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FROM THE AMERICAN PEOPLE

A CORRIDOR OF CONTRASTS

On the road from Abidjan to Lagos, urbanization offers risk and opportunity, hardship and hope



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A CORRIDOR OF CONTRASTS

On the road from Abidjan to Lagos, urbanization offers risk and opportunity, hardship and hope

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Human and traffic congestion along Apapa-Oshodi Express Way in Lagos, Nigeria. The city population, now estimated at approximately 18 million people, continues to grow quickly despite the city's slow infrastructure development.



The West African Abidjan to Lagos transport corridor crosses

five countries through a densely populated and growing urban setting. While rapid economic growth and urbanization in the region have the potential to help pull people out of poverty and advance progress toward the Millennium Development Goals (MDGs), it can also, without proper management, lead to the burgeoning growth of informal settlements, pollution, and crime. To document issues affecting the health of people living in urban areas along the corridor, the US Agency for International Development's (USAID) Africa Bureau and

Global Health Bureau commissioned African Strategies for Health (ASH) to capture the stories of people who live and work along the road. In January 2015, a journalist and photographer traveled the route and interviewed USAID staff, private and public health service providers, USAID implementing partners, and urban residents. This report is a compilation of those stories and the recommendations made by people living along the corridor for improving services for those who need it most.

rom Abidjan in the West to Lagos in the East, a road winds along the West African coast connecting five countries that are home to 245 million people

Text by Mary K. Burket,
Management Sciences for Health

Photography by Pinky Patel,
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Nigeria photos as specified

belonging to more than 250 ethnic groups and speaking upward of 500 languages. With their rich mix of cultures and histories, each country is a study in contrasts.

Nigeria boasts the second largest per capita income on the corridor, but is also home to the greatest proportion of people living in poverty. In Lomé, the capital of Togo, the largest maritime port in the region serves as the corridor's gateway to world markets. Just a few miles away in the heart of the city, the largest fetish market in the world sells the provisions needed for local healing and religious practices—desiccated bats, pigs, and monkeys, bare skulls, horse tails, and earthen idols. In Ghana, fields of crumbled concrete and wood remind vacationers at nearby beach resorts of the bulldozed shanty towns that had been home to thousands of people.

The port of Lomé, Togo is the region's commercial gateway to distant shores.



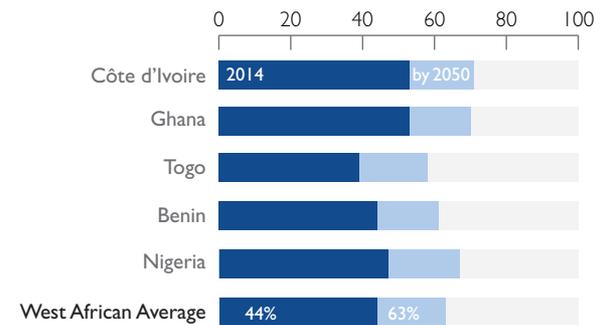




Clockwise from top left:
Traders struggle to make use of the pedestrian bridge at Aswani, a market in Lagos; The highway passes through Lomé; Goods for sale in Lomé's fetish market; Commercial building expands in Ghana.



Figure 1.1 Growth in percentage of urban population from 2014 to 2050 (projected)



As the road follows the Gulf of Guinea from border to border,

travelers are struck by the differences between countries as well. A development of pastel cookie-cutter homes outside of Abidjan, much like one would find on the outskirts of a US city, provides a glimpse into the breadth of Côte

d'Ivoire's middle class, the size of which is yet unimaginable in Togo and Benin. Lomé's wide beaches, palm-tree lined streets, and low-rise skyline give the city a laid-back Caribbean feel that seems a world away from the crowds and frenzied pace of Lagos, the Nigerian megacity just 170 miles to the east.

Commonalities between countries are obvious as well. All along the road, women still sit at rickety road-side stands selling fruit or fried carbohydrates as trucks carrying goods

Statistics show that urban populations are healthier than rural communities, but like fences that hide slums from the view of the rich, these aggregated data disguise the suffering of cities' poorest residents.

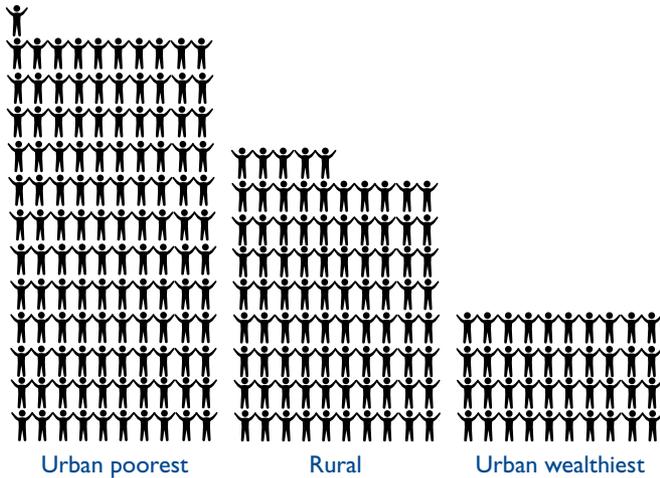
for distant shores pass by. The rise of the middle class is seen in each country, if more prominently in some than in others, through the glut of privately-owned cars and motorcycles, thriving restaurant scenes, and growing options for leisure activities. Economic growth in corridor countries ranged from 4.5 to 8.5 percent in 2014.

Lagos, currently home to 18 million people, is the largest city on the African continent, and is growing rapidly. It is estimated that 5,000

people a day immigrate to the sprawling, congested metropolis. The four other major cities on the road—Cotonou, Lomé, Accra, and Abidjan—are growing as well, as are smaller cities such as Aflao and Ouidah, which not long ago were mere villages. Before the end of the decade, West Africa's urban population will grow by 58 million people. An additional 69 million residents will stretch the limits of the cities' infrastructure and resources between 2020 and 2030.²

The centralization of wealth and population in cities provides opportunities for the industrious, smart, and lucky to build better lives. Cities are a study in extremes though. The wealthiest among us live there, but so do the poorest. The best of modern medical care is found in urban areas, yet cities' poorest

CHILD MORTALITY IS HIGHEST AMONG THE URBAN POOR



For every 1,000 poor urban children born in Ghana, 121 will die before age five. In rural areas, the number is 85 and drops to 40 among the wealthiest urban residents.

residents suffer the greatest burden of disease and receive the lowest quality of care.

Statistics show that urban populations are healthier than rural communities, but like fences that hide slums from the view of the rich these aggregated data disguise the suffering of cities' poorest residents.

In Ghana, for instance, three times as many poor urban children die before their fifth birthday than do children in the wealthiest families (above). Though the country's under-five mortality rate declined by more than 35 percent in rural areas between 1993 and 2008, it increased more than 5 percent over the same time period among the poorest urban children (see Figure 2).³

Children born to the poorest urban residents of Benin and Nigeria are also more likely to die before the age of five than children in rural areas of those countries.^{4,5} At least in Nigeria, living in a slum increases the risk of under-five mortality even after adjusting for the mother's education or income.⁶ Data from Kenya and Bangladesh show similar trends.^{7,8}

The reasons for these inequities are vast and complex and when considering that these five countries have some of the worst nationwide health indicators in the world, the gravity of the situation among the urban poor is heightened. Roughly one in ten children in the corridor countries will die before their fifth birthday.⁹ Life expectancy in Benin is 15 years

less than the average in all developing countries. West Africa is the riskiest region in the world to give birth—Nigeria alone accounts for 14 percent of all global maternal deaths.¹⁰

As the cities along the corridor grow, it is imperative to understand and address the unique emerging drivers of ill health among the urban poor and adapt public health interventions to address them. Only then will these coastal cities deliver on their residents' glimmering hopes and dreams of a healthier future.

