SHOPS PLUS

Guinea Private Health Sector Assessment

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Summary

The private health sector is an important player in Guinea's health system, but the extent of its contribution remains largely unknown. SHOPS Plus, with funding from the United States Agency for International Development, assessed the role of the private sector in improving family planning, malaria, and maternal and child health in Guinea. The assessment focuses on key challenges and opportunities related to the enabling environment, financing, and service delivery to better leverage the private health sector's resources. This brief highlights the methods, findings, and recommendations from the full assessment.

Keywords: Africa, assessments, child health, contraceptives, corporate social responsibility, diarrhea, family planning, Guinea, health financing, maternal and child health, private sector assessment

Photo: Alisha Horowitz, Jhpiego

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SHOPSPLUS
Public-private engagement for better health

July 2022

Guinea Private Health Sector Assessment

Photo: SHOPS Plus


SOE

Introduction

Guinea is home to a mostly young, rural population of 14 million people in West Africa. The country has a low per capita gross national income of $850, with over half of Guineans employed in the agriculture sector. The country's economy is heavily dependent on the extractive industry, and Guinea is the world's second largest bauxite producer. The growth in the mining industry is helping to reshape the country—leading to influxes of foreign investment in the mining sector and related industries, as well as significant population movements that place strains on public resources.

In health, Guinea has made progress in several areas, yet key metrics continue to lag. Nearly 50 percent of the population must travel more than 5 kilometers to reach a health center (Health Focus 2015). The public sector lacks basic equipment, essential medicines, and other necessary products; these gaps are not sufficiently balanced out through a high-performing private sector or high-performing community-based services (Health Focus 2015). As a result, coverage rates of essential health and nutrition services remain low, especially in rural areas where most Guineans live (INS and ICF 2019, henceforth referred to as DHS 2018). Child mortality rates and maternal mortality ratios, while lower than in past years, remain high at 111/1,000 live births and 576/100,000 live births in 2018, respectively (DHS 2018). Children under 5 bear 72 percent of the total disease burden, most of which is associated with preventable causes like malaria, infectious disease, neonatal disorders, and malnutrition. The maternal mortality ratio remains among the highest in West Africa. Additionally, the current family planning market does not meet the estimated need in Guinea. Only 11.8 percent of women of reproductive age report using a modern contraceptive, and 17.7 percent have an estimated unmet need (DHS 2018).

Photo: Alisha Horowitz, Jhpiego

Assessment Scope and Methodology

In late 2020, the USAID Mission in Guinea engaged the global USAID-funded Sustaining Health Outcomes through the Private Sector (SHOPS) Plus project to assess Guinea's private health sector. SHOPS Plus sought to gather in-depth and up-to-date information to describe the Guinean private health sector and identify opportunities and constraints for greater private sector engagement that can guide future mission investments in health. Specifically, the assessment team sought to:

1. Provide an overview of the private health sector in Guinea and the roles of private health actors and stakeholders
2. Assess the enabling environment for the private health sector, including the policy and regulatory environment, the health financing landscape, and public-private engagement platforms
3. Evaluate private sector contributions to key health markets: family planning, nutrition, malaria, and maternal, newborn, and child health
4. Examine and identify existing and potential opportunities and constraints for greater involvement of the mining sector in health
5. Identify strategic opportunities and recommendations for increased private sector engagement in the health sector in Guinea

To achieve these ends, SHOPS Plus implemented this activity using its standard methodology developed over the course of conducting more than 30 private health sector assessments (PSAs) (Figure 1).

Figure 1. Steps in a PSA

Source: SHOPS Plus

Photo: USAID

The general approach consisted of a desk review of available documents, and secondary data analysis, followed by key informant interviews. Due to the ongoing COVID-19 pandemic, most key informant interviews were conducted virtually. In total, the team interviewed 56 stakeholders, including representatives from the Ministry of Health (MOH), key regulatory agencies, private providers, supply chain actors, and mining industry representatives. In addition, the team conducted on-site visits to 25 health facilities and drug outlets. Interviews and visits were conducted in two phases. In the first phase (November 2020–March 2021), the project completed an initial round of data collection and analysis and presented preliminary findings to USAID/Guinea. Subsequently, USAID/Guinea prioritized a few areas for a second phase of investigation (July–November 2021), with additional key informant interviews and analysis. Because of the ongoing COVID-19 pandemic and the political situation in Guinea at the time of this assessment, the team was unable to conduct a stakeholder validation exercise. The findings and recommendations in this brief therefore only represent the team's analysis based on the inputs received through the two rounds of data collection.

Findings

Health Sector Landscape

Guinea's health system is decentralized with various government bodies at the central, regional, and prefecture or community levels providing oversight and direction for their respective areas. At the central level, the MOH sets national policies and strategies, and directly oversees national-level referral hospitals. Regional governments oversee and manage regional referral hospitals. Prefecture and community officials oversee the numerous health posts and health centers that focus on primary health care, as well as prefect hospitals (MOH and WHO 2005). Bauxite and gold mining companies operate their own facilities and are often referred to as the para-public sector.

The private health sector consists of multiple actors. The for-profit health sector largely includes small private facilities, pharmaceutical actors, and a few small social enterprises. The nonprofit sector includes NGOs and faith-based organizations. Finally, the community sector includes community health agents and traditional healers (MOH 2014).

The total number, composition, and distribution of private providers is unknown. Private health practitioners are required to undergo a two-step registration process that many fail to complete. Published materials and key informants reveal that only 10–20 percent of private providers are registered and included in official counts (Health Focus 2015). As a result, there is a large and relatively unknown informal sector composed of non-accredited medical practices and unauthorized medication vendors. Understanding the size and scope of this informal sector requires additional research beyond the scope of this assessment.

Previous efforts to map the private health sector have tended to focus on specific geographic areas. For example, a census by the USAID-funded Health Finance and Governance project focused only on Conakry and found 571 private health facilities (Table 1). These private sector facilities offer a wide range of services including general medicine, family planning and reproductive health, obstetrics and gynecology, pediatric care, maternal and neonatal health, and malaria services (HFG 2018).

