Combined Project Information Documents / Integrated Safeguards Datasheet (PID/ISDS)

Appraisal Stage | Date Prepared/Updated: 17-Jan-2019 | Report No: PIDISDSA25357
## BASIC INFORMATION

### A. Basic Project Data

<table>
<thead>
<tr>
<th>Country</th>
<th>Project ID</th>
<th>Project Name</th>
<th>Parent Project ID (if any)</th>
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<tbody>
<tr>
<td>Cote d'Ivoire</td>
<td>P167959</td>
<td>Strategic Purchasing and Alignment of Resources &amp; Knowledge in Health Project (SPARK-health)</td>
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<table>
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<tr>
<th>Region</th>
<th>Estimated Appraisal Date</th>
<th>Estimated Board Date</th>
<th>Practice Area (Lead)</th>
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<table>
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<tr>
<th>Financing Instrument</th>
<th>Borrower(s)</th>
<th>Implementing Agency</th>
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<tr>
<td>Investment Project Financing</td>
<td>Government of Côte d'Ivoire</td>
<td>Ministere de la Sante et de l'Hygiene Publique (MSHP)</td>
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### Proposed Development Objective(s)

To improve the utilization and quality of health services towards reducing maternal and infant mortality in Cote d'Ivoire.

### Components

- Scale-Up of Strategic Purchasing
- Health System Strengthening to Improve Performance
- Project Management
- Contingency Emergency Response

## PROJECT FINANCING DATA (US$, Millions)

### SUMMARY

<p>| | |</p>
<table>
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<tr>
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<tr>
<td>Total Project Cost</td>
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<tr>
<td>Total Financing</td>
<td>220.00</td>
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<td>of which IBRD/IDA</td>
<td>200.00</td>
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<tr>
<td>Financing Gap</td>
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### DETAILS

World Bank Group Financing
B. Introduction and Context

Country Context

1. **With a population of around 24.3 million in 2017, Cote d’Ivoire has about sixty ethnic groups and nearly seventy languages.** The country has a young population with high dependency ratios: one Ivorian out of two is under 20 years old and nearly two out of three Ivorians are under 25; women of childbearing age represent 24% of the population while 16% are children under 5 years of age. The non-national population is estimated at around 25% of the total. Independent since August 1960, Côte d’Ivoire experienced a long period of instability between 2002 and 2011, marked by two civil wars in 2002-2007 and 2010-11, which not only cost the lives of thousands of people but considerably slowed down the country’s economic development. In 2011, Gross Domestic Product (GDP) shrank by over 4%.

2. **Côte d’Ivoire (CIV) is a lower-middle income country (LMIC)** with a Gross National Income (GNI) per capita of US$1,520 in 2016¹ and is the second largest economy in West Africa. After 10 years of economic stagnation accompanying civil unrest, economic growth picked up and GDP has increased at more than 7% annually since. Since 2012, the country ranks among the top ten countries with the highest growth rate in the world (averaging 9.4% over the period 2012-2015). At 1%, inflation has been lower than the regional average and a series of structural reforms aimed at supporting business activity, accompanied by infrastructure investments to redress the impact of civil conflict, have helped to stimulate economic growth.

growth. The macroeconomic outlook remains positive, with IMF predicting growth at similar rates until 2020,\(^2\) with continued low inflation.

3. However, economic benefits remain concentrated in the capital city of Abidjan, are poorly shared, and have yet to translate into better human development outcomes. The proportion of the population living below the national poverty line in 2015 was 46.3% overall and 56.8% in rural areas. The Human Development Index (HDI) ranks Côte d’Ivoire 171 out of 187 countries, while the Human Capital Index (HCI) ranks it 149 out of the 157 countries.\(^3\) A child born in Côte d’Ivoire today will be 35 percent as productive when she grows up as she could be if she enjoyed complete education and full health. Côte d’Ivoire’s place in the human capital index is lower than predicted by its income level, and largely driven by a low adult survival rate and high stunting. The literacy rate of people over 15 is 45%: 53% for men and 36% for women. Côte d’Ivoire is among the 36 countries described as "fragile" by the World Bank in 2017.

4. The economy is strongly dependent on the production and export of primary agricultural products, particularly cocoa, but also coffee, bananas and tobacco. Côte d’Ivoire is also a net exporter of oil. Robust prices for the agricultural exports contributed to strong growth and government revenues to 2016, but the price of the dominant export, cocoa, fell in 2017 bringing some fiscal and macroeconomic problems. In 2017, the Budget deficit reached 4.2% and the deficit in the external current account reached 2.1% of GDP.

5. Government revenues and expenditures have been steadily increasing in line with economic growth but remain below regional and lower-middle income country averages. Despite economic growth, the government’s capacity to raise and spend tax revenue remains limited. Government revenue is at 19% of GDP (tax-to-GDP ratio is lower at 15%), and government expenditure is at 23% of GDP, lower than sub-Saharan African and lower-middle income averages. Overall tax revenue collection has increased with an average rate of 12% every year, largely due to strong economic recovery post-conflict, despite a drop in the corporate tax rate from 35% to 25%. Up to 35% of Côte d’Ivoire’s economy is in the informal sector, close to the ECOWAS average and 6% of GDP is lost annually to illicit financial flows.\(^4\) A recent fiscal space analysis by UNICEF suggests various recommendations, including widening the tax base, improving the efficiency of administration, rationalizing tax legislation through reducing exemptions, and increasing tax revenues through modifying tax rates. Adherence rates may also be improved by streamlining the different taxes imposed on individuals and corporations.

6. Within the existing fiscal space, social spending is not prioritized, and health spending has remained at about 5% of general government spending, well below the Abuja target of 15%. About 23% of the government’s annual budget goes to servicing debt, and the health sector receives a significantly lower budget than education and infrastructure. An analysis of public expenditures from 2014-2018 shows that about 34% of all expenditures are pro-poor, with the health sector being the second most pro-poor sector in absolute terms, after education. Health spending has grown slower than other public-sector


\(^3\) http://databank.worldbank.org/data/download/hci/HCI_2pager_CIV.pdf

\(^4\) Global Financial Integrity, Average Annual Illicit Financial Outflows by country, 2004-2013
spending. The government has also been spending on reconstruction of health facilities after the conflict, for tertiary facilities, with a total construction and rehabilitation budget of 739 billion FCFA ($1.34 billion) from 2018 to 2020 targeting health facilities at all levels, but with a strong focus on secondary and tertiary care in urban areas as well as training institutions.

Sectoral and Institutional Context

Health Status

7. The conflicts of 2002-2007 and 2010-2011 exacerbated health system challenges in terms of equity, access and quality, leading to poor outcomes including low life expectancy and high infant and maternal mortality. Historically, the Ivorian health system has concentrated services in urban areas with a focus on curative care, with especially the Northern region lagging. During the conflict, funding for the health sector from external funding sources was predominantly for vertical programs and short-term activities, with little health system strengthening activities\(^5\) and the Ministry of Health continued to suffer from a lack of financial and political empowerment. During the conflict of 2010-11, the supply chain was seriously disrupted, almost all hospitals were closed due to looting or occupation, and 800,000 people were internally displaced with more than 70% of the population lacking access to health services.\(^6\)

8. Despite its middle-income status, Cote d’Ivoire’s epidemiological profile remains comparable to low-income countries, and health outcomes are amongst the poorest in the region and globally. Communicable, maternal, neonatal and nutritional diseases are the leading causes of disability and death, representing 62% of the disease burden\(^7\). Increasing prosperity, rising urbanization and an increase in unhealthy lifestyles, has led to a rise in the burden of non-communicable diseases, resulting in a dual burden of disease taxing an already fragile health system. Cote d’Ivoire did not achieve any of the health-related Millennium Development Goals (MDGs)\(^8\), nor any of the health targets set out in the previous National Health Development plan (PNDS, 2012-2015)\(^9\) and is off track to achieve the targets set in the current PNDS (2016-2020). When ranked next to other LMICs West African countries (Table 1), it consistently ranks as one of the worst performers for key indicators including life expectancy, HIV-prevalence, and maternal and under-5 mortality, despite being near the top with respect to Total Health Expenditure (THE). Cote d’Ivoire lags regional countries, sub-Saharan African country averages and low-income country averages in terms of access to the most essential treatment and prevention services and is below the lower-middle income country average for all indicators except for ARV coverage. Notably,


\(^7\) Source: Institute for Health Metrics and Evaluation (2018)

\(^8\) Source: MDG report 2015: Assessing Progress in Africa toward the Millennium Development Goals

The contraceptive prevalence rate is at 18% and skilled birth attendance is at 59%, amongst the lowest in West African countries.

Table 1: Comparison of health indicators across LMIC west African countries, 2016

<table>
<thead>
<tr>
<th>Country</th>
<th>Total Health Expenditure (THE) per capita (US$), 2015</th>
<th>Life expectancy at birth (years)</th>
<th>HIV-Prévalence</th>
<th>Incidence of Malaria (per 1,000 population at risk), 2015</th>
<th>Under-5 death rate (per 1,000 live births)</th>
<th>Maternal mortality ratio (per 100,000 live births), 2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Benin</td>
<td>31.3</td>
<td>60.9</td>
<td>1.0</td>
<td>293.7</td>
<td>97.6</td>
<td>405</td>
</tr>
<tr>
<td>Burkina Faso</td>
<td>33.4</td>
<td>60.4</td>
<td>0.8</td>
<td>389.2</td>
<td>84.6</td>
<td>371</td>
</tr>
<tr>
<td>Cameroon</td>
<td>63.6</td>
<td>58.1</td>
<td>3.8</td>
<td>264.2</td>
<td>79.7</td>
<td>596</td>
</tr>
<tr>
<td>Cote d’Ivoire</td>
<td>75.4</td>
<td>53.6</td>
<td>2.7</td>
<td>348.8</td>
<td>91.8</td>
<td>645</td>
</tr>
<tr>
<td>Ghana</td>
<td>79.6</td>
<td>62.7</td>
<td>1.6</td>
<td>266.4</td>
<td>58.8</td>
<td>319</td>
</tr>
<tr>
<td>Guinea</td>
<td>25.1</td>
<td>60.0</td>
<td>1.5</td>
<td>367.8</td>
<td>89.7</td>
<td>679</td>
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<tr>
<td>Liberia</td>
<td>69.3</td>
<td>62.5</td>
<td>1.6</td>
<td>246.2</td>
<td>67.4</td>
<td>725</td>
</tr>
<tr>
<td>Mali</td>
<td>42.3</td>
<td>58.0</td>
<td>1.5</td>
<td>448.6</td>
<td>110.6</td>
<td>587</td>
</tr>
<tr>
<td>Mauritania</td>
<td>53.6</td>
<td>63.2</td>
<td>0.5</td>
<td>74.2</td>
<td>81.4</td>
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<tr>
<td>Nigeria</td>
<td>97.3</td>
<td>53.4</td>
<td>2.9</td>
<td>380.8</td>
<td>104.3</td>
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<tr>
<td>Senegal</td>
<td>36.1</td>
<td>67.1</td>
<td>0.4</td>
<td>97.6</td>
<td>47.1</td>
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<tr>
<td>SSA</td>
<td>84.9</td>
<td>60.4</td>
<td>4.3</td>
<td>234.3</td>
<td>78.3</td>
<td>547</td>
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Table 2: UHC Index Indicators for West African Countries, 2016 (all units in percentages)

