Understanding the private health sector
in Djibouti

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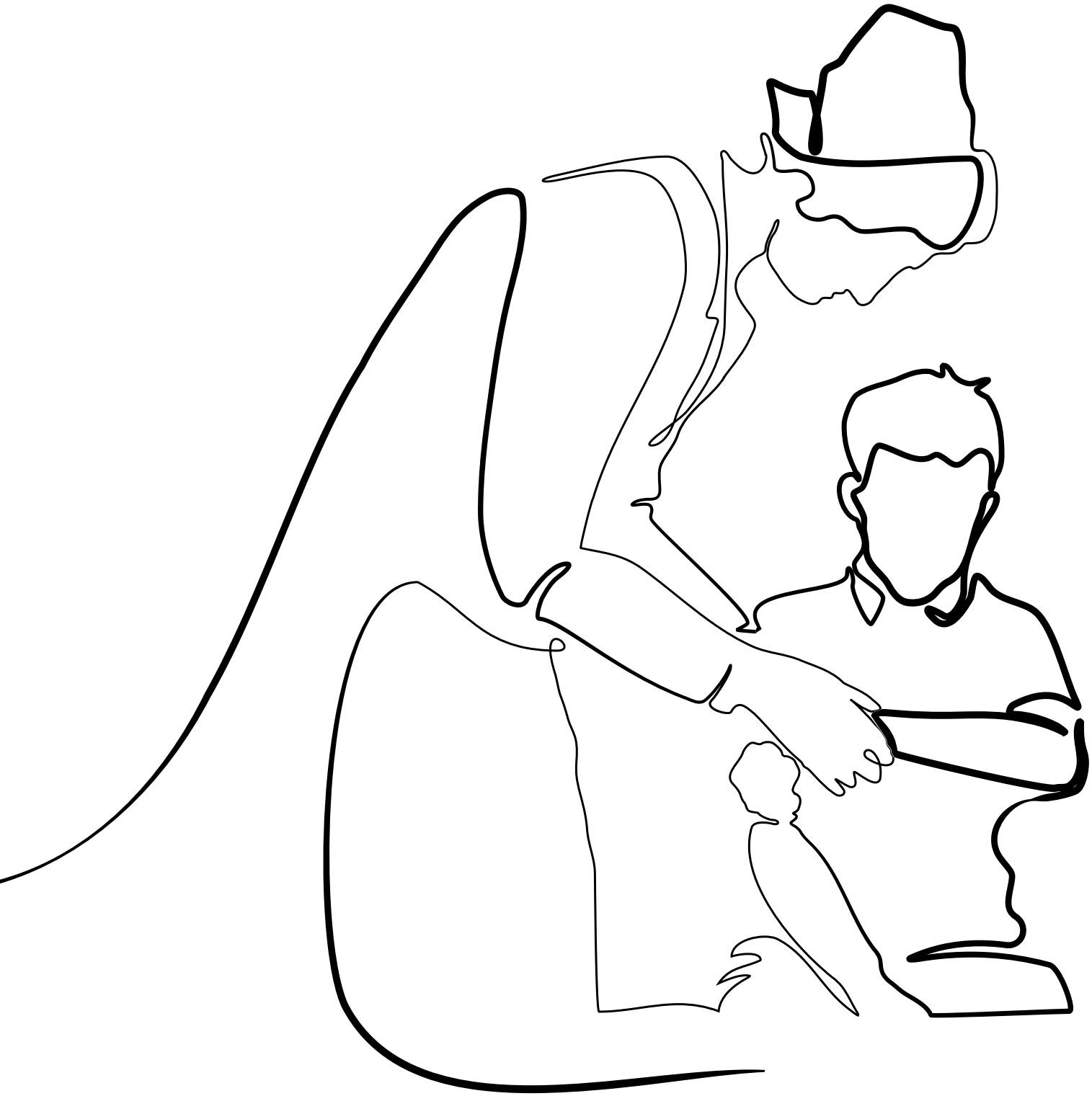

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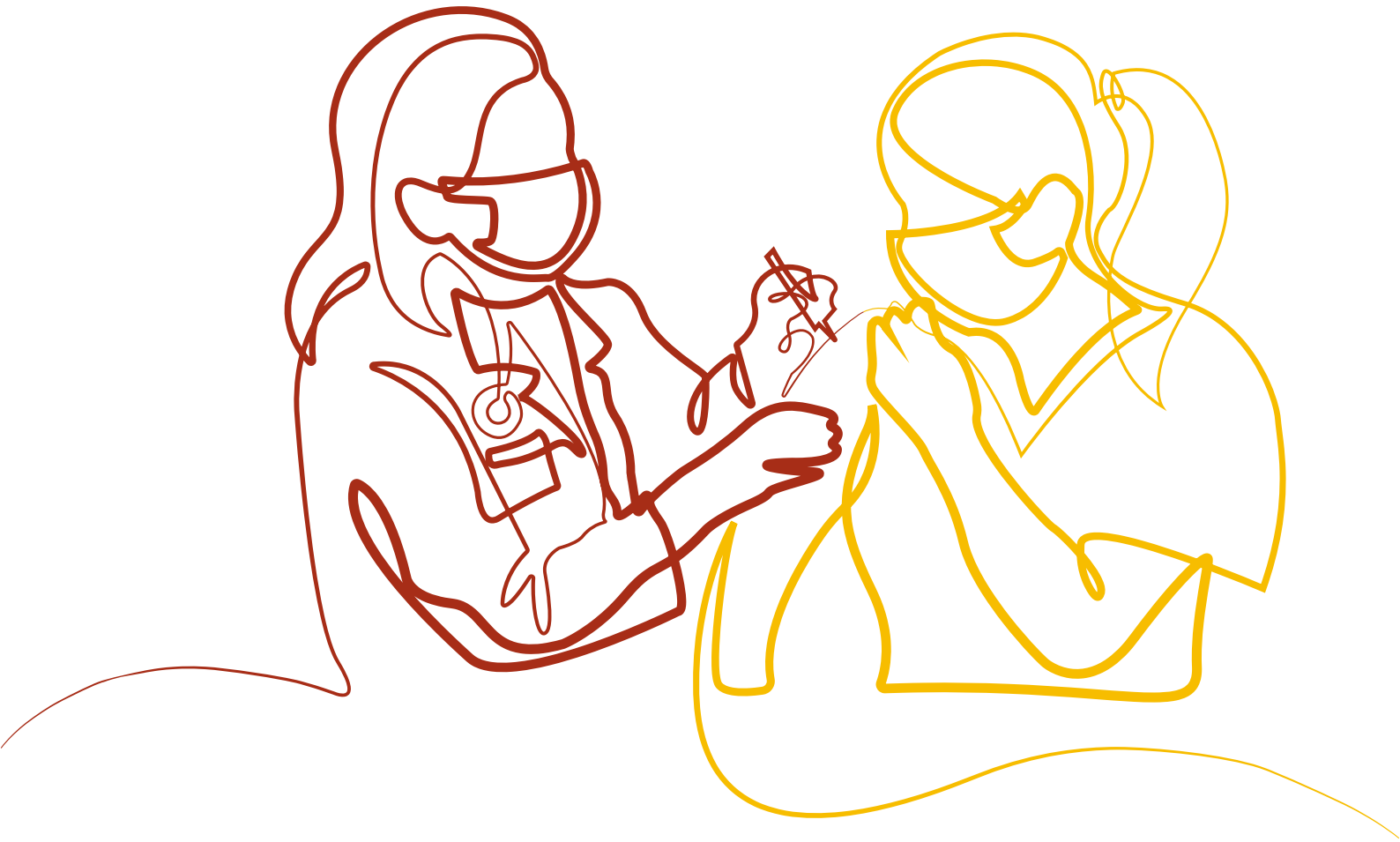