Children living in slums face numerous barriers that often prevent them from attending school or receiving medical care, despite their proximity to urban centers.

Though Ghana's under-five mortality rate declined by more than 35 percent in rural areas between 1993 and 2008, it increased more than 5 percent over the same time period among the poorest urban children.



Figure 2.¹¹ Child mortality is increasing among urban poor in Ghana and Nigeria

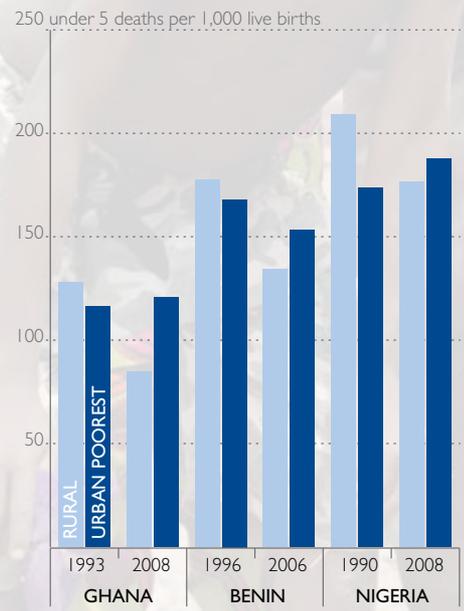


Figure 3.¹² Decreased poverty contributes to longer life expectancy for adults...

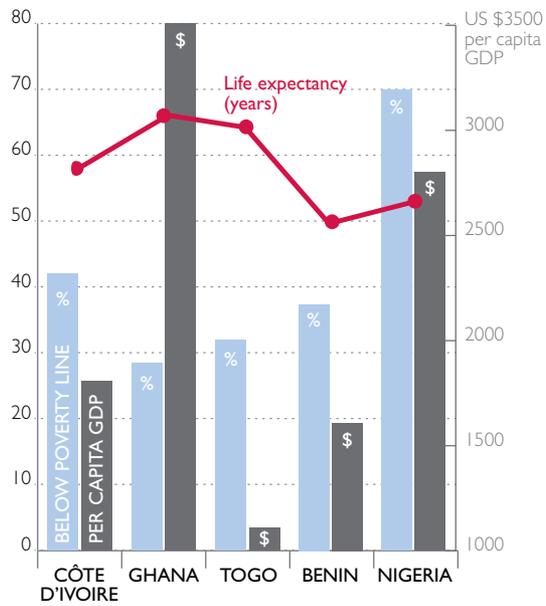


Figure 4. ...and for children and mothers

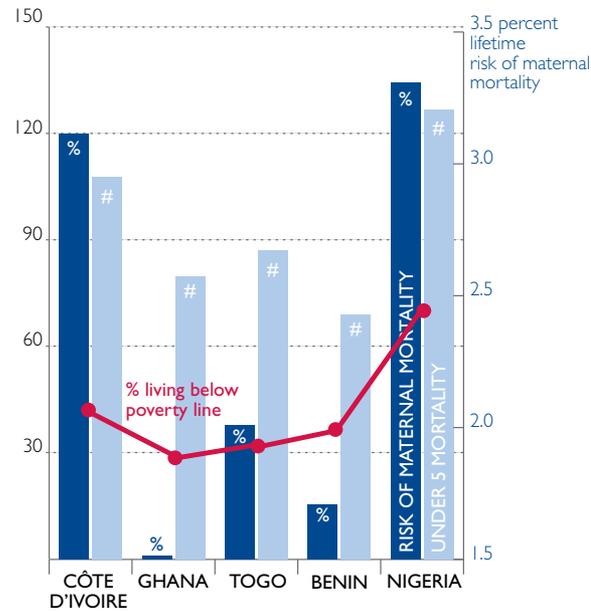


Figure 5.¹³ Faster urban growth in all countries...

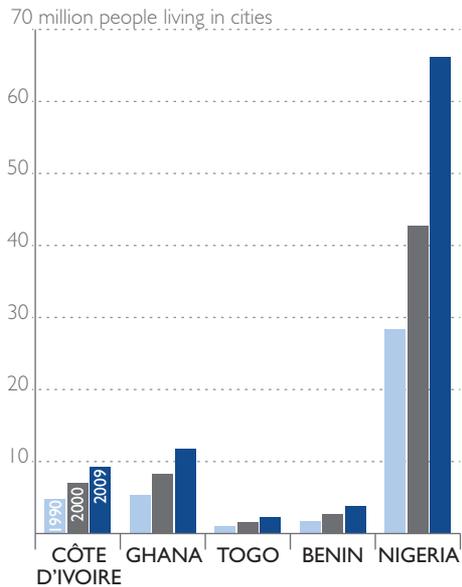
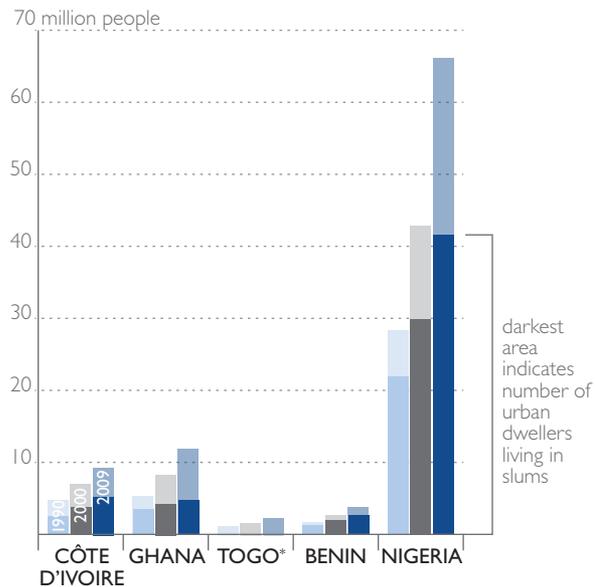


Figure 6. ...means more people living in slums



*Togo data on slum populations was unavailable.



