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FINANCING OF UNIVERSAL HEALTH COVERAGE AND FAMILY PLANNING

Financing of Universal Health Coverage and Family Planning

A Multi-Regional Landscape Study and Analysis of Select West African Countries

January 2017

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The Health Finance and Governance Project
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A MULTI-REGIONAL LANDSCAPE STUDY AND ANALYSIS OF SELECT WEST AFRICAN COUNTRIES

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ACRONYMS

ANAM	*Agence Nationale d'Assistance Médicale* / National Agency for Medical Assistance (Mali)
ANAM	*L'Agence Nationale de l'Assurance Maladie* / National Health Insurance Agency (Benin)
APSAB	*Association Professionnelle des Societés d'Assurances du Burkina Faso* / Professional Association of Insurance Companies of Burkina Faso (Burkina Faso)
CAMNAFAW	Cameroon National Association for Family Welfare (Cameroon)
CAMS	*Cellule d'Appui aux Mutuelles de Santé* / CBHI Technical Support Cell (Cameroon)
CANAM	*Caisse Nationale d'Assurance Maladie* / National Health Insurance Fund (Mali)
CBHI	community-based health insurance
CNPS	*Caisse National de Prévoyance Sociale* / Social Security (Cameroon)
CNSS	*Caisse Nationale de Sécurité Sociale* / National Social Security Fund (Burkina Faso, Guinea)
CONSAMAS	*Concertation Nationale des Structures d'Appui aux Mutuelles et Assurances de Santé* / National Coordination of CBHI Schemes and Health Insurances (Benin)
CPS	*Cellule de Planification et de Statistique* / Planning and Statistics Unit (Mali)
DHS	Demographic and Health Survey
FCFA	West African CFA franc (Burkina Faso)
FP	family planning
GIZ	*Deutsche Gesellschaft für Internationale Zusammenarbeit* / German Corporation for International Cooperation (Cameroon)
HFG	Health Finance and Governance Project
HIV/AIDS	human immunodeficiency virus / acquired immunodeficiency syndrome
HSDP	Health and Social Development Plan (Mali)
INAM	*L'Institut National d'Assurance Maladie* / National Agency for Medical Assistance (Togo)
INSD	*Institut National de la Statistique et de la Démographie* / National Institute of Statistics and Demography (Burkina Faso)
IPM	*Institution de Prévoyance Maladie* / Sickness Insurance Institution (Senegal)
IPRES	*Institut de Prévoyance Retraite et Sociale* / Institute of Social Welfare and Retirement (Senegal)
IUD	intrauterine device

MPHH	Ministry of Public Health and Hygiene (Mali)
MPSWSS	Ministry of Public Service Work and Social Security (Burkina Faso)
MS	*Ministère de la Santé* / Ministry of Health (Togo)
MSHA	Ministry of Solidarity and Humanitarian Action (Mali)
MWCFP	Ministry of Women, Child and Family Promotion (Mali)
NGO	non-governmental organization
NHA	National Health Accounts
NHFS for UHC	National Health Financing Strategy toward Universal Health Coverage / *Stratégie nationale de financement de la santé vers la CSU* (Guinea)
PDS	*Plan de Développement Sanitaire* / Health Development Plan (Niger)
PMAS	*Le pool micro-assurance santé* / The micro health insurance pool (Senegal)
PNDS	*Plan National de Développement Sanitaire* / National Health Development Plan (Benin, Guinea, Togo)
PRODESS	Programme for Social and Health Development (Mali)
PROMUSCAM	*Plateforme des Promoteurs des Mutuelles de Santé au Cameroun* / Platform for the Promotion of CBHI (Cameroon)
RAMED	*Régime d'Assistance Médicale* / Medical Assistance Mechanism (Mali)
RAMU	*Régime d'Assurance Maladie Universelle* / Universal Health Insurance Plan (Benin)
RH	reproductive health
ST-AMU	*Secrétariat technique de l'assurance maladie universelle* / universal health insurance technical secretariat (Burkina Faso)
STI	sexually transmitted infection
TB	tuberculosis
UEMOA	*L'Union Economique et Monétaire Ouest Africaine* / West African Economic and Monetary Union (Niger)
UHC	universal health coverage
UN	United Nations
USAID	United States Agency for International Development
UTM	*Union Technique de la Mutualité Malienne* / CBHI Technical Unit (Mali)
WARHO	West Africa Regional Health Office
WHO	World Health Organization

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EXECUTIVE SUMMARY

Recognizing that a healthy population promotes economic development, resilience, and strength, many governments have started pursuing a universal health coverage (UHC) agenda. The international community, national governments, and private organizations and individuals are converging on the principle that universal access to family planning is a goal worthy of increased financial investment. Improved access to family planning is also important for a country's economic development, and it helps countries improve key population health outcomes for mothers, newborns, and children.

The reality of limited resources for health care has brought increased scrutiny of how health care is financed. To reach UHC, governments are looking to pursue more and better spending mechanisms for health care and to promote financial protection for households. While there is no single or perfect model for financing health care, the health policy community can draw on international experience to identify best practices.

The purpose of this report is to present findings of a landscape study of observed trends and lessons learned from fifteen countries across multiple regions. We conducted detailed analyses of eight countries in West Africa: Benin, Burkina Faso, Cameroon, Guinea, Mali, Niger, Senegal, and Togo ("core countries"). We reviewed the health financing landscapes of seven additional countries at various stages of achieving UHC to draw lessons learned and inform potential strategies: Ethiopia, Ghana, Indonesia, Kenya, Malaysia, Nigeria, and South Africa ("reference countries").

Parties interested in the report may include Ministries of Health or national UHC agencies, regional governments, UHC stakeholders in the West Africa region, the United States Agency for International Development / West Africa Regional Health Office and country Missions, and the private sector.

Chapter 1 of the report discusses the landscape study findings from an analysis across the fifteen countries. Chapters 2–9 of the report present in-depth findings from the eight core countries, including descriptions of each country's health financing landscape and its government's strategies for UHC and family planning, a discussion of the country's health financing challenges and strengths, and potential opportunities for high-impact interventions that could improve the country's health financing landscape for UHC and family planning.

Government Strategies to Pursue Universal Health Coverage and Universal Access to Family Planning

All fifteen governments mentioned UHC or a similar concept in major government health sector strategies, although most countries do not intend to reach universal coverage during their strategy's timeframe. Instead, governments generally plan to implement measures to increase population coverage under existing or new initiatives with a gradual scale-up. In general, countries' UHC strategy documents embrace the concept of progressive universalism, as described by Gwatkin and Ergo (2011) and adopted by the 2013 Lancet Commission on Investing in Health (Jamison et al. 2013). That is, they include multiple strategies to improve coverage for the poor, the informal sector, and the formal sector (and imply this will happen simultaneously). Most countries had specific strategies for engaging the private sector under their umbrella UHC strategy. Family planning, however, was often absent from the main policy documents and was often addressed in separate family planning or reproductive health strategy documents. Governments with separate strategy documents for family planning appear to have more concrete and specific action plans for family planning, whereas governments that mention family planning in a broader health system strategic plan demonstrate less detailed plans.

Although the fifteen countries vary in terms of coverage and use of family planning, many of the strategies for improving access to family planning are common to all of them, such as increasing awareness and demand through social marketing, task shifting to allow for community-based distribution, and increasing the number of distribution points for family planning services.

Health Financing Mechanisms in Core and Reference Countries, and Private Sector Engagement

Even in the least fragmented health care systems, health services are financed through a plurality of mechanisms. Most or all of the health financing mechanisms described below are included in the health financing landscape of all fifteen countries. Levels of service coverage, population coverage, and financial protection varied.

These coverage levels are a key way to measure a country's progress toward UHC and universal access to family planning. To assess the latter, one can evaluate the degree to which health financing mechanisms cover family planning services (i.e., seek to ensure their delivery), the percentage of the population who can and do access those services under each mechanism, and what degree of financial protection is provided for family planning.

Chapters 2–9 of this report elaborate on each of these mechanisms in the eight core countries; lessons from the seven reference countries are woven into the multi-regional analysis of Chapter 1.

Government-financed provision of health services exists in all study countries. Government funding to facilities allows them to operate without charging patients the full cost of providing services. The government often does the purchasing; in some countries, community committees are established to have a say in how facilities spend available funds. In many low- and middle-income countries, the purchasing mechanism employed by government purchasers is *input-based financing* (e.g., paying for health worker salaries, commodities, and infrastructure). Governments often pair such direct financing for health services with *demand-side financing* (e.g., paying for services on behalf of patients to reduce financial barriers to accessing care) to improve equity of access to health services.

User fee waivers or vouchers are two examples of pro-poor financing mechanisms, reducing cost sharing by poor and vulnerable households. Malaysia's experience as an upper middle income country with near-universal health coverage through the public health delivery system provides valuable lessons for West African countries as economies grow, health systems mature, and governments face new challenges arising from an epidemiological transition and an aging population. Governments can implement legal frameworks now to enable health system reforms to address changing needs.

In general, at least some family planning commodities are provided free in facilities and by community health workers who receive public financing, but these distribution systems can be improved. A voucher scheme in Kenya provides targeted subsidies for safe motherhood, long-term family planning methods, and gender-based violence recovery services. These subsidies benefit households as well as public and private providers. They may be applicable in the West African context, where governments are seeking to reduce financial barriers to priority services such as family planning, and to encourage demand and quality improvements among public and private providers.

Social health insurance is often part of a government strategy to purchase health services for members by mobilizing and pooling funds from public and private sources and based on members' ability to pay. Many governments plan to implement or scale up social health insurance schemes and have passed laws to this effect. However, mobilizing the required resources to adequately subsidize even basic benefits for citizens with limited or no ability to contribute can be a challenging and much longer process.

The rollout of Indonesia's ambitious single-payer system starting in 2014 is partly a result of a legal action brought by citizens to hold the government accountable for the 2004 law on the National Social Security System. Nigeria's Basic Health Care Provision Fund needs to receive annual budget appropriations to ensure it gets implemented. In 2012, legislation addressing Ghana's National Health Insurance Scheme reform required inclusion of family planning to be determined by the Minister of Health, but three years later, the government had yet to provide the policy directive and implementation guidelines necessary to make family planning methods part of the scheme. South Africa's government is in advanced preparations to scale up National Health Insurance in a multi-phased approach that is expected to span more than a decade.

Governments need to allocate significant funding to scale up social health insurance, so many countries focus social health insurance programs on employees in the formal sector, where administration is most feasible. However, unequal financial protection between the formal sector (often the wealthier households) and the rest of the population can create a cycle of inequity and higher levels of fragmentation in the health system.

Community-based health insurance (CBHI) is often included the UHC strategies of low- and middle-income countries because of its perceived comparative advantage in targeting and enrolling underserved, uninsured, and largely informal-sector populations into risk-pooling schemes. While increasing the number of CBHI schemes may seem feasible for governments in the short term, the model often leads to government-sponsored health financing mechanisms. For example, in Ghana, community members initially volunteered to manage the schemes; however, eventually they migrated into a more professional management arrangement, and the scheme managers became salaried government staff.

Enrollment in CBHI schemes is often voluntary or not enforced, so schemes are often vulnerable to *adverse selection*, where disproportionate enrollment by high-risk individuals accompanies non-participation by low-risk individuals. CBHI initiatives such as Ethiopia's may eventually evolve into larger risk pools once that transition is operationally feasible for the government. That transition could be beneficial for ensuring CBHI scheme members get financial protection for health services provided by regional or national hospitals.

Private health insurance is a health financing mechanism present in the fifteen study countries, although its role varies from country to country. Private health insurance tends to target wealthier households and workers in the formal sector. There are, however, a few rare examples of private health insurers and private CBHI schemes targeting lower-income households or workers in the informal sector. Some private companies voluntarily offer employees premium subsidies or other health benefits for private health insurance in order to attract and retain skilled people, in Kenya and Nigeria, for example. In general, this model does not contribute significantly to population coverage in countries with small formal sectors.

Household out-of-pocket spending means households pay providers directly for health goods and services at the time of service. This is the dominant financing mechanism in most of the fifteen study countries. Households in all countries invariably pay out of pocket for some health services or commodities, as seen even in Malaysia, where most services are provided free or at very low cost through a strong network of public health facilities. In countries with low levels of other health care financing and risk-pooling mechanisms, out-of-pocket spending on health care accounts for the majority of household spending, and household spending as a proportion of total health expenditure is generally quite high.

There is growing interest in mobilizing private financing. Because household spending is already a large proportion of total health spending and core countries have relatively small formal sectors, this study did not identify many examples of how to engage the private sector in health financing. However,

governments can improve equity and increase efficiency by implementing health financing mechanisms that spread risk among a large pool and protect households from catastrophic costs. Governments must continually reform the health system to pursue better and more-equitable coverage for the population, and the path to UHC needs to evolve over time as population needs and demands change.

Government-subsidized programs that lack the resources to cover all citizens will by necessity or design cover a subset of the population. This can undermine social solidarity and equity, however, and potentially derail the goal of *progressive universalism*. Smaller-scale or more-targeted health financing mechanisms can promote more-equitable access to essential services. Additionally, ensuring universal access to family planning through UHC initiatives is critical.

Many governments of the core countries in this study envision simultaneous interventions to improve financial protection for health care and pursue UHC: finance health facilities with public funds, scale up social health insurance, and encourage the establishment of CBHI schemes to contribute to population coverage of hard-to-reach populations. With relatively small formal sectors, core countries will need to dramatically grow the number of CBHI schemes in order to reach near-universal enrollment among their populations. Population coverage of CBHI and other forms of insurance is low in most of them.

This study's review of health financing landscapes in all core countries reveals several opportunities for each to expand on, or introduce, new health care financing mechanisms that can increase coverage for health care and family planning.

1. INTRODUCTION

1.1 A Groundswell of Support for Universal Health Coverage and Universal Access to Family Planning

Support for universal health coverage (UHC) is growing globally. As the international community increasingly subscribes to the principle that all people have a right to health and well-being, many governments are making strides on the path toward UHC. Similarly, the international community, national governments, and private organizations and individuals are converging on the principle that universal access to family planning is a goal worthy of increased financial investment.

