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SHOPS
Strengthening Health Outcomes *through* the Private Sector

West Africa Private Health Sector: Six Macro-Level Assessments

BRIEF

Summary: This brief is a summary of the West Africa private health sector assessment conducted by the SHOPS project. The assessment looked at six countries: Burkina Faso, Cameroon, Côte d'Ivoire, Mauritania, Niger, and Togo. Chloé Revuz prepared the brief, which presents the assessment methods, findings, and both regional and country-specific recommendations. The recommendations aim to strengthen family planning and HIV service delivery by leveraging the unique capabilities of the West Africa Health Organization as well as each country's private health sector.

Keywords: Burkina Faso, Cameroon, Côte d'Ivoire, family planning, HIV and AIDS, Mauritania, Niger, private health sector, private sector assessment, policy, Togo, West Africa

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Cover Photo: Elizabeth Corley

Project Description: The Strengthening Health Outcomes through the Private Sector (SHOPS) project is USAID's flagship initiative in private sector health. The project focuses on increasing availability, improving quality, and expanding coverage of essential health products and services in family planning and reproductive health, maternal and child health, HIV and AIDS, and other health areas through the private sector. Abt Associates leads the SHOPS team, which includes partners Banyan Global, Jhpiego, Marie Stopes International, Monitor Group, and O'Hanlon Health Consulting.

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West Africa Private Health Sector: Six Macro-Level Assessments

Elizabeth Corley

West Africa is a sub-Saharan region 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: high HIV and AIDS prevalence, particularly among key populations, and low reproductive health indicators. The region accounts for some of the highest fertility rates in the world, which, coupled with 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. In terms of HIV, in 2011 only about 40 percent of patients eligible for antiretroviral treatment (ART) were on treatment in francophone sub-Saharan Africa (Brisset, 2013).

Recognizing that the private health sector represents a key channel through which African countries can work to improve health indicators, the United States Agency for International Development's West Africa Regional Health Office asked the Strengthening Health Outcomes through the Private Sector (SHOPS) project to carry out macro-level assessments[1] of the private health sector in six focus countries: Burkina Faso, Cameroon, Côte d'Ivoire, Mauritania, Niger, and Togo.

This brief summarizes the report's methods, findings, and key recommendations to inform and strengthen USAID/West Africa's regional family planning and HIV and AIDS strategies. The health services data available on the private health sector varies by country, so it was not possible to provide the same types of information for each country.

Background

The private health sector in francophone West Africa includes a wide range of nonprofit and for-profit entities engaged in, for example, service delivery, pharmaceutical dispensing, and laboratory diagnostics. In the six focus countries, nonprofits (faith-based organizations, charitable nonprofit organizations, and community-based organizations) are primarily engaged in service delivery and are especially active in rural areas. Nonprofits play a role in the provision of family planning methods and HIV prevention and testing. For-profit entities are heavily concentrated in urban areas and focus on the delivery of health services, the wholesaling and distribution of medical commodities, and private health financing.

[1] Brunner, Bettina, Andrew Carmona, Alphonse Kouakou, Ibrahima Dolo, Chloé Revuz, Thierry Uwamahoro, Leslie Miles, and Sessi Kotchofa. 2014. *The Private Health Sector in West Africa: Six Macro-Level Assessments*. Bethesda, MD: Strengthening Health Outcomes through the Private Sector Project, Abt Associates.

One measure of the role of the private health sector is the amount of consumers' out-of-pocket spending. Most individuals lack health insurance and therefore pay for health care themselves. Figure 1 shows that the private health sector plays a variable role in the six countries of interest, providing more than 70 percent of modern methods in Cameroon and 60 percent of modern methods in Côte d'Ivoire.

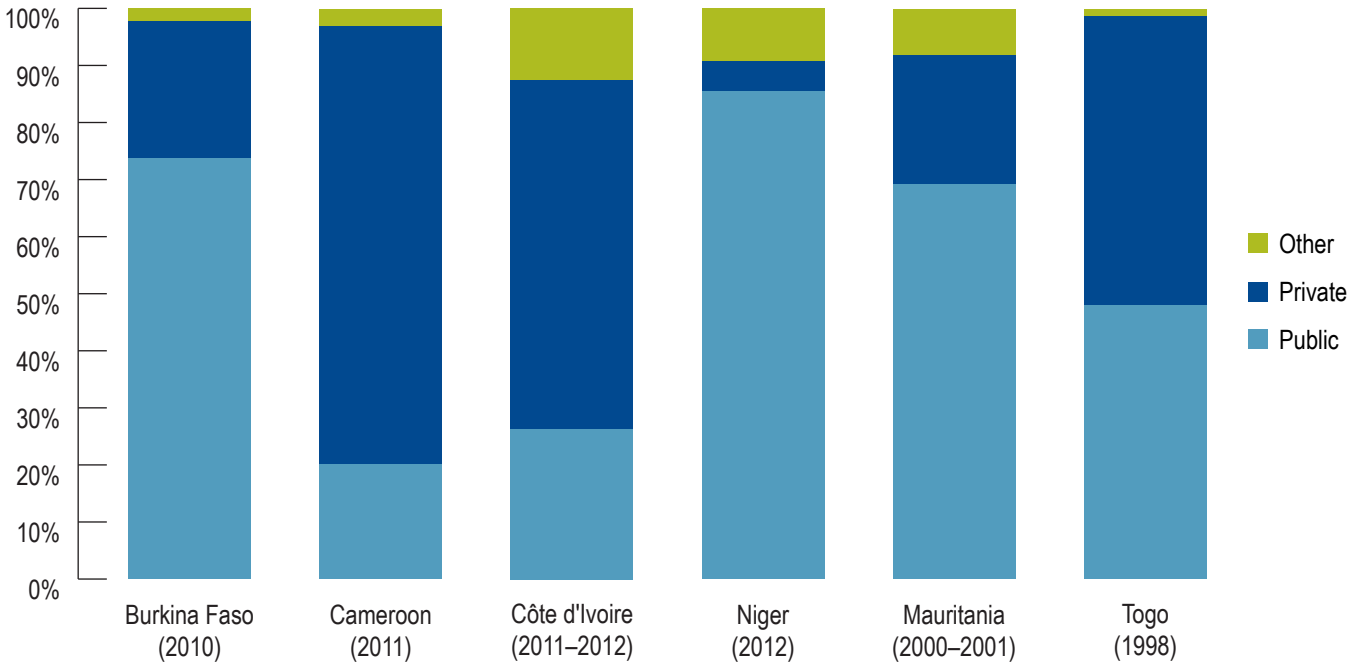
While the region is extremely diverse, the six countries share a strong pronatalist stance and account for some of the highest birth rates in the world. Regional themes that emerged from the assessments and that shape the private health sector include the following:

Health expenditures. Out-of-pocket spending represents more than 75 percent of private expenditures in all six countries.

