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MAPS CÔTE D'IVOIRE: PRIVATE SECTOR DESCRIPTION

Volume IV: Summary of Meetings and Focus Groups

FINAL REPORT

*Bureau for Private Enterprise
U.S. Agency for International Development*

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AFRiONI*

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ACRONYMS

ADB	African Development Bank
AFRAM	African American Insurance Company
AIBEF	<i>Association Ivoirienne du Bien-Etre Familiale</i>
ASDI	Presumptive Tax
BCEAO	<i>Banque Centrale des Etats de l'Afrique de l'Ouest</i> ¹
BEAC	<i>Banque des Etats de l'Afrique Centrale</i> ²
BNDA	<i>Banque Nationale pour le Développement d'Agriculture</i>
BTP	<i>Batiments et Travaux Publiques</i> (Public Works)
BVA	<i>Bourse des Valeurs d'Abidjan</i>
CAA	<i>Caisse Autonome d'Amortissement</i>
CAISTAB	<i>Caisse de Stabilisation</i>
CAMA	Central African Monetary Area
CFAF	<i>Communauté Financière Africaine</i> (Franc parity fixed at CFAF 50 = 1 FF)
CIE	<i>Compagnie Ivoirienne d'Electricité</i>
CIPHARM	<i>Côte d'Ivoire Pharmaceutique</i>
CNPS	<i>Caisse Nationale de Prévoyance Sociale</i>
CREP	<i>Caisse Rurale d'Epargne et de Prêts</i>
DCGTx	<i>Direction Centrale des Grands Travaux</i>
DSP	<i>Direction des Services Pharmaceutiques</i>
EEC	European Economic Community
FIAU	<i>Fonds d'Investissement et d'Aménagement Urbain</i>
FPCL	<i>Fonds de Prêts aux Collectivités Locales</i>
GDP	Gross Domestic Product
GOCI	Government of Côte d'Ivoire
HIV	Human Immunodeficiency Virus
HPD	<i>Hôpital Protestant de Dabou</i>
IEC	Information, Education and Communication
MAF	<i>Mutuelle d'Assistance Familiale</i>
MAPS	Manual for Action in the Private Sector
MC	<i>Mutuelle du Centre</i>
MOH	Ministry of Health
NGO	Non-governmental Organization
ORS	Oral Rehydration Salts
PME	<i>Petites et Moyennes Entreprises</i> (SMEs in English)
PMI	<i>Protection Maternelle et Infantile</i>

¹ Dakar-- Central Bank for the WAMU, consisting of Benin, Burkina Faso, Côte d'Ivoire, Mali, Niger, Senegal and Togo.

² Yaoundé-- Central Bank for the CAMA, consisting of Cameroon, Central African Republic, Chad, Congo, Equatorial Guinea and Gabon.

PSP	<i>Pharmacie de la Santé Publique</i>
REL SO	Regional Development Support Office (of USAID)
SME	Small- and/or Medium-Scale Enterprise
SMIG	<i>Salaire Minimum Interprofessionnel Garanti</i>
SODECI	<i>Société des Eaux de Côte d'Ivoire</i>
SOE	State-owned Enterprise
STD	Sexually Transmitted Disease
UA	<i>Union Africaine (d'Assurance)</i>
UNICEF	United Nations International Childrens Educational Fund
UNIDO/UNDP	United Nations Industrial Development Organization and Development Program
USAID	United States Agency for International Development
UVICOCI	<i>Union des Villes et Communes de Cote d'Ivoire</i>
WADB	West African Development Bank (BOAD in French)
WAMU	West African Monetary Union (UMOA in French)

I. INTRODUCTION

In fiscal 1992, USAID-Côte d'Ivoire became a bilateral program. While USAID has long had projects and activities in Côte d'Ivoire, namely housing, municipal services, health sector activities and training programs under REDSO status, the classification of the program changed as a result of economic decline in Côte d'Ivoire in recent years.

This change in organization and circumstances prompted an interest in new activities and approaches to help the government (GOICI) with its economic difficulties. One option for USAID was to pursue certain policy initiatives and private sector activities to complement work done with the public sector in Côte d'Ivoire. Such an option prompted USAID to engage a MAPS (Manual for Action in the Private Sector) exercise, with specific focus on targeted policy reforms and private sector initiatives in the health and municipal service sectors to be considered for USAID's Concept Paper, due October 1993.

Two consultants, Michael S. Borish (J.E. Austin Associates) and Susan K. Kolodin (USAID/RD/H/HSD) visited Côte d'Ivoire in September 1992 and worked with the Mission to structure the Scope of Work for MAPS. Mr. Borish concentrated on the overall private sector and urban services. Ms. Kolodin focused on private sector issues in the health sector. Activities included reviews of dozens of documents, meetings with key Mission staff, interviews with GOICI, World Bank and other officials, and a field visit to Sinfra where consultants met with the vice-mayor, a private pharmacist, several market traders and shopkeepers, and a Peace Corps volunteer active in municipal services.

This visit was followed by two missions consisting of three consultants in November 1992 and February 1993: Michael S. Borish (Team Leader, J.E. Austin Associates), Robert D. Haslach (J.E. Austin Associates), and Ellen Goldstein (private consultant). During this period, the consultants met with dozens of private sector, government and donor officials in Abidjan, Bouaké Korhogo and Dabou, focusing on the private sector in general as well as specific considerations regarding health and municipal services.

The following document, MAPS Volume IV: Summary of Meetings and Focus Groups, provides a synopsis of the viewpoints expressed by the wide audience interviewed by the MAPS team. The summary has been provided as a snapshot of the general consensus that seems to exist regarding specific questions and findings. Those findings were sourced from MAPS Volumes I-III, focusing on the private sector, municipal services and health services. This document, Volume IV, is formatted to follow findings presented and questions asked. In some cases, tables have been used to support presentations of facts. A list of people and organizations is found in Annex I. Annex II includes tables. It is recommended that this document be used in conjunction with the other four MAPS volumes addressing the private sector (Volume I), municipal services (Volume II), health services (Volume III) and strategy recommendations (Volume V).

All consultants involved would like to thank USAID-Côte d'Ivoire for their cooperation, attentiveness and courtesy. Particular thanks go out to Fritz Gilbert (USAID Director), David

Mutschler (Deputy Director), Margaret Alexander (Chief Legal Advisor and Acting Program Officer), Carleene Dei (Municipal Services), Scott Johnson (Municipal Services), John Paul James (Health Services), Oren Whyche (Private Sector Development) and Lydie Boké-Mene (Deputy Program Officer) for their frequent help and support. The consultants would also like to thank Sydney Lewis of Coopers & Lybrand for her assistance, cooperation and support.

II. THE ECONOMY AND PRIVATE SECTOR

A. PRIVATE SECTOR OVERVIEW

1. Summary

Overall GDP and Per Capita Incomes (see Table 1): GDP at about \$10 billion per year in current dollars since 1987; estimated at \$10.5 billion in 1992; increase of average annual GDP of 7% from 1965-1980, but less than 1% from 1981-1990 (current dollars); per capita incomes falling to about \$700-\$800, and distribution skewed.

Public, Parastatal and Private Sector Contribution to GDP: Public sector contributes about 20% to total GDP; parastatals represent about 45% of formal (measured) GDP; combined, GOCI and SOEs are about 50%-60% of recorded GDP; total private sector contributes about 40%-45% of recorded GDP, of which about 10% is from 130 large-scale enterprises and the rest predominantly from microenterprises.

Public, Parastatal and Private Sector Contribution to Employment: Government and parastatals employ about 125,000; the formal private sector employs about 250,000 (see Table 2 for formal sector employment distribution); total employment was about 4.2 million in 1990 (and is probably 4.5 million today), mostly in agriculture.

Formal and Informal Contribution to Employment: Table 2 shows 370,000 people formally employed in 1992; about 4.2 million people are employed informally, most of whom are in agriculture.

Private Enterprises: Table 2 shows 40,887 formal enterprises in 1992, of which about 39,000 are private; about 250,000 people are employed by private formal enterprises; 62,000 of these are employed by 130 large-scale private firms; the remainder shows about 188,000 privately employed people; thus, the average formal private firm employs no more than five people, with most of these "firms" (about 29,000 of the 39,000) in household work, commercial trade and construction; the large-scale firms, including SOEs, employ several hundred people on average.

Performance Highlights: Since 1960, Côte d'Ivoire has contributed about 50% of total WAMU GDP; Côte d'Ivoire is currently #1 worldwide in cocoa production, #4 in coffee, and #5 in palm oil; good performers (not all private) recently have been volume production of food crops and flour milling in the domestic market, and canned tuna, rubber, petroleum products, wood derivatives, and cotton fibers/fabrics for the export market.

2. Questions

- ***What is the role of the informal sector? Is it providing enough income generation and employment to compensate for formal sector declines (public and private)?***

The economy is primarily microenterprise in its orientation, and increasingly so over the last several years. Some sectors are showing substantial activity (e.g., small trade, food preparation), but margins are generally low. As such, while a sector may show activity in the aggregate, business is generally showing limited profitability at the enterprise level. Further, the cycle appears to be continuously reinforced. As the economic crisis deepens, people with limited skills and capital enter those sectors where barriers to entry are lowest. This further saturates that sector from the enterprise side without commensurate increases in purchasing power (either consumer or producer). The result is further pressure on margins. In the end, the informal and microenterprise sector is absorbing people in the work force who are unable to find employment in the formal sector. However, there is a lack of dynamism because of limited purchasing power, resulting in underemployment and low profit margins. Low margins limit capital accumulation, which in turn limits reinvestment, which in turn limits growth.

- ***Based on the above, how is the economy changing in terms of what people do to make a living?***

There is general recognition that the government and most state enterprises are no longer in a position to hire any longer, at least on as grand a scale as before. People also know that large private firms are not selling or producing as much, thereby curtailing employment. As explained above, the result is that people do whatever they are qualified to do to get paid. Common activities are trade, agriculture and food preparation, mechanical repair work and tailoring. In some areas where construction, housing and furniture sales are up, carpentry and wood working are more common. In the larger towns, there is also a fair amount of electrical repair and blacksmithing.

- ***How are people getting paid? How are people using their money?***

Most people buy and sell in cash. In agriculture, sharecropping appears to be a part of the payment system. As for commercial trade and some artisanal manufacturing and services, supplier credit is available only after the client has established a relationship of trust. This often takes at least six to 12 months, and implies repeat purchases and continued business. Profits are currently being used for household needs in light of limited purchasing power. Ordinarily, people would be adding stocks or reinvesting in their businesses, but they are generally unable to do so right now.

- ***What appear to be the best performing sectors right now? If you had to invest your own money, where would you invest? Why? Are these performance indicators sustainable for the long-term? Why/Why not?***

Commerce and food preparation appear to be the leading sectors. Cheap goods brought in from Nigeria and Ghana are supplying traders with cosmetics, clothes and a range of other consumer items that are affordable. Demand for food is constant, and the women selling on the street are pricing their food according to the purchasing capabilities of consumers. However, artisanal goods which do not generate repeat purchases for long periods (e.g., furniture) are not doing particularly well. This might reflect higher prices for wood products due to efforts to reduce logging. There is a general sense that agriculture and agro-processing represent good investments that will generate sustainable profits for the long term.

B. ECONOMIC SECTOR REVIEW

1. Agriculture

a. Summary

Agriculture accounted for about 34% of 1987-1991 GDP, of which 19% was in food crops, 13% in export crops, and the rest in forestry and fisheries; agriculture accounts for 50%-80% of employment, depending on the season; there has been increased production in recent years of cotton, cassava, maize, rice and rubber; there has been stagnation and decline in other sectors on a volume and/or price basis, usually the latter, reflecting weak terms of trade in critical export commodities; Côte d'Ivoire has about 680,000 farms supporting an average 7.6 people per farm, with at least 3.5 people per farm working (once again, depending on the season); the government has enacted recent reductions in cocoa and coffee producer prices to try to increase competitiveness (e.g., more in line with global production prices); cocoa prices have recently been showing increases.

b. Questions

- ***Given the importance of agriculture to the Ivorian economy, what are the key problems facing the sector? Are there sufficient inputs and technologies for agro-processing? Where does agricultural machinery and agro-processing equipment come from? What are local capabilities for developing small-scale, low-cost, low-maintenance agricultural technologies?***

Inputs seem to be available, but cost and application are a problem. A great deal of the agricultural machinery used is imported, although a few local producers/assemblers (e.g., *Société Moderne d'Équipement Agricole* in Bouaké) operate. There are also NGOs that can play a role in assisting with fabrication and training, depending on levels of sophistication. Hence, there is local capability for developing appropriate technologies for agricultural production, although this capacity is limited. On the other hand, enough capacity exists which could be expanded to generate more suitable equipment that is lower cost than imports, and relies more on labor-intensive methods.

- ***How do most agricultural producers market their output? Describe the "agribusiness" chain in Côte d'Ivoire?***

Most farmers sell their products to intermediaries, or have family sell output in the market. This depends on proximity to markets, transport costs, etc. The "agribusiness" chain breaks down at the processing level. There is limited value-added in the broadly defined agriculture sector because most buyers are traders or end-consumers rather than food processing enterprises. As such, there is limited demand for corn mills, cassava processors, etc. Because other kinds of primary sector activity are not fully developed (e.g., poultry, livestock), there is less demand for animal feed which would also provide a stimulus for more production and agro-processing machinery.