On September 25, 2015, the United Nations General Assembly adopted the resolution "Transforming Our World: The 2030 Agenda for Sustainable Development," defining the post-2015 development agenda. Its Sustainable Development Goal #3 states: *Ensure healthy lives and promote well-being for all at all* ages (2015, p. 14). UHC and universal access to family planning are critical strategies for achieving this goal.[A]

In 2013, the Lancet Commission on Investing in Health reviewed the case for investment in health and reported that reductions in mortality account for about 11% of recent economic growth in low- and middle-income countries as measured in their national income accounts (Jamison et al. 2013). Recognizing that a healthy population promotes economic development, resilience, and strength, many governments in West Africa and other regions have started pursuing a UHC agenda. The political and moral imperative of UHC is gaining ground in Africa as more people recognize that progress toward UHC promotes equity, basic rights, and human security in health (World Bank 2016).

Improving access to family planning is a critical global health imperative. The right to health includes the right to control one's health and body, including sexual and reproductive freedom (United Nations 2000). Improved access to family planning is also important for a country's economic development, and it helps countries improve key population health outcomes for mothers, newborns, and children. Many governments have recognized the importance of including family planning services in the essential package of health services made accessible to and promoted among their populations. Limited availability or high cost of family planning, due to inadequate funding or inequitable financing mechanisms, can be a prohibitive barrier. Health financing mechanisms that do not prioritize family planning services can also create barriers among providers for delivering these services within an integrated package of services. Improving financing for family planning can reduce unmet need among the population and help West African governments achieve key population health milestones.

1.2 Why Health Financing Matters

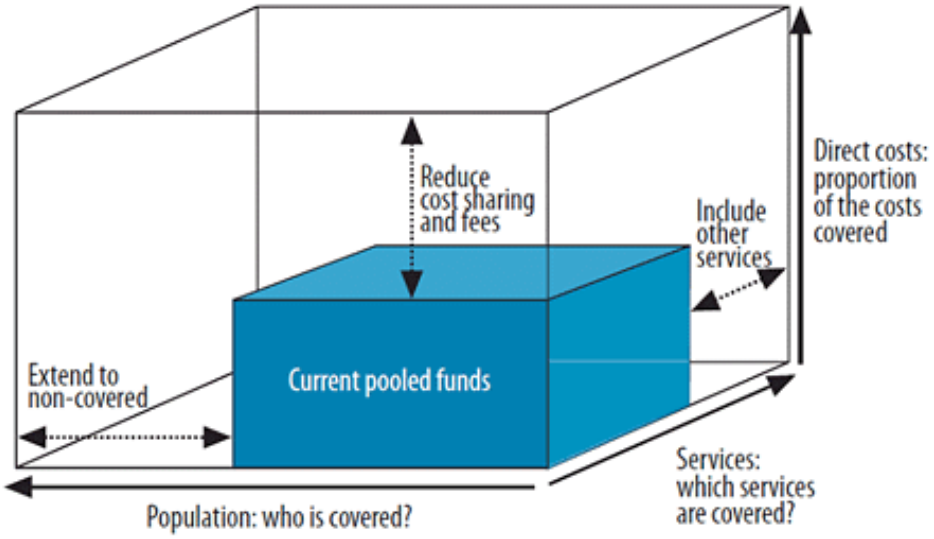
Health financing is one of the six health systems building blocks and underlies all three dimensions of the UHC cube: population coverage, service coverage, and financial protection (Figure 1). Expanding population and service coverage and financial protection involves increasing fiscal space. The reality of limited resources for health has brought increased scrutiny on how health is financed. To reach UHC,

A. Target 3.7: "By 2030, ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes." Target 3.8: "Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all."

governments are looking to pursue more and better spending for health and promote financial protection for households. While there is no single or perfect model for financing health care, the healthpolicy community can draw on international experience to identify best practices.

Health financing is one of the six health systems building blocks, and underlies all three dimensions of the UHC cube: **population coverage, service coverage**, and **financial protection** (Figure 1). Expanding population and service coverage and financial protection involves increasing fiscal space. The reality of limited resources for health has brought increased scrutiny on how health is financed. To reach UHC, governments are looking to pursue more and better spending for health and promote financial protection for households. While there is no single or perfect model for financing health care, the health policy community can draw on international experience to identify best practices.

Figure 1: Universal Health Coverage (UHC) Cube



Source: World Health Organization.

Health is financed everywhere, even in contexts where risk-pooling schemes and other financial protection mechanisms are lacking. In these contexts, household out-of-pocket spending is the default health financing mechanism. However, a health system that relies heavily on households to finance their own health care deters development. These households may either forgo care or incur impoverishing health care costs. Forgoing care can lead to morbidity, disability, mortality, or a reduction in quality of life and productivity, creating lasting consequences for the household and for future generations. Catastrophic health care costs may impoverish the household or cause it to divert funds from other needs that are critical to the household and society at large, such as education and food.

How health care is purchased is also important. Every health financing system incorporates built-in incentives and disincentives. These forces affect the behaviors and actions taken by all participants in the system, including households, other private sector actors, government, donors, and providers, and they can affect the systemic efficiency as well as the health outputs and outcomes that are produced. For example, when households must purchase health services on an as-needed basis, they forgo care, especially preventive and promotive care, when they do not perceive a tangible or immediate benefit. Private employers might be incentivized to offer health benefits to employees to attract talent and to enhance health and productivity. Governments might be dis-incentivized from allocating a higher percentage of government spending to health if the donor community is willing to finance health programs.

The ways health services are purchased also introduce a range of behavioral incentives for providers that affect how they provide care and what services they provide. For example, fee-for-service payments to providers from purchasers—such as households paying user fees, an insurance scheme, or the government—tend to incentivize providers to provide more and more-costly services, without necessarily producing a concomitant increase in the quality of care or improved health outcomes. Alternatively, when health services are purchased through financing the salaries of health workers, the opposite phenomenon can occur, incentivizing the providers to provide fewer and possibly lower-quality services. Large health purchasers such as insurers are more capable than are individuals of holding providers accountable for quality and quantity of services through mechanisms such as strategic purchasing, including results-based financing, and accreditation.

Kutzin (2013) argues that for health financing policy to align with the pursuit of UHC, effective reforms must aim explicitly at improving coverage and the intermediate objectives linked to it, such as improving efficiency, enhancing equity in health resource distribution, and increasing transparency and account-ability. Health system financing functions of revenue collection, pooling, and purchasing should be performed in a coordinated policy and implementation approach to ensure these objectives are met.

In this report, we focus on health financing mechanisms and how they contribute to a government's pursuit of UHC.

1.3 Activity Description

The United States Agency for International Development / West Africa Regional Health Office (USAID/WARHO) supports strengthening country commitment and capacity to achieve UHC. The Health Finance and Governance Project (HFG), a global project funded by USAID, was requested by USAID/WARHO to:

- Enhance general understanding of programs that countries have used to advance UHC goals, including lessons learned and potential roles for the private sector
- Increase capacity for identifying gaps and opportunities in regional and country-specific approaches to achieve UHC
- Identify lessons learned from interventions that advance UHC goals and that advance potential family planning outcomes within UHC programs

This report presents findings of a landscape study on health financing, which include observed trends and lessons learned from fifteen countries across multiple regions and detailed analyses of eight of those countries in West Africa. Parties interested in the report may include Ministries of Health or national UHC agencies, regional governments, UHC stakeholders in the West Africa region, USAID/WARHO and country Missions, and the private sector.

In this chapter, the study team discusses the landscape study methods and findings from a multi-country analysis. In Chapters 2–9, we present in-depth findings from eight West African countries. For each of these countries, we describe the health financing landscape, the government's strategies for UHC and family planning, the health financing challenges and strengths, and potential opportunities for high-impact interventions that could improve the health financing landscape for UHC and family planning.

1.4 Methods

HFG undertook a landscape study to identify regionally relevant strategies and policies for health financing for UHC and family planning. Health financing specialists from HFG reviewed the health financing landscape for UHC and family planning across eight countries in West Africa: Benin, Burkina Faso, Cameroon, Guinea, Mali, Niger, Senegal, and Togo ("core countries"). HFG also reviewed the

health financing landscape of seven additional countries ("reference countries") at various stages of achieving UHC to draw lessons learned and inform potential strategies. Table 1 summarizes key characteristics across the fifteen countries.

HFG selected the fifteen study countries using a scoring system to rank potential study sites. The selection matrix is presented in Annex A. Potential core countries comprised the twenty-one countries in West Africa that are included in the USAID West Africa Regional Development Cooperation Strategy. We assigned scores to four selection criteria and selected the eight countries based on their total scores. HFG identified potential reference countries through consultation with USAID/WARHO and the West Africa Health Organization. From thirteen candidates, we selected seven reference countries based on further consideration of factors such as the country's overall progress toward UHC and the health financing mechanisms in use.

Table 1: Basic Characteristics of Fifteen Countries included in the Landscape Study

		Income level[1]	Population (2015)[2]	Household health expenditure as percentage of total health expenditure[3](%)	Unmet need for family planning[4](%)
Core countries	Benin	Low	10,879,800	32.6	42
	Burkina Faso	Low	18,105,600	24.5	35
	Cameroon	Lower-middle	23,344,200	23.5	52
	Guinea	Low	12,608,600	23.7	62
	Mali	Low	17,599,700	26.0	54
	Niger	Low	19,899,100	16.0	56
	Senegal	Low	15,129,300	25.6	41
	Togo	Low	7,304,600	33.6	60
Reference countries	Ethiopia	Low	99,390,800	26.3	34
	Ghana	Lower-middle	27,409,900	29.9	45
	Indonesia	Lower-middle	257,564,000	11.4	45
	Kenya	Lower-middle	46,050,300	17.5	32
	Malaysia	Upper-middle	30,331,000	15.4	48
	Nigeria	Lower-middle	182,202,000	16.1	72
	South Africa	Upper-middle	54,490,400	16.5	52

[1]World Bank. 2016. World Development Indicators Databank. Accessed August 2016 at http://databank.worldbank.org/data/home.aspx.
[2]World Health Organization. Global Health Observatory. Accessed June 2016 at http://www.who.int/gho/en/.
[3]See Table 5 for sources.
[4]See Table 3 for sources.

Three HFG researchers collected qualitative, descriptive data on the health financing arrangements in the fifteen countries using the data collection template presented in Annex B. They conducted a desk-based review of the following key government strategies and study reports: the government's health sector strategic plan, UHC strategy, or equivalent; the government's health financing policy or equivalent; the government's reproductive health or family planning policy or equivalent; Demographic and Health Survey reports for the country; and National Health Accounts reports for the country. The review also involved collecting data from additional public domain sources identified through web-based searches, including other government strategy documents, studies and reports, peer-reviewed journal articles, news articles, and gray literature.

Three senior health financing specialists based in West Africa traveled to each of the eight core countries to collect additional data in person that had not been identified in the desk-based review. They held meetings with key informants to understand each government's commitment to UHC, implementing structures in place for rollout of initiatives, current challenges to implementation, and

other topics. These key informants included government policy officials and program managers, managers of parastatal agencies or private companies, heads of national associations, development partners, and others. Meetings were conducted in French. In these meetings, the consultants also collected documents that were not available in the public domain. Annex C lists key contacts identified by the consultants.

Next, the HFG research team analyzed the data from all fifteen countries to identify the following:

- Themes across all countries
- Innovative health financing models that may be applicable to the West African context
- Potential opportunities for strengthening the health financing landscape in pursuit of UHC and better access to family planning

Landscape study findings and analyses are presented in the following sections.

1.5 Financing for Universal Health Coverage and Access to Family Planning, and How Countries Are Engaging the Private Sector

In this section, we summarize government strategies to pursue UHC and universal access to family planning, and draw cross-country comparisons of these strategies.

Many governments publicly state their strategy for progressing toward UHC in a government strategy document. Many describe how the government aims to involve the private sector. Table 2 summarizes government strategies for progressing toward UHC and governments' vision for engaging private financing agents and providers.

All fifteen governments mentioned UHC or a similar concept in their strategies, proving the pervasiveness of this concept in the post-2015 era. However, most countries do not intend to reach universal coverage during the strategy timeframe. Instead, governments generally plan to implement measures to increase population coverage under existing programs. Even so, government strategies for expanding population coverage generally involve long-term initiatives with a gradual scale-up. Most countries had specific strategies for engaging the private sector under their umbrella UHC strategy.

There is a trade-off between making rapid gains in population coverage versus pursuing concurrent progress along the three main dimensions of UHC: population coverage, service coverage, and financial protection (Figure 1). The 2013 Lancet Commission argued for public financing of progressive pathways toward UHC that are pro-poor from the outset (Jamison et al. 2013). Gwatkin and Ergo (2011) coined the term "progressive universalism" to mean a "determination to include people who are poor from the beginning." In general, countries' UHC strategy documents embrace the concept of progressive universalism by including multiple strategies to improve coverage for the poor, the informal sector, and the formal sector (and imply this will happen simultaneously).

The principle of progressive universalism also applies to implementation. If the government prioritizes efforts to achieve UHC on implementing social health insurance for civil servants and/or other formal sector workers because they are easier to identify and enroll, the principle is not met.

Strategies to increase or attain universal access to **family planning** were often absent from the higher-level UHC documents from Table 2. Family planning services are often included in governments' essential packages of health services; policies and strategies to increase access were often stated in family planning or reproductive health strategy documents or costed implementation plans and promoted through the Family Planning 2020 Movement.

Unmet need for family planning is higher in most West African countries than in most of the reference countries in the study (Table 3). Benin and Togo have the highest rates of unmet need among study countries at 32.6 and 33.6 percent respectively. Indonesia, Kenya, Malaysia, and South Africa—all countries with middle-income status—have the highest rates of contraceptive use among married women. Although the fifteen countries vary in terms of coverage and use of family planning, many of the strategies for improving access to family planning are common ones, such as increasing awareness and demand through social marketing, task shifting to allow for community-based distribution, and increasing the number of distribution points for family planning services, including through the private sector.