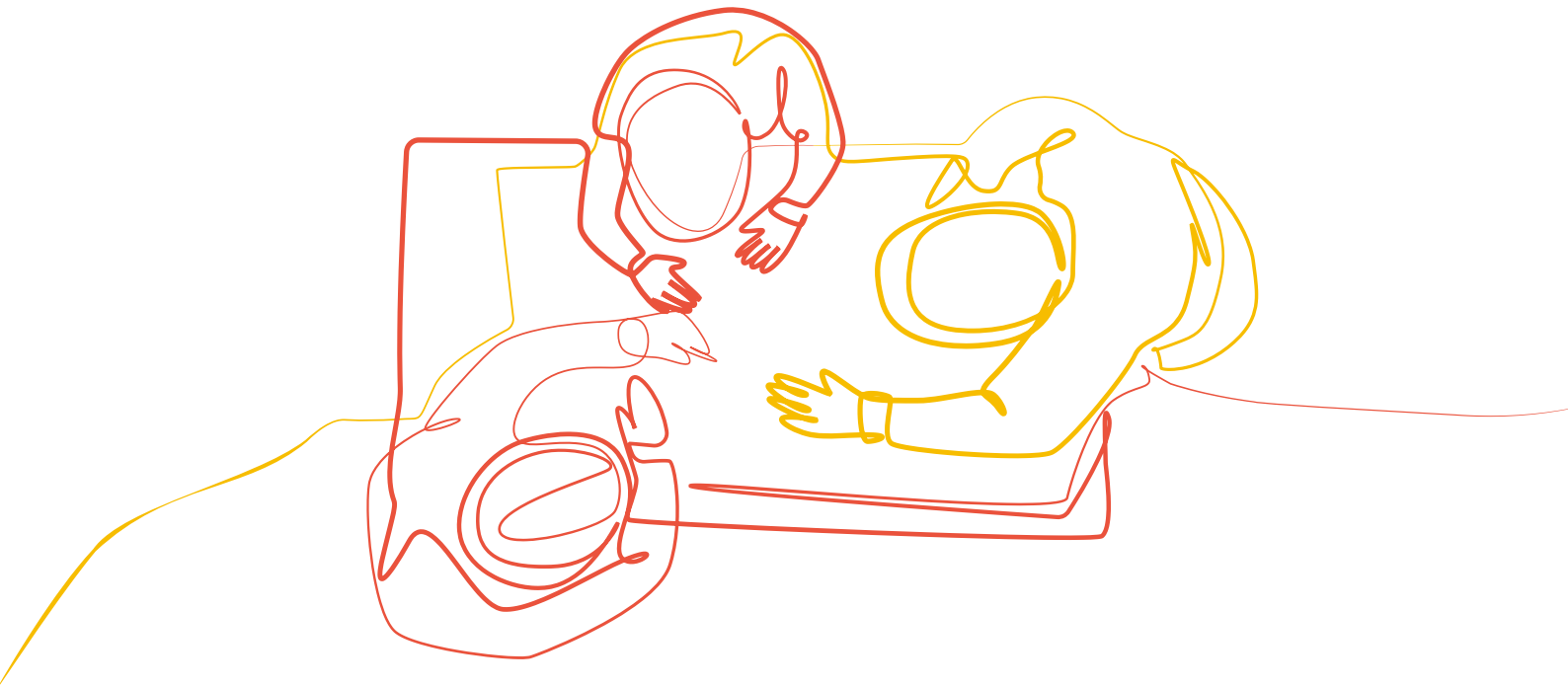
1
Country context

Djibouti is located in the north-east of the Horn of Africa on an area of 23 200 square kilometres. It shares borders in the south with Somalia, in the south and west with Ethiopia, in the north with Eritrea and in the north-east with Yemen. The population was estimated at 992 635 inhabitants in 2017, with a growth rate of 2.8% per year. The Djiboutian population is mostly Muslim (98%). It is a multi-ethnic country. The official languages of Djibouti are Arabic and French, and English is the third language. Women represent 52% of the population and men 48%. Table 1 shows key demographic characteristics *(1)*. The population is relatively young: 91% of the population is under 50 years old, with 47% under 20 years old.