<table>
<thead>
<tr>
<th>Country</th>
<th>Treatment</th>
<th>Prevention</th>
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<tbody>
<tr>
<td></td>
<td>ARV</td>
<td>TB</td>
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<tr>
<td>Benin</td>
<td>57</td>
<td>55</td>
</tr>
<tr>
<td>Burkina Faso</td>
<td>60</td>
<td>47</td>
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<tr>
<td>Cote d’Ivoire</td>
<td>41</td>
<td>49</td>
</tr>
<tr>
<td>Cameroon</td>
<td>37</td>
<td>45</td>
</tr>
<tr>
<td>Ghana</td>
<td>34</td>
<td>28</td>
</tr>
<tr>
<td>Guinea</td>
<td>35</td>
<td>46</td>
</tr>
<tr>
<td>Liberia</td>
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<td>32</td>
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<tr>
<td>Mali</td>
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<td>52</td>
</tr>
<tr>
<td>Niger</td>
<td>32</td>
<td>44</td>
</tr>
<tr>
<td>Nigeria</td>
<td>30</td>
<td>18</td>
</tr>
<tr>
<td>Senegal</td>
<td>52</td>
<td>55</td>
</tr>
<tr>
<td>Sierra Leone</td>
<td>26</td>
<td>47</td>
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9. **Cote d’Ivoire’s maternal mortality ratio (MMR) of 645 deaths per 100,000 live births is among the highest in the world (figure 1).** It ranks 173 out of 179 countries on the mother’s index\(^{10}\), lagging countries like Chad, Benin and the Republic of Congo. Maternal deaths in Cote d’Ivoire are driven by preventable and treatable complications, including hemorrhage (36%); obstructed labor (20%), eclampsia (18%), abortion-related complications (15%) and post-partum infections (4.8%).\(^{11}\) The high prevalence of teenage pregnancies (30%) is particularly concerning\(^{12}\), and accounts for 14.8% of maternal deaths. Almost all (80%) maternal deaths occur due to direct medical causes\(^{13}\), reflecting a lack of coverage and poor quality of obstetric care in the prevention and management of complications during pregnancy, childbirth and postpartum. Only 51% of women attended 4 antenatal visits (ANC 4) during pregnancy (2016), 73.6% of women delivered in the presence of skilled birth attendants (2016) and 83.1% of women are seen by a healthcare professional during the postnatal period\(^{14}\). Even though skilled birth deliveries are high according to administrative data, coverage of ANC4 is at 30% and postpartum checkups is at 22%, indicating the inability of the health system to retain women within the health system once they seek care (figure 2).

<table>
<thead>
<tr>
<th>Lower middle-income average</th>
<th>38</th>
<th>56</th>
<th>49</th>
<th>79</th>
<th>86</th>
<th>83</th>
<th>60</th>
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<tr>
<td>Sub-Saharan African average</td>
<td>45</td>
<td>44</td>
<td>31</td>
<td>64</td>
<td>79</td>
<td>73</td>
<td>35</td>
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**Figure 1. Maternal Mortality in Cote d’Ivoire and Francophone West Africa**

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\(^{10}\) State of the World’s Mothers. 2015. Save the Children.” Indicators of the 2013 mother’s index include (a) lifetime risk of maternal death, (b) under-5 mortality rate, (c) expected years of formal education, (d) gross national income per capita, and (e) participation of women in national government

\(^{11}\) UNFPA, 2017

\(^{12}\) Teenagers pregnancy classified as women pregnant between the ages of 15-19 years.

\(^{13}\) Direct causes include: hemorrhage, obstructed labor, high blood pressure, and abortion complications;

\(^{14}\) MICS 2016
Figure 2: ANC1, ANC4, Skilled delivery and postnatal care coverage rates in Cote d’Ivoire by Region, 2017

Source: WDI, 2017

15 RASS 2017
10. **The high maternal mortality ratio is associated with insufficient coverage of obstetric care, insufficient prevention and management of complications during pregnancy, childbirth and postpartum, and inadequate nutritional care.** The practice of caesarean section is low with a rate of 0.61% compared to the minimum 5% recommended by the WHO. Only 11 out of 100 hospitals (10%) currently offer the complete EmONC package and 18 of the 412 primary care facilities (4%) offer BeMONC. The BeMONC functions least practiced in Côte d’Ivoire are assisted delivery by suction cup (14%) and resuscitation of the newborn (39%).

11. **Lack of access to services contributes to maternal mortality.** In the richest quintile, 95% of women give birth with the assistance of qualified health personnel, compared to 49% of women in the poorest quintile. Seventy-five percent (75%) of women in the poorest quintile indicated that lack of money was a major impediment to maternity care, compared to 55% of women in the richest quintile. Long distances from the nearest facility and weak referral systems also pose a barrier, with 33% of the population living outside a 5-kilometer radius from a health facility, and only 0.22 ambulances per health facility.

12. **One in every ten children in CIV died before the age of five (96 deaths per 1000 live births) and a third of children were stunted (30%) in 2016.** Malnutrition is the primary cause of immunodeficiency in the world, and malnourished children are more susceptible to other infectious diseases (diarrhea, pneumonia, malaria, measles), and less responsive to immunizations. Furthermore, moderate and severe stunting in children increases the risk of death by 1.6 and 4.1 times, respectively. While deaths in children under-five, infants (66 per 1000 live births) and neonates (33 per 1000 live births) have declined by 28%, 26% and 19% since 2005, they remain high (figure 3). More than half of these deaths (60%) are due to preventable and treatable communicable diseases and perinatal causes, with the cause of deaths in children under-five including malaria (25%), pneumonia (15%), diarrhea (9%), premature births (13%) and asphyxia (10%). Immunization coverage remains lower than peer countries, with only 40% of infants fully immunized.

**Figure 3. Neonatal, Infant and under-5 Mortality rate trends in Côte d’Ivoire**

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16 UNFPA 2017
17 MICS 2016
18 DHS 2012
19 RASS 2017
20 Chronic malnutrition defined as height-for-age less than minus two scores below the median of the WHO child growth standards.
22 MICS 2016
23 MICS 2016
13. **Country averages mask large regional disparities**, with significantly worse indicators in the northern and western regions of the country. Regional disparities in child mortality are virtually the same regardless of target, with all three measures higher in the northern, western and central parts of the country. Child mortality is also higher in rural than in urban areas. The gap in mortality rates between rural and urban areas increases as the age group under consideration increases. Thus, rates in rural areas are 5 points (per thousand) higher for neonates, 16 points higher for infants, and 25 points higher for children under-5 years.

14. **Without a rapid fertility transition, CIV will not reap a demographic dividend.** The total fertility rate (TFR) has declined since 1990 (From 6.6 children per women to 4.6 in 2016) but remains high. The persistently high fertility rate has contributed to CIV’s high annual population growth rate of 2.6%, a low worker to dependent ratio of 1.25, which is less than half of that seen in emerging economies. The high fertility rate is due to a low contraceptive rate coverage which has only slightly increased over the last 20 years: from 7% in 1994, to 14% in 2012, to 16% in 2016. 31% of contraceptive needs among women are not satisfied by modern methods of contraception, which leads to early pregnancies (25% of girls aged 20-24 years gave birth before the age of 18), mistimed pregnancies, and high lifetime fertility.

**Health System Challenges**

15. **Low quality of care poses a significant problem.** According to IHME’s Healthcare Access and Quality (HAQ) index, Cote d’Ivoire ranks 187 out of 195 countries in terms of quality, as measured by the prevalence of amenable mortality, i.e. deaths that should not be occurring in the presence of effective care. With 51,029 excess deaths in 2015, 29,117 of which were due to poor quality of care and 21,912 due to non-utilization, Cote d’Ivoire has among the highest prevalence of amenable mortality in sub-Saharan Africa; and Cote d’Ivoire’s rate of 128 deaths per 100,000 due to poor quality is higher than most West African including poorer countries such as Liberia.

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16. **Poor quality leads to suboptimal care.** 23% of women do not get their blood pressure, blood or urine tested during pregnancy\(^{26}\), indicating that even though ANC visits may be common, high quality ANC visits are less so and significantly less common for the poorest and those living in rural areas. Cote d’Ivoire also fares poorly in terms of the availability of essential inputs: average operational capacity at all levels of health facilities is 57%, with only 22% of facilities having all the required items for infection prevention. Main issues identified with structural quality are management of blood transfusion (only 5% at primary care level); interruptions in supply chains leading to stock-outs; and data and management capacity.\(^{27}\) An estimated 87% of the population has experienced at least one stock-out of medicines in the past year, with 53% having experienced multiple stock-outs. These lead to low utilization (only 48% of the population has sought care from any health facility in the past year) and low satisfaction (39% of the population rated health service quality as “bad” or “very bad,” with those living in rural areas rating quality considerably worse\(^{28}\)). Health is among top concerns for Ivoirians, ranking second, only behind unemployment.\(^{29}\)

17. **Weak infrastructure and unavailability of drugs and medical equipment are important challenges, especially for maternal and child health.** 45% of primary and secondary facilities are without electricity; 35% without water; and 32% without both water and electricity.\(^{30}\) For maternal health, low service availability is also a significant concern: although ANC was offered in 90% of health facilities in 2015, only 45% of staff was trained on the right protocols, 36% of facilities had directives available, 12% had hemoglobin test and 36% had protein urea test.\(^{31}\) For deliveries, not a single health facility had all the 21 tracer indicators for basic obstetric care, and availability for treatment of delivery-related complications was reported at a much more limited rate. Only 33% of facilities had treatment for sepsis available, 21% offered neonatal resuscitation, and 62% of facilities monitored and managed labor using a partograph. 37% of facilities had guidelines for deliveries available, 42% of staff were trained in essential delivery care; and 54% of providers were trained in the latest national obstetric guidelines. In terms of child health, only 34% of facilities have staff trained in neonatal resuscitation and 42% on the latest guidelines for child health, and there were significant stock-outs for key commodities such as zinc and vitamin A, as well as low rate of growth monitoring. Across the board, stock-outs of essential medicines posed a significant challenge (table 3). In addition, Cote d’Ivoire experiences persistent stockouts of modern contraceptives methods: male condoms and oral contraceptive pills are the most used methods in the country and yet 74% of facilities were experiencing a stockout of condoms and 42% were experiencing stock out of contraceptive pills on the day of their most recent assessment; among all service delivery points surveyed, only 4.2% had all methods in stock (UNFPA 2017).

![Table 3: Availability of selected essential medications across health facilities (SARA 2015)](#)

<table>
<thead>
<tr>
<th>Category</th>
<th>Availability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ampicillin powder for injection</td>
<td>38%</td>
</tr>
</tbody>
</table>

\(^{26}\) MICS 2016  
\(^{27}\) Service Availability and Readiness Assessment (SARA) 2015  
\(^{28}\) Afrobarometer, 2017  
\(^{29}\) Afrobarometer 2017  
\(^{30}\) PRSSE 2017  
\(^{31}\) All figures in this section come from the SARA 2015
18. **Composition and distribution of Human Resources for Health is a challenge.** Côte d’Ivoire satisfies WHO norms for generalists, nurses, and midwives per capita. While all regions surpass the norms for midwives and nurses per capita (although with significant inequalities between regions), 13 out of 21 regions are below the norm of 1 generalist per 10,000 population. Overall a shortage of specialists is a key problem with many regional hospitals lacking gynecologists, surgeons, anesthesiologists etc. These specialists, as well as other cadres such as midwives, remain concentrated in Abidjan and urban areas. A recent national workload analysis using the WHO’s Workload Indicators of Staffing Need (WISN) methodology found that at an aggregate level, there are gaps in nursing and midwife workforce, but not with doctors. The study also found gaps in health worker assistants and other support staff, with 39% of primary care facilities not having health worker assistants, which imposes an increased burden on nurses and midwives in these facilities. The health workforce in the country is not directly managed by the Ministry of Health but by the Civil Service Directorate, and health districts or facilities do not have hiring or firing authority, which limits the responsiveness to potential quality challenges at the facility level. Other challenges identified with human resources include:

- low quality of training for midwives (lack of internship sites) and other health workers;
- lack of a national information system/tools to identify distribution of health workers and decision-making;
- issues with retention, especially in rural, hard-to-reach and remote areas, and the lack of implementation of financial and non-financial incentives targeting retention, resulting in an unequal distribution of staff across the country;

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32 MSHP, 2017 “Calcul de la charge de travail et détermination des normes de dotation en personnels de santé en Côte d’Ivoire”
• low institutional capacity of the Ministry of Health in terms of regulating and governing the health workforce;
• insufficient production of workforce, particularly to keep up with construction of new facilities; and
• limited financing to rectify the challenges presented above.