Table 2: Government Strategies for Pursuing UHC in the Fifteen Study Countries

Country	UHC strategy document(s)	Summary of main strategies to pursue UHC	How does the government plan to engage the private sector?
Core Countries			
Benin	National Health Development Plan 2009-2018 National Health Financing Strategy for Universal Coverage 2016-2022	• Scale up social health insurance (*Regime d'Assurance Maladie Universelle*) • Scale up CBHI • Strengthen medical assistance to the poor and vulnerable (0-5 years) including: • Strengthen the capacity of facilities to include these populations in service provision • Decentralize the indigent health funds to all municipalities • Expand the indigent health fund to cover all health areas	• Enhance collaboration of public and private sectors for improved health policy implementation • Regulate and contract private sector to improve the coverage and delivery of quality services
Burkina Faso	UHC plan 2015-2017 Law on universal health insurance adopted 2015	• Provide a standard package of services that is 80-100% subsidized by the government • Insure the formal sector through National Social Security Fund (including self-employed) • Insure active and retired government workers through the Retirement Fund for Public Servants • Scale up CBHI for the rural and informal sectors	• Continue to purchase services from private facilities • Increase the role of the private sector in advocating for uptake of *mutuelles* by the population
Cameroon	National Health Development Plan 2011-2015	• Establish mechanisms for risk pooling • Support the establishment and monitoring of CBHI • Set up financial mechanisms to support the indigent population • Identify new public-private partnerships • Develop procedures manual for contracting with private providers • Strengthen government capacity for contracting	• Implement a partnership strategy with private sector, and identify public-private partnerships • Contract with providers

Country	UHC strategy document(s)	Summary of main strategies to pursue UHC	How does the government plan to engage the private sector?
Guinea	National Health Development Plan 2015-2024	• Provide free care for the elderly in public health facilities • Conduct a study on the status of UHC implementation • Establish structures for technical monitoring, piloting, and implementing UHC	• Scale up coordination with the private sector

Mali	Health and Social Development Plan 2014-2023
	(Draft) Health Financing Strategy for UHC, 2014-2023
		• Increase the population covered by risk-pooling schemes, including:
		  ◦ CBHI for informal sector workers
		  ◦ Compulsory Health Insurance scheme for government civil servants
		  ◦ Medical Assistance Mechanism for the indigent
			• Develop an official public-private partnership strategy

Niger	National Health Financing Strategy for UHC in Niger 2012	• Increase mobilization of domestic and external resources • Promote CBHI • Promote health insurance in both public and private sectors • Implement a social security fund for health, including determination of structure, governance, and funding sources	• Engage with private providers in urban centers • Develop a structure for placing private sector health professionals in underserved areas

Senegal	National Health Development Plan 2009-2018
	
	Plan Emergent Senegal
	
	Strategic Plan for the Development of Universal Health Coverage in Senegal (2013-2017)
		• Implement exemptions and assistance programs for vulnerable groups, such as the Sesame Plan for people age 60 and over, subsidies for indigents and for people with specific diseases, free deliveries and caesarean sections (except in the Dakar region), and alternative forms of protection for persons not covered by formal coverage options
		• Reform the institutional and legal framework of social security for workers and retirees
		• Facilitate vulnerable groups' access to resources
		• Strengthen the social reintegration program
		• Improve access to equipment for the disabled and wards of the state
		• Consolidate and expand social transfer mechanisms
		• Implement the UHC initiative that promotes CBHI
			• Develop public-private partnerships by:
			  ◦ Identifying players
			  ◦ Defining terms of reference, objectives, expected results, methodology, and monitoring and evaluation of partnerships
			  ◦ Developing contracting guidelines

Country	UHC strategy document(s)	Summary of main strategies to pursue UHC	How does the government plan to engage the private sector?

Togo	National Health Development Plan 2012-2015	• Support universal access to essential health services through:
		  • Devolution and decentralization
		  • Improving health information and monitoring
		  • Strengthening human resources for health (scaling up community-based services; strengthening public-public and public-private partnerships including traditional medicine, civil society, and community structures; and updating the national policy for contracting originally adopted in 2003)
		  • Improving access and quality of care
		  • Improving access to medicines, vaccines, blood banks, and essential medical technologies
		  • Strengthening health financing through performance-based financing, resource mobilization, optimal resource allocation, and increasing financial protection for vulnerable groups
		  • Strengthening community participation through social networks and community health workers
			• Develop public-private partnerships
			• Contract health services from private sector
			• Increase private financing for health

Ethiopia	Health Sector Transformation Plan 2016-2020	• Improve equity, coverage, and use of essential health services through:
		  • Promoting community engagement through various strategies (certificate of competency evaluation of households; self-reliance movements; health and health systems literacy; rollout of the Health Development Army; rollout of the second-generation health extension program)
		  • Improving efficiency and effectiveness (financial management; transparency and accountability development program; regular financial and performance audits; efficiency gain; efficient use of facility revenues; implementation of social health insurance and community-based health insurance)
			• Implement the 2013 Public-Private Partnership in Health Framework

Country	UHC strategy document(s)	Summary of main strategies to pursue UHC	How does the government plan to engage the private sector?
Ghana	National Health Policy 2007	• Reduce maternal and child mortality; prevent, fight against disease; and improve the quality of care • Develop human resources • Reinforce partnerships in the sector and promote ethics generally and in medicine specifically • Improve resource mobilization from all domestic and international sources of funds • Improve health financing equity, including risk pooling, assistance to the poor and vulnerable, and lowering catastrophic cost of care • Conduct annual review of resource allocation and purchasing mechanisms and realign them in view of national priorities and funding sources • Strengthen harmonization and effectiveness of aid, incentives, transparency, accountability, and efficiency in the public sector • Reinforce sector management	• Promote private sector investment in health service and health-enhancing facilities
Indonesia	Ministry of Health Strategic Plan 2015-2019	• Improve public health • Improve disease control • Increase access to and quality of health facilities • Increase the number, types, and quality of providers • Improve access to pharmaceuticals and medical devices • Increase synergy between national and sub-national levels • Improve partnerships, planning, and monitoring and evaluation • Increase health research • Strengthen transparent and good governance • Improve capacity of the Ministry of Health • Integrate and improve the health information system	• Incorporate large and small private businesses and private households into national health insurance scheme

Country	UHC strategy document(s)	Summary of main strategies to pursue UHC	How does the government plan to engage the private sector?
Kenya	Kenya Health Sector Strategic and Investment Plan 2014-2018	• Manage the Kenya Essential Health Service Package • Manage the service delivery system • Oversee community services • Provide supervision and mentorship services (integrated supportive supervision using updated Kenya Quality Model for Health) • Provide oversight of an integrated, pluralistic health system (e.g., conduct private sector assessments to deepen understanding of the role of the private sector in the health industry) • Develop mechanisms for engaging with stakeholders • Conduct joint development of operational and strategic plans and review processes • Regulate standards for health services, including quality of services, and their assessment • Develop a comprehensive legal and regulatory framework in the health sector	• Promote private sector participation in financing of health through public-private partnerships and other mechanisms
Malaysia	2016-2020 Country Plan	• Enhance targeted support for underserved communities (i.e., expand mobile health care, improve primary health care teams, and establish domiciliary health care programs) • Improve system delivery for better health outcomes (i.e., introducing lean management practices in public hospitals and enforcing health regulations) • Expand health system capacity (i.e., develop new facilities, upgrade existing facilities, enhance health care personnel capacity and capabilities) • Intensify collaboration with private sector and NGOs to increase health awareness	• Intensify collaboration with private sector and NGOs to increase health awareness
Nigeria	National Strategic Health Development Plan 2010-2015 National Health Act of 2014	• Develop a basic minimum package of services • Determine how certain populations can be exempt from payment • Establish a Basic Health Care Provision Fund • Establish new governing bodies for the health sector at the federal level	• Contract with private providers through the National Health Insurance Fund

Country	UHC strategy document(s)	Summary of main strategies to pursue UHC	How does the government plan to engage the private sector?
South Africa	National Health Insurance for South Africa: Toward UHC 2015	• Improve risk pooling through establishment of National Health Insurance • Implement National Health Insurance in three phases (includes strengthening the service delivery platform and improving quality in the public health sector)	• Through National Health Insurance, accredit private providers and purchase services from them on behalf of enrollees • Help private medical schemes adjust their role after health sector reforms

Key: NGO=non-governmental organization.

Table 3: Family Planning Indicators in the Fifteen Study Countries

		Data Source[1]	Unmet need for family planning (%)	Married women currently using any modern method of contraception (%)	Married women currently using long-acting reversible contraceptives (IUD, injections or implants) (%)	Sexually active unmarried women currently using any modern method of contraception (%)
Core countries	Benin	2011-12 DHS	32.6	7.9	3.5	24.4
	Burkina Faso	2010 DHS	24.5	15.0	9.9	58.7
	Cameroon	2011 DHS	23.5	14.4	3.9	48.0
	Guinea	2012 DHS	23.7	4.6	1.6	41.1
	Mali	2012-13 DHS	26.0	9.9	6.9	33.5
	Niger	2012 DHS	16.0	12.2	2.5	39.9
	Senegal	2014 DHS	25.6	20.3	14.0	51.9
	Togo	2013-14 DHS	33.6	17.3	12.6	38.4
Reference countries	Ethiopia	2011 DHS	26.3	27.3	24.5	52.3
	Ghana	2014 DHS	29.9	22.2	14.0	31.7
	Indonesia	2012 DHS	11.4	57.9	39.1	18.8
	Kenya	2014 DHS	17.5	53.2	39.7	60.9
	Malaysia	UN, 2015[2]	15.4	41.7	Not available	Not available
	Nigeria	2013 DHS	16.1	9.8	4.7	54.9
	South Africa	1998 DHS[3]	16.5	55.1	25.0	67.8

Key: DHS=Demographic and Health Survey; IUD=intrauterine device; UN=United Nations.
[1]Unless stated otherwise, indicators source is ICF International. The DHS Program STATcompiler. http://www.statcompiler.com/. Accessed June 2016.
[2]United Nations 2015.
[3]A 2015 DHS was under way in South Africa at the time of analysis for the report.

Strategies to finance and increase coverage of family planning are sometimes integrated into general strategy documents covering the health sector. Sometimes these strategies are found in stand-alone reproductive health and family planning strategy documents or costed implementation plans. Governments with separate strategy documents or costed implementation plans for family planning appear to have more-concrete and more-specific action plans for family planning, whereas governments that roll family planning strategies under a broader health system strategic plan demonstrate less detailed plans. Table 4 summarizes strategies for progressing toward increased access to family planning and the governments' vision for the role of private financing agents and providers.[B]

Table 4: Government Strategies for Increasing Access to Family Planning in the Fifteen Study Countries

	Family planning strategy document or costed implementation plan	Summary of main strategies to pursue increased access to family planning	How does the government plan to engage the private sector?
Core Countries			
Benin	National Multisectoral Strategy for Sexual and Reproductive Health of Adolescents and Youths 2010-2020 National Budgeted Action Plan for Repositioning Family Planning in Benin 2014-2018	• Improve the institutional, socio-cultural, and political development environment around sexual reproduction of adolescents and youth and HIV/AIDS • Improve the level of knowledge and skill of adolescents and youth around sexually transmitted infections and HIV/AIDS, including the provision of reproductive health training • Improve the availability and accessibility of quality services for increased use by adolescents and youth, including free modern contraceptive methods in public health facilities • Increase budget allocation for contraceptive purchasing through 2018 to 250 million FCFA • Strengthen improvements in reproductive health through revisions to policies, norms, and protocols	• Increase collaboration within family planning framework • Leverage community networks to ensure nationwide availability and accessibility of contraceptives

[B] The table includes the most recent family planning strategy or costed implementation plan according to the Family Planning 2020 website where available (http://progress.familyplanning2020.org/). For countries that had not joined the Family Planning 2020 Movement at the time of the study, we identified the document in the public domain.

	Family planning strategy document or costed implementation plan	Summary of main strategies to pursue increased access to family planning	How does the government plan to engage the private sector?
Burkina Faso	National Family Planning Stimulus Plan 2013-2015 Strategic Plan for Reproductive Health Product Security 2009-2015	• Create demand among rural populations through outreach, and among urban populations through mass media campaigns, and educate adolescents and young people about FP • Supply (product availability): reduce supply shortages in public health facilities through better monitoring and management of FP commodities • Improve access to FP services by improving quality of FP services, improving coverage of sub-urban and rural populations through mobile units and advanced strategies (better staffed and equipped facilities to visit less well-off ones one day each month to provide services), and improving coverage of rural population by strengthening community-based services. • Create an individual budget line for RH products and tax and custom duty exemption for RH products (reagents, delivery kits, FP methods)	• National Family Planning Stimulus Plan mentions greater emphasis on private sector, but no further details provided • Improve service availability in private sector • Improve inter-sectoral coordination and include private sector representatives in coordination committees
Cameroon	National Family Planning Action Plan 2015-2020 National Health Development Plan 2011-2015 Strategic Plan for the National Multi-Sectoral Program for Combating Maternal, Newborn & Child Mortality in Cameroon 2014-2020	• Increase national and local government contributions to FP • Improve administration of contraceptives and treatment of side effects through community mobilization, training health workers in IUDs, improving supply of contraceptives • Improve post-partum, post-abortion family planning and family planning for adolescents	• Define a framework for cooperation with private sector so more private facilities can offer FP services and in a way that the Ministry of Health can monitor. Increase social franchising by 100 for each year of the plan
Guinea	National Health Development Plan 2015-2024 National Action Plan for Repositioning Family Planning in Guinea 2014-2018	• Increase family planning contraceptive prevalence through: • Integrating family planning into public and private health facilities	• Integrate family planning into private health facilities

	Family planning strategy document or costed implementation plan	Summary of main strategies to pursue increased access to family planning	How does the government plan to engage the private sector?
		• Implementing family planning services into community-based health care package of services • Offering all modern contraception methods to women of childbearing age • Providing public and private structures with contraception and management tools • Organizing family planning awareness campaigns • Improve the enabling environment for use of family planning services • Improve the monitoring and coordination of family planning services	
Mali	National Action Plan for Family Planning 2014-2018*	• Integrate FP messages in *mutuelles* • Develop a policy for introducing a third-party payer for FP services on behalf of adolescents and poor women • Develop performance-based financing strategy that will include FP • Mali government has committed to financing 10% of costs of contraceptives.	• Development of a strategy for involving the private sector into FP services and to expand social franchising with private sector in all regions
Niger	Health Development Plan 2011-2015 Family Planning in Niger: Action Plan 2012-2020	• Increase the availability of contraceptives, materials, and other family planning inputs • Promote the large-scale and community-based distribution of contraceptives through public and private health facilities including social marketing • Integrate family planning into the basic health care package • Promote an enabling environment for family planning	• Support NGOs conducting social marketing campaigns