Table 1: Demographic and socioeconomic indicators

Indicator	Value		
Population, 2016–2017	992 635	Male: 48%	Urban: 70.6%
		Female: 52%	Rural: 29.36%
Annual population growth (%), 2017	2.8		
Total fertility rate (births per woman), 2017	2.40		
Life expectancy at birth (years), 2018	66.60		
Literacy rate, 15–24 year olds (%)	57.46		
Population under the international poverty line (%), 2017	21.1		

Source: DISED/ RGPH 2009 – EDESIC 2015 – PAPFAM2 2012 *(2)*.



2

Health status and selected health indicators

The Djiboutian population is confronted with epidemic and endemic infectious diseases such as malaria, influenza, cholera, typhoid fever, parasitic and bacterial diarrhoea, viral hepatitis, and HIV/AIDS, with a seroprevalence of 2.9% HIV in the general population. The country has the highest prevalence of tuberculosis in the world, at 1161 cases per 100 000 population. (3). The efforts exerted by the government in the areas of immunization and health workforce augmentation, alongside the efforts of other health service providers, have contributed to improving the health indicators in the country (Table 2).

Table 2: Selected health indicators

Indicator		Value
Infant mortality (per 1000 live births), 2015		43
Maternal mortality ratio (per 100 000 live births), 2015		383
Tuberculosis case notification (per 100 000 population), 2017		1161
Morbidity	Pneumonia (%), 2015	18.12
	General malnutrition (%), 2015	13.36

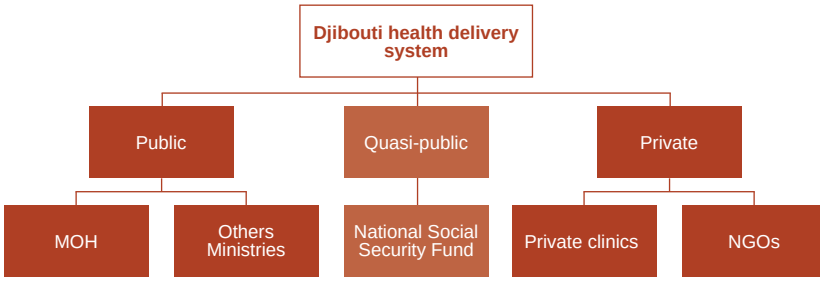
Between 2012 and 2015, an increase in noncommunicable diseases and chronic diseases, such as cardiovascular diseases, diabetes, chronic obstructive pulmonary disease and malnutrition, has been observed (accounting for 40% of admissions to General Peltier Hospital, one third of intra-hospital deaths and 12% of maternal and neonatal deaths in 2015). The general mortality of the population was 17.7 per thousand inhabitants in 2015 *(4)*. Common causes of death in adults are chronic renal failure, anaemia, respiratory disease, malaria, and polytrauma from road traffic accidents.

3

Organization and delivery of health services

In Djibouti, the health care system and health service providers can be classified into three categories: the public health sector, the quasi-public health sector and the private health sector (Figure 1).

Figure 1: Organization and delivery of health services



MOH = Ministry of Health; NGO = nongovernmental organization.

3.1 Public health sector

The public health sector is composed of two main categories of facility: Ministry of Health (MOH) facilities and health facilities operated by other ministries, such as the Ministry of Defence and the Ministry of Interior .

3.1.1 Ministry of Health

The Djiboutian health system is pyramidal (levels 1, 2 and 3). This follows the administrative division of the country.

The country is subdivided into six administrative regions: Djibouti City, Dikhil, Arta, Ali-Sabieh, Tadjourah and Obock. Each region has three or four administrative districts called administrative sub-prefectures.

The health system follows this administrative division. Each health region corresponds to an administrative region and each health division corresponds to an administrative sub-prefecture. The health system is subdivided into five health regions (plus another for Djibouti City – see below). Each of these five health regions has a local hospital located in the administrative headquarters of the region and a mobile team. Rural health centres are located in the sub-prefectures. The number of rural health centres is determined according to the region and to the number of sub-prefectures. There are 38 rural health centres, five local hospitals (33–70 beds), five mobile teams and two level 2 hospitals (one in Arta and one in Ali-Sabieh) in the five regions of the interior.

Djibouti City is considered as its own region and is subdivided into three administrative communes: Boulaos, Ras-Dika and Balballa. Fourteen urban health centres are distributed in the three administrative communes. These provisions are defined by the health map that organizes the health system.

3.1.2 Other ministries

The Ministry of Defence operates its own health facilities, which provide services to its employees. The number of health facilities is one hospital (level 3) and two family health centres. Access to the military hospital is available at a fee for civilian patients. The cost of care there is higher than in the private hospitals.

3.2 Quasi-governmental sector

The quasi-governmental sector includes only the health insurance organization under the supervision of the Ministry of Labour. The health insurance organization provides medical care to patients employed by private establishments and autonomous State bodies and to people covered by health insurance. It has a level 2 hospital with 110 beds and two health centres.