- ***Are there domestic/regional markets for Ivorian food products that are not being developed? What are they? Why is this the case?***

There appears to be substantial opportunity for rice development in Côte d'Ivoire, although it is questionable if the country could be internationally competitive pricewise (e.g., with Thailand, Vietnam). It also appears that Cote d'Ivoire has lost European market share in pineapples and other tropical fruits. Part of this has to do with the decline in investment in the food processing industry and export services in recent years, prompted by the general economic decline, an overvalued currency, and increased competition from Latin American, Asian and African producers of comparable products. Because of the country's climate and soil suitability, it is likely that Côte d'Ivoire could produce substantially more horticultural products for the domestic and export markets, although the latter will not occur until the currency is devalued.

- ***How do people get paid for their products?***

Most transactions appear to be done on a cash basis, and sold in small units.

- ***Are there any agricultural cooperatives operating? How are they organized? What do they do? How successful have they been? Are they private, or organized by the government? Do they receive outside support, or are they strictly member-driven?***

(Obtaining information on this topic was difficult. Despite repeated attempts, the MAPS team was unable to arrange a meeting with the central cooperative organization in Abidjan, where background information on the "cooperative movement" presumably exists. This struck the team as odd, and contrary to the way most member-driven, Western-styled cooperative movements are organized.) There are many agricultural cooperatives operating in Côte d'Ivoire. Random discussions with rural cooperatives indicate that these groups have generally been mobilized through government institutions to provide needed products for agricultural marketing boards (e.g., CAISTAB). There is little "bottom-up" organization, and most cooperatives appear to be links in a larger chain of agricultural activity directed by central government institutions.

2. Industry

a. Summary

Industry contributes about 20% of total GDP (1987-1991), with the greatest proportion in food processing; only 6% of the labor force was employed in industry in 1988 (as opposed to 16% in 1975; see Table 3); the formal industrial sector employs about 80,000, with fatty acids and rubber processing the leading employers; traditionally, industry has accounted for about 40% of production for export (e.g., cocoa/coffee products, canned tuna, frozen fish, palm oil); there has been good performance recently in soft drinks, bags and yarn for the domestic market, and rubber, cotton and some foodstuffs for the export market; investment has declined significantly in food processing, from 42% of sales in 1982 to 6% in 1988; there has been a general decline in industrial investment except in petroleum products, building materials and chemicals, most of the funds of which are provided by donors and GOCI, and not private investors.

b. Questions

- ***Given the above, are more people going from the larger industrial enterprises and working in artisanal manufacturing (e.g., small-scale food processing, household production of textiles, pottery and ceramics)? What do most "industrial" producers do? How do they market their goods? How do they get paid?***

The shift is increasingly to microenterprises, but less to industry and more to agriculture, food preparation and trade. As discussed above, working capital is a problem as is turnover. Under those circumstances, the primary and tertiary sectors seem to have fewer barriers to entry. This has been borne out by statistics as well (see MAPS Volume I: General Private Sector Assessment). Among those active in artisanal industries such as tailoring and metal working, production is done on command with inventory costs often covered (at least partially via up-front payments). Most artisanal work appears to be in services (e.g., shoe repair, electrical repair, tire repair, mechanical repair, carpentry), not in manufacturing.

- ***Are there better opportunities outside of Abidjan for this kind of work? Why/Why not?***

This depends on the type of product and market. Labor and raw materials are generally cheaper in the interior than in Abidjan. However, intermediate and finished goods are more expensive due to transport costs. Also, because Abidjan has been such a large market for manufacturers in the interior, it has sometimes been more expensive to "export" finished goods because of transport and breakage (e.g., furniture, pottery) than to simply send components for final assembly or production in Abidjan. For products manufactured in the interior for the interior market, prices have traditionally been lower. However, this trend is currently being challenged by Nigerian exports to CFAF countries (e.g., cooking utensils, plastic bins, soaps, cosmetics, clothes).

- ***Are the needed means of production available for industrial enterprises, including artisanal producers? Are they affordable? Can they be maintained?***

This question was not directly discussed. Generally, it appears that Ivorian artisans can obtain needed technologies, but per unit prices are expensive because of limited demand and volume. Thus, even with an overvalued currency which creates a bias in favor of imports and capital-intensive means, Ivorian industry is so limited in capacity and skewed in structure that prices for technology are high. Once again, this depends on the industrial activity. Tools and machines are available for food processing, wood working, textiles, pottery, etc. Nevertheless, with only 6% or less of the work force currently classified as manufacturers, there is a small market, which drives up equipment costs as well as after-sale requirements like parts and maintenance. The lack of savings and credit compounds the problem. This is likely yet another reason for increased participation in the primary and tertiary sectors of the economy.

3. Services

a. Summary

Services accounted for about 46% of 1987-1991 GDP, with the greatest proportion from public administration (19%) and trade (12%); about 30% of the total work force is found in services (1988), twice the level of 1975 (see Table 3); the formal service sector employs about 235,000, thus the informal service sector employs approximately 1.25 million people.

b. Questions

- ***There has been a substantial increase in the number of people entering the service sector. Who are they? What are they doing? After public administration and commercial trade, what are the service sector activities people are engaged in?***

This question has been discussed above. The main service activities appear to be commercial trade, food preparation, mechanical repair, tailoring, driving, carpentry and blacksmithing. Agriculture, food preparation and trade all appear to be low-skilled occupations that are absorbing the underemployed work force.

C. PUBLIC FINANCE

1. Summary

Spending on GOCI and SOEs accounts for about 20% of GDP, perhaps more; the public wage bill is about 12% of total GDP; in light of the weaker economy, high government staffing and expenditure, and narrow tax base, the government has experienced chronic deficits, which have been manifested in declines in service levels; tax receipts have declined as has public investment; see Table 4.

2. Questions

- ***Given the GOCI's financial problems, have you noticed any declines in public services? In what areas?***

There is common acknowledgement that municipal services have declined. People do not appear willing to get organized into self-help associations until service levels are intolerable (e.g., stench from garbage). Communities expect the municipal or central government to provide these services, as they always have (e.g., road construction and maintenance). Businesses are too busy to organize and put pressure on local authorities (particularly during the economic crisis). In some communities, people get organized, but this is uncommon. In most cases, it appears that the interior of the household compound is the only responsibility families feel the need to assume. (These points are discussed in greater detail in Section III.)

- ***What do you think people and businesses might do to compensate for the loss of these services? Are there any business opportunities that you can think of in light of these "lost" public services? How would you go about pursuing these opportunities?***

This question was not directly discussed. The reader is encouraged to read MAPS Volume II: Private Sector Provision of Municipal Services, and Chapter III of this report; both deal with municipal service opportunities.

- ***Have you had any problems with the tax authorities?***

While most small businesses (microenterprises) do not complain much about the tax authorities, larger formal enterprises claim the burden to be heavy. This is partly the result of difficult times and high cost structures. It is also the consequence of a narrow tax base, forcing high rates on the obvious larger targets. As elsewhere in the world, few people seem to understand how some taxes are actually levied (e.g., type of economic activity, size of floor space). The informal sector generally pays daily market taxes and some sales taxes. Microenterprises pay monthly taxes to local authorities, and an estimated sales tax to central authorities. Larger enterprises appear to pay a revenue tax, value-added tax and Social Security. The value-added tax (25%) hits most non-food goods (except the increasing volume of smuggled goods, of course).

D. PARASTATAL SECTOR

1. Summary

Financial Performance: Net treasury outflows to SOEs approximate 4% of annual GDP, or \$400 million (1990); this approximates 14% of merchandise export earnings; losses at SOEs have contributed to major fiscal, budgetary and balance of payments problems; inefficient SOEs

have diverted bank credit from private enterprise, and SOE non-performance on these loans have contributed to bank liquidations.

Importance to the Economy: SOE value-added approximates 44% of formal sector value-added; parastatals employ about 50,000 people, or 15% of total formal sector employment.

Prospects for Private Sector Development: There are about 80 SOEs slated for privatization with book values estimated at \$800 million, although market values are likely to be much less; privatization would reduce government expenditure and budget deficits, increase private investment, expand the tax base, and free up credit for private enterprises.

2. Questions

- *What can/should be done to accelerate the pace of privatization? What financial instruments might be introduced to facilitate this? Is this feasible given CFAF zone constraints?*

The main problems appear to be lack of political consensus, and insufficient training of public officials in privatization. The issue conflicts with the privileges enjoyed by some over the past several decades, and the general system of training in which the state has played a central role in the economy.

There are several recommendations to accelerate the pace of privatization. First, training needs to be provided for government officials to understand the issue of valuation. Book value and market value are rarely synonymous. In promising economies, assets or shares may be acquired at a premium because enterprises show potential for strong cash flow. In weaker economies, these enterprises often lack the products, markets, financing and management to induce such confidence. The result is a discounted value, rather than a premium. Côte d'Ivoire falls into the latter category. Second, training needs to be provided for government officials to understand the issue of devaluation (which is clearly related to the first issue). It is widely accepted that the Ivorian CFAF value is at least 50% overvalued, perhaps more. This is borne out by the country's general lack of competitiveness and high cost structure. Even on a book value basis, assets need to take these factors into account. On the other hand, those holding shares or owning assets want to "preserve" these values. Only when privatization officials recognize the fundamental realities of the marketplace will there be any acceleration of the privatization process. This requires recognition that overpriced assets/shares will not sell, and that prospective buyers have opportunities elsewhere. Third, the privatization committee needs to have private sector people playing a larger role in managing the privatization process. Civil servants with little experience in/with the private sector are currently charged with the disposition of state-owned assets. While the possibility of private sector conflict of interest in the privatization of SOEs at discounted values is obvious, a public sector focus on cleaning up the government's portfolio, reducing net Treasury outflows, and transferring the risk of these enterprises to private hands would encourage greater efficiency and less of a fiscal burden on the government. Even with private sector conflict of interest, deals could easily be structured

to benefit the government. Finally, it is felt that debt swaps could be pursued to privatize SOEs, as has occurred in Senegal. This, of course, assumes Côte d'Ivoire intends to service its domestic and external obligations at some juncture to restore confidence in its economy and long-term prospects. Senegal, a country far poorer than Côte d'Ivoire, has managed to service debts and use swaps to promote privatization.

- ***Are debt swaps a feasible option for privatization? What would the investor receive in return? How do prospects compare with other investments around the world?***

Debt swaps are currently unlikely to happen in Côte d'Ivoire because the government is not servicing its debt. There is a technical committee looking into using swaps as a mechanism for privatization, but nothing has happened yet. As with privatization, there will need to be political consensus and training of public officials on the consequences of inactivity in this area. Côte d'Ivoire's reputation as an attractive investment opportunity deteriorates further each day its debt is not serviced. This contrasts sharply with the performance of many countries in Latin America (e.g., Costa Rica, Mexico) which have used debt swaps to increase confidence in their economies as investment opportunities.

- ***Are SOE employees willing to take dramatic cuts in their pay to keep their jobs?***

Most people seem to think not because of the decline in purchasing power in recent years. The sense is that of entitlement to their jobs. As with other countries, layoffs are politically risky. Yet failure to lay off workers or reduce costs relative to productivity runs the risk of jeopardizing the viability of the enterprise as a whole. In Côte d'Ivoire, people are thinking of their jobs, not the enterprise as a whole.

- ***Are there SMEs and informal producers taking away market share from any SOEs? Which areas of activity? If not, why not?***

Most SMEs and microenterprises do not feel they are competing with SOEs. This may reflect the monopoly position so many SOEs and other large-scale companies have traditionally enjoyed in the Ivorian economy. With a bifurcated economy, most microenterprises and SMEs feel they are competing with each other, often in saturated markets, than with SOEs. Where informal activity may be taking away markets from SOEs is in cosmetics, textiles (cloth), and other finished household consumer goods manufactured in Nigeria and smuggled across borders. This largely reflects renewed Nigerian competitiveness with a devalued *naira* in the largely overvalued CFAF zone. Thus, informal commercial trade is taking away market share from formal Ivorian industry.

E. TRADE AND INVESTMENT

1. Summary

Exports: Côte d'Ivoire has a diversified range of export products; the country experienced a 14% and 10% export volume increase in 1989-1990, respectively; total 1987-1990 export values were \$13.8 billion, of which \$11.5 billion was merchandise; exports were cocoa (28%), coffee (11%), petroleum products (10%), cotton (4%) and timber (2%), thus about 45% were from other products; volume growth has occurred in palm oil, canned tuna, cotton and fabrics, rubber, wood products, equipment and coffee.

Imports: There have been volume reductions in merchandise imports except in oil/energy products; total 1987-1990 imports were \$12.3 billion, of which \$7 billion were merchandise; most purchases were capital goods (16%), food products (16%), non-food consumer goods (15%), energy (13%), and intermediate goods (9%); unfavorable trends are increasing energy imports, and declines in industrial imports (capital goods, intermediate goods for additional processing).

Results: Despite merchandise trade surpluses, interest expense on debt (even with relief) has led to current account deficits (see Table 5).

Markets: Leading trade partners (exports and imports) are France, Holland, Germany, U.S., and Italy; trade with West Africa is about 14% of recorded trade, and Côte d'Ivoire traditionally has generated trade surpluses in West Africa at a 3:2 ratio, although this may be changing with oil imports from Nigeria. Cameroon and Gabon and growth of informal trade from non-CFAF countries.

Investment: Private investment is declining, as is investment overall (see Table 6); investment in food processing, transport, telecommunications and power are all largely driven by donors and the GOCI.

2. Questions

- *How have merchandise trade patterns changed in recent years? Discuss in terms of products and markets?*

While official statistics seem to indicate increased export volume in a number of commodities, most people sense that the main change in trade patterns is the change in position from a net exporter to a net importer. This coincides with the gradual decline of Ivorian industry, and the noticeable increase in commercial trade.