Health Financing

19. **Over the past 10 years, Total Health Expenditure (THE) has stagnated.** Between 2008 and 2016, THE declined from US$79 to US$75 per capita and Government spending on health remains low at around 24% of THE (figure 4). Households out-of-pocket payments (OOPs) account for over half of THE. With fluctuating external financing, a more useful indicator is OOP as a percent of total public spending, which averages 63% during the period 2013-16. Notably, households finance 48% of all spending at pharmacies and 35% of spending at hospitals, including high expenditures on maternal health and malaria even though these interventions are covered under the free services package. Elevated level of out of pocket spending translates into poorer financial outcomes for the broader population: in 2015, 17% of the population was pushed further into poverty due to out of pocket spending. Development Assistance for Health (DAH) increased from 9% in 2013 to represent 26% of THE in 2015 (figure 4). The over-reliance of the health sector on household expenditure and DAH, which together represent more than 70% of THE, are a challenge to sustainability, ownership and efficiency of existing resources, especially as donor resources remain fragmented with many duplications, high administrative burden and limited alignment on national priorities. This is particularly important considering upcoming donor transition processes, notably accelerated transition from Gavi and out of World Bank FCV status in 2020. Poor health outcomes relative to high total spending furthermore indicate significant inefficiencies in the system, with a recent WHO study estimating potential efficiency gains of up to 51% in the health sector.

20. **The health share of total government spending, at around 5%, is one of the lowest in Sub-Saharan Africa and across low-and middle-income countries.** The extremely low priority given to health in the national budget reflects, in part, a perceived inefficiency of current spending in the sector as well as donor spending potentially crowding out domestic financing. CIV’s strong and sustained political leadership and commitment to the Universal Health Coverage agenda has not been accompanied by an increase in financial resources. As a result, total government health spending is substantially lower than the estimated requirements to assure universal access with an essential package of health services targeting the health Sustainable Development Goals (SDG) – over $80 per capita annually. Notably, only 21% of the health spending in Cote d’Ivoire is pooled through public pools, which is lower than the sub-Saharan African and lower-middle income country average, indicating that the mix of financing is suboptimal and not designed to maximize health benefits (table 4). In addition to low levels of public spending, most donor spending in Cote d’Ivoire is also not channeled through the government, leading to fragmentation and even more limited fiscal capacity.

*Figure 4: Total Health Spending in Cote d’Ivoire, 2007-2016*

33 Source: National Health Accounts, 2016
Table 4. Level and distribution of total and domestic government spending on health, Cote d’Ivoire and regional countries (2015)

<table>
<thead>
<tr>
<th>Country</th>
<th>Government %</th>
<th>External %</th>
<th>Out of pocket %</th>
<th>Pooled %</th>
<th>Total health expenditure per capita (USD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Benin</td>
<td>20.14</td>
<td>34.23</td>
<td>40.50</td>
<td>38.69</td>
<td>31.29</td>
</tr>
<tr>
<td>Burkina Faso</td>
<td>28.24</td>
<td>29.56</td>
<td>36.11</td>
<td>52.95</td>
<td>33.44</td>
</tr>
<tr>
<td>Cote d’Ivoire</td>
<td>21.83</td>
<td>26.34</td>
<td>36.02</td>
<td>21.26</td>
<td>75.45</td>
</tr>
<tr>
<td>Cameroon</td>
<td>14.46</td>
<td>7.90</td>
<td>69.74</td>
<td>18.93</td>
<td>63.63</td>
</tr>
<tr>
<td>Ghana</td>
<td>34.95</td>
<td>25.57</td>
<td>36.11</td>
<td>52.23</td>
<td>79.59</td>
</tr>
<tr>
<td>Guinea</td>
<td>17.15</td>
<td>24.89</td>
<td>54.49</td>
<td>38.90</td>
<td>25.13</td>
</tr>
<tr>
<td>Liberia</td>
<td>7.41</td>
<td>70.93</td>
<td>19.64</td>
<td>33.46</td>
<td>69.29</td>
</tr>
<tr>
<td>Mali</td>
<td>16.55</td>
<td>36.37</td>
<td>46.31</td>
<td>26.75</td>
<td>42.30</td>
</tr>
<tr>
<td>Niger</td>
<td>21.02</td>
<td>25.76</td>
<td>52.27</td>
<td>35.28</td>
<td>25.72</td>
</tr>
<tr>
<td>Nigeria</td>
<td>16.49</td>
<td>9.92</td>
<td>72.08</td>
<td>19.32</td>
<td>97.52</td>
</tr>
<tr>
<td>Senegal</td>
<td>31.75</td>
<td>11.71</td>
<td>44.18</td>
<td>42.63</td>
<td>36.08</td>
</tr>
<tr>
<td>Sierra Leone</td>
<td>8.96</td>
<td>52.63</td>
<td>38.24</td>
<td>12.79</td>
<td>106.69</td>
</tr>
<tr>
<td>Lower middle income</td>
<td>43.78</td>
<td>12.02</td>
<td>39.84</td>
<td>50.37</td>
<td>132.07</td>
</tr>
<tr>
<td>Sub-Saharan Africa</td>
<td>32.92</td>
<td>24.12</td>
<td>35.65</td>
<td>42.58</td>
<td>111.60</td>
</tr>
</tbody>
</table>

Table 4. (cont.)

<table>
<thead>
<tr>
<th>Country</th>
<th>Share of external funding channeled through government (%)</th>
<th>Compulsory financing as a % of government expenditure</th>
<th>Domestic public health expenditure as a share of total government expenditure</th>
<th>Domestic public health expenditure as share of GDP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Benin</td>
<td>54.19</td>
<td>6.47</td>
<td>3.37</td>
<td>0.80</td>
</tr>
<tr>
<td>Burkina Faso</td>
<td>83.57</td>
<td>13.44</td>
<td>7.17</td>
<td>1.54</td>
</tr>
<tr>
<td>Cote d’Ivoire</td>
<td>15.83</td>
<td>4.91</td>
<td>5.04</td>
<td>1.19</td>
</tr>
</tbody>
</table>

34 In 2015 OOP dipped down to 36%, largely due to increased DAF, before returning to 48% in 2016
### Health Sector Reform Context

21. **Public financial management and governance are weak and a risk to the success of health sector reforms.** The implementation of strategic purchasing involves the purchase of a Package of Activities and, once these activities have been performed and verified, a payment system is triggered through multiple intermediaries. The current accounting framework used by health facilities does not allow transactions to be recorded and linked to activities and results. Therefore, the scaling up of the strategic purchasing and health insurance may introduce a fiduciary risk if necessary reforms have not been enacted during the implementation of the project. To remedy this situation, the government is committed to undertaking various Public Financial Management (PFM) reforms, including launching a program-based budget by 2020 to comply with the West African Monetary Union (WAMU) rules. With this system, line ministries will have more autonomy over their budgets, moving from an input-based to an output and outcome-based approach. The implementation and success of these proposed reforms should be coupled with efforts to devolve more authority to decentralized entities and to build their technical capacity to ensure that the transition to program-based budget does not remain at the central level.

22. **In 2012, the government introduced a free service scheme, or gratuité, to reduce out of pocket spending associated with priority health conditions primarily for malaria, maternal and child health.** While this system did increase utilization of health services (to .48 in 2017), it is now largely not functional, and patients continue to pay OOP for services that are in theory free. Lack of accountability in reimbursement of facilities for services rendered is a major concern. Further issues are delays in reimbursements as well as salaries, operating budgets of facilities, lack of coordination mechanisms, weak institutional framework, frequent stockouts of drugs, degradation of medical equipment, demotivation and strikes, and the inability of the government to pay its providers which leads to lack of confidence of suppliers to continue providing inputs to government.

23. **In part to overcome these challenges, the government launched the National Health Insurance scheme (Couverture Médicale Universelle, CMU).** A Health Insurance Agency (CNAM) has been set up and has piloted the CMU on a cohort of students. CNAM will gradually take on the role as purchaser of an essential package of services, starting with the formal sector and the poor. While there is general agreement on the need to avoid fragmented purchasing and align the financial incentives for providers, there is little technical agreement on how to set up the payment function and link the fund flows. In
addition to the CMU, a number of key reforms aim to improve community accessibility to quality health care and services, particularly for vulnerable populations.

24. **In 2015, the Government, with the support of the World Bank, began implementation of the Health Systems Strengthening and Epidemic Preparedness project (PRSSE, P147740, 2015-19).** PRSSE is a standard investment project financing (IPF) of US$80 million, of which US$70 million IDA Financing (Credit of US$35 million and Grant of US$35 million), US$3 million GF and US$7 million in Government contributions. The purpose of the project is to pilot the PBF approach in 19 (out 86) districts covering about 5 million people. The project addresses several constraints in the sector on different levels and supports increased access to quality health care, especially the most vulnerable through: (i) provision of technical assistance to develop and help with the implementation of the CMU; (ii) piloting of PBF as an approach to increase the volume and quality of services provided to the population, with a specific focus on improving the effectiveness of “Targeted Free Care” (gratuité ciblée) and other Reproductive, Maternal, Neonatal, Child and Adolescent Health and Nutrition (RMNCAHN) interventions, and specifically addressing linkage to CMU; (iii) rehabilitating health centers and providing equipment to support the provision of quality health services (in 25 districts); and (iv) supporting the further development of a robust health management information system (HMIS) and health system management. Over 200,000 poor have been enrolled in CMU and the CMU approach is being piloted in 3 PBF districts. 403 health facilities (both primary care facilities at urban and rural areas and referral hospitals), 8 regional health directorates and 19 district health directorates have been contracted. The number of quarterly outpatient visits in PBF districts went up from 90,201 in 2016 to over 550,000 by the end of quarter 2 of 2018. A very significant increase was obtained for effective postnatal care coverage from 1,577 to 17,020, in the same period. The project has notably reached full immunization rates in target areas and increased utilization rate of health services to 50%, as opposed to below 48% nationally. Notably, skilled deliveries and family planning coverage rates have also gone up. From 2016 to 2018, quality scores have gone up by 20 and 15 percentage points for primary health facilities and hospitals respectively. Based on the success of the pilot, the Government has requested World Bank support to scale up PBF nationally.

25. **The Global Financing Facility in support of Every Woman Every Child (GFF) will provide a grant to the government in Côte d’Ivoire between US$ 15-25 million, linked to the future IDA project (the IPF under proposal).** The GFF is an innovative financing mechanism to increase financing from government, private sector and external financing sources for a concerted effort towards achieving health-related SDGs

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35 Key Health sector reforms: (i) hospital reform; (ii) performance-based financing; (iii) health decentralization; (iv) the reorganization of community interventions; (v) the reorganization of emergency services in the CHUs and CHR; and (vi) health human resources reform.