Table 1. Size and composition of the private health care sector in Conakry

Private Facility Type	Number
Physician offices	205
Clinics	105
Health centers	47
Polyclinics	27
Dentist offices	23
Nursing care providers	22
Faith-based centers	11
Laboratories	10
Medical centers	5
Imaging centers	3
Company health centers	2
Midwife practices	2
Undefined/other	109
Total	**571**

Pharmaceutical Outlets	Number
Drug shops	330
Boutiques with drugs	96
Points of sale (pharmacies)	37
Wholesalers	17
Depot/sale products	1
Non-classified	7
Total	**488**

Source: HFG 2018

In addition to private health care facilities, Guinea's commercial pharmaceutical sector consists of local manufacturers, importers and distributors, and pharmaceutical retail outlets (namely, pharmacies and drug shops). On the manufacturing side, Guinea has three local factories: one producing generic drugs and two producing medications based on medicinal plants (Health Focus 2015). Fifty private importers/wholesalers purchase pharmaceutical products from a wide array of manufacturers worldwide to sell to pharmacies and drug shops; one of these, Laborex, dominates the market and supplies over 500 pharmacies and drug shops across the country.

While data sources offer an incomplete picture of the private health sector, there are some common themes that emerge from the literature and stakeholder interviews:

- The private health sector is concentrated in Conakry and a few urban areas—one estimate indicates up to 95 percent of the private health workforce is located in Conakry alone; the private supply chain also has limited reach into rural areas.
- Dual practice is reportedly common, although not legal for most providers, complicating attempts to understand and oversee the private health sector (Camara and Camara 2014, Health Focus 2015, MOH 2015).
- Quality of care in the private sector is limited by high costs of accessing financing. High interest rates (20–25 percent) and import taxes (33–35 percent) limit providers' ability to make investments in capital improvements and equipment upgrades.
- Guinea's pharmacovigilance and quality control systems and supervision are weak, contributing to a large illicit market that impairs quality and limits the development of a formal pharmaceutical sector (Nfor, Bahati, and Camara 2017, GHSC-PSM 2019).

There are professional associations that help organize or represent private health stakeholders in Guinea—by one count 20 medical-related associations and 12 pharmacy-related associations (HFG 2018). These associations vary in their membership and formality. Key associations include the:

- National Federation of Private Clinics/Association of Clinics, NGOs, and Paraclinics (*Fédération Nationale des Cliniques Privées/Association des Cliniques, ONG Cliniques, et Paracliniques* [FNCP/ACPG])
- Midwives Association of Guinea (*Association des Sage Femmes de Guinée* [ASFEGUI]).
- National Syndicate of Pharmacists (*Syndicat National des Pharmaciens*)
- National Order of Pharmacists of Guinea (*Ordre National des Pharmaciens de Guinée*)
- The Federation of Private Hospitals of Guinea (*Fédération de l'Hospitalisation Privée de Guinée*)

FNCP/ACPG is a new organization of clinic owners that aims to reorganize the private medical sector to improve the quality of health services. FNCP/ACPG includes medical NGOs, health and dental facilities, and private laboratories. It works to improve private facilities' registration and regulation, and increase their participation in continuous medical education and MOH programs. In addition to advocating for the creation of mandatory standards of care, FNCP/ACPG intends to develop a private brand to introduce higher quality standards in the private sector. Key associations such as the ASFEGUI have previously joined inter-ministerial committees and occasionally participated in the review and validation of health plans.

Enabling Environment for the Private Health Sector

The enabling environment for the private health sector is shaped by the sector's relationship with government stewards, the regulatory framework, and the available financing resources. Three national directorates within the MOH are the primary stewards for all health service delivery activities, including the private sector: the National Directorate of Hospitals and Health Establishments (*Direction Nationale des Etablissements Hospitaliers et de Soins* [DNEHS]); the National Directorate of Family Health and Nutrition (*Direction Nationale de Santé Familiale et Nutrition* [DNSFN]); and the National Directorate of Pharmacy and Medicine (*Direction Nationale de la Pharmacie et du Medicament* [DNPM]). In Guinea, the enabling environment is challenged by weak relationships between public and private sectors, limited formal engagement mechanisms, an ineffective registration process, the absence of medical education and clinical training opportunities, and poor access to finance among private providers.

Policy Environment and Governance Practices

Guinea has several laws, policies, and strategies on the books to guide the development and regulation of the private health sector (Box 1). In general, these documents are characterized by high-level statements about the private sector, a lack of specificity to provide direction for public-private engagement in health, and a lack of operational guidelines to move identified opportunities beyond the page to practice.

Box 1. Relevant policies and regulations for Guinea's private health sector

Key pieces of regulation that govern the private health sector include:

- The Public Health Code, 1997
- National Health Policy, 2014
- National Health Development Plan, 2015—2025
- Ordinance No. 199 PRG/84
- Code of Investment
- Public–Private Partnership Law, 2017
- Pharmaceutical Regulatory Law, 2018
- 2018—2023 Costed Implementation Plan for Family Planning

The principal regulations governing the registration and monitoring of the private health sector are not well understood and are poorly applied (Health Focus 2015). The registration of new private health facilities—both clinics and pharmacies—features a two-step registration process. First, interested parties must submit 12–15 documents requesting approval to establish a new private facility to the DNEHS (clinics and

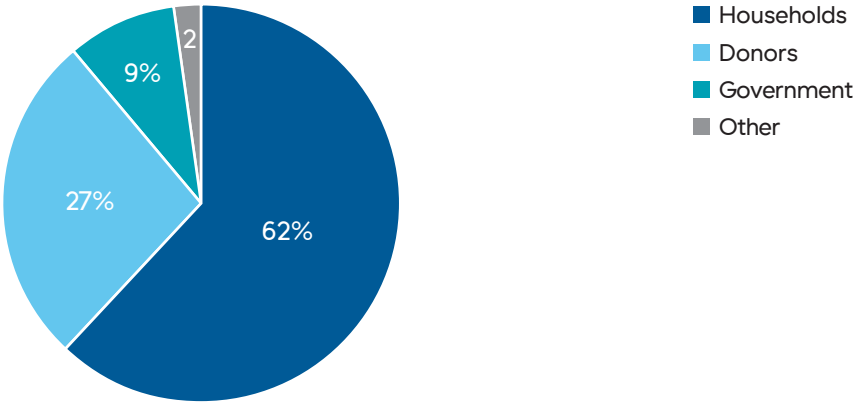
cabinets) or to the DNPM (pharmacies). Once documents are reviewed and approved, an authorization to establish the facility (*agrément*) is provided. Next, providers submit additional documentation for authorization to operate the facility and receive a visit by an inspection committee. Clearance to operate the facility (*arrêté d'exploitation*) is then granted (Camara and Camara 2014). Key informants confirmed that, once approved, there is no requirement to renew a license or authority to operate. Views on this process varied. Government informants viewed it as a substantial factor contributing to the lack of registered private providers. However, established private clinic owners indicated in interviews that it is not particularly difficult compared to other countries in the region, but could be streamlined. They cite weak enforcement of regulations and a lack of transparency in which applications get approved as the main problems.