- ***Have you noticed an increase in informal trade? Where are these goods coming from? Have you noticed increases in goods from Ghana and Nigeria? What goods are coming in from these areas? How are these goods being paid for (e.g., CFAF, other currencies, barter)?***

These questions have been discussed above. Côte d'Ivoire's merchandise imports are increasing significantly from non-CFAF countries. It is likely that much of this trade is unrecorded, but reflected in the export of CFAF. With Côte d'Ivoire's weak purchasing power, a country such as Nigeria with large-scale manufacturing capacity and a weak currency is in a perfect position to take advantage of demand in Côte d'Ivoire. Other neighboring countries such as Ghana are also taking advantage of these opportunities, although most observers believe most imported goods come from Nigeria. (While this may true of cosmetics, kitchen utensils, local cloth and other manufactures, it is not likely true of second-hand clothing.)

F. MONEY, BANKING AND CREDIT

1. Summary

Banks: There are four key banks which have 70% of consolidated bank assets: SGBCI (Société Générale) with 54 branches; BICICI (BNP) with 44 branches; SIB (Crédit Lyonnais) with 23 branches; BIAO (Meridien) with 32 branches.

Credit: Based on 9/91 statistics, BCEAO reported \$3.6 billion in loans of which 59% were short-term, 23% medium-term, 4% long-term, and 16% delinquent; commercial trade had at least 32% of loans; about 50% of loans were extended to the private sector in general.

Deposits: Based on the same 9/91 statistics, about \$2.3 billion was reported in deposits, of which 2/3 was current and 1/3 term; about 80% of deposits were from individuals and SMEs.

Rates: Lending rates have risen from 13.5% in 1987 to 16% in 1990 to nearly 19% today; deposit rates have gone from 5.25% in 1987 to 7% in 1990 to about 13% today; money market rates traditionally have been about 1% higher in Côte d'Ivoire than in France, not enough to compensate investors for perceived risk.

2. Questions

- ***Who are banks really lending to? Under what conditions?***

Commercial lending is limited in Côte d'Ivoire. Most loans are to large companies, often commercial traders. Where loans are going to multinationals, it is because they have access to finance from other sources. This is not likely to change in the near future, particularly as the BCEAO intends to maintain a tight monetary policy, government tax receipts are limited, and equity/collateral values are discounted for possible future eventualities such as devaluation.

- ***Can banks participate in loan guarantee funds without violating WAMU requirements? Is this a feasible option for targeted lending?***

There appear to be no constraints to guarantee funds in the CFAF zone, although they are also not common. This may be a feasible option for targeted lending as guarantee funds do not add money to the system, and therefore will not distort the monetary control system of the BCEAO.

- ***At what rate would money market rates have to be set at to attract funds that are being transferred/repatriated to France?***

This question was only asked once. It is believed that a spread of at least 15%-20% above French money market rates would be required to redirect capital flows back into Côte d'Ivoire.

- ***Is it true that 80% of deposits are from individuals and SMEs? Is there potential for greater savings mobilization than currently exists? If so, how?***

The opinion was that about 50% of deposits are from SMEs and individuals. The 80% figure dates back to 1991 BCEAO statistics, which may have been accurate then. If so, this suggests that savings mobilization opportunities are less, reflecting a general broad-based decline in liquidity. It may also reflect even less interest on the part of banks to attract small deposits given their limited lending opportunities.

- ***Is CREP a viable institution for deposit mobilization and on-lending? What are its strengths and weaknesses?***

CREP is viable as a savings institution. However, it will take time before it is able to play an important role in credit allocation. Currently, CREP has an insignificant share of national savings (less than 0.1%).

G. PUBLIC AND PUBLICLY-GUARANTEED DEBT

1. Summary

Outstanding Debt: Public and publicly-guaranteed debt is about \$18 billion today, with about 2/3 to Paris Club lenders (donors) and about 1/3 to London Club lenders (commercial banks); debt held by the latter is currently trading at about 8% of face value, thus "market value" of total debt is about \$12.4 billion vs. \$18 billion (although market activity would clearly increase the value of Ivorian debt from 8% to probably 20%-40%); at \$18 billion, Côte d'Ivoire's debt is about \$1,500 per capita, the highest in sub-Saharan Africa; this is twice per capita income.

Debt/GDP: About 170%.

Interest Expense/Export Earnings: About 50%.

Donor Assistance: Donor assistance is needed for debt service relief; about 80% of donor assistance has been grant financing in recent years; 88% of aid comes from France, the World Bank, the EEC, and the ADB; USAID accounts for 3%, the second largest bilateral after France (1990 figures from UNDP).

2. Questions

- *What is needed to make Côte d'Ivoire competitive in global markets to be able to increase export earnings and ultimately reduce its debt load?*

The answer to this question is long and complex. Interestingly, Ivorian entrepreneurs appear to accept the inevitability of a devaluation of the CFAF. They are clearly recognizing that informal trade is coming to dominate the economy, and that the formally fixed exchange rate is currently highly distorted. Industrial producers believe the overvalued CFAF is making it easier to import, rather than build an indigenous industrial base more appropriately suited to Ivorian needs. Meanwhile, exports are hampered by the overvalued currency. The result is that substantial informal trade goes on at rates which discount the official CFAF value.

Briefly, most business people seem to believe Côte d'Ivoire will have to reduce its overall cost structure and increase its productivity, efficiency and quality of output. Central to all this will be adoption of a flexible exchange rate policy. It is always much easier to allow currency values to fluctuate to reflect levels of competitiveness. The alternative approach to managing trade is sometimes needed, but generally inefficient and counterproductive. A substantial decline in the exchange rate to account for the country's high cost structure would be a first step in achieving competitiveness. The alternative is for Côte d'Ivoire to continue to miss export opportunities that other countries will capture because they have been courageous enough to devalue. Trends are already evident in Nigeria and Ghana that this will happen. Côte d'Ivoire will also have to recognize that its commodities are not of any real strategic value. The world is not dependent on cocoa or coffee, and substitutes are readily available. What is strategic (e.g., oil and gas prospects) will be needed for domestic consumption. Thus, in the end, Côte d'Ivoire will ultimately have to devalue its currency and price its resources (e.g., labor, money) based on supply and demand criteria. These will be very difficult but inevitable tasks.

H. LABOR AND POPULATION

1. Summary

Total Population and Growth Rates: Côte d'Ivoire has about 12 million people, with 3.8% annual growth rates and 4.7% urban growth rates (see Table 7).

Labor Supply, Growth Rates, and Jobs Needed: The economy had 4.2 million jobs in 1990; by 2000, 6.75 million jobs will be required; annual NEW jobs needed to be created will average 260,000.

Problems: Legislated minimum salaries/wages approximate \$1,500-\$2,000, which is uncompetitive by global standards and more than twice per capita incomes; particularly in services (11 times per capita incomes) and industry (7 times per capita incomes), few can pay these rates, leading to "deformalization", disinvestment, etc.; there was a net loss of 127,000 jobs in the formal private sector from 1975-1988; unemployment is rising, particularly in urban areas (12%) and Abidjan (16%).

2. Questions

- *How can Côte d'Ivoire create 260,000 jobs per year?*

The best way for Côte d'Ivoire to create 260,000 new jobs per year is to allow small businesses to grow so they employ more people. Increased prices for agricultural producers will also encourage greater activity in this area, although prices should be dictated by the market and not artificially subsidized above world market prices. There is no easy answer to this question, but its implications argue for the maximum degree of labor-intensive production possible in the economy.

III. MUNICIPAL SERVICES

A. MUNICIPAL SERVICES OVERVIEW

Number of Potential Clients: Côte d'Ivoire is divided into 194 *communes*. There are only 30 *communes*, or municipalities, with a population greater than 100,000. Of these 30, 10 are part of Abidjan. This has important implications for municipal revenue generation and service delivery.

Role of Municipalities in Service Provision: Municipalities traditionally have been responsible for the provision of some services to their urban residents, but not to *commune* residents living in sub- or ex-urban zones. Municipalities are generally responsible for the maintenance of infrastructure, but not for capital investment.

Municipal Demand: In addition to being the chief market for the provision of municipal services, the municipalities also make the Ivorian market for construction and civil engineering projects, including public housing, public infrastructure and maintenance.

Role of Abidjan: Abidjan's ten *communes*, and the *ville* separately, provide the vast majority of private sector opportunity. Annually, Abidjan's *communes* are worth CFAF 300 million each in contracts, and the *ville* another CFAF 1 billion. This approximates CFAF 4 billion in annual contract value based on conservative estimates.

Role of Secondary Cities: The remainder of Côte d'Ivoire's municipalities offer a much smaller opportunity with much higher transactions costs.

B. MUNICIPAL OPERATIONS AND AUTONOMY

- *How have the municipalities dealt with their need for service provision?*

The municipalities' Technical Services Departments have been fully responsible for the provision of municipal maintenance services, either directly or indirectly. These maintenance services have included solid waste collection, road and bridge maintenance, and maintenance of public spaces (e.g., markets, road and rail stations). Capital investment may be initiated by a municipality, a *préfecture*, or the central government. The municipal civil service includes a Technical Services Director, who is assigned to a municipality by the Ministry of Interior. Within the scope approved for his municipality's size, the Technical Services Director hires and supervises a limited number of city workers. He is also allocated vehicles (e.g., garbage trucks) according to the size or class of his municipality.

Who generally provides municipal services? What has been the municipalities' relationship with contractors?

The provision of electricity, potable water and waste water collection are not within the scope of work of the municipal Technical Services Department. These municipal services have already been contracted out by the central government to two private French entities: CIE and SODECI, respectively. In November 1990, the Government of Côte d'Ivoire gave CIE a concession for 15 years (later amended to 21 years) for the generation, transport, distribution, import and export of Ivorian electricity. SODECI plays a similarly important role in potable water provision and waste water collection.

CIE, effectively the national Ivorian power utility, is majority owned by two French enterprises. These are Saur (a subsidiary of the Bouygues Group), and EDF, the French power utility. CIE ownership is complicated, being owned 51% by the *Société Internationale des Services Publics*, which in turn is 65% owned by the Bouygues Group and 35% by EDF. CIE serves 415,300 customers, equivalent to less than 4% of the population, or 40% of the (nominal 10-person) households of Côte d'Ivoire. Turnover in 1991 was FF 2 billion (or CFAF 100 billion), about 25% of Saur's total company turnover. (Through its ETDE subsidiary, Bouygues is also involved in Gabon and Cameroon through SOGEC and REA, respectively. This reflects significant regional business interests in CFAF countries that transcend Côte d'Ivoire as a single market.)

Bouygues' Saur subsidiary also has the contract to operate Côte d'Ivoire's water utility, SODECI. Municipal domestic potable and waste water service is largely unavailable outside the five major cities of Côte d'Ivoire, and even there not universally. (In addition to Côte d'Ivoire's SODECI, Saur manages and operates Guinea's SEEG, the Central African Republic's *Sodéca*, and the water utilities of 12 other African countries. Thus, as with electricity, Bouygues has significant interests in CFAF countries as a whole.)

Bouygues also plans to participate in the equity of the Ivorian telecommunications company. Thus, the provision of basic utility services is already in the hands of the private sector, albeit monopolistically.

Another municipal service is solid waste collection. In the past, the smaller municipalities have provided this service from in-house resources. These services have broken down due to the lack of municipal autonomy over local tax collection proceeds, the failure of the central government to reallocate funds budgeted for municipal services back to the local authorities, and the lack of community organization prevalent throughout the country.

The two largest municipalities (e.g., Abidjan, Bouaké) have let private contracts for the collection of municipal solid waste, although these have not been successful. Abidjan's was abandoned by the vendor, and Bouaké's is being fulfilled at a level of only 37% (as discussed below).

Municipal transportation services are largely provided by private taxi, van and inter-city bus service companies. Infrastructure maintenance is inconsistent, and provided as budgets permit, either by municipal employees or private contractors.

Municipal budgets for recurrent and capital spending average CFAF 1,400 per capita. Municipal spending on solid waste collection is not adequately documented, and is probably negative relative to the fee stream collected for such services. Maintenance spending relative to capital investment is inadequate.

How have the municipal authorities allocated the funds they are able to commit? How universal is municipal service provision? How effective has service provision been?

The biggest complaint among municipal/local civil servants is the lack of control over public revenues that are technically in their budgets and intended for municipal services. Those tax revenues disappear into the central treasury and do not reflow back to the local level. (Some municipal officials are openly critical of the central government's misuse of revenues from agricultural commodity sales to build "palaces for directors general", rather than investing the proceeds to enhance infrastructure and overall competitiveness in a way that is more immediately recognized by common farmers, industrial workers and service sector providers.)

Senior civil servants and private vendors believe the main contribution to municipal service provision would be the fiscal and operational independence of the *communes*. The central government does not disburse funds from local tax collection back to local governments. Hence, funds that are intended for municipal services and local government operations are effectively unavailable at this level. In addition to funding, local project decisions made at the municipal level are referred to the national level for approval and implementation. The result is that the municipality has responsibility without authority. The *mairie* is then blamed for the sorry state of municipal affairs without having the resources or authority to resolve problems and address community needs.

Municipal service provision is neither universal nor skewed to those least able to pay. Neither public nor private service providers have demonstrated capacity to universally provide "public goods" like garbage collection, electricity, potable water and waste water collection to urban residents. These deficiencies result from lack of money (e.g., local government, consumers, service vendors), inadequate management and training (e.g., government, companies), and limited community organization which has traditionally been weak because government was always expected to provide services.

