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Report No: PAD3048

INTERNATIONAL DEVELOPMENT ASSOCIATION

PROJECT APPRAISAL DOCUMENT

ON A

PROPOSED CREDIT

IN THE AMOUNT OF EUR 174.2 MILLION
(US$200.0 MILLION EQUIVALENT)

GOVERNMENT OF CÔTE D'IVOIRE

FOR THE

STRATEGIC PURCHASING AND ALIGNMENT OF RESOURCES AND KNOWLEDGE IN HEALTH PROJECT (SPARK-HEALTH)

March 1, 2019

Health, Nutrition and Population Global Practice
Africa Region

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CURRENCY EQUIVALENTS

Exchange Rate Effective Jan 31, 2019

Currency Unit =	EUR
EURO 0.87051143 =	US$1

FISCAL YEAR
January 1 - December 31

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Country Director:	Pierre Frank Laporte
Senior Global Practice Director:	Timothy Grant Evans
Practice Manager:	Gaston Sorgho
Task Team Leader:	Emre Ozaltin

ABBREVIATIONS AND ACRONYMS

ACV	Contracting and Verification Agency (*Agence de Contractualisation et Vérification*)
ACDP	Directorate of Public Debt
AFD	French Development Agency (*Agence Française de Développement*)
ARV	Antiretroviral
ASA	Analytic Service Advisory
AWPB	Annual Work Plan and Budget
BEmONC	Basic Emergency Obstetric and Newborn Care
BCEAO	Central Bank of West African States
CAT	Anti-tuberculosis centers (*centres antituberculeux*)
CBO	Community-Based Organization
CDT	Tuberculosis Diagnosis and Treatment Center (*centres de diagnostic et de traitement de la tuberculose*)
CERC	Contingent Emergency Response Component
CHR	Regional Hospital (*Centre Hospitalier et Régional*)
CHU	University Teaching Hospital (*Centre Hospitalier Universitaire*)
CHW	Community Health Workers
CIV	Côte d'Ivoire
CMU	National Health Insurance (*Couverture Médicale Universelle*)
CNAM	Health Insurance Agency *(Caisse Nationale d'Assurance Maladie)*
COGES	School Management Committees
CPA	Complementary Package of Activities
CPF	Country Partnership Framework
CRVS	Civil Registration and Vital Statistics
CTN-PBF	National Technical Unit for Performance Based Financing (*Cellule Technique National*)
DA	Designated Account
DAF	Directorate of Administrative and Financial Affairs, Ministry of Health
DAH	Development Assistance for Health
DDS	District Directorate of Health
DFIL	Disbursement and Financial Information Letter
DGS	Directorate General for Health
DHIS2	District Heath Information Software 2
DHS	Demographic and Health Survey
DIEM	Directorate for Infrastructure, Equipment and Maintenance
DLI	Disbursement Linked Indicator
DPPS	Directorate of the Department of Planning and Forecasting, Ministry of Health
DPT3	Diphtheria, Pertussis, and Tetanus
DRS	Regional Directorate of Health
EA	Environment Assessment
EBID	ECOWAS Bank for Investment and Development
ECOWAS	Economic Community of West African States
EMR	Electronic Medical Record

EmONC	Emergency Obstetric and Newborn care
ESMF	Environmental and Social Management Framework
FM	Financial Management
FY	Fiscal Year
Gavi	The Vaccine Alliance
GDP	Gross Domestic Product
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GFF	Global Financing Facility
GH	General Hospital
GNI	Gross National Income
GRS	Grievance Redress Service
HAQ	Healthcare Access and Quality
HCI	Human Capital Index
HDI	Human Development Index
HFSA	Health Financing Systems Assessment
HHR	Health Human Resources
HMIS	Health Management Information System
ICB	International Competitive Bidding
ID4D	Identification for Development
IDA	International Development Association
IE	Impact Evaluation
IEY	Investigating in Early Years
IFR	Interim Financial Reports
IGF	Internal audit (*Inspection Générale des Finances*)
IGS	Health Inspectorate General
IHME	Institute for Health Metrics and Evaluation
IMCI	Integrated Management of Childhood Illness
IMF	International Monetary Fund
IPF	Investment Project Financing
IsDB	Islamic Development Bank
ISP	Implementation Support Plan
IVA	Independent Verification Agency
LCS	Least Cost Selection
LiST	Lives Saved Tool
LLIN	Long-lasting Insecticide Treated Bed Nets
LMIC	Lower-middle Income Country
MB	Ministry in charge of Budget
M&E	Monitoring and Evaluation
MDGs	Millennium Development Goals
MEF	Ministry of Economy and Finance
MEPS	Ministry for Social Security (*Ministère de Emploi et Protection Sociale*)
MFD	Maximizing Finance for Development
MICS	Multiple Indicator Cluster Survey

MMOPP	Project Procedures and Implementation Manual
MMR	Maternal Mortality Ratio
MNCH	Maternal, Neonatal and Child Health
MP	Ministry of Planning
MSHP	Ministry of Health and Public Hygiene
MOU	Memorandum of Understanding
MWMP	Medical Waste Management Plan
NCB	National Competitive Bidding
NCD	Non-communicable Diseases
NGO	Non-governmental Organization
OOP	Out-of-pocket Payments
PA	Project Account
PAD	Project Appraisal Document
PBF	Performance-based Financing
PDO	Project Development Objective
PEF	Pandemic Emergency Facility
PER	Public Expenditure Review
PFM	Public Financial Management
PforR	Program for Result
PHCPI	Primary Health Care Performance Initiative
PIM	Project Implementation Manual
PIU	Project Implementation Unit
PMNDPE	Multisectoral Nutrition and Child Development Project
PMT	Proxy Means Testing
PND	National Development Plan
PNDS	National Health Development Plan
PPA	Project Preparation Advance
PPP	Public-private-Partnerships
PPSD	Project Procurement Strategy for Development
PSGouv	Government Social Program (*Programme Social du Gouvernement*)
PRSSE	Health Systems Strengthening and Epidemic Preparedness Project
QCBS	Quality and Cost Based Selection
RASS	Annual Health Statistics Report
RMNCAH	Reproductive, Maternal, Neonatal, Child and Adolescent Health and Nutrition
RBF	Results-based Financing
REOI	Requests for expressions of interest
RF	Results Framework
RFP	Request for Proposal
RH	Regional Hospital
SARA	Services Availability and Readiness Assessment
SBD	Standard Bidding Document
SC	Steering Committee
SCD	Systematic Country Diagnostic
SDI	Service Delivery Indicator

SDG	Sustainable Development Goals
SIGFIP	Integrated National FM information system
SNIS	Indicators and National Health Information System
SNPBF	National PBF Strategic Plan
SOE	Statement of Expenditures
SORT	Systematic Operations Risk-Rating Tool
SPARK	Strategic Purchasing and Alignment of Resources and Knowledge in Health Project
SSA	Sub-Saharan Africa
SSR	Single Social Registry
SWEDD	Sahel Women Empowerment and Demographic Dividend Regional Project
TA	Technical Assistance
TFR	Total Fertility Rate
THE	Total Health Expenditure
ToR	Termes of Reference
U5MR	Under 5 Mortality Rate
UCP	Project Coordination Unit (Unité de Coordination du Projet)
UHC	Universal Health Coverage
UN	United Nations
UNAIDS	United Nations Programme on HIV/AIDS
UNDB	United Nations Development Business
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WAEMU	West African Economic and Monetary Union
WBG	World Bank Group
WDI	World Development Indicators
WHO	World Health Organization
WISN	Workload Indicators of Staffing Need

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DATASHEET

BASIC INFORMATION

Country(ies)	Project Name	
Cote d'Ivoire	Strategic Purchasing and Alignment of Resources & Knowledge in Health Project (SPARK-Health)	
Project ID	**Financing Instrument**	**Environmental Assessment Category**
P167959	Investment Project Financing	B-Partial Assessment

Financing & Implementation Modalities

[ ] Multiphase Programmatic Approach (MPA)	[✓] Contingent Emergency Response Component (CERC)
[ ] Series of Projects (SOP)	[✓] Fragile State(s)
[ ] Disbursement-linked Indicators (DLIs)	[ ] Small State(s)
[ ] Financial Intermediaries (FI)	[ ] Fragile within a non-fragile Country
[ ] Project-Based Guarantee	[✓] Conflict
[ ] Deferred Drawdown	[ ] Responding to Natural or Man-made Disaster
[ ] Alternate Procurement Arrangements (APA)	

Expected Approval Date	Expected Closing Date
22-Mar-2019	30-Jun-2025

Bank/IFC Collaboration

No

Proposed Development Objective(s)

To improve the utilization and quality of health services towards reducing maternal and infant mortality in the Recipient's territory.

Components

Component Name	Cost (US$, millions)
Scale-Up of Strategic Purchasing	116.39
Health System Strengthening to Improve Performance	91.58
Project Management	12.02
Contingency Emergency Response	0.00

Organizations

Borrower:	Government of Côte d'Ivoire
Implementing Agency:	Ministere de la Sante et de l'Hygiene Publique (MSHP)

PROJECT FINANCING DATA (US$, Millions)

SUMMARY

Total Project Cost	220.00
Total Financing	220.00
of which IBRD/IDA	200.00
Financing Gap	0.00

DETAILS

World Bank Group Financing

International Development Association (IDA)	200.00
IDA Credit	200.00

Non-World Bank Group Financing

Trust Funds	20.00
Global Financing Facility	20.00

IDA Resources (in US$, Millions)

	Credit Amount	Grant Amount	Guarantee Amount	Total Amount
National PBA	200.00	0.00	0.00	200.00
Total	**200.00**	**0.00**	**0.00**	**200.00**

Expected Disbursements (in US$, Millions)

WB Fiscal Year	2019	2020	2021	2022	2023	2024	2025
Annual	0.00	75.20	65.94	30.30	18.29	16.26	14.01
Cumulative	0.00	75.20	141.14	171.44	189.73	205.99	220.00

INSTITUTIONAL DATA

Practice Area (Lead)

Health, Nutrition & Population

Contributing Practice Areas

Climate Change and Disaster Screening

This operation has been screened for short and long-term climate change and disaster risks

Gender Tag

Does the project plan to undertake any of the following?	
a. Analysis to identify Project-relevant gaps between males and females, especially in light of country gaps identified through SCD and CPF	No
b. Specific action(s) to address the gender gaps identified in (a) and/or to improve women or men's empowerment	Yes
c. Include Indicators in results framework to monitor outcomes from actions identified in (b)	Yes

SYSTEMATIC OPERATIONS RISK-RATING TOOL (SORT)

Risk Category	Rating
1. Political and Governance	Substantial
2. Macroeconomic	Substantial

3. Sector Strategies and Policies	Moderate
4. Technical Design of Project or Program	Substantial
5. Institutional Capacity for Implementation and Sustainability	Substantial
6. Fiduciary	Substantial
7. Environment and Social	Moderate
8. Stakeholders	Moderate
9. Other	
10. Overall	Substantial

COMPLIANCE

Policy

Does the project depart from the CPF in content or in other significant respects?

[ ] Yes [✓] No

Does the project require any waivers of Bank policies?

[ ] Yes [✓] No

Safeguard Policies Triggered by the Project	Yes	No
Environmental Assessment OP/BP 4.01	✓	
Performance Standards for Private Sector Activities OP/BP 4.03		✓
Natural Habitats OP/BP 4.04		✓
Forests OP/BP 4.36		✓
Pest Management OP 4.09		✓
Physical Cultural Resources OP/BP 4.11	✓	
Indigenous Peoples OP/BP 4.10		✓
Involuntary Resettlement OP/BP 4.12	✓	
Safety of Dams OP/BP 4.37		✓
Projects on International Waterways OP/BP 7.50		✓

Projects in Disputed Areas OP/BP 7.60	✓

Legal Covenants

Sections and Description
The Recipient shall establish no later than three (3) months after the Effective Date, and thereafter maintain throughout the period of Project implementation, with terms of reference, mandate, composition and resources satisfactory to the Association, a steering committee, as further detailed in the Project Implementation Manual ("Steering Committee").

Conditions

Type	Description
Effectiveness	The GFF Grant Agreement has been executed and delivered and all conditions relating to its effectiveness or to the right of the Recipient to make withdrawals under it (other than the effectiveness of this Agreement) have been fulfilled.
Effectiveness	The Recipient has adopted the Project Implementation Manual in accordance with the provisions of Section I.B. of Schedule 2 to this Agreement.
Effectiveness	The Recipient has appointed for the Project (i) a financial comptroller and (ii) an accountant, to the satisfaction of the Association.
Disbursement	For payments under Category (2), unless and until grant proceeds made available under the GFF Grant Agreement have been entirely disbursed.
Disbursement	For payment under Category (3), unless and until the Recipient has adopted the PBF Manual under terms and conditions set out in Section I.D. of Schedule 1 to this Agreement.
Disbursement	For payments under Category (4), unless and until the Subsidiary Agreement, satisfactory to the Association, has been signed and executed according to its terms, in accordance with the provisions of Section I.C. of Schedule 2 to this Agreement.
Disbursement	For payments under Category (5), unless the Recipient has determined that an Eligible Crisis or Emergency has occurred, has furnished to the Association a request to include activities in the CERC of the Project in order to respond to said Eligible Crisis or Emergency, and the Association has agreed with such determination, accepted said request and notified the Recipient thereof.

Type	Description
Disbursement	For payments under Category (5), unless the Recipient has prepared and disclosed all Safeguards Instruments required for activities in the CERC of the Project, and has implemented any actions required pursuant thereto, all in accordance with the provisions of Section I.F. of Schedule 2 to this Agreement.
Type	Description
Disbursement	For payments under Category (5), unless the Recipient has ensured that the Coordinating Authority has adequate staff and resources, in accordance with the provisions of Section I.F. of Schedule 2 to this Agreement, for the purposes of activities in the CERC of the Project.
Type	Description
Disbursement	For payments under Category (5), unless the Recipient has approved and maintained the CERC Operations Manual in form and substance acceptable to the Association pursuant to Section 1.F. of Schedule 2 to this Agreement.

I. STRATEGIC CONTEXT

A. Country Context

1. **With a population of around 24.3 million in 2017, Côte 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 percent of the population while 16 percent are children under 5 years of age. The non-national population is estimated at around 25 percent of the total. Independent since August 1960, Côte d'Ivoire experienced a long period of instability between 2002 and 2011, marked by two armed conflicts in 2002-2007 and 2010-2011, 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 percent because of the post-election crisis.

2. **Côte d'Ivoire (CIV) is a lower-middle income country** (LMIC) with a Gross National Income (GNI) per capita of US$1,532.5 in 2017[1] and is the second largest economy in West Africa. After 10 years of economic stagnation accompanying civil unrest, Côte d'Ivoire has experienced a revival of economic activity and since 2012, it ranks among the top 10 countries in the world with the highest growth, having posted on average 8.7 percent over 2012-2017 period. At 0.7 percent in 2017, 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. The macroeconomic outlook remains positive, with International Monetary Fund (IMF) predicting average growth rates of 7 percent as well as a low rate of inflation in the medium term. [2]

3. **However, even with strong economic growth, economic benefits remain concentrated in the capital city of Abidjan and, despite efforts to the contrary, 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 percent overall and 56.8 percent in rural areas. The Human Development Index (HDI) ranks Côte d'Ivoire 170 out of 189 countries in 2018, while the Human Capital Index (HCI) ranks it 149 out of the 157 countries in 2018. [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 on 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 percent in 2015: 53 percent for men and 36 percent for women. Even though Côte d'Ivoire has been designated a pre-emerging country by the IMF in 2018, it was among the 36 countries described as "fragile" by the World Bank[4] in the same year.

[1] WBG https://data.worldbank.org/country/cote-divoire, Atlas method, current US dollars.
[2] http://www.imf.org/en/Countries/ResRep/CIV#news.
[3] http://databank.worldbank.org/data/download/hci/HCI_2pager_CIV.pdf.
[4] "Fragile Situations" have: either a) a harmonized average CPIA country rating of 3.2 or less; or b) the presence of a UN and/or regional peace-keeping or peacebuilding mission during the past three years. Accordingly, as ONUCI departed in 2017, Côte d'Ivoire will lose this designation in 2020.

4. **The economy is strongly dependent on the production and export of primary agricultural products**, particularly cocoa, coffee, bananas, cashew and palm oil. Côte d'Ivoire is also an exporter of oil and a net exporter of energy. Robust prices for the agricultural exports contributed to strong growth and government revenues in 2016. In 2017, the price of the dominant export, cocoa, fell bringing some fiscal and macroeconomic problems. However, even though the budget deficit reached 4.5 percent and the deficit in the external current account reached 2.8 percent of GDP, the real GDP growth rate of Côte d'Ivoire remained the highest in the world with 7.7 percent demonstrating the resilience of the economy to exogenous and endogenous shocks. [5]

5. **Government revenues and expenditures have been steadily increasing in line with economic growth but remain below regional and LMIC averages**. Despite the country's economic growth, tax revenue mobilization remains limited. In 2017, Government revenue is 20.4 percent of GDP (tax-to-GDP ratio is lower at 17 percent), and government expenditure is 24.4 percent of GDP, lower than sub-Saharan African (SSA) and lower-middle income averages. Overall tax revenue collection has increased by an average rate of 12 percent every year, largely due to strong economic recovery post-conflict, despite a drop in the corporate tax rate from 35 percent to 25 percent. Up to 35 percent of Côte d'Ivoire's economy is in the informal sector, close to the Economic Community of West African States (ECOWAS) average.

6. **Within the existing fiscal space, the share of social spending remains low and health expenditure is about 5 percent of general government spending, which is among the lowest in Africa and well below the Abuja target of 15 percent.** About 25 percent 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 percent 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 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 (US$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.

B. Sectoral and Institutional Context

Health Status

7. **The socio-political instabilities 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[6] and the Ministry of Health and Public Hygiene (MSHP) continued to suffer from a lack of financial and political empowerment. Furthermore, the supply chain was seriously disrupted, almost all

[5] FMI Rapport n° 18/367 *https://www.imf.org/fr/Countries/ResRep/CIV#country*.
[6] Gaber Sabrina and Preeti Patel. "Tracing Health System Challenges in Post-Conflict Côte d'Ivoire from 1893 to 2013." *Global Public Health* 8, no. 6 (July 10, 2013): 698–712. *https://doi.org/10.1080/17441692.2013.791334.*

hospitals were closed due to looting or occupation, and 800,000 people were internally displaced with more than 70 percent of the population lacking access to health services.[7]

8. **Despite its lower middle-income status, Côte 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 percent of the disease burden[8]. Increasing prosperity, rising urbanization and an increase in unhealthy lifestyles, has led to a rise in the burden of non-communicable diseases (NCD), resulting in a dual burden of disease taxing an already fragile health system. Côte d'Ivoire did not achieve any of the health-related Millennium Development Goals (MDGs)[9], nor any of the health targets set out in the previous National Health Development Plan (PNDS, 2012-2015)[10] and will hardly reach the targets set in the current PNDS (2016-2020). When ranked next to other low or middle income West African countries **(Table 1),** it consistently ranks as one of the weakest 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). Côte d'Ivoire lags regional countries, SSA country averages and low-income country averages in terms of access to the most essential treatment and prevention services and is below the LMIC average for all indicators except for Antiretroviral (ARV) coverage. Notably, contraceptive prevalence rate is at 18 percent and skilled birth attendance is at 59 percent, amongst the lowest in West Africa.

Table 1: Comparison of health indicators across west Africa, 2016

	Total Health Expenditure (THE) per capita (US$), 2015		**Life expectancy at birth (years)**		**HIV-Prévalence**		**Incidence of Malaria (per 1,000 population at risk), 2015**		**Under-5 death rate (per 1,000 live births)**		**Maternal mortality ratio (per 100,000 live births), 2015**	
		Rank		Rank		Rank		Rank		Rank		Rank
Benin	31.3	10	60.9	5	1.0	4	293.7	6	97.6	9	405	4
Burkina Faso	33.4	9	60.4	6	0.8	3	389.2	10	84.6	6	371	3
Cameroon	63.6	5	58.1	8	3.8	11	264.2	4	79.7	4	596	6
Côte d'Ivoire	**75.4**	**3**	**53.6**	**10**	**2.7**	**9**	**348.8**	**7**	**91.8**	**8**	**645**	**8**
Ghana	79.6	2	62.7	3	1.6	7	266.4	5	58.8	2	319	2
Guinea	25.1	11	60.0	7	1.5	6	367.8	8	89	7	679	9
Liberia	69.3	4	62.5	4	1.6	8	246.2	3	67.4	3	725	10
Mali	42.3	7	58.0	9	1	5	448.6	11	110.6	11	587	5
Mauritania	53.6	6	63.2	2	0.5	2	74.2	1	81.4	5	602	7
Nigeria	97.3	1	53.4	11	2.9	10	380.8	9	104.3	10	814	11
Senegal	36.1	8	67.1	1	0.4	1	97.6	2	47.1	1	315	1

[7] WHO. (2011). Thousands without adequate health care in Western Côte d'Ivoire - WHO scales up its operations. *http://www.who.int/hac/crises/civ/sitreps/18april2011/en/index.html*

[8] Source: Institute for Health Metrics and Evaluation (2018).

[9] Source: MDG report 2015: Assessing Progress in Africa toward the MDGs.

[10] *Ministère de la Santé et de l'Hygiène Publique*. (2016). *Plan National de Développement Sanitaire, Evolution des indicateurs du PNDS* 2012-2015.

SSA	84.9	-	60.4	-	4.3	-	234.3	-	78.3	-	547	-

Source: HFSA 2019

Table 2: Universal Health Coverage (UHC) Index Indicators for West African Countries, 2016 (all units in percentages)

	Treatment		Prevention				
	ARV	TB	Family planning	Skilled birth attendance	Diphtheria, Pertussis, and Tetanus (DPT3)	Water	Sanitation
Benin	57	55	18	77	82	78	20
Burkina Faso	60	47	26	66	91	82	20
Côte d'Ivoire	**41**	**49**	**18**	**59**	**85**	**82**	**22**
Cameroon	37	45	34	65	85	76	46
Ghana	34	28	31	71	93	89	15
Guinea	35	46	6	45	57	77	20
Liberia	19	32	20	61	79	76	17
Mali	35	52	16	49	68	77	25
Niger	32	44	17	40	67	58	11
Nigeria	30	18	20	35	49	69	29
Senegal	52	55	25	53	93	79	48
Sierra Leone	26	47	17	60	84	63	13
Lower middle-income average	38	56	49	79	86	83	60
Sub-Saharan African average	45	44	31	64	79	73	35

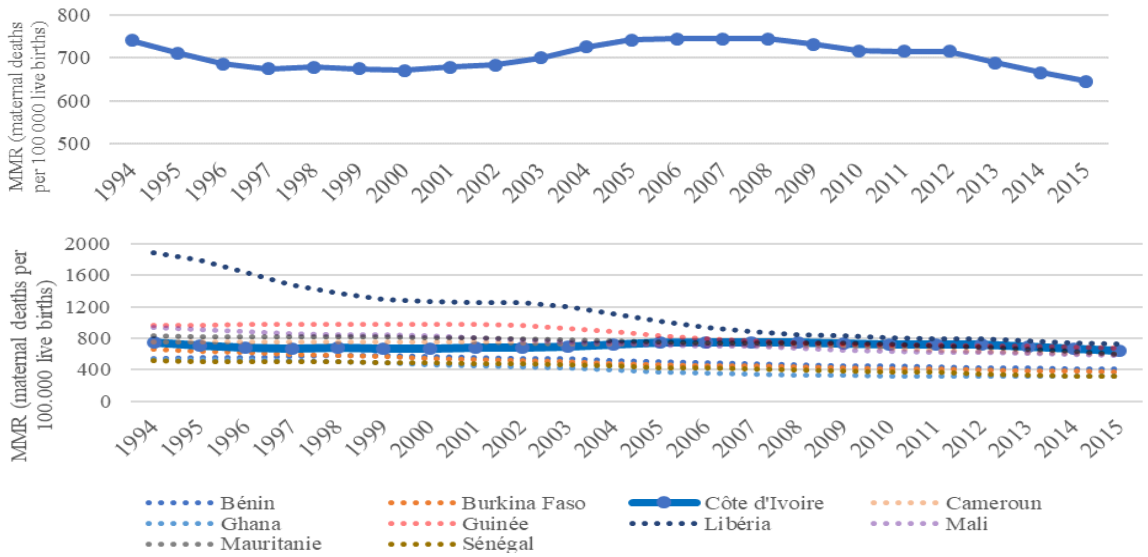
Source: HFSA 2019

9. **Côte d'Ivoire's maternal mortality ratio (MMR) of 645[11] deaths per 100,000 live births is among the highest in the world (Figure 1)**. Côte d'Ivoire ranks 173 out of 179 countries on the mother's index[12], lagging countries like Chad, Benin and the Republic of Congo. Maternal deaths are driven by preventable and treatable complications, including hemorrhage (36 percent); obstructed labor (20 percent), eclampsia (18 percent), abortion-related complications (15 percent) and post-partum infections (4.8 percent).[13] The high prevalence of teenage pregnancies (30 percent) is particularly concerning[14], and accounts for 14.8 percent of maternal deaths. Almost all (80 percent) maternal deaths occur due to direct medical causes[15], reflecting a lack of coverage and poor quality of obstetric care in the prevention and management of complications during pregnancy, childbirth

[11] Official country Figure is 614 based on DHS 2012.
[12] 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.
[13] UNFPA, 2017.
[14] Teenagers pregnancy classified as women pregnant between the ages of 15-19 years.
[15] Direct causes include: hemorrhage, obstructed labor, high blood pressure, and abortion complications.