While the DNEHS handles the registration and oversight of health care facilities, the National Order of Physicians of Guinea (*Ordre National des Médecins de Guinée*), National Order of Midwives of Guinea (*Ordre National des Sage Femmes de Guinée*), National Order of Pharmacists (*Ordre des Pharmaciens de Guinée*), and other professional orders license providers and oversee the practice of medicine in both sectors. Although required by law, there is little regular supervision of facilities by the MOH after their establishment. Private health enterprises do not furnish reports to health district management personnel. FNCP/ACPG and other private associations have begun pushing for major reforms to the National Order of Physicians of Guinea to improve its operations, including calling for better defined minimum requirements for private providers, required continuing medical education for private providers, and improved financial support.

Health Financing Landscape

Guinea aspires to promote good health and reach universal health coverage but is in the very early stages (MOH 2014). Its health system is fragile and underfunded, with total spending on health at just $38.32 per capita in 2018 (World Bank 2018). Funding for health is fragmented. Sixty-two percent of total health expenditures are from out-of-pocket payments, followed by external sources; the government provides less than 10 percent (Figure 2) (MOH 2015). Furthermore, the country has challenges in program execution, spending only about two-thirds of funds allocated for health (WHO 2016).

Figure 2. Health expenditure by source of financing, 2014



Source: PNDS

These constraints cause financial hardship for Guinea's many low-income citizens. Financial barriers are typically greater in the private sector. Nearly all clients must pay fully out of pocket; less than 10 percent of the population has health insurance or other coverage that lowers financial risks of health care (MOH 2015), Currently, Guinea operates a health insurance program for private employers and employees (3–4 percent of Guineans), who pay into the National Social Security Fund (*Caisse Nationale de Securité Sociale*). The Fund operates the Medical Health Insurance Service (*Service Medical Assurance de la Maladie*), a public health insurance scheme for formal sector households. The scheme is viewed as cumbersome and slow, with unclear preauthorization procedures and delayed and limited reimbursement. Informants stated that most of the time people choose private insurance programs that are more responsive and comprehensive instead.

The country is collaborating with development partners to forge a vision to mobilize, pool, and spend funds for health efficiently and effectively to reach universal health coverage (MOH 2014 and 2015). In the National Economic and Social Development Plan (*Plan National de Développement Economique et Social* [PNDS]), the government has committed to establish governing bodies for the technical piloting, monitoring, and implementation of programs that support universal health coverage (Wright et al. 2016). In tandem with this focus, the government's national health financing strategy (*Stratégie de financement de la santé vers la couverture sanitaire universelle en Guinée 2014*)

presents high-level objectives of improving quality of and access to health services, reducing financial risk, as well as risks that affect health to achieve universal health coverage. The World Bank has committed $22 million to strengthen the capacity of Guinea's MOH to support these reforms spending. A major focus will be to implement and oversee a results-based financing program for reproductive, maternal, newborn, and child health that launched in the Kankan and Kindia regions in March 2021 (GFF/ World Bank 2018). Through these reforms, Guinea aspires to (MOH 2015):

- Mobilize 85 percent of the funds it needs for health by 2024 to reduce out-of-pocket spending
- Expand publicly financed health insurance by establishing and scaling multiple insurance programs in parallel, with a vision to eventually consolidate them, possibly into a single national scheme
- Implement health insurance for government workers, who currently have their health expenses reimbursed by the government
- Increase strategic purchasing of health services, including from private providers

The broader insurance sector in the country is nascent. Guinea's PNDS proposes to expand private health insurance programs—both for-profit insurance programs and community-based, not-for-profit schemes. Three licensed insurers (NSIA, Saham, and Ugar) offer for-profit health insurance or other benefit programs such as reimbursement plans or workplace health care to corporate clients (Health Focus 2015). One informant estimated that private health insurance enrollment, though small (an estimated 10,000 current beneficiaries), is growing by about 10 percent annually. Guinea's experience with community-based, not-for-profit health insurance is limited to a few donor-supported schemes called mutuelles. While the PNDS mentions *mutuelles* as a health financing strategy to serve low-income and underserved groups, key informants were not aware of any imminent plans to subsidize or integrate health *mutuelles* into other government financing initiatives.

Public–Private Engagement in Health

Guinea lacks a clear focal point to direct public-private engagement in the health system. There is no dedicated unit within the MOH charged with developing public-private partnerships; instead, the 2017 public-private partnership law places the responsibility under the remit of the Ministry of Investment and Public-Private Partnerships (*Ministère des Investissements et des Partenariats Publics-Privés* [MIPP]). The MIPP mostly focuses on major infrastructure investments, including the construction or rehabilitation of hospitals and clinics on behalf of the government. It does not currently emphasize small-scale, non-infrastructure partnerships in health. Several new government units have been created to support public-private partnerships, but since they are new, management structures, roles, and responsibilities are still being developed.

Beyond these infrastructure-focused efforts, there appear to be several nascent efforts to broaden systemic public-private engagement in the health system. Two directorates attempted to create coordinating committees (*commissions d'agrément*) that would include representatives from the professional associations, orders, and central health administration. They would be charged with validating the health planning process (Health Focus 2015). However, these efforts have not been funded and informants indicate there is still no engagement platform that functions in any meaningful way. Despite the lack of cross-sectoral dialogue, private doctors and clinic owners indicated that they are increasingly organizing and demanding change through ad hoc relationship-based strategies.

Despite the lack of a government focal point to drive public-private engagement in the health system, there have been some promising recent initiatives. These include:

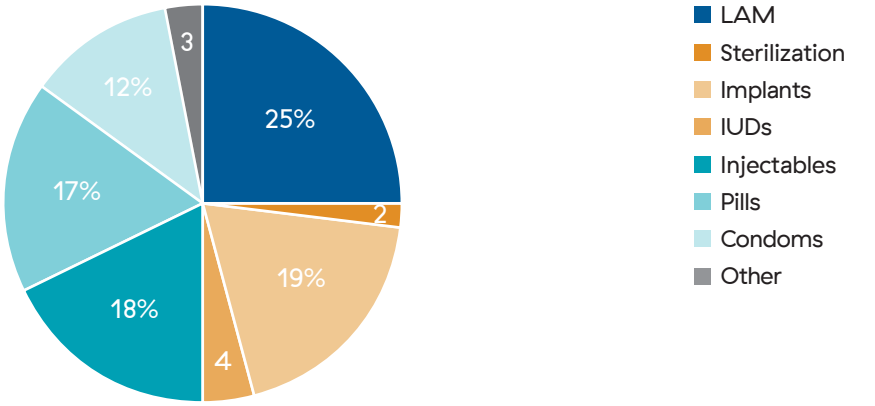
- An effort by the MOH to contract with private providers to offer discrete priority products and services under the National Malaria Program that has since been replicated to increase access to family planning
- Agreements between the MOH and private providers during immunization and national campaigns, including screening for colon and breast cancers
- A new partnership between the MOH and Nutriset to begin local manufacturing and distribution of Plumpy'Nut nutritional product to address childhood malnutrition
- A partnership between the MOH, the German Agency for International Cooperation, and mining companies to provide discrete HIV and malaria services for mine employees, their families, and the surrounding communities