3.3 Private sector

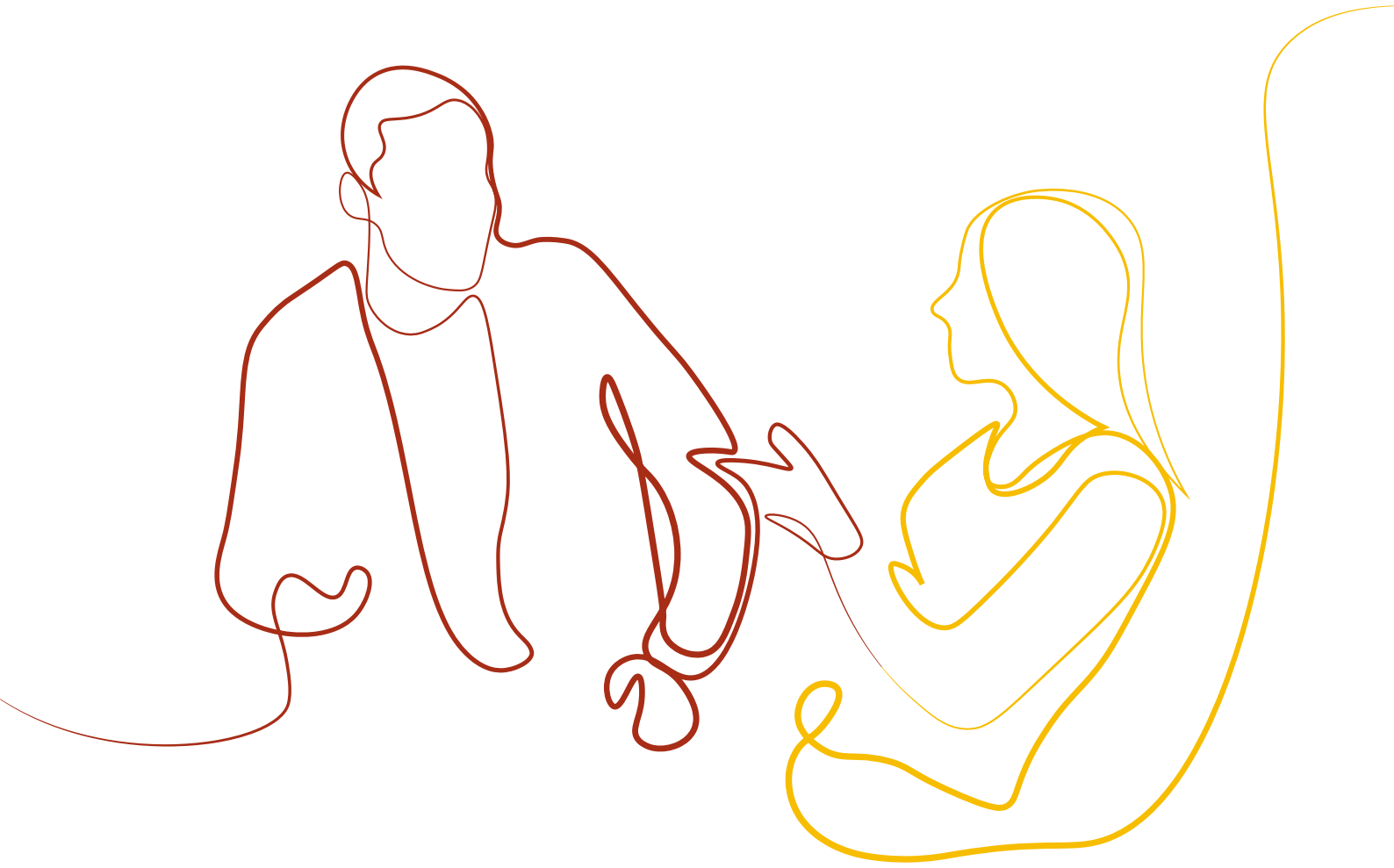
Table 3 describes the medical services provided by the private sector at various levels (primary, secondary and tertiary).

The private health sector in Djibouti is made up of commercial organizations (for profit); there are no non-profit organizations.

The private health sector has grown gradually over the past decade, in line with the pace of the country's rapid economic development. It has been boosted by the needs of private clients from foreign companies operating in the country. In addition, the establishment of a policy framework and facilitation regulation for foreign and domestic investors has contributed enormously to the development of this sector.

Private clinics for medical care and consultations are limited to Djibouti City. There are no private facilities in the other cities of the country. They are also not equally distributed in the three administrative municipalities of Djibouti City. There are 36 private health sector facilities:

- 19 private pharmacies;
- 10 private practices with general medical consultation;
- 4 small private hospitals (levels 1 and 2) offering several medical care specialties, including maternity and emergency services;
- 3 medical analysis laboratories.



4

Health sector resources

Table 3 presents data on available resources in the Djibouti health system's public and private sectors *(4).*

Table 3: Health resources by sector

Indicator	Sector	2016
Number of medical facilities	Governmental	75
	Private	15
Number of beds	Governmental	1459
	Private	140
Number of doctors	Governmental	234
	Private	35
Number of nursing staff members	Governmental	942
	Private	58

Source: MOH statistical report 2015-2016 *(4).*

Table 3 shows a huge gap in private and public sector resources. The public sector has more resources than the private sector (the public sector accounts for 92% of beds, while the private sector accounts for only 8%). The private sector does not have enough capacity to compete with the public sector.

Private clinics are concentrated in the capital Djibouti City. This concentration is justified by the fact that 58% of the national population lives in Djibouti City and by the fact that Djibouti City contributes more than 85% of the economic activities of the country.

People from other regions come to Djibouti City to buy the medication that their doctors have prescribed if this medication is not found in the community pharmacy of their local hospital. The community pharmacies of local hospitals sell generic drugs at lower cost to avoid the need for patients to incur additional transport costs in travelling to Djibouti City.

There is a need to promote private clinics and pharmacies in the main cities of the regions. The goal would be to enable the population living in the regions outside Djibouti City to access medication without incurring additional costs.

5

Health sector finance and expenditure

5.1 Health finance

Health financing is based on the contribution of several financing agents in the public and private health sectors. As described in Table 4 on the evolution of health financing, 2011–2014, in 2014 the share of the State was estimated at 82.4%, and households contributed 13.6%.

Table 4: Health financing sources

Source of funding	2011	2012	2013	2014
Source of funding	2011	2012	2013	2014
Public administration regimes (%)	82.4	85.1	81	82.4
Direct household payment (%)	14.9	14	14.8	13.6
Rest of the world / donors (%)	2.3	0.1	3.9	1.7
Private companies (%)	0.4	0.8	0.3	2.3
Total (%)	100	100	100	100

5.2 Health expenditure

Over the period 2011–2014, the share of the State budget allocated to health decreased. Indeed, health expenditure represented 8.8% of total government expenditures in 2011 and 6.96% in 2014, a decrease of 1.91 percentage points. The share of health expenditure covered by health insurance was higher in 2013 (16.54%) than in 2012 (12.52%) *(5)*.