	Family planning strategy document or costed implementation plan	Summary of main strategies to pursue increased access to family planning	How does the government plan to engage the private sector?
		• Employ mobile and other advanced strategies for the provision of family planning and reproductive health services	
Senegal	National Action Plan for Family Planning, 2012-2015**	• Broaden the range of social marketing products • Conduct effective implementation of product delivery through the *Pharmacie Nationale d'Approvisionnement* • Set up mobile units • Improve the regulatory framework and engage in better regulation of the market • Ensure insurance support for FP services through CBHI schemes and social security • Establish social franchises • Increase the number of points of service in the private sector	• Establish a multi-sectoral structure dedicated to public-private partnerships • Provide direct training for private actors, especially for administration of long-lasting methods • Systematically integrate private data
Togo	Action Plan for Repositioning Family Planning, 2013-2017	• Scale up community-based distribution of family planning services • Develop mobile and outreach strategies for rural populations • Develop plans to secure and strengthen logistics and product management	• Sign memoranda of understanding with civil society organizations to advocate for increased government funding • Contract with private media outlets • Integrate FP services in private clinics • Develop a civil society and private sector engagement strategy; contract with private sector providers
Ethiopia	National Reproductive Health Strategy, 2005-2015	• Rationalize the current method mix through strategic assessment of contraceptive needs • Identify sources of new donor funding for commodity procurement	• Increase distribution at private facilities and NGOs

	Family planning strategy document or costed implementation plan	Summary of main strategies to pursue increased access to family planning	How does the government plan to engage the private sector?
		• Allocate, as part of the Federal Ministry of Health and regional budgets, funds for procuring no less than half of contraceptive stocks for public sector use • Document the costs/benefits of eliminating import tariffs on FP commodities procured for non-commercial purposes	
Ghana	Ghana Family Planning Costed Implementation Plan 2016-2020	• Promote and nurture change in social and individual behavior • Increase age-appropriate and rights-based information, access, and use of contraception among young people ages 10-24 • Improve availability and access to a full method mix; quality of client-provider interactions with a particular focus on improving counseling on delaying, spacing, and limiting for all client age and population groups • Improve distribution and ensure full financing for commodity security in public and private sectors • Strengthen advocacy to build political will for rights-based family planning amongst community leaders, religious and cultural institutions, and policymakers at all levels • Strengthen provision of family planning services and information through Community-Based Health Planning and Services	• Encourage the private commercial sector to become more involved in family planning commodity procurement, distribution, sales, and promotion • Engage the Society for Private Medical and Dental Practitioners • Strengthen training and supportive supervision to promote client rights, conduct client follow-up, provide long-acting reversible contraception and permanent methods, and complete proper record keeping and reporting • Scale up public-private partnership ventures as alternative supply and distribution mechanisms
Indonesia	Strategic Plan for Population and National Family Planning Development 2010-2014	• Reduce total fertility rate of 2.1 births per woman and net reproduction rate of 1.0 by 2015 • Reduce the number of teenage pregnancies through prevention of pre-marital sex, early marriage and abuse of drugs	• Maintain a registry of health facilities that provide routine FP services and Family Information System

	Family planning strategy document or costed implementation plan	Summary of main strategies to pursue increased access to family planning	How does the government plan to engage the private sector?
Kenya	Reproductive Maternal Neonatal Child and Adolescent Health Investment Framework	• Address supply-side barriers for contraceptives method mix, including: long-acting reversible methods, efficient distribution systems, and competency-based training and updates using World Health Organization medical eligibility for contraceptive use for nurses, clinical officers, and doctors in long-acting reversible methods, FP/contraception counseling, and follow-up • Ensure contraceptive commodity security and adequate financing for contraceptives • Train pharmacy staff to provide FP methods • Increase/expand community-based distribution of FP commodities and services through initiatives, which will include task sharing • Expand the output-based aid voucher program to include a wider range of FP services focusing on underserved groups and youth • Increase the coverage of postpartum FP planning services in facilities • Encourage long-acting and reversible methods among underserved groups such as adolescents/youth • Increase the availability of facilities providing voluntary FP services integrated into other services, including services for HIV/AIDS. Also increase availability of voluntary FP services in the non-health sector, and promote dual method use for HIV prevention.	• Scale up youth-friendly health services and use NGOs, community-based organizations and social media to more effectively reach youth • Involve a wide range of stakeholders such as private sector, schools, universities, and uniformed forces to increase availability and quality of voluntary FP/contraceptive services
Malaysia	None identified	• None identified	• Not specified

	Family planning strategy document or costed implementation plan	Summary of main strategies to pursue increased access to family planning	How does the government plan to engage the private sector?
Nigeria	Nigeria Family Planning Blueprint (Scale-Up Plan)	• Provide free commodities at public facilities • Permit injectables provision by community health extension workers, to greatly expand the potential number of service providers	• Increase private sector delivery channels, including faith-based organizations, private hospitals/clinics, and pharmacies
South Africa	South Africa's National Strategic Plan on HIV, STIs, and TB 2012-2016	• Integrate family planning into maternal and child health services as part of preventing new HIV, STI, and TB infections	• Not specified

1.6 Health Financing Mechanisms in Core and Reference Countries, and Private Sector Engagement

In this section, we discuss mechanisms found in the health financing landscape and draw cross-country comparisons of the study countries.

Even in the least fragmented health systems, health services are financed through a plurality of mechanisms. Table 5 shows the breakdown of financing sources in each of the fifteen countries, as well as the percentage of total health expenditure managed by private pre-paid plans (private insurance). The landscape of health financing sources varies from country to country. The table demonstrates how households must shoulder a larger proportion of the health financing "pie" in countries where government and donors finance a smaller proportion of health care costs. Across all countries, households shoulder the largest proportion of health spending. In general, households in West Africa (the eight core countries plus Ghana and Nigeria) shoulder a larger proportion of total health expenditure than do households in most countries outside the region.

To better understand the private sector's financing role in a health system, it helps to understand the extent to which publicly financed health services meet the health care needs of households in that country. If public financing for health services does not fully cover the costs to facilities to deliver services, facilities will usually mobilize private financing by charging user fees to supplement their operating budgets. Furthermore, if the publicly financed service delivery system is under-resourced and cannot deliver quality services, many households that can afford to will opt out of the system and seek care in the private sector. However, without proper regulation and supervision, private providers and private insurers often cannot meet the needs of poor and vulnerable households, or those of the non-poor informal sector.

Table 5: Financing Sources of Total Health Expenditure in the Fifteen Study Countries

		Data source	House-holds (%)	Others (NGOs, employers) (%)	Govern-ment (%)	Rest of the world (donors) (%)	Total (%)	Private pre-paid plans as percentage of total expenditure on health
Core Countries	Benin	2012 NHA	42	5	24	29	100	<1
	Burkina Faso	2013 NHA	35	7	30	26	100	2
	Cameroon	2011 NHA	52	1	33	14	100	1
	Guinea	WHO Guinea fact sheet 2014	62	2	9	27	100	Not available
	Mali	2013 NHA	54	6	12	28	100	<1
	Niger	2013 NHA	56	1	30	12	100	<1
	Senegal	2008 NHA	41	5	37	17	100	21.1
	Togo	2008 NHA	60	0	23	17	100	2
Reference Countries	Ethiopia	2010/11 NHA	34	1	16	50	100	Not available
	Ghana	2012 NHA	45	6	40	5	100	2
	Indonesia	2014 NHA	47	14	39	0	100	2
	Kenya	2012/13 NHA	32	11	31	26	100	9
	Malaysia	1997-2014 NHA	48		52	0	100	7
	Nigeria	Global Health Expenditure Database, estimate for year 2014	72	21		7	100	2
	South Africa	Global Health Expenditure Database, estimate for year 2014	52		4	0	100	Not available

Key: NGO=non-governmental organization; NHA=National Health Account report; WHO=World Health Organization.

Note: Percentages in the table signify the percentage of total health expenditure contributed by that financing source in that country.

Most or all of the health financing mechanisms described below are included in the health financing landscape of all fifteen countries. Levels of service coverage, population coverage, and financial protection vary. These coverage levels are a key way to measure a country's progress toward UHC and

universal access to family planning.[c] To assess the latter, one can evaluate the degree to which health financing mechanisms "cover" family planning services (i.e., seek to ensure the delivery of such services), the percentage of the population who can and do access those services under each mechanism, and what degree of financial protection is provided for family planning.

Chapters 2–9 of this report elaborate on each of these mechanisms in each of the eight core countries and provide a more comprehensive picture of health coverage there. Text boxes throughout this section highlight health financing reforms implemented in reference countries, providing lessons that could be relevant to the West African context.

1.6.1 Publicly financed health services

Government-financed provision of health services exists in all study countries. While the specifics and degree of public subsidies vary across countries, governments recognize that health services are a public good. Publicly provided health services are financed using general tax revenue, other public funds, or donor funds. While the government might be considered a financing source for general tax revenue, that money ultimately comes from private households and employers who pay taxes. Governments may subsidize preventive, basic, secondary, and sometimes tertiary services, provided at public facilities or by community health workers. Box 1 describes how Malaysia's government has focused on financing public facilities to reach nearly universal coverage of basic health services throughout the country. Box 2 describes how the government of Ethiopia publicly finances essential health services, including family planning services.

Government funding to facilities allows them to operate without charging patients the full cost of providing services, unlike in a system fully financed by household out-of-pocket spending. Public financing tends to be directed to publicly owned and managed health facilities; increasingly, however, governments additionally contract with private for-profit and not-for-profit facilities to increase access. Government funding for community health workers allows citizens, particularly those in rural and underserved areas, to receive essential public health services without incurring the full direct and indirect costs of traveling to a facility.

Resources for financing of facilities are usually mobilized through several means: general tax revenue; local government budgets; taxes on alcohol, tobacco, or sugar (so-called sin taxes); or cost-recovery mechanisms such as user fees, paid by patients. Risk pooling occurs when the healthy subsidize the sick: the cost of any given patient's care is paid from funds available to the broader population. The government often does the purchasing; in some countries, however, community committees are established to have a say in how facilities spend available funds. In many low- and middle-income countries, the purchasing mechanism employed by government purchasers is *input-based financing*. This means that the government pays for inputs such as health worker salaries, commodities, and infrastructure instead of paying for outputs such as the number of services provided or number of patients treated (*output-based financing*). Togo's government, for example, employs input-based purchasing exclusively. Senegal's government purchases services at public facilities using a combination of input-based and results-based financing (which pays on the basis of outputs plus a quality assessment).

Governments often pair direct financing for health services with demand-side financing to improve equity of access to health services. User fee waivers or vouchers are two examples of pro-poor financing mechanisms that work by reducing cost sharing by poor and vulnerable households to access services. Box 3 describes a voucher mechanism in Kenya that provides targeted subsidies to poor

[c] The World Health Organization and the World Bank published a framework for monitoring progress toward UHC with input from the global community (WHO and World Bank 2014). Indicators include tracer measures of coverage of essential health services and measures of financial protection. Both categories of measures include measures of equitable distribution among the population. HFG has applied the methodology in 2 of the 15 study countries: Ethiopia and Senegal (Alebachew et al. 2014, Tine et al. 2014).

women to access family planning and other services. With a pro-poor policy objective comes the requirement for a government to ensure that subsidies benefit the needy. Though effective targeting theoretically allocates scarce resources to those in need, implementing it can be administratively challenging and therefore costly. Some governments instead provide universal subsidies for certain priority health services such as institutional deliveries and family planning commodities.

Box 1: Malaysia: Adapting health financing strategies in the face of changing demand

West African countries have demonstrated political will to adopt new—or adapt existing—health financing strategies to expand service and population coverage and increase financial protection. Governments in these countries have recently published health sector strategic plans or universal health coverage strategies that show a commitment to reviewing current evidence, identifying gaps and weakness in the health financing landscape, and addressing those gaps and weaknesses through a multi-year strategic plan.

Malaysia's experience as an upper-middle-income country with near-universal health coverage through the public health delivery system provides valuable lessons for West African countries as economies grow, health systems mature, and governments face new challenges arising from an epidemiological transition and an aging population.

Malaysia does not have a publicly managed and financed health insurance scheme. Some 95% of the cost of treatment in public facilities is financed by the government; patients pay the remainder through low user fees. The government uses general tax revenue to purchase services on behalf of the population through input-based financing. Malaysian public health facilities receive line-item budgets based on historical spending, and health care workers in these facilities are salaried civil servants. Government sources state that 90% of the Malaysian population has access to some form of care through this system (Ministry of Health Malaysia, n.d.). Use of services is reportedly high and equal across income groups, and poor and vulnerable groups do not incur high out-of-pocket spending for health services.

However, Malaysia's experience shows that UHC is never fully attained and governments must continue to implement health systems reform to meet changing needs. Malaysia is experiencing an epidemiological transition, an aging population, and increasing demand for costly and more advanced health care technology and procedures, such as renal dialysis. The government also expresses concern that the high level of subsidy encourages overuse of health services (Ministry of Health Malaysia). To maintain near-universal health coverage, the health system must become more efficient. There are reports of health services rationing in the form of long waiting times and limited availability of essential medicines at public facilities; these challenges will only worsen if resources become more constrained. Real or perceived higher quality delivered in private facilities has created a situation where wealthier people opt out of the public system. Though this trend can relieve pressure on public facilities if they treat fewer people, it also can have adverse consequences, including fragmenting service delivery and reducing equity.

West African countries can anticipate some of these same challenges as they advance toward UHC and their health systems evolve and disease burden shifts. Governments can implement legal frameworks now to enable health system reforms to address changing needs.

Box 2: Public financing for essential health services in Ethiopia

West African governments finance essential health services in part by providing input-based financing for public health facilities to pay for their provision of services, with oversight and supervision from local governments and the community. Indeed, this strategy is shared by many governments around the world.

The government of Ethiopia provides input-based financing for public health facilities across the country. Health facilities provide essential services to the local population with oversight and supervision from local governments and the community. The Essential Health Services Package for Ethiopia, published by the central government in 2005, provides guidance to local governments and health facilities on the services that must be available and provided at a minimum standard of care at public health facilities. Several family planning services are included in the package, among them promotion and advice on family planning; information, education, and counseling on family planning; provision of condoms, pills, combined pills and injectable contraceptives; provision of long-term contraceptives at health centers; and provision of permanent methods at district hospitals. The package is designed to foster an integrated service delivery approach essential for advancing the health of the population.

Input-based public financing is transferred to facilities for the provision of the Essential Health Services Package. Though patients pay user fees for some services, many of the services in the Essential Health Services Package, including services for family planning, are exempted from cost-sharing requirements.

Box 3: Kenya: Vouchers for safe motherhood, family planning, and violence recovery services

A voucher scheme in Kenya provides targeted subsidies for safe motherhood, long-term family planning methods, and gender-based violence recovery services. These subsidies benefit households as well as public and private providers. They also may be applicable in the West African context, where governments are seeking to reduce financial barriers to priority services such as family planning and to as encourage demand and quality improvements among public and private providers.