Like sanitation-related services, the provision of road construction and maintenance has not kept pace with urbanization, especially in secondary cities. This has increased costs for service providers, and alienated residents from their municipalities. Even the ruling party's newspaper publishes articles openly critical of *les mairies* that ignore districts except when in need of votes and taxes.

Municipalities are responsible for infrastructure maintenance paid for and built by others. Lack of funds for maintenance have serious health consequences for the local population. In late 1992 and early 1993, numerous municipalities lacked sufficient operating funds to buy fuel and parts to perform basic urban maintenance and sanitation services.

While SODECI runs and maintains the potable water hookups and collects fees, the *mairies* are responsible for maintaining watersheds. Municipalities do not have the resources to perform this task. In fact, one reservoir catchment area in a northern city is the home of an unknown number of families living in spontaneous settlements. These people dump all of their household waste in the catchment, and have dug latrines that drain into the water table. The ability of many municipalities to plan, subdivide and transfer unzoned urban land to private ownership is being overtaken by spontaneous settlements.

Under existing circumstances, municipal authorities cannot do very much for public hygiene and health. For example, in Korhogo, SODECI has about 4,000 subscribers, but also knows there are an additional 4,000 private wells producing water of unknown quality. As long as households in the city are permitted to draw well water that may be contaminated from latrines, there is little government or utilities can do.

C. PRIVATE BUSINESS PERSPECTIVES

- *How interesting is it, financially, to seek business relations with a municipality?*

While municipalities represent most of the market, they do not pay (directly) for the work they contract. While municipalities are able to contract out work, they have not been empowered to pay vendors directly upon performance. Payments are the responsibility of the central treasury. The main limiting factor to the provision of services by and development of private sector providers is municipal autonomy in the full cycle of the contracting process.

As a result of the opportunity municipalities represent, smaller Ivorian contractors would like to work with these entities. However, given their lack of autonomy over tax revenues, these same contractors are hesitant to seek work with the *mairies*. Private sector bids to municipalities are priced according to the risk they represent. The price for construction projects tends to be about three times the commercial rate to cover the cost of not being paid for about two to three years. Thus, municipalities are not able to attract the lowest priced vendors among the small, indigenous firms. Larger foreign firms (e.g., Colas) are thereby able to win contracts more easily, and at greater cost to the central treasury.

The cost of waiting to get paid is not the only issue. The majority of contractors, large and small, are located in Abidjan, which offers the vast majority of all municipal contracts. When considering a bid on a secondary municipality contract, a significant issue for indigenous contractors is the higher costs involved. Nearly all inputs must be transported from Abidjan. Actual delivered costs in the interior are significantly higher than the nominal costing structure

applied by the central government's Direction et Contrôle des Grands Travaux (DCGTx), which secondary municipalities have traditionally applied for budget planning.

- ***Is it possible to build a relationship with the municipal technical services officials in order to obtain contracts?***

The problem with doing business with municipalities is that they are not technically autonomous. Their technical services personnel are usually not sufficiently trained in engineering and construction to properly judge proposals. Also, the Technical Services Directors are eager to be moved by the Ministry of Interior from smaller to larger municipalities. Thus, forming relationships with municipal officials may only have transitory value.

As a rule, rural and secondary municipalities do not have current maps reflecting the actual extent of settlement or construction within their own boundaries. A project may be independently planned and contracted without their knowledge, and ultimately funded and completed within their borders by a number of ministries and authorities. Even then, it is not likely to appear on the municipal maps. Municipalities are also unlikely to have full access to, and/or mastery of, central government census or tax records relevant to their populations. Thus, even if relationships are established, municipalities do not have sufficient functional autonomy for contracts to be competitively designed, let and bid on at the local level.

Except for Abidjan and Bouaké, municipalities do not have professionally trained civil or mechanical engineers or architects on staff. Municipal staff, especially in secondary cities, generally understand neither the price components of a private contractor's business, nor the technical elements of their bids on a project. Their staff may be untrained, or trained only in public management. Secondary municipalities rely on DCGTx for technical support. Once DCGTx takes on a project, the municipality loses financial and technical control of that project.

The municipal government does not have hire-fire control over such officials as its *Chef des Services Techniques*. Career civil servants are assigned and transferred by the Ministry of Interior. This makes it difficult for a municipality to identify and hire the qualifications it requires. Additionally, non-performance or under-performance can be corrected only by transferring the offender to another municipality.

Thus, municipalities are not autonomous in the financial cycle, in project design and implementation, or in human resource allocation. The best way is to get to know the mayor or the secretary general and work out a private arrangement. However, these prospects are limited by the very lack of autonomy at the local level.

D. CONTRACT BIDDING AND PAYMENT PROCEDURES

- *Could you describe the actual bidding procedure to obtain a municipal contract?*

There are distortions in the public bidding procedure which make it very difficult for the smaller, indigenous private enterprise to gain a foothold. First, it is very difficult to compete with public and publicly-linked enterprises (e.g., DCGTx, municipal Technical Services). Private contractors have to bid against these government agencies that use free operating capital and labor, and under-price their bids on unrealistic cost bases.

When a private company bids, it must make a cash deposit of 3% of the project value just to receive the bid documents. The *mairie* then requires a certified statement of a firm's bank balance. As most contractors do not leave large cash balances in the bank, a bank guarantee is always required as a condition for making a bid. To get its guarantee, the bank requires the firm to put a further 5% of the potential contract value in escrow. That done, and if the firm wins the contract, the *mairie* may advance 20-25% of the contract value. This is supposed to be working capital. In fact, the winning firm cannot use this money as project capital, but must deposit it in full with the bank. The end effect is to tie up scarce working capital which the private enterprise must supply with borrowings against payment. As payments from such projects are generally not paid on schedule and/or in full, the small contractor is required to buy operating funds from the same bank at 22%. (A banker independent of this conversation said the cost of funds would be "at least 18.5%").

When such a firm realizes it is bidding against better capitalized foreign firms (e.g., Colas, SICOGI, SIFERCOM) which can use cheaper money from outside Côte d'Ivoire, or access additional resources from the government or French-funded projects through DCGTx, it is no wonder that so few small to medium Ivorian companies get contracts.

IMPLICATION OF CONTRACTING BIDDING PROCEDURE IN COTE d'IVOIRE		
LINE ITEM	CFAF	US\$
Contract Value	100,000,000	\$357,143
3% deposit for bid documents	3,000,000	\$ 10,714
5% Deposit for Bank Guarantee	5,000,000	\$ 17,857
PRE WORK ESCROWED FUNDS	8,000,000	\$ 28,571
25% contract advance to bank	25,000,000	\$ 89,286
TOTAL IN BANK ESCROW	33,000,000	\$117,857
Cost of Operating Funds @22%	17,600,000	\$ 62,857
Industry Profit Margin @20%	20,000,000	\$ 71,429
Net Pre-Tax Benefit	2,400,000	\$ 8,571

- ***What about getting paid? You mentioned that everyone expects to wait a long time before collecting. How does that work?***

While the *mairie* may initiate a contract, payment is made by the central treasury. A firm cannot simply go to the office that contracted the work. A contractor can typically wait years rather than months to receive payment. For a small company - or any company - this can be devastating to cash flow.

If and when a firm succeeds in receiving a check from the central treasury for work done, the company still has to attend to the account from which payment is made. The central treasury operates from two different bank accounts. If the check is issued by the BCEAO, one can assume that it will be honored in full. But if payment is made from an account with the postal checking authority, it is unlikely to be paid out in full. For the past year, the postal authorities have been making payments in small installments. The effect on operating capital has damaged small enterprises.

Construction projects are not the only problem area. Service contracts also are not being paid. A Bouaké firm contracted to maintain approximately 300 CNPS (national social welfare service) offices and service centers reports difficulty in collecting from CNPS, its largest client. It now has cash flow problems and is unable to pay its suppliers. The same holds for private contracts. The same owner claims to have once had between 2,000-4,000 clients who engaged him to clean courtyards and property around apartment buildings. These have fallen off with the general economic decline. Knowledge of Bouaké's inability to pay its present private solid waste collection contractor, SITRANE, has deterred a number of private vendors from soliciting business with the municipality. The private contractors have learned that the municipality of Bouaké is attempting to solve its problems by getting free services from donors rather than putting its accounts in order. This also stymies private sector development and service provision.

E. FOREIGN COMPETITION

- ***What about the element of foreign competition: has it hurt the market?***

Some of this issue has been discussed above insofar as it relates to the virtual utilities monopoly established by the French group, Bouygues. Local contractors had assumed that the reason for this discussion was an opportunity for a contract with a U.S. agency. U.S. agencies have a positive market reputation, since they pay strictly according to contract provisions. In addition, contractors volunteered the view that if a project is under foreign direction, it would be run properly; if under local control, this is often not the case.

The presence of DCGTx in the market is highly significant. DCGTx is a subsidized competitor of the private sector which succeeds more often than not in winning projects. This creates problems in developing local capacity to meet infrastructure and maintenance

requirements. The same private contractors who bid on construction projects are those who also bid to provide such municipal services as solid waste collection, cleaning of the drainage ditches, and road and building maintenance. Without an opportunity to build their capital from major construction projects, local firms are unlikely to be in a financial position to provide municipal services.

As a practice, all municipal contracts valued in excess of CFAF 200,000,000 are automatically referred to DCGTx. This organization does not have to operate under the capital constraints of indigenous enterprises. Beyond cost of funds, DCGTx prices are said to be unrealistic. DCGTx estimates project costs on the basis of a nominal (and long outdated) price of CFAF 50,000 per m³ of concrete. This price is apparently possible only by unbundling the true total m³ construction costs. The DCGTx unit cost is only that portion relevant to the concrete itself. In final project pricing (at the billing stage), it adds on the other necessary cost components (e.g., iron work, forms, carpentry). According to the independent contractors, CFAF 115,000 per m³ is a more realistic estimate of construction costs.

While the *Hôtel de Ville* and some of the *communes* of Abidjan have professional engineers on staff, the secondary municipalities generally use DCGTx for engineering design and project management, both due to habit and a lack of qualified in-house project engineers. Originally, DCGTx was an advisory bureau. It gradually added on engineering and construction services. Now, once a municipality asks DCGTx for assistance in technical project design and planning, DCGTx takes over all phases of the project, even if there is an open bid phase. Once DCGTx gets control of the municipal project, its ultimate cost may be assumed to increase significantly. Municipalities may not receive their cash requirements from the central treasury, but are certain to be saddled with higher capital investment expenses than they had planned.

Moreover, DCGTx performs its own construction as well as contracts with the major (mainly French-owned) public works firms operating in Côte d'Ivoire. This has created opportunities for substantial importation of valuable construction materials for personal sale on the private market. The reasons for the links with French companies include comparatively high capitalization, access to off-shore working capital from French and other banks, the presence of French advisory staff inside DCGTx, and tied donor funds which are required to be spent on French goods and services.

In addition to tied donor funds, there are other distortions. SETAO, a Bouygues subsidiary, is a major player in the Ivorian public works market. Another Bouygues subsidiary, Colas, is a stockholder in Total, which in turn is a stockholder in Côte d'Ivoire's sole asphalt operation, the SMB. No other firm can possibly compete with Colas on price or delivery of bituminous products in maintenance or construction. Therefore, Bouygues is the dominant player in construction as well as water and electricity.

Other distortions are built in. DCGTx project technical specifications require that components be purchased by brand name. This means that the contractor is required to purchase

from a sole (usually French) source at a controlled price and may not look for competitively priced acceptable substitutes.

There is general frustration among the small indigenous contractors with the role of DCGTx. Some claimed to have attempted to create working relations within DCGTx, but to no avail. Some believed that only having French nationality would confer on them a reasonable opportunity to get contracts. The system is perceived to be closed to competition.

Independent contractors outside the DCGTx circle believe there is a "mafia" inside DCGTx. The *chef de projet* is considered autonomous and not subject to any serious audit. The result is the opportunity for secret deals, as well as over-ordering of components for resale on the informal market. The informal/used construction materials market in Abidjan certainly reveals the presence of material that may reasonably be assumed to have been ordered for major civil works.

DCGTx is not the only public organization suspected of such practices. The *commune de Cocody* was singled out as being notorious for closed-door deals. The *ville* of Abidjan and the *commune* of Bouaké were also suspected.

- ***Moving from civil construction and maintenance to other services, what about the opportunity to contract with municipalities to collect the garbage?***

This is nothing new for Côte d'Ivoire. Abidjan and Bouaké have had contracts with outside firms (SITAF and SITRANE, respectively) to collect solid waste. These do not seem to work. In the case of Abidjan, a Marseilles firm, SITAF, was paid CFAF 7 billion annually to collect Abidjan's trash. When the municipality instituted a weight-basis system for payment, SITAF's fee was cut in half. The Marseilles parent withdrew rather than follow the new procedure. The municipality's Technical Services Department assumed trash collection with a grant from Canada to pay for 12 new garbage trucks. Today, actual collection still depends on the economic level of the neighborhood. Collection rates are believed to be no better than 37%, with a bias towards wealthier neighborhoods.

One Abidjan contractor saw his opportunity when the contract between Abidjan and SITAF was under review and then suspended in 1991. He worked out a collection proposal based on private service to a *quartier*, or neighborhood. He believed he could serve an entire *quartier* with a single truck and labor force of three, and then successfully provide services to other *quartiers*. He had worked out recovery and recycling prices of various classes of solid waste, including unused railway iron, steel and wood. The window of opportunity was closed without public notice or discussion when the municipality decided to take on the work itself. The contractor would still like to take on such a contract as long as agreed payments could be collected on a monthly basis. This point was also made in conversations in Bouaké. However, smaller municipalities are not seen as potential markets.