36 Full inventory of all facilities (560) in 25 health districts for renovation and equipment needs. Needs estimated at 85 billion CFA. PRSSE granted 8 billion CFA to support rehabilitating 82 health centers (including two warehouses for the National Institute of Public Hygiene (INHP)) and providing 86 health centers with latrines, and water and hygiene systems. The ECOWAS Bank for Investment and Development (EBID) has earmarked a sum of US$20 million to rehabilitate a further 26 health centers and equip 102 centers in 25 PRSSE target districts. The Ivorian Government has created a hospital program with 739 billion CFA for new construction: 1 teaching hospital (CHU), 9 regional hospitals (CHR), 6 general hospitals (HG), 1 psychiatric hospital, 6 hot labs and specialized units in 6 existing hospitals, 1 radiotherapy and oncology center, 3 military hospitals, and 200 first-contact health establishments, and Rehabilitations: 2 teaching hospitals, 4 regional hospitals, 13 general hospitals, and 400 to 800 first-contact health establishments.
with a focus on maternal, child and adolescent health. Cote d’Ivoire joined GFF in November 2017, and the process provides resources for the preparatory work and technical assistance for the operationalization and financing of the key priority areas under the PNDS as well as the operationalizing of the Compact, signed by donor partners in 2017 but lacking enforcement and coordinating mechanisms.

26. **Cote d’Ivoire is member of several international initiatives.** Cote d’Ivoire is one of three pilot countries for co-financing between the Islamic Development Bank (IsDB) and the WBG, in the context of the GFF. Based on a joint mission, the government of Cote d’Ivoire has requested an $US80 million financing from the IsDB and it is planned that this financing will be fully parallel to SPARK components (see below). Cote d’Ivoire is also one of four pilot countries for the 4G initiative, which formalizes intensified collaboration on sustainable financing between the World Bank, GF, GAVI, and the GFF. In the medium term, the 4G will develop joint work plans that aim to support national health policies, strategies, plans, and UHC roadmaps. This includes exploring opportunities for co-financing beyond technical assistance, for example through loans/buy-down, or the results-based financing (RBF) platforms that exist in several of the proposed countries and coordinating communication and advocacy efforts to promote a shared vision of the health sector. Cote d’Ivoire is among 14 “trailblazer” countries in PHCPI, aimed at developing a common framework for measuring the performance of primary health care systems and sharing knowledge on strategies and ideas for improvement. PHCPI comes in the context of the GFF and aims to support measurement and evaluation of the GFF investment through development of additional tools and frameworks to measure with greater precision and timeliness the key interventions in primary care necessary to achieve reductions in maternal and child mortality. PHCPI objectives are fully aligned with the SPARK PDO (see below). A first version of the “vital signs profile” of quality indicators has been publicly released as of October 2018 (figure 5).

![Figure 5: Cote d’Ivoire Primary Health Care Vital Signs Profile](image)

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37 The Compact commits the government, sectoral stakeholder and development partners (40 total signatories) to one national health plan (PNDS) in a harmonized and aligned way

38 [https://improvingphc.org/about-us/about-phcpi](https://improvingphc.org/about-us/about-phcpi)
27. The World Bank has been supporting the Government to execute projects across different practices, synergetic with SPARK. Within the HNP global practice, the Multisectoral Nutrition and Child Development Project (P161770) shares with SPARK the same indicators for nutrition under strategic purchasing and provides a link between demand-side interventions and supply-side PBF interventions. It is proposed that these projects will be fully integrated in all intervention areas of the nutrition project. The Sahel Women’s Empowerment and Demographic Dividend Regional Project (P150080), effective since 2017, implements behavior change communication interventions on family planning and women’s empowerment; education, advocacy, outreach and sensitization; training midwives to improve quality of care; and supporting the procurement of contraceptives and other relevant commodities. The project seeks to increase the demand for contraceptives and reduce early marriages through this approach. SPARK also has a component on strengthening both the supply-side and the demand-side for family planning and will integrate with SWEDD particularly on demand generation aspect and through involvement of community health workers (CHW). Other synergies to be considered include the Regional Disease Surveillance Systems Enhancement Program in West Africa, which is in the pipeline, and the Pandemic Emergency Facility (through component 4, CERC) which would ensure a rapid response to contain pandemics or other emergency situations. SPARK will also coordinate and harmonize with projects under other practices, such as the Enhancing Government Effectiveness for Improved Public Services (P164302) PforR $100 million, particularly to improve financing and reimbursement of primary health care services; Education Service Delivery Enhancement Project (P163218) of $23.35 million under the education governance practice, to invest in early years (IEY) to improving childhood outcomes; Social Protection and Jobs Global Practice within the Productive Social Safety Nets Project (P143332) of $180 million for harmonized poor targeting and package of services and linking CMU and cash transfer programs; the West Africa Unique Identification for Regional Integration and Inclusion (WURI) Program (P161329) of $90 million for FY19-23 to link national unique identifier to CMU and to improve Civil

39 Cote d'Ivoire is in the process of finalizing an implementation plan for its CHW strategy. All aspects of Spark-health related to CHW will be fully aligned with this strategy.
Registration and Vital Statistics (CRVS). A new DPO series is planned in 2019 and it is proposed that health, with a focus on key reforms, be included as a pillar or sub-pillar.

28. **Several recently completed, high-quality ASAs set the stage for SPARK and inform its methods**, including (i) a health sector Public Expenditure Review (PER); (ii) a Health Financing Systems Assessment (HFSA) with Vaccine and HIV transition and Public Financial Management (PFM) deep dives; and (iii) a regional piece on “Covering the Informal Sector in Francophone West Africa”. Further studies financed through the PRSSE include (i) costing of CMU; (ii) a study on population capacity to pay for health insurance premiums; (iii) a study on cost of service provision in public and private facilities; (iv) infrastructure and equipment needs of all facilities in 25 districts; (v) health human resources training and distribution assessment; (vi) a fiscal space for UHC analysis; and (vii) a qualitative and a quasi-experimental impact evaluation of PBF.

**C. Proposed Development Objective(s)**

**Note to Task Teams:** The PDO has been pre-populated from the datasheet for the first time for your convenience. Please keep it up to date whenever it is changed in the datasheet. *Please delete this note when finalizing the document.*

**Development Objective(s) (From PAD)**

29. To improve the utilization and quality of health and services towards reducing maternal and infant mortality in Cote d’Ivoire.

**Key Results**

30. **The Key outcome result indicators for the project are in table 5.** Further details about the outcome and intermediate indicators are presented in the results framework.

**Table 5. PDO Outcome Indicators**

<table>
<thead>
<tr>
<th>Indicator Name</th>
<th>Baseline (2018)</th>
<th>End-Target (FY 2024)</th>
</tr>
</thead>
<tbody>
<tr>
<td>(i) Average facility quality score (%)</td>
<td>52</td>
<td>75</td>
</tr>
<tr>
<td>(ii) Utilization rate of health services in target health districts (%)</td>
<td>48</td>
<td>60</td>
</tr>
<tr>
<td>(iii) Number of Births attended by a qualified health personnel</td>
<td>549,957</td>
<td>2,883,969</td>
</tr>
<tr>
<td>(iv) Number of fully vaccinated children</td>
<td>70,732</td>
<td>1,514,714</td>
</tr>
<tr>
<td>(v) Direct Project Beneficiaries (% female)</td>
<td>0 (0%)</td>
<td>67,184,550 (60%)</td>
</tr>
</tbody>
</table>
D. Project Description

31. **With US$200 million (IDA) and US$20 million (GFF) co-financing**, the project will focus on improving the utilization and quality of health services to contribute to reducing maternal and infant mortality by integrating strategic purchasing into the national system through the national scale-up of PBF combined with deployment of national health insurance (CMU). It will also finance and support specific priority areas of the GFF investment case: rehabilitating and equipping health establishments; human resources for health; health information system; and quality of primary care, with special focus on RMNCAH. GFF co-financing will focus specifically on reforms and capacity building (component 1.3) and on strengthening HMIS (component 2.4). Project financing budgets by component and sub-component is shown in [table 6](#).

32. **The project has four complementary components (figure 7).** Component 1 focuses on the scale up of strategic purchasing and governance reforms needed to ensure its success and sustainability. Component 2 finances select GFF investment priorities beyond strategic purchasing, to support the strengthening of key health system elements. Component 3 is for project management and knowledge and learning and Component 4 is a Contingency Emergency Response Component (CERC) zero-dollar component.

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40 Donor Partner parallel financing of project components discussed in Section E. Rationale for Bank Involvement and Role of Partners
Figure 7: SPARK -Health Components

Table 6. Budget by SPARK Component

<table>
<thead>
<tr>
<th>Component</th>
<th>IDA</th>
<th>GFF</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Strategic Purchasing</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.1 PBF</td>
<td>92,864,934</td>
<td>-</td>
<td>92,864,934</td>
</tr>
<tr>
<td>1.2 CMU</td>
<td>17,422,808</td>
<td>-</td>
<td>17,422,808</td>
</tr>
<tr>
<td>1.3 Reforms &amp; Capacity Building</td>
<td>1,100,000</td>
<td>5,000,000</td>
<td>6,100,000</td>
</tr>
<tr>
<td>2. Health System Strengthening (HRSS)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.1 Rehab, Equipment, Hygiene</td>
<td>27,030,000</td>
<td>-</td>
<td>27,030,000</td>
</tr>
<tr>
<td>2.2 Reproductive Health &amp; Nutrition</td>
<td>14,742,800</td>
<td>-</td>
<td>14,742,800</td>
</tr>
<tr>
<td>2.3 Health Human Resources (HHR)</td>
<td>24,000,000</td>
<td>-</td>
<td>24,000,000</td>
</tr>
<tr>
<td>2.4 Governance &amp; HMIS</td>
<td>10,810,298</td>
<td>15,000,000</td>
<td>25,810,298</td>
</tr>
<tr>
<td>3. Project Management</td>
<td>12,029,160</td>
<td>-</td>
<td>12,029,160</td>
</tr>
<tr>
<td>4. Contingency Emergency Response (CERC)*</td>
<td>-</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>Total (USD)</td>
<td>200,000,000</td>
<td>20,000,000</td>
<td>220,000,000</td>
</tr>
</tbody>
</table>

*Funds released in case of emergency
Component 1: Scale-up of Strategic Purchasing (Estimated Financing: US$116.39 million IDA+GFF)

❖ Subcomponent 1.1: Extension of PBF in the context of strategic purchasing (Estimated Financing: US$92.86 million IDA)

33. Based on results of the PBF pilot, the Ministry of Health and Public Hygiene (MSHP) intends to integrate and extend this contractual approach. This sub-component will support costs related to (i) implementation of the core pillars of the PBF program including piloting of contracting, verification, quality evaluation and community-based counter-verification (additional methodological details in Annex 3); (ii) integration of PBF into the national system; and (iii) sequenced scale-up\(^{41}\) of PBF in the context of strategic purchasing.\(^{42}\) SPARK builds on the successes and lessons learned from PRSSE. It largely retains elements of the PBF program, while simplifying procurement processes and guidelines and a reducing the costs of verification; engaging patients through citizen report cards; an increased focus on continuous measurement; and a dynamic approach to contracting and a phasing in of CMU as it scales up. This is in addition to strengthening the supply-side (component 2) and addressing governance bottlenecks (component 1.3) to maximize the performance of strategic purchasing.

34. PBF aims to increase the volume and quality of health services, with a specific focus on MNCH interventions. Performance-based incentives will be used to support: (a) increased utilization of targeted services related largely to MNCH; (b) improved clinical practice and health worker motivation as well as motivation of decentralized and central cadres (both intrinsic and extrinsic); (c) structural improvements (e.g. availability of drugs and commodities, and health facility rehabilitation); and (d) improved management capacity, governance, monitoring and record keeping at health facilities. Performance payments can be used for: (i) health facility operational and capital costs (e.g. including maintenance and repair, drugs and consumables, (ii) outreach activities (e.g. for transport and performance payments to community workers to stimulate demand); and, (iii) financial and non-financial incentives for health workers according to defined criteria. Notably, performance-based incentives will be additional to existing financial resources at target facilities and fully harmonized with the planned scale-up of CMU (component 1.2).