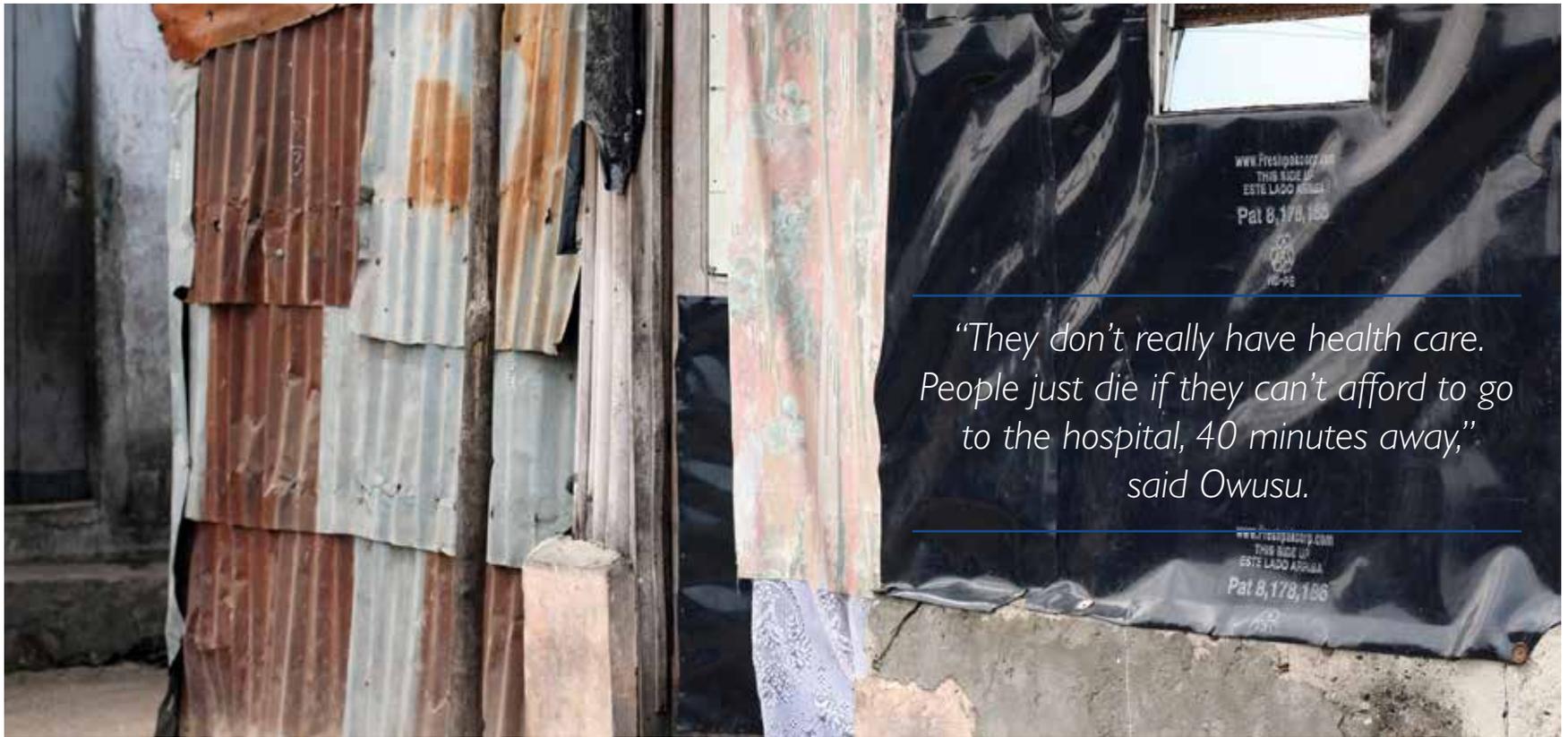
This community in Côte d'Ivoire was hidden from view behind high walls. Less than a month after this photo was taken, the settlement was dismantled.



1 in 10



CHILDREN BORN IN
CORRIDOR COUNTRIES
DIE BEFORE
THEIR FIFTH BIRTHDAY.



“They don’t really have health care. People just die if they can’t afford to go to the hospital, 40 minutes away,” said Owusu.

Kweku Owusu grew up in an area of Accra called The Center for National Culture.

The Government of Ghana built the neighborhood about 50 years ago to house state workers. Soon thereafter, migrants and other needy residents of Accra began building informal housing around and in between the government’s buildings. Though the increased crowding exacerbated sanitation problems, the government-employed residents and others coexisted peacefully for decades.

It wasn’t an ideal place to live, said Owusu. There were no sanitation facilities and from early grade school on, he had to travel an hour each way to get to school.

“They don’t really have health care [in the neighborhood]. People just die if they can’t afford to go to the hospital, 40 minutes away,” said Owusu.

Nonetheless, The Center for National Culture was home. Owusu grew up there. His 58

year-old mother, three sisters, and two nieces still lived there until January 2015, when the Government of Ghana evicted all residents and tore down the informal housing. Residents of the government housing were given about a month to evacuate. Others had just one week to find a new place to live. The government offered no compensation or relocation assistance to either group.

“Most of the people will be on the street,” said Owusu. “I don’t know what they will do now.”

All along the road, in clusters of available land within city limits or on the outskirts of town, people have built communities from corrugated metal, tarps, earthen bricks, and discarded building materials.

Left: An example of housing in an informal settlement

Below left: Children play in Benin slum

Below right: Modern, newly-constructed buildings in Côte d'Ivoire mask the issue of the urban poor from visitors.

These homes, many of them built by people who have traveled to cities in search of a better life, are located on the least-desirable pieces of land in and around cities—often in a flood plain, on steep slopes, in wetlands, or close to major transportation interchanges—making them prone to natural disasters. The houses generally lack any way to secure families from violence or theft.

Because they evolve outside of formal urban planning processes, informal settlements have no access to basic infrastructure and limited social services. Without options for sanitary disposal of waste, neighboring water sources are contaminated with feces, and a thick blanket of garbage chokes the ground of common areas. Many of these communities are built on the outskirts of cities, forcing



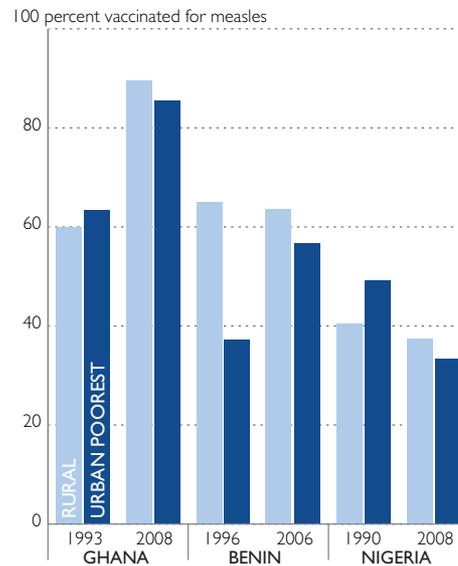
“We place community health workers as close to people as possible in rural areas and reinforce the systems in cities. But we never think of the people in between. They are in that no-man’s land. That is where there is no health system,” said Dr. Diallo.





A tanker headed for commercial hub port Lomé, Togo, passes by a Benin slum built on a spit of land near Cotonou.

Figure 7.¹⁴ Measles vaccination coverage



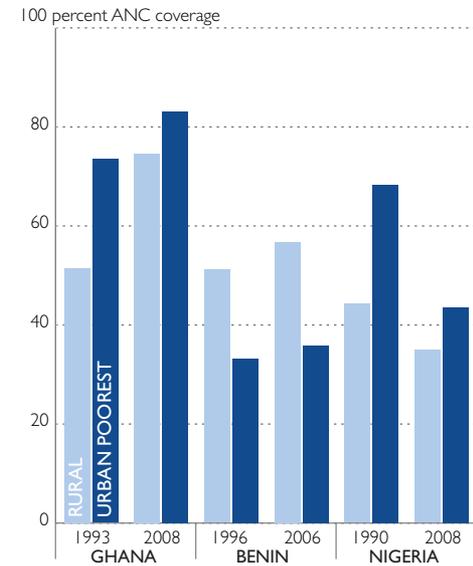
residents to travel long distances into urban centers to access public services.

“There is more unmet need in peri-urban slums than anywhere else in West Africa,” said Dr. Rouguiatou Diallo, Chief of Party for the regional Accelerate Family Planning (Agir-PF) project managed by EngenderHealth, about the state of family planning in the region.

Statistics show this to also be true for maternal and child health services in some corridor countries (see figures above).

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Figure 8.¹⁵ Antenatal care coverage



Illness caused by close living quarters, lack of sanitation, and insufficient access to health care is a financial burden, as well as a health risk. In Benin, children living in slums attend school for less than two years, the lowest average of any socioeconomic group in the country.¹⁶ Without access to safe, sanitary housing, health care, and social services, the urban poor are stuck in a cycle of poverty fueled by high fertility rates and systemic marginalization.

Yet the potential for a better life exists within cities and migrants will continue to flock to the corridor, bringing hope for opportunity and change. The middle and upper classes and their governments want to capitalize on the growth of the corridor’s cities and economies. Informal settlements, however,

where the majority of urban populations on the corridor live, complicate the rise of urban West Africa.