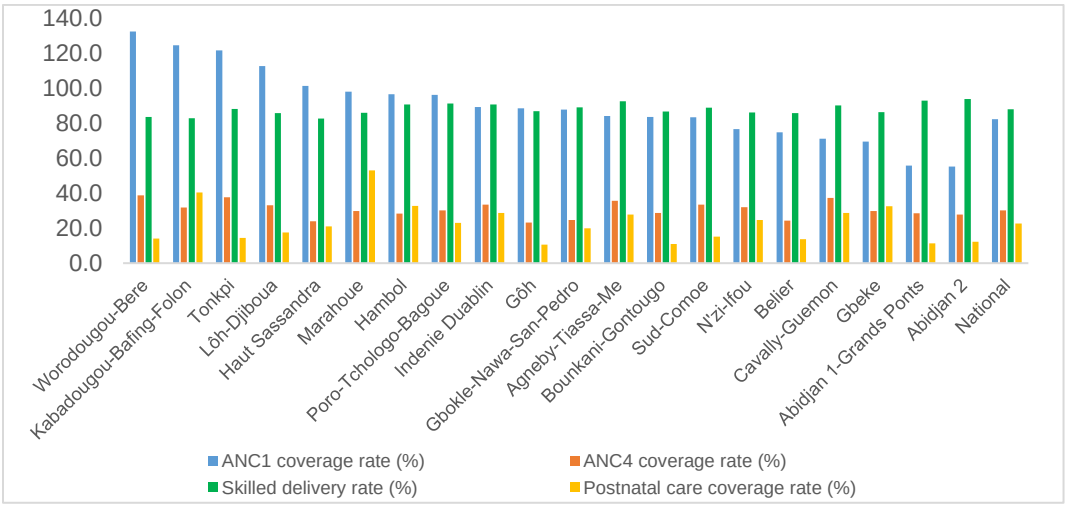
and postpartum. Only 51 percent of women attended four antenatal visits (ANC 4) during pregnancy (2016), 73.6 percent of women delivered in the presence of skilled birth attendants (2016) and 83.1 percent of women are seen by a healthcare professional during the postnatal period[16]. Even though skilled birth deliveries are high according to administrative data, coverage of ANC4 is at 30 percent and postpartum checkups is at 22 percent, indicating the weak capacity of the health system to retain women within the health system once they seek care **(Figure 2)**.

Figure 1. Maternal Mortality in Côte d'Ivoire and Francophone West Africa



Source: World Development Indicators (WDI), 2017.

Figure 2: ANC1, ANC4, Skilled delivery and postnatal care coverage rates in Côte d'Ivoire by Region, 2017



Source: RASS 2017

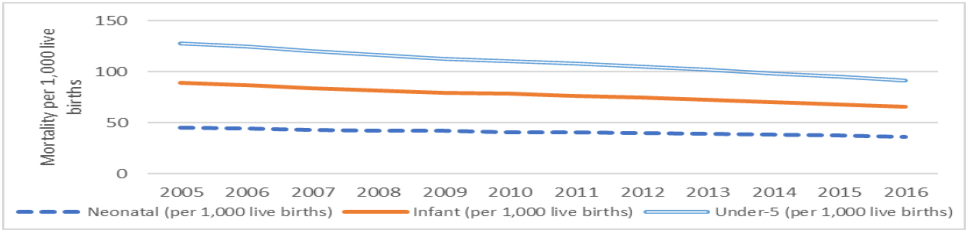
[16] MICS 2016.

10. **The high MMR is associated with insufficient coverage of obstetric care, insufficient prevention and management of complications during pregnancy, childbirth and postpartum, and inadequate nutritional care.** The Caesarean sections are low with a rate of 0.61 percent compared to the minimum 5 percent recommended by the World Health Organization (WHO). Only 11 out of 100 hospitals (10 percent) currently offer the complete Emergency Obstetric and Newborn care (EmONC) package and 18 of the 412 primary care facilities (4 percent) offer Basic Emergency Obstetric and Newborn Care (BEmONC). The BEmONC functions least practiced in Côte d'Ivoire are assisted delivery by suction cup (14 percent) and resuscitation of the newborn (39 percent).[17]

11. **Lack of access to services contributes to maternal mortality.** In the richest quintile, 95 percent of women give birth with the assistance of qualified health personnel, compared to 49 percent of women in the poorest quintile[18]. Seventy-five percent (75 percent) of women in the poorest quintile indicated that lack of money was a major impediment to maternity care, compared to 55 percent of women in the richest quintile[19]. Long distances from the nearest facility and weak referral systems also pose a barrier, with 33 percent of the population living outside a 5-kilometer radius from a health facility, and only 0.22 ambulances per health facility.[20]

12. **One in every ten children in CIV died before the age of five (96 deaths per 1000 live births) and over a fifth of children were stunted (21 percent)[21] 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.[22] 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)[23] have declined by 28 percent, 26 percent and 19 percent since 2005, they remain high **(Figure 3)**. More than half of these deaths (60 percent) are due to preventable and treatable communicable diseases and perinatal causes, with the top causes of under-five mortality including malaria (25 percent), pneumonia (15 percent), diarrhea (9 percent), premature births (13 percent) and asphyxia (10 percent). Immunization coverage remains lower than peer countries, with only 40 percent of infants fully immunized.[24]

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



Source: World Development Indicators (WDI), 2017

[17] UNFPA 2017.
[18] MICS 2016.
[19] DHS 2012.
[20] RASS 2017.
[21] Chronic malnutrition defined as height-for-age less than minus two scores below the median of the WHO child growth standards.
[22] Caulfield, LE, et al (2004). Undernutrition as an underlying cause of child deaths associated with diarrhea, pneumonia, malaria and measles. AM J Clin Nutr 2004; 80(1): 193-8.
[23] MICS 2016.
[24] 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 with age: 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 percent, 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 percent in 1994, to 14 percent in 2012, to 16 percent in 2016. Thirty one percent of contraceptive needs among women are not satisfied by modern methods of contraception, which leads to early pregnancies (25 percent 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 Institute for Health Metrics and Evaluation (IHME) Healthcare Access and Quality (HAQ) index, Côte d'Ivoire ranks 187 out of 195 countries in terms of quality, as measured by the prevalence of amenable mortality (deaths that should not be occurring in the presence of effective care).[25] 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, Côte d'Ivoire has among the highest prevalence of amenable mortality in SSA; and Côte 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.[26]

16. **Poor quality leads to suboptimal care.** Twenty-three percent of women do not get their blood pressure, blood or urine tested during pregnancy[27], 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. Côte d'Ivoire also fares poorly in terms of the availability of essential inputs: average operational capacity at all levels of health facilities is 57 percent, with only 22 percent of facilities having all the required items for infection prevention. Main issues identified with structural quality are management of blood transfusion (only 5 percent at primary care level); interruptions in supply chains leading to stock-outs; and data and management capacity.[28] An estimated 87 percent of health facilities have experienced at least one stock-out of medicines in the past year, with 53 percent having experienced multiple stock-outs. These lead to low utilization (48 percent of the population has not sought

[25] Barber, R.M. et al, 2017. Healthcare Access and Quality Index based on mortality from causes amenable to personal health care in 195 countries and territories, 1990–2015: a novel analysis from the Global Burden of Disease Study 2015. The Lancet 390, 231–266. https://doi.org/10.1016/S0140-6736(17)30818-8.
[26] Kruk, M.E., Gage, A.D., Joseph, N.T., Danaei, G., García-Saisó, S., Salomon, J.A., 2018. Mortality due to low-quality health systems in the universal health coverage era: a systematic analysis of amenable deaths in 137 countries. The Lancet. *https://doi.org/10.1016/S0140-6736(18)31668-4.*
[27] MICS 2016.
[28] Service Availability and Readiness Assessment (SARA) 2015.

care from any health facility in the past year) and low satisfaction (39 percent of the population rated health service quality as "bad" or "very bad," with those living in rural areas rating quality considerably worse[29]). Health is among top concerns for Ivoirians, ranking second, only behind unemployment.[30]

17. **Weak infrastructure and unavailability of drugs and medical equipment are important challenges, especially for maternal and child health.** Forty-five percent of primary and secondary facilities are without electricity, 35 percent without water, and 32 percent without both water and electricity.[31] For maternal health, low service availability is also a significant concern: although ANC was offered in 90 percent of health facilities in 2015, only 45 percent of staff was trained on the right protocols, 36 percent of facilities had directives available, 12 percent had hemoglobin test and 36 percent had protein urea test.[32] For deliveries, not a single health facility had all the 21 tracer indicators for basic obstetric care. Only 33 percent of facilities had treatment for sepsis available, 34 percent of facilities have staff trained in neonatal resuscitation, 21 percent offered neonatal resuscitation, and 62 percent of facilities monitored and managed labor using a partograph. Thirty seven percent of facilities had guidelines for deliveries available, 42 percent of staff were trained in essential delivery care; and 54 percent of providers were trained in the latest national obstetric guidelines. In terms of child health, only 34 percent of facilities have staff trained in neonatal resuscitation and 42 percent of facilities have staff trained 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, Côte d'Ivoire experiences persistent stockouts of modern contraceptives: male condoms and oral contraceptive pills are the most used methods, yet 74 percent of facilities were experiencing a stockout of condoms and 42 percent were experiencing stock out of contraceptive pills on the day of their most recent assessment; among all service delivery points surveyed, only 4.2 percent had all methods in stock[33].

Table 3: Availability of Selected Essential Medications Across Health Facilities (SARA 2015)

Category	Availability
Ampicillin powder for injection	38%
ORS sachets	73%
CTA	86%
Gentamicin injection	50%
Amoxicillin syrup / suspension	78%
Paracetamol syrup / suspension	55%
Vitamin A capsules	24%
Procaine benzylpenicillin Powder for Injection	12%
Zinc sulphate	31%
Ceftriaxone powder for injection	74%
Rectal or injectable forms of artesunate	14%
Morphine granule, injectable or tablet	1%

[29] Afrobarometer, 2017.
[30] Afrobarometer 2017.
[31] PRSSE 2017.
[32] All figures in this section come from the SARA 2015.
[33] UNFPA 2017.

Average	**45%**

18. **Composition and distribution of Health Human Resources (HHR) 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 percent of primary care facilities not having health worker assistants, which imposes an increased burden on nurses and midwives in these facilities.[34] The health workforce is not directly managed by the MSHP 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;
- low institutional capacity of the MSHP 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, 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 percent 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 percent during the period 2013-2016. Notably, households finance 48 percent of all spending at pharmacies and 35 percent 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 percent of the population was pushed further into poverty due to out of pocket spending. Development Assistance for Health (DAH) increased from 9 percent in 2013 to represent 26 percent of THE in 2015 **(Figure 4)**. The over-reliance of the health sector on household expenditure and DAH, which together represent more than 70 percent 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 the Vaccine Alliance (Gavi) and out of World Bank FCV status in 2020. Poor health outcomes relative to high total spending furthermore indicate

[34] MSHP, 2017 "Calcul de la charge de travail et détermination des normes de dotation en personnels de santé en Côte d'Ivoire".

significant inefficiencies in the system, with a recent WHO study estimating potential efficiency gains of up to 51 percent in the health sector.

20. **The health share of total government spending, at around 5 percent, is one of the lowest in SSA 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 US$80 per capita annually. Notably, only 21 percent of the health spending in Côte d'Ivoire is pooled through public pools, which is lower than the SSA and LMIC 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 Côte d'Ivoire is also not channeled through the Government, leading to fragmentation and even more limited fiscal capacity.

Figure 4: Total Health Spending in Côte d'Ivoire, 2007-2016[35]

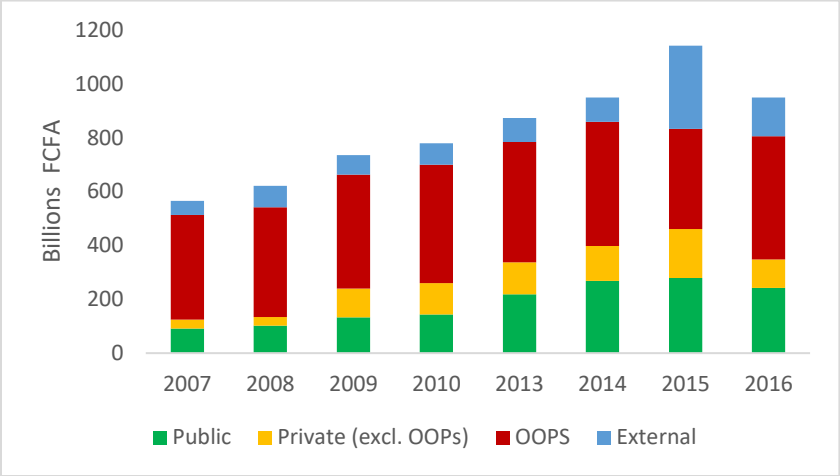


Table 4. Level and distribution of total and domestic government spending on health, Côte d'Ivoire and regional countries (2015)

Country	Government %	External %	Out of pocket %	Pooled %	Total health expenditure per capita (US$)
Benin	20.14	34.23	40.50	38.69	31.29
Burkina Faso	28.24	29.56	36.11	52.95	33.44
Côte d'Ivoire	**21.83**	**26.34**	**36.02[36]**	**21.26**	**75.45**
Cameroon	14.46	7.90	69.74	18.93	63.63
Ghana	34.95	25.57	36.11	52.23	79.59
Guinea	17.15	24.89	54.49	38.90	25.13
Liberia	7.41	70.93	19.64	33.46	69.29

[35] Source: National Health Accounts, 2016.
[36] In 2015 OOP dipped down to 36 percent, largely due to increased DAF, before returning to 48 percent in 2016.

Mali	16.55	36.37	46.31	26.75	42.30
Niger	21.02	25.76	52.27	35.28	25.72
Nigeria	16.49	9.92	72.08	19.32	97.52
Senegal	31.75	11.71	44.18	42.63	36.08
Sierra Leone	8.96	52.63	38.24	12.79	106.69
Lower middle income	43.78	12.02	39.84	50.37	132.07
Sub-Saharan Africa	32.92	24.12	35.65	42.58	111.60

Table 4. (continuation)

Country	Share of external funding channeled through government (%)	Compulsory financing as a % of government expenditure	Domestic public health expenditure as a share of total government expenditure	Domestic public health expenditure as share of GDP
Benin	54.19	6.47	3.37	0.80
Burkina Faso	83.57	13.44	7.17	1.54
Côte d'Ivoire	**15.83**	**4.91**	**5.04**	**1.19**
Cameroon	56.60	4.08	3.11	0.74
Ghana	66.01	10.58	7.08	2.06
Guinea	87.39	6.19	2.73	0.78
Liberia	36.73	12.10	2.68	1.13
Mali	28.07	7.21	4.46	0.96
Niger	55.36	7.70	4.59	1.51
Nigeria	27.85	6.21	5.30	0.59
Senegal	92.88	5.64	4.20	1.26
Sierra Leone	7.27	11.21	7.86	1.64
Lower middle income	54.63	9.38	8.16	2.52
Sub-Saharan Africa	50.69	9.63	7.06	1.93

Health Sector Reform Context

21. **Public financial management (PFM) and governance are weak and a risk to the success of health sector reforms.** The current accounting framework used by health facilities does not allow transactions to be recorded and linked to activities and results. As the implementation of strategic purchasing involves the purchase of a Package of Activities and, a payment triggered through multiple intermediaries once these activities have been performed and verified, the scaling up of the strategic purchasing and health insurance may introduce a fiduciary risk if necessary reforms have not been enacted. To remedy this situation, the Government is committed to undertaking various PFM reforms, including launching a program-based budget by 2020 to comply with the West African Economic and Monetary Union (WAEMU) 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 and for maternal and child health**.

While this system did increase utilization of health services (to .48 per person per year 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 (*Caisse Nationale Assurance Maladie,* 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[37] 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, 2015-2020).** 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 Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) 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 (TA) 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)[38]; 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. Four hundred and three 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

[37] Key Health sector reforms: (i) hospital reform; (ii) PBF; (iii) health decentralization; (iv) the reorganization of community interventions; (v) the reorganization of emergency services in the CHUs and CHRs; and (vi) health human resources reform.

[38] 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 Ivoirian Government has created a hospital program with 739 billion CFA for new construction: one teaching hospital (CHU), nine regional hospitals (CHR), six general hospitals (GH), one psychiatric hospital, six hot laboratories and specialized units in six existing hospitals, one radiotherapy and oncology center, three military hospitals, and 200 first-contact health establishments, and Rehabilitations: two teaching hospitals, four regional hospitals, 13 GHs, and 400 to 800 first-contact health establishments.

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 second quarter 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 rates of health services to 50 percent, as opposed to below 48 percent 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.

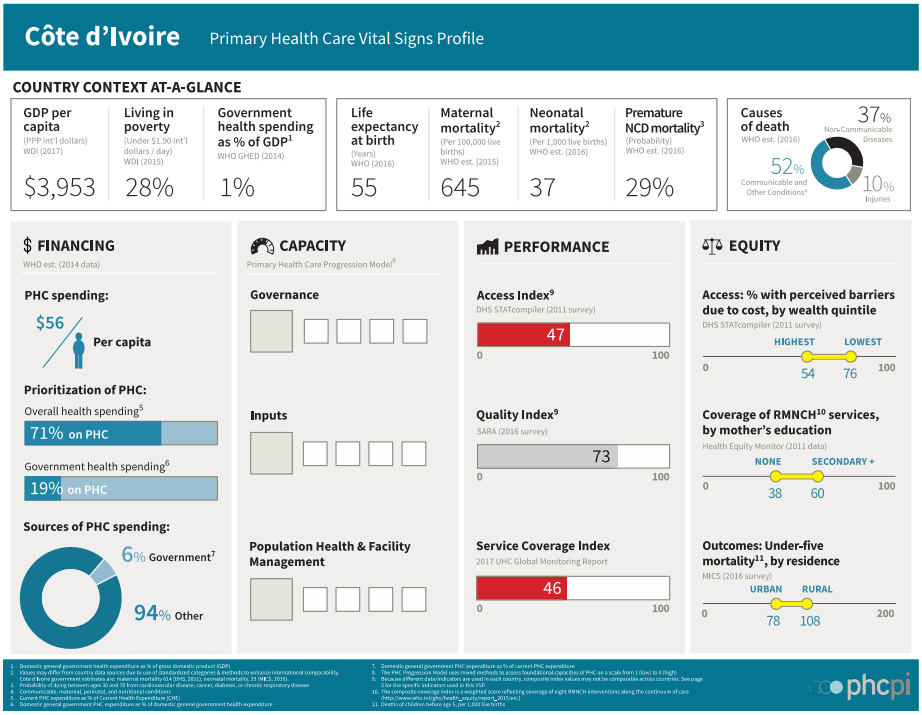
25. **The Ivorian Government announced that 2018 will be particularly focused on improving living conditions and creating stable jobs for youth "*l'année du social*" and launched the Government Social Program (PSGouv 2018-2020).** The PSGouv's purpose is to accelerate the pace of implementation of major projects from the National Development Plan (PND) 2016-2020 to strengthen social achievements. In this context, the PSGouv is keen to implement a set of key government measures to boost interventions with high social impact.

26. **The Global Financing Facility (GFF) will provide a grant to Côte d'Ivoire of US$20 million, linked to 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 with a focus on maternal, child and adolescent health and supporting progress towards UHC. Côte d'Ivoire joined GFF in November 2017, and the process provides resources for the preparatory work and TA for the operationalization and financing of the key priority areas under the PNDS as well as the operationalizing of the Compact,[39] signed by donor partners in 2017 but lacking enforcement and coordinating mechanisms.

27. **Côte d'Ivoire is member of several international initiatives**. Côte d'Ivoire is one of three pilot countries for joint financing between the Islamic Development Bank (IsDB) and the World Bank Group (WBG), in the context of the GFF; in Côte d'Ivoire, the financing will be parallel. Based on a joint mission, the Government of Côte d'Ivoire has requested an US$80 million financing from the IsDB and it is planned that this financing will be fully parallel to SPARK components (see below). Côte d'Ivoire is also one of four pilot countries for the 4G initiative, which formalizes intensified collaboration on sustainable financing between the World Bank, GFATM, 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 TA, 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. Côte d'Ivoire is among 14 "trailblazer" countries in PHCPI[40], 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 project development objective (PDO) (see below). A first version of the "vital signs profile" of quality indicators has been publicly released as of October 2018 **(Figure 5)**.

[39] The Compact commits the government, sectoral stakeholders and development partners (40 total signatories) to one national health plan (PNDS) in a harmonized and aligned way.
[40] https://improvingphc.org/about-us/about-phcpi.

Figure 5: Côte d'Ivoire Primary Health Care Vital Signs Profile



Source: Primary Health Care Performance Initiative (PHCPI), 2019

28. **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 (SWEDD - 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 the (SWEDD) particularly on demand generation aspect and through involvement of community-based health workers (CHW)[41]. 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, Contingent Emergency Response Component - 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) Program for Results (P*for*R) US$100 million, particularly to improve financing and reimbursement of primary health care services; the Education Service Delivery Enhancement Project (P163218) of US$23.35 million under the education governance practice, to invest in early years (IEY) to improving childhood

[41] Côte 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.

outcomes; the Social Protection and Jobs Global Practice within the Productive Social Safety Nets Project (P143332) of US$180 million for harmonized poor targeting and package of services and linking CMU and cash transfer programs; and the West Africa Unique Identification for Regional Integration and Inclusion (WURI) Program (P161329) of US$90 million for FY19-23 to link national unique identifier to CMU and to improve Civil 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.

29. **Several recently completed, high-quality analytic service advisories (ASA) 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 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. Relevance to Higher Level Objectives

30. **The proposed IPF is strongly linked to country priorities,** as outlined in the Country Partnership Framework (CPF FY16-19)[42] including (i) Accelerating Private Sector-led Growth; (ii) Building human capital for economic development and social cohesion; and (iii) Strengthening PFM and accountability, more comprehensively and in a way that would not be possible in a traditional project. The IPF is further aligned with the cross-cutting themes of Gender and Geographic inequity and the proposed adjustments to the CPF identified during the Performance and Learning Review (PLR)[43], namely: focus further on shared prosperity; sharing the dividends of growth by focusing on resilience, PFM, protection of vulnerable groups, and gender equity; and strengthening the private sector to generate more diversified growth and creating productive jobs - piloting the maximizing finance for development (MFD) approach.

31. **The proposed IPF is strongly linked to IDA18 and regional priorities**, namely Gender; Fragility; and Governance and Institutions, under IDA18 and operationalizing UHC; scaling up pilots; MFD and public-private-partnerships (PPP); Hospitals and equipment; and Reproductive health, under regional priorities.

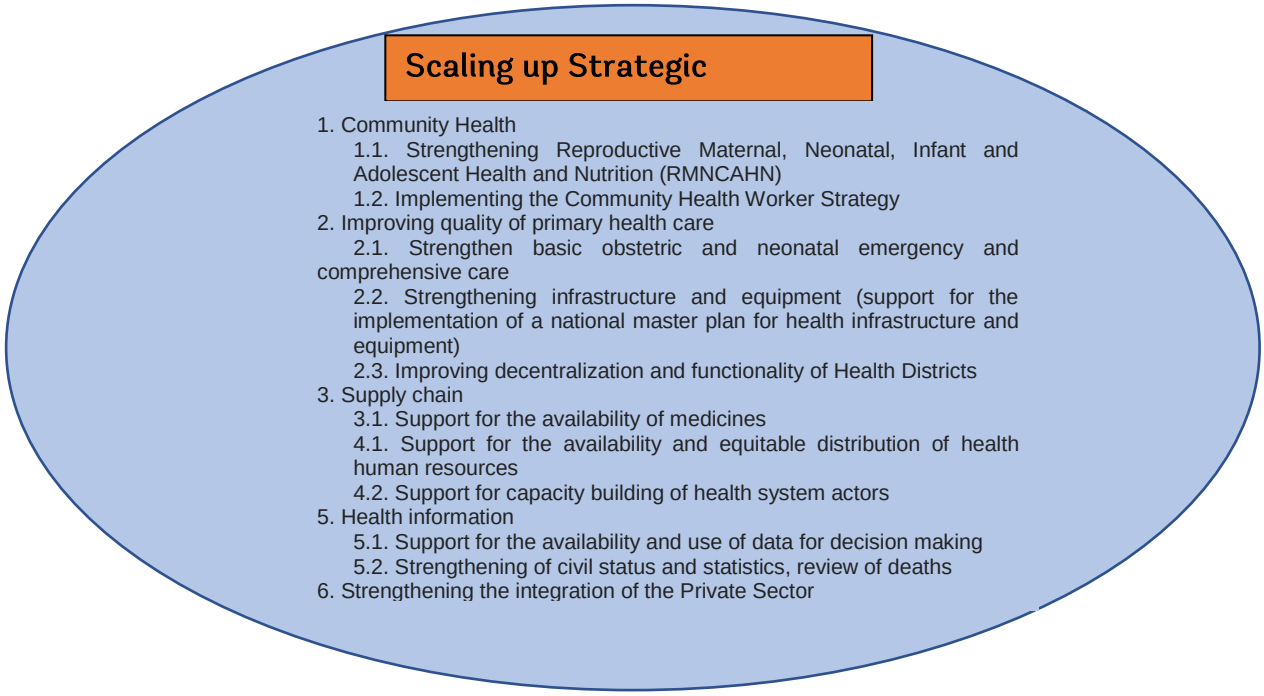
32. **The proposed IPF is fully aligned with the Government's efforts and strategies**, particularly the PND, PNDS, and the PSGouv. It is aligned with pillars one, two and four of the PND 2016-2020: (i) Strengthening the quality of institutions and governance; (ii) Acceleration of the development of human capital and social well-being; and (iv) Development of infrastructures on the national territory and preservation of the environment; and with the six pillars of the PNDS 2016-2020: (i) Strengthening of governance and leadership in the health sector; (ii) Improved internal and external financing of the health system; (iii) Enhanced availability and utilization of quality health services; (iv) Morbidity and mortality from major diseases reduced by 50 percent; (v) Health of mothers, newborns, children, adolescents and young people; and (vi) Strengthening health promotion and disease

[42] Report No.96515-CI (2015).
[43] Report No.122566-CI (2018). The PLR also extended the period of implementation of the CPF by two years, until FY21.

prevention, and on the first pillar of the Government's Social Program (PSGouv 2018-2020): 1) Provide local health services, healthy food and nutrition and improve social protection; and particularly measures / reforms related to targeted free healthcare, human resources, vaccination and CMU, to increase access to care, especially for disadvantaged populations.

33. **The IPF is fully aligned with the Government's investment case for the GFF Trust Fund.** A National Platform is in the process of actualization and six priority areas have been identified under the overall priority reform of scaling up strategic financing (Figure 6). The investment case is being finalized, with a target date of March 2019 and a national dialogue on health financing planned for April 2019.