35. A strong emphasis will be placed on verification of results through both ex-ante (i.e. prior to making a payment), and ex-post verification\(^{43}\). Specifically, the quantity and quality of services delivered will be verified through independent verification. Ex-post verification is expected to be carried out in three ways. Firstly, quarterly verification of the quantity and quality of services will take place by Contracting and Verification Agencies (ACV). Second, community-based organizations (CBO) will be contracted to visit homes of randomly chosen clients (selected from health facility registers). Finally, the Inspector General

\(^{41}\) Scale-up all the 1\(^{st}\) and 2\(^{nd}\) level public facilities, according to budget availability, and all the regulatory structures through to the central level. Component 1 will also pilot contracting with the private sector and the tertiary level.

\(^{42}\) Strategic Purchasing refers to the use of performance contracts and the harmonization of PBF and CMU, with mechanisms to facilitate further harmonization and defragmentation eventually (gratuité, vertical programs, complementary packages, etc.).

\(^{43}\) There is evidence that under a PBF scheme, contracted entities have an incentive to over-report the achievement of results, and/or manipulate data.
of Health (IG) will perform select counter-verification missions to validate the work of the ACV. An emphasis will be placed on the sustainability of this approach, with piloting of novel verification schemes and a plan to hand over financing fully to national entities by year 5.

36. An important element is capacity building and communication, including training on PBF concepts and procedures, behavior change education, information, education, communications related to demand generation and other strategic communication related to the PBF program and health facility management and administration related to, for example, the development of business and operational plans and appropriate accounting and use of PBF incentives. This capacity building will focus not only on health care workers and administrative staff at the central, region and district level, but also on the general public, so that they understand the nature of the new approach, are encouraged to make use of the services that are available and participate in providing oversight and feedback as part of the process.

37. Overall, subsidy payments make up about 56% of the estimated $US93 million dollars financing of this sub-component. Verification makes up about 24% and the remaining 20% is training, M&E, and other operational costs.

38. Through a three-phased approach\(^44\), strategic purchasing will be operational nationwide by the end of 2021 (figure 8).

- **Phase 1: PBF in 31 new districts, bringing the total to 50 (2019):** In the pilot phase, PBF was implemented in 19 districts in 9 regions\(^45\). The project proposes to expand to 12 regions and cover all 31 districts in these regions. These include 11 “rehabilitation only” districts in the PRSSE, and 20 districts covered under the World Bank Early Years project (PMNDE).
- **Phase 2: PBF in 23 new districts, bringing the total to 73 (2020):** Starting in 2020, 5 new regions, chosen by highest rates of maternal mortality, with 23 health districts will be integrated.
- **Phase 3: PBF in 13 new districts PBF, bringing the total to 86 (2021):** In 2021, PBF will cover the entire country with the addition of 13 districts in the 3 remaining regions.

\(^{44}\) Finalized in consultation with MHPH.
\(^{45}\) 14 districts in 7 regions financed by the World Bank and 5 districts in 2 regions financed by the Global Fund. Not all districts in a given region were covered.
39. **National PBF will progressively be financed through the national budget**, with the DAF issuing payment orders for the PBF National Technical Unit to disburse the resources required for results-based purchasing while at the same time piloting/pursuing new cost-effective approaches to simplify funds transfer and accountability (e.g., mobile money, blockchain, etc.). It is projected that in 2021, 67% of the costs related to strategic purchasing will be covered by the government, going up to 87% in 2022, 89% in 2023, 98% in 2024 and 100% in 2025.

❖ **Subcomponent 1.2: Scale-up of National Health Insurance (CMU) (Estimated Financing: US$17.42 million IDA)**

40. **CMU will be progressively scaled up starting in 2019 drawing on lessons from the 3-district pilot**. The Government proposes that the CMU will first be extended to the current 19 PBF districts and thereafter follow the progressive scale-up of PBF (see subcomponent 1.1). Project support for the scale-up of these two structural reforms for the health sector – PBF and CMU – will take the form of an integrated framework (figure 9).

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46 Following a pilot phase on a population of students, which enabled the CNAM to test its information system, the PRSSE is extending this phase in three (3) health districts on PBF contracts to review its overall implementation system and to pilot harmonization of fragmented financing at health facilities, including harmonization with PBF. Regarding population coverage, emphasis is on the provision of health care to the poor and the development of an informal sector integration strategy.
41. **Operationalization of the Medical Assistance Scheme:** finance activities related to (i) the targeting (i.e. identification) and enrollment of vulnerable and low-income households using proxy means testing (PMT); (ii) provision of social security cards to households; (iii) development of a household management tool (population and health care consumption) for the implementation of the Single Social Registry (SSR); (iv) annual revision of the SSR by the Ministry of Social Security (MEPS); and (v) the establishment of PBF/CMU quality indicators for the payment of subsidies to the health establishments. Beneficiary targeting operations will also be coupled with the systematic enrolment and mapping of vulnerable and poor households based on the results of the community validation. The extension of CMU will initially be financed exclusively by the project with Government progressively increasing its financial contribution to CMU starting in 2019 and 2020. SPARK-Health project will also provide technical assistance to support the conceptualization and implementation of CMU.

42. **Coverage of the informal sector:** finance activities related to (i) the determination and collection of CMU premiums; (ii) targeting of the informal sector in terms of identification and enrollment of segmented groups; (iii) development of technological solutions to premium payments; and (iv) technical assistance to strengthening the legal, regulatory and governance reforms required for the integration of the informal sector. These activities will build on the progress made with the identification of poor and vulnerable population, as well as electronic payment innovations introduced and launched as part of social protection and cash transfer programs.

43. **Computerized management tools for CMU:** financing to cover costs in developing an electronic system that will monitor activities related to the CMU including, but not limited to: (i) identification and

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47 National database of individuals classified as “poor” using the proxy means test (PMT) targeting survey
enrolment of CMU beneficiaries; (ii) health services received by enrollees; (iii) hospital admissions and discharges etc. (iv) computerization of health facilities; and (v) training of all health professionals in the use of the new CMU tools

❖ **Subcomponent 1.3: Support for health reforms and national capacity building** *(Estimated Financing: US$1.10 million IDA, US$5.00 million GFF)*

44. **Support for transition readiness and sustainability:** Capacity building and key reforms for increased financial and programmatic management of external financing. The GFF process envisions initially increasing external funding, going through and strengthening government channels, with progressively increasing domestic resources for health taking over from external financing. The GFF investment case is currently being prepared in the government budget format and will be on the government's budget in the next fiscal year. This is expected to increase government's oversight and execution of key health systems strengthening initiatives, especially the strengthening of the current financial management system. To improve capacity to manage external funds, this sub-component will finance stock-taking, training, and development of new tools, particularly at the level of the DGS, DAF, DPPS and IG. These will include PFM assessments, the development of tools to increase budget transparency and links to strategic objectives as well as the switch to programmatic budgeting at the MSHP.

45. **Support for the implementation of program-based budgeting in the health sector:** Given the impending transition of the MSHP from output-based budgeting to program-based budgeting, there is a need for preparing mechanisms to reformulate the current budget allocation methodology, ensure appropriate financial management units are in place, define effective and accurate programs that are aligned with the sectoral priorities as defined by PNDS and operationalized through the GFF investment case. There is further need to support the health facilities regarding expected results and a more coordinated articulation of sectoral objectives and ensuring equity in the use of resources. Spark-Health will support ensuring sectoral reforms are well harmonized with national Financial and Budget reforms, operationalizing coordination mechanisms between and within budgetary program mechanisms, ensuring a successful transition of programs, linking program-based budgeting reform to the reforms of scaling up health insurance and strategic purchasing, ensure coherence between national and decentralized entities in terms of the institutionalization of budget reform, and provide technical assistance in the form of training.

46. **Implementation of management accounting and financial information systems across different units of the MSHP:** This sub-component will support reform to align funding with health outcomes, through setting up instruments in health facilities and MSHP to track the use of financial resources and their allocation to services through an integrated management accounting system which includes both financing and outcomes, with the goal of linking payments to results at a national level. This subcomponent will furthermore support development of flexible financial management tools at the level of health facilities, to manage funds (received through PBF, CMU and other sources), with appropriate

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48 Côte d’Ivoire General Classification of Medical Procedures and Biology, medical claim forms, etc.
linkages to district, regional and national PFM systems. This may include the development of sub-ledgers for the government’s integrated financial management information system (IFMIS), if the government chart of accounts does not have sufficient levels of detail to include individual health facilities. At the facility level, it will also need to include the capacity to record revenue from multiple sources (e.g., general budget funds, PBF, CMU, patient contributions, etc.), and a simple but robust expenditure management capability.

47. **Capacity building for scale-up of strategic purchasing:** Given the sector-wide implications of the scale-up of strategic purchasing, there is a significant need for training and technical support at all levels. The project will support the development and operationalization of tools for strategic purchasing, revision of texts and advocacy for reforms, and supporting financial management capacity at all levels. Technical support will be provided to MSHP at the central level to ensure the link between technical unit of the PBF, DAF and the Treasury. Electronic payment tools used by social cash transfer programs will also be incorporated into the scale-up, including exploring the feasibility of opening bank accounts for health workers to receive incentive payments and introducing electronic payments more proactively for reducing administrative burden and increasing traceability. Finally, district and regional health officers will be capacitated further to execute their role of regulation for PBF, and health facilities will be trained further on financial management, as the new facilities will have to manage their own budgets for the first time.

48. **Capacity building for scale-up of national health insurance (CMU):** Like the activities outlined above for the scale-up of strategic purchasing, tools will be implemented to minimize the risks of leakages with the implementation of national health insurance. Technical support would be provided to the CNAM to execute the purchasing function, including the harmonization and revision of the benefits package, revision of costing and reimbursement rates, quality adjustments, payments through third parties, verification, information systems, indicator harmonization between PBF and CMU as well as the determination of who would be paying for what indicator, and harmonization with MSHP across key priority areas. The Project could support a system of accreditation and contracting within the CNAM to ensure a full link between reimbursement of services and quality of services. It would support the development and implementation of national, district and facility-level stakeholders to fully use the tools of the health insurance mechanism.

**Component 2: Health System Strengthening to Improve Performance (Estimated Financing: US$91.58 million IDA+GFF)**

❖ **Subcomponent 2.1: Rehabilitation, Equipment and Environmental Sanitation** (Estimated Financing: US$27.03 million IDA)

49. **Development of a national infrastructure and equipment master plan & strengthening the capacity of DIEM:** A national infrastructure and equipment master plan, developed in close coordination with PMO, AFD, DIEM and other key stakeholders, will map needs and current financing to identify gaps to be covered. In addition, a national health facility maintenance policy will be developed by DIIEM and shared with all donors and stakeholders to strengthen governance and compliance. This will be supported by the design of a software and tools to computerize and facilitate the management of health assets. This
system will be tested at the DIEM and subsequently piloted in 3 regions before deploying it in all nationwide regional infrastructure directorates (CRIEM).

50. **Rehabilitation of 50 health centers & connecting 420 health centers to power and a piped water source:** This sub-component will finance the full rehabilitation of 50 health, chosen based on gaps identified. It also proposes to connect an estimated 420 health facilities without power and/or water to the power grid and a water supply. This plan builds on the innovative strategy financed by PRSSE, implemented through UNICEF, that provided WASH services to 93 health centers and further adds a component of linking health facilities to electrical grids or to off-grid solar energy.

51. **Implementation of the sanitary waste management plan, and environmental safeguard policies (CGEES and PNGS):** The scale-up of strategic purchasing is predicted to increase utilization of health services, which will result in an increase in medical waste. Four main interventions will be implemented: 1) strengthening the legal and institutional framework; (2) strengthening communication for social and behavioral change of stakeholders; (3) strengthening the capacity of the health waste management process; and (4) strengthening the capacity of health facilities to manage waste. The activities will consist in the trainings, acquisition and installation of incinerators for certain district hospitals, the provision of small waste sorting equipment and consumables to the establishments, all under the supervision of the DMH. To mitigate environmental and social risks, an ESMF and MWMP have been prepared.