Family Planning and the Private Health Sector

Demand

The Guinea family planning market is characterized by high fertility rates, low use of modern contraceptive methods, and high unmet need. On average, Guinean women have five children, with significant variations based on wealth (DHS 2018). Only 11.4 percent of married women of reproductive age use a modern family planning method and an estimated 22 percent have an unmet need for family planning (DHS 2018). The modern contraceptive prevalence rate varies among market segments: it is twice as high among urban women as it is among rural women, and four times higher among women in the highest income group compared to women in the lowest. Urban women account for 54 percent of all family planning users despite accounting for less than 40 percent of the overall population (DHS 2018). Various factors and social norms influence contraceptive behavior: pressures for married women to quickly have children, personal or partner opposition, religious prohibition, or a fatalistic attitude. Only about 10 percent of non-users cite method-specific (side effects or health concerns) or access-related (cost, physical access, or method availability) reasons for non-use (DHS 2018).

Figure 3. Overall modern family planning method mix



Source: Track20

The method mix is varied between short- and long-acting methods (Figure 3). One in four modern method users opt for lactational amenorrhea. Another quarter opt for long-acting or permanent methods (i.e., implants, IUDs, and sterilization). And the remaining half is relatively equally split between injectable users (18 percent), pill users (17 percent), and condom users (12 percent). Use patterns vary by wealth. Women making less than $1.90/day are almost twice as likely to use lactational amenorrhea or other methods compared to women in the wealthiest income group (39 percent vs 20 percent), and injectable contraceptives (21 percent vs 12 percent). Women in the highest income group use condoms and IUDs at much higher rates.

The public sector is the primary source of contraceptive methods in Guinea: 64 percent of users report obtaining their method from a government health facility compared to 28 percent of users who rely on a private source (DHS 2018). Sourcing patterns vary with the method used: most IUD, implant, and injectable users obtain them from a public source, while more than half of pill users and three-quarters of condom users report a private source, typically a pharmacy or shop. Similarly, sourcing patterns vary depending on where users live. For instance, almost three-quarters of private sector users are urban women, while public sector users are more evenly split between urban and rural (Family Planning Market Analyzer 2021). Among women who go to the private sector, three-quarters are accessing pills or condoms, mostly from pharmacies and shops (Family Planning Market Analyzer 2021). This pattern reflects the urban-centric distribution of these outlets and possibly contributes to lower private sector activity in rural areas. Only 10 percent and 22 percent of urban women who opt for implants and IUDs respectively obtain these methods from a private source, suggesting these methods may not be easily available, or may be too expensive, in urban areas.

Geographic regions with high private market share typically align with areas highlighted in the 2018 DHS as having high unmet need for family planning. This suggests that more should be done to directly address the reasons behind low use among women with a need for family planning. Boké, Conakry, Kindia, and Mamou offer the best potential for increasing private sector participation in the family planning market because of their population density and high levels of unmet need. Existing private health care infrastructure in these regions makes it possible to offer family planning services to women who prefer and can pay for private health services. Private pharmacies and clinics can help serve the growing family planning market in the more urbanized areas of these regions.

Product Supply in the Private Sector

Guinea has a well-developed pharmaceutical distribution network with the ability to import products from Europe and other countries for resale to local wholesalers and retailers. Guinean distributors import both branded products from research and development manufacturers and branded generics from companies located primarily in India. Contraceptives are typically brought in from a variety of countries including France, Germany, the UK, India, and Indonesia. Commercial outlets in Conakry sell a limited range of condoms. Pharmacies also sell hormonal contraceptives, namely oral contraceptives, emergency contraceptive pills, and injectables. The assessment team identified only one brand of injectable DMPA for sale in private pharmacies. This infrastructure could be leveraged to scale up the availability of contraceptives beyond Conakry, but stakeholders stress the need for substantial demand creation.

Population Services International (PSI) previously operated a social marketing program to distribute affordable family planning, HIV, malaria, and oral rehydration solution (ORS) and zinc products. With USAID support, PSI Guinea sold 8.2 million condoms, 261,000 pills, and 180,000 injectables in 2016 (DKT International 2020). With reductions in funding for the program, social marketing sales fell by 50 percent in 2017 and PSI brands were eventually discontinued. The 2018 DHS reported significant client reliance on socially marketed brands that are no longer available—a potential threat to sustained use (DHS 2018).

DKT International, which defines itself as a social enterprise, has stepped in to serve the Guinean market with IUDs and condoms since 2017. DKT previously worked through VisionSmart, a local distributor, to reach a wide variety of retailers nationally, but was looking to identify a new local partner as of October 2021. In 2020, DKT sold 2,100 IUDs and 1.3 million condoms in Guinea (DKT International 2020). The same year, DKT registered its emergency contraceptive brand, and is currently awaiting registration approval for two new oral contraception brands, Levofem (Microgynon equivalent) and Delifem (Diane 35 equivalent). While waiting for approval for these brands, DKT signed

a two-year contract with Mylan Inc. to distribute Zinnia, a combined oral contraceptive, in commercial pharmacies. DKT has also registered Sayana Press (DMPA-SC) and the two-rod implant Levoplant, for which it holds commercial distribution rights in Guinea.

Service Provision in the Private Sector

NGO and for-profit facilities provide family planning services in Guinea. For example, the Guinean Association of Family Well-Being (Association Guinéenne pour le Bien Être Familial) is an affiliate of the International Planned Parenthood Federation and is the only NGO dedicated to family planning. It provides sexual and reproductive health services and education through eight clinics, and trains community health agents in contraceptive technology and services. Overall, though, only a minority of private providers offer family planning services, and these outlets serve a minority of family planning users. The 2018 census of 580 private facilities operating in Conakry reported that only 33 percent offer family planning services (HFG 2018). Fewer than 18 percent of IUD users, 8.4 percent of implant users, and 10.3 percent of injectable users obtain their method from a private hospital or clinic (DHS 2018).

