.: DELIVER, for the U.S. Agency for International Development.

DELIVER. 2010. *Continuous Financing Helps Advance Contraceptive Security in Burkina Faso*. Arlington, VA: John Snow, Incorporated. <http://deliver.jsi.com/dlvr_content/resources/allpubs/policypapers/ContFinaHelpAdvCS_BF.pdf>. Accessed April 9, 2014.

DIPE (Direction de l'Information, de la Planification et de l'Evaluation). 2011. *Répertoire des Structures Sanitaires Publiques et Privées de Côte d'Ivoire*. Abidjan, Côte d'Ivoire: Ministère de la Santé et de l'Hygiène Publique, DIPE.

Drake, J. K. 2011. *Developing a Total Market Plan for Family Planning in Vietnam*. Seattle, WA: PATH.

Ebongue, Geraldine. 2014. *Prise en Charge du VIDA/SIDA: Le Secteur Privé s'Engage*. <http://newsducamer.com/index.php/societe/ca-bouge/item/2695-prise-en-charge-du-vida-sida-le-secteur-priv%C3%A9-s%E2%80%99engage>. Accessed February 10, 2014.

Egal, S., and V. Kapahou. 2013. *Evaluation du Systeme Logistique pour la Securisation des Produits Contraceptifs au Cameroun.* UNFPA.

EngenderHealth. 2014. Burkina Faso. <http://www.engenderhealth.org/our-countries/africa/burkina-faso.php>. Accessed April 2, 2014.

Family Planning Ouagadougou Partnership. *Family Planning: Francophone West Africa on the Move: A Call to Action*. <http://www.prb.org/pdf12/ouagadougou-partnership_en.pdf>. Accessed April 15, 2014.

Fondation GlaxoSmithKline. 2006. *La responsabilité sociale des entreprises dans la lutte contre le VIH*. <http://www.gsk.fr/fondation_gsk/publications/lettre_fondation/fond_lettre_11.pdf>. Accessed April 9, 2014.

Fondation Medicale Ad Lucem Cameroun. 2005. "Organization." <http://www.fondationadlucem.org/>. Accessed June 6, 2014.

Ford Foundation. 2010. *West Africa*. New York, NY: Ford Foundation. <http://www.fordfoundation.org/pdfs/library/West-Africa-brochure-2010.pdf>. Accessed March 31, 2014.

Futures Group. *AWARE II – Support for Investing in People through Health Action for West Africa Region 2009–2012*. <http://futuresgroup.com/projects/45>. Accessed April 2, 2014.

Global AIDS Response Progress Reporting. 2012. *Rapport d'Activités sur la Riposte au Sida du Burkina Faso 2012*. <http://www.unaids.org/en/dataanalysis/knowyourresponse/countryprogressreports/2012countries/ce_BF_Narrative_Report[1].pdf>. Accessed May 9, 2014.

Government of Burkina Faso. *Carte Sanitaire du Burkina Faso*. <http://www.sante.gov.bf/files/Carte%20sanitaire/sante_bf/liste_cartes.htm>. Accessed April 15, 2014.

Government of Burkina Faso. 2013. *Plan National de Relance de la Planification Familiale 2013–2015*.

Government of Côte d'Ivoire. 2013. *Partenariat Public-Prive: le Gouvernement Sollicite des Investisseurs Européens pour la Reconstruction des Infrastructures de Sante Publique*. <http://www.gouv.ci/actualite_1.php?recordID=3602>. Accessed April 9, 2014.

Government of Niger. 2014. *Portail Officiel du Gouvernement du Niger*. <http://www.gouv.ne/index.php/276-au-conseil-des-ministres-du-27-mars-2014-le-gouvernement-adopte-plusieurs-projets-de-textes-et-des-mesures-nominatives>. Accessed May 7, 2014.

Government of Togo. 2009. Code de la Santé Publique de la Republique Togolaise. <http://apps.who.int/medicinedocs/documents/s21006fr/s21006fr.pdf>. Accessed April 15, 2014.

_____. 2012. *Plan National de Developpement Sanitaire du Togo 2012–2015*. <http://www.internationalhealthpartnership.net/fileadmin/uploads/ihp/Documents/Country_Pages/Togo/PNDS_TOGO.PDF>. Accessed April 15, 2014.