Table 5: Health expenditures 2014–2015

Indicator	Value
Current expenditure on health (% of GDP), 2014	5.7
Out-of-pocket expenditure (% of total health expenditure), 2017	55.7
General government expenditure on health (% of expenditure), 2014	5.7
Population with catastrophic health expenditure (%), 2014	1.0
Population impoverished due to out-of-pocket health expenditure (%), 2014	11.97
Household expenditure on health (% of total health expenditure), 2014	13.64
External aid / donor expenditure on health (% of total health expenditure), 2017	2.24

GDP = gross domestic product.

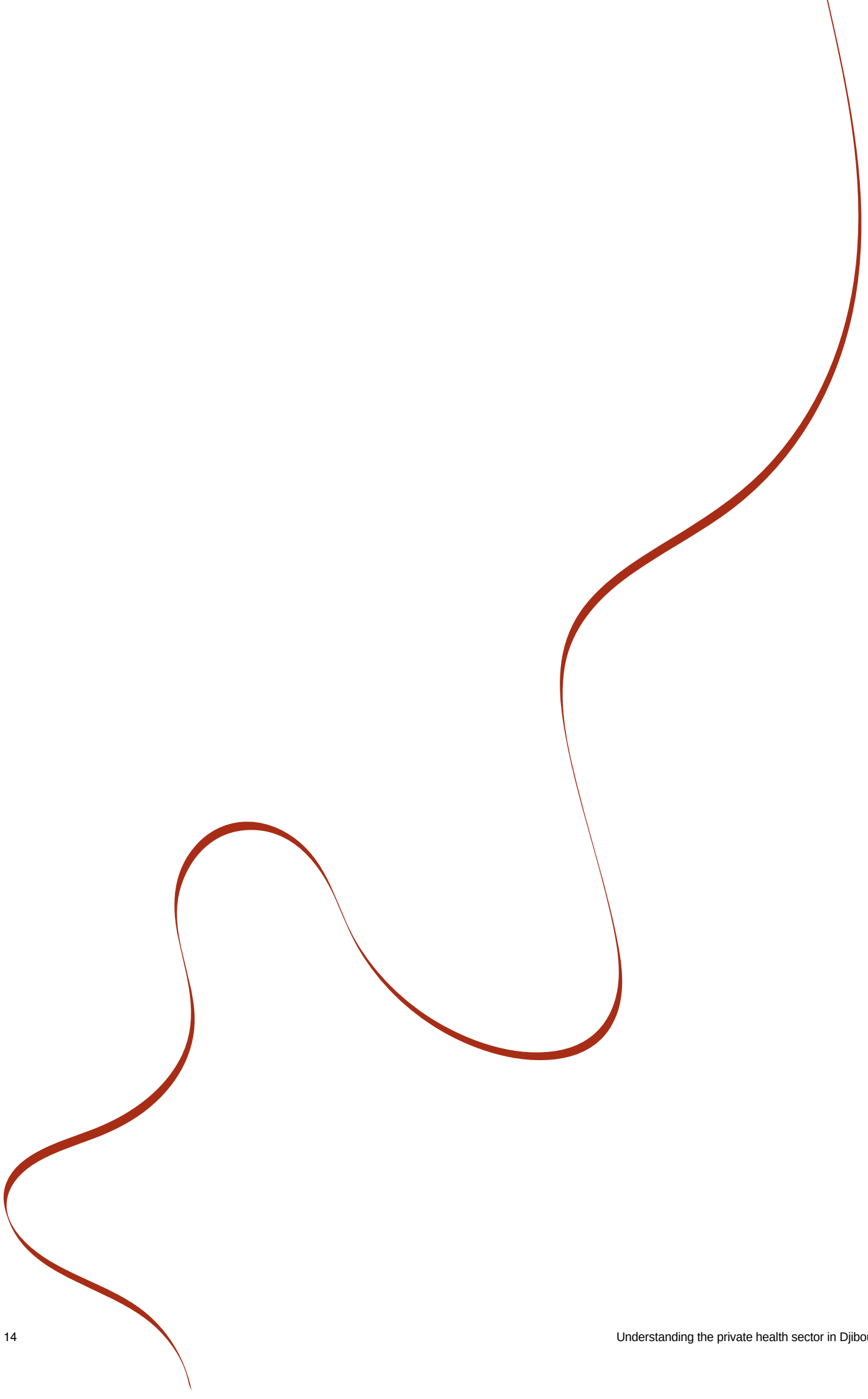
5.3 Financial accessibility

In Djibouti, there is no specific funding policy that encourages the creation of private clinics. The sources of financing of the private health sector are banks or the Development Fund department of the Secretariat of State for Investment and Private Sector Development.

Most of the clinics visited have taken long-term loans (repayment over five years) from banks. Few of them had loans from the Development Fund. But the Development Fund's conditions for granting loans are much more stringent than those of banks; for example, to open a business or clinic, the Development Fund requires that the applicant should not be a State employee (code of work) and should not have a bank loan in progress, among other conditions.

The private clinics' revenue (99%) comes from the direct payment of patients, except for the Al-Rahma Hospital, whose sources of income are the direct payment of private clients and reimbursement from public health insurance.

Poorer people do not have access to the services of private clinics, unless the clinic has a care provision contract with the public health insurance.



6

Private health sector analysis and stakeholder perspectives

6.1 Private sector growth and its determinants

In Djibouti, the participation of the private sector in health coverage is estimated at around 15%, according to the respondents to our questionnaires. The policy of facilitation of private investors is a regulation favouring entrepreneurship, which also promotes the emergence of the private health sector. This sector has developed gradually. During our study, we identified two categories of factor that assist or hinder development of the private health sector, as outlined in Table 6.

Table 6: Factors that assist or hinder development of the private health sector

Favouring factors	Barriers
▪ The facilitation policy granted to private investors in general. ▪ Overloading of public health services since the creation of universal health insurance on 21 December 2014. ▪ The needs of private cliente le from foreign companies established in the country. ▪ The increase in the number of clients who can afford private care (the wealthy and some government officials). Private health facilities offer these patients two important services: reception in a clean environment and a short waiting time (according to the patients interviewed). ▪ Lack of regulation of the private health sector.	▪ The narrowness of the market. ▪ The absence of a policy favouring the development of the private health sector (tax exemption, access to public facilities to train their health care staff, etc.). ▪ Difficulties in accessing bank credit with a low interest rate. ▪ The high cost of rent and electricity.