For-profit health providers face several difficulties to scaling family planning services. The financing environment in Guinea places a premium on high-demand services that generate good profit margins. Family planning services, as noted, are in low demand; they are also accessible in the public and NGO sectors at very low prices. This market environment makes family planning relatively unattractive to for-profit providers. For-profit facilities with no government or donor connections are limited in their ability to provide long-acting reversible contraceptives. To offer these methods, private doctors must have have been trained by a donor or government program. The commodities associated with these services are also less accessible through pharmaceutical wholesalers. DKT International intends to develop a network of private providers in implant insertion and supply them with Sayana Press and Levoplant. This effort, however, is resource intensive and subject to developing market-building partnership with other actors in family planning.

Box 2. Public–private partnership for family planning

A recent effort funded by the Bill & Melinda Gates Foundation and implemented by Jhpiego has sought to build the capacity of Guinea's private facilities to offer a wider range of family planning methods and accelerate the use of DMPA–SC. The program seeks to address many of the gaps that private providers currently face by offering clinical trainings that cover the full range of modern methods, including self–injection counseling, and strengthening access to family planning commodities by offering an initial supply and integrating participating providers into the public supply chain with support from USAID's Global Health Supply Chain–Procurement and Supply Management project.

In 2019, Jhpiego and DNSFN consulted with medical orders, civil society, USAID, government, and FNCP/ACPG to design a policy framework for the MOH to engage private facilities for family planning (DNSFN 2020). The partnership directives define roles and responsibilities for government actors at different levels of the health system to review provider applications, ensure they meet minimum requirements, and integrate providers into public supply chains. The DNSFN directives are designed to ensure quality of care, an uninterrupted supply of commodities, and regular reporting of consumption data to the government.

Currently, the MOH engages 33 private facilities under these partnership directives. Half of them are integrated into the public sector procurement system, and the remainder still have remaining stock from their initial donation of products. Stakeholders observed that, overall, the partnership is working relatively smoothly. However, providers voice some concerns that they are responsible for procuring consumables and that long procurement processes could result in future stockouts. Overall, the number of participating for–profit clinics is small compared to the private sector's footprint in Guinea. Scaling the partnership model up would require substantial investments, and it is heavily dependent on donors for training and commodities. Over time, the government will need to commit to procuring sufficient commodity levels and develop a strategy to continue training participating providers at scale.

Maternal Health, Child Health, and Malaria in the Private Sector

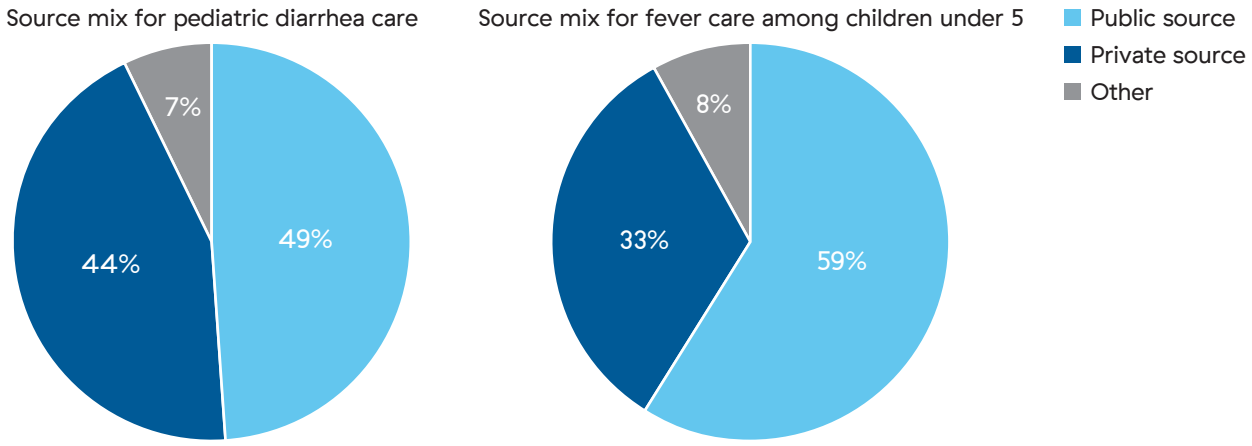
Guinea currently fares poorly on multiple indicators for maternal and child health and malaria. Its high maternal mortality ratio (576 maternal deaths per 100,000 live births) is driven by early pregnancies, lack of pre- and postnatal care, and high rates of home deliveries (DHS 2018). Further, children under 5 bear 72 percent of the total disease burden in Guinea, most of which is associated with preventable causes: malaria, infectious disease, neonatal disorders, and malnutrition (INS 2017). Vaccination coverage in Guinea is also very low: only 25 percent of children complete all recommended age-appropriate childhood vaccinations, and 25 percent receive none.

Though the malaria burden is high, Guinea has made substantial progress in recent years. Malaria transmission occurs throughout the year in Guinea, with essentially the entire population at risk. It is the primary cause of consultations, hospitalizations, and death among the general population (President's Malaria Initiative 2021). Treatment rates are increasing, although they are low (DHS 2018). Combined with increased distribution of long-lasting insecticide-treated bed nets, these efforts have reduced the percentage of children testing positive from 44 percent in 2012 to 15 percent in 2016 (DHS 2014, INS 2017).

Demand

Guinea's private sector plays a varying role across maternal and child health and malaria markets. Its footprint is quite limited in maternal health. Only a small fraction of women (5 percent) deliver at a private health facility, primarily under the care of a trained nurse or midwife (DHS 2018). Moreover, only 6 percent of antenatal care is sought in the private sector. Four of five women who access antenatal care in the private sector are from urban areas and from the two wealthiest quintiles (DHS 2018). However, the private sector provides a much more substantial share of sick child and malaria treatments: 44 percent of child diarrhea treatments and 33 percent of fever (proxy for malaria) treatments among children under 5 (Figure 4). This is largely due to the role that non-clinical outlets play. In all three major childhood illnesses—diarrhea, acute respiratory infection, and fever—caregivers were much more likely to access treatments from non-clinical sources (boutiques or small shops, traditional healers, and large markets such as the *Marché Madina* in Conakry) than from clinical sources (DHS 2018). This market share reflects the product-focused nature of many of these treatments. For example, beginning in 2004, ORS accompanied by a 10-day course of zinc dispersible tablets became the WHO's recommended treatment for childhood diarrhea. These products do not require a prescription and can be sold outside of health facilities or pharmacies.