❖ **Subcomponent 2.2: Reproductive Health and Nutrition (Estimated Financing: US$14.74 million IDA)**

52. **The project will support the GFF investment case regarding the establishment of maternal, neonatal, infant and perinatal death review committees in health regions, as well as the strengthening of referral and counter-referral systems at all levels of the health pyramid.** Health providers will be trained in case management and sensitized to case investigation and reporting. CHWs will be involved in screening and providing maternal and neonatal care, as well as generating demand for care-seeking. Information and awareness-raising campaigns on the importance of assisted childbirth, ANC, CPoN and obstetric fistulas will be organized. Strategic purchasing will be used to scale-up to address supply side interventions and integrate family planning with other services to improve continuity (e.g. with 6-month post-partum visits to support birth spacing, as well as with antenatal care, deliveries, child health visits and immunization).

53. **Strengthening of obstetrical and newborn emergency care (EmONC) in health centers.** In addition to the proposed system-level interventions, health facilities will be equipped for the management of obstetric complications and newborn resuscitation through interventions providing high quality of EmONC at primary health care center and hospitals through three strategies: (i) Improving the availability and accessibility of maternal and neonatal health services; (ii) Increased availability of qualified personnel for maternal and newborn care; (iii) Increased availability, accessibility and utilization of maternal and newborn health services at the community level. The actions will concern health staff updating related to EmONC new practice, providing the small equipment for gynecology, obstetrical and pediatric practice and training and supervision. These interventions will be led by the reproductive health national program and partially implemented through UNFPA technical assistance and support.
54. **The project will also support demand generation activities to increase the very low contraceptive prevalence rate, in collaboration with UNFPA and the World Bank SWEDD project.** To support the government in achieving its ambitious national goal of increasing modern contraceptive prevalence from 18% today to 30% by 2024, the Project will include the development and implementation of an advocacy plan for repositioning family planning; the development and implementation of a national plan for community-based distribution of contraceptives; and the development and implementation of a plan for scaling up long-term contraceptive method coverage. The project will work closely with SWEDD to increase the demand for family planning services through interpersonal communication, social dialogue, community mobilization and social marketing. As most of family planning commodities are currently being delivered by the private sector, the project will also explore ways to better engage private sector in service delivery. In addition, the project will support and incorporate the learnings from SWEDD to identify the best channels to reach adolescents with contraceptive services. At a national level, the project will support government efforts to align development partners around a national forecast and supply chain strategy, including the short-term use of external financing to address contraceptive supply gaps and a longer-term dialogue on filling these gaps through the national budget as well as through the purchasing agency. This will be integrated into the strategic purchasing scale-up, with family planning as a key indicator and particular attention paid to improving the quality of family planning services. Demand will also be stimulated through supporting the national CHW strategy.

55. **Extension of nutrition activities in health facilities.** These activities include capacity building of health providers in target facilities, the provision of anthropometric equipment (MUAC tool, mother-child scale, kitchen batteries, etc.), the supply of therapeutic nutritional products (Plumpy’nut, F75 and F100 milk, etc.), the replication of communication aids and data collection tools, and the supervision and monitoring-evaluation of activities. In addition, the project will acquire Vitamin A for selected health districts to support the routine Vitamin A distribution strategy already operationalized. As under PRSSE, these activities are planned in partnership with UNICEF. SPARK will furthermore reinforce the Multi-Sectorial Nutrition and Child Development Project (PMNDPE) by extending PMNDPE’s community-based actions to SPARK’s zones of interventions. These include the scale up of the government’s recently adopted *Foyers de Renforcement des Activités de Nutrition à base Communautaire* (FRANCs).

56. **Pilot for portable pregnancy diagnostics in 3 districts.** This sub-component will also pilot a “See your baby” mobile ultrasound clinic in three districts with the highest mortality rates. This approach consists of taking trained local healthcare workers to pregnant women living in remote villages (>5 km health facility) to provide mothers-to-be with the opportunity to see their baby through ultrasonography. This free ultrasound scan service will (i) allow mothers to visually connect with their unborn babies; (ii) incentivize pregnant women to start antenatal care visits early in pregnancy (first trimester); and (iii) increase the frequency and timeliness of ANC visits\(^\text{49}\). During these monthly “see your baby” visits, pregnant women attending the clinic will be screened for the leading causes of maternal mortality (i.e.

hemorrhage, anemia, malaria, hypertension and HIV-infection) using technology (portable ultrasound) and evidence-based, low-cost screening tools, and provided with preventative and curative interventions, which have been shown to independently reduce perinatal morbidity and mortality. Women identified as “high-risk” (e.g. twin pregnancy, abnormal fetal lie, etc.), will be referred to the most appropriate healthcare facility for follow-up and delivery under the guidance of a skilled birth attendant.

❖ **Subcomponent 2.3: Strengthening human resources for health** *(Estimated Financing: US$24.00 million IDA)*

57. **Strengthen health human resources (HHR) across policies and governance, distribution, quality of training and coaching, and data.** The national human resource for health strategy is being operationalized through the Global Financing Facility (GFF) process. Under this framework, this sub-component proposes the following areas of intervention:

- **Support for development and implementation of key policies for human resources for health:** support the design and implementation of reforms a national task-shifting policy, especially to reduce the overreliance on specialists for key maternal health processes, and for increased district and health facility autonomization for hiring and firing. Results of a recent Workload Indicators of Staffing Need (WISN) would also be considered for supporting the update of guidelines around staffing needs, specifically on increasing the availability of nurses and midwives.

- **Support for the roll-out of a national human resource information system for decision-making:** support the development and scale-up of a national human resource information system (iHRIS), to ensure that there is real-time, reliable data on staffing levels across health facilities in the country. This system would be integrated into DHIS2. Relevant staff and key stakeholders will be trained on how to analyze, evaluate, and use the system data for better decision-making to increase accountability and efficiency.

- **Support the increase of pre-service training capacity and quality for health workers:** contribute to increasing the INFAS training capacity through equipment and rehabilitation. In addition, the quality of the pre-service training curriculum will be improved by updating the guidelines, training the instructors, emphasizing common elements of good medical practices as well as addressing knowledge gaps that emerge from quality assessments.

- **Support the harmonization of in-service training curricula and regularly update to reflect needs:** to strengthen INSP, support harmonizing curriculum for in-service training, set up an online platform including e-learning courses, and a rigorous system to evaluate in-service training and support needs, based on the results of periodic assessments of clinical gaps.

- **Scale-up coaching, mentoring and supervision:** empower districts and central level to improve coaching, mentoring and supervision to facilitate the exchange of best practices and specific guidance to providers to allow them to improve, and close the know/do gap.

- **Establish a system of periodic assessment of competence** for certain clinical skills (e.g. administration of clinical vignettes or simulation) so that district and central managers can verify the effectiveness of their mentorship activities. This information could be incorporated into the iHRIS described above.
• **Introduce incentives to improve retention in remote areas:** As part of the scale-up of strategic purchasing, the increase in availability of key inputs in rural health centers, as well as the increase in provider pay through incentives, is projected to contribute to retention of HHR in remote areas. The introduction of both financial retention incentives (through higher performance subsidies for those in rural facilities, other hardship allowances to cover for housing or schooling, updating the strategic purchasing incentive allocation formula to incorporate motivation and experience more proactively over seniority) as well as non-financial retention incentives (community recognition events, assessing the potential for career advancement and learning, assessing the feasibility of mandatory rural services for recent graduates) is proposed.

❖ **Subcomponent 2.4: Governance and Health Management Information Systems (HMIS)**
(Estimated Financing: US$10.81 million IDA; US$15 million GFF)

58. **Strengthening the operational capacity of regional and district health directorates:** MSHP’s current strategy includes developing an adapted regulatory framework for the organization of the regions and districts, profiles and the necessary capacities, and activities to strengthen these structures. As a first step, PRSSE supported the revision of health region and district profiles, definition of the conditions for their functionality, developing a training strategy, and designing an operational plan, expected in March 2019. The SPARK-Health project will finance the operationalization of this plan. Districts and regions will be contracted under strategic purchasing, facilitating incentive structures around nationally defined roles and functions. This activity will also explore supporting decentralization activities to make strategic purchasing more effective, notably around increased managerial autonomy (e.g. hiring and firing, full control over both government and strategic purchasing funds, strengthened facility and district-level management). The project will also support and encourage collaboration and sharing of best practices from different facilities and districts on a quarterly or bi-annual basis to facilitate learning and improve quality.

59. **Developing an integrated health information system to secure higher quality health data (availability, accessibility, validity).** Interventions will include:

• **Implementation of the electronic medical record (EMR) system in referral hospitals, and creation of electronic patient registries in primary care facilities.** The initial focus of the hospital EMR system will be to abstract selected information about quality and utilization for each discharge, to allow managers to monitor demand & staffing needs, manage patient flow, and identify and address quality issues. 38 referral hospitals in the regional capitals (18 CHR and 20 HG) will be covered between 2019 and 2024. Targeted health facilities will be provided with equipment and software. Interoperability of EMR with the PBF portal and the CMU information systems will be addressed, with data linked to CNAM to facilitate processes such as claims management, as well as with the INS for Civil Registry and Vital Statistics for the registration of births and deaths. Electronic patient registries will be designed to allow for more accurate tracking of quality indicators, reduce staff burden for manual data tasks and provide decision support to primary care facilities. Capacity

50 Currently piloted under PRSSE in 3 District Hospitals
building for and integration of EMR use into daily routine of health workers and facility management will be a key component.

- **The integration of data from the PBF portal, CMU information system, and private facilities** including (i) identification of sources of health data production; (ii) inventory of data production tools from each source; (iii) the design of a standardized data collection tool through the harmonization of the indicators in different paper registries; and (iv) implementation of a platform for integrating data from the various sources. Technical assistance will be provided to develop the data integration application (PBF, CMU, DHIS2), draft legislation relating to HMIS covering all data production sources and reforms of the regulatory and legal frameworks and carry out a series of workshops to rationalize and harmonize indicators. The project would also support the interoperability of existing HMIS tools. Electronic patient registries will be created at the facility level, capturing selected individual visit-level data for all patients and incorporated into DHIS2, or with another platform (e.g. OpenMRS) with aggregate data pushed automatically to DHIS2. This integration will also ensure linkages between the EMR unique identifier, the CMU identifier, and the national ID numbers under development under the ID4D regional MPA, including technical support to improve civil registration and vital statistics (CRVS) linked to national identification. DHIS2 would also incorporate the consolidated supervision data collected by districts as part of their quarterly PBF quality checklist evaluation, enabling tracking the availability of key inputs and facilitate the use of these data. Lastly, data integration efforts will be aligned with PHCPI such that the future integrated data collection system will be able to supply information about internationally standardized indicators on an ongoing basis, to allow for international comparisons on performance.

- **Implementation of a facilities registry.** This tool would monitor adequacy of basic amenities, equipment, sanitation, staffing and stocking of drugs and supplies. The tool would allow for tracking of improvements made under subcomponent 2.1 and 2.2 on an ongoing basis and would build upon existing infrastructure (e.g. district-level supervisors, who already visit facilities on a quarterly basis).

- **Preparation of the National Health Statistics Document (RASS).** The RASS is a key document to enhance accountability at each level of the health system. In accordance with the new methodology adopted by the DIIS in 2018, health data will be harmonized and validated in a series of workshops with regional directorates, the CHUs, and health programs and directorates. Trained regional actors will then pilot the drafting of the regional RASSs that will be consolidated by the DIIS at the central level to produce the national RASS. Conferences will be organized for the dissemination of the data coming out of RASS.