Bouaké's private solid waste collection contract is held by SITRANE (*Société Ivoirienne de Transport et Nettoyage*), worth about CFAF 360 million annually. This company was created and is controlled by a former mayor of Bouaké. SITRANE has had difficulty both in collecting garbage and getting paid. Service frequency has been declining along with the number of rolling vehicles (currently 12 of 50). The *mairie* reportedly is working out a solidarity scheme in which unserved households will pay unemployed youth CFAF 10-30 per pick-up to take their trash in a pushcart and dump it at collection centers. While the Secretary General of the *commune* spoke at length about a plan to mobilize unemployed youth to collect garbage in the *quartiers*, the private contractors had not heard of this plan. They wondered why the *commune* did not involve private sector operators in project design.

In addition to project design problems, there are likely to be organizational and financial difficulties in organizing the project on this basis. The *chefs de quartier* have no financial or contracting authority. Ultimately, firms must work with the *mairie*, either to get paid or to provide the *chefs de quartier* with the legal status needed to organize the contract. But as the *commune* lacks the money or capacity to clean something as basic as drainage ditches along the streets, there is little incentive for private businesses to consider such a project in the first place.

F. COMMUNITY ORGANIZATION

- *What about you as a householder: what do you do when the trash is not picked up?*

This has been a big problem in Abidjan. Trash is collected less and less frequently, and then only from affluent neighborhoods. Wealthy people do not pay for services aside from their taxes, but they always get their trash collected. The poorer and middle class neighborhoods are generally neglected. Some of the middle class neighborhoods are taking matters into their own hands and organizing their own services, such as trash collection, private schools and clinics. In one middle class neighborhood, residents hired a man with a barrow to haul their trash to a nearby ravine where they dumped and burned it. The same thing happened with an apartment building in the Marcory area. Trash had piled up in front of the building and was attracting flies. One resident tried to persuade the other tenants to contribute to hire someone. In the end, he was unable to collect from everyone. Either they refused or were out of work. Trash is removed on this basis once in a while, but that man does not believe his building could ever make a contract with a private company.

Small but formally organized contractors know there is an opportunity to provide municipalities with solid waste collection services. They see the small barrowmen working, and the uncollected trash of the neighborhoods. While there is a market for *ad hoc* service provision, there does not appear to be one for regular contracts. Family trash removal is a child's responsibility. Few people appear to be willing to clean up trash outside their compound or building. This partly explains the frequent presence of spontaneous dumpsites in ravines and by the side of the road, where people dump their own trash. Since there is no penalty, trash removal is currently cost-free. It will be difficult to convince people to start paying hard cash

for something they presently get for free. It will take a well planned education and training campaign to get people to recognize the beneficial health and quality of life effects of continuous trash removal. Only then will peoples' attitudes change for enhanced community organization and service provision.

Another problem is that it has been impossible to get the municipality to think about the small contractor as a solution. Municipalities might consider a social-work project, like the one in Bouaké, but they do not appear to be interested in contracting and paying a regular company.

From the formal private company standpoint, it is not financially attractive to have to solicit many individual or neighborhood contracts, and then try to collect. The administrative and time costs are too high, and payment is uncertain. Competing with the informal sector is also difficult for formal private companies. The informal barrowman is nearly impossible to trace and prosecute for illegal dumping, while the formal operator incurs the higher costs of vehicle registration, operation and taxes, as well as the costs of dumping trash in a formal landfill rather than a ravine.

IV. PRIVATE SECTOR PROVISION OF HEALTH SERVICES

A. HEALTH INSURANCE AND MANAGED CARE

1. Summary

Low Purchasing Power for Health Care: Insufficient consumer purchasing power was unanimously identified as the main constraint to private sector health care provision in Côte d'Ivoire.

Health Insurance to Increase Purchasing Power: Health insurance is a risk-sharing mechanism which increases the purchasing power of subscribers who need health care. It redistributes income from the wealthy to the poor, and from the healthy to the sick.

Managed Care to Control Costs: Managed care, through pre-determined fees for services, strict referral systems and/or development of health maintenance organizations, can be an effective way to control the costs of health care.

Côte d'Ivoire--Health Insurance for the Wealthy: Private insurance companies in Côte d'Ivoire typically offer indemnity insurance at premiums ranging from CFAF 200,000-350,000 per person per annum--an amount which equals or exceeds the country's per capita income. Thus, it is only available to the wealthiest echelons of society, or to those who share the cost with large, formal sector employers.

Affordable Health Insurance: Private sector initiatives are underway to organize non-profit mutual associations for health insurance, linked to managed care. These mutuals have negotiated substantially reduced rates for health services with providers, and have established dramatically lower premiums for subscribers. However, feasibility studies are needed to evaluate risk pools, assess financial viability at prevailing premium rates, and adjust premiums to ensure viability, if necessary.

2. Questions

Discussions were held with commercial insurance companies (*Union Africaine, AFRAM*), non-profit mutual associations (*Mutuelle du Centre, Mutuelle d'Assistance Familiale*) and one private hospital interested in managed health care and risk-sharing mechanisms (*Hôpital Protestant de Dabou*). The objective of these discussions was to: 1) better understand the market for health insurance; 2) evaluate the existing data on health service utilization and unit costs; and, 3) examine several initiatives to provide insurance at a lower cost to a broader segment of the population.

- ***Please describe your typical indemnity insurance for health care, and comment on its cost and profitability.***

Union Africaine (UA), Côte d'Ivoire's largest insurer, confirmed the information presented in MAPS Volume III: Private Sector Provision of Health Services on the high cost and negative profitability of health insurance. UA controls 30% of the health insurance market in Côte d'Ivoire. Most policies are employment-related group policies, although UA also offers individual policies and, until recently, special policies for small- and medium-scale enterprises (SMEs). Coverage is comprehensive (ambulatory care, hospitalization and pharmaceutical products), and reimburses either 80% or 100% of costs, depending on the policy. In 1992, the yearly base premium for an adult ranged from CFAF 142,000 for 80% coverage under an employer's group policy to CFAF 247,000 for 100% coverage under an individual policy. Medical evacuation (CFAF 20,000) and taxes (14.5%) are not included. Health insurance has not been a profitable undertaking for UA, nor for any other insurance company in Côte d'Ivoire. For example, UA's ratio of health care costs to premiums (*sinistres/primes*) in 1992 was 93.3% for group policies, 92.3% for individual policies and 133.1% for SME policies. Including commissions, taxes and administrative costs equal to around 25% of total costs, all three categories of health insurance were in deficit in 1992 and in earlier years. Despite substantial losses on health insurance, companies continue to provide it as part of a complete package of services. Union Africaine requires health subscribers to use UA for all their other more profitable forms of insurance (e.g., theft, life insurance) to subsidize health coverage. This practice is widespread among insurance companies. The technical director for health insurance attributed UA's poor financial performance to the almost complete lack of cost control mechanisms. Fraudulent use of policies by extended families and friends, overconsumption of specialized services, and overprovision of laboratory tests and other services were among the problems cited. The special premium rates offered to SMEs were particularly abused, leading UA to eliminate this category in 1993, and channel SME subscribers into individual or group policies.

- ***Is your company involved in any initiatives (such as non-profit mutual associations) to provide insurance at a lower cost to a broader segment of the population?***

Union Africaine also offers coverage for hospitalization alone (e.g., catastrophic care), or for hospitalization in public hospitals alone at substantially lower rates than comprehensive care. However, UA's negative experience with SMEs has made the company leery of schemes which broaden coverage beyond formal sector employees and well-off individuals. AFRAM, on the other hand, has agreed to underwrite and market the *Mutuelle d'Assistance Familiale* (MAF), a non-profit mutual association which was described in MAPS Volume III: Private Sector Provision of Health Services. MAF links managed care in contracting clinics to comprehensive insurance coverage at monthly rates of CFAF 5,500-13,000 for a family of six or less. Since its inception in late 1992, MAF has attracted 500-600 subscribing households. AFRAM hopes to have 2,000 MAF households by end-1993. Indeed, AFRAM would like to see this type of managed care arrangement replace its conventional indemnity insurance, which

is plagued with fraud and escalating costs. The *Mutuelle du Centre* (MC) is another nascent non-profit mutual association committed to managed care. As described in Volume III, monthly premiums are calculated as 3% of monthly income, to heighten the progressivity of the system. Services are provided at a contracting clinic for predetermined rates. Service provision has not yet begun because the nearly 1,000 subscribing households are in the three-month waiting period between their initial enrollment fee of CFAF 10,000 and the start of coverage. The chief financial officer is negotiating with several insurance companies to underwrite and/or market the MC program. Both MC and MAF have contracting clinics in urban areas, and attract a largely urban, middle-class clientele. The *Hôpital Protestant de Dabou* (HPD), located about 50 kilometers from Abidjan, serves a lower-income, mixed urban-rural population. This private hospital, run by an Ivorian NGO, generates about 50% of its revenues from user fees, 30% from government subsidies (mostly civil service personnel) and 20% from private contributions and international grants. The HPD has asked Government to let them manage the surrounding public sector primary health care facilities to create a private sector Health Zone with an appropriate referral system. The hospital has felt the impact of declining purchasing power on the demand for health care in the zone, and would like to explore risk-sharing mechanisms that would increase the purchasing power of those who need care. They believe such mechanisms could be successful, particularly if organized through village leaders in the area. As provider and insurer, the hospital would essentially become a health maintenance organization, continuing its existing policies of managed care to reduce costs.

- *Are your premiums based on historic data on utilization and cost of services for your insured population? What data are available on utilization rates and unit costs?*

Insurance companies are adjusting their annual premiums solely on the basis of the aggregate ratio of health care costs to total premiums. A rough adjustment is made in the hope of eliminating losses on health insurance. However, although the insurance companies have aggregate data on health care costs for outpatient visits, hospitalization and pharmaceutical charges, information on the number of outpatient visits, number of hospital admissions, average length of stay, etc. are not available. Premiums are not being calculated on the basis of probabilities for service utilization and the average cost of services used by the insured population. There is very little solid data on the existing insured population which could serve as a starting point for calculating premiums under a managed care arrangement with a potentially lower-income group of subscribers. Both mutual associations (MAF and MC) have established premiums through very rough calculations of the demand and cost of health care for families who currently bear the full burden of cost for care. Premiums were adjusted upward to take into account the expected increase in demand under an insurance plan that bears much of the cost burden. At best, these premiums are rough "guesstimates" which may prove financially viable once service provision starts. Both mutual associations intend to maintain databases on utilization and cost of services once the plans are underway to make more intelligent adjustments to premiums, and ensure the financial viability of the mutual association. Both are eager for technical assistance in setting up and maintaining appropriate financial and administrative information systems. The HPD is attempting to computerize its information systems. The hospital has cost and revenue data by service category (e.g., outpatient, hospitalization, surgery,

pediatrics), as well as data on the number of outpatient visits and hospital admissions (new and repeat cases), average length of stay, bed occupancy rates and other useful information. They, too, need technical assistance to strengthen financial analysis and management.

- ***How can the cost of care be controlled?***

Union Africaine is studying ways to reduce health care costs under its insurance coverage. The company is considering introducing ceilings on cost reimbursement for certain services, negotiating reduced rates with contracted clinics, and issuing photo identification cards to reduce fraudulent use of insurance cards by family and friends. Both the mutual associations are based on managed care, through contracting clinics. Reduced rates for bulk service provision have been negotiated with these participating clinics. All subscribers pay 20-30% copayments to discourage overconsumption of services, and carry photo identification cards to prevent fraud. Consultations with specialists and all lab testing is strictly on a referral basis from a primary physician. The MC will also have independent physicians who monitor requests for specialized services and drug prescriptions. The directors of the MC envision creating a group practice someday, transforming the mutual association into a health maintenance organization. They would also like Government authorization to import generic drugs, to reduce pharmaceutical costs for subscribers. The HPD has a humanitarian mission to serve those in need, regardless of ability to pay. Care is subsidized, but the hospital has a long tradition of user fees and a great deal of experience operating on a shoestring budget. Costs are controlled within the hospital by adhering to a referral system, applying standard treatment algorithms to avoid unnecessary services and importing generic drugs. The cost of care is also kept down by the hospital's strong emphasis on preventive care and health education, and by community outreach through mobile units which provide preventive and primary curative care in villages--rather than waiting until patients come to the hospital when their problems become serious.

B. PRIVATE INFIRMARIES

1. Summary

Most Commonly Treated Conditions: Malaria was most common, followed by both sexually-transmitted diseases (STDs) and diarrheal disease. Treatment of minor injuries and injection of prescribed drugs were among the most common services rendered.

Preventive Care: Very little preventive care and health education were offered at infirmaries. These include: family planning services, pre- and post-natal visits, protection against STDs, and childhood growth monitoring.

Pricing Policy: In principle, infirmaries apply the fee structure established by the *Syndicat National*, but due to unfavorable economic conditions, flexible pricing is the rule. The estimated average price paid per visit was CFAF 1,150; this included consultation and, in some cases, basic drugs.

Patient Load: The average number of clients per day was between six and seven. Most infirmaries reported a decline in the number of clients this year relative to last year, attributed to worsening economic conditions.

Constraints to Activity: The limited purchasing power of the client population was unanimously cited as the greatest constraint to increased activity. The high cost of drugs was cited as a secondary--but interrelated--constraint.

Public Confidence: A survey of health care consumers indicated a lack of confidence in an average private nurse's ability to diagnose and treat more than just the most common of illnesses such as malaria and diarrheal disease.