Figure 4. Sources of care for diarrhea and fever (malaria) among children under 5



Source: DHS 2018

Product Supply in the Private Sector

Similar to family planning, several importers and wholesalers serve the private market for child health products. While PSI helped introduce ORS and zinc co-packs for diarrhea management, the funding shifts that affected its family planning programs also contributed to the closure of its child health programs. Commercial supply chain actors have since stepped in to fill the gap left by PSI's exit. They procure ORS and zinc diarrhea treatment kits from manufacturers in India and Dubai for sale in both pharmacies and the *Marché Madina* market in Conakry. In addition to these co-packs, several individual ORS products are also on the market. Individual zinc products were not found in the market. Amoxicillin is the recommended treatment for children with acute respiratory infection and is widely available in pharmacies in Conakry. It is a main-line product imported by all the major importers and distributors in Guinea from sources in France, Germany, Austria, India, and China; it is well known in local private clinics and prescribed for pneumonia in children. The assessment team found two brands of an amoxicillin dispersible tablet on the market, as well as a number of syrups, suspensions, and capsules.

Several nutritional products are available in Guinea to address childhood malnourishment. Cooking oil is fortified with vitamin A. Nestlé Guinea manufactures fortified nutritional products from local wheat, maize, cocoa, and rice, and produces fortified flour for the market. Therapeutic products are typically offered for free as part of humanitarian interventions, making them a less profitable market opportunity for private providers. The assessment team found no nutrition-related commodities in private clinics, pharmacies, or drug shops.

In general, there are limited data on the availability of malaria-related products in the private sector. While front-line artemisinin-based combination therapy drugs are available in pharmacies and some drug shops in Conakry, there are no good data on their volume or sales and the assessment team found no information to indicate whether quality-assured or non-quality-assured medicines were available in outlets outside of Conakry. Beyond these medicines, the assessment found little evidence that would indicate long-lasting insecticide-treated nets or rapid diagnostic test kits were available through the private sector.

Service Provision in the Private Sector

Availability of priority maternal and child health services varies across priority areas. About one-third of private for-profit providers in Conakry offer obstetric and gynecological services and 46 percent offer maternal health services "on demand" (HFG 2018). Private providers indicated that they lack needed equipment, affordable supplies, and accessible trainings to provide quality maternal health services. In many countries, midwife-owned and -operated clinics are important sources of maternal health care; however, ASFEGUI reported that Guinea has an insufficient number of midwives to meet the needs of pregnant women. Furthermore, there is no structure or supportive system to help midwives obtain premises, purchase equipment, or cover operating expenses to establish or run their own midwifery practices.

Availability of essential child health and nutritional services in the private sector remains low. Only half of for-profit providers in Conakry offer pediatric care services (HFG 2018). These facilities charge a fee for these services to cover the cost of personnel, infrastructure, and supplies. The presence of free services in the public sector, without an adequate financing mechanism to reduce out-of-pocket payments in the private sector, serves as a competition disincentive for many private providers to offer these services.

The private sector has experience partnering with the MOH to offer routine childhood immunizations. Several private clinics in Conakry and the MOH's Director of Immunizations indicated that both NGOs and a few for-profit private providers participate in national immunization campaigns. NGO and faith-based organizations' clinics, especially, are well integrated in routine and annual vaccination campaigns. They help the MOH plan, deliver, and report on immunization activities. The for-profit sector plays a more limited role. Only five large for-profit private clinics regularly deliver immunizations as part of annual campaigns; they are not fully integrated into planning or reporting elements. Scaling this engagement to additional for-profit clinics could help increase coverage of these campaigns. Many private clinics already have the refrigeration units required for the immunization cold chain, especially in Conakry and other small cities, and have expressed an interest if partnership terms can cover staff and infrastructure costs.

As with the supply chain for malaria products, there are few data on availability of malaria diagnostic or treatment services in the private sector. While DHS data (using treatment of fever as a proxy) indicate that the private sector potentially plays a large role, the malaria response is viewed by key informants as a largely public sector responsibility. The National Malaria Control Program (*Programme National de Lutte contre le Paludisme*) indicates that case management in the private sector is a challenge.

The Mining Sector and Health

Guinea has the world's largest bauxite reserves, as well as large reserves of gold, iron, diamonds, manganese, zinc, cobalt, nickel, and uranium. The formal mining sector directly employs 10,000 to 15,000 workers with another 20,000 to 30,000 employed by subcontractors working in various stages of developing and operating mines. Indirectly, the mining industry supports an additional 100,000 to 150,000 jobs in industries that cater to mining company activities—hotels, restaurants, transportation, agriculture, etc. The growth of the mining industry has led to substantial migration within Guinea; over the last 10 years, some towns and villages along the mining corridor have doubled or tripled in size (Dobbin and Ergo 2018). These massive flows of people place substantial health and economic burdens on cities that were not designed to accommodate so many inhabitants.

Box 3. Major mining companies in Guinea

The PSA team identified 12 companies currently operating mines in Guinea:

- Compagnie des Bauxites de Guinée (CBG)
- Guinea Alumina Corporation (GAC)
- Société Minière de Boké (SMB–Winning)
- Société AngloGold Ashanti Guinée (SAG)
- Alufer/BelAir Mining
- Société Minière de Dinguiraye (SMD)
- Alliance Minière Responsable
- Henan–China International Mining Development Company
- Compagnie de Bauxite de Kindia (CBK)
- Compagnie de Bauxite et d'Alumine de Dian–Dian (COBAD)
- Friguia
- Société des Mines de Mandiana

At the same time, the mining industry has substantial resources that could help address these burdens and a history of investing in health and development programs. These companies are largely located in Boké and a few other prefectures. The team identified 12 mining companies that are currently operating in Guinea (Box 3). Many of these are owned by international actors. For example, Guinea Alumina Corporation (GAC) is a subsidiary of Emirates Global Aluminium and Société Minière de Boké (SMB-Winning) is part of a Chinese consortium. Two notable exceptions are Compagnie des Bauxites de Guinée (CBG), which is 49 percent owned by the state, and Alufer/BelAir Mining, which is an independent Guinean company.