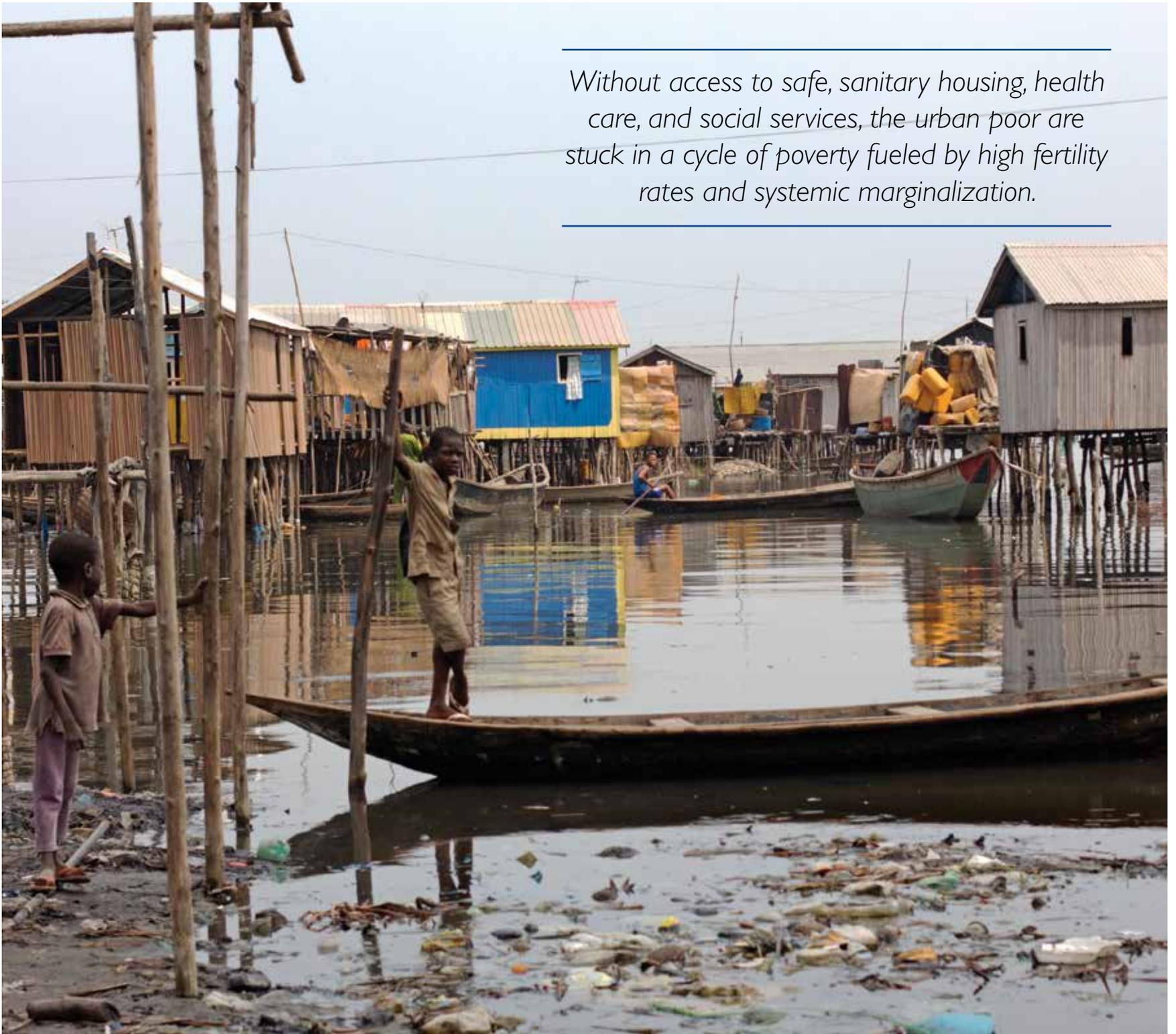
Though the proportion of urban residents living in informal housing has been declining in all countries except Côte d'Ivoire, it is not dropping as quickly as the cities themselves are growing. Interventions to improve poor urban residents' access to health and social services are, therefore, increasingly vital. Some of these practices are known and described in the following pages. Others will need to be designed based on the available data and realities along the corridor; tested, adapted, and brought to scale.



Clockwise from above:
Children play among trash in Côte d'Ivoire; Walls and barbed wire separate industry from residential areas in Togo; A woman cares for her sick child, as the other sleeps, along a road in the Ojota neighborhood of Lagos, Nigeria.



Without access to safe, sanitary housing, health care, and social services, the urban poor are stuck in a cycle of poverty fueled by high fertility rates and systemic marginalization.



Late one morning in Ladji, a slum on the outskirts of Cotonou, a young mother sharply dressed in a traditional West African *complèt*—a long skirt, fitted blouse, head wrap, and scarf all made from the same brightly, wildly patterned cloth—sat on a bench in the entry way of *La Nouvelle Vie*,

waiting for a joint post-partum and well-baby visit. The waiting area was cool and neatly kept, a welcome reprieve from the hot sun and stench emanating from piles of garbage outside the clinic's doors. Her baby, Isabella, fussed and she offered her breast. The pair was relaxed and content, a contrast to the faces seen waiting outside many crowded facilities in cities along the corridor. It wasn't the lack of lines, however, that brought the mother to this privately-run clinic.

"I come here because they treat me with respect," she said, a trait of service provision she finds lacking at government-run health facilities.

She isn't alone in her preference for private health care. Just 51 percent of Benin's poorest residents had their last baby in a government facility, compared to 67 percent of the wealthiest and 76 percent of the second-wealthiest quintile.¹⁷ The reasons often

cited in official reports for why clients don't attend public health centers aren't relevant to her. The cost of services is the same. The public health center is about the same distance from her home as *La Nouvelle Vie*. The hours of operation are comparable. The wait isn't long at the public facility either.

Isabella's mother simply prefers the way she is treated at *La Nouvelle Vie*.

Her feelings are echoed by lower-income men and women throughout the corridor. "Those services are not for us," said Fofana Karamoko, a trucker from Abidjan, about public health centers. "Because we are dirty, they don't treat us well." He tugged at his tank top for emphasis.

Staffing and space in urban health facilities has not kept pace with population growth along the corridor. Though Benin's public health centers do not appear to be overburdened—many seem completely empty on weekday



Clockwise from above:
Dr. Theophilus Hounhouedo of La Nouvelle Vie;
Crowded waiting room at L'Hôpital de Bê in Togo;
A nearly empty public health center in Benin.

Dr. Hounhouedo of La Nouvelle Vie has worked in peri-urban Cotonou for decades. Not only does he serve his community's health needs, he has obtained funding to build and run a local private school as well.



“Those who are illiterate have no way of knowing the quality of the care they are receiving. But if someone makes them feel comfortable, they will return...They don’t see the difference. The baby comes out on its own whether the mother is at home or the hospital. If a mother or a baby dies, they see it as a matter of destiny.”

mornings—the same cannot be said in neighboring countries. At nine o’clock on a Monday morning in Lomé, the line for family planning and maternal health services at *L’Hôpital de Bé* looped around a corner and extended down the center of the main waiting room through rows of benches stuffed with clients waiting shoulder-to-shoulder outside a half-dozen consultation rooms.

The unrelenting work at countless health facilities along the corridor negatively affects the quality of providers’ interactions with clients, as does the power dichotomy between them and poor, illiterate clients. Far from being unique to the corridor; humiliation, coercion, procedures done without clients’ consent, and even physical violence toward patients, are well documented in African countries.¹⁸

The overburdening of the health sector also leads to long waits and shortages of supplies and medicines. The growing gap in governments’ abilities to provide health services to all urban citizens, combined with many residents’ discomfort in seeking services from public facilities, has created a void that entrepreneurial West Africans have begun to fill.