Figure 6. GFF National Priority Areas



II. PROJECT DESCRIPTION

A. Project Development Objective

34. To improve the utilization and quality of health services towards reducing maternal and infant mortality in the Recipient's territory.

PDO Level Indicators

35. **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 (RF).

Table 5. PDO Outcome Indicators

Indicator Name	Baseline (2018)	End-Target (FY 2025)
(i) Average health facility quality score (%)	48	75
(ii) Utilization of health services (%)	39	60
(iii) Number of deliveries attended by a skilled health personnel	489,149	3,182,938
(iv) Number of children immunized	234,095	1,525,326
(v) Direct Project Beneficiaries (% female)	0 (0%)	59,270,770 (60%)

B. Project Components

36. **With US$200 million (IDA) and US$20 million (GFF) co-financing**[44], 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 CMUs. It will also finance and support specific priority areas of the GFF investment case: rehabilitating and equipping health facilities; 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 strengthening HMIS (Component 2.4). Project financing budgets by component and sub-component is shown in **Table 6**.

37. **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 project management and knowledge and learning and Component 4 is a CERC zero-dollar component.

[44] Donor Partner parallel financing of project components discussed in Section E. Rationale for World Bank Involvement and Role of Partners.

Figure 7: SPARK -Health Components

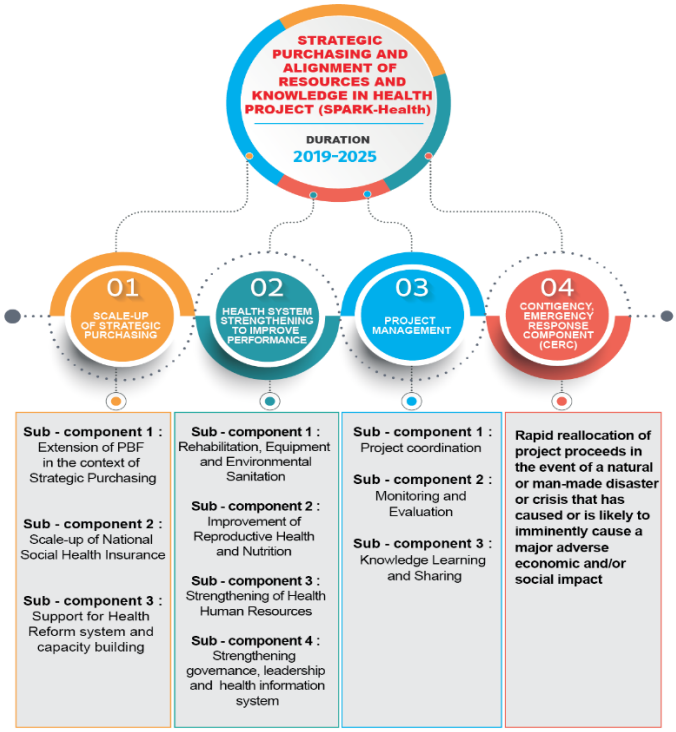


Table 6. Budget by SPARK Component

Component	IDA	GFF	Total
1. Scale-up of Strategic Purchasing (US$116.39 million)			
1.1 Extension of PBF in the context of strategic purchasing	92,864,934	-	92,864,934
1.2 Scale-up CMU	17,422,808	-	17,422,808
1.3 Support to Health Reforms and National Capacity Building	1,100,000	5,000,000	6,100,000
2. Health System Strengthening to Improve Performance (US$91.58 million)			
2.1 Rehabilitation, Equipment and Environmental Sanitation	33,142,800	-	33,142,800
2.2 Reproductive Health and Nutrition	14,742,800	-	14,742,800
2.3 Strengthening Health Human Resources (HHR)	19,887,200	-	19,887,200
2.4 Governance and HMIS	8,810,298	15,000,000	23,810,298
3. Project Management (US$12.02 million)	12,029,160	-	12,029,160
4. Contingent Emergency Response (CERC)*	-	-	
Total (US$)	**200,000,000**	**20,000,000**	**220,000,000**

**Funds released in case of emergency.*

Component 1: Scale-up of Strategic Purchasing (Estimated Financing: **US$116.39 million equivalent, of which US$111.39 million from IDA and US$5.00 million from GFF**)

- **Sub-component 1.1: Extension of PBF in the context of strategic purchasing (**Estimated Financing: **US$92.86 million from IDA)**

38. **Based on results of the PBF pilot, the 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 health services; and (iii) capacity-building and training to key stakeholders to support structural improvements and implementation of PBF and increase awareness. These will result in a sequenced scale-up[45] of PBF in the context of strategic purchasing.[46] SPARK-Health builds on the successes and lessons learned from PRSSE. It largely retains elements of the PBF program, while simplifying procurement processes and guidelines and 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.

39. **PBF aims to increase the volume and quality of health services, with a specific focus on Maternal, Neonatal and Child Health (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).

40. **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[47]. 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 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.

41. An important element is capacity building and communication, including training on PBF concepts and procedures, behavior change education, information, 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

[45] Scale-up all the 1st and 2nd 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 tertiary facilities.
[46] Strategic Purchasing refers to the use of performance contracts and the harmonization of PBF and CMU, with mechanisms to facilitate further harmonization and defragmentation (*gratuité*, vertical programs, complementary packages, etc.).
[47] There is evidence that under a PBF scheme, contracted entities have an incentive to over-report the achievement of results, and/or manipulate data.

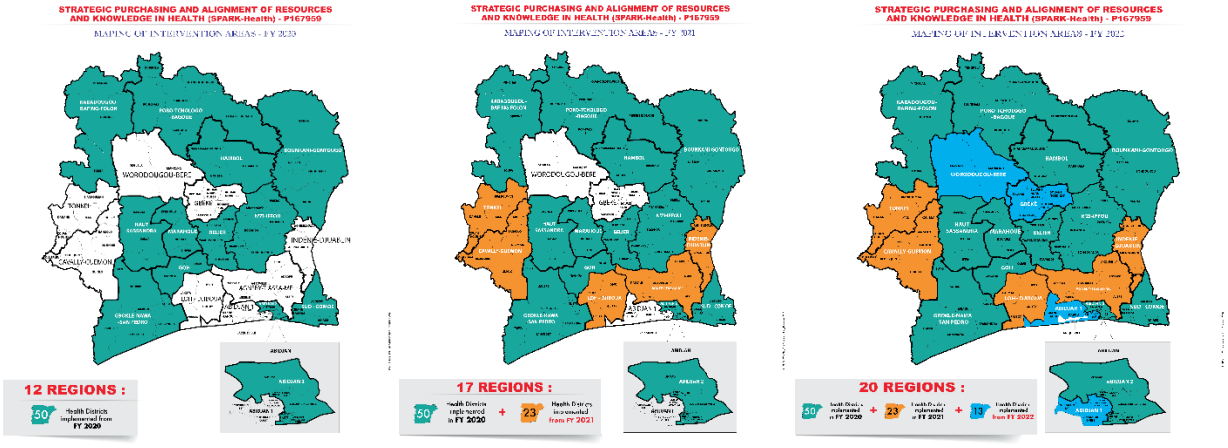
incentives. This capacity building will focus not only on health care workers and administrative staff at the central, region and district level, but also on the public, so that they understand the nature of the new approach, are encouraged to make use of the services that are available and participate in providing oversight and feedback as part of the process.

42. Overall, subsidy payments make up about 56 percent of the estimated US$93 million dollars financing of this sub-component. Verification makes up about 24 percent and the remaining 20 percent is training, monitoring and evaluation (M&E), and other operational costs.

43. **Through a three- phased approach[48], strategic purchasing will be operational nationwide by the end of 2022** (Figure 8).

- **Phase 1: PBF in 31 new districts, bringing the total to 50 (2020)**: In the pilot phase, PBF was implemented in 19 districts in 9 regions[49]. 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 (2021):** 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 (2022):** In 2021, PBF will cover the entire country with the addition of 13 districts in the 3 remaining regions.

Figure 8: Progressive Scale-up of SPARK-Health Project



44. **National PBF will progressively be financed through the national budget**, with the Financial Affairs Department (DAF) issuing payment orders for the PBF National Technical Unit (NTU) 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, 68

[48] Finalized in consultation with MHPH.

[49] Fourteen districts in seven regions financed by the World Bank and five districts in two regions financed by the Global Fund. Not all districts in a given region were covered.

percent of the costs related to strategic purchasing will be covered by the Government, going up to 87 percent in 2022, 89 percent in 2023, 98 percent in 2024 and 100 percent in 2025 **(Table 7).**

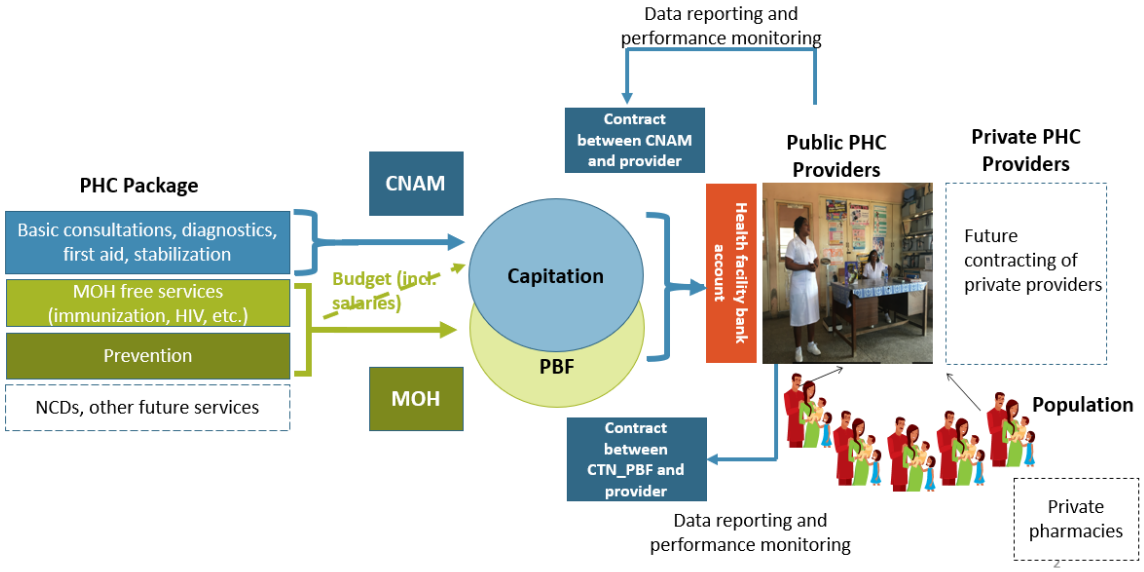
Table 7. PBF Financing by Source and by Year (XOF billions)

	2019	2020	2021	2022	2023	2024	Total (XOF)	Total (US$)
WBG	13.7	18.4	7.3	3.3	3.1	0.7	46.4	92,864,934
CIV	-	-	15.4	22.0	24.7	31.6	93.7	187,397,342

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

45. **CMU will be progressively scaled up starting in 2019 drawing on lessons from the three-district pilot[50].** 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 Sub-component 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)**.

Figure 9. CMU Integrated Architecture



46. **Operationalization of the Medical Assistance Scheme:** to extend enrolment and coverage to vulnerable households and the informal sector. For poor households, the project will finance activities related to (i) the targeting (i.e. identification) and enrollment of vulnerable and low-income households using proxy means testing (PMT); (ii) development of a household management tool (population and health care consumption) for the

[50] 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.

implementation of the Single Social Registry (SSR);[51] (iii) annual revision of the SSR by the Ministry of Employment and Social Protection (MEPS). 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. For the informal sector, the project will 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; (iv) TA to strengthening the legal, regulatory and governance reforms required for the integration of the informal sector; and (v) TA to progressively cover more of the informal sector through tax financing. 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. The project will further support the provision of social security cards to households and the establishment of PBF/CMU quality indicators for the payment of subsidies to the health establishments. 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 TA to support the conceptualization and implementation of CMU.

47. **Development of electronic tools to improve monitoring:** 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 enrolment of CMU beneficiaries; (ii) health services received by enrollees; (iii) hospital admissions and discharges etc.; and (iv) computerization of health facilities.

48. **Capacity-Building and Training to Key Stakeholders**: This will include training of all health professionals in the use of the new CMU tools[52], training at all levels for targeting and poor enrollment, for targeting of informal sector and expanding coverage, as well as for expanding fiscal space for CMU.

- **Sub-component 1.3: Support for health reforms and national capacity building (**Estimated Financing: **US$1.10 million from IDA, US$5.00 million from GFF)**

49. **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 (FM) 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 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 TA in the form of training.

[51] National database of individuals classified as “poor” using the PMT targeting survey.
[52] Côte d’Ivoire General Classification of Medical Procedures and Biology, medical claim forms, etc.

50. **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 FM 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 Director General for Health (DGS), DAF, Director of the Department of Planning and Forecasting (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.

51. **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 sub-component will furthermore support development of flexible FM tools at the level of health facilities, to manage funds (received through PBF, CMU and other sources), with appropriate 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 enough levels of detail to include individual health facilities. At the facility level, it will also 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.

52. **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 FM 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 FM, as the new facilities will have to manage their own budgets for the first time.

53. **Capacity building for scale-up of national health insurance (CMU):** Similar to 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 will 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, of which US$76.58 from IDA, and US$15.00 million from GFF**)

- **Sub-component 2.1: Rehabilitation, Equipment and Environmental Sanitation (**Estimated Financing: **US$33.14 million from IDA)**

54. **Development of a national infrastructure and equipment master plan and strengthening the capacity of** Directorate for Infrastructure, Equipment and Maintenance (**DIEM):** A national infrastructure and equipment master plan, developed in close coordination with PMO, French Development Agency (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 DIEM 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).

55. **Rehabilitation of 50 health centers and connecting 420 health centers to power and a piped water source:** This sub-component will finance the full rehabilitation of 50 health centers, 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 United Nations Children's Fund (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. 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. This component will furthermore contribute to increasing the National Institute of Health Education (INFAS) training capacity through equipment and rehabilitation.

56. **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 Environmental and Social Management Framework (ESMF) and Medical Waste Management Plan (MWMP) have been prepared.

- **Sub-component 2.2: Reproductive Health and Nutrition (**Estimated Financing: **US$14.74 million from IDA)**

57. **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 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).

58. **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; and (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 United Nations Population Fund (UNFPA) TA and support.

59. **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 percent today to 30 percent 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 learning 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 attention paid to improving the quality of family planning services. Demand will also be stimulated through supporting the national CHW strategy.

60. **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-Sectoral Nutrition and Child Development Project (PMNDPE – P161770) 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) and extend the PBF approach to PMNDE intervention areas.

61. **Pilot for portable pregnancy diagnostics in three districts.** This sub-component will also pilot a ***"See your baby"*** mobile ultrasound clinic in three districts[53]. 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[54]. 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.

❖ **Sub-component 2.3: Strengthening health human resources (**Estimated Financing: **US$19.89 million IDA)**

62. **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 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 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

[53] To be selected based on maternal and infant mortality.
[54] Anderson-Knight, H et al. (2015) The role of Portable Ultrasound in a Global setting. Journal of Pregnancy and Child Health 2: 143 and Cherniak, W et al. (2017) Effectiveness of advertising availability of prenatal ultrasound on uptake of antenatal care in rural Uganda: A cluster randomized trial. Plos One 12(4): e0175440.

ensure that there is real-time, reliable data on staffing levels across health facilities in the country. This system would be integrated into District Heath Information Software 2 (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:** 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.

❖ **Sub-component 2.4: Governance and Health Management Information Systems (HMIS) (**Estimated Financing: **US$8.81 million from IDA; and US$15.00 million from GFF)**

63. **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.

64. **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.**[55] 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. Thirty-eight 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 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 Identification for Development (ID4D) regional MPA, including technical support to improve 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 on-going 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 Sub-components 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 Annual Health Statistics Report (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 Cocody University Teaching Hospitals (CHU), and health programs and directorates. Trained regional

[55] Currently piloted under PRSSE in 3 District Hospitals.

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.
- **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.

65. **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 Côte 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.

66. **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.[56] 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."[57] 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.[58] An option for the participation pillar is three meetings operating through the School Management Committees (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.

[56] See Bjorkman and Svensson, 2009 & Bjorkman, de Walque and Svensson, 2017.
[57] Flores, 2018 "How Can Evidence Bolster Citizen Action? Learning and Adapting for Accountable Public Health in Guatemala."
[58] 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.

67. **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.

Component 3: Project Management (Estimated Financing: **US$12.02 million from IDA)**

- **Sub-component 3.1: Project coordination (**Estimated Financing: **US$6.20 million from IDA)**

68. 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 UCP will continue to play this role, while preparing the complete handover to national entities by the end of the project.

- **Sub-component 3.2: Monitoring-Evaluation (monitoring, supervision, and support) (**Estimated Financing: **US$2.82 million from IDA)**

69. The general underlying principle is to ensure alignment of the M&E process developed for the project with the national M&E 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).

70. The RF 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 RF 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, Multiple Indicator Cluster Survey (MICS), SARA or Service Delivery Indicator (SDI), which the project will finance (or co-finance) based on need.

71. 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.

- **Sub-component 3.3: Knowledge Sharing and Dissemination of Results (**Estimated Financing: **US$3.00 million from IDA)**

72. 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)

73. This contingent emergency response component is included under the project in accordance with World 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.

74. 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 World Bank to re-allocate project funds to support emergency response and early recovery.

75. 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 World 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 Côte 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.**

76. 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 FM, procurement, safeguards and any other necessary implementation arrangements.

C. Project Beneficiaries

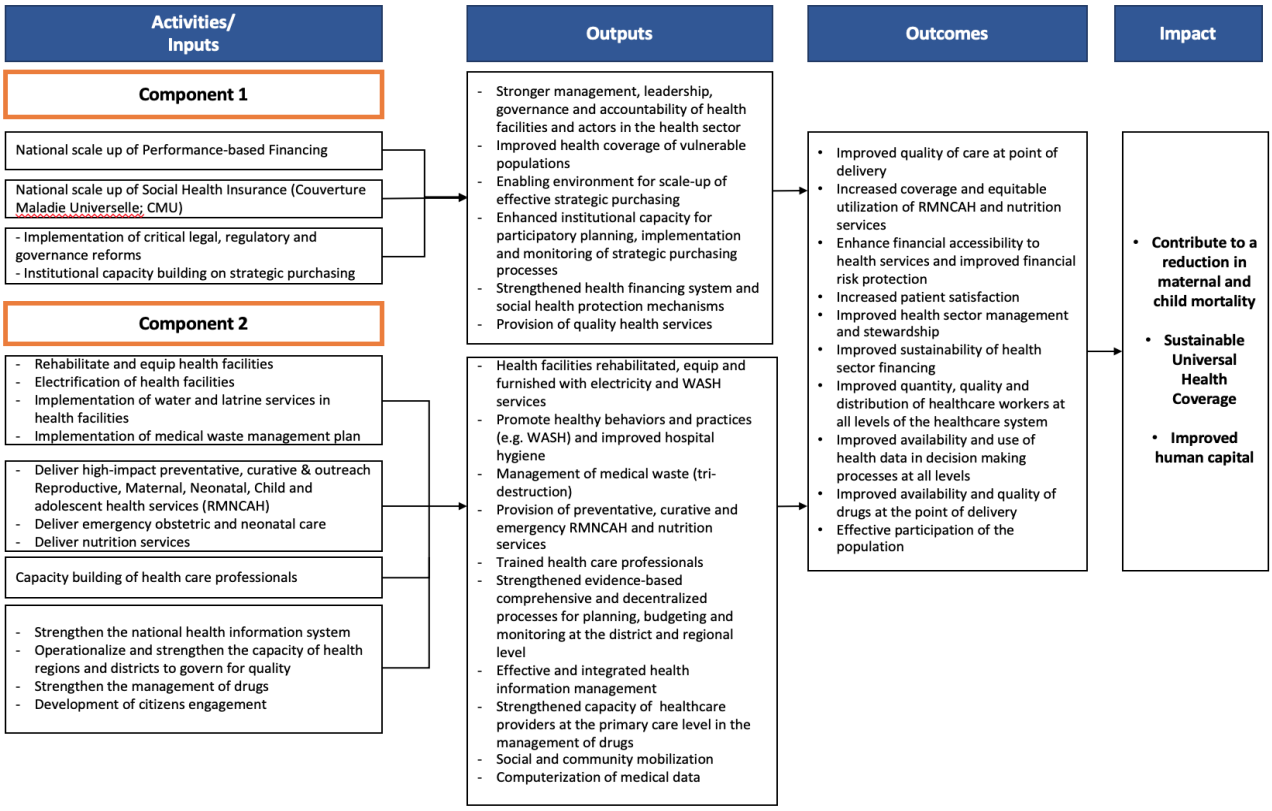
77. The primary project beneficiaries will be: (i) women of reproductive age; (ii) pregnant and lactating women; (ii) children 0-23 months; and (iii) children under 5 years. The priority focus will be those covered by the strategic purchasing program (PBF and CMU combined), which progressively scales up from covering 22 percent of the population in 2018 to 59 percent in 2019 to 80 percent in 2020 to 100 percent at the end of 2021. From 2021 to 2024, the program will be implemented nation-wide. **Table 8** shows project beneficiaries by grouping.

Table 8. Project beneficiaries by category by year (Cumulative)

	FY 2020	FY A2021	FY 2022	FY 2023	FY 2024	FY 2025
Number of women of reproductive age	67,143	176,470	340,987	559,660	864,637	1,300,625
Pregnant women	86,106	213,069	375,840	554,334	752,471	974,648
Children under one year	150,023	364,396	630,425	910,991	1,208,276	1,525,326
Children under five years	310,450	254,816	619,374	1,070,274	1,546,311	2,592,390
Poor enrolled in CMU	1,328,778	3,523,920	5,773,041	8,081,234	10,449,439	12,879,217
Direct Beneficiaries	5,761,893	13,830,285	24,274,293	35,360,067	46,999,706	59,270,770
Percent female in Direct beneficiaries	60 %	60 %	60 %	60 %	60 %	60 %

D. Results Chain

Figure 10: Casual Framework linking SPARK-Health activities to outcomes



78. **Program Results Chain. Figure 10** illustrates how the proposed project activities and related outputs and outcomes are expected to contribute toward the achievement of the PDO. The key elements in the causal results chain to achieving of the PDO are: (i) increase the equitable utilization and coverage of a guaranteed package of quality RMNCAH and nutrition services, known for their efficacy to reduce mortality, and appropriateness to address key health challenges in women and children. Some of the well-established low-cost, high impact, interventions include family planning services, quality antenatal, perinatal, postpartum and postnatal care; management of labor and delivery by a skilled birth attendant for low risk women, and specialized obstetric and neonatal care for high-risk women, and those with complications during labor and delivery. Moreover, the most impactful and cost-effective interventions to reduce infant deaths include the promotion of breast feeding, vaccinations, distribution of long-lasting insecticide treated bed nets (LLINs), and timely detection and treatment of malnutrition. The delivery of these services along the continuum of care, particularly through community and primary health care platforms, could reduce an estimated 77 percent of preventable maternal, newborn, and child deaths and stillbirths,[59] with the remaining deaths being averted through advanced management at hospitals. To increase the delivery and utilization of quality health services, supply and demand-side constraints would need to

[59] Black RE, Levin C, Walker N, et al. Reproductive, Maternal, newborn and child health: key messages from Disease Control Priorities 3rd Edition. Lancet 2016; 388:2811-24.

be addressed by (ii) rehabilitating and equipping health facilities, increasing the number and distribution of trained health care workers and improving the availability and quality of drugs; (iii) strengthening the performance, financing, efficiency and stewardship of the health sector and, (iv) enhancing the financial accessibility for health, and improving financial risk protection for households. The project will also strengthen convergence with other ongoing or pipeline operations that address the multifactorial causes of poor maternal and child health and contribute towards human capital development.

E. Rationale for World Bank Involvement and Role of Partners

79. The World Bank has a long engagement in the health sector, globally and in Côte d'Ivoire in particular. The World Bank has been supporting the MSHP through multiple concurrent and consecutive projects and TA, including for planning and stakeholder consultations for health sector reform, UHC and for HMIS. Overall, in health, the World Bank's comparative advantage is in systems building and strengthening. The World Bank's health sector strategy is focused on supporting countries to create health systems that deliver results for the poor and that are sustainable[60]. This includes leading in multisectoral action in health and functions related to financing, management, pharmaceuticals, human resources, and insurance in national health systems.

80. The World Bank has unique expertise in coordinating the complex set of interventions that comprise this project. Overall, the project will aim to strengthen existing government systems and programs to strengthen the health system with the ultimate intention of reducing maternal mortality and improving quality of care. The World Bank has long been involved in MCH, with over 400 projects completed in over 100 countries. In addition, the World Bank has experience implementing and evaluating performance-based financing (PBF) programs in various settings, including many countries in West Africa. In both fields, the World Bank provides strong technical expertise and project design and management. Improving the health workforce in developing countries is an important pillar of the World Bank's health systems strengthening agenda; the World Bank assists countries in implementing evidence-based human resources for health strategies in selected thematic areas (labor market, fiscal and costing analysis, pre-service training costing, as well as political economy of human resources for health reform) and is a global leader in performance based financing and designing incentivization systems to improve quality and retention of health workers. HMIS reform involves many actors and systems across the health sector and, as such, is strongly aligned with the World Bank's comparative advantage in systems strengthening. HMIS reform touches on health financing, patient management, surveillance, pharmaceuticals and health human resources among others and requires stakeholder coordination and consensus building across many departments, ministries, and organization, all areas where the World Bank can potentially add value.

81. Furthermore, the program action plan includes key system strengthening activities, which the World Bank has experience carrying out across countries and projects. The social and environmental safeguards are fields where the World Bank brings experience and expertise. Finally, the World Bank can provide the technical and financial support required to achieve key program goals. This includes dialogue with the Ministry of Finance to

[60] President Jim Yong Kim (2012) Opening Plenary of the International AIDS Conference 2012, Washington, DC, United States.

ensure that the health sector is adequately funded to ensure resources required to achieve targets are available. It also includes mobilizing trust fund and other sources for TA in identified target areas.