The "output-based aid voucher scheme," funded by the German Development Bank and the government of Kenya, launched in 2006. The scheme has operated in Kisumu, Kitui, Kiambu, and Kilifi counties and in Korogocho and Viwandani informal settlements in Nairobi. Safe motherhood and family planning vouchers are sold through distributors to poor women in rural districts and low-income areas of Nairobi for a highly subsidized price. The gender-based violence recovery services vouchers are provided free in accredited facilities, regardless of the patient's socio-economic status.

The output-based aid voucher scheme allows the government to mobilize private sector resources for delivery of priority health services. It also strengthens the health service delivery system by encouraging demand-side use of priority public health services with a targeted subsidy, as it provides additional revenue for providers. This revenue can be used to cover the facility's operating costs and improve quality of care. Managers at private for-profit and faith-based facilities report the additional revenue as the biggest benefit from the program. A majority reported the extra revenue improved availability of supplies, drugs, and equipment; it enhanced client comfort through the provision of meals, accommodation, and improved cleanliness. Public facility managers reported the revenue from the program as a benefit, but a majority expressed disappointment with being unable to use the funds to improve public services due to restrictive guidelines from the Ministry of Health (Njuki et al. 2015).

A secondary benefit of the output-based aid voucher scheme is that it helps the government build health sector experience in targeting, accreditation, claims, reimbursement, and quality assessment—all useful capabilities for the government's National Health Insurance Fund.

The landscape study revealed that in general, at least some family planning commodities are provided free in facilities and by community health workers receiving public financing. Ghana, for example, provides free family planning commodities and services through public and some private providers. International donors often finance such commodities, which are then distributed through the health care

delivery system. These distribution systems can do better, however, as evidenced by persistent levels of unmet need for family planning. Additionally, many government strategies acknowledge an urgent need to improve uptake of family planning and to improve health worker skills to administer certain long-acting and permanent family planning methods such as intrauterine devices and vasectomies (see Table 4).

1.6.2 Social health insurance

Social health insurance is an umbrella term for a health financing mechanism used by governments to purchase health services for members by mobilizing and pooling funds from public and private sources. Social health insurance differs from other kinds of insurance in that people contribute regular prepayments ("premiums") according to their ability to pay. As a result, wealthier people pay more into the scheme and cross-subsidize the less wealthy, in a progressive rather than regressive financing model. In addition, a social health insurance scheme, as with other health insurance schemes, pools health risks of all members. This means that healthy members subsidize the costs to care for those who are sick; all members receive the same level of financial protection against unpredictable health events, regardless of their contributions or health status. When participation in a social health insurance scheme is mandatory and membership is sufficiently large, adverse selection is minimized. [D]

Many governments plan to implement or scale up social health insurance schemes and have passed laws to this effect. Nevertheless, mobilizing the required resources to subsidize adequately even basic benefits for citizens with limited or no ability to contribute can be a challenging and much longer process (see Box 4). This is particularly true for countries with a limited tax base and a small formal sector.

For this reason, many countries focus social health insurance programs on those employed in the formal sector. Formal sector employees and their employers have greater capacity to contribute and advocate more effectively for government resources. Additionally, it is easier for a scheme to identify, enroll, and collect premiums from the formally employed. Schemes often mobilize resources through employer contributions via a payroll tax and employee contributions via mandatory payroll deductions. Contributions from employers and employees are usually a flat percentage of the employee's salary, so that people with higher salaries contribute more money in absolute terms than do people with lower salaries. However, governments that implement social health insurance first for formal sector employees may not be adhering to the *progressive universalism* concept. Unequal financial protection between the formal sector (often the wealthier households) and the rest of the population can create a cycle of inequity and higher levels of fragmentation in the health system.

Most countries in the study offer a social health insurance scheme or are planning one, although features of the schemes and their population coverage vary widely. For example, Togo's scheme covers civil servants and government retirees, Kenya's scheme covers civil servants and retirees as well as private sector workers, and Indonesia's scheme aims for a "single-payer" health system that will cover the entire population. Box 5 describes South Africa's plan to establish social health insurance. In another variation, the government may require certain populations to enroll in privately operated risk-pooling schemes. For example, a law in Senegal requires large employers to enroll their employees in *Institutions de Prévoyance Maladie* (Sickness Insurance Institutions). Chapter 8 covers this Senegal model in more detail.

[D] Adverse selection can be defined as strategic behavior by the more informed partner in a contract against the interest of the less informed partner(s) (Belli 2001). In this example, it refers to the tendency for the sick to enroll and the healthy to opt out of the social health insurance scheme.

Box 4: Ghana, Indonesia, and Nigeria: Turning commitment to UHC into reality

Enabling legislation is a first step in realizing universal health coverage. To turn political commitment into reality, countries must determine how to finance the expansion of coverage through the annual budgeting and appropriations process.

Across West Africa, governments are implementing health financing reforms in pursuit of UHC. The implementation phase involves many steps, such as setting up a stream of financing for an institute like Togo's National Institute of Health Insurance to oversee and operationalize a social health insurance scheme, or establishing a coordinating body like Niger's Federation of CBHI Schemes. Below are three examples of how governments from the study's reference countries have taken further actions beyond publishing a health sector strategy or law to implement a reform.

Family planning advocates in Ghana successfully lobbied national legislators to address access challenges by covering family planning education and services under the National Health Insurance Scheme, which includes free maternal health care. In 2012, reform legislation required inclusion of family planning services that would be determined by the Minister of Health (Naik, Morgan, and Wright 2014). However, a legal mandate for coverage expansion does not ensure effective coverage expansion. Three years later, the government had yet to provide the policy directive and implementation guidelines necessary to make family planning methods part of the National Health Insurance Scheme package in practice (IPPF 2015).

The rollout of Indonesia's ambitious single-payer system starting in 2014 is partly a result of a legal action brought by citizens to hold the government accountable for the 2004 law on the National Social Security System. That law stipulated that the government must establish non-profit bodies to implement five mandatory social insurance programs covering health care, workplace accidents, death, old-age risks, and pensions, to be funded by beneficiary contributions. By 2011, the government was criticized for delaying to transform the four state-owned insurance companies into non-profit entities. Delays motivated citizen groups to file a lawsuit and organize street protests (Hatt et al. 2015).

Nigeria's former administration successfully lobbied the Senate to pass the National Health Act of 2014, which legally established a Basic Health Care Provision Fund and other structures for expanding coverage to the informal sector and the poor under the National Health Insurance Scheme. However, the Basic Health Care Provision Fund ultimately needs to receive annual budget appropriations, which makes the Fund susceptible to changes in government and government fiscal priorities. Civil society, indeed, voiced concerns that one year after the National Health Act had been passed and a new government had come to power, the new government would not fund the Act in the 2016 government budget (Ikhuoria 2016).

1.6.3 Community-based health insurance

Community-based health insurance (CBHI) schemes were present in all of the study countries, although their presence is very small in Togo, Indonesia and Malaysia. CBHI is often included in UHC strategies in low- and middle-income countries because of its perceived comparative advantage in targeting underserved, uninsured, and largely informal-sector populations and enrolling them into risk-pooling schemes.

The CBHI model tends to be popular in countries where health system coordination mechanisms (e.g., health management information systems with high-quality patient-level data) are less developed and where social solidarity is a prominent social value. Community members volunteer to manage the schemes and undertake most of the health financing functions, including resource mobilization (from members), risk pooling, purchasing, and claim settlement. Regional, national, or parastatal agencies that are not physically located in CBHI service areas are not often well positioned to assume these functions.

Box 5: Implementing social health insurance in phases: South Africa's experience

Most governments across West Africa are engaged in or about to start implementation of social health insurance. Implementing a social health insurance scheme requires an enormous effort, including complementary health system strengthening to enhance success of the scheme. The introduction of social health insurance can also disrupt other parts of the health sector. In response to this disruption, governments must plan and manage accordingly. The government of South Africa prepared a detailed implementation plan of its health insurance scheme which illustrates the complexity of such an effort and provides helpful lessons for West African countries.

South Africa's government is in advanced preparations for reforming the health system to implement National Health Insurance, in line with its UHC strategy. The health system is currently fragmented: eighty-three Medical Schemes represent relatively small risk pools that provide financial protection against catastrophic costs. These schemes are mainly employment based. The informal sector and the poor have few options for accessing and financing health care. The government produced a green paper in 2011, which received many comments from stakeholders; subsequently, it produced a revised white paper in 2015. The detailed white paper outlines a roadmap to reform all aspects of the complex health system to align with National Health Insurance by 2025 (Department of Health 2015). The roadmap illustrates all the many moving pieces to be considered during a health system reform effort.

In phase 1, the government will establish a Transitional Fund to finance National Health Insurance start-up activities before it can start mobilizing revenue through prepayments. It will undertake various health systems strengthening initiatives such as scaling up quality improvement efforts in public clinics and hospitals, implementing a Centralized Chronic Medication Dispensing and Distribution program, and amending applicable laws. It will also develop systems and processes for a provider payment system, a patient registration system, a provider accreditation and registration system, and a fraud and risk mitigation system.

In phase 2, the government will use the Transitional Fund to purchase primary health services on behalf of enrollees. Later, the government will start purchasing hospital and emergency services on behalf of enrollees. National Health Insurance will start mobilizing resources to replenish its funds by realigning public funding that will no longer be necessary once National Health Insurance is functional, such as Compensation Funds and state subsidies to medical schemes. The government will deploy the patient registration system in public health facilities and start enrolling the population, focusing first on vulnerable groups.

In phase 3, the government will start collecting mandatory prepayments, accrediting private hospitals and specialists, and purchasing those services.

The reforms may require private medical schemes to transition their role in the health system or risk going out of business. The white paper lays out such options as creating a single virtual pooling arrangement for the schemes, having schemes transition from providing comprehensive to supplemental coverage, and hiring experts from the shrinking medical scheme industry to administer National Health Insurance.

In some countries, such as Ethiopia, Ghana, and Nigeria, the central agency running a large social health insurance scheme has oversight and management responsibility over CBHI schemes, and the CBHI schemes must operate and provide coverage according to the central agency's standards. In Mali, the Technical Union of Community Based Health Insurance launched a mobile money application with Mali's CBHI schemes, and paying premiums with mobile money is growing in popularity among enrollees (see Chapter 6). In other countries, although governments are moving to integrate CBHI schemes with government health financing initiatives, they remain only loosely or not at all coordinated with government. In Benin, the government intends to incorporate existing CBHI schemes under the *Régime d'Assurance Maladie Universelle* (Universal Health Insurance Plan).

Increasing the number of CBHI schemes may seem feasible for governments in the short term, but the model often leads to government-sponsored health financing mechanisms. For example, community members in Ghana initially volunteered to manage the schemes, but eventually they migrated into a

more professional management arrangement and the scheme managers became salaried government staff. Box 6 discusses how Ethiopia's CBHI initiative is evolving.

Box 6: How Ethiopia's CBHI initiative is evolving to incorporate regional and national risk pools

Governments across West Africa have publicly adopted CBHI as a strategy for expanding health care coverage to the indigent and informal sector workers, but many CBHI schemes in these countries are still operating with small risk pools. One trend observed in this study is governments seeking to consolidate these small risk pools to improve financial stability and gain other benefits. Ethiopia's government is engaging in such an effort now. Its experience may provide helpful lessons for other governments as they move in a similar direction.

Ethiopia's government is showing how health financing mechanisms can evolve over time to improve health coverage in pursuit of UHC. As Ethiopia's CBHI initiative matures, the government is looking for ways to improve the financial stability of the model and continue to improve access to services. As of June 2016, CBHI schemes are providing services to beneficiaries in a total of 181 districts, covering over 10 million people throughout Ethiopia (HFG 2016). Building upon the gains in coverage already achieved through rollout of district-level schemes, Ethiopia's government expects reforms to create larger regional- and national-level risk pools and expanded service coverage. While district-level CBHI schemes helped the government mobilize critical resources and target uninsured, informal sector low-income communities, these smaller schemes are exposed to financial instability due to the small size of their risk pools. Consolidating risk pools will enhance overall scheme viability by increasing cross-subsidization of risk, and enable CBHI schemes to expand access to and continuity of care at secondary and tertiary facilities.

To execute this reform initiative, the Federal Ministry of Health issued a Directive for local governments to link district-based risk pools with a regional and a national risk pool. Each region is expected to establish a regional risk pool. The Federal pool will be formed later to incorporate experience gained from the operation of regional risk pools. The regional CBHI risk pools will contract with secondary- and tertiary-level hospitals in their region. CBHI members will obtain a referral from their district facilities to receive full benefits for regional or tertiary hospital services, paid through the regional CBHI risk pool. Failure to get a proper referral would result in reduced benefits, offset by a cost-sharing requirement for the patient. The Regional CBHI pool is proposed to be funded by a fixed federal government subsidy and by a portion of the prepayments made by or on behalf of paying and indigent members mobilized by district-level CBHI schemes.

Experience also shows that resource mobilization, pooling and purchasing can be administratively challenging. Many communities struggle to fulfill these functions in a way that keeps schemes financially viable. Schemes collect prepayments from members, pool the funds, and then use the pooled funds to pay providers for services rendered. A CBHI scheme must therefore determine which services it can afford to cover based on how much it collects in prepayments from the community. Often, CBHI schemes face challenges collecting enough revenue from members to fully cover the cost of services that members will use. Instead, some governments heavily subsidize CBHI schemes and establish a minimum list of covered services, which the scheme must cover. Under this alternative arrangement, CBHI schemes can still perform the administrative functions of mobilizing prepayments from the community and paying providers, especially in remote and underserved areas which regional and national agencies would find difficult to fulfill. CBHI enrollment tends to be voluntary (or when mandatory, enrollment is not enforced by the CBHI administrators). CBHI schemes are therefore particularly vulnerable to adverse selection where disproportionate enrollment by high-risk individuals accompanies non-participation by low-risk individuals. CBHI initiatives like the one in Ethiopia may eventually evolve into larger risk pools once that transition is operationally feasible for the government. This transition could be beneficial for ensuring CBHI scheme members get financial protection for health services provided by regional or national hospitals.

1.6.4 Private health insurance

Private health insurance is a health financing mechanism present in all fifteen study countries, although its role varies from country to country. Private health insurance tends to target wealthier households and workers in the formal sector, although there are a few examples of private health insurers and private CBHI schemes targeting lower-income households or workers in the informal sector.