- **Assistance to DIIS to implement these reforms** through (a) development of a master plan to guide the development and implementation of digital health interventions; (b) development of an interoperability framework to map all of the data flows in the health sector and develop standards for the exchange of data between different information systems; (c) development of change management and business process engineering strategies to ensure that new technologies are effectively used throughout the health system and are integrated into clinical workflows; and (d) development of robust knowledge management and training strategies to ensure that health workers have the ability to use the technology and there are sufficient number of technical staff to keep digital health systems fully operational at all times. To ensure that the DIIS can fully carry out its functions, the project will also strengthen the operational capacities of DIIS through the rehabilitation of a space for its headquarters.
• **Support implementation of the Demographic and Health Survey (DHS) in 2019**, select results from which will serve as a baseline for assessing Spark-Health impact.

60. **Improving quality of data on quality of care.** The Project will support activities to coordinate measurement of quality of care with the PHCPI to align with international definitions and tools. This will allow Cote d’Ivoire to compare its performance with other countries and help it strive to match performance among leading peers. Data activities supported through the Project which may participate in this process of alignment include: the electronic patient registry in primary care facilities; the integrated routine data collection system (leading to alignment of PBF, CMU, DHIS2); the iHRIS data set on human resources; proposed data collection on clinical competence; and measurement of patient experience within PBF.

61. **Strengthening voice of populations and accountability to improve the quality of care through citizen report cards.** Strengthen community participation to improve responsiveness of the health system through launching a “Citizen Report Cards,” providing timely feedback and accountability through two pillars: information and participation with potential to improve quality of care as well as health outcomes on infant mortality and anthropometric measurements. The information pillar would incorporate the dissemination of information to the community regarding the performance of the health facility/facilities serving them, as it is benchmarked towards national and regional/district averages, thereby providing patients with information on the level of quality of their facilities and enabling them to transform “from passive users of services to active citizens that demand accountability.” The data would initially come from SARA 2015 in districts without PBF, and as PBF scales up nation-wide, from the program’s evaluations of quality of care at the facility level based on the checklist.

An option for the participation pillar is three meetings operating through the COGES: in the first one, evaluation bulletins are discussed within the community and concrete steps for quality improvement are taken, within the scope of the existing resources and budgets at the local level; in the second, the same type of meeting is held with all the health providers at the facility, where they can offer concrete recommendations; in the third, the community and the health workers meet and prepare a specific plan of action based on the concrete propositions from the preceding two meetings.

62. **Strengthening medical supply management at primary health facilities:** i) the revision of norms and standards for the management of pharmaceutical products in collaboration with PNDAP and other relevant structures; ii) strengthening the capacity of rural health centers (CSR) to supply and manage medical commodities and to integrate the management of revenues from the sale of medicines through training, equipment, reproduction and dissemination of management tools, supervision and control, and iii) working with relevant authorities at the central level to enact legislative reforms, where necessary, for increased facility autonomy for managing their medical supplies.

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51 See Bjorkman and Svensson, 2009 & Bjorkman, de Walque and Svensson, 2017
52 Flores, 2018 “How Can Evidence Bolster Citizen Action? Learning and Adapting for Accountable Public Health in Guatemala.”
53 Currently, PRSSE and independent/community verification agents collect quarterly data on the performance of facilities across 149 quality indicators, which is used for the quality bonus as part of PBF.
Component 3: Project Management (Estimated Financing: US$12.03 million IDA)

❖ Subcomponent 3.1: Project coordination (Estimated Financing: US$6.20 million IDA)

63. The World Bank-financed Health Project Coordination Unit (UCP Santé-BM), which was established by Order 0082/MSHP/CAB of May 8, 2018 and currently manages the PRSSE (P147740), was selected to coordinate the IPF. This unit will be responsible for managing fiduciary aspects and monitoring and evaluating the proposed operation. Technical duties are being performed jointly with the implementing agencies such as the DGS (including CTN-FBP), the CNAM, the DIIS, and DIEM. Given the novel nature of strategic purchasing in Côte d'Ivoire, the Project Coordination Unit will continue to play this role, while planning the complete handover to national entities by the end of the project.

❖ Subcomponent 3.2: Monitoring-Evaluation (monitoring, supervision, and support) (Estimated Financing: US$2.82 million IDA)

64. The general underlying principle is to ensure alignment of the M&E process developed for the project with the national monitoring and evaluation system. Technical assistance to formulate an M&E plan for the project will therefore be provided. This alignment approach will enhance the project’s investment efficiency, as well as enable the project to benefit from M&E capacity building and leverage this process through previous WBG investments in Côte d’Ivoire (for example, strengthening of the HMIS).

65. The Results Framework focuses on accountability for results in the delivery of maternal and infant health services, going beyond the usual tracking of inputs and outputs to focus on intermediate outcomes. The proposed results framework uses, to the extent possible, existing national indicators and data to measure the project's progress and its contribution to the overall national program, to help strengthen existing data collection mechanisms. The project monitoring system will include (i) the identification and consolidation of M&E indicators; (ii) training and capacity-building initiatives at the national, regional, and local levels; (iii) standardized methods and tools to facilitate systematic information collection and sharing; (iv) an internal review of performance and work plans; and (v) annual evaluations of the program and strategic planning exercises for each component. In addition to routine data, the Project results will be measured through national surveys, such as DHS, MICS, SARA or SDI, which the project will finance (or co-finance) based on need.

66. An impact evaluation (including baseline) will be conducted to assess the results of the Strategic Purchasing component. This evaluation aims to (i) identify the links between strategic purchasing and health service quality and the reduction of maternal and infant mortality rates, (ii) identify the key factors responsible for the project’s observed impacts, and (iii) evaluate the cost-effectiveness of Strategic Purchasing as a strategy to improve service coverage and quality.

❖ Subcomponent 3.3: Knowledge Sharing and Dissemination of Results (Estimated Financing: US$3.00 million IDA)

67. A communication/dissemination strategy will be launched at the beginning of the project with the following strategic goals: (i) ensure that all target population groups understand the program, (ii) promote the progress made, and (iii) leverage and disseminate its results. This communication and dissemination
strategy will also enable decision-makers, health professionals, health program planners and managers, medical scientific community, beneficiary communities and civil societies to have updated information regarding project progress and results using a blend of actions and communication tools.

**Component 4: Contingent Emergency Response Component (CERC) – (US$0.00)**

68. This contingent emergency response component is included under the project in accordance with Bank’s Investment Project Financing Policy, paragraphs 12 and 13, for situations of urgent need of assistance. This will allow for rapid reallocation of project proceeds in the event of a natural or man-made disaster or crisis that has caused or is likely to imminently cause a major adverse economic and/or social impact.

69. To trigger this component the government needs to declare an emergency or provide a statement of fact justifying the request for the activation of the use of emergency funding. To allocate funds to this component the government may request the Bank to re-allocate project funds to support emergency response and early recovery.

70. If the WBG agrees with the determination of the disaster, and associated response needs, this component would draw resources from the unallocated expenditure category and/or allow the government to request the Bank to re-categorize and reallocate financing from other project components to cover emergency response and recovery costs. This component could also be used to channel additional funds should they become available because of an emergency. One such potential source of funding is the Pandemic Emergency Financing Facility (PEF), an insurance-based mechanism that provides surge financing to help prevent a high-severity infectious disease outbreak from becoming a pandemic. If the emergency in Cote d’Ivoire is a disease outbreak that meets the activation criteria of the PEF, the country may be eligible receive a PEF grant to support their response efforts. Details on how the PEF works can be found in Annex 6.1 of the PAD.

71. Disbursements would be made against a positive list of critical goods or the procurement of works, and services required to support the immediate response and recovery needs. A specific Emergency Response Operations Manual will apply to this component, detailing financial management, procurement, safeguards and any other necessary implementation arrangements.

**E. Implementation**

Institutional and Implementation Arrangements

1. **Implementation Arrangements.** The Ministry of Health and Public Hygiene will have the responsibility for implementing the overall project. The design of implementation and institutional arrangements of this project has been informed by lessons from the effective arrangements of the PBF pilot operation under the PRSSE. The project will be implemented at the national, regional, and district levels. The technical coordination and fiduciary aspects of the project will be managed by the existing fiduciary units of the Project Coordination Unit of the Ministry of Health and Public Hygiene.
2. **PIU roles and responsibilities:** Under the guidance of project Steering Committee, the PIU (UCP Santé-BM) will ensure the effective and technical coordination and fiduciary implementing of the project. He will be also responsible for all requirement project reports as part of financial agreement and disbursement letter and facilitate the Bank’s support missions and ad hoc meetings as necessary. This includes overall project reporting from MSHP, such as financial reports, AWP, budgets, results framework data and progress reports. The PIU will also serve as the interface between IDA and the Government and be responsible to contribute to national capacity building to coordinate and implement external financing.

3. **National Technical Unit (NTU).** The MSHP has a long track record in implementing Bank-financed projects, including the PRSSE. The PIU, experienced with the subject matter and in working in the sector, will continue to ensure appropriate fiduciary control and project management. A National Technical Unit (CT-PBF) was created under Strategic Planning Director (DPPS) and responsible for: (i) preparing PBF Steering Committee (PBF SC) meetings and supporting implementation of the decisions made by the PBF Steering Committee; (ii) supporting the regulatory function of the Ministry in the implementation of PBF; (iii) monitoring the progress of PBF implementation in the field, and promoting ownership of PBF by the Ministry; and (iv) exploring ways and mechanisms to both institutionalize PBF as a national policy in Côte d’Ivoire, and progressively expand the PBF approach. The CT-PBF was recently moved from the department of plan to under the director general of health (DGS), to reflect and support the sector level reforms that will be supported. The office of the DGS will be supported by key personnel from the major departments affected by the project.

4. **Role and responsibilities of the DGS:** The DGS will oversee coordination of NTU, monitor overall technical and financial progress of the NTU, analyze the bottlenecks and formulate proposals for remedial measures. As part of its secretariat functions, the DGS will prepare and/or consolidate all documentation for PBF SC information, decision, and approval.

5. **Role and responsibilities of the CNAM:** The CNAM ensure the prime responsibilities of the National Health Insurance implementing activities. In that case, this agency will oversees and implement as part of the project all activities or interventions in link with project technical assistance to CNAM in order to scale up the CMU at nationwide.

6. **The Health Inspector General** will play a key role in PBF scaling up approach, the implementation, and the monitoring of the overall strategy.

7. **Others Ministry of Health.** The following departments of MOH Department of Information, Department of Infrastructure, Department of Finances, Department of Human Resources, Department in charge of health private sector, Department of Hospital Medicine, and others health programmes will contribute to the project implementation as part of their roles et missions.

8. **UN Agencies** (WHO, UNICEF, UNFPA). To ensure that the quality of interventions follows international guidelines, and that lessons learned from previous countries benefit Cote d’Ivoire, the UN agency—WHO, UNICEF, UNFPA—will provide technical assistance to the MSHP in nutrition, WASH and rural solar electricity, obstetrical and newborn care, and leadership and management.
9. **Institutional Arrangements.** The leadership of CMU and PBF is under two different ministries. This would require efficient coordination of the different ministries involved in project implementation. Accordingly, a project Steering Committee (SC) will be set up to oversee and monitor the progress of the project activities.

10. **Steering Committee (SC).** A project Steering Committee will be created by the MSHP with the following composition: MSHP, Ministry of Employment and Social Protection, Ministry of Finance, Ministry of Budget, Ministry of Plan, Health Private Sector representative, decentralize collectivity representative and health civil society actors.