One quarter of Benin’s registered health care providers are privately employed. Yet as many as 88 percent of private providers may be unregistered and thus could be entirely unqualified.¹⁹ The growing private health sector along the corridor is relieving much of the pressure on the government system, but better coordination and regulation is required to ensure high quality, respectful care throughout the health system.

The young woman in Ladjì is fortunate. The owner of *La Nouvelle Vie*, Dr. Theophilus Hounhouedo, has received training and assistance from several international organizations and works closely with the local public health center to ensure that he and his staff provide the best possible quality of care. This cooperation and mutual respect between private and public providers, however, is rare, according to many interviewed along the road.

Dr. Laurinda Gbagui Saizonou, *Médecin Chef* at the government-run Cotonou 4 Health Center, knows of twenty private clinics in

Cotonou 4. Though she and her staff try to visit each one regularly, she laments that their oversight is neither systematic nor frequent enough. The quality of care in some private facilities is ok, she says, but in most it is far from adequate. The Ministry of Health can shut down clinics that are grossly unsafe, but there is little the system can do to prevent the same provider from setting up shop again across town.

This, according to Dr. Saizonou, is the biggest problem in Benin’s health system and throughout the corridor.

“Those who are illiterate have no way of knowing the quality of the care they are receiving. But if someone makes them feel comfortable, they will return,” she said, explaining why the poorest residents of Cotonou are most likely to use unqualified private providers. “They don’t see the difference. The baby comes out on its own whether the mother is at home or the hospital. If a mother or a baby dies, they see it as a matter of destiny.”

Despite efforts to expand coverage to all residents, such as Ghana’s national health insurance policy and other countries’

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provision of free or reduced-cost maternal and child health services, public health systems disproportionately serve the corridor’s middle class and wealthy.²⁰ One third of all spending in the Ghanaian public health sector benefits the richest fifth of the country while the poorest fifth receives just 12 percent of the benefit.²¹ Only one in four of the poorest Ghanaians seek care from the public sector for a sick child. The proportion in Nigeria is slightly higher at 47 percent, but still below the average found in a ten-country survey.²²

Though approximately 50 to 75 percent of all money spent on health care in the five countries flows through the private sector, private providers and facilities receive little support from the government or international donors.²³ To improve overall quality of health care along the corridor, interventions will need to focus on the entire health system, not just the public sector.

Ensuring respectful care of all patients regardless of their socioeconomic or health conditions will require changes in both pol-

icies and practices and is an integral part of USAID’s Maternal Health Vision for Action.²⁴ Interventions and policies focused directly on respectful and compassionate care will be required to improve providers’ interactions with clients. There has been some evidence in Nigeria that training can improve this relationship, however, the same study showed no improvement in Ghana.²⁵

The White Ribbon Alliance has held public hearings to address the issues of disrespect and abuse in Nigerian health facilities. Testimonies revealed that laboring Nigerian women have been smacked, neglected, coerced, and harassed by health care providers and avoid health centers as a result.^{26,27} In June 2014 the Nigerian Minister of Health announced stiffer sanctions for disrespect or abuse of patients. In December, after a decade of advocacy by the White Ribbon Alliance, the Federal Government signed the National Health Bill into law, which will further protect mothers, children, the elderly, and other vulnerable groups.







Clockwise from top left:
Woman walks on Benin street;
Dessicated animal heads used
in traditional medicine in Togo;
Informal market on streetside;
Diabetes clinic in Togo



Conventional wisdom says that urban residents, especially the most highly educated, would hold fewer mystical beliefs about health care, but along this corridor, that idea does not appear to hold true.

Seventy to eighty percent of West Africans use traditional medicine to manage diseases such as malaria, HIV, diabetes, hypertension, and tuberculosis. A study in Ghana, Mali, and Nigeria showed that traditional medicine was the first line treatment for 60 percent of children with malaria.²⁸ It seems city dwellers and villagers, the highly educated and illiterate, the rich and the poor, the young and the old are equally likely to consult traditional healers.²⁹

"Everyone consults traditional healers first," said Dr. Hector Atiobgé, *Médecin Chef* at the Grand Popo Health Center. "It is a problem because then they wait until they are too sick to come here."

Xavier Weti just finished his university degree in marketing and is living in Lomé. Weti's childhood was split between Lomé and a village about an hour and a half north called Agou Nyogbo, where his family home abuts the German-run Bethesda Hospital. Despite his education, exposure to western culture and medicine at an early age, and proximity to modern medicine in Lomé, when Weti is ill and does not have enough money to visit a

clinic, he takes teas provided by local therapists or travels to Agou to visit a traditional healer.

Traditional healers' services are not free, however, and neither is travel to the village. Despite sometimes charging higher fees than teaching hospitals, people still rely on traditional healers.³⁰

"In cities, 100 percent of people use traditional medicine. In village, it is 125 percent," said Dr. Diallo in Lomé.

Clinical trials of some traditional remedies have been shown to effectively treat malaria and raise CD4/CD8 counts, decrease viral load, and increase weight gain in HIV-infected people.³¹ Unfortunately, not all traditional remedies are effective and some may even be harmful.

Though each of the five countries has policies and laws regarding traditional medicine, the frameworks for regulating the practice are currently weak. The West African Health Organization (WAHO) and the WHO Regional Office for Africa are collaborating to create a harmonized regional strategy to not only sup-

port and regulate traditional medicine, but to encourage further scientific study of common herbal remedies to determine which remedies can be proven to be effective and which should be replaced.

While many public health projects, particularly those trying to increase use of family planning, have worked with Christian and Muslim leaders, few have engaged traditional healers in the region. Dr. Diallo attributes this to the lack of an organizing body for village doctors. Working closely with traditional healers and priests could strengthen public health interventions by increasing populations' trust in modern medicine as well as providing an opportunity to educate traditional healers about the warning signs that should alert them to send a client directly to a public health facility and could have a profound impact on social norms regarding health care in the region. The Strengthening HIV/AIDS Response Partnership with Evidenced-Based Results (SHARPER) project, implemented by FHI360, collaborated with traditional healers in Ghana to improve detection of HIV.³²

A young woman selling medications takes a break in the Attecoube truck stop, Côte d'Ivoire.

Bottom left: Zinc marketed by the SHOPS project along with oral rehydration solution for treatment of diarrhea in young children.

THE CORRIDOR'S PROBLEM WITH FAKE MEDICINES

Nearly half of a square mile of Benin's Dantokpa market, the largest in the country, is carpeted with stalls selling medicines purported to cure malaria and tuberculosis, antibiotics, antiretrovirals, and pain relievers.

Many are packaged identically to the genuine products, thus consumers have no way of discerning real from fake. Local residents say that none of them are authentic, yet the vendors do not want for clients.

Counterfeit or substandard drugs account for 50 to 60 percent of all medicines sold in the region.³³ Nearly 80 percent of antimalarial medications sold in Ghana and 22 percent sold in Togo are not registered with the countries' regulatory authorities. Three quarters of antimalarials sampled in Togo and 80 percent of samples in Ghana were found to have levels of the active ingredient outside of accepted ranges, most often, too low.³⁴

A 2008 study of availability of antimalarial medications found that just 69 percent of facilities in Benin had the medication in stock.

Just five percent of those that had antimalarials available were public facilities.³⁵ Similar trends have been documented in Ghana.³⁶ The health center in Grand Popo Benin, not far from the Togolese border, has so much trouble keeping essential medicines in stock, that a wealthy resident who frequently travels to Paris and heads a local NGO regularly imports medicines from France to supply the government facility.

