SOCIAL HEALTH PROTECTION NETWORK

Institutional frameworks in the area of health financing systems

CÔTE D'IVOIRE Summary

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CONTENTS

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1. BACKGROUND

1.1. Introduction

The P4H Network develops innovative collaborations in its role as an honest broker, whose mission is to promote, develop and strengthen exchange and collaboration for social health protection and health financing. In this context, a consultant, Virgile Pace, was engaged by the P4H Network Coordination Desk to review the institutional frameworks of ten countries. Virgile worked in countries where the P4H Network was engaged and collaborated with several members of P4H and P4H country focal persons (P4H-CFPs). The summaries Virgile produced were first intended to help familiarize P4H-CFPs with the countries and regions where they work to thus enhance their agency in facilitating their work with national stakeholders. The summaries will also be helpful to anyone interested in institutional frameworks related to SHP and HF in general and in the context of the selected countries.

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2. ANALYSIS

2.1. Constitutional/Legal/Governance Challenges

- The right to healthcare is expressively mentioned by the Constitution of 2016 in several articles. Article 9 states that "Everyone is [also] entitled to access to healthcare services"[1]. And Article 32 further points out that "The State is committed to guaranteeing the specific needs of vulnerable persons. It takes the necessary measures to prevent the vulnerability of children, women, mothers, the elderly and persons with disabilities. It is committed to guaranteeing the access of vulnerable persons to healthcare services, education, employment, culture, sports and leisure". Interestingly, Article 125 says that "The objectives of the organizations referred to in Article 124[2] may notably include […] cooperation in the field of health".
- Constitutional protection of broad right to health is thus a reality in Côte d'Ivoire. In addition, it should be noted that children's right to health or medical care is guaranteed, and such is the case as well for persons with disabilities and the elderly and the socio-economically disadvantaged. This places Côte d'Ivoire among the most protective countries from a constitutional point of view regarding access to healthcare.
- The recent adoption of Decree n°2021-465 of September 08, 2021, Organizing the Ministry of Health, Public Hygiene and Universal Health Coverage (*Ministère de la santé, de l'hygiène publique et de la Couverture Maladie Universelle* - MSHP-CMU) is fully in line with the Constitution. It clearly

[1] In addition, Article 16 points out : "It is prohibited to employ children in an activity that puts them in danger or affects their health, their growth, as well as their physical and mental balance".

[2] The Republic of Côte d'Ivoire may conclude association or integration agreements with other African states including the partial relinquishment of sovereignty with a view to achieving African unity. The Republic of Côte d'Ivoire agrees to establish with these States, intergovernmental organizations for joint management, coordination and free cooperation.

demonstrates, at least from a theorical point of view, the commitment of the Government towards UHC. UHC is actually central to the organization and attribution of the new MSHP-CMU. Provisions related to UHC and health financing are very detailed as well as structures in charge of implementing them. For example, the new Health Economy Directorate is expressively tasked with carrying out every year all needed analysis likely to optimize the health sector, or to produce the health accounts. In addition, the Directorate should develop and implement strategies with the purpose of optimizing resources for health. In a very significant way, the Decree clearly requests the Directorate to participate in resources mobilization for health, to attract additional resources for health financing and to develop sustainable health financing mechanisms. Three sub-directorates assist the Directorate in the fulfilment of its missions: the sub-directorate for the planification and realization of health studies; the sub-directorate for the mobilization of resources; and the sub-directorate for the sustainability of foreign aid for health. Likewise, a General Directorate exclusively dedicated to UHC is established, tasked with seventeen (!) missions. The General Directorate for UHC is assisted by two Central Directorates: The Directorate for the Policy, Extension and Management of the Health Benefit Package for UHC, and the Directorate for the Promotion of UHC and External Relations.