Training and Qualifications: One-quarter of the infirmaries surveyed did not have a nurse on duty full-time, relying instead on nursing assistants with little or no formal training. Of those infirmaries with full-time nurses, only one-half of the nurses had received a diploma in nursing.

2. Questions

Discussions were held with *infirmiers privés* in Bouaké and Abidjan to review the informal survey results presented above, and assess interest in short-term training linked to sales of low-cost products for: 1) family planning/protection against STDs; 2) prevention and treatment of malaria; and, 3) management of diarrheal disease. In addition to individual interviews with *infirmiers* (those with diplomas and without), a group discussion was held which included the President, Vice-President and Secretary-Treasurer of the *Syndicat National des Infirmiers autorisés à exercer a titre privé*. The following questions were raised:

- *What do you see as the major constraints to operating an infirmary in the private sector?*

All agreed that the constraints identified in the informal survey--a lack of consumer purchasing power and the high cost of drugs--were paramount. Given the prevailing economic situation and its impact on purchasing power, *infirmiers* were feeling increased pressure to supply low-cost drugs and other treatments. Considerable rancor was expressed toward the private pharmacists who supply *infirmiers*, and pharmacists were accused of taking low-cost products off the market to increase sales of high-priced specialty drugs. This was said to be the case for ORS packets and several moderately-priced malaria treatments. On the whole, the *infirmiers* were receptive to the idea of training (*recyclage*) to simplify and improve existing treatment algorithms, as well as build their skills as health educators in the community. They preferred training sessions during the work day, because most of their clients came before or after work. They also responded favorably to the idea of social marketing low-cost products through private infirmaries--but feared that there would be substantial opposition to this from the *Syndicat des Pharmaciens privés*. Social marketing through both private pharmacies and infirmaries was perceived as less favorable for the *infirmiers*. Another means of making drugs more affordable was suggested: allowing pharmacists to sell pills one at a time, as is currently

the case in Burkina Faso (and in the open markets for smuggled drugs in Côte d'Ivoire). In fact, the Ivorian Government had just published a list of drugs which could be sold one pill at a time, but reaction to this policy was mixed among the *infirmiers*. It was pointed out that the list was quite limited, and that the drugs ended up costing the consumer more over the course of the treatment than if the entire prescription had been filled at one time. Some felt that encouraging consumers to take an insufficient dose--one day's worth of antibiotics, for instance--was bad medicine. No consensus was reached on this issue.

- ***Would you be interested in training in family planning services and protection against STDs? Would you be interested in having access to low-cost contraceptives to sell to your clients?***

The Syndicat has already approached Government about carrying out public awareness fora in *quartiers populaires* on prevention of AIDS and other STDs. The leadership of the Syndicat expressed interest in USAID support for this activity. In particular, they mentioned the need for training in information, education and communication skills, as well as in recent advances in treatment of AIDS and STDs. For the most part, the *infirmiers* interviewed (all male) had not considered expanding their role to become full-service family planning providers. Several of them currently offer family planning services to women if they request it. However, all believed that if private nurses had appropriate training, and access to the same low-cost contraceptives as AIBEF, women would come to them for family planning services.

- ***Do you think women would be willing to talk to male nurses about their family planning needs? Would they come to male nurses for physical exams necessary for contraceptive use?***

The nurses interviewed (all male) agreed that if male nurses were well-trained and had an inexpensive supply of contraceptives, women would not hesitate to come to them for all their family planning needs. However, female family planning users were not as sanguine (see Section C below). One reason for their hesitation would be that many male nurses stated that women would be required to come with their husbands, and have their husbands' approval, before receiving family planning services. If the husband did not come and/or did not approve, this was a sure sign that "the woman wants to be unfaithful to her husband". However, unmarried women could receive family planning services without male approval. This attitude among male nurses precludes their use as full-service, community-based family planning providers, although they could still play a useful role as a retail resupply point for many contraceptives, and in educating men about family planning and protection against STDs.

- ***Would you be interested in training in childhood growth monitoring and control of diarrheal disease? Would you be interested in having access to low-cost treatments, such as Oral Rehydration Salts (ORS) packets, to sell to clients?***

Some *infirmiers privés* do childhood growth monitoring, but rarely in a sustained and systematic way. For the most part, they weigh children when brought to the infirmary, and

record the weight in the *Carnet de Santé* given to mothers at the *PMI* during prenatal visits. Several lacked scales with which to weigh children, and all expressed an interest in training in growth monitoring and nutrition education. Many *infirmiers* already tell mothers to prepare a *bouillie* with cereal, salt and sugar to combat diarrheal disease. However, they have seen firsthand that women are eager to buy ORS packets instead--presumably because they give an impression of "modern medicine" rather than a home remedy. One nurse sold ten ORS packets (given to him by a friend in the public sector) in two days. *Infirmiers privés* claim to have difficulty in obtaining ORS packets. UNICEF provides them through the public sector, but private nurses cannot purchase them at public facilities. Pharmacies sometimes carry them, but are accused of 1) taking them off the market to promote higher-priced anti-diarrheal drugs, or 2) charging an inflated CFAF 250 per packet. The *Syndicat des Pharmaciens privés* refutes these charges, claiming that ORS packets are widely available at private pharmacies for CFAF 30 per packet. Nonetheless, nurses expressed a great deal of interest in marketing ORS packets through private infirmaries, and receiving training in diarrheal disease management.

- *Would you be interested in training on drug-resistant malaria? Would you be interested in having access to low-cost antimalarial products such as treated mosquito nets and prophylactic drugs to sell to your clients?*

Infirmiers privés are unaccustomed to educating clients on the prevention of malaria through use of screens, mosquito nets and insect repellent, but this is increasingly seen as the best defense against the growing problem of resistant malaria in Côte d'Ivoire. As one nurse explained, people come to infirmaries to cure their malaria, not to prevent it. However, treatment offers an opportunity for health education on avoiding recurrences of malaria, and nurses were interested in training to become more effective educators. The nurses interviewed could list more than a dozen drugs on the market for treatment of malaria. Most of their information on these products comes from the companies marketing these drugs. Nurses often prescribe three or four of these drugs simultaneously, which 1) highlights the need for a more rational and simplified treatment algorithm, 2) raises the cost of treatment to CFAF 2,500-4,000 or more per episode, and 3) stimulates the development of drug-resistant organisms. The recommended algorithm is to prescribe only nivaquine initially, then move up to drugs such as fansimef and halfan if the case proves resistant to nivaquine. Private nurses do not follow this--according to one nurse--because if they prescribe nivaquine alone and it fails to work, people will assume the nurse cannot help them, and will go elsewhere for treatment. Therefore, nurses prescribe enough drugs to battle resistant cases right from the start, to ensure immediate success. Nurses need educating to dissuade them of this harmful practice, and improve their IEC skills for malaria prevention. Linking this training to social marketing of malaria prevention products through private infirmaries would put new emphasis on private nurses' roles as the first line of defense against malaria in urban areas.

- ***Should nurses operating without a diploma have access to training on malaria, diarrheal disease, STDs and family planning?***

The *Syndicat des Infirmiers autorisés* estimates its national membership at around 400, with perhaps triple this number operating as "*clandestins*" (e.g., operating without, or with falsified, diplomas and/or licenses). Not surprisingly, the *Syndicat* wants Government to crack down on the *clandestins*, but recognizes that past efforts to shut down these infirmaries have led to new infirmaries springing up in their place. In some cases, nurses and nurses' assistants operating without diplomas, and with minimal formal training, represent the only health care available in poorer neighborhoods. Should these people receive at least some training in the treatment of the most frequently confronted diseases? The *Syndicat* opposes this--one member said that, in any case, *clandestins* would be afraid to come to any group training at which the *Syndicat* was represented because the *Syndicat* works closely with Government to shut them down. Any strategy for training private nurses would have to take this concern into account.

- ***What other ways could a donor like USAID assist in improving the quality of care offered at private infirmaries?***

Private nurses have no access to labs in which to perform simple analyses and tests, even though many nurses specialized in performing these tests during their many years in the civil service. Lab tests through private clinics cost too much for most of the clients using private infirmaries. The *Syndicat* is talking about setting up a small lab in urban areas for the use of *infirmiers privés*. USAID could help organize and equip such a lab, which would enhance the diagnostic capability of nurses with respect to frequent illnesses, especially malaria and diarrheal disease.

C. FAMILY PLANNING USERS

1. Summary

Curative Care at Private Infirmaries: Sexually-transmitted diseases (STDs) were mentioned second, behind malaria, as the illness most frequently treated at private infirmaries. Illegal abortions are reportedly also carried out at private infirmaries, although the *infirmiers* declined to confirm this.

Preventive Care at Private Infirmaries: Most private infirmaries claimed to offer advice on avoiding STDs; a few sold condoms. Only 20% claimed to offer family planning services of any kind, usually just advice on condom use.

HIV/AIDS Awareness: Virtually all health care consumers surveyed had heard of AIDS on radio and television, but less than half the men, and less than a third of the women, could identify a local place to go for additional information. The public hospital was mentioned most frequently as a source of additional information.

Family Planning Awareness: Less than half the health care consumers surveyed (both men and women) could identify a local place to go for family planning information and services. The public sector's PMIs and social centers were mentioned most frequently as sources of information and service providers.

Contraceptive Use: According to AIBEF, oral contraceptives and injectibles are the most popular family planning methods among Ivorian women. Injectibles are popular because they are discreet; however, pills cause less problems with menstrual cycles.

Contraceptive Pricing: At AIBEF and social centers, pills cost CFAF 150 per cycle, and 2-3 month injectibles cost CFAF 500. A cycle of pills at private pharmacies can cost CFAF 700-1,000. Pharmacies in towns where AIBEF is located have stopped stocking contraceptives because low AIBEF prices have shifted demand away from private pharmacies.

2. Questions

MAPS Volume III: Private Sector Provision of Health Services suggested that the distribution network for low-cost contraceptives--and associated family planning services--be extended to include private sector nurses and midwives operating in the *quartiers populaires* of urban areas. Private infirmaries rarely offer family planning education, examinations or contraceptive supplies. To assess the interest of contraceptive users in family planning services provided by private nurses and midwives, focus groups of first-time users and continuing users were organized at AIBEF centers in Treicheville and Youpougou. Included were 20 women who were either single, married or cohabitating. Educational attainment levels ranged from less than primary to on-going university study. Occupations included homemakers, students, seamstresses and merchants, as well as a considerable number who were unemployed. Most women already had 1-4 children, and wanted a total of 3-6 children in their reproductive lifetime. All were using family planning for child spacing, except for one woman with nine children who wished to stop childbearing. Following the focus group discussions, AIBEF staff were also interviewed.

- *Which family planning method do you prefer? Why do you prefer it?*

First-time contraceptive users had not yet selected a method. Continuing users relied on pills, injectibles and IUDs. Pills were considered convenient; those using IUDs chose the method after experiencing minor health problems or unpleasant side effects with hormonal contraceptives.

- *Have you ever gone anywhere else for family planning services, or to buy contraceptives? Where did you go?*

None of the women had gone anywhere else (e.g., private pharmacy, clinic) for family planning services or contraceptive supplies.

- ***Why did you decide to come to AIBEF? How did you hear about AIBEF?***

Among the reasons cited were 1) low cost of supplies, 2) willingness to answer client questions, and 3) maintenance of a permanent file and close medical follow-up. Most heard about AIBEF through friends or female family members; one heard from her husband; another was sent by a Government social center.

- ***Where do you and your family go for health care?***

Most respondents mentioned public sector facilities. Three were eligible for care at clinics operated by the *Caisse Nationale de Prévoyance Sociale*, one had employer-based care, while three relied on private sector clinics.

- ***Do you or your family ever go to private infirmaries for health care? What are the illnesses or services for which you go to a private infirmary?***

Only about half of the respondents--nearly all those interviewed at Treicheville--indicated that they use private infirmaries for health care. They use infirmaries mostly for treatment of malaria and minor injuries, as well as for receiving injections.

- ***If contraceptives like pills or injectibles were available at private infirmaries for about the same price as AIBEF, would it be more convenient to buy them at an infirmary? Would you go to an infirmary in your neighborhood?***

If prices were "nearly the same", or even somewhat higher, most women agreed that it would be much easier and less costly to go to a local infirmary than to come to AIBEF for supplies. Transport costs and time lost were the main problems in coming to AIBEF clinics. The women at Treicheville spent CFAF 300-600 (equivalent to 2-4 pill cycles) in transport costs for each visit. Continuing contraceptive users at Treicheville were emphatically in favor of creating community-based distribution points, and returned to this point several times after the discussion had moved on to other questions. The women interviewed at Youpougou paid CFAF 0-200 in transport costs per visit, and felt less of a need for alternative distribution points. AIBEF staff supported the idea of community-based distribution, and thought private infirmaries could be a convenient distribution point if accompanied by a public awareness campaign to identify them as resupply points. However, staff wondered how one could ensure that private nurses would charge the AIBEF price, plus a "reasonable" mark-up, instead of doubling or tripling the AIBEF price. One questioned whether private nurses, who reportedly charge CFAF 30,000-80,000 for an illegal abortion, would have adequate financial incentives to promote family planning.