Scope of the private sector. Data show the large extent of the private health sector in West Africa. In Cameroon and Côte d'Ivoire, for example, private facilities represent 44 and 52 percent of all health facilities, respectively. The informal sector is thriving in all six countries, but, beyond anecdotal information, the data are limited. In addition, the six focus countries are at the bottom of the World Bank's *Ease of Doing Business Report* (2014).

Enabling environment for private health sector. The six countries demonstrate weak enforcement of laws regarding noncompliant private health facilities; lack of incentives to develop private health facilities in rural areas; outdated, inadequate, and lax enforcement of inspection standards; and poor private sector reporting, including disease surveillance. Where fora (*platform* in French) for a public-private dialogue interaction exist, they do not meet regularly and may not include the for-profit health sector. The two exceptions are Burkina Faso and Côte d'Ivoire.

Figure 1. Source of modern family planning methods in six countries



Source: MEASURE DHS

HIV and family planning product and service provision. The private sector varies as a major source of family planning methods, responding to the needs of just 5.4 percent of Nigeriens and to more than 50 percent of residents of Togo, Côte d'Ivoire, and Cameroon. Free or subsidized provision of many family planning and HIV products limits the private sector's incentive to offer such products. Private provision of HIV and AIDS services varies by country, by type of service, and by private provider category, but, in general, the for-profit sector is marginally involved. However, the nonprofit sector is much more involved in HIV and AIDS treatment, delivering 45 percent of all ART treatment in Togo and maintaining 65 treatment sites in Côte d'Ivoire. Private providers in all six countries expressed an interest in expanding the provision of family planning and HIV services, provided that a clear regulatory environment legally allows them to charge a fair price for service delivery.

Corporate social responsibility. Corporate social responsibility (CSR) is not well developed in the region. It is largely limited to oil and mining companies as well as to large-scale agricultural and brewery conglomerates that focus more on HIV than on family planning. Within each of the six countries, CSR organizations and business coalitions can help USAID navigate the CSR landscape and develop connections with companies interested in forging health partnerships.

Public-private partnerships. The region accounts for a low number of public-private partnerships (PPPs) as compared with other regions such as East Africa. Among the six countries, most PPPs focus on service contracts with NGOs tied to the community-based distribution of HIV and family planning products and services.

Susan Mitchell

Scope

The overall goal of the macro-level assessment was to develop an accurate picture of the scope of West Africa's private health sector and develop strategies for better leveraging the sector's role in family planning, HIV, and AIDS to complement AGIR-PF and PACTE-VIH project activities. Within that framework, the assessment set forth five subgoals:

- Assess the private sector's current role in providing family planning and HIV and AIDS commodities and services.
- Determine the legal and regulatory framework governing the private health sector.
- Determine the private health sector's current involvement in public-private partnerships as well as opportunities for private sector collaboration to expand coverage and reach.
- Identify the major local and international NGOs active in family planning and HIV and AIDS in each country as well as companies with corporate social responsibility activities directed to these health areas.
- Identify opportunities for partnerships with the private sector.

Methods

The assessment team followed the SHOPS approach to conducting a private sector assessment: plan, learn, analyze, share, and act, engaging with local stakeholders at each step to ensure accuracy and support.

The team began by compiling a review of the published and gray literature as well as available data from the most recent Demographic and Health Surveys (DHS), national health accounts (NHA), and international donor reports. They interviewed more than 150 major stakeholders between December 2013 and March 2014, analyzing quantitative data and qualitative interview responses in order to synthesize major findings and draft recommendations. At a March 2014 meeting in Accra, Ghana, USAID implementing partners validated the findings and recommendations and offered suggestions for revisions to the final report, which was completed in September 2014.

Findings

Ryan's Well Foundation

FINDINGS

Burkina Faso

While Burkina Faso, a landlocked country with 16.5 million inhabitants, has seen significant decreases in maternal mortality and mortality under age 5, it ranked 181 out of 187 countires on the United Nations Development Program's Human Development Index in 2013. According to the 2010 DHS, the country has a low contraceptive prevalence rate, particularly in rural areas. Nearly a quarter of all households across all wealth quintiles have an unmet need for family planning. The private sector is an important source of modern contraceptive methods; in 2010, nearly one-quarter of modern contraceptive users turned to the private sector for needed products (MEASURE DHS, 2010).

The prevalence of HIV in Burkina Faso has declined by half, from 1.9 percent in 2003 to 1 percent in 2010. However, even though 57 percent of urban pregnant women undergo counseling and testing, only 21 percent of rural women receive such services (MEASURE DHS, 2010; Rosenberg, 2014). In 2011, the private sector provided 71 percent of all HIV testing (UNAIDS, Global AIDS Response Progress Reporting, 2012).

Structure of private health sector

Private health facilities in Burkina Faso comprise for-profit and nonprofit entities. The country's two largest cities—Ouagadougou and Bobo-Dioulasso—account for 90 percent of private facilities. In 2012, the 361 registered for-profit health establishments in the private sector represented about 20 percent of the country's health facilities, of which 70 percent deliver specialized services (Table 1).

Financed primarily by donors, Burkina Faso's extraordinarily active nonprofit sector is characterized by significant contracting with the government for HIV and, to a much lesser extent, reproductive health services.

No local pharmaceutical manufacturing takes place in Burkina Faso, and *Centrale d'Achat des Médicaments Essentiels Génériques et des Consommables Médicaux*, or CAMEG, the nonprofit central procurement and distribution agency, represents 48 percent of total market value in pharmaceutical sales. Eight private wholesalers also operate in the country's pharmaceutical supply chain. Alongside the formal drug market, an illicit drug market thrives in Burkina Faso, with Asian and Nigerian products dominating.

Table 1. Private health sector, Burkina Faso, 2012

Type of facility	Total
Clinic	40
Polyclinic	9
Medical center	482
Hospital	0
Medical office	17
Dental office	5
Total	553

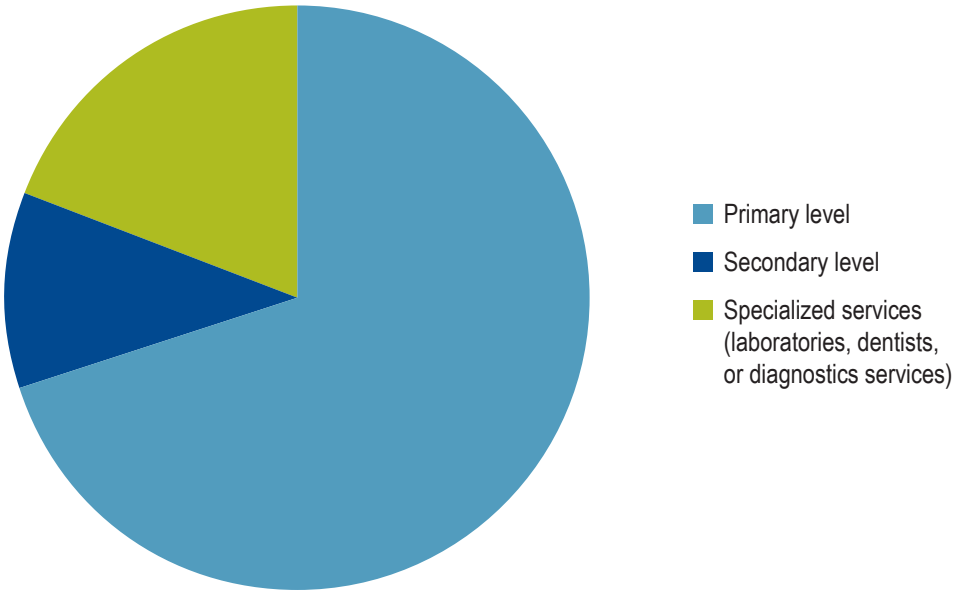
Source: Burkina Faso Ministry of Health, 2013