Private insurers offering comprehensive health care benefits are likely to target younger, wealthier, and healthier individuals and avoid people at high risk for using costly health services (a practice often referred to as "cherry picking" or "cream skimming"). In countries with low market penetration, the risk pools are also small and somewhat unstable, which further motivates private insurers to avoid potentially costly enrollees. In the absence of regulation and enforcement, the private insurance market excludes a large majority of a population.

Market penetration of private health insurance is limited across most study countries, especially the core West African countries (see Table 5). Senegal appears as an outlier in Table 5 for private health insurance penetration because *Institutions de Prévoyance Maladie* (Sickness Insurance Institutions) technically are private insurance companies. However, the government regulates them and mandates enrollment, so they more resemble social health insurance than voluntary private health insurance. A few voluntary private insurance products offered in Senegal have market penetration closer to what is observed across other study countries.

Some private companies voluntarily offer employees premium subsidies or other health benefits for private health insurance in order to attract and retain skilled people, in Kenya and Nigeria, for example. In general, however, the private health insurance model does not contribute significantly to population coverage in countries with small formal sectors. Private health insurance might also offer supplemental coverage if the formal sector is already required to contribute to a social health insurance scheme, such as the plan under South Africa's UHC roadmap. Private insurers might offer alternative coverage to a social health insurance scheme, as in Kenya, where wealthier households who prefer to access care at private facilities not covered by the mandatory social health insurance scheme purchase private health insurance.

Private insurance products tailored to meet the needs and incomes of lower-income households are uncommon in the health financing landscape in most study countries, but can still play a role. Some private CBHI schemes exist in Burkina Faso and elsewhere, but information about them is very limited in the literature. Ghana had many private CBHI schemes prior to the initiative to bring them under the government-run National Health Insurance Scheme. In Kenya, some private insurers offer health insurance products with limited benefits, lower-cost provider networks (e.g., faith-based hospitals or public facilities), and correspondingly lower premiums that target non-poor informal sector workers.

Simple, affordable health insurance products can play a role in reducing burdensome costs associated with health care (e.g., for transportation or to offset lost wages). However, unsubsidized private health insurance plans with comprehensive benefits are usually unaffordable to all except the wealthiest households.

1.6.5 Household out-of-pocket spending

Household out-of-pocket spending is the dominant financing mechanism in most of the study countries, meaning households pay providers directly for health goods and services at the time of service. The household acts as the resource mobilizer and the purchaser. Risk pooling is essentially absent, exposing the household to catastrophic health care costs. As mentioned previously, a health system that heavily relies on most households having to pay directly for their health care is economically inefficient, promotes inequity, and deters development.

Households in all countries invariably pay out of pocket for some health services or commodities, as seen even in Malaysia, where most health services are provided free or a very low cost through a strong network of public health facilities. Consumer choice is important, and consumers may choose to pay more out of pocket for services at private or non-covered providers, or for non-covered services or supplies, such as brand-name pharmaceuticals.

Table 5 shows the percentage of total health spending borne by households in each study country. Total spending for health comprises both out-of-pocket spending and prepayments for risk-pooling schemes. In countries with low levels of other health financing and risk-pooling mechanisms, out-of-pocket spending accounts for the majority of household spending, and household spending as a proportion of total health expenditure is generally quite high. The goal of UHC is not to eliminate out-of-pocket spending for health entirely, but to ensure households have adequate financial protection against catastrophic costs when someone in the household experiences a health shock.

1.7 Discussion

Pursuing UHC and universal access to family planning often requires major health financing reforms to strengthen the health care system, mobilize new sources of funding, and improve efficiency. Governments can improve equity and increase efficiency by implementing health financing mechanisms that spread risk among a large pool and protect households from catastrophic costs. Such mechanisms can also encourage households to seek care that lowers morbidity and can improve micro- and macro-economic outcomes. No country can claim to have a perfectly equitable and efficient health financing landscape. Studying how other countries have successfully made gains in equity, service coverage, and financial protection can be illuminating. Reviewing lessons learned across countries can help a government design reforms that anticipate future challenges and needs.

Nevertheless, governments face challenges mobilizing resources to expand equitable service coverage and financial protection. The study identified evidence of this in the core West African countries as well as the reference countries outside the region (Box 6 discusses the cases of Ghana, Indonesia, and Nigeria). The World Health Organization (2011) reported that none of the countries in the study that had been part of the 2001 Abuja Declaration, and therefore had committed to allocate at least 15% of government budgets to health, had reached the target 10 years later. Because governments are not funding health care at recommended levels, and because health reforms can be costly, interest is growing in mobilizing private financing. However, Table 5 shows that private sources (households, employers, domestic non-governmental agencies) are already the main financiers of health care (not to mention that government financing is mainly sourced from general tax revenue, which comes from households and industry).

Governments have opportunities to improve the efficiency and equitability of private financing by removing barriers to and implementing more-efficient health financing mechanisms. The reference countries in this study did not provide many examples of how to engage the private sector in health financing.

The path to UHC is long and evolving. Governments must continually reform the health care system to pursue better and more equitable coverage for their populations. Population needs and demands change, as illustrated in Malaysia, where the government is now seeking health system reform to introduce new (or bolster less prominent) financing mechanisms to build on the system of publicly funded health services. In South Africa, the health financing landscape that evolved under Apartheid covers some of the population well, but leaves many out. Instead of building parallel and separate systems for different populations, that government is now aiming to reform the health system to introduce national health insurance that will cover everyone. In Ethiopia, the government plans to reform the existing CBHI landscape by rolling community-level schemes into regional and national-level

risk pools, similar to how Ghana allowed CBHIs to formally become part of its National Health Insurance Scheme.

Government-subsidized programs that lack the resources to cover all citizens will by necessity or design cover a subset of them. This can undermine social solidarity and equity and potentially derail the goal of *progressive universalism*. Unequal financial protection between the formal sector (often the wealthier households) and the rest of the population can create a cycle of inequity and higher levels of fragmentation in the health system. If wealthy households are excluded or are allowed to opt out, they cannot efficiently cross-subsidize the provision of care for the poor and vulnerable. If wealthier people obtain health services at private facilities instead of the public service delivery system, the parallel service delivery systems may deliver unequal quality of care. Similarly, if a financing mechanism such as social health insurance excludes the informal sector because of operational challenges with enrollment and resource mobilization, a large proportion of the population will be left without financial protection. Furthermore, an efficient financing approach directs limited resources for subsidies to those who need them, but accomplishing this is operationally challenging.

Many countries have promoted CBHI as a strategy to cover the informal sector and poor and vulnerable populations. CBHI is popular because it is more feasible to implement health financing functions (resource mobilization, risk pooling, and purchasing) by mobilizing human resources within communities. However, CBHI schemes often have limited benefit packages and present many administration and financial stability challenges. As health systems mature, private CBHI schemes often consolidate and may provide a foundation for an expanding government-sponsored insurance program, as seen in Ghana. In another approach, Ethiopia is scaling up health insurance for rural and informal sector low-income households with district-level schemes that operate with community-based governance. CBHI may be a stepping-stone to higher levels of coverage—beginning by enrolling hard-to-reach populations, and leveraging principles of community solidarity for health, and eventually transitioning into more sustainable schemes with government oversight and subsidy. In a similar scenario, Indonesia is now consolidating district-run social insurance schemes under a national single-payer system.

Smaller-scale or more-targeted health financing mechanisms can promote equitable access to essential services. A voucher scheme in Kenya is benefitting both providers and patients. It provides additional revenue for providers, and it helps patients access family planning and gender-based violence recovery services by removing some financial barriers and encouraging them to seek care. The voucher scheme fills a gap in Kenya's health financing landscape and in Kenya's ability to ensure access to family planning services, and it complements other health financing programs such as the National Health Insurance Fund.

Ensuring universal access to family planning through UHC initiatives is critical. Most of the study countries did not mention family planning under the high-level UHC strategy document, although many have separate family planning or reproductive health strategy documents. Since UHC is an enabler of health and well-being and of economic and development gains, integration of family planning services under UHC schemes and throughout the country's health financing landscape is not only a moral imperative but also a strategic one. As donor resources for family planning decline, governments will need to replace and expand alternative financing mechanisms to reduce both unmet need and maternal, newborn, and child deaths.

Most core West African countries in this study share commonalities. Many governments envision simultaneous interventions to improve financial protection for health and pursue UHC: finance health facilities with public funds, scale up social health insurance, and encourage the establishment of CBHI schemes to contribute to population coverage of hard-to-reach populations. With relatively small formal sectors, core countries will need to dramatically grow the number of CBHI schemes in order to reach near-universal enrollment among their populations. Population coverage of CBHI and other forms of insurance is low in most core countries. Out-of-pocket spending for health services is a very large

proportion of total household spending for health, and often a large proportion of total health expenditure in the country, while household spending for health insurance is relatively small. Government allocations to health are still below the Abuja Declaration target. Financing for family planning predominantly comes from donors, although the governments manage some family planning distribution through public health facilities or other mechanisms. This study's review of health financing landscapes in all core countries reveals several opportunities for each country to expand on or introduce new health financing mechanisms that will increase coverage for health care and family planning.

The next parts of this report review in detail the health financing mechanisms and coverage of family planning in each of the eight core West African countries. For each country, the authors identify opportunities to expand coverage across the three coverage dimensions.

1.8 Sources

Alebachew, Abebe, Laurel Hatt, Matt Kukla, and Sharon Nakhimovsky. April 2014. *Universal Health Coverage Measurement in a Low-Income Context: An Ethiopian Case Study.* Report prepared by Abt Associates. Washington, DC: United States Agency for International Development, Health Finance & Governance Project.

Belli, Paolo. March 2001. *How Adverse Selection Affects the Health Insurance Market* (Policy Research Working Papers). http://dx.doi.org/10.1596/1813-9450-2574.

Department of Health, Republic of South Africa. 2015. *National Health Insurance for South Africa: Towards Universal Health Coverage. Version 40. White Paper.* Published in the Government Gazette on 11 December 2015. http://www.gov.za/sites/www.gov.za/files/39506_gon1230.pdf.

Gwatkin, D. R., and A. Ergo. 2011. Universal Health Coverage: Friend or Foe of Equity? *The Lancet* 377: 2160–2161.

Hatt, Laurel, et al. December 2015. *Rapid Analytical Review and Assessment of Health System Opportunities and Gaps in Indonesia.* Report prepared by Abt Associates. Washington, DC: United States Agency for International Development, Health Finance & Governance Project. https://www.hfgproject.org/rapid-analytical-review-assessment-health-system-opportunities-gaps-indonesia/.

Health Finance and Governance Project (HFG). 2016. News and Announcements: Empowering women through community based health insurance. Accessed October 2016 at https://www.hfgproject.org/ethiopia-empowering-women-community-based-health-insurance/.

Ikhuoria, Edwin. 2016. *Nigeria: Will the 2016 Health Budget Fund the 2014 National Health Act?* Blog post published 2 February 2016 at http://allafrica.com/stories/201602041407.html.

International Planned Parenthood Federation (IPPF). 2015. *Ghana Spotlight on Family Planning: Tracking Progress on the FP2020 Pledges.* [Brochure]. http://www.ippf.org/sites/default/files/spotlight_ghana_v301_web.pdf.

Jamison, Dean T., et al. 2013. Global Health 2035: A World Converging within a Generation. *The Lancet* 382 (9908): 1898–1955.

Kutzin, Joseph. 2013. Health Financing for Universal Coverage and Health System Performance: Concepts and Implications for Policy. *Bulletin of the World Health Organization* 91: 602-611. doi: http://dx.doi.org/10.2471/BLT.12.113985.

Ministry of Health Malaysia. No date. *Country Health Plan (2011–2015).* http://www.moh.gov.my/images/gallery/Report/Country_health.pdf.

Naik, Reshma, Lindsay Morgan, and Jenna Wright. 2014, December. The Role of Health Insurance in Family Planning (Policy Brief). Washington, DC: Population Reference Bureau. http://www.prb.org/pdf15/health-insurance-family-planning.pdf.

Njuki, Rebecca, et al. 2015. Does a Voucher Program Improve Reproductive Health Service Delivery and Access in Kenya? *BMC Health Services Research* 15:206. http://dx.doi.org/ 10.1186/s12913-015-0860-x.

Tine, Justin, Sophie Faye, Sharon Nakhimovsky, and Laurel Hatt. 2014, April. *Universal Health Coverage Measurement in a Lower-Middle-Income Context: A Senegalese Case Study.* Report prepared by Abt Associates. Washington, DC: United States Agency for International Development, Health Finance & Governance Project.

United Nations. 2000. Committee on Economic, Social and Cultural Rights. General Comment No. 14 on Article 12 of International Covenant on Economic, Social and Cultural Rights. New York: Author.

United Nations, Department of Economic and Social Affairs, Population Division. 2015. *Model-Based Estimates and Projections of Family Planning Indicators 2015.* "Unmet Need for Family Planning. Median Estimate, 2014." New York: United Nations.

United Nations General Assembly. 2015, October 21. *Transforming Our World: The 2030 Agenda for Sustainable Development.* Resolution adopted at the seventieth session by the General Assembly on 25 September 2015. http://www.un.org/ga/search/view_doc.asp?symbol=A/RES/70/1&Lang=E.

World Bank. 2016. *Universal Health Coverage (UHC) in Africa: A Framework for Action.* Washington, DC: World Bank Group. http://documents.worldbank.org/curated/en/735071472096342073/Universal-Health-Coverage-UHC-in-Africa-a-framework-for-action.

World Health Organization. 2011. *The Abuja Declaration: Ten Years On.* http://www.who.int/healthsystems/publications/abuja_declaration/en/.

World Health Organization (WHO) and World Bank. 2014. Monitoring Progress Toward Universal Health Coverage at Country and Global Levels: Framework, Measures and Targets. Geneva: WHO Press. http://apps.who.int/iris/bitstream/10665/112824/1/WHO_HIS_HIA_14.1_eng.pdf?ua=1.