Privately-run pharmacies are plentiful along the corridor, as are neatly stacked packets of pills sold alongside flip flops, canned tomatoes, and batteries at roadside stands or from baskets atop women's heads. Just like privately-employed doctors and nurses, private pharmacists and local vendors are filling a gap left by government systems. Unfortunately,



Counterfeit or substandard drugs account for 50 to 60 percent of all medicines sold in the region.





Clockwise from above:
Signs direct patients from outside
a public health facility in Benin;
Street markets sell fake drugs that
attest to alleviate such diseases
as malaria and tuberculosis; A well-
stocked shelf at a health facility.

despite regulations on the import of pharmaceuticals in each country, the flow of counterfeit medicines into and between countries along the corridor is fueled by under-regulated private pharmacies and medicine vendors.

The trade of fake drugs in West Africa is big business. Thus, despite significant seizures in recent years by the ECOWAS Medicines Anti-Counterfeit Committee (EMACCOM), Interpol, the World Customs Organization, and the Institute of Research Against Counterfeit Medicines (IRACAM), there is little evidence that the flow of fake drugs has ebbed.

In 2009, sale of malaria treatments alone accounted for \$438 million of trade in West Africa.³⁷ Only the trafficking of oil, cocaine, and cigarettes bring more money to the region. If estimates were available for the value of other trafficked medications, the sum would likely show that the trade of counterfeit medicines is the largest illicit business in the region.³⁸ In fact, the profits are so great that many organized crime groups have shifted their focus from the trade of arms and narcotics to counterfeit medicines.³⁹

No country along the corridor will be successful in decreasing the flow of these drugs

without the full cooperation of its neighbors. Given governments' financial interest in allowing the trade to continue, the private sector may once again hold the solution to the problem.

In Liberia, Côte d'Ivoire's eastern neighbor, the Bill & Melinda Gates Foundation has supported the Sustainable Drug Seller Initiative (SDSI), which has had great success decreasing the availability of counterfeit medicines by regulating the sale of medicines in the private sector and educating the population on how to ensure they purchase authentic medicines.

As is common along the corridor, before SDSI began operations in Monrovia, medicines were sold from roadside vendors and stacks on dusty store floors.

"It was so messy! So disorganized! I'd never seen anything like it," said Edmund Rutta, Principal Technical Advisor with Management Sciences for Health (MSH), the organization implementing SDSI. Rutta had previously led a similar project in Tanzania with great success, but the starting point did not seem as chaotic in East Africa as it did in Liberia. "I didn't think it was possible. But I said, we will try!"

The team advocated with Liberian policy makers who passed a law mandating the establishment of a pharmaceutical regulatory system and quality improvement mechanism. A six-month-long advocacy campaign in Monrovia and the surrounding county educated residents about counterfeit medications and introduced them to the Accredited Medicine Store logo, which they would soon find displayed at all accredited vendors in the country, so that they would know how to identify reputable stores.

Working with the Ministry of Health, the police, pharmacists, and associations of shop owners, SDSI systematically educated drug sellers on how to ensure the quality of their stock and made the registration process fast and transparent, thus closing loopholes that had facilitated corruption.

As a result, the percent of medicine stores in Monrovia and the surrounding country that sold expired, damaged, or counterfeit medicines decreased from a high of 83 percent in September 2013 to just 8 percent in March 2014, and the proportion of stores stocking medicines not approved for sale in private medicine stores decreased from 90 percent in March 2012 to 3 percent in March 2014.



“To educate consumers, we used what Tylenol and Pepto Bismol have taught us,” said Joseph Addo-Yobo, Chief of Party for the SHOPS project in Accra. SHOPS made a locally-produced oral rehydration solution a household name through radio and television ads, billboards, and point-of-sale displays.

The abundance of knowledge and information in cities and the open sale of medications often leads people to self-medicate. Evidence from Côte d'Ivoire shows that the sale of antibiotics from private pharmacies without a prescription and without giving proper information about dose, duration of treatment, or when to take the medication is widespread.^{40,41} Programs such as SDSI, which both educate consumers and also create supportive regulatory systems for sellers, are essential to protect the population against improper self-medicating and the emergence of antibiotic resistance.

Much like the approach used by SDSI, in Ghana, SHOPS used social marketing and thorough training and support of drug sellers to increase use of low-osmolality oral rehydration solution (ORS) and zinc, the best treatment for diarrhea in children under five years of age.

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Mothers' familiarity with the product led them to choose it when their children were sick. SHOPS found that the use of ORS and zinc increased from 1.3 percent of cases in 2012 to nearly 35 percent in 2014. At the same time, the proportion of mothers who reported treating their children's diarrhea with antibiotics, a commonly prescribed, but ineffective treatment for this age group, decreased from 60 to 20 percent. The President's Malaria Initiative has had similar success with social marketing of pharmaceuticals.

These children lived in a slum in Côte d'Ivoire that was removed shortly after this photo was taken.

LOW CONTRACEPTIVE USE CONTRIBUTES TO POPULATION GROWTH IN CITIES

With more opportunities for employment, ostensibly easier access to services, and the escape from watchful eyes of mothers-in-law and aunties that cities afford, urban women the world over are more likely to use contraception than their rural sisters.

The situation along the corridor echoes worldwide trends. The highest use of modern contraception is seen in the coastal cities—26 percent of women in Lagos compared to 11 percent nationally and just 6 percent in rural areas.⁴² However, compared to other African cities—such as Nairobi, where 55 percent of women use contraception—the corridor's cities have a long way to go, especially for the poorest residents. In Nigeria, less than one percent of women in the lowest wealth quintile use contraception.

Without capitalizing on the power that controlling their fertility gives them, women along the corridor cannot fully benefit from the opportunities of city life. In the cities along the corridor, women have about four children each. Rural averages in the five countries range from 5.4 children per woman in Benin

to 6.3 in Côte d'Ivoire. The cost of urban life, however, means that raising four children in a city may be just as difficult as six in a rural area. Without extended family nearby, urban women must often pay for childcare and all of life's necessities—food, clothing, water, housing, and transportation—are more expensive in cities. High fertility rates among the cities' most vulnerable residents anchor this population to poverty perhaps more strongly than any other factor.

According to some experts, however, the cities along the corridor are poised for a breakthrough.

"More and more, people are changing," says Dr. Diallo. "They see their neighbors with fewer kids and how well they can take care of them. There are more women working

and more opportunities. The ball is on our side to educate women about the benefits of family planning and take this opportunity to accelerate the speed of change."

Accessing contraception is likely relatively easy in city centers, but women in peri-urban slums are less likely to have the opportunities, knowledge, or freedom necessary to control their fertility.

"In peri-urban areas, they still live like they are in village," said Dr. Edmond Kifouly, an independent consultant in Cotonou.

Extended families are more likely to live together in peri-urban slums, thus women's choices are more likely to be limited by mothers-in-law, traditional beliefs, lack of privacy, and sparse services.