The Chambre des Mines de Guinée (CMG) coordinates more than 50 mining and non-mining companies to stimulate the mining industry, promote collaboration among the mining companies and with international donors, and support investment in social and economic development. In this last role, it helps carry out health initiatives supported by the mining sector by developing community programs, brokering partnerships, and encouraging companies to invest in community development projects. CBG, GAC, Société AngloGold Ashanti Guinée (SAG), SMB-Winning, and Simfer are the mining companies most involved in these programs; they tend to contract with specialized NGOs such as Doctors Without Borders for health initiatives. The CMG supports engagement with key government organizations include the Ministry of Mines and Geology (the government agency responsible for the development and proper functioning of the mining sector) and the MOH. That Ministry's Community Relations and Local Content Development Department oversees the implementation of the Mining Corporate Social Responsibility Policy. The MOH is involved in health projects carried out by the CMG and the mines. Through its Health Committee, the CMG has also developed partnerships with various donors including USAID, the World Bank, the Global Fund, UNAIDS, and the United Nations. Examples include:

- Since 2018, the United Nations Capital Development Fund has assisted local governments as part of the $4 million Mining Royalty Governance Support Project. The initiative, implemented with the CMG, helps mobilize financial contributions from mining companies and provides technical support to local governments and their partners to support access to basic services by building service roads and schools and renovating health centers.
- The CMG previously implemented a public-private partnership project with the German Agency for International Cooperation to combat HIV by training workers and health facilities to reduce HIV prevalence. The project was stopped because of COVID-19.
- The Global Fund works with the mining industry to increase access to priority health products. In 2020, it funded the procurement of 835,000 mosquito nets, the treatment of 60,000 people with antiretroviral drugs, and the treatment of 16,000 people with tuberculosis, some of which are provided by mining companies to the surrounding public.

There are two main avenues by which the mining sector finances community programs and investments in health programs: mandatory financing through public taxation systems and voluntary corporate social responsibility programs. The public taxation scheme raises revenue through multiple channels:

- Taxes and fees (approximately $500 million in 2018), which are paid to the Public Treasury and distributed to the national budget (80 percent), local governments (15 percent), and the Mining Investment Fund (5 percent), which finances mining exploration.
- Contributions to the Local Economic Development Fund (*Fonds de Développement Economique Local* [FODEL]). Since 2015, companies with operational mines have had to pay a fee equal to 0.5 percent of revenue for bauxite and iron, and 1.0 percent of revenue for other mining substances (EITI 2020). The FODEL is intended to support basic infrastructure, employment and income-generating activities, development of human capital, and carrying out intermunicipal projects. Between 2015 and 2018, mining companies contributed just over $4 million to FODEL.
- Local development agreements, which are intended to promote effective and transparent management of funds from the mining industry for development programs (EITI 2020). In practice, though, these agreements rarely exist.
- Mandatory social contributions, which many companies have made in their conventions or via ad hoc agreements with local communities. These payments can be used to benefit the local communities in various ways. For example, CBG provides an annual operating subsidy for a hospital in Kamsar. In 2017, Alufer/BelAir Mining provided in-kind or cash support to populations impacted by their mining project.

Beyond their core businesses and these mandated contributions, many mining companies have initiated corporate social responsibility programs that reinvest profits in their local communities. These programs are at the discretion of the company and there is no penalty for breaching their commitments. Many companies fund voluntary programs, motivated by a desire to have positive impacts on the health of workers and their families, enhance corporate culture, and foster good relations with surrounding communities. Because they directly control how funds are spent, mining companies have historically preferred voluntary mechanisms over FODEL and other mandatory contributions. In 2017 and 2018, mining companies channeled over $13.3 million into corporate social responsibility programs; however, only 4.2 percent went to health. The rest went mostly to construction and infrastructure projects (e.g., roads, community centers, schools), purchase of foodstuffs for the public (e.g., rice, livestock, etc.), support for cultural and sports activities, and direct in-kind or cash assistance.

Combining mandatory and voluntary social payments, CBG and SAG are the most active companies in health. CBG's contributions largely fund the construction, renovation, and operation of health facilities in the Boké region. SAG subsidizes a program to combat maternal mortality with the NGO Les Enfants de Layé and spends more than $200,000 per year to combat malaria. Other health investments include:

- **COVID-19**: The ongoing pandemic has led the mining sector to suspend most ongoing health programs to reinvest resources in the COVID response. GAC has built a testing center. SMB-Winning spent $1.8 million to support health authorities in its COVID response.
- **Malaria**: All the companies interviewed for this assessment have made malaria control their priority under a CMG-led program. Individual companies plan to spend $40,000 to $100,000 per year, directly or through the CMG on awareness-raising, prevention, and distribution of long-lasting insecticide-treated nets; there is also an interest in childhood vaccination campaigns (Box 4).

Box 4. Mining programs in malaria

GAC is interested in a child malaria vaccination program in partnership with the MOH's Expanded Program on Immunization and has allocated an annual budget of $100,000. SAG expressed a similar interest, although it lacks the expertise to run such a program.

- **HIV and AIDS**: HIV prevalence among high-risk populations, which includes truck drivers and miners, is almost three times higher than that of the general population (CMG 2019). Mining companies invest in awareness-raising among their staff and cooperate with the CMG on similar activities in surrounding communities.
- **Prevention of waterborne diseases with epidemic potential**: Waterborne diseases such as cholera spread very rapidly in mining areas due to overcrowding and inadequate public services. Given the population increases in mining areas, the issues of potable water and sanitation are major concerns. Many mining companies, which have public works equipment and expertise, conduct water, sanitation, and hygiene activities for communities. Stakeholders highlighted the high visibility and immediate results of these investments as key selling points.
- **Financing medicines, consumables, and personnel for hospitals and health centers**: Mining companies have a history of funding the construction and renovation of health infrastructure due to the project's visibility and the company's ability to manage implementation directly. A few informants indicated a need to build partnerships with other stakeholders to mobilize resources (medical equipment, supplies, drugs, trained health care staff) to complement their capital improvement projects.
- **Prevention and treatment of accidents caused by the ingestion of soda**: Unregulated home production of soaps, detergents, herbicides, and other dyes has increased in poor and underprivileged households, particularly in areas where soda is used by mining companies. This trend has occurred without sufficient measures to prevent the accidental absorption of chemical products by children. The CMG is developing a partnership with Terre des Hommes to help fight caustic stenosis of the esophagus in children, a consequence of the ingestion of caustic soda.

