



Public-Private Partnerships in African Health Financing

Mauritius, Cameroon, Kenya, South Africa



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Public-private partnerships are becoming an increasingly important part of Africa's health-financing landscape, particularly as governments face fiscal pressure, rising demand for specialized care, and growing infrastructure needs. This chapter examines how different African countries are using PPPs to mobilize investment, expand service delivery, and strengthen manufacturing capacity while also highlighting the governance and regulatory conditions required for these partnerships to succeed.

Core exemplar

Public-private partnership models for health financing, service delivery, and pharmaceutical manufacturing across Mauritius, Cameroon, Kenya, and South Africa.

Why it matters for ALM: It shows how governments can use regulated partnerships with private actors to mobilize domestic investment, expand health-system capacity, and support universal health coverage objectives.

Primary ALM contribution: More money for health, governance and accountability, and more health for the money through investment mobilization, provider contracting, and blended-finance manufacturing partnerships.

Replicability potential Moderate to high depending on context, particularly for countries seeking to expand infrastructure, contract private providers, or develop pharmaceutical manufacturing through structured PPP frameworks.

1. Context: The Growing Role of Public-Private Partnerships in Health Financing

Across Africa, public budgets alone cannot meet the scale of need in health—especially when countries are managing debt pressure, rising NCD costs, and shocks like COVID 19. That is why many health financing analyses recommend public private partnerships (PPPs) as one tool to expand capacity, improve quality, and mobilize investment—if they are well regulated. The ALM framework treats PPPs as a cross cutting enabler, and several countries have already piloted or scaled PPP models between 2019 and 2026. In 2025, AUDA NEPAD launched the Programme for Investment and Financing in Africa's Health Sector (PIFAH)—officially launched by H.E. President William Ruto of Kenya and H.E. Mrs Nardos Bekele Thomas (CEO, AUDA NEPAD)—to provide a continental platform for structuring and coordinating health sector investment under the ALM agenda.

2. Mechanism: Four PPP Models in Practice

Mauritius (Investment-Led PPP)

The Economic Development Board's Health PPP Framework unlocked USD 150 million in domestic corporate investments (2023–2025) for hospital modernization and digital health. The Premium Investor Certificate provides preferential incentives for pharmaceutical manufacturers investing USD 11 million or more. Three new manufacturing facilities were established by late 2025.

Cameroon (Service Delivery PPP)

The April 2023 UHC Phase 1 contract with SUCAM (Société Santé Universelle Cameroun) — a private entity — to manage UHC implementation in selected regions represents a novel model where a private contractor delivers public insurance infrastructure, unique on the continent. The 2024 second-year evaluation found the PPP functional but flagged governance and transparency concerns.

Kenya (Provider Contracting PPP)

SHA's provider contracting model includes both public and private facilities, with private providers delivering publicly-financed services at SHA-determined rates. The Facility Improvement Financing Act allows public facilities to retain and reinvest SHA revenues — a quasi-PPP autonomy mechanism. The 2025 provider-payment crisis, however, highlights the downside risk when the purchaser side of the PPP underperforms on reimbursement.

South Africa/Biovac (Manufacturing PPP)

The Biovac Institute is a public-private partnership established in 2003 between the South African government and private partners. The April 2026 R1.47 billion EIB/EC/IFC investment in Biovac's multi-vaccine facility represents the continental benchmark for manufacturing-PPP blended finance, with public-offtake commitments through AVMA anchoring private-investor returns.

3. Outcomes: Expanded Investment, Service Delivery and Manufacturing Capacity

PPPs in African health financing remain early-stage and context-dependent. Mauritius demonstrates the investment-led model for upper-middle-income SIDS. Cameroon's SUCAM contract is the boldest service-delivery PPP but faces governance and transparency challenges. Kenya's provider contracting is the most scalable model but is undermined by payment delays. Biovac's 2026 expansion is the most ambitious continental manufacturing PPP. The evidence base for health PPPs in Africa remains thin — more than half of the literature relies on case studies rather than rigorous evaluations. AUDA-NEPAD's PIFAH, endorsed at the 38th AU Assembly in 2025 (Decision Assembly/AU/Dec.922(XXXVIII)), explicitly addresses this evidence gap by providing four synergistic workstreams: Resource Mobilisation and Domestic Financing Ecosystem Strengthening; Investment Structuring and Advisory; Capacity and Knowledge Empowerment; and Political Steering, Impact Measurement and Accountability.

Key Vulnerability

- **What is at risk:** Equity and value for money if PPPs are expanded faster than regulatory and purchasing capacity.
- **Why it matters (evidence):** PPPs can fail in predictable ways: profit motives can undermine equity, weakly designed contracts can allow rent extraction, and limited regulatory capacity makes contract enforcement difficult. Payment delays (as seen in Kenya's purchaser challenges) and governance concerns (as flagged in Cameroon's SUCAM model) show how quickly trust can erode when the public side underperforms.
- **What would reduce the risk:** Minimum safeguards in every PPP: independent quality accreditation, transparent pricing, ring fenced pro poor provisions, and robust dispute resolution. Egypt's purchaser-provider-regulator separation (UHIA, EHA, GAHAR) remains the strongest continental reference for building these guardrails before scaling PPPs.

4. Key Lessons and Policy Implications

- No one-size-fits-all. PPP models must be tailored to national context — investment-led for SIDS, service-delivery for fragile systems, provider-contracting for emerging insurance markets, manufacturing for industrially capable states.
- Regulation before contracting. Egypt's three-authority model (UHIA, EHA, GAHAR) demonstrates that institutional separation of purchaser, provider, and regulator is a prerequisite for effective PPP governance in health.
- PIFAH as continental coordination. The 2025 launch of PIFAH gives the ALM agenda its missing investment-structuring arm. Countries with bankable health-sector projects can now access a coordinated platform for blended finance — closing the gap identified by the 2019 ALM Declaration between political commitment and operational execution.
- Continental manufacturing as platform PPP. The PAVM/AVMA/APPM architecture provides a continental template for PPPs in pharmaceutical manufacturing that can be adapted for health service delivery.
- Transparency as non-negotiable. The governance concerns around Cameroon's SUCAM contract, and the implementation uncertainty around South Africa's NHI, underscore that PPP legitimacy depends on transparent pricing, publicly disclosed contracts, and accessible dispute resolution.

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