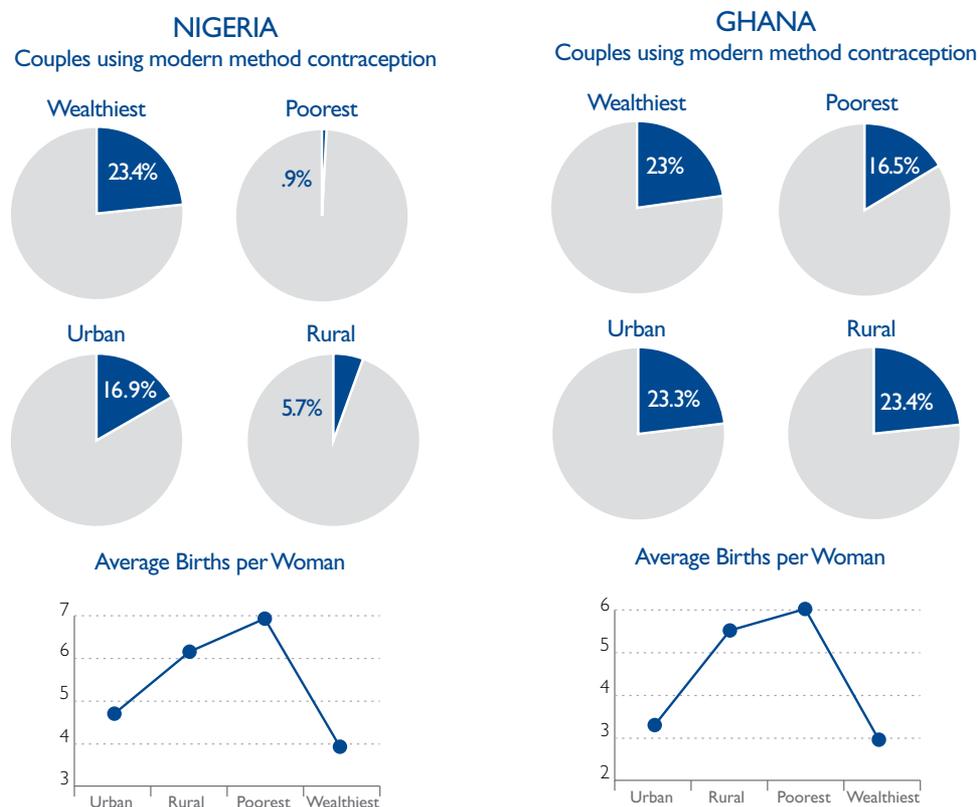




Clockwise from top left: Girl carries her young sibling; Florence Dagadi, a midwife at L'Hôpital de Bè in Togo, shows contraceptive options; Dr. Edmond Kifouly, a consultant in Cotonou; Mobile clinic provides family planning services in Benin.



Figure 9. Contraceptive use and fertility trends are similar along the corridor



	Wanted fertility	Unmet need for family planning among married women
Côte d'Ivoire	4.5	27%
Ghana	3.5	30%
Benin	4.0	33%
Togo	4.1	34%
Nigeria	5.2	16%

“The biggest barriers are side effects, husbands’ opinions, and traditional beliefs,” said Florence Dagadi, a midwife at *L’Hôpital de Bé*, who is receiving support from Agir-PF.

In Togo, Agir PF is addressing the problems women face when trying to access contraception from multiple angles. To ensure consistent supplies of contraceptives, they have negotiated a partnership between a privately-owned transportation company and the Ministry of Health. In the first six months, stock-outs in peri-urban areas were completely eliminated.

The project is advocating with the Togolese Ministry of Health to include community health workers in their official roster of staff. Though voluntary community health workers, who have personal knowledge of local beliefs regarding contraception, have been shown to help women in rural areas overcome challenges accessing contraception, cities complicate their use. In places where migration is common, social networks aren’t as tightly knit nor as geographically clustered, so community health workers have a harder time establishing rapport with potential clients. Urban com-

munity health workers often sever their ties to supporting organizations or facilities when they move across town. Furthermore, city culture and the high cost of living mean that city-based community health workers expect to be paid for their services. Agir-PF hopes that formalizing community health workers’ roles within the public health sector will secure their positions and support system.

Other organizations, such as *L’Association Beninoise Pour La Promotion De La Famille* (ABPF), have established social franchises, which provide community health workers with a source of income through the sale of contraceptives and other health care items, thus motivating them to work and maintain their link with ABPF despite moving throughout the city.

Lower birth rates combined with a relatively large working-age population create ideal conditions for economic growth. As women have fewer children, the population’s age structure will shift, allowing for countries to capitalize on the demographic dividend.⁴³

Figure 10.⁴⁴ Urban versus rural differences in HIV prevalence

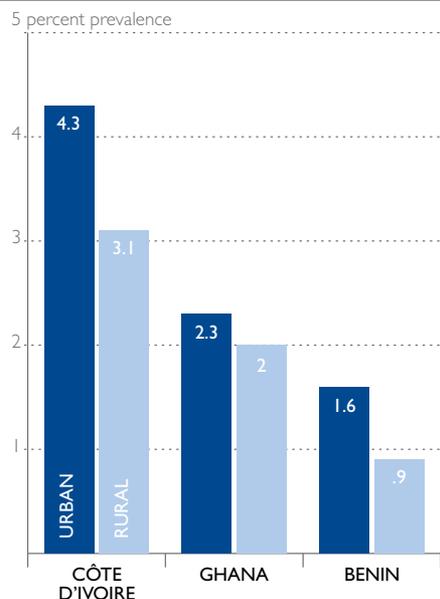
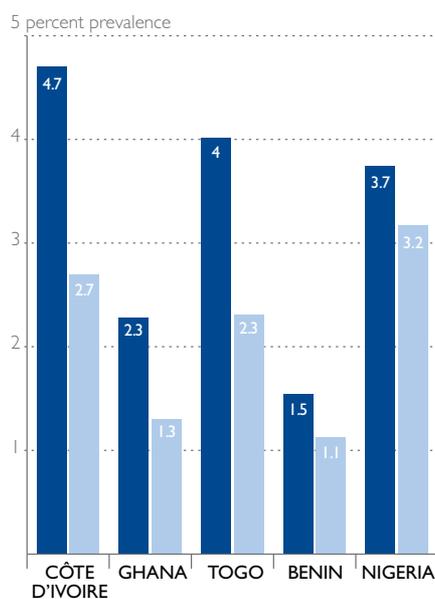


Figure 11. Decrease in HIV prevalence since the height of the epidemic



PROGRESS AND CHALLENGES MANAGING HIV ON THE CORRIDOR

Throughout sub-Saharan Africa, HIV prevalence among adults in cities is about twice that of rural areas.

Though urban-rural differences along the corridor are not as stark as elsewhere in Africa, cities still bear the brunt of the HIV burden in these countries (see graphs above). In Côte d'Ivoire, 43 percent of all residents infected with HIV live in Abidjan.⁴⁵

In the general adult population, prevalence of HIV infection has decreased steadily since the height of the epidemic (see Figure 12). Yet among sex workers, men who have

sex with men, people who inject drugs, and long-distance trucker drivers—all of whom are largely centralized in urban areas or along transport corridors—the virus continues to spread rapidly.⁴⁶ AIDS remains the leading cause of death in Côte d'Ivoire and Togo and the second and third in Nigeria and Ghana, respectively.

The Abidjan-Lagos Corridor Organization (ALCO) has been working at the borders

and truck stops on the road between Côte d'Ivoire and Nigeria since 2001 to mitigate the spread of HIV among truckers and sex workers. ALCO distributes condoms, sponsors mass-media education, and has trained truckers and sex workers to educate their colleagues about HIV prevention, provide opportunities for testing, and help those who test positive find treatment. Condom use and knowledge about HIV have increased steadily as a result.

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The truck driver's daily life involves constant travel and finding a bed where you can. Much work has been done to encourage condom use and educate this population.

The battle is far from won, however. There is a continuous flow of young men and women into these trades and, as traffic along the corridor increases, so will risk among these populations.