82. Several key partners support the project both directly (through implementing or parallel financing activities) and indirectly through their activities in the health sector. The GFF context ensures a high degree of shared objectives and harmonization of activities. Specifically, WHO, UNFPA and UNICEF are proposed to be implementors of several project activities; these institutions (along with United States Agency for International Development (USAID), PEPFAR, United Nations Programme on HIV/AIDS (UNAIDS) and Japan International Cooperation Agency (JICA) are also key partners under the GFF framework. The IsDB will provide $US80 million of parallel financing to project activities, focusing on Components 2 and 3 **(Table 9)** and further parallel financing is expected from GAVI, GFATM, UNICEF and UNFPA. Furthermore, AFD is planning a budget support with indicators related to heath human resources, which will be harmonized with a potential World Bank DPO. Other critical sectoral issues are addressed by other partners and projects, for example USAID, GFATM and World Bank through the SWEDD project addressing drug supply chain.

Table 9. IsDB Parallel Financing by Component

Component	BM+GFF	IsDB	Total
1. Scale-up of Strategic Purchasing			
1.1 Extension of PBF in the context of strategic purchasing	92,864,934	-	92,864,934
1.2 Scale-up CMU	17,422,808	-	17,422,808
1.3 Support to health reforms and national capacity building	6,100,000	-	6,100,000
2. Health System Strengthening to Improve Performance			
2.1 Rehabilitation, Equipment and Environmental Sanitation	33,142,800	34,540,000	67,682,800
2.2 Reproductive Health and Nutrition	14,742,800	18,329,880	33,072,680
2.3 Strengthening Health Human Resources (HHR)	19,887,200	-	19,887,200
2.4 Governance and HMIS	23,810,298	23,540,000	47,350,298
3. Project Management	12,029,160	3,590,120	15,619,280
4. Contingent Emergency Response (CERC)*	-	-	-
Total (US$)	**220,000,000**	**80,000,000**	**300,000,000**

**Funds released in case of emergency.*

F. Lessons Learned and Reflected in the Project Design

83. The key lessons learned from the PRSSE project are summarized in the mid-term review document and are incorporated into the project.[61] A key lesson was both on indicator definitions (that allow for data collection within national systems) and indicator targets, now adjusted based on several years of measurement in pilot districts. Another key lesson was the need to involve all MSHP departments throughout the process. For the PRSSE, key departments were involved in the design, but not thereafter in the implementation. Also, it is important to include decentralized entities: district Prefects have been included in project implementation but not local mayors and governing bodies, who are principally involved in health decisions locally. Another important lesson is related to the use of PBF funds: the financial mechanisms put in place proved to be cumbersome and counterproductive for rural health facilities to rapidly use funds received for facility improvements. Mitigation measures have been discussed with the Government and reflected in the project design. Finally, we noted that

[61] *http://wbdocs.worldbank.org/wbdocs/viewer/docViewer/indexEx.jsp?objectId=090224b0858f33d7&respositoryId=WBDocs&standalone=false*.

capacity building components (between ACV and national entities and between Project Implementation Unit (PIU) and CTN-PBF did not work as well as intended, and a Sub-component 1.3 was designed around this. As indicated in 1.1, changes were also made in terms of increasing demand for services (i.e. citizen report cards and community health workers), policy reforms on decentralization, and strengthening the supply side (infrastructure, human resource for health). Finally, a major expected learning opportunity is the integration of measurement activities in all processes of the project. Real-time data collection, analysis and evaluation will inform the implementation of the current project as different components of the project will be generating significant amount of data as the project progresses.

III. IMPLEMENTATION ARRANGEMENTS

A. Institutional and Implementation Arrangements

84. Overall implementation arrangements are illustrated in **Figure 11**. The project will be implemented by the World Bank-financed Health UCP Santé-BM, which was established in the MSHP by Ministerial Order No. 82 MSHP/CAB of May 8, 2018. This UCP is currently implementing the PRSSE (P147740) and manages the Multisectoral nutrition and child development project (PMNDPE: P161770) preparation advance (PPA). The UCP is organized into three departments (administrative and FM; program and monitoring-evaluation; procurement and contract management) and the staff has strong experience in World Bank-financed projects and other donors related to programmatic and fiduciary management.

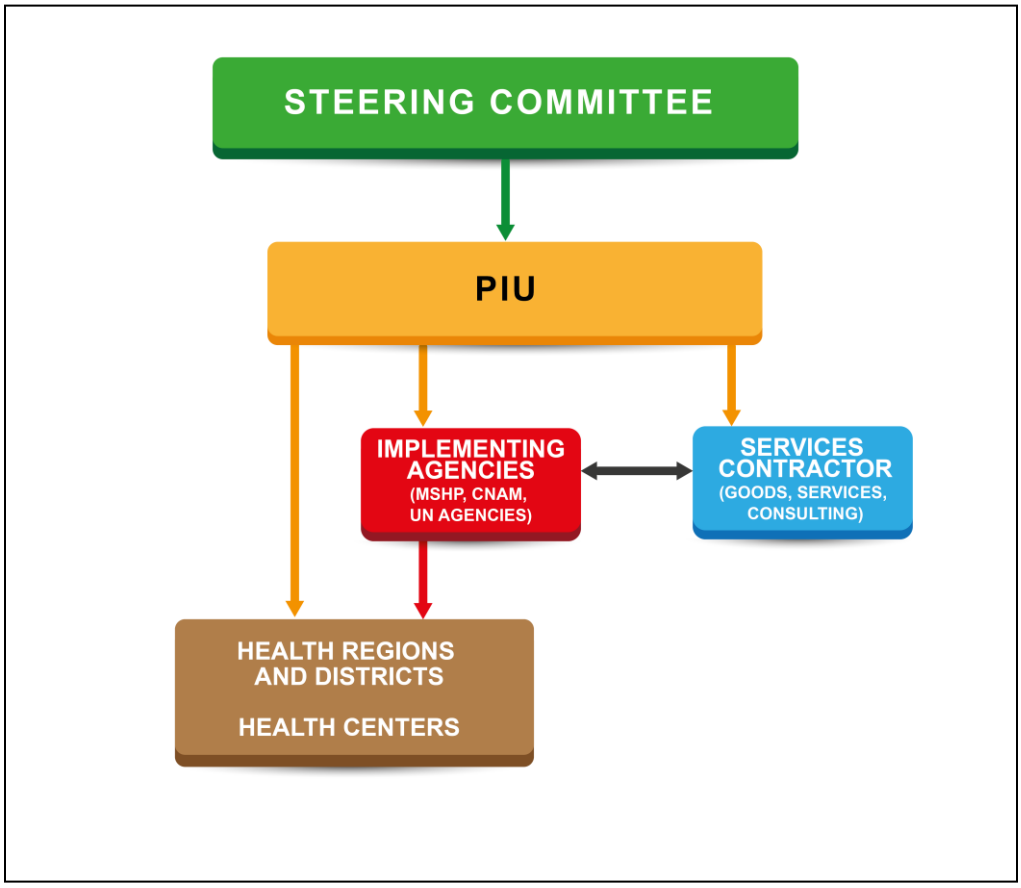
85. The UCP will report to a Steering Committee (SC) that will be established by Order issued by the Minister of Health no later than three months after project effectiveness. This SC, whose composition will be approved by IDA, will be responsible for supervising and overseeing management of the project.

86. Several implementing entities of the MSHP (central departments, health regions and districts, national program, health centers) and the CNAM will serve as implementing agencies and be responsible for the operational implementation of the activities selected for the project. Each of these agencies will perform this role in accordance with its respective missions and mandates. In the context of implementation of strategic purchasing, the CTN-FBP under the DGS is responsible for the operational implementation of activities consistent with PBF implementation, under the supervision of the PBF national SC chaired by the MSHP. Given that PBF development covers all pillars of the health system, the ministry departments, in accordance with their respective mandates, will help implement the reforms or actions for which they are responsible. The CNAM will implement the CMU scale-up interventions.

87. The project proposes to channel some financing through the following United Nations (UN) Agencies: WHO, UNICEF, UNFPA to support external services reform; nutrition; WASH and rural solar electricity; obstetrical and newborn care.

88. The key contracting actors of the performance-based contracting approach are the health entities and the regulatory bodies at the regional, district, and central levels. A detailed implementation and institutional arrangements are outlined in **Annex 1**.

Figure 11: Implementation and Institutional Arrangements



B. Results Monitoring and Evaluation Arrangements

89. A detailed RF is provided in **Section VI**. The project will create a comprehensive Monitoring and Evaluation (M&E) system that will generate data and evidence to track implementation and progress of each phase towards results throughout implementation. The implementing agency will manage monitoring activities through both project-specific systems and normal government systems, consolidated in quarterly reports. To facilitate project monitoring, the existing HMIS, which has been strengthened with the support of the PRSSE project and other development partners will ensure that results are available and can be monitored on a timely and ongoing basis.

90. The combination of regular[62] household surveys (DHS/MICS) and health service surveys (SARA or SDI) will also provide key inputs for M&E, including evaluating the impact of the national scale-up of strategic purchasing and the CMU using a quasi-experimental difference-in-differences design. This survey-based data will be augmented over the life of the project as the digital health and ID4D/CRVS interventions are developed and scaled-up. The proposed digital health interventions, including the introduction of a national electronic health record, should allow real-time monitoring of issues such as antenatal and post-natal care, the frequency of Caesarean

[62] Next DHS planned 2019; MICS in 2021.

section and other obstetrical interventions, as well as infant health issues such as well-baby care, immunizations and Integrated Management of Childhood Illness (IMCI) interventions. Such monitoring can also help to better target corrective measures when and where they are needed.

C. Sustainability

91. **Sustainability is built in the design of the project,** as the project targets government priorities and plans a transition of funding of key components to the government budget. Key stakeholders are committed to the objectives of the project. These include most importantly the MSHP, Ministry of Economy and Finance (MEF), MoB and the PMO, as well as key donor partners. The design of the Program is consistent with the government's health policies and strategies and there is broad support for the proposed interventions. The proposed interventions are furthermore supporting national priorities defined in an inclusive and consensual manner, under the GFF priorities. Transition preparedness and integration of external financing are key components of the project. In addition, the Government will progressively finance a larger share of the project, going up progressively from 68 percent in 2021 to 87 percent in 2022 to 89 percent in 2023 to 98 percent in 2024 with strategic purchasing fully nationally owned and financed by 2025.

IV. PROJECT APPRAISAL SUMMARY

A. Technical, Economic and Financial Analysis

92. **By expanding sustainable UHC in Côte d'Ivoire, this IPF is expected to reduce maternal and child deaths, and improve human capital, leading to higher GDP levels, greater economic growth and lower income inequality.**[63,64] Investments in health have been shown to reap significant economic and social benefits. For example, in low to middle-income countries, reductions in mortality accounted for 24 percent of the growth observed between 2000-2011[65]. Conversely, each maternal death in Africa is estimated to decrease per capita GDP by US$0.36 per year,[66] and in 2010, maternal deaths in 12 lower middle-income African countries[67], including Côte d'Ivoire, contributed to a GDP loss of US$2 billion (PPP), equivalent to 0.34 percent of the total GDP of these countries.[68] Healthier mothers and children contribute to societies that are better educated and more productive.[69] In Bangladesh, maternal orphans only have a 24 percent chance of survival to 10 years, while in South Africa, Kenya and Indonesia, children who have lost their mothers are less likely to be enrolled or complete school[70], which in the long term leads to a lower number of skilled individuals entering the workforce.

[63] Amiri A, Gerdtham, UG. (2013) Impact of Maternal and child health on economic growth: New Evidence Based Granger Causality and DEA Analysis.
[64] Jamieseon DT, Summer LH, et al. (2013). Global health 2035: a world converging within a generation. 382:1898-955
[65] Idem.
[66] Onarheim KH, Iversen JH, et al. (2016). Economic benefits of investing in women's health: a systematic review. Plus one
[67] Cameroon, Cape Verde, Congo, Côte d'Ivoire, Ghana, Lesotho, Mauritania, Nigeria, Sao Tome and Principe, Senegal, Swaziland and Zambia.
[68] Kiringia JM, Mwabu GM, et al (2014). Indirect cost of maternal deaths in the WHO African Region in 2010. BMC Pregnancy and Childbirth 14:299: 1-11.
[69] Onarheim KH, Iversen JH, et al. (2016). Economic benefits of investing in women's health: a systematic review. Plos one
[70] Idem.

93. **SPARK focuses specifically on strengthening the health system and improving the utilization and quality of health and nutrition services.** Through scaling up strategic purchasing, the project increases the availability of non-earmarked funding and quality of care at rural health centers and district hospitals, which serve the poorest and most vulnerable of the population that are underfunded by public investment and do not receive funding from any other sources. The project also seeks to increase the performance of the health workforce through training and supervision, seeking to close the know/do gap and maximize the benefits coming from strategic purchasing. In addition to strengthening equity in the supply side, the project also seeks to increase equity with regards to the demand side, through the scale-up of health insurance. Impoverishing health expenditure in Côte d'Ivoire is a significant problem, as almost half of all healthcare costs are financed out of pocket and 18 percent of the population has incurred catastrophic health expenditure in 2016.

94. **The impact of health on economic outcomes can be measured through the impact on income or expenditure and at both the micro and macro levels.** A reasonable estimate, based on the sum of the literature, is that health accounts for 20-30 percent of the variation in income across countries. These effects mainly come from productivity, human capital and demographic effects. Low quality of care in and of itself leads to lost productivity. Better health also contributes to human capital and increases productivity directly by reducing incapacity, debility, and number of days lost to sick leave, and indirectly through its effect on education and cognitive development; healthy people can work harder, have more energy, are more physically robust and earn a higher return in the labor market. Changing health and mortality can indirectly affect income through changing the age structure of a population. Declines in mortality spurs the demographic transition, where declining mortality followed by subsequent declining fertility creates a population "bulge" which then moves across the age groups creating the "demographic dividend" which is a period where the dependency ratio (ratio of dependents to working age population) is very low.

95. **The projected impact of scaling up strategic purchasing was calculated through using the Lives Saved Tool (LiST), which measures the impact of scaling up specific interventions on maternal and infant mortality rates, given effect sizes based on the literature.** The LiST projection included in this economic analysis presents the impact of scale-up of coverage of these interventions nationally from 2019 through 2025, as part of the progressive scale-up of strategic purchasing starting 2019 and ending in 2021 when it covers the entirety of the country. It should be noted that these projections do not include the impact of other components of this project, but it can be hypothesized that investments in strengthening the health system through improved availability of inputs (infrastructure, human resources for health, health information systems) would improve the effective coverage of the interventions that are included in these projections. [71]

96. **Through strategic purchasing, the IPF is expected to reduce maternal and infant mortality with accelerating decline rates due to improvements in coverage rates through the course of the program.** It is estimated that the IPF would result in a reduction in maternal mortality from 645/100,000 in 2015 to 411/100,000 in 2025, as opposed to 578/100,000 in the absence of the program. This is an average decline of 7 percent each year through the program (as opposed to an annual decline of 1 percent without the program). Infant mortality is

[71] As LiST does not support additive or synergistic effects at varying population levels, these projections are based on coverage rates that are calculated by multiplying the share of the population living in districts covered under PBF together with the coverage rate of that intervention under PBF, which comes from data from the previous.

expected to decline from 64/1,000 in 2017 to 29/1,000 in 2025, as opposed to 52/1,000 without the IPF, with an expected decline of over 10 percent with the program (as opposed to a decline of 2 percent without the program). Because of the IPF, it is estimated that the lives of an additional 2,230 women and 50,730 children (16,620 of whom are neonates) will be saved by 2025. A detailed economic analysis is included in **Annex 2**.

97. **Market failures in the health sector and the case for public intervention and financing are well established.** There are at least 9 criteria related to public intervention in the health sector: economic efficiency criteria (public goods, externalities, catastrophic cost, and cost-effectiveness), ethical reasons (poverty, horizontal and vertical equity, and the rule of rescue), and political considerations (especially demands by the population). The project satisfies all nine criteria It seeks to support the government of Côte d'Ivoire so that it can intervene in assuring high levels of quality and access in the provision of public health services, and to assist in doing so equitably. Through scaling up strategic purchasing, the project increases the availability of non-earmarked funding and quality of care at rural health centers and district hospitals, which serve the poorest and most vulnerable of the population that are underfunded by public investment and do not receive funding from any other sources. In addition to strengthening equity in the supply side, the project also seeks to increase equity with regards to the demand side, through the scale-up of health insurance. Impoverishing health expenditure in Côte d'Ivoire is a significant problem, as over a third of all healthcare costs are financed out of pocket and 18 percent of the population has incurred catastrophic health expenditure in 2015.[72] The scale-up of health insurance to start with the poorest and most vulnerable, coupled with increased public health expenditure, would be able to reduce the incidence of catastrophic health spending.

98. **The World Bank has unique expertise in coordinating the complex set of interventions that comprise this project, as well as** vast experience in health systems strengthening, MCH, and in implementing and evaluating performance-based financing programs. The World Bank will provide strong technical expertise and project design and management, in improving the health workforce through implementing evidence-based human resources for health strategies, and in HMIS. The World Bank will furthermore support stakeholder coordination and consensus building across many departments, ministries, and organizations.

B. Fiduciary

(i) Financial Management

99. Detailed FM analysis in **Annex 5**. The UCP of the ongoing Health Systems Strengthening and Epidemic Preparedness project – P147740- (PRSSE) under the oversight of a SC chaired by the Director of Cabinet of MSHP or his representative will have the overall fiduciary responsibility of the SPARK. The FM mechanisms for SPARK will be based on the existing mechanisms established under the PRSSE, supplemented with additional measures. Overall FM of the PRSSE after the last supervision mission, carried out in December 2018, was evaluated as ***moderately satisfactory*****.** There are no overdue unaudited Interim Financial Reports (IFR) and audit reports of PRSSE at the time of the appraisal. The external auditor expressed an unqualified opinion (clean) but raised some observations regarding the non-recruitment of a firm to play the role of an Independent Verification Agency (IVA) in charge of the verifications and post-audits of the implementation of the PBF activities and the ineffectiveness of the COGES. This IVA issue was discussed during Appraisal and finalized at negotiations, whereby a condition of

[72] Defined as over 10 percent of household income; source: ENV 2015.

disbursement has been set until the Recipient has adopted the PBF Manual under terms and conditions set out in Section I.D of the Schedule 1 (i.e. IVA contracting and role) of the SPARK-Health financing agreement.

100. The PRSSE PCU fiduciary staffing is adequate and has acceptable experience both with World Bank's FM requirements and national processes. One additional accountant and one assistant accountant assigned 100 percent to the SPARK, will be hired to strengthen the FM team of PRSSE FM team and based on the workload deriving from this new project, additional FM staff may be hired. As part of national Decree No. 475 governing implementation arrangements for donor-financed projects in Côte d'Ivoire, a financial controller from the Ministry in charge of Budget (MB) and a public accountant *(agent comptable du projet)* from the MEF are assigned to the Health UCP. Similar arrangements will be put in place for the new project SPARKS.

101. Overall FM risk for the SPARK project is assessed as ***substantial*.** Aside from the current level of risk for the proposed UCP, fiduciary risk for the new project is assessed as *substantial* primarily because of the project design and the following factors: (i) a multiplicity of actors, resulting in a large number of transactions expected; (ii) beneficiaries based in geographically remote areas and scattered across the country; (iii) funds transfers to implementing agencies for direct management; (iv) subprojects in various locations; (v) lack of effective and reliable mechanisms currently in place to check and post-audit the accuracy of funds transferred to health centers (PBF activities) and their utilization of the intended purposes; and (vi) disbursement to beneficiaries based on progress reports. Consequently, additional mitigation measures will be incorporated into the design of the project's FM mechanisms. These measures include the following: (i) specific and detail fiduciary manual for implementing agencies with clear transparency rules; (ii) PCU supervision to oversee and evaluate the implementing agencies work plan achievement and fiduciary operations; (iii) use of a firm to train and build the fiduciary capacity of the beneficiaries including health centers, implementing entities before the transfers of funds; (iv) use of national entities / local non-governmental organization (NGO) to conduct post verifications and audits of PBF activities; (v) additional resources allocated to Health Inspectorate General (IGS) and IGF to fulfill in an effective manner their legal mandate; and (vi) accountability and participation mechanisms.

102. The FM assessment confirmed that the FM arrangements satisfy the World Bank's minimum requirements regarding its policy and directive on investment projects and, therefore, are adequate to provide, with reasonable assurance, accurate and timely FM data on the status of the project as required by the World Bank. Nevertheless, the PIU will be required to prepare and submit to the World Bank (i) a consolidated annual work plan and budget (AWPB) not later than 30 November every year; (ii) unaudited IFR 45 days following the end of each quarter; and (iii) audited financial statements six months after the end of each government fiscal year. The project will comply with the World Bank disclosure policy of audit reports. Furthermore, the Project Procedures and Implementation Manual (MMOPP) incorporating the fiduciary procedures will also be updated to include specific procedures associated with the management of this project. The configuration of the existing Accounting software will be updated and personalized to integrate the project's new chart of accounts. A mechanism, as part of the internal control system, for sharing operating costs between projects managed by the Health UCP will be designed to determine the contribution of each project, to the overall operating costs of the Health UCP. Lastly, an external auditor will be hired through a competitive process. Most of these mitigation measures have specific deadlines and should be implemented within one to five months following the project effectiveness.

103. A designated account (DA) denominated in CFA francs will be opened at the Central Bank of West African States (BCEAO). The DA will be managed by the Directorate of Public Debt (ACDP). A project or transaction bank account – project account (PA) denominated in CFA francs managed by the Agent Comptable du projet (from the Ministry of Finance) will be opened in a commercial bank on terms and conditions deemed acceptable to the World Bank. The ceiling of the DA will be stated in the DFIL. Any interest on the deposit account/transaction account will be deposited in a specific account opened in a commercial bank. Others bank accounts (sub-accounts) will be opened in commercial banks or in Treasury accounts (*comptes de dépôt ouverts au Trésor Public*), as needed, for the transfer of funds to certain Implementing Agencies and Health centers/Districts.

104. Upon signing of the memorandum of understanding (MoU) between the Government and UN agency, application for withdrawal of proceeds will be prepared by the PCU/PRSSE and submitted to IDA. The special World Bank disbursement procedures will be used to establish a "Blanket Commitment" to allow the amount to be advanced.

(ii) Procurement

105. Detailed procurement arrangements analysis is in **Annex 4**. The Health UCP, which is currently implementing the PRSSE without significant procurement issues, will have primary responsibility for project implementation. The disbursement rate is acceptable and is in line with the disbursements forecast in the PAD. This unit will also be responsible for managing the financial and procurement needs of the new project. Capacity assessment revealed that the risk level is "average" based on changes made to the implementation conditions and requirements for the application of the new procurement framework entitled, "Procurement Regulations for IPF Borrowers." This average risk will be mitigated through preparation of the MMOPP detailing the requirements for complaint management as described in the new procurement framework, "Procurement Regulations for IPF Borrowers," and the use of these regulations in general.

106. The Health UCP is managing the PRSSE with staff possessing the required experience and skills and a manual of procedures deemed acceptable by the World Bank, which indicates that it will serve as the project coordination unit for the new project as is the case for the PRSSE, based on the provisions of the procurement guidelines in force. The Health UCP has two procurement specialists and a procurement assistant. The current portfolio includes the PRSSE and the PPA for the PMNDPE, as well as TA for other projects such as the Sahel Women's Empowerment and Demographics Project (SWEDD). The procurement specialists in the Health UCP received training on the new procurement framework, and specifically on the Project Procurement Strategy for Development (PPSD).

107. The Contract Management department of the Health UCP will be responsible for coordinating all procurement activities, particularly the following: (a) preparation and updating of procurement plans; (b) preparation, finalization, and launch of requests for expressions of interest (REOI) and bidding documents; (c) drafting of bid opening reports/proposal and preparation of assessment reports; (d) submission of procurement documents (terms of reference (ToR), requests for expressions of interest, bidding documents, assessment reports, contracts, etc.) to the World Bank when a preliminary assessment is required; (e) contract preparation and supervision of payments to contractors; and (f) drafting of the status report on procurement and coordination of activities.

108. **Summary of the PPSD:** The total value of the financing for Côte d'Ivoire is US$220 million, of which over 50 percent is allocated to procurement of goods, works, and consultants' services:

- **Goods:** represent 20 percent in value. They mainly concern standard goods and equipment, similar to those purchased for the implementation of the PRSSE, and available in the local environment. However, the contract for incinerators must be subject to open international consultation due to the unsatisfactory experience that the PRSSE has had in the past with local suppliers.
- **Consultants:** The selection of consultants will be mainly open. Indeed, the recent nature of strategic purchase and UHC in Côte d'Ivoire justifies the scarcity of local expertise for certain studies. However, the experience of the PRSSE has allowed the transfer of skills to the national market. Thus, some selection such as the recruitment of OBCs can be done from the national market. It will be the same for the recruitment of the 5 ACV for the implementation of the PBF. As a result of the expertise and preferential prices enjoyed by some UN agencies, some conventions will be directly contracted with UNFPA, UNICEF and WHO's. This practice has brought satisfactory results under the PRSSE.
- **Works**: The national market offers a diversity of entrepreneurs of different sizes for most activities in this category, with an insufficient financial base. With its experience, the PRSSE suggests national preference with allotment for the rehabilitation of health centers.

C. Safeguards

(i) Environmental safeguards

109. The positive impacts are inter-alia job creation and poverty reduction, better management of medical waste and a reduction in the forms of various types of pollution and an improvement in care services.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, ground).

110. The project was rated as a category "B" and triggers two (02) environmental safeguards policies that are Operational Policy OP 4.01" Environmental Assessment" and OP 4.11" Physical Cultural Resources". To prepare for addressing the potential negative impact, the Government has prepared two (02) appropriate safeguards instruments namely: An ESMF and a MWMP.

111. 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 contains chapters to consider Physical Cultural Resources matters. That means guidance and guidelines have been included in the ESMF to this end.

112. 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 Côte d'Ivoire and at the World Bank website on January 15, 2019.

113. Like the ESMF the MWMP was also disclosed in Côte d'Ivoire and at the World Bank website on January 15, 2019. 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.