11. **Role and responsibilities of the SC:** The SC will provide overall strategic guidance for effective project implementation, monitor performance, and ensure cross-sectoral coordination and consistency of project activities with sector policies and strategies. The SC will review and approve annual work programs (AWPs), budgets, procurement plans, annual audits reports, and semi-annual progress reports. It will also make recommendations to facilitate implementation and resolve bottlenecks. Finally, the SC will meet at least twice a year and as a needed basis as requested by the MSHP to ensure timely approval of project documents in compliance with the Project Financing Agreement.

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**Note to Task Teams:** The following sections are system generated and can only be edited online in the Portal. Please delete this note when finalizing the document.

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**F. Project location and salient physical characteristics relevant to the safeguard analysis (if known)**

This new operation will be nationwide.

**G. Environmental and Social Safeguards Specialists on the Team**

Abdoul Wahabi Seini, Social Specialist  
Abdoulaye Gadiere, Environmental Specialist

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**SAFEGUARD POLICIES THAT MIGHT APPLY**

<table>
<thead>
<tr>
<th>Safeguard Policies</th>
<th>Triggered?</th>
<th>Explanation (Optional)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Environmental Assessment OP/BP 4.01</td>
<td>Yes</td>
<td>The new operation will finance some rehabilitations and equipment (see component 2). These types of activities are not usually associated with major</td>
</tr>
</tbody>
</table>
adverse impacts. However, as the exact location of these investments are not identified with certainty yet, the most relevant safeguard instrument to be prepared is the Environmental and Social Management Framework (ESMF). In addition, to properly manage medical wastes, a Medical Waste Management Plan (MWMP) was developed. Thereafter, both documents were reviewed, consulted upon in Cote d'Ivoire and on the Bank's website on November 16, 2018.

| Performance Standards for Private Sector Activities OP/BP 4.03 | No | This policy is not triggered by the operation. |
| Natural Habitats OP/BP 4.04 | No | The project does not involve or affect natural habitats. |
| Forests OP/BP 4.36 | No | It is not anticipated that forests will be impacted by the project. |
| Pest Management OP 4.09 | No | The project does not finance activity that may induce the use of pesticides. |
| Physical Cultural Resources OP/BP 4.11 | Yes | Activities supported by the proposed project such as rehabilitations could involve excavations with possibilities to discover physical cultural resources. However, the triggering of this policy does not entail the preparation of a specific safeguard instrument. A specific section was included in the ESMF to provide guidance in case physical cultural resources is discovered. |
| Indigenous Peoples OP/BP 4.10 | No | There are no Indigenous People as defined by the policy in the project areas. |
| Involuntary Resettlement OP/BP 4.12 | Yes | Some activities as construction and rehabilitations of infrastructures could induce potential adverse social impacts and may lead to land acquisition and/or restrictions on access to resources and sources of income or livelihoods. Consequently, a RPF was prepared, reviewed, consulted upon, and publicly disclosed within Cote d'Ivoire and on the World Bank website on November 16, 2018. |
| Safety of Dams OP/BP 4.37 | No | The project will not finance dams nor rely on dams. |
| Projects on International Waterways OP/BP 7.50 | No | The project is not expected to affect international waterways. |
| Projects in Disputed Areas OP/BP 7.60 | No | The project will not be located in a Disputed Area. |
KEY SAFEGUARD POLICY ISSUES AND THEIR MANAGEMENT

A. Summary of Key Safeguard Issues

1. Describe any safeguard issues and impacts associated with the proposed project. Identify and describe any potential large scale, significant and/or irreversible impacts:

Activities under the SPARK are likely to generate both positive and negative impacts on the socio-economic and components. However, some activities as construction and rehabilitation of infrastructures could induce potential adverse social impacts and may lead to land acquisition and/or restrictions on access to resources and sources of income or livelihoods. That is why the project has triggered Operational Policy 4.12 on Involuntary Resettlement.

On environment side, the negative impacts associated with investments could be expressed in terms of disruption of the living environment, disruption of care services, generation of solid and liquid waste (medical or non-medical), insecurity linked to the work, occupation of private land and pollution of natural resources (water, air, soil, etc.).

In anticipation of the negative environmental and social impacts, an Environmental and Social Management Framework (ESMF), a Medical Waste Management Plan (MWMP) and a Resettlement Policy Framework (RPF) were prepared by the Client.

2. Describe any potential indirect and/or long term impacts due to anticipated future activities in the project area:

No major indirect or long-term impacts are specifically expected. Nonetheless, the constructions/rehabilitations as well as the upgrading of health centers will unquestionably lead to more and more medical waste production and if those health care wastes are not well managed, that situation could therefore, constitute a major global concern for public health and the environment. For instance, the Ivorian health system in all sectors is estimated to produce 25,548.18 kg or about 25.55 tons per day and 9,325,086.92 kg or about 9,325.09 tons per year. 62% of this sanitary waste is infectious, consisting of 8% sharp, sharp, sharp objects and 54% infectious medical waste other than Pungent, Sharp and Cutting Objects. 36% equates to household and similar waste and 2% chemical and pharmaceutical waste. This large amount of hazardous waste is likely to spread both pathogenic microorganisms and hazardous chemicals.

3. Describe any project alternatives (if relevant) considered to help avoid or minimize adverse impacts.

The most relevant alternative is to ensure the effective implementation of the MWMP. In addition to this, the Government must (i) strengthen the legal and institutional framework; (ii) lead awareness-campaigns for social and behavioral change of actors; (iii) strengthen the capacities of the sanitary waste management sector and (iv) develop a sustainable financing system for the sanitary waste management sector and the public-private partnership.

4. Describe measures taken by the borrower to address safeguard policy issues. Provide an assessment of borrower capacity to plan and implement the measures described.

To address potential social adverse impacts related to resettlement, the client has developed a Resettlement Policy Framework (RPF). After its development, that document was reviewed, consulted upon, and publicly disclosed within Cote d’Ivoire and on the World Bank website on November 16, 2018. The RPF will guide the social assessment for each sub-project to determine whether land is acquired, and whether a sub-project-specific Resettlement Action Plan (RAP) is required or not.

In order to prepare for addressing the potential environmental negative impacts, the Government has prepared two...
(02) appropriate safeguards instruments. There are the Environmental and Social Management Framework (ESMF) and the Medical Waste Management Plan (MWMP).

The ESMF outlines an environmental and social screening process for component's activities. It also includes: Guidelines for an Environmental and Social Impact Assessment (ESIA); Environmental Guidelines for Contractors as well as sub-contractors; and a summary of the World Bank's safeguard policies. It will also contain chapters to take into account Physical Cultural Resources matters. That means guidance and guidelines have been included in the ESMF to this end.

The ESMF has been prepared, in full compliance with national legal and regulatory framework and World Bank safeguard policies, including a broad consultation framework involving all relevant stakeholder groups, both public and private, as well as civil society. After consultations, it has been disclosed within Cote d'Ivoire and at the World Bank website on November 16, 2018.

Like the ESMF the Medical Waste Management Plan (MWMP) was also disclosed within Cote d'Ivoire and at the World Bank website on November 16, 2018. It aims at playing a key role, on the one hand in the management of the quality of care, the safety of patients and caregivers, and on the other hand in the protection of the environment and the community against the risks of pollution and contamination.

A Grievance Redress Mechanism (GRM) was set up to allow stakeholders and interested parties to bring up any concern regarding the project to the PIU with the aim of finding solutions.

Safeguards documents include guidelines on Occupational, Health and Safety (EHS/OHS) clearly mentions that the company Environmental and Social Management Plan (Works-ESMP) must be approved by the PIU and their partners prior to the works commencement. Moreover, the tender documents and the contracts for main contractors as well as the sub-contractors must also include sections related to EHS/OHS.

With respect to potential labor influx, the project will establish guidance and rules for (i) contractors to enhance the ESMPs and workers contracts will include measures for managing the potential impacts of such an outside workforce on the local community. Specific details will be prepared during the investment activities for contractors who will bring in workers and operators from outside the area, and these are likely to be housed in work camps during construction.

To ensure that the safeguard instruments prepared in line with policies triggered by the project are implemented properly, the PIU will hire an environmental safeguard specialist and a social safeguards specialist. The environmental safeguards specialist must have additional experience in EHS/OHS, and the social safeguards specialist in GBV, Social inclusion and any labor related risk. Both specialists will be fully in charge of all aspects of environmental and social safeguards aspects and will regularly monitor all safeguard requirements. More specifically, the two specialists, the whole PIU, the implementing agencies as well as the other stakeholders will ensure that children are not employed in civil works as labor force.

World Bank implementing support missions will also include environmental and social safeguards specialists to ensure that all safeguard issues are addressed properly and, in a timely manner.

5. Identify the key stakeholders and describe the mechanisms for consultation and disclosure on safeguard policies,
with an emphasis on potentially affected people.

One of the key principles of this project from the outset was to foster participation of all relevant stakeholders. This approach will be sustained throughout project implementation. The environmental and social assessment studies, namely the ESMF, MWMP and RPF, were also carried out according to the same principle, using broad-based public consultation approach, involving the stakeholder groups. The objective was to raise awareness of project activities and impacts and foster ownership on their part. All the relevant bodies have been adequately informed of the Project. Concerns of the communities and some details of consultations have been taken into account in the body of the report and other results provided as Annexes in the ESMF, MWMP and RPF. The key concerns raised during the consultation process included: (i) permanent information and sensitization of the population, (ii) compensation process for those impacted by the project, (iii) participation of local population as employee on works they qualify for, etc. All these concerns have been addressed in the alternatives proposed through the ESMF, MWMP and the RPF.

B. Disclosure Requirements

<table>
<thead>
<tr>
<th>Environmental Assessment/Audit/Management Plan/Other</th>
<th>For category A projects, date of distributing the Executive Summary of the EA to the Executive Directors</th>
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<tbody>
<tr>
<td>Date of receipt by the Bank</td>
<td>Date of submission for disclosure</td>
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<td>16-Nov-2018</td>
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"In country" Disclosure

<table>
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<tr>
<th>Resettlement Action Plan/Framework/Policy Process</th>
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<td>Date of receipt by the Bank</td>
<td>Date of submission for disclosure</td>
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<td>25-Oct-2018</td>
<td>16-Nov-2018</td>
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</tbody>
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"In country" Disclosure

C. Compliance Monitoring Indicators at the Corporate Level (to be filled in when the ISDS is finalized by the project decision meeting)

OP/BP/GP 4.01 - Environment Assessment

Does the project require a stand-alone EA (including EMP) report?
Yes
If yes, then did the Regional Environment Unit or Practice Manager (PM) review and approve the EA report?
Yes
Are the cost and the accountabilities for the EMP incorporated in the credit/loan?
Yes

**OP/BP 4.11 - Physical Cultural Resources**
Does the EA include adequate measures related to cultural property?
Yes
Does the credit/loan incorporate mechanisms to mitigate the potential adverse impacts on cultural property?
Yes

**OP/BP 4.12 - Involuntary Resettlement**
Has a resettlement plan/abbreviated plan/policy framework/process framework (as appropriate) been prepared?
Yes
If yes, then did the Regional unit responsible for safeguards or Practice Manager review the plan?
Yes

The World Bank Policy on Disclosure of Information

Have relevant safeguard policies documents been sent to the World Bank for disclosure?
Yes
Have relevant documents been disclosed in-country in a public place in a form and language that are understandable and accessible to project-affected groups and local NGOs?
Yes
All Safeguard Policies

Have satisfactory calendar, budget and clear institutional responsibilities been prepared for the implementation of measures related to safeguard policies?
Yes

Have costs related to safeguard policy measures been included in the project cost?
Yes

Does the Monitoring and Evaluation system of the project include the monitoring of safeguard impacts and measures related to safeguard policies?
Yes

Have satisfactory implementation arrangements been agreed with the borrower and the same been adequately reflected in the project legal documents?
Yes

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APPROVAL

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