HANSHEP. 2014. Mining Health Initiative. *Harnessing Non-state Actors for Better Health for the Poor*. <http://www.hanshep.org/our-programmes/mining-public-private-partnership-study>. Accessed April 9, 2014.

HiA. 2010. *Togo Country Report*. World Bank.

ICMM. 2013. *Community Health Programs in the Mining and Metals Industry*. International Council on Mining and Metals. <http://www.icmm.com/document/5788>. Accessed May 9, 2014.

Institut National de la Statistique (Côte d'Ivoire) and ORC Macro. 2006. *Enquête sur les Indicateurs du Sida, Côte d'Ivoire 2005*. Calverton, MD.

Institut National de la Statistique (Niger) and ORC Macro. 2013. *Enquête Démographique et de Santé et à Indicateurs Multiples du Niger 2012*. Calverton, MD.

International Finance Corporation. 2008. *The Business of Health in Africa: Partnering with the Private Sector to Improve People's Lives*. Washington, DC: International Finance Corporation World Bank Group. <http://www.unido.org/fileadmin/user_media/Services/PSD/BEP/IFC_HealthinAfrica_Final.pdf>. Accessed April 9, 2014.

_____. 2011. *Health in Africa – Factsheet*. <https://www.wbginvestmentclimate.org/advisory-services/health/upload/FINAL-HiA-factsheet.pdf>. Accessed April 2, 2014.

_____. 2014a. *Ease of Doing Business in Cameroon*. International Finance Corporation World Bank Group. <http://www.doingbusiness.org/data/exploreeconomies/cameroon/>. Accessed April 11, 2014.

_____. 2014b. *Economy Rankings*. Washington, DC: International Finance Corporation World Bank Group. <http://doingbusiness.org/rankings>. Accessed April 9, 2014.

International Health Partnership + Related Initiatives (IHP+). 2011. *Analyse de la Situation du Secteur de la Santé au Togo*. <http://www.snu.tg/bonus/sites/default/files/Analyse%20de%20la%20Situation%20du%20Secteur%20de%20la%20Sante%20au%20Togo%20-%20Mai%202011.pdf>. Accessed April 15, 2014.

Investir au Cameroun. 2012. "160 Tonnes de Médicaments Contrefaits Saisis." Yaounde, Cameroon. <http://www.investiraucameroun.com/securite/0604-3212-160-tonnes-de-medicaments-contrefaits-saisis>. Accessed April 11, 2014.

IRIN. 2010. "Niger: Health Centres Bracing for Malnutrition Surge." Niamey/Zinder. <http://www.irinnews.org/report/88541/niger-health-centres-bracing-for-malnutrition-surge>. Accessed April 2, 2014.

Kagone, Meba, Eric Takang, Antoine Ndiaye, Olga Sankara, and Ernest Ouédraogo. 2005. *Country Assessment Report: Burkina Faso*. Arlington, VA: John Snow, Inc./DELIVER, for the U.S. Agency for International Development.

L'Afrique s'Eveille. 2011. *Côte d'Ivoire: Responsabilité Sociétale des Entreprises (RSE) en Afrique : SIFCA montre la voie aux multinationales*. <http://www.thierrytene.com/article-cote-d-ivoire-responsabilite-societale-des-entreprises-rse-en-afrique-sifca-montre-la-voie-aux-multinationales-69468694.html>. Accessed April 9, 2014.

Lecerf, Michel, Adama Doe Bruce, Olivier Wybo, and Benoit Louis. 2009. *Guide Faire des Affaires et Investir au Togo: Etude Juridique et Institutionnelle*.

Maiga, Modibo, and Aissatou Lo. 2012. *Repositioning Family Planning in Mauritania: A Baseline.* Washington, DC: Futures Group and the William and Flora Hewlett Foundation.

Mauritania Ministry of Health. 2011. *Plan National de Développement Sanitaire 2012–2020*.

_____. 2013. *Plan d'Action en Faveur de l'Espacement des Naissances 2014–2018*. <http://partenariatouaga.org/wp-content/uploads/2013/11/Plan-Repositionnement-PF-Mauritanie.pdf>. Accessed May 9, 2014.