6.1.1 Private health sector resources

6.1.1.1 Human resource distribution

Private clinics are usually run by a doctor and a medical secretary who handles all the administrative tasks.

Training of medical and nursing staff is provided by the government. Small hospitals tend to hire public sector staff on a half-time basis in an illegal manner. For this reason, small hospitals refused to provide us with data.

Table 7: Distribution of human resources in public and private sector

Category	Government (no.)	Private (for profit) (no.)	Total national (no.)	Public sector (%)	Private sector (%)
Doctors (general)	154	12	166	92.77	7.23
Specialists	63	17	80	78.75	21.25
Dentists	17	6	23	73.91	26.09
Nurses	375	45	420	89.29	10.71
Paramedical staff	403	10	413	97.58	2.42
Technicians and midwives	164	3	167	98.20	1.80

Table 7 is a comparative overview of the distribution of human resources in the private and public sectors. The public sector has more human resources than the private sector in all categories; 92.77% of general doctors work for the public sector.

6.1.1.2 Multilateral agencies (interviews)

The various officials of the United Nations agencies unanimously believe that the establishment of a public-private partnership (PPP) framework would be beneficial to the country in achieving universal health coverage.

In addition, as part of the African Union initiative called Shared Responsibility and National Solidarity, focused on the fight against communicable diseases such as HIV/AIDS and malaria, the Joint United Nations Programme on HIV/AIDS (UNAIDS) office in Djibouti has developed a plan for mobilizing resources from the private sector. This document could be a source to identify action plans in the implementation of PPP in Djibouti.

6.1.1.3 Characteristics of the private health sector

In comparison to the public health facilities, the private health sector facilities provide a more personalized and pleasant reception for their patients.

But the majority of officials (public authorities) and the patients interviewed agreed that the cost of certain services is high and considered that some private sector clinics are further increasing their charges by performing unnecessary services. We also noted that most clinics illegally employ public sector practitioners (doctors, midwives and nurses).

During our study, we conducted a survey with 45 patients at private health facilities to understand the reason for seeking care there as well as their satisfaction from the received services. We analysed the data using Ethnos software. Results have shown that 40% of the patients go first to private facilities, except in the case of major problems, or they go to the Peltier General Hospital or abroad. The most common reason for seeking care at the private sector was staff hospitality (38%) followed by shorter waiting times (27%) and geographical proximity (13%). Most patients were satisfied with their experience at private health facilities (36%). For those who were not satisfied, the most common reason for dissatisfaction was the process of settling payments (24%) followed by the high cost of care (20%) and poor quality of services (20%)

6.2 Legal, regulatory framework and governance in the private health sector

Law No. 48/AN/99/4th L of 3 July 1999 (6) states in article 76:

> *Authorizations for the opening, creation, purchase or transfer of cabinets, pharmacies and health facilities are granted by presidential decree on the proposal of the Minister of Health, after the opinion of the National Committee of the Sanitary and Social Organization*

and the National Council of the professional order concerned. The constitution of the file of application for authorization meets the modalities established by the law and specified by the regulations.

And in article 22 of section 2:

For-profit or non-profit private health establishments hold an authorization of opening granted by presidential decree on the proposal of the minister in charge of health. The constitution of the application for authorization is determined by specific texts.

The opening conditions are defined in article 26 of Law No. 63/AN/99/4th L on hospital reform *(7)*:

1 °) responds, in the health zone considered, to the needs of the population and to the objectives defined by the health map;

2 °) satisfies the technical operating conditions, fixed by decree, relating to the quality of equipment, the number and qualification of medical and paramedical personnel and the safety of patients.

In cases of refusal of authorization or extension of the clinic, pharmacy, laboratory or hospital by the responsible authority (MOH), the applicant can appeal in accordance with article 35 of Law No. 63/AN/99/ 4th L on hospital reform *(7)*: "An appeal against the decision of authorization, or renewal of authorization, may be brought by the interested in the National Committee of Health and Social Organization and / or resort to justice."

This law also specifies that "private hospitals, for profit or humanitarian purposes, participate in the execution of the public health service under the conditions provided for by this law and that they must undertake to respect the obligations of public service imposed on public hospitals." In terms of pricing, the law specifies that clinics and private hospitals of a humanitarian nature recognized as being of public utility are subject to the pricing rules applicable to public establishments (articles 85 and 86 of Law No. 63/AN/99/4th L *(7)*).

6.3 Regulatory bodies in the health sector in Djibouti

In Djibouti, there are no specific regulations for the private health sector. However, according to the law on hospital reform, private health facilities are subject to the same rules as the public sector with regard to medical care. The private health sector facilities are less compliant with the regulations in force. This non-compliance with laws is due to the weak capacity of the government entities responsible for control and the fact that the MOH does not have enough laws to regulate all aspects of care services in the private health sector.

The General Health Inspectorate of the MOH is the only body responsible for enforcing the regulations concerning the private health sector. The protection of patients' rights is guaranteed by the laws in force in Djibouti, in particular the code of medical ethics and the criminal law.

In cases of violations on patients committed by private health sector actors, the victim may lodge a complaint with the competent court of justice (Ministry of Justice), which then seeks the technical expertise of the Inspector General of Health of the MOH and proposes sanctions if acts of medical negligence and other violations by health care providers are found to have occurred.

6.3.1 Private sector regulations

6.3.1.1 Registration, contracting and licensing private health facilities

The General Health Inspectorate of the MOH is the only body responsible for issuing licences for private health facilities (hospital, clinic or mini hospital, laboratory, pharmacy, etc.). The Inspector General of Health explained during our interview that the authorization of the licence is linked to the following conditions:

- administrative status of the applicant (certificate of registration to the national council of the relevant professional order, authorization to practise in the territory of Djibouti, project document, etc.);
- from the technical point of view, an inspection by the government of the premises, materials, safety, equipment and human resources (including their qualifications), according to the type of facility to be created.