ANNEX A: SELECTION MATRIX

Potential "core" countries: Countries included in the USAID West Africa Regional Development Cooperation Strategy	Selection criteria				Score
	Potential high impact country for technical assistance Weight of criterion = 3	Country is in the Ouagadougou Partnership Weight of criterion = 2	Country is a USAID family planning priority country Weight of criterion = 2	Country does not have a USAID mission Weight of criterion = 1	
Benin	3	2			**5**
Burkina Faso	3	2		1	**6**
Cameroon	3			1	**4**
Cape Verde				1	**1**
Chad				1	**1**
Cote d'Ivoire		2		1	**3**
Equatorial Guinea				1	**1**
Gabon				1	**1**
Ghana*			2		**2**
Guinea	3	2			**5**
Guinea Bissau				1	**1**
Liberia			2		**2**
Mali	3	2	2		**7**
Mauritania		2		1	**3**
Niger	3	2		1	**6**
Nigeria*			2		**2**
Sao Tome & Principe				1	**1**
Senegal	3	2	2		**7**
Sierra Leone					**0**
The Gambia				1	**1**
Togo	3	2		1	**6**
*Ghana and Nigeria are being proposed as reference countries					
Selected = 8					

Short list of potential "reference" countries	Country is in broader Africa region (to facilitate possible twinning)	Country is a USAID family planning priority country	Potential for UHC, private insurance regulation and/or family planning learnings
Bangladesh		X	High level of involvement of private sector and NGOs to deliver FP
Ethiopia	X	X	CBHI and SHI
India		X	RSBY and NHM, FP learnings
Indonesia		X	JKN
Ghana	X	X	Ghana National Health Insurance Scheme
Kenya	X	X	Well-documented UHC strategy
Malaysia			UHC strategy does not include SHI and will elucidate an alternative model
Nigeria	X	X	Experience with national health insurance and public-private partnerships
Philippines		X	PhilHealth
Rwanda	X	X	Mandatory enrollment in *mutuelles*
Nepal		X	Clear UHC vision
South Africa	X		Strong regulatory framework over private insurance
Tanzania	X	X	Single national health insurer, national RBF scheme, GFF recipient
Selected = 7			

ANNEX B: DATA COLLECTION TEMPLATE

Case Study Matrix Template

Background and Approach

The USAID West Africa Regional Health Office (WA/RHO) Mission has asked the Health Finance & Governance Project (HFG) to lead a landscape study on health financing strategies being used to pursue Universal Health Coverage (UHC). The landscape study will synthesize lessons learned and findings will inform potential interventions that are implementable in the West Africa region. The study will also review the role of private health financing in achieving UHC and assess if and how family planning is included within UHC strategies.

HFG will gather comparable information for countries selected. This template will be completed for each country using desk-based research of documents available in the public domain, key informant interviews and in-country data collection for up to five selected "focus" countries. Sources of data will include health sector strategic plans and their annual / mid-term evaluations, health financing strategies, Health Accounts, costed implementation plans for family planning, peer-reviewed journal articles, gray literature and other documents available in the public domain.

Based on data gathered, HFG will prepare succinct country snapshots on the major health financing arrangements for each country, including their coverage of family planning. Findings from the data collection will be consolidated and summarized in a 10-15 page report that will include cross-country comparisons.

Objectives

1. To identify health financing strategies that are successfully being used to move towards UHC in 15 LMICs in Africa and Asia
2. To highlight the role of private health financing within these strategies
3. To highlight the extent to which these strategies are successfully expanding FP coverage in these countries
4. To identify which of these strategies have reasonable potential for successful implementation in West African contexts, and why

Health Policies Overview: Country Context

Please review the government's current or most recent health sector policy documents. Keep responses to one paragraph, and include citations.

Health Sector Strategic Plan (or equivalent):

What are the overarching vision and goals outlined in the document? Does the document mention UHC and its three components? If so, what is the strategy for moving towards UHC? How is the role of the private sector defined in this strategy? Does the document mention increasing coverage of FP services? If so, what is the strategy for moving towards better coverage of FP? Do the plans address the needs not only of public facilities and clients, but also private service providers?

1. **Health Financing Policy (or equivalent):** What are the overarching vision and goals laid out in the policy? If applicable, are UHC and FP specified? What technical approach(es) does the policy propose to achieve UHC and/or expand FP coverage?
2. **Reproductive Health or Family Planning Policy (or equivalent):** What are the overarching vision and goals for FP laid out in the policy? If applicable, how is UHC specified?
3. **All Documents / National Health Accounts:** As available, describe what is known about household spending on health and FP. For example: what is the household share of total health spending/family planning services; what is the per capita household spending on health/family planning services; what do households pay for (e.g., premium payments, out of pocket payments for services, etc.)?

Health Sector Overview

In this section, we will describe arrangements that provide partial or comprehensive health coverage to a portion or all of the population. These arrangements may have potential for contributing to UHC in the country. Under each distinct arrangement, we will review aspects of revenue collection, risk pooling, purchasing mechanisms, program performance and equity. Revenue collection refers to how resources are raised to fund health care goods and services. Risk pooling is the function that transfers collected revenues to organizations purchasing health care goods and services. Pooling ensures that the risk of paying for health interventions is borne equitably by all the members of the pool and not by each contributor individually, to increase financial protection of those who use services. For the purchasing function, the data collection will focus on payment mechanisms used by purchasing organizations (like health insurers or governments) to purchase health goods and services, for example input-based payments, fee-for-service, capitation. Provider payment mechanisms will help the team to assess the financial sustainability of the financing arrangements used to achieve UHC.

Each financing arrangement may be funded, managed or implemented differently. Examples of financing arrangements may include: Government direct funding of health facilities, government sponsored social health insurance, community-based health insurance, private health insurance (offered through insurance companies), employer-sponsored financing for health.

Enter "NA" in the matrix if the question on the left is not applicable to the program.

Population coverage and services Identify major arrangements that aim to reduce financial barriers and expand access to more and better health services for the population, when the program started and date of any major reforms. List one program per column.		Financing arrangements Government direct funding of health facilities (including public facilities and contracted private/FBO facilities)	Private commercial health insurance	[Social health insurance scheme]	[Community-based health insurance]	[Other arrangement]
Population covered: • Who is eligible? Include key statistics such as number enrolled, others? • How are beneficiaries identified and targeted?	Poor/vulnerable. Define these groups (per program, if necessary)					
	Non-poor informal sector					
	Formal sector employees					
Benefits • Summarize main benefits • Summarize exclusions • Document family planning benefits, if any	Poor/vulnerable Define these groups (per program, if necessary)					
	Non-poor informal sector					
	Formal sector employees					

Population coverage and services		Financing arrangements				
Identify major arrangements that aim to reduce financial barriers and expand access to more and better health services for the population, when the program started and date of any major reforms. List one program per column.		**Government direct funding of health facilities (including public facilities and contracted private/FBO facilities)**	**Private commercial health insurance**	**[Social health insurance scheme]**	**[Community-based health insurance]**	**[Other arrangement]**
Service delivery • At what types of facilities are services provided, including FP services? • Can beneficiaries of government programs access private facilities? • What degree of choice/access does each program include? • What degree of choice do beneficiaries have to access FP services?						
Functions and characteristics of financing arrangements						
Resource mobilization	• From government e.g., general taxes, earmarked taxes, sin taxes, payroll taxes for formal sector workers? • From private sources, e.g., employer contributions, employer-subsidized program, beneficiary contributions? • Beneficiary cost sharing at the point of service?					

Population coverage and services		Financing arrangements				
Identify major arrangements that aim to reduce financial barriers and expand access to more and better health services for the population, when the program started and date of any major reforms. List one program per column.		**Government direct funding of health facilities (including public facilities and contracted private/FBO facilities)**	**Private commercial health insurance**	**[Social health insurance scheme]**	**[Community-based health insurance]**	**[Other arrangement]**
	• Relative percentage of national health services provided through program?					
Risk pooling	• How is risk pooling structured? E.g., is there one or multiple risk pools?					
Performance	• What are the successes and challenges of this program in contributing to UHC? • How financially viable is the program currently? • How does this program control costs (e.g., co-payments, provider payment strategies e.g., DRG or capitation, utilization reviews)?					

Population coverage and services		Financing arrangements				
Identify major arrangements that aim to reduce financial barriers and expand access to more and better health services for the population, when the program started and date of any major reforms. List one program per column.		**Government direct funding of health facilities (including public facilities and contracted private/FBO facilities)**	**Private commercial health insurance**	**[Social health insurance scheme]**	**[Community-based health insurance]**	**[Other arrangement]**
Institutional oversight	• Which entity/ agent/stakeholder manages/oversees revenue collection, pooling and purchasing? • Is there a regulatory body? • How are functions managed? • Are there known strengths & weaknesses?					
Purchasing—provider payment mechanisms	• Describe the provider payment mechanisms for outpatient health care (including preventive and promotive care and FP; consultations; diagnostics, pharmacy). • Describe the provider payment mechanisms for inpatient care.					

Population coverage and services		Financing arrangements				
Identify major arrangements that aim to reduce financial barriers and expand access to more and better health services for the population, when the program started and date of any major reforms. List one program per column.		**Government direct funding of health facilities (including public facilities and contracted private/FBO facilities)**	**Private commercial health insurance**	**[Social health insurance scheme]**	**[Community-based health insurance]**	**[Other arrangement]**
	• Are there provider incentive payments and, if so, how does this work? E.g., results-based financing, voucher programs					

Financial equity		Government direct funding of health facilities (including public facilities and contracted private/FBO facilities)	Private commercial health insurance	[Social health insurance scheme]	[Community-based health insurance]	[Other arrangement]
Subsidies for pre-payments	• Describe the program's approach to subsidies for pre-payments (i.e., premiums), if applicable. • To what extent are subsidies designed to improve equity (i.e., do the poor receive a higher subsidy than non-poor)? • Provide specific information about any separate features of subsidies covering poor and vulnerable people, the non-poor informal sector, and the formal sector.					
Financial protection at the point of care	• What is the general exposure of users of health services to out-of-pocket expenditure under this system? • Describe financial protection mechanisms for households under this system (e.g., user fee exemptions, vouchers for certain services, limits on cost sharing, etc.) How are these targeted, if at all? • Do households have to pay out of pocket for family planning benefits?					

ANNEX C: KEY INFORMANTS

Country	Name	Title	Office address	Office number	Mobile number	Email address(es)	Interviewed
Benin	Dr Toukourou Tidjani	*Présidente de la Plateforme du secteur sanitaire privé (PSSP)*	01 BP5355 Cotonou	229 65 01 40 05	229 95 33 85 20/95 95 20 66	tidjkr@yahoo.fr	Yes
Benin	Dr Dossou Gbete Lucien	*Vice Président PSSP ex Président de l'Association des cliniques privées du Bénin DG clinique Louis Pasteur Cotonou*	01 BP5355 Cotonou	229 65 01 40 05	229 95 96 38 32	luciendgl@gmail.com	Yes
Benin	Gainsi Epiphane	*PSSP*	01 BP5355 Cotonou	229 65 01 40 05	229 97 60 99 49	codgan9124@yahoo.fr	No
Benin	Mr Hugues B, M, Tchibozo	*Directeur Général adjoint de l'Agence Nationale de l'Assurance Maladie (ANAM)*	06 bp 3960 Cotonou	22997 60 11 01	229 95 45 41 25	htcourrier@yahoo.fr	Yes
Benin	Christian Marcel Lodjou	*Directeur des Partenariats Stratégiques, de la communication et de la Mobilisation des Ressources de l'Agence Nationale de l'Assurance Maladie (ANAM)*	03 BP 3245 Bénin		229 97 98 24 73	lodjou_christian@yahoo.fr	No
Benin	Dr Serge F, Hazoume	*Médecin cnseil NSIA Assurances*	08 BP 0258 TripostalCotonou	229 21 36 54 04		hazoumeserge@yahoo.fr	Yes
Benin	Mr Koto—Yérima Aboubakar	*Président du Conseil National des Structures d'Appui aux Mutuelles de Santé (CONSAMUS)*	03 BP 1151 Cotonou	229 97 84 86 47	229 95 84 37 58	kotoyerimaa@yahoo.fr	Yes
Benin	Dr A hounou D, Gaston	*Direction de la Santé de la Mère et de l'Enfant—Chef Division Planification Familiale et Santé des Adolescents et des Jeunes-Ministère de la Santé*		229 21 33 20 21	229 97 27 99 57	ahoudes2001@yahoo.fr	Yes
Benin	Justin Sossou	*Secrétaire Général Adjoint du Ministère de la Santé*			229 95 38 21 31/97193780	adanjus2014@gmail.com	
Benin	Léandre Hounhoui	*Chef Division Etudes Point Focal Comptes Nationaux de la Santé: Direction de la Programmation et de la Prospective—DPP-Ministère de la Santé*			229 96 48 57 04	leandrehounhoui@yahoo.fr	Yes

Country	Name	Title	Office address	Office number	Mobile number	Email address(es)	Interviewed
Benin	Mr Adam Tairou Yafradou	*Directecteur Général des Affaires Sociales et de la Solidarité Nationale—Ministère de la Famille*			229 67 00 96 47	yafradou@yahoo.fr	Yes
Benin	Mr Eustase Zounghan Cyrille	*Chef adjoint de la Cellule Suivi Evaluation de la DPP-Ministère de la Santé*			229 959576 97	eustcz2002@yahoo.fr	Yes
Benin	Mr Nicolas Ayedayo	*Chef de Service Bureau Budget et Comptabilité—Direction des Ressources Financières et Matériel (DRFM) Ministère de la Santé-*			229 97 11 27 88	niadjidayo@yahoo.fr	Yes
Benin	Mr Armand Yahounou	*Secrétaire Général Association des Assureurs Privés (SIG)*			229 97 47 20 75/ 95 95 15 12	armandyeh68@yahoo.fr	No
Benin	Pascal Soglohoun	*EX HFG projet USAID ANCRE*			229 97 49 12 70	psoglohoun@gmail,com	No
Burkina Faso	Dr Dipama S. Sylvain	*Directeur Général des études et des statistiques sectorielles, Ministere de la Sante*		+226 70 25 78 14		dipamas@yahoo.fr	
Burkina Faso	Dr Sanon Théophile	*Directeur de la prospective et de la planification opérationnelle*				theosan26@yahoo.fr	
Cameroon	Mr Djouldé Maina	*Chef Division Coopération*	Ministère de la Santé			mainadjoulde@yahoo.fr	No
Cameroon	Dr Cheumaga	*Directeur de la Promotion de la Santé*	Ministère de la Santé		675 37 51 97		No
Cameroon	Dr Fezeu Maurice	*Chef de la Cellule des Informations Sanitaires*	Ministère de la Santé		695 11 08 52	mauricefe@yahoo.fr	
Cameroon	Mme Djukam Germique Epouse Bouba	*Directrice de la Sécurité Sociale*	Ministère du Travail et de la Sécurité Sociale		696 87 24 29	germiqueb@yahoo.fr	No
Cameroon	Dramane Batchabi	*Protection Sociale*	Bureau International du Travail/Cameroun		655 35 00 58	batchabi@ilo.org	No
Cameroon	Mr Gaston De Foix Evina	*Chef Cellule Promotion de la Mutualité*	Ministère du Travail et de la Sécurité Sociale		696 60 05 83	gastondefoix2@yahoo.fr	No
Cameroon	Dr Matezou Jacqueline	*Coordinateur Secrétarait Technique du Comité de pilotage et de Suivi de la Mise en Oeuvre de la Politique Sectorielle de santé*	Ministère de la Santé		696 12 13 12	jumaz6@yahoo.com	No