MEASURE DHS. Various Years. *Demographic and Health Surveys*. STAT Compiler. Calverton: ICF International. <http://www.statcompiler.com>. Accessed April 9, 2014.

Meddeb, Slah. 2009. *Plan Stratégique SR 2008–2012*. Nouakchott, Mauritania: Programme National de Santé de la Reproduction.

Médecins Sans Frontieres. 2014. "West and Central Africa Patients Have Been 'Left Behind' by the AIDS Revolution." <http://www.msf.org/article/west-and-central-africa-patients-have-been-left-behind-aids-revolution>. Accessed May 9, 2014.

Mining Health Initiative. 2013. "Good Practice Guidelines: Partnering for Effective Mining Health Programming." <http://www.hanshep.org/member-area/programmes/mining-health-initiative/good-practice-guidelines_final_130204.pdf>. Accessed April 9, 2014.

Ministère de la Sante et de la Lutte contre le SIDA (MSLS). 2012. *Plan National de Développement Sanitaire 2012–2015*. Abidjan, Côte d'Ivoire: MSLS.

Ministère de la Santé et de l'Hygiène Publique (MSHP). 2008. *Répertoire National des Structures de Prise en Charge des Personnes Infectées par le VIH, des Centres de Conseil et Dépistage Volontaire, des Services de Prévention de la Transmission du VIH de la Mère à l'Enfant*. Abidjan, Côte d'Ivoire: MSHP.

_____. 2010. *Comptes Nationaux de la Santé, Exercices 2007, 2008: Compte Général, Sous Compte VIH/SIDA*. Abidjan, Côte d'Ivoire: MSHP.

Ministry of Public Health (Cameroon). 2013. *Politique Pharmaceutique Nationale*.

MICS (Multiple Indicator Cluster Survey). 2012. *Suivi de la Situation des Enfants et des Femmes: Enquête par grappes à indicateurs multiples 2010*. Yaounde, Cameroon.

National AIDS Control Committee Central Technical Group. 2010. *Plan Stratégique National de Lutte Contre le VIH, le Sida, et les IST 2011–2015*. Yaounde, Cameroon. <http://www.africanchildforum.org/clr/policy%20per%20country/cameroun/cameroon_hivaids_2011-2015_fr.pdf>. Accessed April 11, 2014.

_____. 2012. *Rapport National de Suivi de la Déclaration Politique sur le VIH/SIDA Cameroun*. Yaounde, Cameroon.

National Order of Pharmacists of Burkina Faso. 2013. *Bulletin d'information*. Edition 12. <http://www.onpbf.org/doc/Bulletin012.pdf>. Accessed April 2, 2014.

Nations Online. 2013. *Official and Spoken Languages of African Countries*. <http://www.nationsonline.org/oneworld/african_languages.htm>. Accessed April 9, 2014.

Ndeboc, Fonkwo Peter. 2011. *Report on the Evaluation of Family Planning Services in Cameroon*. GIZ and Ministry of Public Health, Cameroon.

Nfor, Monde Kingsley. 2013. "Cameroonians 'Dying' for Fake Drugs." Yaounde, Cameroon: Inter Press Service. <http://www.ipsnews.net/2013/09/cameroonians-dying-for-fake-drugs/>. Accessed April 11, 2014.

_____. 2014. "Saving Cameroonians from Ill Health." Yaounde, Cameroon: Inter Press Service. <http://www.ipsnews.net/2014/01/saving-cameroonians-ill-health/>. Accessed April 11, 2014.

NPR. 2014. "As Health Crisis Looms, Cameroon Cracks Down on Illegal Clinics." <http://www.npr.org/player/v2/mediaPlayer.html?action=1&t=1&islist=false&id=279213793&m=279405690>. Accessed April 11, 2014.

Office National d'Edition et de Presse. *Partenariat Public-Privé au Niger: les Cadres de l'Administration, des Collectivités et les Operateurs Privés en Seminaire*. <http://www.lesahel.org/index.php?option=com_k2&view=item&id=1946:partenariat-public-prive-au-niger--les-cadres-de-ladministration-des-collectivites-et-les-operateurs-prives-en-seminaire&Itemid=102>. Accessed April 11, 2014.