114. A Grievance Redress Mechanism (GRM) has been defined in the ESMF and will be set up before the start of activities, to allow stakeholders and all parties concerned to submit to the PIU any possible project-related grievances with the aim of finding solutions.

115. 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.

116. 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.

117. 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 Gender- Based Violence (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.

118. 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.

119. **Citizen engagement**. The project will support citizen engagement through public consultation on the information related to the implementation of civil works management as well as to the development and implementation of training programs in logistics. As part of the implementation of World Bank-financed projects executed by the MSHP, a methodological guidance note is being prepared for all projects. To this end, the project will adapt it to guarantee strong citizen engagement through an inclusive participation process of all the actors. Considering that the scaling up of strategic purchasing constitutes a major reform of how health is delivered and paid for in Côte d'Ivoire, regular feedback on these reforms from the Ivoirian population is essential. The project has included in its result framework an indicator measuring the satisfaction of project beneficiaries from SPARK-Health scale-up interventions. This will be addressed through citizen report cards as well as measuring the involvement of citizens and communities in the planning, implementation and evaluation of these reforms.

(ii) Social (including safeguards)

120. Activities under the SPARK are likely to generate both positive and negative impacts on the socio-economic and components. However, the project is mostly associated with positive social impacts such improving the quantity and quality of health services by focusing on maternal and child health as well as nutrition. Nonetheless, 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 OP 4.12 on Involuntary Resettlement.

121. In anticipation of the negative social impacts, a Resettlement Policy Framework (RPF) was prepared by the Borrower. Thereafter, it was reviewed, consulted upon, and publicly disclosed within Côte d'Ivoire and on the World Bank website on January 15, 2019. 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.

(iii) Grievance Redress Mechanisms

122. Communities and individuals who believe that they are adversely affected by a World Bank (WB) supported project may submit complaints to existing project-level grievance redress mechanisms or the WB's Grievance Redress Service (GRS). The GRS ensures that complaints received are promptly reviewed to address project-related concerns. Project affected communities and individuals may submit their complaint to the WB's independent Inspection Panel which determines whether harm occurred, or could occur, because of WB non-compliance with its policies and procedures. Complaints may be submitted at any time after concerns have been brought directly to the World Bank's attention, and Bank Management has been given an opportunity to respond. For information on how to submit complaints to the World Bank's corporate Grievance Redress Service (GRS), please visit http://www.worldbank.org/en/projects-operations/products-and-services/grievance-redress-service. For information on how to submit complaints to the World Bank Inspection Panel, please visit www.inspectionpanel.org.

(iv) Climate Change Screening

123. This project has been screened for short- and long-term climate change and disaster risks. The following hazards are applicable to the geographic areas covered under the project: extreme temperature, extreme precipitation and flooding, drought, heavy storms, strong winds, sea level rise, and storm surges. The impact of these hazards in the short-to-medium term is assessed as "moderate". Côte D'Ivoire is already experiencing climate-related changes in the transmission patterns of climate sensitive infectious diseases, including vector (e.g. malaria), food and water-borne diseases (diarrhea, cholera and schistosomiasis).[73] Moreover, in the short-term, climate change is expected to increase the incidence of injuries and malnutrition, and increase population displacement and insecurity, while threatening economic development and poverty alleviation in the long term.

[73] Ministère de la Salubrité, de l'environnement et du développement durable (2017). Rapport de la troisième communication nationale (TCN) de la Côte D'Ivoire Dans le cadre de la convention cadre des nations unies sur les changements climatiques (CCNUCC).

124. The proposed project activities are expected to have a positive impact on the lives of beneficiaries through health system strengthening initiatives, both at the health facility and community level. These activities will enhance the resilience of health service delivery to the hazards and improve the coping capacity of the health system when faced with extreme events. In terms of adaptation measures the project will build emergency/disease surveillance preparedness and response capacity to detect, monitor and respond to vector, food and waterborne diseases, many of which are particularly climate sensitive. Specifically, activities under Sub-components 2.4 (cost allocated to Sub-component 2.4 = US$25,810,298) will strengthen surveillance systems - at the national, regional and community level - involved in the monitoring of climate-sensitive diseases and weather events and will enhance the relevant early warning systems. Furthermore, under Sub-component 2.3 (cost allocated to Sub-component 2.3 = US$24,000,000) health care workers will receive training on the health impacts of climate change to enhance their capacity to prevent, diagnose and treat vulnerable populations. Moreover, this component will finance sensitization activities at the community level to promote adaptive behavior in vulnerable populations.

125. Under Component 1 (cost allocated to Sub-component 1.1 and 1.2 = US$109,410,942) the project will expand coverage and access to health services for climate-sensitive diseases, including in areas with intermittent periods of access, due to drought and floods, thereby increasing the resilience of community's both in terms of the direct provision of health services to climate sensitive diseases including nutrition, as well as improving the wider environmental and social determinants of health. This will have additional equity benefits particularly for displaced and vulnerable populations who are also disproportionally affected by climate change. In the event of a natural disaster, the project would ensure a higher state of preparedness with emergency action plans and protocols to be implemented under the CERC component (Component 4), should financing under this component be triggered.

126. Health facilities will be vulnerable to the impacts of climate change such as increasing temperatures, flooding, and rising sea level. As a result, it is expected that health service delivery to incoming patients will be compromised. Therefore, it is critical to make these facilities resilient to the risks of disaster and climate change and ensure that health services are delivered unhindered to the beneficiaries. Specifically, under Sub-component 2.1 (cost allocated to this sub-component = US$27,906,800), the following activities will be undertaken: (i) extreme weather events and climate change impacts will be factored into the National Infrastructure and Equipment Master Plan, (ii) 150 health facilities across the country will be rehabilitated using climate-smart approaches, and 150 health facilities will be equipped with climate -friendly, low carbon technologies such as energy saving appliances (iii) implementation of an innovative WASH intervention with off-grid solar (renewable) energy/electrification source for an estimated 2000 rural health centers across the country. In implementing these measures, healthcare infrastructure In Côte D'Ivoire will be climate smart, thereby enhancing their overall resilience to impacts of disasters and climate change. Further mitigation benefits will be realized through improved procurement practices that will seek to reduce the embedded carbon in medications and other medical supplies (cost allocated to strengthen the management of medicines = US$4,000,000).

V. KEY RISKS

127. **Key Risks to the project:** The overall implementation risks are **Substantial** due to the relative newness of Strategic Purchasing, as conceived, and the substantial learning curve that will result from it. The leadership of CMU and PBF under two different ministries is a political challenge. Further, while issues of capacity building and understanding of the nature of the proposed interventions can be mitigated, there are number of residual risks relating to the country situation and governance which will continue regardless and will need to be addressed during project implementation[74]. A concerted effort will be required throughout project implementation and will include extensive policy dialogue and TA to ensure that those who will be implementing the project understand the activities that are being financed and are able to begin implementation once the project is approved. It will also require ongoing dialogue with other development partners to ensure proper coordination in support of the overall government objectives.

128. **Overall Project Risk Rating Explanation and Risk Mitigation Measures.** Based on the risk assessment, the project risk is rated as **Substantial.** Risk mitigation measures by project component and sub-component are outlined in **Table 10**.

129. **Political and Governance risk is substantial**. This risk has been assessed as "Substantial" and is applicable to the entire country portfolio at project and program levels. Cote d'Ivoire's presidential elections at the end of 2020 could impact implementation. The leadership of CMU and PBF under two different ministries will be a political challenge. A concerted effort will be required including extensive policy dialogue and TA to ensure that both implementations can begin immediately at project approval and that the reform and capacity building required for sustainability is addressed throughout. The focus of this project on communities and beneficiaries, with a performance-based approach to incentivize service delivery and generating demand for services, will help to manage this risk and keep the focus on results.

130. **Macroeconomic risks are substantial, primarily due to the need for fiscal adjustment over the next few years**. The Government must reduce its fiscal deficit by approximately 1.5 percent of GDP over the next two years to ensure fiscal and debt sustainability, in line with the IMF-supported program and WAEMU targets. While this adjustment is manageable, it will require redoubling efforts in terms of revenue mobilization and containing public spending. Not only will this represent a shift from previous policy, it will take place as the country prepares for the forthcoming presidential elections in 2020. This risk will be closely monitored through dialogue with the Government in close coordination with the IMF. The World Bank also plans to provide policy advice on both fiscal policy and management through its governance operation and ASA (most notably on taxes).

131. **Technical Design of project risk is substantial**. The integration of two parallel service delivery systems (CMU and PBF) at central and community level is new and will require personnel from two ministries to work together in a harmonized way. To minimize the risks of leakages with the implementation of national health insurance, technical support will be provided to 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

[74] http://iosrjournals.org/iosr-jbm/papers/Vol17-issue2/Version-4/H017244253.pdf.

PBF and CMU as well as the determination of who would be paying for what indicator, and harmonization with MSHP across key priority areas. A system of accreditation and contracting within the CNAM to ensure a full link between reimbursement of services and quality of services will also be pursued. The project will furthermore support the development and implementation of national, district and facility-level stakeholders to use the tools of the health insurance mechanism.

132. **Institutional Capacity for Implementation risk is substantial**. The program will be managed PIU (UCP Santé-BM), which has built strong capacity to implement World Bank projects. Several implementing entities of the MSHP (central departments, health regions and districts, national program, health centers) and the CNAM will serve as implementing agencies and be responsible for the operational implementation of the activities selected for the project. Given this inclusive design of the project, it is essential that all entities have the same speed of implementation supported by a strong coordination mechanism. To mitigate these risks, MSHP, which is responsible for the technical aspects of the project, will coordinate implementation activities and ensure that the project is fully embedded into the MSHP's broader program. More effective training and coaching approaches will be provided to build skills on program management, including supervision and PBF.

133. **Fiduciary risk is substantial**. Fiduciary risk for the new project is assessed as *substantial* primarily because of the project design and the following factors: (i) a multiplicity of actors, resulting in a large number of transactions expected; (ii) beneficiaries based in geographically remote areas and scattered across the country; (iii) funds transfers to implementing agencies for direct management; (iv) subprojects in various locations; (v) lack of effective and reliable mechanisms currently in place to check and post-audit the accuracy of funds transferred to health centers (PBF activities) and their utilization of the intended purposes; and (vi) disbursement to beneficiaries based on progress reports. Consequently, additional mitigation measures will be incorporated into the design of the project's FM mechanisms. These measures include the following: (i) detailed fiduciary manual for implementing agencies with transparency rules; (ii) PCU supervision to oversee and evaluate the implementing agencies work plan achievement and fiduciary operations; (iii) use of a firm to train and build fiduciary capacity of the beneficiaries including health center and, implementing entities; (iv) use of national entities / local NGO to conduct post verifications of PBF activities; (v) additional resources allocated to Health Inspectorate General (IGS) and IGF to fulfill in an effective manner their legal mandate; and (vi) accountability and participation mechanisms.

Table 10. Risk mitigation by component

COMPONENTS	RISK	MITIGATION MEASURES
GENERAL	- insufficient understanding of the project content by the actors - No ownership of the project by the stakeholders - Integrated National FM information system (SIGFIP) is not consistent with the project disbursement target	- Organize an ownership meeting or workshop with the main stakeholder during the preparing process and implementing phase. - Wide dissemination of project document content to stakeholders. - Advocacy to implement a specific FM system with the project compliance and disbursement requirement.
COMPONENT 1		
PBF	- No control of the implementation procedures by the actors - Insufficient capacity of health staff for PBF	- Training the implementer's actors in project FM process. - FM supervision and coaching of PIU to the

COMPONENTS	RISK	MITIGATION MEASURES
	resources management - Non-functionality and demotivation of COGES: difficulty to use PBF resources - Public FM rule and regulation not adapted to the health sector environment and challenges - Delay in payment of PBF resources to health centers due the absence of the Government Counterpart - Turnover of CTNPBF staff - Unavailability of qualified personnel within the CTNFBP for scaling up	implementing actors. - Set up the incentive mechanism for COGES member. - Elaborate and set up the adapted rules and regulations (Financial management) for health sector. - Hiring a supplement staff to CTNPBF according to needed assessment recommendation - Contracting CTNPBF.
Scale up of CMU	- Interaction of multisectoral actors in the implementation of the CMU - Dissatisfaction of the insured vis-à-vis the health benefits offered - Non-adherence of the populations to the CMU - Administrative costs of the CMU exceed the contributions - Government does not finance the indigent contribution - Low Enrollment Operator Deployment Capability - Subsidy / Subsidies needed for the contributory scheme	- Establishment of an inter-ministerial dialogue framework. - Align with the evolution timeline of the PBF to benefit from the achievements. - Strengthen the mandatory nature of the CMU - Raise awareness and engender national solidarity.
COMPONENT 2		
Rehab & Equipment	- Poor identification of needs taking into account standards - Ability of companies to carry out rehabilitation work in compliance with standards and deadlines - Absence of a durable Equipment maintenance device	- Strengthen the DIEM capacities. - Develop and implement a national strategy for equipment management such as including equipment maintenance into future contracts.
Health Management information system	- Low capacity (material and logistics) of the DIIS to manage the Indicators and National Health Information System (SNIS) - Poor quality of health information impacting decision-making - Insufficient coordination of health information needs - Insufficient qualified staff in health information management at the decentralized level (Regional Directorates of Health (DRS) / DDS) - Diversity of health information sources	- Strengthen the operational capacities of the DIIS and the actors of the decentralized level - Assignment of personnel dedicated to data management at the DRS / DDS level.
Health System Management and Quality of care	- Interventions related to regulatory missions are not properly functioning at Health Region and Districts (DRS and DDS)	- Define DRS/DDS profile and competencies based on the ongoing study recommendation - Capacity budding of DRS/DDS staff according their mission. - Coaching DRS/DDS team to better undertaking their mission.

COMPONENTS	RISK	MITIGATION MEASURES
		- Reinforce the supervision and leadership role of DGS. - Ensure the co-sharing in equipment's, logistics and practices between DRS/DDS.
Project Management	- Incapacity to achieve the project goal according the RF and Disbursement plan	- Reinforce the PIU in staff (program and fiduciary staff). - Address lack of FM information system (SIGMAP and SIGFIP). - Ensure the M&E of implementing activities - Identify and implement the keys procurement activities with high level of disbursement according to the PPSD.

VI. RESULTS FRAMEWORK AND MONITORING

Results Framework

COUNTRY: Cote d'Ivoire

Strategic Purchasing and Alignment of Resources & Knowledge in Health Project (SPARK-Health)

Project Development Objectives(s)

To improve the utilization and quality of health services towards reducing maternal and infant mortality in the Recipient's territory.

Project Development Objective Indicators

Indicator Name	DLI	Baseline	End Target
People who have received essential health, nutrition, and population (HNP) services			
People who have received essential health, nutrition, and population (HNP) services (CRI, Number)		723,244.00	4,398,683.00
Number of children immunized (CRI, Number)		234,095.00	1,525,326.00
Number of deliveries attended by skilled health personnel (CRI, Number)		489,149.00	3,182,938.00
Average Health Facility Quality Score			
Average Health Facility Quality Score (Percentage)		48.00	75.00
Utilization of Health Services			
Utilization of Health Services (Percentage)		39.00	60.00
Direct Project Beneficiaries (% Female)			
Direct Project Beneficiaries (% Female) (Number)		0.00	59,270,770.00

Intermediate Results Indicators by Components

Indicator Name	DLI	Baseline	End Target
Scale-up of Strategic Purchasing			
Number of Health Districts Covered (Number)		17.00	86.00
Number of Poor and vulnerable supported by the CMU (Number)		31,872.00	12,879,217.00
Health System Strengthening to Improve Performance			
Health Facilities rehabilitated and / or equipped (Number)		0.00	890.00
Number of Women completing at least 4 prenatal visits (Number)		131,733.00	974,648.00
Number of Women of reproductive age who are new users of modern contraceptive methods (Number)		89,700.00	1,300,625.00
Number of "Healthy" children 12-59 months seen for Nutritional consultation visit (Number)		310,450.00	2,592,390.00
Number of people trained (Number)		0.00	31,764.00
Availability of last year's RASS in the first half of the following year (Yes/No)		No	Yes
Number of Women completing at least 3 CPoN visits (Number)		278,099.00	1,822,389.00
Citizens and/or communities involved in planning/implementation/evaluation of development programs (Yes/No) (Yes/No)		No	Yes
Contingent Emergency Response Component (CERC)			
Number of emergency response beneficiaries (Number)		0.00	0.00

Monitoring & Evaluation Plan: PDO Indicators					
Indicator Name	**Definition/Description**	**Frequency**	**Datasource**	**Methodology for Data Collection**	**Responsibility for Data Collection**
People who have received essential health, nutrition, and population (HNP) services					
Number of children immunized		Bi-Annual	Quarterly Report CTN - PBF	PBF Portal	CTN - PBF, DIIS
Number of deliveries attended by skilled health personnel		Quarterly	Activity Reports of Health Facilities	Activity Reports of Health Facilities	DIIS
Average Health Facility Quality Score	This is a the quality score of health care and services obtained by health facilities under PBF in the last quarter of the fiscal year.	Quarterly	Quarterly Report CTN-PBF	Quarterly Report CTN-PBF	CTN-PBF
Utilization of Health Services	This is the percentage of the population in the health area who consulted for a first episode of illness during a given period in a health facility	Annual	Quarterly, RASS Report	CTN - PBF	DIIS - CTN-PBF
Direct Project Beneficiaries (% Female)	This is the number of people, including health personnel, who benefited	Quarterly	Activity Reports of Health	Activity Reports of Health Facilities	UCP-BM

	from a project intervention in a given period of time		Facilities		

Monitoring & Evaluation Plan: Intermediate Results Indicators					
Indicator Name	**Definition/Description**	**Frequency**	**Datasource**	**Methodology for Data Collection**	**Responsibility for Data Collection**
Number of Health Districts Covered	This is the number of health districts for which all target health facilities were put under performance during a given period	Annual	Quarterly Report CTN-PBF	PBF Portal	CTN-PBF
Number of Poor and vulnerable supported by the CMU	This is the number of vulnerable people identified and covered under universal health coverage in the target health districts	Quarterly	Activity Reports of Health Facilities	PBF Portal	CNAM, CTN-PBF
Health Facilities rehabilitated and / or equipped	This is the number of health facilities rehabilitated and / or equipped as part of the project	Annual	Activity Reports	Activity Reports	UCP BM
Number of Women completing at least 4 prenatal visits	This is the number of pregnant women who performed 4 prenatal consultations according to the current schedule	Annual	RASS	RASS	DIIS
Number of Women of reproductive age who are new users of modern contraceptive methods	This is the number of women of reproductive age (15 to 49 years) who initiated the use of modern methods of family planning	Quarterly	RASS	PBF Portal	DISS, CTN-PBF

	during a given period				
Number of "Healthy" children 12-59 months seen for Nutritional consultation visit	The number of "healthy" children aged 12 to 59 months who went for consultation and whose anthropometric measures were evaluated and nutritional counseling was provided.	Quarterly	Activity reports of health facilities	PBF Portal	CTN-PBF
Number of people trained	This is the total number of people from the central directorates, health institutions, public administrations, the community, the auditors trained in each of the different themes necessary for the implementation of the strategic purchasing or any other project target.	Quarterly	Activity reports of health facilities	PBF Portal	CTN-PBF
Availability of last year's RASS in the first half of the following year	The RASS of the year n (electronic format / paper) finalized at the latest on June 31 of the year n + 1	Annual	RASS	RASS	DIIS
Number of Women completing at least 3 CPoN visits	The number of pregnant women consulted in CPoN 1, 2 and 3 according to the schedule (6th hour, 6th day and 6th week)	Quarterly	PBF Portal	PBF Portal	CTN-PBF
Citizens and/or communities involved in planning/implementation/evaluation of	Citizen/community collaboration (on planning	Quarterly	Survey	User groups, Participatory budgeting	CTN-PBF

development programs (Yes/No)	and/or execution of a policy, program or project)			etc	
Number of emergency response beneficiaries	In case of emergency this is the number of people who will specifically benefit from the proceeds of the project interventions.	Quarterly	Project Activity Report	Project Activity Report	UCP BM

ANNEX 1: Implementation Arrangements and Support Plan

COUNTRY: Côte d'Ivoire
Strategic Purchasing and Alignment of Resources & Knowledge in Health Project (SPARK-Health)

1. **Implementation Arrangements.** The MSHP 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 UCP of the MSHP.

2. **PIU roles and responsibilities:** Under the guidance of project SC, 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 World Bank's support missions and ad hoc meetings as necessary. This includes overall project reporting from MSHP, such as financial reports, AWPB, RF 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 (CTN-PBF).** The MSHP has a long track record in implementing World 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. The CTN-PBF was created under DPPS and responsible for: (i) preparing PBF SC meetings and supporting implementation of the decisions made by the PBF SC; (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 CTN-PBF was recently moved from the DPPS to under the 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 and monitor the overall technical and financial progress of the CTN-PBF, 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 TA 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. **MSHP Departments.** The following departments of MSHP 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 programs will contribute to the project implementation as part of their roles and 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 Côte d'Ivoire, the UN agency— WHO, UNICEF, UNFPA— will provide TA 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 SC will be set up to oversee and monitor the progress of the project activities.

10. **Steering Committee (SC).** A project SC will be created by the MSHP with the following composition: MSHP, MEPS, MEF, MB, MP, 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 AWPBs, 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.

ANNEX 2: Economic Analysis

COUNTRY: Côte d'Ivoire
Strategic Purchasing and Alignment of Resources & Knowledge in Health Project (SPARK-Health)

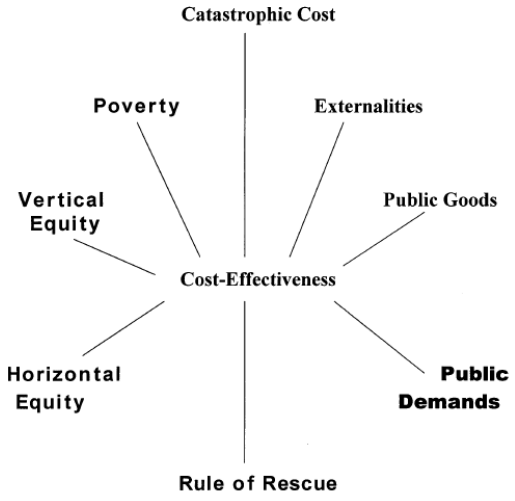
1. **The economic analysis of the project focuses on two key areas**: (i) justification for public sector provision; and (ii) the project's development impact.

2. **The PDO of improving the utilization and quality of health services is strongly aligned with the WBG twin goals** of eliminating poverty and boosting shared prosperity, improving human capital, as well as the HNP Global Practice's orientation towards Universal Health Coverage, to ensure that all Ivorians obtain the health services they need without suffering financial hardship when paying for them.

Public Sector Justification

3. **Market failures in the health sector and the case for public intervention and financing have been well established starting as far back as 1965 with Klarman's[75] analysis**. There are at least 9 criteria related to public intervention in the health sector[76]: economic efficiency criteria (public goods, externalities, catastrophic cost, and cost-effectiveness), ethical reasons (poverty, horizontal and vertical equity, and the rule of rescue), and political considerations (especially demands by the population) (Figure 2.1).

Figure 2.1: Nine criteria for public intervention in the health sector



Source: Musgrove Health Policy 47 (1999) 207–223.

4. **This IPF fits within all nine criteria of public intervention in the health sector**. It seeks to support the Government of Côte d'Ivoire so that it can intervene in assuring high levels of quality and access in the provision of public health services, and to assist in doing so equitably. Through scaling up strategic purchasing, the project

[75] 1. Klarman HA. (1965). The case for public intervention in financing health and medical services. Med Care.;3:59–62.
[76] Philip Musgrove (1999). Public spending on health care: how are different criteria related? Health Policy 47 207–223.

increases the availability of non-earmarked funding and quality of care at rural health centers and district hospitals, which serve the poorest and most vulnerable of the population that are underfunded by public investment and do not receive funding from any other sources. In addition to strengthening equity in the supply side, the project also seeks to increase equity with regards to the demand side, through the scale-up of health insurance. Impoverishing health expenditure in Côte d'Ivoire is a significant problem, as over a third of all healthcare costs are financed out of pocket and 18 percent of the population has incurred catastrophic health expenditure in 2015.[77] The scale-up of health insurance to start with the poorest and most vulnerable, coupled with increased public health expenditure, would be able to reduce the incidence of catastrophic health spending.

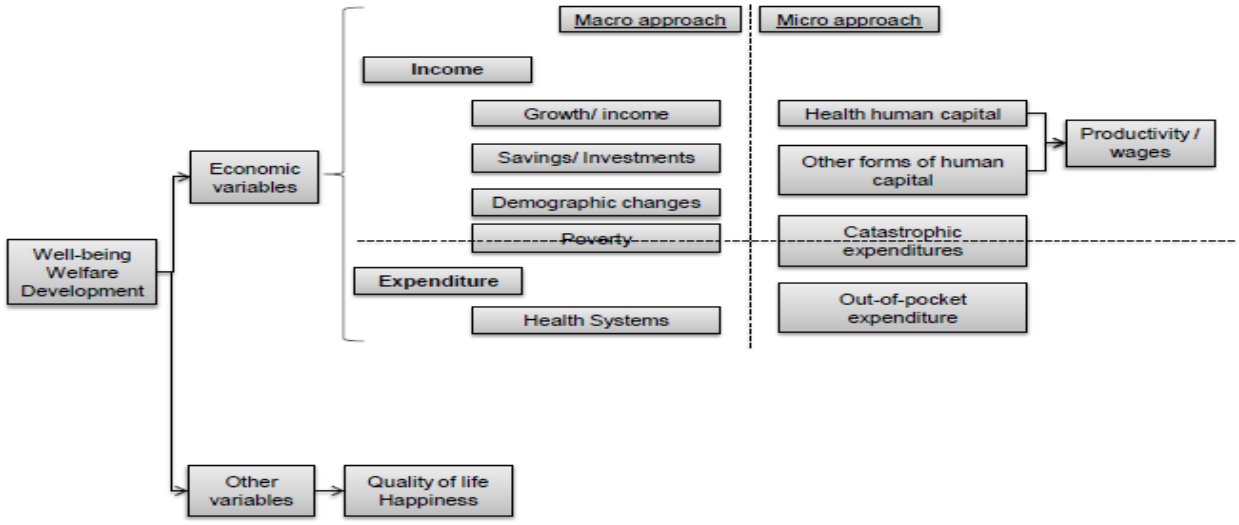
5. **In addition to equity, there are other significant considerations with the public service provision of this project.** Through strengthening the health system as well as the health information system, the Government is providing the public goods that it is uniquely positioned and has the competitive advantage to provide. The public's demands from the health system in terms of quality are not being met: according to a recent Afro-barometer survey, 39 percent of the population has rated their satisfaction level with the health services as "bad" or "very bad;" improvement of quality with the scale-up of strategic purchasing would meet public demands.