Two private health sector organizations are particularly active in family planning and HIV activities: *L'Association Professionnelle des Cliniques et Polycliniques Privées du Burkina* and the *Fédération des Associations Professionnelles de la Santé Privée du Burkina*. Private sector organizations focused on CSR and HIV include *Actions des entreprises contre le VIH-Sida au Burkina*, the *Coalition Nationale du Secteur Privé et des Entreprises Contre le VIH-Sida et les IST,* and *Sida-ENTREPRISES*. A World Bank study in 2010–2011 demonstrated that for-profit facilities largely deliver primary care (Figure 2).

Enabling environment

Burkina Faso's regulation of the private health sector began in 1990 with the authorization of private health facilities, and it continued with the specification of conditions for private providers in 2000 and pharmacists in 2003. The government has been working to strengthen the reproductive health commodity supply by, for example, involving the private sector as a source of products. The Ministry of Health operates an extensive contract program with local and international NGOs for the provision of HIV and family planning services. These contract-based arrangements are widely seen as successful as well as essential for increasing access to family planning and HIV services. Through its Repositioning Family Planning Strategy as part of the Ouagadougou Partnership, the government of Burkina Faso is supporting family planning through a dedicated budget line item and the authorization of new products such as Depo-Provera Uniject. One goal of the strategy is to increase contraceptive prevalence to 25 percent among married women by 2015, primarily by working through community leaders and mass media campaigns.

Figure 2. For-profit facilities in Burkina Faso by category



Source: World Bank, 2012

Public-private dialogue and partnerships

In efforts spanning more than 10 years and aimed at improved public-private dialogue, Burkina Faso has established several fora for dialogue including the *Commission Technique Permanente de Concertation*, the Committee for the Relaunch of Family Planning, a donor coordination committee called the *SR-VIH Comité*, and an NGO platform that assembles 20 family planning and HIV NGOs on a monthly basis. Health PPPs that bring together NGOs are well developed, particularly for HIV services. The Ministry of Health has identified care, equipment, human resources, and maintenance as areas of concentration for future health PPPs.

Trends in health financing

In 2009, households financed 37 percent of total health expenditures in Burkina Faso, the government funded 35 percent, and donors and NGOs financed 26 percent. Companies and parastatals financed 2 percent over the same time period. In the absence of national health insurance, approximately 4 percent of the population is covered by employer-provided private health insurance. In 2011, the government began to establish mandatory health insurance for salaried workers and voluntary health insurance for nonsalaried workers in both the formal and informal sectors.

European Commission DG ECHO

Cameroon

Cameroon is a lower-middle-income country with a 2012 population estimated at 22 million and a per capita gross national income of $1,170. Maternal mortality increased from 669 per 100,000 live births in 2004 to 782 in 2011. The total fertility rate was 5 percent in 2013. The contraceptive prevalence rate is 16 percent for modern methods and 8 percent for traditional methods, with urban areas recording more than twice the rate of contraceptive prevalence as rural areas. While all family planning methods are available in Cameroon, users prefer long-acting and permanent methods such as IUDs.

In 2012, an estimated 600,000 individuals, of whom 50 percent were female, were HIV positive, and the HIV prevalence rate among the general population was 4.5 percent (UNAIDS, 2012). The HIV prevalence rate was much higher among sex workers and men who have sex with men, at 36.7 and 37.2 percent, respectively. Cameroon faces a significant gap in ART coverage; the 105,563 individuals on ART in 2011 represented just 49 percent of eligible HIV-positive patients, despite the country's policy that makes ART free to eligible patients (UNAIDS, 2012). In 2012, UNAIDS recorded 681,948 patient visits to for-profit health facilities and more than 1.7 million patient visits to faith-based facilities.

The private sector dominates the provision of family planning and reproductive health products, with only 20 percent of all modern methods obtained in the public sector. The private sector is also actively engaged in the provision of family planning and reproductive health services, particularly through the Profam social franchise—a network of the *Association Camerounaise pour le Marketing Social*, which is a Population Services International affiliate—and the Cameroon National Association for Family Welfare, an International Planned Parenthood Federation affiliate. Some clients procure family planning products from private pharmacies, whose prices are typically higher than those offered through social marketing. For-profit clinics do not offer family planning services.

The private health sector is also a provider of HIV and AIDS services. In 2012, the faith-based and for-profit sectors operated 6 and 14 percent of all ARV sites, respectively. Many private sector entities are active in the HIV and AIDS response, including faith-based networks, NGOs, and for-profit companies such as Exxon Mobil, construction companies, insurance companies, and telephone companies.

ECC Chicago

Maternity clinic in Cameroon

Structure of private health sector

The private health sector, which comprises nonprofit (faith- and community-based) and for-profit facilities, is an important component of Cameroon's health system. The majority of private health workers are nurses (Table 2). The for-profit pharmaceutical sector is made up of 8 manufacturers, 23 wholesalers, and 388 pharmacies. A large number of for-profit health facilities in Cameroon operate illegally, including private medical training institutions, clinics, and unlicensed drug sellers.

Enabling environment

Cameroon's legal environment is favorable to the growth of the private health sector, and most legal documents recognize both public and private providers. For family planning services, the *Direction de la Santé de la Famille* is responsible for all reproductive health policies across the public and private health sectors. The *Direction de la Santé de la Famille* collaborates with pharmaceutical regulatory bodies, which allow nonprofit entities to access contraceptive stocks from CENAME, the national supplier of drugs and essential health products. For-profit pharmaceutical retailers also obtain supplies from CENAME for a pre-established list of drugs, but contraceptives are not on the list.

Several civil society organizations in Cameroon advocate for improvements in the health sector, including the *Conseil National de l'Ordre des Médecins*; *Coalition de la Communauté des Affaires contre le SIDA, la Tuberculose et le Paludisme*; the Employers' Group of Cameroon (*Groupement Inter Patronal du Cameroun*, or GICAM); *Réseau Camerounais des Associations de Personnes Vivant avec le VIH*; and Cameroon Business Forum.