Ould Mohamed El Moctar, Salem. *Présentation de l'Assurance Maladie en Mauritanie et du Rôle de la CNAM dans sa Gestion*. Nouakchott, Mauritania : Caisse Nationale d'Assurance Maladie.

PACTE VIH (Prévention et prise en charge du VIH/Sida en Afrique de l'ouest). 2013. *Rapport final de l'étude exploratoire*. Burkina Faso.

Paré, Fulbert. 2013. *Sous-secteur de la Santé Privée au Burkina : Un Cadre Fédérateur Mis en Place*. Lefaso.net. <http://www.worldbank.org/en/country/togo>. Accessed May 30, 2014.

Population Reference Bureau. 2013. *2013 World Population Data Sheet*. Washington, DC: Population Reference Bureau. <http://www.prb.org/pdf13/2013-population-data-sheet_eng.pdf>. Accessed April 11, 2014.

Private Healthcare in Developing Countries. 2008. *Private Healthcare in Developing Countries*. <http://ps4h.org/globalhealthdata.html>. Accessed 9 April 2014.

Programme National de Lutte Contre le Sida et les IST. 2012. *Rapport Annuel des Activités : Année 2012*. <http://www.pnls.tg/rapports/R2012.pdf>. Accessed April 11, 2014.

PSI. *Togo*. <http://www.psi.org/togo>. Accessed April 15, 2014.

Randgold Resources Limited. 2014. *Sustainability Health and Safety*. <http://www.randgoldresources.com/randgold/content/en/randgold/randgold-health-and-safety>. Accessed April 9, 2014.

Reproductive Health Supplies Coalition (a). "About Us." <http://www.rhsupplies.org/about-us.html>. Accessed May 7, 2014.

_____ (b). Burkina Faso. <http://www.rhsupplies.org/resources-tools/country-profiles/burkina-faso/burkina-faso.html>. Accessed April 9, 2014.

Rosenberg, Matt. 2014. "Maps: Burkina Faso, Cameroon, Côte d'Ivoire, Mauritania, Niger, and Togo." About.com. <http://geography.about.com/library/maps/blindex.htm>. Accessed April 11, 2014.

RSE et PED (Ressources et Communauté sur la RSE dans les Pays en Développement). 2011. *Nos Partenaires*. <http://www.rse-et-ped.info/partenaires/groupe-tedamoun-mauritanie-bilan-des-activites-2009-2011/>. Accessed April 9, 2014.

_____. 2014. *Orange Cameroun Lance un Service de Prévention Médicale, en Collaboration avec le Ministère de la Santé Camerounais*. <http://www.rse-et-ped.info/orange-cameroun-lance-un-service-de-prevention-medicale-en-collaboration-avec-le-ministere-de-la-sante-camerounais/>. Accessed April 9, 2014.

RSE Senegal. 2012. *Forum Francophone de Lyon Preparant Rio+20 Contribution RSE Senegal Pour l'Atelier sur la RSE*. <http://www.rsesenegal.com/pdf/ContributionRSEsenegal.pdf>. Accessed April 9, 2014.

Sandiford, Peter, Anna Gorter, and Micol Salvetto. 2002. *Vouchers for Health: Using Voucher Schemes for Output-Based Aid*. Washington, DC: World Bank. <https://openknowledge.worldbank.org/bitstream/handle/10986/11349/multi0page.pdf?sequence=1>. Accessed April 9, 2014.

Santé en Entreprise. 2014. *Etat des Lieux de l'Engagement du Secteur Privé dans la Lutte Contre le Paludisme: Afrique Francophone*. Paris, France. <http://www.santeenentreprise.com/wp-content/uploads/2012/10/etat_des_lieux_engagement_secteur_priv%C3%A9_8-avril.pdf>. Accessed April 9, 2014.

Sanou, Arlette. Partenariat Public-Privé: Expérience du Burkina Faso. <http://www.google.com/url?sa=t&rct=j&q=&esrc=s&frm=1&source=web&cd=7&ved=0CGkQFjAG&url=http%3A%2F%2Fwww.afro.who.int%2Fen%2Fdownloads%2Fdoc_download%2F2281-partenariat-public-prive--experience-du-burkina-faso.html&ei=yBVDU8ysIvfIsASWn4LABw&usg=AFQjCNFEbumD52KhPfAVW_cZNeNSeRZJvw&sig2=9cHg94Q2nMvva4GD-cwFlw>. Accessed April 9, 2014.