Health and Economic Development

6. **Improving equitable access to health services, through the scaling up of strategic purchasing, incentivizing structural health reforms and consolidating the health system, impacts directly on health status and health spending through mechanisms described below.** Increased accountability, improved infrastructure, improved quality, increased financial protection and strengthened HMIS can impact health and health spending both directly and indirectly as well as potentially improve economic outcomes through increased government efficiency.

7. The impact of health on economic outcomes can be measured through the impact on income or expenditure and at both the micro and macro levels **(Figure 2.2).**

Figure 2.2: Analytic framework to assess the economic impact of health



[77] Defined as over 10 percent of household income; source: ENV 2015.

Source: Health Effects of Econ Develop: Evidence from developing countries. World Bank 2014.

8. **Improved health directly impacts income at national and household levels through the costs associated with diagnosis and treatment of illnesses as well as mitigating negative impacts on workforce and decreasing productivity**. Changing health status and demographics may have other behavioral effects such as changing the incentives to innovate or to use current innovations if the value of labor is changing due to these factors. While estimates of the size of the positive effect of health on economic development range from almost none[78] to over 90 percent,[79] a reasonable estimate, based on the sum of the literature, is that health accounts for 20-30 percent of the variation in income across countries. Three principal mechanisms account for this variation: human capital effects, through both productivity and education; demographic effects; and savings and investment effects.

9. **Low quality of care in and of itself leads to lost productivity**. The value of output to be lost due to amenable deaths (deaths that would not happen in the presence of high-quality care) is a cumulative US$11.2 trillion in low- and middle-income countries between 2015-30, or 2.6 percent of GDP in low-income countries.[80] Low quality of care poses a significant problem. This is a problem in Côte d'Ivoire. According to IHME's HAQ index, Côte d'Ivoire has the 187th lowest quality of care over 195 countries as ranked in terms of the prevalence of amenable mortality, i.e. deaths that should not be occurring in the presence of effective care.[81] Another recent study puts Côte d'Ivoire as one of the countries with the highest prevalence of amenable mortality in SSA; specifically, in 2015, there were 51,029 excess deaths amenable to healthcare, 29,117 of which were due to poor quality of care and 21,912 due to non-utilization. Côte d'Ivoire's rate of 128 poor quality deaths per 100,000 is higher than most West African including poorer countries such as Liberia.[82] As such, improving the quality of care in Côte d'Ivoire has the potential to unlock significant economic gains.

Human Capital Effects

10. *Direct effect of health on income through productivity.* Human capital is the set of knowledge and skills acquired throughout life that are used to produce goods, services and ideas, both inside and outside the labor market. Better health contributes to human capital and increases productivity directly by reducing incapacity, debility, and number of days lost to sick leave, and indirectly through its effect on education and cognitive development; healthy people can work harder, have more energy, are more physically robust and earn a higher return in the labor market. This may be particularly working through nutritional status, especially at early ages, to health to productivity. Declining health, especially in the older ages may induce early retirement and skilled, experienced workers leaving the labor force. This effect may be conceptualized by including health into the Mincer wage equation and estimating the system as a three equations model. Equation 1 shows that health is a function of health and other inputs and exogenous factors. Equation 2 shows that health inputs are a function of income,

[78] Acemoglu D., Johnson S., Robinson J. 2002. Disease and Development in Historical Perspective. Journal of the European Economic Association Papers and Proceedings, v.1, 397-405.
[79] Lorentzen P., McMillan J., Wacziarg R. 2005. Death and Development. NBER Working Paper Series. Working Paper 11620.
[80] Alkire, B.C., Peters, A.W., Shrime, M.G., Meara, J.G., 2018. The Economic Consequences Of Mortality Amenable To High-Quality Health Care In Low- And Middle-Income Countries. Health Aff. (Millwood) 37, 988–996. https://doi.org/10.1377/hlthaff.2017.1233.
[81] Barber, R.M. et al, 2017. Healthcare Access and Quality Index based on mortality from causes amenable to personal health care in 195 countries and territories, 1990–2015: a novel analysis from the Global Burden of Disease Study 2015. The Lancet 390, 231–266. https://doi.org/10.1016/S0140-6736(17)30818-8.
[82] Kruk, M.E., Gage, A.D., Joseph, N.T., Danaei, G., García-Saisó, S., Salomon, J.A., 2018. Mortality due to low-quality health systems in the universal health coverage era: a systematic analysis of amenable deaths in 137 countries. The Lancet. https://doi.org/10.1016/S0140-6736(18)31668-4.

availability of health inputs. Equation 3 shows that income is a function of health education and other factors. In this model the coefficient on health is the productivity of health, not the rate of return to health. We note that the health inputs (I) are endogenous.

$$H = h(l, g, e1) \quad \textbf{(1)}$$

$$l = d(X, W, g, e2) \quad \textbf{(2)}$$

$$W = w(H, E, Z, e3) \quad \textbf{(3)}$$

Where H = health; I = health inputs; g = exogenous health factors; W = wage (income); X = availability of inputs; Z = covariates on income; E = education; e = error

11. ***Indirect effect of health on income through education***. A longer life-span means a longer horizon over which to recuperate investments in education. Lower mortality implies a higher rate of return to education, increasing incentives to invest in education of each child. Decreases in child mortality are associated with decreased fertility which may be mediated through a quality-quantity tradeoff, whereby families have fewer children and invest more in each. The net present value of earning is given in equation 4. Absent from the model is that students who are healthier may have a higher quality of schooling due to improved cognitive uptake, do better in school, and have higher rates of attendance.

$$V(s) = w_S \int_s^n e^{-rt} dt = w_S \frac{e^{-rs} - e^{-rn}}{r} \quad \textbf{(4)}$$

Where s = length of schooling; n =retirement age; Ws =wages; r = discount rate

12. **This effect of better health on economic growth through human capital accumulation can be illustrated with the example of reducing child mortality**. Reducing Under 5 Mortality Rate (U5MR) by 33 percent is one of the long-term objectives of this IPF and would have important economic benefits. Besides simple welfare effects, substantially reducing U5MR will have important socio-economic benefits for Côte d'Ivoire, including on its human capital formation:

a. **Cognitive Development:** Improved child health has an important influence on the cognitive development. Children who are frequently sick experience significant psycho-motor development delays. Preventing illnesses in young children and treating them effectively when they do get sick is an important part of human capital development.

b. **Nutritional Effects:** Children who are frequently sick are also at high nutritional risk. Frequent illness and malnutrition combine in a vicious cycle. Children who are sick have increased metabolic needs and are also less able to consume and absorb nutrients, while children who are malnourished have compromised immunity which renders them more prone to becoming sick. Breaking this vicious cycle is an important aspect of human capital formation.

c. **Fertility reduction:** There has never been a significant reduction in fertility that wasn't preceded by a steep reduction in U5MR. Families the world over will continue to have high fertility if they fear that many of their

children will die in childhood. Since reducing U5MR is critical to fertility reduction, it also an essential aspect of obtaining a demographic dividend.

d. **Economic Growth:** A paper by Dean Jamison, Larry Summers and others[83] has argued that reductions in mortality account for about 11 percent of recent economic growth in low and middle-income countries based on national income accounts. Using a more encompassing measure of growth based on "full income," they argue that 24 percent of the growth observed between 2000 and 2011 in full income was due to mortality reduction.

Age-structure effects

13. **Changing health and mortality can indirectly affect income through changing the age structure of a population**. Declines in mortality spurs the demographic transition, where declining mortality followed by subsequent declining fertility creates a population "bulge" which then moves across the age groups creating the "demographic dividend" which is a period of time where the dependency ratio (ratio of dependents to working age population) is very low. This influx of working-age people into the population may be a boon for a country's economy and lead to an increase in income. The effect of the age-structure on income may work through both pure accounting and behavioral effects. Accounting and behavioral effects as related to savings are discussed in detail below. Improved health should improve both the dependency ratio by reducing mortality among economically active and by reducing premature retirement resulting from illness. The effect of age structure on income is shown in equation 5 where income per capita is a function of the traditional measure of output per worker, participation rate effects and the age structure effect. It is important to note that demographic effects do not happen automatically but appear to be dependent on the policy, education, and the institutional environment in which they take place.

$$\frac{Y}{N} = \frac{Y}{L}\frac{L}{WA}\frac{WA}{N} \qquad \textbf{(5)}$$

Where Y = Income; N = Population Size; L = Workers; WA = Working age population

14. **Côte d'Ivoire's future economic growth and transformation into an emerging economy will depend largely on its ability to implement the necessary policies to benefit from the demographic dividend.** Côte d'Ivoire's TFR has declined steadily since the 1970s, however, it has stagnated for the past decade at five children per woman. The high fertility rate, coupled with a slow decline in mortality, means that CIV will face an age structure that is heavily skewed toward young dependents. Moreover, as the crude birth rate exceeds the crude death rate, Côte d'Ivoire will also experience rapid population growth. This contrasts with a typical age structure from East Asia, where the working age population is proportionately greater than the share of dependents. CIVs young population structure presents challenges in providing healthcare, education and jobs to the large cohorts surviving childhood and entering their reproductive ages. The high dependency ratio[84] of 83[85], could decline to 48 by 2050, if the country undergoes a rapid fertility decline (UN TRF low variant projections, which assumes TFR

[83] Jamieson DT, Summers LH, et al: Global health 2035: a world converging within a generation. *Lancet*: 2013, 382: 1898-955.
[84] This is defined as: number of dependents aged 0-14 and over 65, per 100 total working age population, 15-64.
[85] WDI 2018.

will decrease to 2.1 by 2050)[86]. Minimizing the dependency ratio or maximizing the ratio of working age population to dependents rapidly will lead to a more rapid and higher demographic dividend.

15. **The proposed project aims to make significant investments in reproductive health and family planning, which could result in a rapid decline in fertility levels, and improvements in maternal and child health.** Lower fertility rates are associated with better maternal and child health outcomes[87]. Fewer births and longer intervals between births expose women to fewer pregnancy risks and chances of maternal death and result in better health outcomes for children. Lower fertility also means that families can invest more in each child, allowing for better health and education outcomes of children. In terms of the demographics and human capital link, healthier children miss fewer days of school, have greater cognitive flexibility and development, and ultimately perform better in school.

16. **The returns on investment of investing in family planning are enormous.** Providing family planning services to women needing it and offering them high quality comprehensive reproductive and maternal health services has important health, social and economic benefits. Positive impact of family planning programs (leading to demographic change) on economic growth and development is their contribution to higher education of children, greater use of preventive health services and an increased employment of women. In francophone West Africa, investing in family planning to meet the unmet needs expressed by women to space or limit births would avert 7,400 maternal deaths and 500,000 child deaths in the next 10 years. Cumulative savings of the costs of maternal and child health care will be US$182 million for the next 10 years and US$1.9 billion by 2040[88].Moreover, a regional analysis indicates that every US$1 invested in family planning saves US$3 in other development sectors that contribute to achieving the MDGs (education, vaccinations, water and sanitation, maternal health, and malaria treatment)[89]. However, evidence from the region also shows that uptake of family planning services is much higher when these services are bundled with other Health, Nutrition and Population services, as is being done in the proposed IPF. This not only allows for greater economies of scale and service delivery, but also empowers mothers and young women to access these services without the stigma and social disapproval of accessing family planning services.

Savings (Investment) Effects

17. **Standard economic theory holds that individuals will borrow at younger ages, save through the middle ages and spend these savings after retirement.** A longer life-span, given a fixed retirement rate and ignoring bequests, means a longer horizon over which to recoup investments and savings and should increase saving behavior. The effect of increasing life expectancy is to create a temporary savings boom where, due to the resulting capital stock accumulation, the county settles at a new, higher equilibrium. Savings differ at different ages, peaking between 40 and 60. Demographic effects can temporarily increase the number of people in the prime saving years in a population. How health changes with increased life expectancy is very important for this

[86] Côte D'Ivoire. World Population aging 1950-2050. Source: http://www.un.org/esa/population/publications/worldageing19502050/pdf/072coted.pdf.
[87] Black, RE, et al. (2017). Disease Control Priorities 2, third edition. Reproductive, Maternal, Newborn, and Child Health.
[88] Achieving the MDGs: The Contribution of Family Planning in francophone West Africa. Health Policy Project, Futures Group International, Washington, D.C., January 2011.
[89] Futures Group Inc. (2011). Family planning: Francophone West Africa on the Move. A call to Action, Source: https://static1.squarespace.com/static/56c8133a27d4bd3fdb27af58/t/56e7a63507eaa026972a8497/1458021945286/Family+Planning+Francophone+West+Africa.pdf.

model. Compression or expansion of morbidity may affect retirement decisions and impact savings rates. This raises questions of participation versus savings; staying in the work force longer reduces incentives to save. Furthermore, increased income should reduce the marginal utility of consumption and favor an increase in leisure thus reducing productivity. At the macro level, the presence of institutions, pensions, social security, health insurance are very important mediators of savings behavior and how it is affected by changes in life expectancy and health status.

Component-Specific Impacts

Component 1: Scaling up of strategic purchasing

By combining activities on the supply-side (extension of PBF) and on the demand-side (scaling-up of health insurance), the IPF is addressing both margins of health care and is therefore well placed to maximize impact in terms of quantity. Both activities have also the potential to improve quality of health care provision.

Sub-component 1.1 Extension of PBF in the context of strategic purchasing[90]

18. **There is considerable evidence from low- and middle-income countries on the potential of strategic purchasing to improve utilization, quality of care and health outcomes.** PBF works through different pathways to improve these outcomes, and a key pathway PBF seeks to address is through provider effort: as provider effort is directly related to quality of care and is responsive to incentives, then it follows that PBF can tackle high absenteeism as well as the know-do gap by increasing provider motivation. A framework by (Miller and Babiarz, 2013) focuses on what to reward, who to reward, how to reward and perverse incentives in the design of these programs. This framework can for example explain that the PBF scheme in Rwanda had the largest impact on services with the highest payment rates, and requiring the lowest provider effort: for example, while prenatal care quality or administering a tetanus toxoid vaccine, both services with high payment rates, are fully under the provider's control, the number of prenatal visits require higher effort by the facility to conduct outreach. Deliveries had the highest unit payment rate, which implied that providers exerted the highest amount of effort in getting mothers to deliver in facilities (Basinga et al., 2010). Given these results, the study suggests that it would make sense to provide higher incentives for higher effort services, to introduce more clinical content indicators as they are closely related to outcomes. Another study from Rwanda shows that PBF improved the quality of care of services that had the highest marginal productivity of effort and largest price increases, such as prenatal care quality; in contrast, PBF did not increase activities which required significant provider outreach, such as the number of women who completed four antenatal care visits. The study shows that quality increased not due to improvements in provider knowledge, but rather due to incentives (Gertler and Vermeersch, 2012). Although it is commonly posited that PBF can increase structural quality, a study looking at the Rwandan experience from 2006-2007 finds that these improvements may not last, and in fact may create perverse incentives, as can be seen with a decline in delivery statistics monitoring, which is a crucial input for increasing the quality of deliveries, although it has increased the presence of maternity staff and facility management (Ngo et al., 2017).

19. **PBF has the potential to increase quality as a function of the services it is incentivizing.** In Cameroon, PBF increased structural quality, presence of qualified staff, and provider and patient satisfaction, but not the completeness of service provision for antenatal and child health consultations (De Walque et al., 2017). Specifically, patient satisfaction with both antenatal and sick child care visits increased by over 10 percentage

[90] Combines Sub-components 1.1 and 1.3.

points, and the increases for both were only attributable to financing, as opposed to additional supervision. In Burundi, the overall quality score for health facilities increased by 17 percentage points during the study point, but PBF had no impact on patient-reported quality (I. Bonfrer et al., 2014) as it was not directly incentivized: the quality indicator was equal to the sum of the performance of quantity indicators which could be topped up with a bonus ranging from 0 to 25 percent, and facilities could use 50 percent of the bonus for staff remuneration, with the other 50 percent invested in service quality improvements (Bonfrer et al., 2014). In other contexts, the quality incentive, instead of being a top-up to the quantity payments, can be deducted from the quantity bonuses: for example, in the Rwanda program, the facility's total payments were discounted by the score in the quality metric, such that if the facility received 75 percent in the quality index, it received 75 percent of the PBF payments. Facilities in Rwanda are given full discretion on how they use their PBF payments, and they increased their payments, on average, by 22 percent, and allocated 77 percent of this increase directly on increasing personnel compensation, which led to an almost 40 percent increase in staff salaries (Sherry et al., 2017). Overall, a common pattern is that the largest provider effort will be exerted on services where the "marginal productivity of effort" is the highest, and where the relative benefit increases are also the largest (Gertler and Vermeersch, 2012). Similarly, directly incentivized measures of quality of care for antenatal care and other maternal and child health interventions went up, especially for the better off. PBF has increased provider knowledge in Indonesia, Burundi and Democratic Republic of the Congo (Soeters et al., 2011). A key question with PBF is which indicators are more likely to improve, and here, a helpful typology is to think about what is incentivized and not, as well as what is within and outside the control of providers to improve. PBF will likely increase the input of services that earn a higher bonus payment relative to their production costs, and are jointly produced with other highly rewarded services (Sherry et al., 2017). PBF is also more likely to increase services and outcomes which are easily controlled by the providers, but when those services and outcomes are mainly influenced by the behaviors of the community or the patients PBF incentives might be less effective and demand-side interventions and incentives, such as health insurance, might be preferred.

Sub-component 1.2 Scale-up of National Health Insurance (CMU)

20. **In many SSA countries, there is an increasing intention to introduce contributory health insurance schemes with the intention of decreasing out of pocket payments at the point of care, and this is generally used as a primary policy instrument to reach UHC.** Usually, these schemes start by covering the formal, salaried population, and this is followed by establishing a separate pool for the informal sector. This often leads to the poorer groups being forced to seek care at facilities with lower quality of care. Risk equalization between different pools, and consolidating towards larger and more diversified pools is a way to mitigate this challenge (Kutzin, 2009). However, health insurance has the potential to increase demand for health services and therefore its utilization and decrease out of pocket expenditures and could have a positive impact on health status as well.[91]

21. **Health insurers have a set of tools they can use to incentivize quality of care, such as investment and contracting, although most of the channels through which insurance can drive quality, such as contracting and accreditation, provider payment mechanisms and benefit packages, fall under the purchasing function.** The way insurance is launched and structured has a direct bearing on service delivery, and the context through which it emerges can impact quality of care. For example, Mexico's scale up of its health insurance program, Seguro Popular, was coupled with a National Crusade for Quality in Health Care, which was a cohesive strategy to improve quality through leveraging performance gaps and politics. In addition, given its focus on the demand-side,

[91] http://siteresources.worldbank.org/HEALTHNUTRITIONANDPOPULATION/Images/IMPACTofUHCSchemesinDevelopingCountries-AReviewofExistingEvidence.pdf.

insurance can activate patient and public demand for quality care, and the success of an insurance program hinges upon its ability to meet patient expectations. Pooling also influences how care is delivered on the supply-side, and insurers can use accreditation to ensure a minimum standard of quality is offered across the board; they can incentivize the use of clinical guidelines that increase quality and cost-effectiveness, together with data that would ensure compliance with these pathways and guidelines (Mate et al., 2013).

Component 2: Health system strengthening the to improve performance.

22. **The pricing of the health system infrastructure, information and management systems is challenging: they all constitute factors of production which are difficult to isolate in the production function and/or measure in use.** Benefits from rehabilitated facilities include lower infection rates, better use of medical equipment, facilities that are more attractive for patients and therefore increase demand and improve health-worker morale and satisfaction leading to better productivity. Those benefits are important but challenging to isolate and measure. Particularly the long-term benefits to population health are difficult, if not impossible, to quantify and to assign causally. However, the potential impact of improving access to and rehabilitating health facilities can be gleaned from various HMIS indicators. Over 30 percent of the Ivorian population lives outside a 5-kilometer radius to a health facility without a proper ambulance or referral network, and the project will seek to improve these rates. Over 29,000 deaths every year are attributable to low quality care in Côte d'Ivoire, and better infrastructure has the potential to reduce this and unlock both economic and human capital benefits.[92] Another systematic review aggregates evidence from low-and middle-income countries, finding that building health worker capacity, strengthening health systems at the community level and strengthening health information systems are all associated with increased utilization and reduced mortality and morbidity.[93]

23. **Benefits from a strengthened HMIS include reduced administrative burden; increased efficiency gains from improved base information available to all stakeholders for planning, delivery, and financing; operational efficiency increases from increased speed and efficiency of a less paper-dependent systems; increased quality through reduction of errors and integrated patient management across facilities and the sector; availability of increasingly reliable population statistics.** However, other potential benefits such as reduced error rates, unnecessary treatment, use of information, facilitating reform towards more advanced provider payment systems to name a few are difficult to quantify. These measurement and methodological problems mean that quantitative cost-benefit and cost-effectiveness analysis, which requires specifying alternative approaches to achieving comparable results, are usually not practical instruments for economic analysis of information and management systems strengthening in the health sector. Despite these difficulties, a review of existing evidence from 2017 points to health information technology as an important tool for improving quality of care and patient safety.[94] Another recent study points out to mortality reductions of up to 0.21 percentage points for electronic health record systems after they have had the chance to mature, with potential for future increases as well.[95]

[92] Kruk, M.E., Gage, A.D., Joseph, N.T., Danaei, G., García-Saisó, S., Salomon, J.A., 2018. Mortality due to low quality health systems in the universal health coverage era: a systematic analysis of amenable deaths in 137 countries. The Lancet. https://doi.org/10.1016/S0140-6736(18)31668-4.

[93] Hatt, Laurel, Ben Johns, Catherine Connor, Megan Meline, Matt Kukla, and Kaelan Moat, June 2015. Impact of Health Systems Strengthening on Health. Bethesda, MD: Health Finance & Governance Project Abt Associates.

[94] Alotaibi, Y., Federico, F., 2017. The impact of health information technology on patient safety. Saudi Medical Journal 38, 1173–1180. https://doi.org/10.15537/smj.2017.12.20631.

[95] Lin, S.C., Jha, A.K., Adler-Milstein, J., 2018. Electronic Health Records Associated With Lower Hospital Mortality After Systems Have Time To Mature. Health Affairs 37, 1128–1135. https://doi.org/10.1377/hlthaff.2017.1658.

24. **The project also seeks to strengthen human resources for health, through evidence-based interventions proposed to improve health care worker performance.** A qualitative review of evidence points to lack of training, low salaries, poor management and low facility budgets as factors leading to low provision of deliveries and postnatal care; this project proposes interventions to address each of these factors.[96] A recent systematic review[97] pointed to training combined with supervision, group problem solving and community support plus provider training as the most effective interventions, all of which are also included in this project through quality improvement collaboratives, as well as supervision and coaching included through strategic purchasing.

25. Improvements in governance, similarly, are difficult to quantify, although a study looking at health outcomes and governance in SSA countries using panel data finds that public health spending can improve health outcomes faster in the presence of strong governance, indicating the mediating impact of good governance.[98]

Overall IPF Impact

26. **To estimate the overall impact of the IPF over its six-year period, the projected impact of scaling up strategic purchasing was calculated by using the Lives Saved Tool (LiST), which measures the impact of scaling up specific interventions on maternal and infant mortality rates, given effect sizes based on the literature[99].** The expansion of strategic purchasing will lead to an increase in coverage of key curative interventions that lead to reductions in maternal and infant mortality.[100] The LiST projection included in this economic analysis presents the impact of scale-up of coverage of these interventions nationally from 2019 through 2028, as part of the scale-up of strategic purchasing starting 2019.

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[96] Munabi-Babigumira, Susan, Claire Glenton, Simon Lewin, Atle Fretheim, and Harriet Nabudere. "Factors That Influence the Provision of Intrapartum and Postnatal Care by Skilled Birth Attendants in Low- and Middle-Income Countries: A Qualitative Evidence Synthesis." Edited by Cochrane Effective Practice and Organisation of Care Group. *Cochrane Database of Systematic Reviews*, November 17, 2017. https://doi.org/10.1002/14651858.CD011558.pub2.

[97] Rowe, Alexander K, Samantha Y Rowe, David H Peters, Kathleen A Holloway, John Chalker, and Dennis Ross-Degnan. "Effectiveness of Strategies to Improve Health-Care Provider Practices in Low-Income and Middle-Income Countries: A Systematic Review." *The Lancet Global Health* 6, no. 11 (November 2018): e1163–75. https://doi.org/10.1016/S2214-109X(18)30398-X.