Table 2. Public-private health worker distribution in Cameroon

Provider	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

Public-private dialogue and partnerships

The nonprofit sector is a recognized partner in Cameroon's national AIDS response, participating in policy document development, resource mobilization, and the HIV and AIDS continuum of care. The for-profit sector, however, is not as involved as the nonprofit sector. In 2006, Cameroon passed a general law on PPP contracts, but implementation has been slow. Nonetheless, in the health sector, PPPs involve some of the major telecommunications, extractive, and insurance companies. For example, GICAM entered into a public-private partnership with the Ministry of Health to establish a fund for procuring ARVs from vetted suppliers.

Trends in health financing

Cameroon allocates 5 percent of its national budget to health, a figure far below the 15 percent pledged in the Abuja conference in 2001, when member countries of the African Union pledged to increase their health budget to at least 15 percent of the GDP. Private resources account for 70 percent of total health expenditures. Of these resources, 94 percent come from out-of-pocket spending, a figure higher than for other West African countries with comparable per capita health expenditures (Table 3). Only an estimated 3 to 5 percent of Cameroonians have health insurance coverage, and health insurance plans do not cover family planning products. International donors and organizations finance most family planning and HIV and AIDS activities (Egal and Kapahou, 2013).

Table 3. Health expenditures and sources in Cameroon, 2011

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

Source: World Bank, 2012

Côte d'Ivoire

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. From 2005 to 2012, Côte d'Ivoire's maternal mortality rate increased from 543 to 614 deaths per 100,000 live births. The total fertility rate is five children per woman. According to the 2012 DHS, unmet need for family planning exceeded 30 percent for the two lowest wealth quintiles and was 27 and 20 percent for the fourth and fifth quintiles, respectively.

Due to more than 30 years of national and donor commitment, Côte d'Ivoire's HIV prevalence rate has been steadily decreasing, from more than 10 percent in the 1990s (Barnes et al., 2013) to 3.7 percent in 2012 (DHS, 2013). At the same time, ART service delivery improved, from 2,473 ART patients in 2003 to 89,410 in 2011 (*Ministère de la Santé et de l'Hygiène Publique*, 2008; *Ministère de la Santé et de la Lutte Contre le Sida*, 2012), thanks in part to the President's Emergency Plan For AIDS Relief and Global Fund support. However, based on United Nations Special Session Assembly's statistics from 2011, SHOPS estimated the unmet need for ART at

Table 4. Private health sector, Côte d'Ivoire, 2008–2010

Type of facility	Total	
	2008	2010
Polyclinics	15	13
Clinics	182	136
Nursing centers	556	964
General medicine and ob/gyn offices	227	114
Dental offices	NA	101
Laboratories	11	20
Radiology centers	4	4
Chinese clinics	36	67
Ambulatory care centers	NA	4
Hemodialysis centers	NA	1
Osteopathy centers	NA	2
Miscellaneous care units*	NA	147
Workplace health centers	463	463
Total	1,494	2,036

**Counseling centers, homeopathic offices, and so forth*

Source: DIPE, 2011

140,000 people. In 2009, 450,000 people were living with HIV, and there were 36,000 AIDS-related deaths (*Conseil National de Lutte Contre le Sida*, 2011).

Structure of 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. Private facilities represent 52 percent of all health facilities in Côte d'Ivoire, divided between 49.5 percent for-profit facilities and just under 2.5 percent nonprofit/faith-based facilities (*Direction de l'Information, de la Planification et de l'Evaluation, 2010*). The government authorized only 27 percent of private facilities. Both dual-practice care and unauthorized care delivered by lower-echelon providers are common. In 2010, the two largest categories of private sector providers were nursing centers and workplace health centers (Table 4).

Côte d'Ivoire's growing pharmaceutical manufacturing sector meets international standards, and manufacturers are interested in producing HIV and AIDS drugs, including ARVs. At the same time, the country is home to a black market for drugs, including contraceptives. Black market drug sellers operate primarily in markets such as Abidjan's large Adjamé-Roxy market.

Varying in size and scope, many civil society organizations play an advocacy role in the Ivorian health sector. They include professional provider associations, networks of people living with HIV, local coalitions of for-profit sector businesses, and the *Association des Cliniques Privées de Côte d'Ivoire*. Key private sector providers of family planning services in Côte d'Ivoire include the *Agence Ivoirienne de Marketing Social* and the *Association Ivoirienne pour le Bien-Être Familial* as well as private wholesalers and pharmacies.

European Commission DG ECHO

Enabling environment

Few policies govern Côte d'Ivoire's private health sector. Decree No. 96-877 (October 1996) defines and regulates the private health sector, but fiscal constraints limit the *Ministère de la Santé et de l'Hygiène Publique's* (MSHP) enforcement powers and engagement with the private sector.

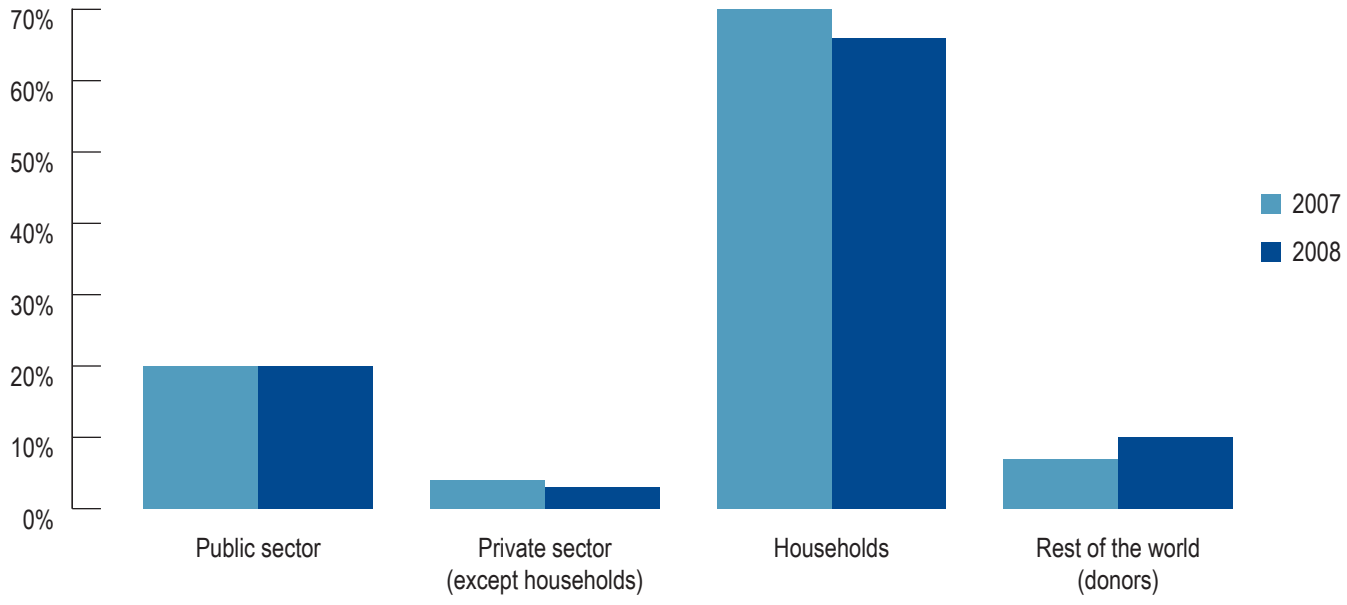
Public-private dialogue and partnerships

Côte d'Ivoire was a pioneer in West Africa with its establishment of the first PPP project for water supply in the early 1960s (World Bank, 2012a). Today, however, the country still lacks a formal health PPP policy, and formal engagement of the private sector remains limited. In 2014, only a few partnerships met the strict definition of a PPP.