SIFCA. 2012. *Actualités*. <http://www.groupesifca.com/mecenat.html>. Accessed April 9, 2014.

Sow, Djiby, and Fatim Louise Dia. 2013a. *Pour un Environnement de la Réponse au VIH au Burkina Faso Plus Tolérant avec les Populations Clés*. Burkina Faso.

_____. 2013b. *Environnement de la Réponse au VIH en Lien avec les Populations Clés au Togo: Entre Tolérance Programmatique, Ambiguïté Légale et Hostilité Sociétale*. Lomé, Togo.

Trading Economics. 2013. "Health Expenditure Per Capita (US Dollar) in Sub Saharan Africa." <http://www.tradingeconomics.com/sub-saharan-africa/health-expenditure-per-capita-us-dollar-wb-data.html>. Accessed April 11, 2014.

UHC Forward (Universal Health Coverage Forward). *Niger Equitable Health Financing*. <http://www.equitablehealthfinancing.org/countries/niger>. Accessed April 1, 2014.

UNAIDS. 2012. *Rapport d'Activité sur la Riposte au Sida au Niger 2012*. <http://www.unaids.org/en/dataanalysis/knowyourresponse/countryprogressreports/2012countries/ce_NE_Narrative_Report[2].pdf>. Accessed May 9, 2014.

_____. 2013a. "Global Report: UNAIDS Report on the Gloabal AIDS Epidemic 2013." <http://www.unaids.org/en/media/unaids/contentassets/documents/epidemiology/2013/gr2013/UNAIDS_Global_Report_2013_en.pdf>. Accessed June 6, 2014.

_____. 2013b. "Estimated HIV Prevalence." <http://www.unaids.org/en/dataanalysis/datatools/aidsinfo/>. Accessed March 13, 2014.

U.S. Department of State. 2007. *Report on International Religious Freedom*. Washington, DC. <http://www.state.gov/j/drl/rls/irf/2007/>. Accessed April 15, 2014.

_____. 2013. U.S. *Relations with Togo*. Washington, DC. <http://www.state.gov/r/pa/ei/bgn/5430.htm>. Accessed April 11, 2014.

UNDP. 2013. *Burkina Faso Human Development Indicators*. <http://hdr.undp.org/en/countries/profiles/BFA>. Accessed April 2, 2014.

UNFPA. 2011. *Global Programme to Enhance Reproductive Health Commodity Security*. New York, NY: Commodity Security Branch United Nations Population Fund. <http://www.unfpa.org/webdav/site/global/shared/documents/gprhcs/GPRHCS_Burkina_Faso.pdf>. Accessed April 9, 2014.

Veervoort, Katrien. 2012. "Ensuring the Availability of Medicines in Burkina Faso: a Shared Responsibility." <http://www.globalhealthcheck.org/?p=505>. Accessed April 9, 2014.

Viswanathan, R. and E. Schatzkin. 2013. "Clinical Social Franchising Compendium: An Annual Survey of Programs: findings from 2012. San Francisco: The Global Health Group, Global Health Sciences, University of California, San Francisco.

West African Health Organization. 2009. "About WAHO." <http://www.wahooas.org/spip.php?page=rubriqueS&id_rubrique=24&lang=en>. Accessed May 7, 2014.

_____. 2011. "The CIB System for Pharmaceutical Products in the ECOWAS Region: Where Are We Today?" <http://www.wahooas.org/docs/cibulletineng.pdf>. Accessed May 9, 2014.

West African Health Organization and Kfw Entwicklungsbank. *Regional Program Reproductive Health and HIV Prevention in the ECOWAS Region*. <http://www.wahooas.org/IMG/pdf/FICHES-ANGLAIS.pdf>. Accessed April 9, 2014.

Witter, Sophie. 2010. *Mapping User Fees for Health Care in High-Mortality Countries: Evidence from a Recent Survey*. HLSP Institute. London. <http://www.hlsp.org/LinkClick.aspx?fileticket=BmlwPoRonho%3D&tabid=1570>. Accessed April 2, 2014.