[98] Makuta, I., O'Hare, B., 2015. Quality of governance, public spending on health and health status in Sub Saharan Africa: a panel data regression analysis. BMC Public Health 15. https://doi.org/10.1186/s12889-015-2287-z

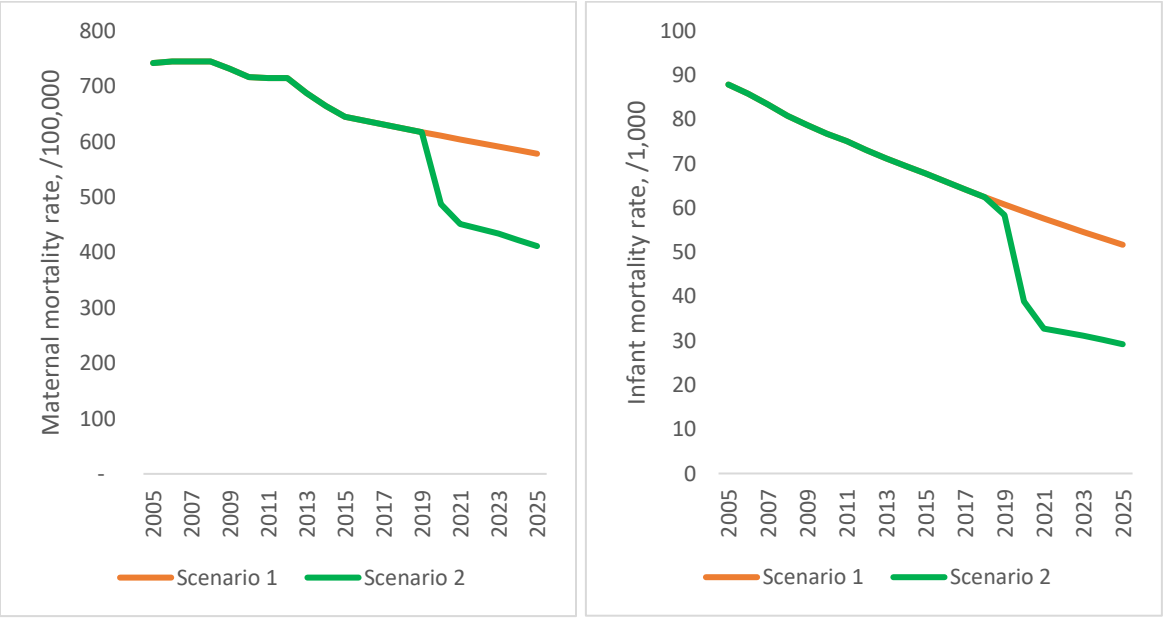
[99] More on the methods used with the LiST tool can be found at http://livessavedtool.org/121-training/for-new-list-users/documents/218-list-manual

[100] We followed the methodology in Chou VB, Bubb-Humfryes O, Sanders R, *et al* Pushing the envelope through the Global Financing Facility: potential impact of mobilizing additional support to scale-up life-saving interventions for women, children and adolescents in 50 high-burden countries. BMJ Global Health 2018;3:e001126.
The interventions included are: TT - Tetanus toxoid vaccination, *IPTp - Intermittent preventive treatment of malaria during pregnancy, Syphilis detection and treatment*, Micronutrient supplementation (iron and multiple micronutrients), Multiple micronutrient supplementation in pregnancy, *Hypertensive disorder case management, Diabetes case management, Malaria case management, MgSO4 management of pre-eclampsia*, Skilled birth attendance, Health facility delivery, Clean birth practices, Immediate assessment and stimulation, Labor and delivery management, Neonatal resuscitation, Antibiotics for pPRoM, MgSO4 management of eclampsia, AMTSL - Active management of the third stage of labor, Induction of labor for pregnancies lasting 41+ weeks, Clean postnatal practices, Vitamin A supplementation, Zinc supplementation, Case management of premature babies, Thermal care, *Case management of neonatal sepsis/pneumonia, Injectable antibiotics for neonatal sepsis/pneumonia*, *ORS - oral rehydration solution*, *Antibiotics for treatment of dysentery, Zinc for treatment of diarrhea, Oral antibiotics for pneumonia*, Vitamin A for treatment of measles, *ACTs- Artemisinin compounds for treatment of malaria*, SAM - treatment for severe acute malnutrition, MAM - treatment for moderate acute malnutrition, DPT; Three doses, H. influenzae type b; Three doses, HepB; Three doses, Pneumococcal; Three doses, Rotavirus; Two doses, Measles; Single dose. The interventions that are not italicized are those that are directly incentivized by strategic purchasing (i.e. facilities receive a payout directly for these services), and those that are in italics are indirectly incentivized through strategic purchasing payments for outpatient visits (different rates for pediatric or non-pediatric outpatient visits).

27. **Through the impact of scale-up of the coverage of key interventions covered under strategic purchasing, it is estimated that this IPF would lead to significant reductions in maternal, under 5 and infant mortality.** For each of these indicators, two different scenarios were estimated: first, assuming a constant decline rate for PBF based on the average mortality rate declines recorded in the last decade; and second, based on the LiST model incorporating the effectiveness of interventions that are being scaled up through the IPF. It should be noted that these projections do not include the impact of other components of the IPF, but it can be hypothesized that investments in strengthening the health system through improved availability of inputs (infrastructure, human resources for health, health information systems) would improve quality of care and therefore increase the effective coverage of the interventions that are included in these projections.

28. **Through strategic purchasing, the IPF is expected to reduce maternal and infant mortality with accelerating decline rates due to improvements in coverage rates through the course of the project.** It is estimated that the IPF would result in a reduction in maternal mortality from 645/100,000 in 2015 to 411/100,000 in 2025, as opposed to 578/100,000 in the absence of the project. This is an average decline of 7 percent each year through the project (as opposed to an annual decline of 1 percent without the project). Infant mortality is expected to decline from 64/1,000 in 2017 to 29/1,000 in 2025, as opposed to 52/1,000 without the IPF, with an expected decline of over 10 percent with the program (as opposed to a decline of 2 percent without the project). Because of the IPF, it is estimated that the lives of an additional 2,230 women and 50,730 children (16,620 of whom are neonates) will be saved by 2025 (Figures 2.3 & 2.4).

Figures 2.3 & 2.4: Declines in Maternal Mortality Rate (left) and Infant Mortality Rate (right) in Côte d'Ivoire, 2005-2025, without (scenario 1) and with (scenario 2) Spark-Health



ANNEX 3: Methodological Details – Sub-component 1.1

COUNTRY: Côte d'Ivoire
Strategic Purchasing and Alignment of Resources & Knowledge in Health Project (SPARK-Health)

1. **Use of PBF/CMU funds by health facilities.** The resources resulting from the execution of performance contracts will be earmarked to cover (i) health structure operating and investment costs (e.g. maintenance and repairs, medicines and consumables), and advanced strategic activities (traveling expenses and performance-related bonus for community-based workers to stimulate demand); and (ii) financial and non-financial bonuses for health workers in accordance with defined criteria.

2. **The CTN-FBR will steer the process** and will monitor the different phases of public expenditure execution (commitment, payment order and payment); actors involved in the administrative and accounts phases of the expenditure execution procedure are the MSHP DAF, the MSHP financial controller and the District Financial Manager.

3. **PBF indicators and CMU insurance package have been harmonized and will be progressively integrated as health insurance scales up.** PBF will progressively become a vehicle for quality assurance as well as to cover a complementary package of activities, through national mechanisms, permitting both the MSHP to finance activities not covered in the CMU package and for vertical programs to finance specific indicators (e.g. NCDs, HIV etc.). This mechanism also allows integration of quality related to quantity indicators – e.g. CNAM reimburses Antenatal Visits regardless of timing; the PBF mechanism will pay for ANC 1-4 done at appropriate times during pregnancy as a quality bonus, channeled through the CNAM. MSHP will continue to pay the quality bonuses corresponding to the health facilities quality evaluations done through district and regional health departments.

2. **CMU Contracting and Payment.** The CNAM will take advantage of the dispensatory measure granted by the Ministry of Economy for the implementation of PBF by signing medical care contracts with the health centers and paying the amount of the service reimbursements into the existing bank accounts. As started in the extension phase for the three health districts, the project will continue to provide TA with provider payment methods (including capitation, homogeneous patient groups, and other methods) in addition to fee for service.

- ***Piloting Contracting (central, private and tertiary)***

3. In addition to signing contracts with all primary and secondary health facilities, the ACV[101] will contract:

- Deconcentrated regulatory bodies (regional and district health directorates) and at the central MSHP.
- Secondary contract with health establishments that do not offer the entire Minimum Package of Activities.[102]
- A tertiary level performance-based contracting pilot with the CHU.

[101] The Ministry of Health together with the Ministry of the Economy and Finance and the technical and financial partners will recruit ACV to handle the performance-based contracting.
[102] Not contracting the anti-tuberculosis centers (CAT) and diagnosis and treatment centers (CDT) in the pilot phase resulted in a tuberculosis care shortfall for PBF. Given the typology of the health establishments in Côte d'Ivoire and the problems encountered in the pilot phase, there will be two types of contracting extension for the public health establishments – main contracts and secondary contracts.

- A private health sector performance-based contracting pilot in three pilot districts (Cocody-Bingerville, Yamoussoukro and Vavoua) in 2019 and expanding to 19 districts in 2021. This pilot will test accreditation, licensing, supervision and performance as well as integration of private sector data. Approaches to develop the basic contracting document with the private sector and to develop the tools and the basic evaluations will be developed in the 3 initial districts.

➢ ***Verification***

4. The project will continue to finance the ACV for the first five years of the project, while piloting several sustainable verification solutions, including a pilot that utilizes Blockchain methodology for telephone-based validation of services received. In the pilot CMU districts, an approach will be developed to integrate the different verification bodies. In addition, with respect to central level contracting, the General Inspectorate of Health will be scaled up to check, monitor and evaluate the performance of the structures concerned. For the PBF pilot phase, quantity indicators have been defined in the National PBF Strategic Plan (SNPBF) based on the national health priorities in keeping with the IPF for first-contact health establishments and the Complementary Package of Activities (CPA) for hospitals. The General Inspectorate of Health/General Inspectorate of Finance will organize six-monthly missions to check the findings of the different quality evaluations and quantitative data checks as well as the evaluations of the strategic purchasing implementation mechanism. These cross-checks will take representative samples at the different levels. The structures' performance outcomes will serve to steer the contractual approach (including continuation/renewal of ACV contracts).

➢ ***Quality evaluation***

5. Quality evaluations will be conducted by the regulatory structures[103] and overseen and validated by the ACV. The findings of the quality evaluations factor into performance payments. Evaluation of regulatory structure performances will be conducted by the ACVs and their immediate hierarchy. An accreditation system will be put in place to improve the validity of these evaluations with a view to improving the quality of the healthcare and health services. At the national level, qualified bodies will be selected for their expertise, professionalism and impartiality to guarantee credible, uniform oversight. The quality evaluations will be conducted based on a nationally validated tool.[104]

➢ ***Community-based counter-verification***

6. The CBO will conduct community-based counter-verifications, overseen and validated by the ACV. The community surveys will produce bi-annual reports. The findings of these community surveys factor into performance payments.

[103] These include: district health directorates for first-contact health facilities and regional health directorates for GHs/regional hospitals)
[104] Current tool covers 15 components, seven of which relate to mother and child health: Vaccination; Maternity; Family Planning; Antenatal Visits; Malaria Treatment; Treatment of Acute Respiratory Infections and Diarrhea; and AIDS Control.

ANNEX 4 : Procurement Arrangements

COUNTRY: Côte d'Ivoire
Strategic Purchasing and Alignment of Resources & Knowledge in Health Project (SPARK-Health)

Applicable Procurement Procedures

1. **Generality:** Following the 2004 Country Procurement Assessment Report (CPAR), and the feedback received on the Procurement Code (Decree N°2005-110 dated February 24, 2005), a new Procurement Code (Decree N°2009-259 dated August 6, 2009), in line with the WAEMU procurement Directives and international good practices, and key implementing regulations and documentation was adopted. This Procurement Code was amended and modified in July 2015 through the Decree N°2015-525 dated July 15, 2015 also with implementing regulations thereunder. A national procurement capacity building program exists and is being implemented at the central and deconcentrated entities level. A new code is under preparation and will hopefully be reviewed adopted during the first semester of 2019. An electronic system for collecting and disseminating procurement information and for monitoring procurement statistics has been set up and it's been recommended that its use be applicable to all the contracting authorities. An audit of single source awarded contracts from 2011 to 2013 has been done in May 2014 and findings were published. However, persisting issues remain that affect transparency and efficiency of the national procurement system: (i) establishment and operation of procurement units in the ministries are still new, (ii) training of enforcement officers on these new texts is not yet effective. In addition, the volatile socio-political situation due to the armed conflicts does not guarantee an effective functioning of the system and has considerably increased fraud and corrupt practices. The new government is trying to fight this scourge by implementing certain mechanisms such as the code of ethics at the central level, but the results are not yet visible due to lack of evaluation.

2. **Guidelines:** Procurement for the proposed project will be carried out in accordance with the World Bank's *"Procurement Regulations for Borrowers"* in force since July 2016, revised in November 2017 and in August 2018.

3. **Procurement Documents:** Procurement would be carried out using the World Bank's Standard Bidding Documents (SBD) for all International Competitive Bidding (ICB) for goods and works and for Standard Request for Proposal (RFP) for the selection of consultants through competitive procedures. The Recipient will develop standard documents based on the World Bank's SBDs for National Competitive Bidding (NCB) for goods and works and the World Bank's RFP for the selection of consultants through methods other than Quality and Cost Based Selection (QCBS), with modifications that will be submitted to the IDA for prior approval in compliance with the New Procurement Framework.

4. The different procurement methods or consultant selection methods, the need for pre-qualification, estimated costs, prior review requirements, and time frame are agreed between the Recipient and the World Bank in the Procurement Plan through the PPSD when need be. The Procurement Plan will be updated at least annually or as required to reflect the actual project implementation needs and improvements in institutional capacity.

Advertising procedure

5. General Procurement Notice, Specific Procurement Notices, Requests for Expression of Interest and results of the evaluation and contracts award should be published in accordance with advertising provisions in the guidelines mentioned above.

6. For ICB and request for proposals that involve international consultants, the contract awards shall be published in the United Nations Development Business (UNDB) online within two weeks of receiving IDA's "no objection" to the recommendation of contract award. For Goods, the information to publish shall specify: (a) name of each bidder who submitted a bid; (b) bid prices as read out at bid opening; (c) name and evaluated prices of each bid that was evaluated; (d) name of bidders whose bids were rejected and the reasons for their rejection; and (e) name of the winning bidder, and the price it offered, as well as the duration and summary scope of the contract awarded. For Consultants, the following information must be published: (a) names of all consultants who submitted proposals; (b) technical points assigned to each consultant; (c) evaluated prices of each consultant; (d) final point ranking of the consultants; and (e) name of the winning consultant and the price, duration, and summary scope of the contract. The same information will be sent to all consultants who submitted proposals. The other contracts should be published in national gazette periodically (at least, quarterly) and in the format of a summarized table covering the previous period with the following information: (a) name of the consultant to whom the contract was awarded; (b) the price; (c) duration; and (d) scope of the contract.

Procurement methods

7. The procurement methods should be developed and defined through the PPSD and the Procurement plan. However, indications are given below to assist the Borrower in the implementation phase.

8. **Procurement of Works.** The national market offers a diversity of entrepreneurs of different sizes for most activities in this category. However, they do not have enough financial base Thus, for rehabilitation work, we recommend a national preference with allotment.

9. **Procurement of Goods.** The Goods to be financed by IDA would include: office and furniture, and equipment, office supplies, etc. Similar Goods that could be provided by a same vendor would be grouped in bid packages estimated to cost at least US$4,000,000 per contract and would be procured through ICB. Contracts estimated to cost less than US$1,000,000 equivalent may be procured through NCB. Goods estimated to cost less than US$ 100,000 equivalent per contract may be procured through shopping procedures. For shopping, the project procurement officer will keep a register of suppliers updated at least every six months. They represent 20.99 percent of the portfolio of purchases in value and 50 percent in number of markets. They mainly concern standard goods and equipment, like those purchased for the implementation of the PRSEE, and available in the local business environment. However, the market for the acquisition of incinerators must be the subject of open international consultation.

10. **Selection of Consultants.** The project will finance Consultant Services such as surveys, technical and financial audits, TA, and activities under the institutional strengthening component. Specific consultant services, trainers and workshops facilitators should be included. Consultant firms will be selected through the following methods: (a) QCBS; (b) selection based on the Consultant's Qualification (CQS) for contracts which amounts are

less than US$2000,000 equivalent and are relative to exceptional studies and researches which require a rare and strong expertise; (c) Least Cost Selection (LCS) for standard tasks such as insurances and, financial and technical audits costing less than US$2000,000; (d) Single Source Selection costing less than US$100,000 with prior agreement of IDA, for services in accordance with the paragraphs 3.8 to 3.11 of Consultant Guidelines. Individual Consultant (IC) will be hired in accordance with paragraph 5.1 to 5.6 of World Bank Guidelines; Sole source costing less than US$100,000 may be used only with prior approval of the World Bank. Whatever the cost, any ToR needed to consultant selection must get prior approval of the World Bank.

11. The recruitment of consultants will be mainly open. Indeed, the recent nature of strategic purchase and UHC in Côte d'Ivoire justifies the scarcity of local expertise. However, the experience of the PRSSE has allowed the transfer of certain skills to the national market. Thus, some consultation such as the recruitment of OBCs may make a preference for the national market. Some contracts may be granted to UN Agencies due to their comparative advantages in service delivery and TA regarding specific activities. This practice has yielded satisfactory results under the PRSSE.

12. Short lists of consultants for services estimated to cost less than US$300,000 equivalent per contract may be composed entirely of national consultants in accordance with the provisions of paragraph 2.7 of the Consultant Guidelines, if enough qualified individuals or firms are available. However, if foreign firms express interest, they would not be excluded from consideration.

13. **Procurement from United Nations Agencies:** There may be situations in which procurement directly from UN agencies may be the most appropriate method of procurement. In such circumstances, the project would make specific arrangements with the UN Agencies concerned through a single source selection and then they follow their own procurement procedures to purchase and deliver the goods and services needed.

14. **Procurement of consulting services other than consulting services covered by** *Procurement Regulations for Borrowers*: Eventually, those might include designing, editing and printing project promotion supports; providing logistic support such as car rental for field visits, travel services and logistic support for workshop and the like, LCS or shopping will be used.

15. **Training, Workshops and Conferences.** The training (including training material and support), workshops and conference attendance, will be carried out based on approved quarterly training and workshop/conference plan. A detailed plan giving the nature of training/workshop, number of trainees/participants, duration, staff months, timing and estimated cost will be submitted to IDA for information prior to initiating the process. The appropriate methods of selection will be derived from the detailed schedule. After the training, the beneficiaries will be requested to submit a brief report indicating which skills have been acquired and how these skills will contribute to enhance his/her performance and contribute to the attainment of the project objective.

16. **Operational Costs**. Operating costs financed by the project are incremental expenses, including office supplies, vehicles operation and maintenance, maintenance of equipment, communication costs, supervision costs (i.e. transport, accommodation and per diem), and salaries of locally contracted staff. They will be procured using the procurement procedures specified in the Project Financial and Accounting Manual.

Assessment of the capacity of the agency to implement procurement

17. The lead responsibility for project implementation will be vested with PCU of the past PRSSE**.** The capacity assessment has shown that it was a World Bank-financed project, with experience, skills, knowledge and personnel, and a procedure manual acceptable to the World Bank to act as they do with the past project.

18. A decision has been taken to entrust the new project implementation to the PCU of the PRSSE with the responsibility of the project fiduciary management (procurement and FM).

Procurement Capacity Assessment of the PCU

19. The PCU of the PRSSE has been entrusted with the fiduciary management (procurement and Financial management) of the SPARK.

20. The past PRSSE is still implementing health project without any major procurement issues. The disbursement rate is acceptable and online with the PAD.

21. Therefore, it is proposed that the new project be implemented by the PCU of the past PRSSE as a standard Project implementation Unit, as per the provisions of the procurement guidelines in force.

Turnaround times

22. The information available to us indicate that some of the contracts have not been executed within the deadline. These delays are due to: (a) the complexity of the project; (b) the low capacity of contractors, and (c) the poor quality of ToR and technical specifications.

Mitigation measure:

23. To mitigate above listed turnaround times, the following provisions shall be taken:
- Set realistic timeframes;
- Ensure selected public contractors have the required implementation capacity;
- Recruit consultants for the elaboration of ToR and technical specifications where need be;

Procurement team

24. The PCU does have two procurement specialists and a procurement assistant. One of them is a recruit but has previous experience on World Bank projects. The PCU as the other PIUs in Côte d'Ivoire has received training on the New Procurement Framework especially on the PPSD.

Mitigation measure:

- Even if they have received prior training on the NPF, the PCU members are invited to act urgently to revisit and reinforce their knowledge on the Procurement Regulation for Borrowers.

25. The PCU will be responsible for the coordination of all procurement activities, including the following: (a) preparation and update of the procurement plans; (b) preparation, finalization and launch of the requests for proposals and bidding documents; (c) drafting of minutes of bids opening /proposal and preparation of the evaluation reports; (d) submission of procurement documents (ToRs, RFP, bidding documents, evaluation reports, contracts, etc.) to the Wordl Bank when prior review is required; (e) preparation of the contracts, and overseeing the payments to contractors; and (f) drafting of procurement progress report and coordination of the *activities.* Each beneficiary entity will be involved in the implementation as the procurement manual will describe.

- With regard to the new provisions of the Decree n°2015-475, and the new World Bank procurement guidelines, the project manual of procedures should be developed and submitted for the World Bank's no objection.
- To minimize the delay associated with the drafting of the appraisal reports, competent Firms/Individual Consultants should be hired to evaluate the proposals where necessary.

Frequency of procurement reviews and supervision

26. World Bank's prior and post reviews will be carried out based on thresholds indicated in the following table. The IDA will conduct six-monthly supervision missions and annual Post Procurement Reviews (PPR); with the ratio of post review at least one to five contracts. The IDA may also conduct an Independent Procurement Review at any time until two years after the closing date of the project.

Country Overall Procurement Risk Assessment:

High	
Average	**X**
Low	

Table 4.1: Procurement and Selection Review Thresholds

Expenditure Category	**Contract Value (Threshold)**	**Procurement Method**	**Contract Subject to Prior Review**
	US$		**US$**
1. Works			
	≥10 000,000	ICB	≥15 000,000
	<10,000,000	NCB	
	<200,000	Shopping	
	No threshold	Direct contracting	
2. Goods	≥1 000,000	ICB	≥4, 000,000
	<1 000,000	NCB	
	<100,000	Shopping	
	No threshold	Direct contracting	
3. Consultants Firms	≥300,000	QCBS; QBS; LCS; FBS, CQ	≥2, 000,000
	<300,000	QCBS; QBS; LCS; FBS, CQ	

Individuals	≥100,000	EOI	<400,000 and Project manager, PS and FS
	<100,000	comparison of 3 CVs	
(Selection Firms & Individuals	<100,000	Single Source	≥2,000,000 for consultant firms <400,000 for individuals
Terms of reference may be subjected to prior review in accordance with TTLs			

ANNEX 5: Detailed FM and Disbursement Arrangements

COUNTRY: Côte d'Ivoire
Strategic Purchasing and Alignment of Resources & Knowledge in Health Project (SPARK-Health)

1. An FM assessment of the PCU of PRSSE, identified to manage the SPARK, was carried out in December 2018. The objective of the assessment was to determine whether the PCU has acceptable FM arrangements in place to ensure that the project funds will be used only for intended purposes, with due attention to considerations of economy and efficiency. The assessment complied with the FM Manual for World Bank IPF operations, effective December 11, 2014.

2. Arrangements are deemed acceptable if the PCU is capable of accurately recording all transactions and balances, supporting the preparation of regular and reliable financial statements, safeguarding the project's assets, and are subject to auditing arrangements acceptable to the World Bank. These arrangements should be in place when the new project implementation starts and be maintained as such during project implementation. The assessment concluded that the FM of the PCU satisfies the World Bank's minimum requirements under World Bank Directive and Policy - IPF and therefore is adequate to provide, with reasonable assurance, accurate and timely FM information on the status of the project required by the World Bank.

3. The overall FM risk rating is assessed as Substantial and mitigation measures proposed (see Table 5.1) will strengthen the internal control environment and maintain the continuous timely and reliability of information produced by the PCU and an adequate segregation of duties.

Table 5.1 FM Action Plan

Topic	Remedial Action Recommended	Responsible Entity	Completion date	FM Condition
Staffing	Recruit one additional accountant and one assistant accountant assigned 100 percent to the SPARK	PCU/PRSSE	Two months after project effectiveness	NO
	Appoint the financial controller and one project public accountant in accordance with Decree 475 for the PIU	PCU/PRSSE	**By project effectiveness**	**YES**
	Appoint / assign additional staff (one accountant/assistant accountant) assigned 100 percent to certain implementing entities (IE)	PCU/PRSSE and IE	Two months after the project effectiveness	NO
Budgeting	Create a budget line in the DAF of Ministry of Public Health to allow the use of SIGFIP and ASTER for budget execution and payment of expenditures/invoices	Ministry of Finances and Ministry in charge of Budget	Before first disbursement to the PCU and IE	NO
	Create line items "imputation budgétaire" in the MPH budget for the allocation of budget to the CTN-FBR	MPH (DAF) / MEF and MB		NO
	Prepare and submit a detailed and consolidated AWPB reflecting the budgets of all donors-financed projects and programs	MPH/ DGS	Before second disbursement to DGS	NO

Topic	Remedial Action Recommended	Responsible Entity	Completion date	FM Condition
	managed by DGS			
Information system accounting software	Update the configuration of the existing accounting software for the SPARK and train all inexperienced users.	PCU/PRSSE	Two months after	NO
	Follow up the improvement of the configuration of the PFM accounting software (SIGFIP and ASTER) to ensure that both can be used in the project by closing date.	World Bank and MEF	By project closing date	NO
Accounting and financial manual	Revise / update the existing FM and administrative procedure manual.	PCU/PRSSE	**Before project effectiveness**	**YES**
	Prepare a specific section as an "Annex" to the main FM procedure manual, on the FM arrangements and requirements for Implementing Entities (e.g. DGS, CTN-FBR, IPS/CNAM, COGES, Health centers etc…)	PCU/PRSSE and IE	**Before project effectiveness**	**YES**
Internal auditing	Discuss and agree with IGF, the government institution in charge of the internal audit function for World Bank-financed operations, the modalities of its interventions, including allocation of additional resources to fulfill its mandate mainly the audit of PBF activities	PCU/PRSSE & MEF/IGF	Three months after project effectiveness	NO
Funds flows/Disbursement	Open treasury accounts "*Compte de dépôts ouvert au Tresor »* for each Health Centers and participating Directorate of the MPH	MEF/DAF of MPH & PCU/PRSSE	Before transfer of funds from the PCE/PRSSE to the IE/Health Centers and directorates	NO
External auditing	Appoint the external auditor and sign the contract.	PCU/PRSSE	Five months after	NO
Other measures	Appoint a firm to train / build the fiduciary capacity of the Implementing Entities on the World Bank fiduciary procedures and requirements.	PCU/PRSSE and MPH	Before transfer of funds to IE and Health Centers	NO
	Identify some government institutions/entities and or recruit local NGO to conduct verifications and audits of PBF activities including payments of subsides and utilization of funds received by beneficiaries.	PCU/PRSSE and MPH	Before the second transfer of funds to IE and Health Centers	NO
	Design a mechanism for sharing the operating costs of the PCU/PRSSE among the different projects managed by the PCU/PRSSE; this will allow to reflect the contribution of each project to the overall operating cost of the PCE/PRSSE	PCU/PRSSE and MPH	Two months after the project effectiveness	NO

4. **Internal control system and Internal audit arrangements**. An FM Manual is available to provide guidelines to control the implementation of agreed activities and an internal audit function to carry out ex post reviews and to evaluate the performance of the overall internal control system. This manual will be updated to reflect the new project arrangements and requirements. In addition, in line with the Decree No. 475 governing the modalities of donors-financed project implementation in Côte d'Ivoire, the Internal audit (IGF) will oversee the internal audit function of the project. Due to the high risk facing the implementation of the PBF activities, sufficient resources will be allocated to the IGF and the capacity of the CTN-PBF will be strengthened to allow the two institutions to fulfill adequately their legal mandate. To address the weaknesses identified during the implementation of PRSSE, the composition, mandate, and frequency of the SC meetings will be strengthened to ensure adequate oversight of the project. Similarly, the role of the COGES will be clarified in the project implementation manual (PIM) and adequate resources allocated to allow them to play their role. The IGF mission reports should be communicated systematically to the World Bank and the President of the SC as required by the Inter-ministerial order (arrêté no 106) of February 2018.