Recommendations

Recommendations

Generate Additional Knowledge on the Private Sector—In Partnership with the Private Sector

The lack of detailed, accurate, and up-to-date information on the private health sector on the total number, composition, and distribution of private providers in Guinea contributes to many challenges. Policy makers and provider associations lack clarity on the scale, scope of services, and quality of offerings available in the private sector. Without this information, they cannot make effective plans to leverage private resources. Addressing this gap should therefore be a high priority for USAID/Guinea and MOH counterparts. The Health Finance and Governance-led census in Conakry can serve as a good starting point, updating and expanding it to cover the remaining regions and build a knowledge base that can be used to increase private sector engagement in policy and planning. The census should include questions related to service offerings and clinical capacity in key areas (e.g., malaria, family planning) to help identify opportunities to leverage the private sector's footprint and demonstrate the potential value of improved engagement to the government.

To gain credibility and facilitate trust between the public and private sectors, learning efforts should be co-led by the MOH and a leading association such as the FNCP/ACPG. Building on this assessment and the census mentioned above, USAID/Guinea could support its public and private sector partners to carry out other learning opportunities that go behind just data generation. Opportunities include sponsoring national and subnational meetings to better disseminate and improve understanding of existing laws and regulations to reach providers and community-level actors; using data and modeling tools to develop advocacy messages that illustrate the burdens and missed opportunities created by a lack of engagement with the private sector; and sponsoring efforts to conduct a participatory legal and regulatory review to discuss proposed reforms in areas such as registration, inspection, and supervision.

Previous page:
View of Conakry, Guinea.

Photo: Dominic Chavez, World Bank

Streamline and Strengthen Mechanisms for Public–Private Engagement in Health

No single agency is charged with developing public-private partnerships specifically for health or mobilizing the private sector to meet national health goals and objectives. Experience in countries like Kenya, Malawi, and the Democratic Republic of the Congo has demonstrated the value in creating a streamlined focal point such as a public-private partnership unit within the health ministry to champion private sector engagement. In Guinea, FNCP/ACPG has proposed a national directorate for the private sector within the MOH that could serve this function and work with the MIPP to implement the 2017 public-private partnership law in the health system.

Efforts to build capacity for public-private engagement need to also strengthen the private sector's voice. There are currently multiple associations each representing different stakeholders within the private health sector. USAID/Guinea could support associations in furthering their individual missions and developing a strategy to improve their coordination with each other and engagement with the government.

Improve the Enabling Environment for the Private Sector to Expand its Offerings in Priority Areas

The enabling environment for the private health sector in Guinea poses many challenges. Regulations are not matched with government oversight capacity. Providers feel that they do not have sufficient opportunity to voice their needs and requests to policy makers. Access to finance is expensive, limiting private providers' ability to invest in and grow their businesses. And access to trainings and specific commodities can be difficult. Private provider associations have already identified several concrete steps to address these gaps. These include streamlining and strengthening mechanisms for public-private engagement in health; revisiting facility registration requirements to increase formalization of the private sector and improve alignment with MOH oversight goals; and improving access to finance to help more health care providers start and operate private health facilities—including paying the necessary registration fees. The new government has indicated that it stands behind many of these ideas, though supportive policies are yet to be enacted. USAID/Guinea should strategically engage with relevant private associations and MOH counterparts to guide and co-develop roadmaps for achieving these reforms.

Invest in Demand-Creation Efforts in Priority Health Areas that Leverage Existing Private Sector Capacity

The assessment identified the need to continue investments that increase demand for priority health services across family planning, malaria, and maternal and child health. Addressing unmet need for family planning and increasing uptake of ORS and zinc co-packs both require these types of investments. Partnering with the private sector can help implement demand-creation strategies. Private providers can be trained to better counsel on the full range of modern family planning methods to help women achieve their fertility intentions. Supply chain actors like DKT can coordinate their promotion of specific products and brands with broader donor-funded category campaigns. Private pharmacists and drug shop operators can be trained to advise and negotiate with clients to promote appropriate ORS and zinc use. And private mining companies can sponsor awareness-raising campaigns around specific health areas in their local communities that help link individuals to nearby facilities and retail outlets where they can access a desired product or service.

Strengthen the Private Supply of Priority Products and Services

As demand for priority products and services grows, USAID should consider how it can support private providers to help meet that higher demand. This recommendation cuts across multiple health areas. USAID could support relevant provider associations in developing and rolling out sustainable, scalable strategies to address challenges private providers face to access trainings on the full range of contraceptive methods, including newer long-acting reversible contraceptives. Retired nurses could be supported to start their own private maternity homes that offer a wide range of family planning, reproductive health, and maternal health services. Pharmaceutical partnerships with DKT and other low-cost, high-quality supply chain actors can help to expand the family planning method mix, particularly in urban areas, and improve access to affordable products in the private sector. Boutique and market staff can be coached to improve diarrhea and pneumonia case management. And expanded use of partnership models with for-profit providers can increase their involvement in immunization campaigns. These skills-building efforts should be restricted to registered providers both to ensure that they are investing resources in outlets that meet MOH standards and to create an incentive for more providers to go through the registration process.

Build Foundational Skills to Purchase Health Care

As more Guineans look to access priority health services in the private sector, there is a need to reduce financial barriers to access. As noted in this report, public-private purchasing mechanisms are one avenue to this end. Eventually, the goal should be to operate a comprehensive government-sponsored financing program that includes private providers. To start, though, simpler contracting initiatives that follow the model used in the family planning partnership directives could be expanded—in terms of both the number of services covered and the number of providers engaged. USAID could work with the MOH to identify an appropriate home for managing these contracts within the ministry and help build the skills and resources among relevant staff to issue procurements, negotiate contract terms, implement contracts, and monitor the program's and providers' performance under contracts.

Increase Strategic Engagement with the Mining Industry

The mining industry is an insufficiently tapped partner for USAID/Guinea. Given the scale and the longevity of many of these mining projects, companies that operate mines have incentives to invest in their local communities and are already making substantial investments. However, many of these investments are in non-health areas. USAID could work through the CMG to improve the functionality of existing mechanisms for engagement with the broader mining industry in social development programs, coordinate that engagement with other donors working in this space to expand the reach of their programs, and align its own investments to complement ongoing investments in infrastructure and community development.

Conclusion

For many Guineans across various geographic and socioeconomic strata, private health providers and retail outlets represent important access points to the health system. This PSA represents an important step toward increasing private sector engagement to support better health outcomes in Guinea. The assessment findings paint a picture of a largely unknown, loosely regulated, and under-tapped sector that could otherwise be strengthened to improve access to priority health products and services. Nascent public-private partnerships could pave the way for increased and improved future engagement. The mining sector and its investments in community development could be leveraged to align with USAID's and national health goals. Fully realizing these opportunities will require sustained investments over the medium to long term. This assessment represents a starting point for USAID/Guinea and its partners to build a roadmap toward a shared vision.

Photo: USAID/RTI

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