Wong, Alexandre, and Urbain Kiswend-Sida Yameogo. 2011. *Les Jardins de la Cité*. Paris, France. <http://docs.eclm.fr/pdf_livre/350ResponsabilitesSocietalesDesEntreprisesEnAfriqueFrancophone.pdf>. Accessed April 9, 2014.

World Bank. n.d. *Data: Burkina Faso*. <http://data.worldbank.org/country/burkina-faso>. Accessed April 2, 2014.

_____. 2012a. *Étude sur le Secteur Privé de la Santé au Burkina-Faso*. Washington, D.C.: World Bank. <http://issuu.com/world.bank.publications/docs/9780821397015>. Accessed April 15, 2014.

_____. 2012b. *Taking Public-Private Partnerships (PPPs) Forward in Francophone Africa*. <http://wbi.worldbank.org/wbi/news/2010/03/12/taking-public-private-partnerships-forward-francophone-africa>. Accessed June 6, 2014.

_____. 2012c. *World Development Indicators 2012*. <http://data.worldbank.org/sites/default/files/wdi-2012-ebook.pdf>. Accessed May 9, 2014.

_____. 2013a. *Burkina Faso Hospital PPP*. <http://www.dgmarket.com/tenders/np-notice.do?noticeId=10366689>. Accessed June 6, 2014.

_____. 2013b. *Burkina Faso Overview*. <http://www.worldbank.org/en/country/burkinafaso/overview>. Accessed April 2, 2014.

_____. 2014a. *Côte d'Ivoire Overview*. <http://www.worldbank.org/en/country/cotedivoire/overview>. Accessed April 11, 2014.

_____. 2014b. *Data*. <http://data.worldbank.org/>. Accessed May 9, 2014.

_____. 2014c. *Explore. Create. Share: Development Data, Togo*. <http://databank.worldbank.org/data/home.aspx>. Accessed April 11, 2014.

_____. 2014d. *Global Economic Prospects: Country and Region Specific Forecasts and Data*. <http://www.worldbank.org/en/publication/global-economic-prospects/data?region=SST>. Accessed April 11, 2014.

_____. 2014e. *Out-of-Pocket Health Expenditure*. <http://data.worldbank.org/indicator/SH.XPD.OOPC.ZS/countries>. Accessed April 2, 2014.

_____. 2014f. *Togo: Country at a Glance*. <http://www.worldbank.org/en/country/togo>. Accessed April 11, 2014.

World Health Organization. n.d. *Global Health Expenditure Database*. <http://apps.who.int/nha/database/DataExplorerRegime.aspx>. Accessed May 9, 2014.

_____. 2005. *Summary Country Profile for HIV/AIDS Treatment Scale-Up*. <http://www.who.int/hiv/HIVCP_BFA.pdf>. Accessed May 7, 2014.

_____. 2006. Country Cooperation Strategy at a Glance. <http://www.who.int/countryfocus/resources/ccsbrief_niger_ner_06_en.pdf> Accessed April 2, 2014.

_____. 2010. *Cartographie des systèmes d'approvisionnement et de distribution des médicaments et autres produits de santé au Burkina Faso*. <http://apps.who.int/medicinedocs/documents/s18637fr/s18637fr.pdf>. Accessed April 2, 2014.

_____. 2011a. "The Abuja Declaration: Ten Years On." <http://www.who.int/healthsystems/publications/abuja_report_aug_2011.pdf?ua=1>. Accessed June 6, 2014.

_____. 2011b. *National Health Accounts, 1995–2011*. Uploaded by Knoema. <http://knoema.com/WHONHA2013R1/national-health-accounts-1995-2011?country=1000330-niger>. Accessed April 2, 2014.

_____. 2014. Global Health Expenditure Database. Geneva. <http://apps.who.int/nha/database/StandardReport.aspx?ID=REP_WEB_MINI_TEMPLATE_WEB_VERSION&COUNTRYKEY=84552>. Accessed April 2, 2014.

Yina, Dominique. 2011. Evaluation des Pratiques de Collaboration entre le Secteur Public et le Secteur Communautaire dans le Domaine de la Santé et Proposition d'une Demarche pour le Renforcement de la Collaboration entre les Deux Secteurs. PNLS Togo and PASCI.