5. **Planning and budgeting**. The PCU of PRSSE will prepare a detailed consolidated annual work plan and budget (AWPB) for implementing the project SPARK activities. The AWPB will be submitted to the Project SC for approval and thereafter to IDA for no-objection, not later than November 30 of the year preceding the year the work plan should be implemented.

6. **Accounting**. The prevailing accounting policies and procedures in line with the West African Francophone countries accounting standards—SYSCOHADA—in use in Côte d'Ivoire for ongoing World Bank-financed operations will apply. The accounting systems and policies and financial procedures used by the project will be documented in the project's administrative, accounting, and financial manual. The PCU will customize the existing accounting software to meet project requirements. However, the IPS-CNAM will apply the CIPRES accounting principles and standards.

7. **Interim financial reporting (IFR).** The unaudited IFRs will be prepared every quarter and submitted to the World Bank regularly (for example, 45 days after the end of each quarter) and on time. The frequency of IFR preparation as well as its format and content will remain the same as in the PRSSE. The consolidated quarterly IFR for the project includes the following financial statements: (a) Statement of Sources of Funds and Project Revenues and Uses of funds; (b) Statement of Expenditures (SOE) classified by project components and/or disbursement category (with additional information on expenditure types and implementing agencies as appropriate), showing comparisons with budgets for the reporting quarter, the year, and cumulatively for the project life; (c) cash forecast; (d) explanatory notes; and (e) Designated Account (DA) activity statements.

8. **Annual financial reporting.** In compliance with International Accounting Standards and IDA requirements, the PCU of PRSSE will produce annual financial statements. These include (a) a Balance Sheet that shows assets and liabilities; (bi) a Statement of Sources and Uses of Funds showing all the sources of project funds and expenditures analyzed by project component and/or category; (c) a DA Activity Statement; (d) a Summary of Withdrawals using SOEs, listing individual Withdrawal Applications by reference number, date, and amount; and (e) notes related to significant accounting policies and accounting standards adopted by management and underlying the preparation of financial statements.

9. **External Auditing**. The PCU of PRSSE will submit audited project financial statements satisfactory to the World Bank every year within six months after closure of the government fiscal year. The audit will be conducted by an independent auditor with qualifications and experience acceptable to the World Bank. A single opinion on the audited project financial statements in compliance with the International Federation of Accountants will be required. In addition, a Management Letter will be required. The Management Letter will contain auditor observations and comments and recommendations for improvements in accounting records, systems, controls, and compliance with financial covenants in the Financial Agreement. The report will also include specific controls such as compliance with procurement procedures and financial reporting requirements and consistency between financial statements and management reports as well as findings of field visits (for example, physical controls of infrastructure and transfer to health centers and implementing entities including UN Agencies). The audit report will thus refer to any incidence of noncompliance and ineligible expenditures and mis-procurement identified during the audit mission (see Table 5.2). The project will comply with the World Bank disclosure policy of audit reports and place the information provided on the official website within two months of the report being accepted as final by the team and the World Bank. The consolidated financial statements of IPS-CNAM audited by its statutory auditors *"co-commissaires aux comptes"* will reflect the funds received from the SPARK project (IDA).

Table 5.2 Due Dates of the Audit Reports

Audit Report	Due Date	Responsible Party
Audited financial statements including audit report and Management Letter	(a) Not later than June 30 (2000 + N) if effectiveness has occurred before June 30 (2000 + N-1). (b) Not later than June 30 (2,000 + N+1) if effectiveness has occurred after June 30, (2000 + N-1)	PCU/PRSSE

10. **Assessment of CNAM**: ***The assessment concluded that IPS-CNAM has the minimum FM staff, systems, tools and governance structures in place to manage effectively IDA funds***. IPS CNAM is a government entity created by decree no 2014-395 dated on June 25, 2014. The Directorate of Finance and Accounting (DFC) is headed by a qualified and experienced Director and is composed of the Accounting Unit (3 staff) and the Treasury / Finance Unit (3 staff). The recruitment of 5 additional staff are planned in the coming months/years. the Entity has also an Internal Audit Unit and a Budget and Management Unit; both reporting directly to the Managing Director. However, there is no audit committee yet in place. IPS/CNAM applies the CIPRES accounting system and has a very detailed FM procedures manual. A fully computerized accounting system is in place. It was developed using the Enterprise Resource Planning Software (ERP/SAP). There are two (2) appointed external auditors at IPS-CNAM (called *Commissaires aux Comptes* or external auditors). They are appointed by the board of directors. The current two auditing firms are acceptable to the World Bank. IPS-CNAM annual financial statements which should include IDA and others donors-financed project activities will be audited by qualified and experienced external auditors "statutory auditors" as required by law on ToR agreed on by all parties. The auditors will be required to issue one report on IPS-CNAM consolidated financial statements including IDA financing with a specific section showing the financial position related to the World Bank funds and a management letter. The audited financial statements and the management letter will be submitted together to IDA not later than six months after the end of each fiscal year.

11. **FM Assessment of the DAF of the MPH:** The assessment concluded that the DAF is not very familiar with World Bank-financed FM procedures and requirements. Overall, the DAF which applies the country FM system to execute the budget of the MPH faces some challenges like other DAF of the line ministries including: (i) late commitments; (ii) lengthy delays in processing transactions; (iii) lengthy procurement delays; (iv) delays in payments of invoices; and (v) limitation of expenditures commitment to the availability of cash estimated. The

role of the DAF is mainly to prepare the budget of the MPH, sign the commitments /purchasing orders and prepare the mandate for visa of the finance controller. The DAF execute the budget of the MPH through the SIGFIP. The DAF will not receive any funds or manage directly any bank accounts for this SPARK projects.

12. **Assessment of the CTN-PBF: A**t the time of the appraisal, the assessment concluded that the CTN-PBF does not have, the capacity in terms of HR and tools to receive and manage the project funds. However, in line with the use of country systems, line items should be created in the MPH budget to allow the allocation of budget to the CTN-PBF. Part of these resources will be used to strengthen the capacity of the CTN-PBF. Budget allocated to the CTN-PBF will be managed through the country FM system.

13. **FM Assessment of the DGS:** Based on the information gathered, the assessment concluded that the funds allocated to the activities of the DGS could flow through the FM country system. However, significant delay may be encountered during the phase of payment of invoices. Therefore, for the SPARK operation and until the program budget system becomes effective, funds will be transferred from the transaction account of the PCU/PRSSE to a treasury account *"compte de dépôts ouvert au Tresor"* managed by a *"Régisseur"* to be appointed by the DGTCP. The DGS and CTN-PBF will initiate the requests for commitment for expenditures including the preparation of "Purchasing orders and the Payment orders or the *"Mandats"*. The budget allocated to DGS estimated at XOF 6 billion over the entire period of the project implementation will finance mainly the costs of training of health staff (perdiem, hotel, oil), missions, supervisions, coaching etc. The assessment concludes based on past experiences in the sector and in World Bank-financed projects, that most of these activities and expenditures are prone to irregularities. Therefore, the following actions and arrangements should be put in place to mitigate the fiduciary risks: (i) assign to DGS, an experienced an accountant assistant to support the DGS team to prepare the financial reports and a "Regisseur" to manage the treasury account "*compte de dépôts ouvert au Tresor*"; (ii) prepare and submit a detailed and consolidated AWPB reflecting the activities and budgets of all the donors-financed programs and projects implemented or managed by the DGS; (iii) submit periodic financial reporting on the use of the funds transferred to DGS; and (iv) conduct every year, at least one full internal audit mission by the IGF on the use of the funds managed by the DGS. The section of the specific FM manual prepared for the Implementing Entities will provide more details on the FM requirements applicable to DGS.

14. **Assessment of UN Agencies (WHO, UNFPA and UNICEF): Financial reporting and auditing arrangements (Audit of the funds managed)**: The funds transferred to any UN agency will be managed by this supplier following UN Financial Regulations and Rules. As a result, reliance will be placed on the UN agency's external auditor's reports as necessary. Request for elimination of audit requirements will be prepared and should be granted during the project preparation. To mitigate any risks of inappropriate use of the project funds, some alternative mechanisms should be put in place including the followings: (i) at least two field based-visits, will be conducted during the first 12 months of the project implementation period. The supervision intensity will be adjusted over time taking into account the project FM performance and FM risk level; (ii) the Government will have the entire responsibility to ensuring that works, goods and service are delivered effectively to the intended beneficiaries during the project implementation; however where deemed appropriate (e.g. UN agency systems and IFRs have showed some weaknesses or deficiencies or delays) , the World Bank team may request the Government to put in place adequate arrangements to conduct some physical inspections of goods and services delivered by the UN agency ; and (iii) the World Bank FM team will have adequate access to the financial information and documents for activities implemented by the UN agency on behalf of the Government of Côte d'Ivoire.

15. **Disbursements/Flows of funds arrangements**: Upon credit effectiveness, transaction-based disbursements will be used. The project will finance 100 percent of eligible expenditures inclusive of taxes. A

Designated Account (DA) will be opened at the Central Bank (BCEAO) and a PA in a commercial bank under terms and conditions acceptable to IDA. The ceiling of the DA will be stated in the Disbursement and Financial Information Letter (DFLI). An initial advance up to the ceiling of the DA will be made and subsequent disbursements will be made against submission of statements of expenditures (SOE) reporting on the use of the initial/previous advance. The option to disburse against submission of quarterly unaudited IFRs (also known as report-based disbursements) could be considered, as soon as the project meets the criteria. Other methods of disbursing the funds (reimbursement, direct payment, and special commitment) will also be available to the project. The minimum value of applications for these methods is 20 percent of the DA ceiling. The project will sign and submit Withdrawal Applications electronically using the eSignatures module accessible from the World Bank's Client Connection website.

16. **Payments to implementation agencies, including Health Centers, CNAM, CTN-PBF, DGS, and Service providers**: The PCU through the project Accountant will make payments to contractors, service providers, and the implementing agencies for activities specified in the project and in contracts. In addition to supporting documents, when approving payments, the PCU will consider the findings of the IGF and IGS. The PCU will have the right to verify expenditures and may request refunds if contractual provisions have not been honored. Activities not authorized could result in suspension of financing for an entity. All payments will be made by the PCU or by implementing agencies as agreed with the PCU/PRSSE for some activities. That is why, as the country PFM system specifies, a financial controller and a public accountant have been appointed. In compliance with Decree n° 475 and to avoid delays in transactions and payments, these two civil servants should help in management of project funds, mainly by prior reviews and later checks of whether goods, work, and services were effectively provided, and payments are based on supporting documents, such as contracts, services/goods delivery receipts and invoices. Funds will be transferred from the PA managed by the PCU to the accounts opened in commercial banks or at the Treasury *"comptes de dépôts ouverts au Tresor"* for each Implementing Entity. The utilization of the funds by the Health Centers /Regional or Departmental Directorate of Health (DRS and DDS) will follow the country PFM system applicable to the entities. Each Health center and DDS or DRS will open a treasury account *"comptes de dépôts ouverts au Tresor"* to manage the funds received from the PA managed by the PCU/PRSSE. Initial advance to the accounts opened by the CNAM and DGS will represent 3 months of the approved annual budget. Replenishments of the CNAM and DGS accounts will be on a quarterly basis or when at least 75 percent of the initial advance has been utilized. A detailed statement of expenditures and a financial report and any supporting document will be attached to the requests for replenishment of the accounts. These modalities could be revised based the actual FM performance and disbursement status of the Implementing entities.

17. **Disbursement of funds to UN Agencies (WHO, UNICEF and UNFPA):** When UN agencies are used as implementing agencies or suppliers, upon signing of the MoU between the Government and UN agency, application for withdrawal of proceeds will be prepared by the PCU/PRSSE and submitted to IDA. The special World Bank disbursement procedures will be used to establish a "Blanket Commitment" to allow the amount to be advanced. Funds withdrawn from the IDA grant account will be deposited directly into the UN bank account provided by the UN agency for the project activities to be implemented by the UN agency. The amount advanced will be documented through the quarterly unaudited Interim Financial Reports as actual expenditures are incurred by the UN agency.

Table 5.3. Eligible Expenditures

Category	Amount of the Credit Allocated (expressed in EUR)	Percentage of Expenditures to be Financed (inclusive of Taxes)

(1) Goods, works, non-consulting services, consulting services, operating costs and training for Parts 1.1, 2.1, 2.2, 2.3, and 3 of the project	103,600,000	100%
(2) Goods, works, non-consulting services, consulting services, operating costs and training for Part 2.4 of the project	9,400,000	100%
(3) Performance-based payments for Part 1.1 of the project	45,000,000	100%
(4) CNAM payments for Parts 1.2 and 1.3(ii) of the project.	16,200,000	100%
(5) CERC under Part 4 of the project	0	
TOTAL AMOUNT	174,200,000	

18. **Local taxes**. Funds will be disbursed in accordance with project categories of expenditures and components, as shown in the Financing Agreement. Financing of each category of expenditure/component will be authorized as indicated in the Financing Agreement and will be inclusive of taxes according to the current country financing parameters approved for Côte d'Ivoire.

19. **Support to the implementation plan.** FM supervisions will be conducted over the project's lifetime. The project will be supervised on a risk-based approach. Based on the outcome of the FM risk assessment, the following implementation support plan (ISP) is proposed. The objective of the ISP is to ensure the project maintains a satisfactory FM system throughout its life.

Table 5.4. FM Implementation Support Plan

FM Activity	Frequency
Desk reviews	
IFRs' review	Quarterly
Audit report review of the project	Annually
Review of other relevant information such as interim internal control systems reports	Continuous, as they become available
On-site visits	
Review of overall operation of the FM system (Implementation Support Mission)	Twice a year for Substantial risk
Monitoring of actions taken on issues highlighted in audit reports, auditors' Management Letters, internal audits, and other reports	As needed
Transaction reviews	As needed
Capacity-building support	
FM training sessions	Before project effectiveness and during implementation as needed

Table 5.5 Update of the FM Risk Rating of the PCU of PRSSE

Type of Risk	Residual Risk Rating		Brief Explanation of Changes and any New Mitigation Measures
	Last SPN	FMAR	
Inherent Risk			
Country level	H	H	
Entity level	S	S	The PCU of PRSSE has gained additional experiences and is more familiar with World Bank FM procedures. However, additional
Project level	S	S	The implementation of PBF activities including the transfers of resources to health centers, DRS, DDS and other COGES at decentralized level impact the risks. Some actors also face capacity challenges. Training will be provided and detailed FM procedure manuals.
Overall Inherent Risk	**S**	**S**	
Control Risk			
Budgeting	S	M	PCU of PRSSE has adequate HR and tools in place to manage adequately, the preparation and execution of the budget/ AWPB
Accounting	M	M	
Internal control	S	S	The transfers of funds to health centers, DDS, DRS and other COGES (PBF activities) needs additional oversight mechanisms and reliable internal control systems. Use of government institutions as well as local NGOs for verification and post-audit of PBF activities and other expenditures
Funds Flow	S	S	Arrangements and modalities of transfer of funds to beneficiaries (CNAM, DGS/CTN-FBR, Health centers, DRS, DDS, COGES etc.…) are being designed and strengthened. *« Compte de depots ouverts au Tresor public »* and commercial banks accounts will be opened to manage the funds transferred to CNAM, DGS/CTN-FBR and COGES. Training prior to transfer of PBF resources and use of funds. Use of government institutions as well as local NGOs for verification and post-audit of PBF activities and other expenditures
Financial Reporting	M	M	
Auditing	M	M	The FM action plan requires the selection of the auditor on TOR acceptable to the World Bank within 6 months following the project effectiveness date.
Overall control risk	**S**	**S**	
Overall FM risk	**S**	**S**	**Substantial**

Note: M = Moderate; S = Substantial; H = High.

ANNEX 6: How the Pandemic Emergency Facility (PEF) Works

COUNTRY: Côte d'Ivoire
Strategic Purchasing and Alignment of Resources & Knowledge in Health Project (SPARK-Health)

1. The PEF was developed by the WBG, in consultation with the WHO and other development partners, and the private sector, to help fill a critical gap in the international aid architecture, as one part of the global solution to strengthening pandemic risk management. The PEF helps fill the financing gap that occurs after the initial outbreak and before large-scale humanitarian relief assistance can be mobilized. Funds made available quickly in this timeframe are essential to preventing a severe outbreak from becoming a pandemic.

Figure 6.1 Visualization of how PEF works

2. **Beneficiaries:** All IDA-eligible countries are eligible to access PEF funds. In addition, international organizations and NGOs supporting response efforts in affected countries that have been accredited as responding agencies under the PEF are also eligible to access PEF funds. PEF premiums are covered by donors for the initial period of three years, ending June 30, 2020, and beneficiary countries are not required to bear any costs.

3. **Design and activation:** The PEF provides surge funding for countries and accredited responding agencies to respond to infectious disease outbreaks. PEF provides funding through two windows: Insurance and Cash. The Insurance Window leverages funding from capital markets via Catastrophe Bonds and SWAPs. The Cash Window is funded by traditional donor contributions.

4. *The Insurance Window* covers high-severity events that have met a specific, pre-determined, activation

criteria. These criteria are based on outbreak size (i.e., number of cases or number of deaths), outbreak growth (i.e., the outbreak must be growing over a defined time-period) and outbreak spread (i.e., two or more countries affected by the outbreak). The details on the Insurance Window activation criteria are included in Box 6.1. The determination of an outbreak reaching the Insurance Window activation criteria is made by an independent calculation agent, based on publicly available data published by the WHO. Payout amounts from the capital markets into the PEF vary by disease and by the outbreak size and spread, as shown in Table 6.1. Allocations to affected countries are pro-rated according to each county's population and outbreak size.

5. *The Cash Window* provides greater flexibility in funding high-severity infectious disease outbreaks in accordance with the PEF objectives when such funding is not eligible to be provided under the PEF Insurance Window, either because it has not yet met or will not meet its activation criteria. The activation criteria of the Cash Window are based on epidemiological thresholds, independent expert advice and the decision of the PEF Steering Body. The determination of an outbreak reaching the Cash Window activation criteria will follow a process described in Box 6.2.

6. **Covered diseases:** The Insurance Window covers a pre-established group of diseases identified as likely to cause major pandemics. This group of diseases includes: pandemic Influenza (new or novel influenza A virus), Coronaviruses (e.g. SARS, MERS), Filoviruses (e.g. Ebola, Marburg), Crimean Congo hemorrhagic fever, Rift Valley fever, and Lassa fever. The cash window covers all diseases covered by the insurance window, as well as other infectious diseases caused by different pathogens, including new or unknown pathogens, in the event of a high-severity outbreak consistent with the PEF objectives.

7. Additional information on the PEF, including the Operations Manual and the PEF Framework, is publicly available at *www.worldbank.org/pef*.

Box 6.1: Insurance Window activation criteria

For Flu outbreaks

(a) There must be at least 5,000 confirmed cases (counted from all countries worldwide) within a rolling 42-day period. For these cases, the virus needs to satisfy the following conditions:
(i) WHO Report states that such Virus is an influenza A virus (either through a statement or by denoting such influenza Virus with an "A" prior to its genetic subtype);
(ii) Such WHO Report states either:
- that such influenza A virus is a new or novel influenza A virus with a new or novel genetic subtype, and no Case of or Death relating to such influenza A virus has been reported in any WHO Report published prior to July 2017; or
- that such influenza A virus is an influenza A virus whose hemagglutinin gene is antigenically distinct, due to an antigenic shift, from those in seasonal influenza viruses circulating in the 35 years prior to July 2017; and
(iii) Such WHO Report states that the influenza A virus is experiencing sustained or effective human-to-human transmission.
(b) The Growth Rate needs to be greater than zero after the first 42 days and the Growth Rate Mean needs to be greater than or equal to 0.265, for any day after the first 42 days.
(c) When (a) and (b) are met, the influenza pandemic would be confirmed, and 100 percent of the maximum US$275 million coverage would be released.

For Non-flu outbreaks

(a) At least 12 weeks have passed from the date of the start of the event.
(b) The outbreak needs to be in more than one country (IDA or IBRD), with each such country having greater than or equal to 20 Confirmed Deaths.
(c) The Growth Rate needs to be greater than zero to ensure that the outbreak is growing at a specific statistical confidence level
(d) The Total Confirmed Death Amount needs to be greater than or equal to 250.
(e) The Rolling Total Case Amount needs to be greater than or equal to 250.
(f) The Rolling Confirmed Case Amount needs to comprise a minimum percentage of the Rolling Total Case Amount.

(g) Regional outbreaks affecting two to seven countries would activate payments of Pandemic Bond/Insurance Payout Amounts at three stages as the number of total confirmed deaths increases. Global outbreaks affecting eight or more countries also activate payments at three stages but provide access to higher funding levels at the first two triggers.

Table 6.1: Insurance Window payouts from capital markets into the PEF

Influenza has 1 payout of $275M at 5,000 cases		Pay-out based on: Aggregate Number of Confirmed Deaths within IDA Countries		
		At 250	At 750	At 2,500
Coronavirus Maximum. Coverage: $195.83m	Regional (outbreaks affecting 2 to 7 countries)	▪ 29% (US$56.25m)	▪ 57% (US$112.5m)	▪ 100% (US$195.83m)
	Global (outbreaks affecting 8 or more countries)	▪ 34% (US$65.63m)	▪ 67% (US$131.25m)	▪ 100% (US$195.83m)
Filovirus Maximum Coverage: $150m	Regional (outbreaks affecting 2 to 7 countries)	▪ 30% (US$45m)	▪ 60% (US$90m)	▪ 100% (US$150m)
	Global (outbreaks affecting 8 or more countries)	▪ 35% (US$52.5m)	▪ 70% (US$105m)	▪ 100% (US$150m)
Other diseases (Rift Valley, Lassa Fever, Crimean Congo) Maximum Coverage: $75m	Regional (outbreaks affecting 2 to 7 countries)	▪ 30% (US$22.5m)	▪ 60% (US$45m)	▪ 100% (US$75m)
	Global (outbreaks affecting 8 or more countries)	▪ 35% (US$26.25m)	▪ 70% (US$52.5m)	▪ 100% (US$75m)

Box 6.2: Process for determination of Cash Window activation criteria

Activation of the PEF Cash Window will follow a sequential three-step process based on (i) pathogen type; (ii) epidemiological thresholds; and (iii) technical assessment.

Pathogen type: Consistent with the goal to mitigate or prevent severe epidemic threats with regional or global pandemic potential, the PEF Cash Window will provide financing for the response to outbreaks of pathogens that are not currently endemically transmitted within the human population. This includes all pathogens covered by the PEF Insurance Window plus viruses with a primary zoonotic reservoir (including, but not limited to, Chikungunya, Nipah, Zika, equine encephalitis viruses, Hanta viruses, West Nile, Monkeypox), novel viral pathogens which are genetically determined to originate from a zoonotic source, and smallpox. Pathogens not posing an acute regional or global pandemic threat are excluded. Therefore, all non-viral pathogens and pathogens that are currently endemic in human populations are excluded (endemicity is defined here as continuous sustained human-to-human transmission of a pathogen in the global human population). Note: The list of included and excluded pathogens is indicative and will be reviewed and updated periodically upon the expert advice of the Strategic & Technical Advisory Group for Infectious Hazards (STAG-IH), constituted by WHO.

Epidemiological thresholds: The adoption of case number based epidemiological thresholds is intended to ensure the PEF Cash Window provides a more flexible and rapidly triggering financing mechanism than the PEF Insurance Window while retaining the primary goal of PEF to mitigate severe epidemic threats with regional or global pandemic potential. Determination of whether

an outbreak has reached the epidemiological thresholds will be based on publicly available epidemiological data published by WHO (headquarters or regional offices) and/or national public health agencies. Note: The indicative thresholds will be reviewed and updated periodically upon the expert advice of the WHO STAG-IH.

Technical assessment: An event that is deemed eligible according to pathogen type and that has reached the epidemiological thresholds will be referred to subject-matter experts from the WHO STAG-IH for a technical assessment of (a) whether the outbreak is driven by human-to-human transmission, in the case that evidence for human-to-human transmission is available; (b) whether underlying incidence trends suggest continued growth in weekly numbers of new confirmed cases; and (c) unless the proposed response plan submitted by the country has been endorsed by WHO, whether this proposed plan is consistent with prevailing expert opinions in specialized agencies, such as WHO, and is aligned with applicable WHO public health recommendations relating to the outbreak in question.

The PEF Coordinator will present the application together with the advice obtain through the technical assessment to the Steering Body, which will take a decision on the payout from the Cash Window within 24 hours.