UNAIDS estimates HIV prevalence among sex workers along the corridor to be between 11 and 25 percent (see Figure 13). Though knowledge about prevention is common, fear of violence is one reason infection rates are still high in this group. Sex workers in Ghana reported fear of rape or physical violence as a reason to consent to sex without a condom.⁴⁷ In Togo and Burkina Faso, sex workers who had been victims of violence were twice as likely to have had sex without a condom with a client in the past 30 days.⁴⁸ Youth, drug and alcohol use, and the promise of more money were also cited as reasons sex workers agreed to intercourse without a condom with their clients.⁴⁹

Etienne N'Guessan, who runs the HIV prevention project in Attécoubé, a truck stop in Abidjan, through *Syndicats Nationaux des Transporteurs de Marchandises et Voyageurs de Côte d'Ivoire* (SNTMVCI), the national transport union), says that the regional approach that has been taken by ALCO and others for HIV education must be adapted along the

corridor for testing, care, and treatment services. The proportion of the general population along the corridor who know their status is just 5 to 13 percent and far too few people living with HIV are on treatment. In Nigeria, just 23 percent of people in need of antiretroviral medication receive it.

"Keeping commercial sex workers and men who have sex with men in care seems to be even harder than the general population," said Serwaa Owusu-Ansah of FHI360's Linkages across the Continuum of HIV Services for Key Populations Affected by HIV (LINKAGES) project. "They are more mobile and don't trust providers." The retention rate among sex workers in Côte d'Ivoire is just 75 percent 6 months after starting treatment and only 47 percent after 36 months compared to 79 percent at 6 months and 56 percent at 36 months in the general population.⁵⁰

Owusu-Ansah agrees that a region-wide approach to care along the corridor would help reach mobile populations such as sex workers, transport workers, and men who have sex with men and keep them on treatment. But reaching this latter group is particularly difficult.

Prevalence rates among men who have sex with men range from 12 percent in Benin to 20 percent in Togo and like trends among

Figure 12. Percent of sex workers who are HIV infected

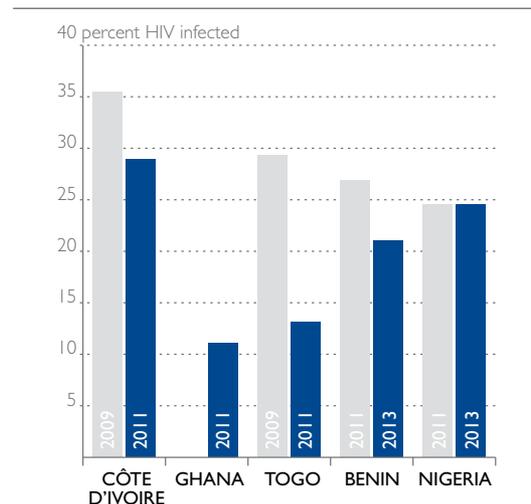
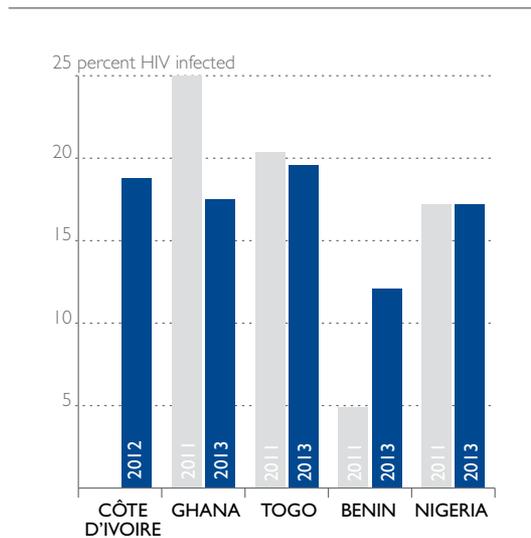


Figure 13. Percent of men who have sex with men who are HIV infected



Similar data is unavailable for populations of long-distance truck drivers and people who inject drugs.

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sex workers, prevalence of HIV among men who have sex with men is stagnating, or more alarmingly, in the case of Benin, increasing (see Figure 14). The growing urban population may be a factor—as more men move to cities, the pool of willing partners increases. It is also likely fueled by the deep discrimination so ingrained in West African culture that it is virtually unheard of for men to openly self-identify as homosexual.

The few men who will admit to being gay—or being friends with someone who is gay (the term men who have sex with men, though popular within the public health community was unfamiliar to interviewees)—tell stories of unthinkable violence. Living in fear of this violence, gay men are often hesitant to seek health services targeted to them.

Most men who have sex with men in this region also have a wife or a girlfriend. Though one interviewee expressed how difficult having sex with a woman is for gay men, he explained that they do it for fear of being found out as gay and the ostracism and violence that

are sure to result. It is likely that there is little disclosure of HIV status to long-term partners.

Projects such as LINKAGES and SHARPER have trained men who have sex with men to educate their peers about HIV, much like ALCO and others do for truck drivers and sex workers. Safe houses staffed with peer educators and health workers provide a safe place to access information, condoms, HIV testing, and other medical care but many men are hesitant to visit these places or don't know they exist.

To address these challenges SHARPER is using social media and social networks to broaden their reach. In Accra they asked men who have sex with men who test positive for HIV but had never before interacted with a peer educator to refer their friends for testing. Thirty-three percent of men referred through this method tested positive for HIV, compared to just eight percent reached through peer educators. With continuous research, innovation, and adaptation such as this, public health interventions will become

increasingly successful in reaching people who are most vulnerable to infection.

Laws and policies that criminalize homosexuality, sex work, and drug use in these five countries perpetuate this cycle of fear, violence, and disease by making it nearly impossible for victims to seek protection from the law. Some of these issues are being addressed at the policy level. All five countries have National Strategic Frameworks for HIV that include targeted interventions for key populations (though people who inject drugs are notably omitted from those of Benin and Togo),⁵¹ and all five countries signed on to the Dakar Declaration on Factoring Key Populations in the Response to HIV and AIDS in ECOWAS Member States in April 2015.⁵² Ensuring that these policies are translated into action on the ground is critical.



Clockwise from left:
Truck Life: Workers load rebar for transport; Repairs are made while waiting for another load in Attecoube, Côte d'Ivoire; Transient trucker communities form in every city.





Launched in 2014, a \$2 billion project will expand the road connecting the five countries into a six lane superhighway, facilitating trade and movement throughout the region.



What is also clear is that along the Abidjan to Lagos corridor, when governments struggle to provide for their citizens, citizens find solutions.

BUILDING ON TRADITION TO FACILITATE CHANGE

The idea of trying an intervention, testing it, and adapting as necessary may be the key to improving health and well-being on this rapidly-changing strip of land.

“It’s ok to fail, as long as we learn from it,” says Clea Finkle, the program officer working on the Nigerian Urban Reproductive Health Institute, funded by the Bill & Melinda Gates Foundation. “But we want to fail quickly.”

As these coastal cities grow and countries become more urban and less rural, governments and donors must adapt their approaches to health service delivery to the new environment. Cities change quickly. What is state-of-the-art today will become obsolete tomorrow. Public health interventions must be equally nimble. The communities along the road are intractably connected through migration and cultural and family ties. The best approach to addressing the corridor’s needs will be a region-wide response that takes into account the communities’

unique contexts and commonalities and contrasts between them.

It is clear that we do not yet have all the answers. What is also clear is that along the Abidjan to Lagos corridor, when governments struggle to provide for their citizens, citizens find solutions. It seems wise, therefore, to support this enterprising spirit through financial and technical assistance to private for-profit and nonprofit health care providers and social entrepreneurs. If monitored closely, supported, and adjusted as needed, the enormous energy of the corridor’s private sector and citizens, coupled with strengthened public health systems and policies, could drive the region toward a healthier and more prosperous future. ■

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