Trends in health financing

In 2008, Cote d'Ivoire's total health expenditure was CFA 613,406,905,505 ($1.3 billion), with an annual per capita expenditure of CFA 29,827 ($66) (*Ministère de la Santé et de l'Hygiène Publique*, 2010). As shown in Figure 3, the slight reduction of the household burden from 2007 to 2008 came from external funding; the public sector's contribution did not change, and the private sector's contribution dropped by one percentage point. Households bear 96 percent of household health expenditures. According to an NHA analysis, the largest *mutuelle* in the country accounts for only 1.8 percent of household spending on health. For HIV and AIDS, 88 percent of total spending in 2008 came from donors and international nonprofits (MSHP, 2010).

Figure 3. Share of total health spending in Côte d'Ivoire, 2007–2008



Source: MSHP, 2010

Mauritania

Located in the Sahel, Mauritania has a population of 3.4 million. 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. Survey data indicate that 49 percent of women of childbearing age want to space or limit births (Mauritania Ministry of Health, 2011), but contraceptive prevalence is at 9.3 percent for all methods and at 8 percent for modern methods. Mauritania's HIV prevalence rate is relatively low at 0.4 percent (DHS, 2012).

Structure of private health sector

In 2011, a relatively new law (Decree No. 90/2011/PM) established the Ministry of Health and its administrative structure. Mauritania's large private health sector, however, remains largely unregulated; current law fails to provide for adequate quality assurance. Moreover, no forum exists for communication between the public sector and the for-profit sector. In contrast, the nonprofit sector is actively involved in all aspects of public health.

Even though Mauritania's private health sector continues to grow, geographic distribution of medical facilities is uneven: one in four people lives more than five kilometers from a health facility (Africa Health Workforce Observatory, 2009). Family planning and reproductive health services are concentrated in the main urban areas and are less available in rural locations. The country's two largest cities, Nouakchott and Nouadhibou, are home to the following private health facilities: 15 medical and surgical clinics; 47 medical consulting offices; 37 dental offices; 15 primary health care stations; 118 pharmacies; and 280 shops selling pharmaceutical products (Maiga, 2012). According to a 2009 *Africa Health Workforce Observatory Report*, private health facilities employ 90 percent of Mauritania's qualified health professionals (Africa Health Workforce Observatory, 2009).

The private sector largely comprises NGOs and health associations, such as *Santé Sans Frontière*, Stop Sida, Caritas Mauritania, Society for Women and Aids in Africa, *Association Mauritanienne pour la Promotion de la Famille*, and *SOS Pairs Educateurs*. These organizations focus on reproductive health, family planning, HIV services, child health care, prevention of female genital mutilation, and malaria treatment and prevention. Medical associations active in the country include *L'Ordre National des Médecins*, *Pharmaciens et Chirurgiens Dentistes*, and *L'Association des Cliniques Privées de Mauritanie*.

Enabling environment

Following the Ouagadougou conference, Mauritania drafted a plan to reposition family planning for 2014–2018, pledging to increase its contraceptive prevalence rate to 18.5 percent in 2018 by addressing the country's challenges related to the supply of and demand for family planning services.

Elizabeth Corley

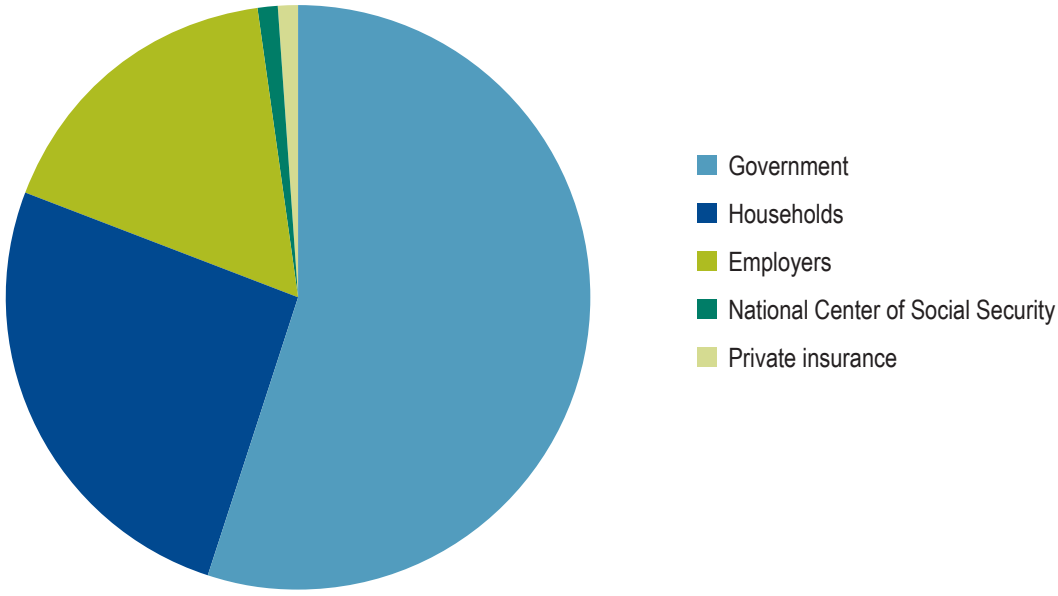
Public-private dialogue and partnerships

Partnerships between the public and private sectors (particularly the for-profit sector) face communication and dialogue challenges. The Directorate of Hospital Medicine (*Direction de la Médecine Hospitalière*) manages PPPs but lacks the funding and influence needed to monitor the private sector and partnerships, and PPPs largely focus on the public sector and NGOs. For example, the Ministry of Health is working with the NGO *Santé Sans Frontière* to ensure the delivery of integrated services such as health products, HIV testing, family planning and reproductive health services, and nutrition. Technical and financial partners are currently working with the Ministry of Health to develop a stronger partnership between the public and private health sectors.

Trends in health financing

Government commitment to health financing in Mauritania is low, with only 5 percent of the country's total budget allocated for health care expenditures—a level below the 15 percent recommended by the Abuja conference (World Health Organization, 2011). The public sector relies heavily on international donors for financing. 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, 2014b). As illustrated in Figure 4, the 6 percent of expenditures covered by insurance is paid mainly by the government (55 percent), followed by households (26 percent) and employers (17 percent) (Ould Mohamed El Moctar Salem, 2010). The range of covered services is limited, with family planning not included in most insurance plans.