6.3.1.2 Registration, contracting and licensing of health care professionals

Medical professionals are registered with the medical association council. This body grants the licences to all professionals (doctors and pharmacists) to exercise their profession. For a doctor or pharmacist to become the owner of a private pharmacy, they must be entered in the register of the National Order of Medical Professions.

6.3.1.3 Pricing regulation

The MOH sets the prices for care in collaboration with the Ministry of Finance and Economy. However, the care price grids have not been updated since 2009. The MOH's health inspection service, which oversees private health services, does not generally control prices. This is why it is not surprising to see different prices for the same medical intervention in private health services.

6.4 Quality, accreditation and oversight of services in the private health sector

There is no formal quality certification process or quality of care regulation and no standard for quality of services. The MOH refers to general indicators and specific indicators relating to the management of materials and equipment, business planning, and financial management.

There are no formal written documents available on standards or the quality control process. However, the low level of regulation of the

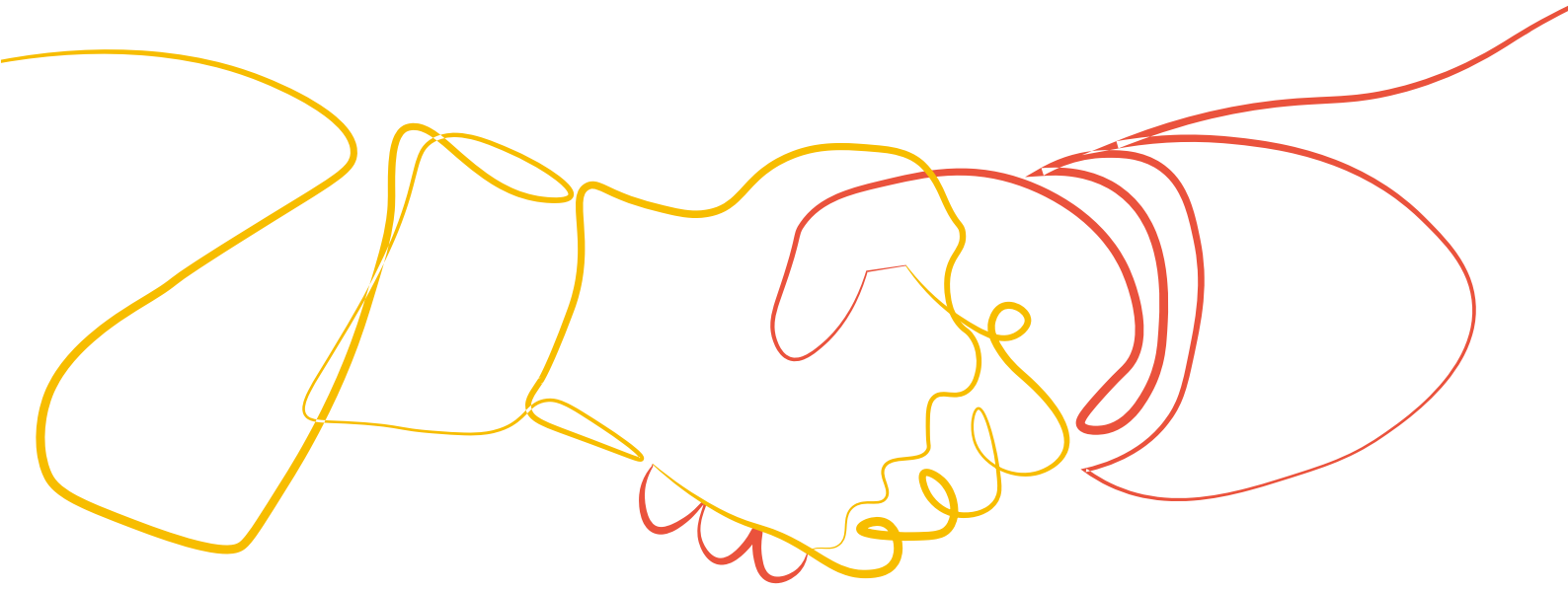
private sector provides a favourable environment for promoters in the sector. As the various laws cited in this report allow, the government authorizes the creation of private health service facilities. The department in charge is the General Inspectorate of Health of the MOH.

Also, as explained by the General Inspector of Health during our interview, there are no written documents that clearly explain the licensing process or the accreditation process. The head of the department (the General Inspector) and their staff determine the conditions and the list of documents to be required to grant the licence.

6.5 The new insurance law and the private health sector

The health insurance system provides prevention and social protection against the risks of illness. It provides basic medical coverage to the entire population living in Djibouti and establishes health insurance, which includes compulsory health insurance for workers and the social assistance programme of health for the poor.

The health insurance service draws up contracts for the provision of care with public health facilities, but not with private health facilities. Only the Egyptian NGO Al-Rahma from the private health sector has obtained a contract with public health insurance. This body provides care in the same way as public health care services. The involvement of all private clinics could reduce the overload of patients in public hospitals.



7

The legal and institutional environment for PPPs

According to the Director of the PPP Department at the Ministry of Finance and Economy (based on interview), in 2017 the government produced a document defining its PPP strategy and general policy. The document was developed following a consultative process, including a review of policies and sectoral, institutional and legal frameworks as well as discussions with the various ministries and public agencies concerned, and with the private sector, in Djibouti.

The process of developing the strategy and policy also took into account best practices used abroad in the implementation of PPP projects. This strategy and policy contribute to the implementation of the country's overall prospective planning strategy, entitled Vision Djibouti 2035.

The new law on PPPs adopted by the government in May 2017 (Law No. 186/AN/17/7th L of 29 May 2017 on public-private partnerships (8)) defines "PPP" as generally referring to forms of cooperation between public authorities and the business world to provide financing, construction, renovation, management or maintenance of public infrastructure or provision of a public service (such as the provision of health care).

The law describes the different forms of contract and the obligations of the contracting parties.