Country	Name	Title	Office address	Office number	Mobile number	Email address(es)	Interviewed
Cameroon	Dr Okala	*Coordinateur de l'Unité de Coordination du Programme Conjoint Minsanté KfW/AFD*	Ministère de la Santé		656 40 25 05	perspectivesante2012@gmail.com	Yes
Cameroon	Mr Enandjoum Bwanga	*Coordinateur National du Projet d'Appui aux Investissements du Secteur Santé (PAIS)*	Ministère de la Santé		699 90 41 31	enandjoumbwanga@yahoo.fr	Yes
Cameroon	Mr Ngue David Emmanuel	*Directeur Technique Adjoint*	Caisse Nationale de Prévoyance Sociale (CNPS)	22 23 40 11	677 61 26 84	emmanuel.ngue@cnps.cm	No
Cameroon	Mr Otou Yves Lucien	*Chargé d'Etudes et Assistant*	Caisse Nationale de Prévoyance Sociale (CNPS)	22 23 40 11	699 77 20 43	yvesotou@gmail.com	No
Cameroon	Mr Hozier Nana	*Secrétaire Général*	Service d'Appui aux Initiatives Locales de Développement (SAILD)		99 93 17 81	hozier.nana@saild.org	Yes
Cameroon	Bernard Onambélé	*Service Clientèle*	Contrat sous gestion ASCOMA Cameroun 445, Bd du Gal de Gaulle	21 21 30 55		bernardonambele@yahoo.fr	Yes
Guinea	Dr Mohamed Faza Diallo	*Chef Service Formation et Perfectionnement*	Ministère de la Santé				No
Guinea	Dr Yéro Boye Camara	*Directeur Adjoint, Bureau de Stratégies et du Développement*	Ministère de la Santé		655 98 16 34	yeroboye@yahoo.fr	No
Guinea	Mme Aissatou Noumou Barry	*Secrétaire Générale*	DYNAM		657 97 04 15	aissatousidy@yahoo.fr	Yes
Guinea	Dr Madina Rachid	*Chef de Division SR*	Ministère de la Santé		664 25 64 70	mdinakebe@gmail.com	Yes
Guinea	Mohamed P. Sagno	*Directeur Santé*	UGAR—Activa		656 96 00 16	smohamedpeyrenamou@ugar-activa.com	Yes
Guinea	Dr Fodé Momo Cissé	*Directeur des Ressources Humaines*	Caisse Nationale de Sécurité Sociale		664 58 71 12	cissefodemomo@yahoo.fr	No
Guinea	Mr Haba Jules	*Chef Section Frais Médicaux et Pharmaceutiques*	Caisse Nationale de Sécurité Sociale		622 59 45 26	cissefodemomo@yahoo.fr	Yes

Country	Name	Title	Office address	Office number	Mobile number	Email address(es)	Interviewed
Guinea	Mr Moussa Traore	*Directeur National de l'Action Sociale*	Ministère de l'Action Sociale de la Promotion Féminine et de l'Enfance		621 54 70 56	traore592003@yahoo/fr	No
Guinea	Dr Mamady Kourouma	*Directeur National de la Santé faliliale et de Nutrition*	Ministère de la Santé		664 39 58 97	mamadykourouma@yahoo.fr	No
Guinea	Dr Yolande	*Chef d'Equipe Santé*	USAID/Guinée		664 23 36 61		No
Guinea	Dr Adzodo Mawuli	*Expert Sénior Systèmes de santé*	OMS Guinée		621 84 57 37	adzodom@who.int	No
Guinea	Dr Sékou CONDE	*Directeur National des Etablissements Hospitaliers et de Soins*	Ministère de la Santé		621 17 55 32	sekou53conde@gmail.com	No
Mali	Dr Salif Samake	*Conseiller Technique Ministère de la Santé et de l'Hygiène Publique*	Ministère de la Santé et de l'Hygiène Publique	76,111,606	76111606		No
Mali	Mme Koné Sissi Odile Dakouo	*Directrice Adjointe de la Protection Sociale et de l'Economie Solidaire*	Direction de la Protection Sociale et de l'Economie Solidaire	20237583	76111606	minjul2@yahoo.fr	No
Mali	Mamadou S. Ballo	*Coordonnateur Cellule d'Appui à la Décentralisation et à la Déconcentration*	Ministère de la Santé et de l'Hygiène Publique	20733126	76450543	balloomb@yahoo.fr	No
Mali	Sékou Oumar Tangara	*Directeur de Production*	Assurances Lafia, Hamdallaye ACI 2000	20,290,940		sekou.oumar@yahoo.fr	Yes
Mali	Mme Fadima I. Maiga	*Assistante au Service Commercial*	Assurances Lafia, Hamdallaye ACI 2000	2029040	66735328	zelpdgp@yahoo.fr	No
Mali	Saleck Ould Dah	*Advocacy &Campaign Advisor*	Save The Children, Hamdallaye ACI	20296135	96482572	saleck.dah@savethechildren.org	Yes
Mali	Mountaga Bouaré	*Directeur*	Cellule de Planification et de Statistiques SS—DS—PF	20733139	66720578	pa27mountag12debore@yahoo.fr	
Mali	Ankoundio Luc Togo	*Directeur Général*	CANAM, Bamako, Mali	44901987	66135555	togoluc52@yahoo.fr	Yes

Country	Name	Title	Office address	Office number	Mobile number	Email address(es)	Interviewed
Mali	Issa Bengaly	*1er Secrétaire Administratif*	Union Nationale de Travailleurs du Mali, Boulevard de l'Indépendance, Bamako	20222031		isbengaly@yahoo.fr	No
Mali	Issa Sissouma	*Directeur Général*	Union Technique de la Mutualité Malienne, Médina Coura, Rue 32, Bamako	20213349	66751650	sissoumaissa@yahoo.fr	Yes
Mali	Dr Marguerite Demblé Coulibaly	*Chef Division santé de la Reproduction*	Direction Nationale de la Santé, Bamako		666031245		No
Niger	Mr Galadima Abdoul. Karim Souley	*DRFM/Directeur des Ressources Financières et Matériels/ Direction Générale des Ressources/M.S.*	BP 623 Niamey	227 20 72 47 26	227 96 97 81 52/227 90 40 87 64	souleygala@yahoo.fr	Yes
Niger	Mr Djibo Garba	*directeur Directeur des Etudes et de la Programmation (DEP)/M,de la Santé*	BP 623 NIAMEY	227 20 72 47 26	96507078	djibogarba@yahoo.fr	Yes
Niger	Mme Ocquet Sakina	*chef Chef Division Etudes et Recherches/ DEP*	BP 623 NIAMEY	227 20 72 47 26	96 29 05 33	sakinahabou@yahoo.fr	Yes
Niger	mme Djibo Halima	*Division Finances*	BP 623 NIAMEY	227 20 72 47 26	90 33 73 53	halimatoudjibo@yahoo.fr	Yes
Niger	Brem Adisa Laoian	*chargé Chargé de planification suivi évaluation*	BP 623 NIAMEY	227 20 72 47 26	96960591	tchouchoumdiz@yahoo.fr	Yes
Niger	Dr Adama Kemou	*Directrice de la Santé de la Mère et de l'Enfant (DSME)*	96 96 05 91	227 20 72 47 26	90 38 23 55/98 07 69 31	kemou_adama@yahoo.fr	Yes
Niger	Aladji Abaché Chaibou	*chef Chef Division Finances /DSMI*	BP 623 NIAMEY	227 20 72 47 26	96091210	abach71@yahoo.fr	Yes
Niger	Zackor Arona	*Chef Divisio PF/DSMI*	BP 623 NIAMEY	227 20 72 47 26	96282970	razackhe@gmail/com	
Niger	Dr Souley Arzik	*chef Chef Division secteur privé au M. de la santé*	BP 623 NIAMEY	227 20 72 47 26	96210006/91585515	souleyarzik@yahoo.fr	Yes
Niger	Dr Dansono	*président Président de l'association des médecins privés du Niger-ex syndicat santé*			93 92 97 74	dansonoa@gmail.com	Yes

Country	Name	Title	Office address	Office number	Mobile number	Email address(es)	Interviewed
Niger	Mme Koffi Mariama	*ministère Ministère de la population de la promotion de la femme et de la protection de l'enfant/ interim directeur de la solidarité natinale chef division protection famille*				Mariama.cofi@yahoo.fr	Yes
Niger	mme djibrilou Bintou	*directrice Directrice de la solidarité nationale*				bintoumary@yahoo.fr	No
Niger	Mr Balo Mamadou Djibril	*Secrétaire Exécutif Comité des Assureurs du Niger*		BP 10934	227 20737731/20737730 96888123/94679745/ 93347362/90105352		Yes
Niger	Dr Moussa Fatimata	*DG Agence nigérienne pour la mutualité sociale (ANMS)*	BP 12905	Fixe bureau: 20351335	90357399/96972435	Moussafatimata3@gmail.com	Yes
Niger	Dounama Abdou	*DG du Travail*			96299592	dounamaa@yahoo.fr	Yes
Niger	IDRISSA Boubacar	*Chef Division Ministere du Travail*				Idrissaboubacar14@yahoo.fr	Yes
Niger	Mr El Hadji Idé Djermakoye	*Représentant de l'Afrique de l'Ouest francophone de la Plateforme Africaine pour la Protection Sociale (APSP) et Coordonnateur National de la Plateforme des OSC pour la Protection Sociale au NIGER (PROTECSO)*	BP 54305-00200	227 2035 11 05	91 18 70 01	protecsoniger@yahoo.fr	Yes
Niger	Mr Abdourahmane Salifou	*Conseiller Technique Ministère de la Santé*	BP 623 NIAMEY		96997363/92612300	salifou_abdramane@yahoo.fr	No
Niger	Ada Kassoum	*Directeur Mutualité Sociale/Ministere Travail*			96 89 73 58/96 87 01 48		
Niger	Noufou Insa	*Coordonnateur CAPED*			97 57 99 99	abary1@yahoo.fr	No
Niger	Samaila Mamadou	*SG ROASSN*			96 87 31 14	ondphid@yahoo.FR	No
Niger	Dr Hassan Sanda Maiga	*Conseiller principal PM chef departement santé publique population et assistance humanitaire*			98 94 80 20/ 93 94 80 20	hsmaiga@yahoo.com	Yes
Senegal	Mr Cheikh Ibra Fall	*Président Association des IPM*	Km 3,5 Bd du Centenaire de la Commune de Dakar	33 832 29 17	77 638 85 65	fallibra@orange.sn	Yes

Country	Name	Title	Office address	Office number	Mobile number	Email address(es)	Interviewed
Senegal	Mr Abdou Diagne	*Directeur Transvie*	3063 HLM Angle Mousse, Dakar	33 824 33 44	77 644 72 08	diagne.abdou@transvie.sn	Yes
Senegal	Mme Seck Marie Rose	*Responsable Bourses de Sécurité Familiale et Cartes d'égalité de chance*	Agence de la Couverture Maladie Universelle		77 871 76 24	maliloce70@yahoo.fr	No
Senegal	Mr El Hadj Abdou Aziz Fall	*Directeur PMAS*	Immeuble FT n°27731 Cité Sud Foire	33 867 38 30	774,060,022	pmassenegal@orange.sn	Yes
Senegal	Dr. Ndiambé Diagne	*Responsable Assistance médicale Mère et Enfant/ACMU*	Agence de la Couverture Maladie Universelle		77 630 13 31	ndiague@yahoo.fr	No
Senegal	Ndèye Sophiètou Guèye	*Responsable Suivi des Mutuelles de santé*	Agence de la Couverture Maladie Universelle		77 650 88 49	gsophietou@hotmail.com	No
Senegal	Oumar SY	*Alliance Secteur privé de la Santé*	Dakar Plateau		77 633 38 03	asps2014@hotmail.com	No
Senegal	Mme Mbaye Rokhaya Badiane	*Division Promotion des Mutuelles de santé*	Agence de la Couverture Maladie Universelle		77 631 39 71	khayambaye@yahoo.fr	No
Senegal	Francois P. Diop	*Chef d'Equipe R2S*	Sacré Cœur 2, Dakar		77 559 14 86	francois.diop@abtsn.com	No
Senegal	Dr Ousseynou Diop	*Responsable Couverture Maladie Universelle*	Direction Générale de la Protection Sociale et de la Solidarité Nationale		77 640 68 00		No
Senegal	Mamadou Lamine Faty	*Directeur de la Promotion et de la Protection des Personnes Handicapées*	Direction générale de l'Action Sociale		77 558 02 75	mlfaty70@yahoo.fr	No
Senegal	Mr Mamadou Ousmane Sall	*Président Union départementale de MS de Mbour*	Mbour Sénégal		77 555 60 07	mamadouousmanesall@yahoo.fr	Yes
Senegal	Cheikh A. Mbengue	*Directeur Général Agence de la Couverture Maladie Universelle*	Ngor Almadies, Dakar		77 444 77 10	chieikh.mbengue@gmail.com	No
Senegal	Demba Mame Ndiaye	*Président de l'Union Nationale des Mutuelles de santé Communautaires*	Diourbel				Yes

Country	Name	Title	Office address	Office number	Mobile number	Email address(es)	Interviewed
Senegal	Dr Aboubackry Fall	*Directeur Assurance Maladie/ACMU*	Agence de la Couverture Maladie Universelle		77 659 26 55	guelewy@gmail.com	No
Togo	Bignandi Palakimyém	*Directeur Général de la Protection Sociale—Ministère du Travail, de l'Emploi et de la Sécurité Sociale*	BP 350	228/22212947/22213260	222/998633923	adwinga@inam.tg	Yes
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