Figure 4. Source of funding for six percent of insurance coverage in Mauritania, 2011



Source: Ould Mohamed El Moctar Salem, 2014

Niger

Niger is a landlocked country bordered by seven West African countries. According to the Population Reference Bureau, Niger had a fertility rate of 7.6 children per woman in 2010, the highest in the world.

With Niger's relatively low HIV prevalence rate (0.4 percent), the country is typically excluded from major donor aid directed to countries with high prevalence rates. Among sex workers, however, HIV prevalence is extremely high at 24 percent (UNAIDS, 2013). The public sector delivers most HIV and AIDS services.

Structure of private health sector

Niger's private health sector consists of a small NGO and faith-based sector and a growing for-profit sector. Relative to its neighboring countries, Niger's private health sector 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 regulatory body, a prerequisite for formal licensing and operation in Niger.

Within the capital, a handful of major polyclinics caters to expatriates and the wealthiest Nigeriens; large and medium-sized clinics are located 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 Niamey and other major cities, the for-profit health sector is virtually nonexistent. Table 5 illustrates the size of Niger's for-profit sector.

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. There are 16 private pharmaceutical wholesalers and a well-established informal market for pharmaceutical drugs throughout the country. Local NGOs (such as the Nigerien Association for the Wellbeing of the Family and ANIMAS-SUTURA) are major distributors of family planning methods, especially condoms and pills.

The private sector's role in HIV and AIDS service delivery is limited to testing. In Niamey and other urban centers such as Maradi, large private clinics have the capacity to carry out HIV tests. By law, HIV testing and treatment is free in Niger, and the government contracts with doctors at private clinics to test patients for referral to an ambulatory treatment center.

Civil society organizations particularly active in Niger's health sector include the Order of Doctors, Pharmacists, and Dental Surgeons; the Association of Private Pharmacists; and the Business Coalition against HIV and AIDS, Tuberculosis, and Malaria.

Table 5. Private health sector, Niger, 2012

Private provider	Total
Pharmacies in Niamey	85
Pharmacies outside Niamey	17
Total pharmacies	102
Physicians, pharmacists, and dental surgeons registered with local regulatory body	750
Estimated total	900–1,000

Enabling environment

A Ministry of Health directorate oversees private sector practice. Laws declaring universal rights and free access to reproductive health services, including family planning and HIV treatment, have been in place since 2006 and 2007, respectively. Following the Ouagadougou Regional Conference on Family Planning in 2011, Niger's Ministry of Health adopted a plan for scaling up family planning services between 2013 and 2020. In addition, the National Pharmaceutical Legislation, enacted in January 1997, targets the private sector, allowing private products to enter the market and legalizing private pharmaceutical practice.

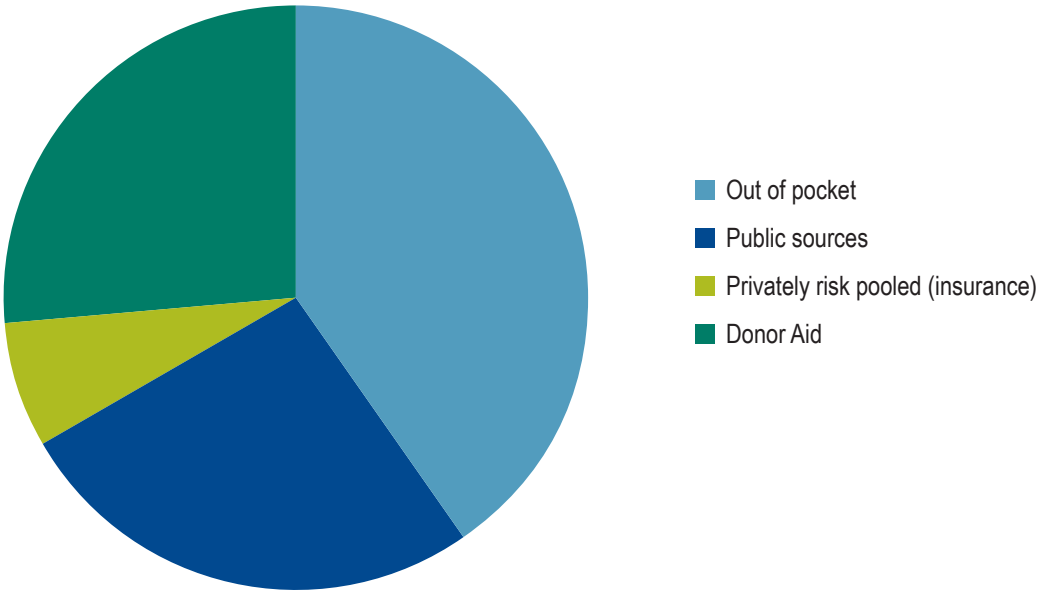
Public-private dialogue and partnerships

In the absence of official channels for dialogue, communication between the private health sector and the government is limited. Niger's PPP law dates from 2011, while a March 2014 decree amended the PPP law in support of its implementation (Government of Niger, 2014). Existing PPPs include the Areva-Ministry of Health partnership, under which the Ministry of Health provides support to AREVA, a for-profit corporation, to procure ARVs and reactives for HIV testing. AREVA provides all health services to the Arlit population at no charge. Another example is SIM, a faith-based organization that operates two hospitals in partnership with the Ministry of Health.

Trends in health financing

Out-of-pocket health expenditures in Niger have declined from 95 percent of private health expenditures in 2005 to 84 percent in 2011 (World Bank, 2013). A 2010 survey by the HLSP Institute, a global health policy knowledge center, estimated the breakdown of sources of public and private health financing as 40 percent out of pocket, 26 percent public, 26 percent donor aid, and 7 percent privately risk-pooled (insurance) (Figure 5) (Witter, 2010).

Figure 5. Sources of public and private health financing in Niger



Source: HLSP Institute, 2010

Togo

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, 2014c). Of the 39 percent of Togo's population living in urban areas, 71 percent reside in the capital city of Lomé (World Bank, 2014c). Overall contraceptive prevalence is low in Togo, with only 15 percent of women of reproductive age using a family planning method, including 13 percent overall using modern methods in 2010 (Multiple Indicator Cluster Survey, 2010). The total fertility rate remains high, with five births per woman in 2012 (World Bank, 2014a).

The prevalence rate of HIV in Togo has been stable at 3.2 percent since 2006, although it varies by region, with the highest at 6.8 percent in Lomé. Generally, HIV prevalence is greater in urban areas than in rural areas, and more than 60 percent of adults living with HIV are women (CNLS-IST, 2012).

Structure of private health sector

Togo's for-profit sector employs 75 percent of all doctors and more than 92 percent of all pharmacists in Togo, making that sector an important partner in the country's delivery of health services (IHP+, 2011). Accredited private sector facilities include 9 private hospitals, 16 private clinics, and 251 private practices (Government of Togo, 2012). The private sector delivers a greater volume of services than does the public sector, especially for ambulatory services (HiA, 2010). The pharmaceutical sector is heavily concentrated in Lomé, with only 18 authorized pharmacies operating outside the capital (Table 6). Within the private sector, the nonprofit subsector accounts for the most active delivery channels for HIV prevention and care and family planning services.