7.1 The challenges of PPP contracts in Djibouti

The World Bank and many other international institutional actors, like UNAIDS, the United Nations Development Programme, UNICEF and the United Nations Population Fund, are interested in these types of contract, which can potentially bring significant benefits for economic development as well as improve universal health coverage in a country. Naturally, some risks correspond to these benefits and must be managed by regulation. The main benefits include the introduction of private sector technology and innovation, as well as the use of the private sector's financing capacities.

7.2 The institutional framework for implementing PPPs

As described in Table 8, the law establishes an institutional framework for PPPs characterized by the separation of different functions.

Table 8: Function of PPP-related institutions

Function	Institution responsible
Operational	Contracting authority concerned, final recipient of the project
Assistance and technical support	Relevant Director in charge of PPPs at the Ministry of Finance and Economy
Pre-control	National Commission for Public Procurement
Post control	The PPP Regulatory Commission or the administrative court
Regulation	PPP Regulatory Commission

PPP = public-private partnership.

Collaborations and PPPs exist in the field of health for specific activities. An example is the construction of an HIV/AIDS prevention and communication centre in the PK12 district (Djibouti City). Actors associated with this project were the operating company Djibouti Port DP World, the MOH, the Ministry of Budget, the US Agency for International Development–FHI 360 and UNICEF. This project is a concrete example of the feasibility of a health-based PPP. The centre is yet to be operational.

The private health sector is also involved in improving health coverage, particularly health programmes All managers, experts and private sector representatives interviewed agreed that the implementation of a PPP programme could improve universal health coverage.

Areas that may be of interest to private clinics for an official collaboration are:

- supply of care (participation in medical care, health programme, etc.)
- acquisition of drugs and medical consumables
- training of medical students.

In the future, the implementation of PPP in the health sector in Djibouti is possible. But this implementation will depend on how long it takes to overcome the existing barriers at the public and private level. According to the respondents, the current barriers for PPP in the health sector in the country are:

- lack of private sector organization
- difficult access to bank credit with a low interest rate in the private sector
- lack of regulatory updates (quality control and quality assurance; standards and standardization)
- weak technical capacity of the private health sector.

7.3 SWOT analysis for private sector engagement (PSE) in the health sector

The results of the interviews and the document reviews are reflected in the following SWOT analysis, describing the opportunities, weaknesses, challenges and priorities for the implementation of PSE in Djibouti.

STRENGTHS

- Strong political commitment by the government to PPPs in general
- Creation of a private sector support department in charge of investments within the Ministry of Finance and Economy
- Functional universal health insurance structure

WEAKNESSES

- Lack of organization of the private health sector
- Difficulties accessing bank credit with a low interest rate
- Absence of regulations (quality control and quality assurance; standards and standardization)
- Weak technical capacity of the private health sector

OPPORTUNITIES

- A small country with a predominantly urban population, where there are no political or security problems
- Presence of many active international donors engaged in health system strengthening, and funds available for health system strengthening
- Continued commitment by WHO and United Nations agencies to provide technical assistance to the MOH

THREATS

- Establishment of an incentive and facilitation mechanism for the private health sector to participate actively in universal coverage in Djibouti
- Mobilization of the private health sector
- Extension of universal health insurance throughout the country and for the entire population

The five main priorities identified during our various interviews can be classified as follows:

- Political and administrative commitment. This commitment exists with the PPP law. The creation of a joint commission of the health sector (private and public) would be of great benefit.
- Development of a policy framework. The political framework is there, but the laws and regulations related to the health sector need to be updated.
- Creation of a financing mechanism dedicated to PPP.
- Scaling of best practices and new models of innovative PPPs. To do this, study tours to countries where PPP in the health sector exists and works should be undertaken.
- Development of an institutional PPP management system and strengthening of the capacity of the PPP unit.

8

Recommendations on private sector and universal health coverage

The evaluation of the private sector's participation in universal coverage provided improved understanding of the health system, the existence of internal gaps in the health sector, and the lack of collaboration between different health stakeholders, resulting in a private health sector that is left on its own, unorganized and struggling to grow.

The implementation of a health sector PPP programme must first go through steps that we consider crucial for the better functioning of PPP in Djibouti:

- reorganization of the public and private health system;
- set up of a framework for exchange and consultation;
- strengthening of management, with appropriate complementary regulatory management tools;
- regular control and monitoring of the private health sector;
- a policy favourable to the development of the private health sector.

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Annexes

Annex 1. List of participants – interviewees

Dr Saleh Banoîta Tourab, Inspector General, Ministry of Health
Mr Ali Silaye Abdallah, Technical Advisor to the Prime Minister (Former Secretary General)
Ms Fatouma Ahmed Moussa, Director of Public Private Partnership, Ministry of Economy and Finance
Dr Said Omar Moussa, Pharmacist, Manager of the Horn of Africa Pharmacy and SOM Clinic
Dr Acina, Private Clinical Pediatrician
Dr Christian Galelle, Medical House Clinic
Dr Rachid Hadji Ali, “Affi” Clinical Director
Dr Meke Mohamed Moussa, Inspector, Ministry of Health
Dr Hassan Moussa Hassan, Pharmacist Inspector, Ministry of Health
Mr Houssein Mohamed Houssein, Managing Director, General Peltier Hospital
Mrs Deka Aboubaker, Private Clinical Patient
Ms Amina Barreh, Private Clinical Patient
Mr Idriss Djama, Laboratory Assistant, “Affi” Private Clinic

Annex 2: Private health sector regulations in Djibouti

Law No. 48/AN/99/4th L of 3 July 1999, described in article 76: "Authorizations for the opening, creation, purchase or transfer of cabinets, pharmacies and health facilities are granted by presidential decree."

Law No. 63/AN/99/4th L on hospital reform:
- "1 °) responds, in the health zone considered, to the needs of the population and to the objectives defined by the health map;
- 2 °) satisfies the technical operating conditions, fixed by decree, relating to the quality of equipment, the number and qualification of medical and paramedical personnel and the safety of patients."

Law No. 186/AN/17/7th L of 29 May 2017 concerning the public-private partnership adopted by the government.

Law No. 24/AN/14/7th of 5 February 2014 establishing a universal health insurance system.