- ***If private infirmiers were well-trained in family planning services, would you go to them for examinations, advice and contraceptives? How do you feel about seeing a male nurse for family planning services?***

All but one of the women interviewed said they would be willing to go to a private infirmary for family planning services--if the infirmary provided the same range and quality of services as the AIBEF clinics. They were particularly concerned about medical follow-up, continuity of relationship with the provider, availability of information and educational materials, and range of contraceptive methods offered. The Director of Programs for AIBEF believed that trained nurses had appropriate skills to perform physical exams, insert IUDs, etc., but that short-term refresher/updating courses would be needed to make them full-service family planning providers. AIBEF has two mobile teams (one for contraceptive technology, the other for IEC activities) for training of civil servants which could also be used to train private nurses. Most of the nurses in the private sector are male. This did not pose a problem for 80% of the women queried, who said gender did not matter as long as nurses were well-trained. However, the remaining 20% preferred to see a woman for physical exams, claiming that "women understand women's problems better", and that "family planning is something to discuss between women". The proportion of women who feel this way is likely to be higher in the general population than among contraceptive users, and this could be a significant disadvantage in using private nurses as community-based family planning providers. However, private nurses could still serve as resupply points for many contraceptive methods, as well as provide outreach to men on family planning issues and protection against STDs.

- ***Have you ever been to see a sage-femme privée? What services did she provide?***

None of the women had ever been to see a private midwife, although almost all had given birth at least once. Only some knew of a midwife operating in the private sector. AIBEF staff later confirmed that most midwives operating in the private sector were on contract at formal sector clinics and employment-related infirmaries, rather than working independently in the informal sector.

- ***If sages-femmes privées were well-trained in family planning services, and offered contraceptives for about the same price as AIBEF, would it be more convenient to visit a sage-femme in your neighborhood?***

As with private nurses, women were willing to see private midwives for family planning services, but only if they offered the full range and quality of services offered at AIBEF. The group of continuing contraceptive users at Treicheville pointed out that midwives should already be discussing family planning, but they are too few, and too busy with other duties, to give it appropriate attention. They strongly recommended that AIBEF train other people--local opinion leaders--as community-based family planning providers. They wanted this done as soon as possible, to reduce the time and cost involved in visiting AIBEF clinics.

- ***Do you have health insurance for yourself, your spouse and your children? How much does your family pay each month for this health insurance?***

Two of the twenty women had health care provided by their employers or their husbands' employers, at no out-of-pocket cost to themselves. One university student was insured under her father's policy, but was unsure of the cost. The rest were uninsured.

- ***Would you be interested in buying health insurance for your family that costs CFAF 10,000 per month? 5,000?***

Of the 17 women without insurance, 12 expressed an interest in family coverage costing CFAF 10,000 per month. One more woman was willing to spend CFAF 5,000 per month, but the four others thought this was still too expensive.

D. PHARMACISTS AND PHARMACEUTICAL IMPORTERS

1. Summary

Spending on Drugs: Expenditure on drugs is the largest share of health expenditures for most households in Côte d'Ivoire. An average visit to a private pharmacy costs CFAF 2,000-4,000.

High-priced Drugs: Eighty-eight percent of imported drugs are from France, where lower-priced generic drugs are not available. Private pharmacies in Côte d'Ivoire offer only brand-name drugs, not generics.

Import and Distribution: Import and wholesale distribution of drugs are almost entirely in the hands of two authorized private enterprises: Gompoci and Laborex. A third importer/wholesaler was authorized in late 1992. Authorization is granted only to enterprises in which 51% of equity is held by pharmacists.

Pricing Policy: Increasing the number of importers/wholesalers is of little benefit to consumers because pharmaceutical prices are fixed throughout Côte d'Ivoire by a *Commission d'Enregistrement* consisting of various Government ministries, the *Ordre National des Pharmaciens* and the *Syndicat National des Pharmaciens Privés*.

Fixed Mark-ups: Wholesale and retail mark-ups are regulated as a fixed percentage of cost: 18% for wholesalers and 37% for retailers. This flat percentage rate creates an incentive to market higher-priced products.

Market Entry: The *Commission d'Enregistrement* controls the licensing and location of all private pharmacies, to prevent competition (*concurrence déloyale*).

Economic Slowdown: The number of clients per pharmacy was estimated by pharmacists to be 100-150 per day for most pharmacies, down from as much as 250 per day several years ago. They attribute this reduction to the economic decline in Côte d'Ivoire. The total number of pharmacies (320 to 340, depending on the source) has not increased significantly in recent years.

2. Questions

The private pharmaceutical market is the least competitive health care market in Côte d'Ivoire, with a high degree of vertical integration, and significant barriers to market entry and price competition. To better understand the regulatory environment, and assess the political feasibility of reform, discussions were held with 1) representatives of the *Syndicat des Pharmaciens privés*, 2) a spokesman for Gompçi, one of the two main pharmaceutical importers, 3) officials in the Ministry of Health's *Direction des services pharmaceutiques* (DSP), and 4) the director of the *Pharmacie de la santé publique* (PSP). Their responses, which reflect the prevailing attitudes of some of the major interest groups concerned with pharmaceutical policy, are summarized below.

- ***Are pharmacies able to order any drug from Gompçi and Laborex, or do the importers have a predetermined list from which pharmacies choose? Do pharmacies order by brand, or by generic formula? Why are most drugs supplied through France?***

All imports must be on the list of authorized drugs. Only the company marketing the drug (not the importer) can apply for authorization, which is granted by a committee consisting of government officials and representatives of the *Ordre des Pharmaciens* and the *Ordre des Medecins*. Only that brand of the drug is authorized for import, not its generic formulation. Other brands or generic formulations of the same drug must also apply for authorization. Only the few international drug companies which have marketing representatives in Abidjan tend to apply for authorizations, and the only generic drugs available tend to be those which have been launched by these major drug companies to compete with their own brand-name products. Indeed, the *Syndicat* suggested that drug companies which are not represented in Côte d'Ivoire "don't act responsibly", supplying the country with low-quality drugs. Gompçi confirms that about 80% of its 200 suppliers are French firms or French subsidiaries of multinational companies. The importer claims this is because of the country's "privileged relationship with France", and because France carries out pre-shipment quality control which Côte d'Ivoire lacks the capacity to do (Gompçi is also 49% French-owned). The director of the PSP defends the country's technical ability to perform quality control, but agrees that working with large, well-known multinationals who do their own testing relieves the burden of quality control for the overstretched national lab. He explains the reliance on French suppliers as follows: only drugs which are marketed in their country of origin can be authorized for import into Côte d'Ivoire. Ivorians want drugs with French-language packaging. To invest in French-language packaging, non-French drug companies generally want the right to market in France--but vested interests make it very difficult to obtain authorization to import into France. Thus, marketing in France is ruled out, which also tends to bar any exports to francophone Africa. In an effort to explore alternative French-language suppliers, the Ivorian Government made contacts with Canadian drug

companies, but these companies never applied for authorization to import into Côte d'Ivoire. The *Syndicat*, whose members own 51% of Gompoci and 65% of Laborex (the law requires 51% ownership by Ivorian pharmacists for any drug importing enterprise), claims that the French interests who hold the remaining shares control the daily management and supply decisions of the two companies.

- *Many pharmacists and pharmacy staff surveyed previously had never heard of generic drugs. What information is available on generic drugs? What efforts are underway to market generic drugs in the private sector?*

The *Syndicat* responds: Last year, the Government asked private pharmacists to adopt a policy of promoting generic drugs. Now that they have adopted this policy, they will start receiving more information on generic drugs. They do not fear a loss of revenue as they will gain in volume what they lose in price. Revenues have already dropped due to the general decline in purchasing power. However, they are very concerned about low-quality generic drugs--they have heard many stories about ineffective drugs.

Gompoci responds: Generics are already being marketed in Côte d'Ivoire. For example, Gompoci offers five or six generic forms of the antibiotic amoxicillin (samples are produced). One problem is the lack of demand for generics--doctors, pharmacists and the general public are not aware of lower-cost generic alternatives. A public awareness campaign is needed. However, the biggest threat to marketing generics is the Government's policy of *préférence nationale*, or protecting the market for domestic production of drugs. CIPHARM has had a monopoly on the marketing of nivaquine and aspirin, and now a much longer list of drugs has been approved for CIPHARM monopoly. For example, CIPHARM has signed an exclusive agreement with one multinational drug company for the local manufacture of amoxicillin--all other amoxicillin products (brand-name or generic) will be shut out of the market.

The DSP responds: It is true that, by Interministerial Decree No. 32 (dated February 14, 1991), preference is granted to national production (thus far, only by CIPHARM) for nearly 20 products, shutting three to four times as many competing imports, both brand-name and generic, out of the domestic market. CIPHARM has not yet begun production of any of these products, but exclusive agreements have been signed with various multinational drug companies for domestic production. Included are widely-used drugs such as amoxicillin, bactrim, fansidar and paracetamol. The Ministry of Health (MOH) is aware that a CIPHARM monopoly undermines the goal of promoting low-cost drugs, but the policy of *préférence nationale* is delicate, and surpasses MOH authority.

The PSP responds: The donors are all preaching about generics, but quality control is a major problem here. Côte d'Ivoire doesn't have the equivalent of your (U.S.) Food and Drug Administration. I have plenty of examples of fraudulent, low-quality--even dangerous--generic drugs that have entered this country (samples are produced). Even the bulk purchases by groups like UNICEF in places like Holland are made up of drugs manufactured somewhere in Asia, packaged in Europe and sold as European drugs. They can be bought anywhere and labeled as

UNICEF drugs. Often they use inferior active ingredients which may even pass quality control tests, but they do not work in our hospitals and clinics. Our health personnel avoid these drugs. UNICEF imports a lot of generic drugs that do not work, but no one will tell them the truth. Many generic drugs are low-priced because they contain low-quality ingredients, and are not properly finished and packaged to maintain quality. Price is not of primary importance here. Quality is. We are encouraging the private sector to import good-quality generics, but we cannot oblige them to do so. The private sector will only import generics if the public demands them, but the public is not sufficiently aware of this option.

- *If a brand-name drug is prescribed in Côte d'Ivoire, do pharmacists have the right to substitute an identically-formulated generic drug?*

The *Syndicat* claims that the Government had issued a decree last year granting pharmacists the right to substitute generics for brand-name drugs, unless indicated by the prescribing physician. The decree does not have the force of a permanent change to the *Code de Santé*, and the details of the decree were not well known.

A Gompçi pharmacist explained that the new policy allows pharmacists to substitute generics only if the customer indicates that he/she cannot afford the brand-name drug, and if the prescribing physician does not expressly prohibit substitution. Only the pharmacist (who is often not at his/her pharmacy) can make the substitution; unlicensed pharmacy staff cannot. However, many pharmacists in Côte d'Ivoire are unaware of the generic options for substitution.

The MOH clarifies that there is no substitution allowed in Côte d'Ivoire, because the *Code de Santé* is identical to that of France, which prohibits substitution by pharmacists. However, the subject is under discussion in Côte d'Ivoire, but faces heavy opposition from physicians. The director of the PSP thinks it may not be a very good idea, because pharmacists can abuse their privilege. If an appropriate generic substitute is not available, they may substitute any drug rather than lose a sale. Unlicensed pharmacy staff may also begin making substitutions, because the pharmacist-owners are frequently absent. Finally, the pharmacists themselves are not well informed on generic equivalents. To overcome this problem, the Government has named a committee to produce a *Guide Thérapeutique* which equates brand-name drugs to their generic equivalents. The committee has not yet met to establish a timetable for completion of the guide.

- *Some say that the system of fixed percentage mark-ups creates an incentive to sell higher-priced drugs. Why are fixed mark-ups necessary? How would you react to a system of regressive mark-ups-- higher mark-ups on low-cost drugs, lower mark-ups on high-cost drugs-- as is used in France?*

Representatives of the *Syndicat* were offended at the suggestion that wholesale and retail mark-ups were contributing to the high cost of drugs in Côte d'Ivoire. From their perspective, the true culprits are the French drug companies--and the best thing donors could do for Côte d'Ivoire would be to pressure these drug companies to lower their prices for sales to developing

countries. Equally offensive was the suggestion that allowing a fixed percentage mark-up created an incentive to market higher-priced drugs. As one pharmacist stated, "we strive, first and foremost, to protect the health of the country--making profits is secondary". Apparently generating employment is also important, with the *Syndicat* arguing that retail mark-ups could not be reduced in Côte d'Ivoire because every pharmacy supports ten employees, instead of two or three, as in France. Any pressure from donors to change the fixed mark-up policy will be resisted. A regressive system of mark-ups is rejected as being "the French way, not the Ivorian way". On the subject of price competition, it is claimed that one cannot do the same thing in Côte d'Ivoire as in a developed country. With a poor, illiterate population, any price competition for drugs will lead to an influx of inexpensive, fraudulent, low-quality drugs. Pharmacists must protect the public by ensuring the quality of drugs. In sum, they said, "with the economic crisis, we don't have time to concern ourselves with economic competition, we must concern ourselves with the health of the population".

- ***Why must all pharmacies be owned by pharmacists? Why should the Syndicat have a voice in deciding whether licensed pharmacists can open a pharmacy? Why should the Government and the Syndicat approve the location of every pharmacy?***

It is the *Code de Santé* which dictates that pharmacies must be owned by pharmacists. The *Syndicat* strongly supports this view. They fear that if just anyone could invest in a pharmacy, then the owners would only care about making money, not about the health of the population and the role of the pharmacist as a health educator. As one pharmacist asked, "how could we have a policy of supplying generic drugs, with people who do not care?". Likewise the *Syndicat* is seen as having a voice in authorizing new pharmacies and approving their location. "If not, they would put pharmacies right next to each other! It would be chaos!" The price and service competition that could be generated by such "chaos" is viewed strictly as a punishable offense--*concurrence déloyale*--by the *Syndicat*.