The *Direction des Etablissements de Soin*, the body responsible for licensing medical facilities, estimates that about half of the private health facilities in Lomé operate without a license. The DES also notes that accredited facilities may disappear from government records due to poor communication between the regulatory authority and private providers.

Civil society organizations that are particularly active in health in Togo include the *Association Togolaise pour le Bien-Être Familial, Aides Médicales et Charité*, the *Association pour la Santé de la Mère, du Nouveau-né et de l'Enfant*, *Appui au Développement et à la Santé Communautaire* (ADESCO), *Espoir Vie Togo*, the *Ordre des Médecins*, and the *Ordre des Pharmaciens*.

Enabling environment

Togo's policy environment is favorable to the private sector's participation in the health system, although the government has yet to implement fully its contracting policy. Through the *Direction des Etablissements de Soin*, the Ministry of Health is responsible for accrediting health facilities and ensuring adequate service coverage, quality

Table 6. Private health sector, Togo, 2013

Type of Facility or Provider	Total
Private pharmacies: Togo	180
Private pharmacies: Lomé	162
Registered private physicians	200
Private health providers in Togo (estimated)	2,000
Total	2,542

Source: Interviews with Ordre des Médecins and Ordre des Pharmaciens*, 2014*

of services, and epidemiological reporting. Accreditation, which must be renewed every five years, is mandatory for both nonprofit and for-profit facilities.

Public-private dialogue and partnerships

Despite laws that encourage public-private coordination and partnerships, the *Plan National De Développement Sanitaire du Togo* 2012–2015 (National Health Development Plan of Togo 2012–2015, 2011) acknowledges that the collaboration framework set forth in an earlier plan is not operational and that Togo's contracting policy has seen little application over the past 10 years (IHP+, 2011). In 2009, the United Nations Development Program created a platform to coordinate civil society organizations' participation in the AIDS response. The platform, called the *Plateforme des Organisations de la Société Civile Impliquées dans la Riposte au VIH Sida au Togo*, currently consists of 166 organizations under a national coordinating body (Yina, 2011).

Examples of public-private partnerships in Togo include Caritas Togo, which has entered into a contract with the Ministry of Health for delivery of services in specified health centers. Another partnership, with Global Fund support, involves the Ministry of Health in subsidizing the cost of malaria test kits in public and private sector pharmacies across the country.

Trends in health financing

As summarized in Table 7, 2008 NHA data indicate that Togo spent more than CFA 70 billion ($146 million) on health services, representing about 7 percent of gross domestic product (GDP). The World Bank reports that 85 percent of all private health expenditures were out of pocket (World Bank, 2014b). Private insurance is available through several companies, including the *Groupement Togolais d'Assurances*, the *Groupe NSIA*, the *Fédérale d'Assurance du Togo*, and the *Groupe COLINA*; however, insurance through these structures is still marginal. A law ratified in 2011 (No. 2011-003) mandated health coverage for civil servants and spurred the creation of the *Institut National d'Assurance Maladie* in March 2012.

Table 7. Health expenditures in Togo, 2008

Health expenditure indicator	Amount/percent
Total health expenditure	CFA 70 billion
Total health expenditure as percent of GDP	6.90%
Out-of-pocket expenditures as percent of health-related spending	51%
Out-of-pocket expenditures as percent of private health expenditures	84.60%

Source : 2008 NHA, Government of Togo 2012, World Bank 2014

Recommendations

Elizabeth Corely

RECOMMENDATIONS

The six West African countries represent considerable diversity in terms of economic and social development, unmet family planning and reproductive health need, level of HIV delivery in the private sector, and market maturity. Yet, the countries share characteristics unique to the region, particularly with respect to reproductive behavior, private sector growth, and health sector reforms. Drawing on interviews with key stakeholders as well as on Internet research, the assessment team developed regional and country-specific recommendations, as presented below.

Regional Recommendations

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 important drivers of public-private collaboration and set the tone for partnerships. In collaboration with WAHO, they could develop a regional private sector alliance to advocate for the development of standards across West Africa for private sector engagement, reporting, and disease surveillance. Each country, in turn, could develop its national private health sector strategy to increase the private sector's role in health care delivery.

Develop total market approaches to family planning by relying on contraceptive security committees.
Currently, WAHO is involved in a total market approach for contraceptive procurement, yet government stakeholders interviewed for the assessment demonstrated little understanding of or voiced no interest in pursuing a total market approach. USAID/West Africa projects could work with WAHO and the contraceptive security committees in the six countries to conduct national market segmentation exercises and ensure involvement of the for-profit health sector with each country's contraceptive security committee.

Increase access to family planning services through collaboration with affiliates in focus countries.
Collaboration with private provider networks that include social franchises and clinic outreach programs, such as Marie Stopes International, International Planned Parenthood Association, and Population Services International, offer the most direct way to increase access to family planning methods in rural and urban areas. Building on existing programs can help leverage scarce family planning resources while attaining economies of scale.

Increase corporate social responsibility opportunities within countries and across the region.
The CSR landscape has undergone significant change, and multinationals are more selective and less willing to engage in CSR activities unrelated to their core business. In each country, it is important to reach companies through CSR associations and business councils in order to preselect companies interested in HIV- and family planning-focused partnerships.

Develop public-private partnerships with mining companies in West Africa.
While mining companies in the region are smaller than those in other parts of Africa, they offer the best opportunity for health-related PPPs among multinationals in the region. These companies could integrate family planning services into existing HIV-related activities at their workplaces.

Increase learning within the region.
Stakeholders interviewed in each country expressed interest in learning more about both unauthorized health facilities and illegal drug sellers. Research documenting the scale and scope of the informal sector's involvement in service provision and delivery of health products would be a first step in determining how to improve the sector's role in the provision of high quality family planning and HIV services. The development of a regional private sector alliance requires a regional mechanism for the 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.

West African countries are increasing their attention on PPP infrastructure, with some countries passing laws to encourage companies' investment. Nonetheless, the countries need assistance in moving from partnerships focused on infrastructure to those focused on health.

Country-Specific Recommendations

Burkina Faso

Improve policies and regulations regarding the private health sector.

USAID/West Africa could partner with the World Bank to strengthen Burkina Faso's legal and regulatory environment, coordinate the efforts of the private health sector federation, and step up enforcement related to unlicensed clinics.

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

Burkina Faso needs to streamline import regulations and value-added tax exemptions. To improve family planning and HIV outcomes, USAID/West Africa projects could design incentives to spur private providers to serve peri-urban areas characterized by low access to health products and services.

Increase the role of faith-based organizations in providing HIV services to most-at-risk populations.

Burkina Faso's faith-based organizations enjoy strong relationships with the Ministry of Health, but the organizations should expand their role with respect to key populations through, for example, safe sex messages and the development of tailored counseling activities.