ANNEX I: MEETINGS AND INTERVIEWS

A. PRIVATE SECTOR

1. Private Sector

Aguie, Jean-Charles, *Fondé de Pouvoir*, African American Insurance Company, Abidjan

Appia, Jean-Denys, *Cabinet Comptable du Centre et du Nord*, Bouaké

Boniface, Yohou, *Résponsable Adjoint du Programme*, Opportunities Industrialization Center, Bouaké

Hanks, Sheila, Administrative Director, BHP-Utah International, Abidjan

Komenan, Berthilde, *Pharmacienne*, Pharmacie Bokosso, Sinfra

Lilli, Tre, *Directeur Général*, SAFRICO, Bouaké

Malan, Yobouet, *Division Technique*, Union Africaine, Abidjan

Modi, Raman, Production Manager, Pioneer Agrogenetique, Abidjan

Thornton, Robert, *Directeur Général*, Citibank, Abidjan

Wenholz, Mark, General Manager, Pioneer Agrogenetique, Abidjan

Representatives from SITAB, TRITURAF, FIBACO, BRACODI, SOLIBRAS in Bouaké

Nine members of CREP in Bouaké and Mr. Kra, the director, in Abidjan

Anonymous Abidjan Entrepreneurs:

Livestock producer, Songon

Ceramics cooperative, Grand Bassam

Shopkeeper, Yopougon

Food processor, Abobo

Bakery, Koumassi

Printer, Koumassi

Tailor, Adjamé

Hairdresser, Abobo

Food products, Adjamé

Nightclub, Adjamé

Jeweler, Treicheville

Mechanic/Garage owner, Abidjan

Transporter, Yopougon

Furniture maker, Adjamé

Anonymous Bouaké Entrepreneurs:

Cosmetics trader

Television repair

Tailor

Basket maker

Bakery
Hotel operator
Bar man

2. Government and Donor Officials

Abissa, Mathurin, *Analyste Financier, Comité de Privatisation et Restructuration du Secteur Para-public*, Abidjan
Aka, Achille, *Administrateur National*, UNDP, Abidjan
Alledji, Siaka, *Secrétaire Général, Commune de Bouaké*
Ballivian, Amparo, Senior Economist, World Bank, Abidjan
Danho, Lucas, *Résponsable Adjoint, Comité de Privatisation et Restructuration du Secteur Para-public*, Abidjan
Dem, Aly, *Conseil Fiscal*, Korhogo
Diabi, Moustapha, *Directeur, Comité Technique de Gestion de la Dette Extérieure, Caisse Autonome d'Amortissement*, Abidjan
Harbi, Djamal, *Représentant Résident Adjoint*, UNDP, Abidjan
Houghton, Catherine, Commercial Attache, U.S. Embassy, Abidjan
Rachidi, Radji, *Economiste Chargé des Opérations*, World Bank, Abidjan
Reekmans, Tony, *Etudes Economiques, Direction et Contrôle des Grands Travaux*, Abidjan
Toboe, Paul, *Premier Adjoint au Maire*, Sinfra

B. MUNICIPAL SERVICES

Alao Ayo Sadikou, President, G.E.R.D.D.E.S.
Alledji, Siaka Ernest, *Secrétaire Général*, Bouaké
Anonymous, female head of household, Port Bouet, Abidjan
Anonymous, female head of household, Port Bouet, Abidjan
Anonymous, female head of household, Port Bouet, Abidjan
Anonymous, neighborhood storekeeper, Dar Es-Salaam II, Bouaké
Anonymous, SITRANE employee, Bouaké
Anonymous, trash picker, Korhogo
Anonymous, trash picker, Korhogo
Anonymous, trash picker, Abidjan
Anonymous, trash picker, Abidjan
Anonymous, used bottles seller, Abidjan
Anonymous, used build materials seller, Abidjan
Anonymous, used materials recycler, Abobo area, Abidjan
Awato, Thomas, Gerant HATT, *Hygiene Assainissement et Tous Travaux*, Abidjan
Boké-Mene, Lydie, middleclass householder, Abidjan
Burkinabe, informal trash picker, Plateaux II area, Abidjan
Burland, Julie K, Assistant Director, Peace Corps Côte d'Ivoire
Butcher, street merchant on Route de Sokoura, Bouaké
Coulibaly, Mayor of Korhogo
Dem, Aly, *Premier Adjoint au Maire*, Korhogo

Diouff Mathurin, *Conseiller Technique*, Bouaké
Enan Eboua Francis, *Directeur General*, E.I.E.N.I., Bouaké
Johnson, Scott, USAID/REDSO
Komelan Coulibaly Lézin, Valentin, *Bourse des Valeurs d'Abidjan*
Merchant, used bottles, Korhogo public market
Merchant, used metal, Korhogo public market
Mohamed, Abdul J., *Directeur Adjoint*, ADB
Nohon Gnepa Louis, *Directeur de Services Techniques*, Korhogo
Shongwe, Meshack M.L., Division Chief, Country Programs Department, ADB
Sodeci Branch Manager, Korhogo
Sodeci Office Manager, Korhogo
Sunther, Jean Louis Lino, *Directeur Gerant*, CITX sarl
Sylla, Manager, SITRANE, Bouaké
Thornton, Robert, *Directeur General*, Citibank, Abidjan

C. HEALTH SERVICES

1. Private Sector:

Dr. Michèle Kassi, *Centre de Pédiatre de Cocody*
Mr. Konan, *Caisse d'Assistance Médicale de Côte d'Ivoire (CAMCI)*
Mr. Fofana, *Délégué Régional, Nationale d'Assurance de Bouaké*
Mr. Joseph Gnagoran Okon, *Délégué Régional, African American Insurance (AFRAM)*
Mr. Appia, Management Consultant, Certified Accountant, Director, *Mutuelle du Centre de Bouaké*
Mr. Jay Drosin, PSI
Dr. Pascal Adou, *Président, Syndicat National des Médecins Privés de Côte d'Ivoire (SYNA MEPCI)*
Mr. Hans Eberwein, Representative, Ciba-Geigy
Ms. Diakaté, GOMPCI
Mr. Brown, GOMPCI
Ms. Yvette Koue-Lou-Tie, *Directrice Générale, Association Ivoirienne du Bien-être Familiale (AIBEF)*
Ms. Anick Djikalou, *Directrice des Programmes, AIBEF*
Mr. Drissa Traoré, *Président, Syndicat des Infirmiers autorisés à exercer à titre privé*
Mr. Vincent Godosolo, *Vice-Président, Syndicat des Infirmiers autorisés à exercer à titre privé*
Mr. Moussa Outtara, *Tresorier-Général, Syndicat des Infirmiers autorisés à exercer à titre privé*
Mr. Blanchard Yapo, *Syndicat des Travailleurs des Cabinets Médicaux*
Ms. Jeanne N'Dhatz, *Syndicat des Personnels Techniques de la Santé*
Mr. Pélégué Outtara, *Syndicat des Infirmiers autorisés à exercer à titre privé*
Mr. Yobouet Malan, *Directeur, Assurance Médicale, Union Africaine*
Ms. Ouedraogo, *Sage Femme, AIBEF-Treicherville*
Mr. Aguié, Marketing Representative for the *Mutuelle d'Assistance Familiale, AFRAM Insurance Company*
Ms. Sangaré and Mr. Koffi, AFRAM Insurance Company

Ms. Christine Kouamelan, *Syndicat des Pharmaciens Privés*
Mr. Arsène Sibailly, *Syndicat des Pharmaciens Privés*
Dr. Bakary Ouattara, unemployed physician
Dr. Abbeu, *Directeur Général, Hôpital Protestant de Dabou*
Mr. Bessé, *Directeur Financier, Hôpital Protestant de Dabou*
Dr. Watson, *Conseiller Technique, Hôpital Protestant de Dabou*

20 new and continuing contraceptive users at AIBEF-Treicherville and AIBEF-Youpougou

Approximately 30 *infirmiers privés* in Abidjan, Bouaké, Korhogo and Ferkessedougou

Approximately 12 *pharmaciens privés* in Abidjan, Bouaké and Korhogo

Approximately 6 traditional healers, medicinal plant dealers and *tradipraticiens* in Abidjan, Bouaké and Korhogo

2. Government and Donors:

Mr. Coulibaly, *Directeur, Direction de l'Informatisation, des Etudes et de la Planification, Ministère de la Santé et de la Protection Sociale*

Professor Manlan, *Directeur Général, Ministère de la Santé et de la Protection Sociale*

Mr Emmanuel Ezan, *Directeur du Cabinet, Ministère de la Santé et de la Protection Sociale*

Mr. Ernest Alledji Siaka, *Secrétaire Générale de la Mairie de Bouaké*

Dr. Konian Kangha, *Directeur, Direction des Etablissements Sanitaires et Sociaux, Ministère de la Santé et de la Protection Sociale*

Mr. N'Goran, *Sous-directeur des Etablissements Privés, Direction des Etablissements Sanitaires et Sociaux, Ministère de la Santé et de la Protection Sociale*

Mr. Aké and Ms. Katié, *Direction des Services Pharmaceutiques, Ministère de la Santé et de la Protection Sociale*

Dr. Coulibaly, *Directeur, Pharmacie de la Santé Publique*

Dr. Soaré, *Pharmacie de la Santé Publique, Ministère de la Santé et de la Protection Sociale*

Mr. Félix Ekra, *Direction Générale de la Douane, Ministère des Finances*

Ms. Ballivian, Senior Economist, World Bank

ANNEX II: TABLES

TABLE 1

GDP AND PER CAPITA INCOMES IN COTE D'IVOIRE

	GDP-Current CFAF	GDP-Current US\$	Per Capita-US\$
1980	2,150,000,000,000	10,176,070,000	1,222
1981	2,225,000,000,000	8,188,275,000	961
1982	2,487,000,000,000	7,568,242,000	855
1983	2,581,000,000,000	6,773,212,000	728
1984	2,869,000,000,000	6,565,818,000	687
1985	3,138,000,000,000	6,984,819,000	703
1986	3,244,000,000,000	9,367,600,000	908
1987	3,127,000,000,000	10,404,605,000	970
1988	3,068,000,000,000	10,300,487,000	926
1989	2,948,000,000,000	9,241,090,000	800
1990	2,705,000,000,000	9,935,356,000	829

Source: IMF

TABLE 2

FORMAL SECTOR DISTRIBUTION OF FIRMS AND EMPLOYEES

SECTOR	NUMBER OF FIRMS	NUMBER OF EMPLOYEES
Manufacturing (including agro-industry, wood processing)	3,252	82,673
Commerce (including export-import)	10,763	60,887
Public Agencies (separate from Ministerial government functions and state-owned enterprises)	331	55,528
Agriculture (includes livestock, forestry products)	1,658	45,838
Construction/Public Works	4,446	20,188
Transportation (includes maritime)	1,049	17,429
Public Services	1,605	23,354
Housework	14,036	14,949
Other (includes health care, finance, professions, private schools, restaurants)	3,747	49,564
TOTAL	40,887	370,410

Source: BIIPS Informatique

TABLE 3

SECTOR DISTRIBUTION OF THE LABOR FORCE

	1975	1988
Primary Sector	69%	64%
Secondary Sector	16%	6%
Tertiary Sector	15%	30%

Source: Economist Intelligence Unit

TABLE 4

CENTRAL GOVERNMENT FINANCES: 1987-1990

	1987	1988	1989	1990
Revenues/Receipts	794	789	680	639
Current Expenditure:				
Wages	338	356	354	340
Other	371	476	457	280
Public Investment	123	143	93	75
NET BALANCE	(38)	(186)	(224)	(56)
Revenues/GDP	25.5%	25.7%	23.1%	23.6%
Expenditure/GDP	26.7%	31.8%	30.7%	25.7%
Deficit/GDP	(1.2%)	(6.0%)	(7.6%)	(2.1%)

Source: IMF

TABLE 5**COTE D'IVOIRE'S CURRENT ACCOUNT: 1987-1990 (US\$ Millions)**

	1987	1988	1989	1990
Export Earnings	3,670	3,298	3,221	3,642
Import Costs	(3,214)	(3,007)	(2,942)	(3,203)
Net Balance	456	291	279	439
Net Factor Income/Transfers	(1,249)	(1,303)	(1,250)	(1,495)
Current Account	(793)	(1,012)	(971)	(1,056)

Source: IMF

TABLE 6

GROSS FIXED CAPITAL FORMATION (CFAF billions): 1988-1990

	1988	1989	1990
100% Public Enterprises	17.5	17.6	13.6
Majority Private Firms	88.0	72.1	65.7
100% Private Firms	41.0	23.8	27.9
TOTAL	146.5	113.4	107.1

Source: BIIPS Informatique

INVESTMENT TRENDS IN COTE D'IVOIRE (CFAF billions): 1987-1990

	1987	1988	1989	1990
GDP	3,127	3,068	2,948	2,705
Investment	366	463	304	203
Investment/GDP	11.7%	15.1%	10.3%	9.8%

Source: IMF

TABLE 7

1988 POPULATION IN COTE D'IVOIRE BY NATIONALITY AND GENDER

	IVORIAN	NON-IVORIAN	TOTAL
MALE	3,820,569	1,670,161	5,490,730
FEMALE	3,935,888	1,322,351	5,258,239
TOTAL	7,756,457	2,992,512	10,748,969

Source: Government of Côte d'Ivoire

AGE DISTRIBUTION OF COTE D'IVOIRE POPULATION: 1970-2000

	0-14 Years	15-24 Years	25-59 Years	>60 Years
1970	42.7%	18.6%	33.3%	5.5%
1985	45.6%	18.3%	31.4%	4.7%
2000	45.9%	19.3%	29.8%	4.9%

Source: United Nations agencies