Cameroon

Ensure greater access to family planning services and products.

Cameroon's access to family planning services is concentrated in urban areas. To increase the coverage of family planning services in rural areas, USAID/West Africa implementing partners should work with the Ministry of Health to stock community pharmacies with family planning products. Currently, community pharmacies stock only child health products.

Encourage private providers to deliver HIV treatment.

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

Elizabeth Corley

Work with the private sector to improve health outcomes.
Existing donor-funded activities would benefit from expanded scale. For example, USAID implementing partners should 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.

Develop a public-private partnership with a mining or agribusiness company.
Cameroon has a strong mining sector that includes multinational companies that deliver health services. USAID implementing partners should partner with mining companies and the Cameroon Business Coalition against AIDS to undertake prevention and education campaigns.

Côte d'Ivoire

Strengthen policies to bolster private-sector participation in family planning and HIV service delivery.
The country's Reproductive Health Law, drafted five years ago, has not yet been signed into law. It would be useful to work with the *Commission Paritaire*, an emerging public-private forum, to amend the law to include the private health sector.

Work with the private sector to promote and strengthen activities through public-private partnerships and corporate social responsibility.
USAID/West Africa implementing partners should work with the Africa Center for Information and Development to provide HIV and family planning services to mining companies such as Newmont Overseas Exploration and Occidental Gold.

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Mauritania

Promote an enabling environment for the private sector at the national level and through public-private partnerships.

Implementing partners should increase the role of the private sector as specified in strategic documents such as the National Health Development Plan (*Plan National de Développement Sanitaire*) and advocate with the government, assigning a high priority to PPPs' delivery of family planning and HIV services in conjunction with the Plan to Reposition FP 2014–2018.

Promote public sector strengthening of family planning and reproductive health rights and access.

USAID/West Africa implementing partners should advocate for rapid adoption of the Reproductive Health Law and promote access to high quality planning services for remote populations through community-based distribution, in partnership with the *Association Mauritanienne de Planning Familial*.

Niger

Invest in community-based family planning and HIV activities through partnerships with local NGOs.

USAID/West Africa implementing partners should support community-based family planning extension services through partnerships with the Nigerien Association for the Wellbeing of the Family, ANIMAS-SUTURA, Population Services International, and other local NGOs. Implementing partners should also take advantage of opportunities to work through community radio stations to disseminate family planning messages and partner with the Nigerien chapter of the Society for Women and AIDS in Africa to support the delivery of preventive HIV services to sex workers.

UNFPA Flickr

Engage the for-profit sector in improving health outcomes.
USAID/West Africa should support the *Coalition Nationale des Entreprises de Lutte Contre le Sida, la Tuberculose et le Paludisme* as a coordinating mechanism for the for-profit sector. It also should work through Asusu's women's groups to disseminate family planning messages at the community level.

Togo

Improve private sector reporting.
Private sector facilities need to be trained in reporting as well as in monitoring and evaluation. Training opportunities for NGOs and private providers should be openly advertised through existing HIV and family planning forums, such as the *Plateforme des Organisations de la Société Civile contre le VIH/Sida* and the *Fédération Nationale des ONG/Associations de Lutte Contre le VIH/SIDA/IST et de Planification Familiale*.

Invest in community-based family planning and HIV activities through partnerships with local NGOs.
Community-based activities are well established in Togo. USAID/West Africa implementing partners should expand existing affiliations with community health workers and local health authorities per the AWARE II model, which was developed with the NGO ADESCO in three districts. Local NGOs such as *Espoir Vie Togo* and *Aides Médicales et Charité* are well positioned to form similar partnerships.

Develop partnerships between the corporate and NGO sectors for the provision of HIV and family planning services.
The International Labor Organization's model for HIV prevention in the workplace should be implemented in Togo in partnership with the Association of Employers and the Chamber of Commerce.

PSTH/Gabe Bienczycki (Gates Foundation)

CONCLUSION

This macro assessment describes the scope and scale of the private health sector in the West Africa region with the goal of helping USAID/West Africa, the West African Health Organization, governments, and private health sector stakeholders in the six countries to better leverage the opportunities that arise from public-private collaboration in health.

Considering the limitations on public health budgets and the reality of current out-of-pocket spending flowing to the private health sector, it is time to consider the private health sector in Francophone Africa as a true ally in the effort to improve health outcomes in the region.

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REFERENCES

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.

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.

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

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

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

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

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.

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

Ford Foundation. 2010. *West Africa*. New York, NY: Ford FoundationGlobal AIDS Response Progress Reporting. Rapport d’Activités sur la Riposte au Sida du Burkina Faso 2012, 2012. <http://www.unaids.org/en/dataanalysis/knowyourresponse/countryprogressreports/2012countries/ce_BF_Narrative_Report[1].pdf>. Accessed May 9, 2014.

Government of Niger. 2014. “Portail Officiel du Gouvernement du Niger, 2014.” <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.

HiA. 2010. “Togo Country Report. World Bank, 2010.”

International Health Partnership + Related Initiatives (IHP+). “Analyse de la Situation du Secteur de la Santé au Togo, 2011.” <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.

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.”

MEASURE DHS. n.d. *Demographic and Health Surveys. STAT Compiler*. Calverton, MD: ICF International, various years. <http://www.statcompiler.com>. Accessed April 9, 2014.

Ministère de la Santé et de l’Hygiène Publique (MSHP). 2010. *Comptes Nationaux de la Santé, Exercices 2007, 2008: Compte Général, Sous Compte VIH/SIDA*. Abidjan, Côte d’Ivoire: 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.

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

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

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.

Rosenberg, Matt. 2013. “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.

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

UNAIDS. 2013. “Global Report: UNAIDS Report on the Global 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.

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

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

World Bank. 2014. *Ease of Doing Business Report. http://www.ifc.org/wps/wcm/connect/2dc93d0041a09327a3a1b78d8e2dafd4/DB14+Scorecard_China.pdf?MOD=AJPERES*. Accessed June 6, 2014.

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

———. 2012. “World Development Indicators 2012, 2012b.” <http://data.worldbank.org/sites/default/files/wdi-2012-ebook.pdf>. Accessed May 9, 2014.

———. 2014. “Data, 2014.” <http://data.worldbank.org/>. Accessed May 9, 2014.

———. 2014. “Explore. Create. Share: Development Data, Togo, 2014a.” <http://databank.worldbank.org/data/home.aspx>. Accessed April 11, 2014.

———. 2014. “Togo: Country at a Glance, 2014c.” <http://www.worldbank.org/en/country/togo>. Accessed April 11, 2014.

World Health Organization. 2011. “The Abuja declaration: ten years on.” *Geneva: World Health Organization*, 53.

World Health Organization. 2011. “The Abuja Declaration: Ten Years On.” <http://www.who.int/healthsystems/publications/abuja_report_aug_2011.pdf?ua=1>. Accessed June 6, 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 Démarche pour le Renforcement de la Collaboration entre les Deux Secteurs*. PNLS Togo and PASCI.

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