- However, despite these remarkable progresses from a legal perspective, it should be noted that the broad policy, legal and regulatory framework regarding UHC, and health financing is still weak. Core pieces are still lacking or need to be updated in order to accelerate effectively and efficiently the progressive instituting of UHC in the country. For example, better involving private sector service providers in strategic purchasing, which is of the utmost importance, would require new legal reforms through regulation, accreditation, and contracting mechanisms. Likewise, the way insurance is launched and structured has a direct bearing on service delivery, and the institutional arrangements through which it emerges can impact quality of care. With regard to critical health information such as unique identifier for Electronic Medical Record (EMR), the *Couverture Maladie Universelle* (CMU) identifier, and the national ID numbers under development under the Identification for Development (ID4D) regional Multiphase Programmatic Approach (MPA), technical assistance has still to be provided to develop the data integration application, support the interoperability of existing Health Management Information System (HMIS) tools and reform the existing regulatory and legal frameworks.

2.2. Political and Socio-Economic Challenges

- Ivory Coast still faces poverty and inequity, despite strong economic growth[3]. Though it is classified as a lower middle-income country, Côte d'Ivoire's epidemiological profile remains comparable to low-income countries, and health outcomes are amongst the poorest in the region and globally [4].

[3] Approximately 50% of the Ivorian population live below the national poverty line with more than half living in rural areas.

[4] Life expectancy is 55, which is one of the lowest in the world. HIV- prevalence, and maternal and under-5 mortality are among the highest in the world.

Communicable, maternal, neonatal and nutritional diseases are the leading causes of disability and death, representing almost 65% of the disease burden[5]. Indeed, Côte d'Ivoire did not achieve any of the health-related Millennium Development Goals (MDGs), nor any of the health targets set out in most recent National Health Development Plan - *Plan National de Développement Sanitaire,* PNDS : PNDS (2012-2015) and PNDS (2016-2020).

- In 2012, the Government introduced a free service scheme, or *gratuité*, to reduce Out-of-Pocket (OOP) spending associated with priority health conditions primarily for malaria and for maternal and child health. While this system did increase utilization of health services, 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.
- Low quality of care poses a significant problem. According to Institute for Health Metrics and Evaluation (IHME), Côte d'Ivoire ranks 187 out of 195 countries in terms of quality, as measured by the prevalence of amenable mortality[6], according to the Healthcare Access and Quality (HAQ) index. Poor quality leads to suboptimal care. Health is among top concerns for Ivoirians, ranking second after unemployment. Weak infrastructure and unavailability of drugs and medical equipment are important challenges, especially for maternal and child health.
- To overcome these challenges, the Government launched in April 2017 the National Health Insurance Scheme (CMU) and established a Health Insurance Agency (*Caisse Nationale Assurance Maladie*, CNAM)[7]. After the pilot programme was successfully completed, the Government began the wider rollout in 2019, with the first contributions collected from workers in the formal sector[8]. As of April 2020, 3 million people were enrolled[9]. The CMU has two tiers of payment : the contributory basic general system offers a package for a monthly contribution of CFA1000 ($1.72) per insured person and is 70% funded by the CNAM; a non-contributory medical assistance system is also available for the financially vulnerable. The CMU has been launched to reduce OOP expenditures and alleviate the risk of poverty due to significant health costs.

[5] 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.

[6] Deaths that should not be occurring in the presence of effective care.

[7] CNAM gradually takes 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

[8] By October 2019 the first medical services were provided under the system.

[9] The Government aims to cover around 40% of the population by 2023.

- CMU's financial sustainability should be ensured through a prioritized benefits package, rational rate-setting and negotiations, as well as by ensuring that the CNAM should receive contributions from the Government and external financing partners to deliver on its core mandate. It is also of the utmost importance to ensure that a broad base of the population enrols in CNAM, to reduce adverse selection and maximize social protection.
- In addition to the CMU, a number of key reforms have been developed to improve community accessibility to quality health care and services, particularly for vulnerable populations. UHC initiatives are steered by a central structure, e.g. the National Health Insurance Fund (NHIF), which delegates responsibility for parts of its mission to "Delegated Management Authorities"[10].

2.3. Financial Challenges

- Very few people in Côte d'Ivoire have health insurance[11]. They are mainly private sector employees, civil servants, and members of the military. The rest of the population, e.g. people in the agricultural and informal sectors, the self-employed, and the indigent, lacks a stable income and is excluded from coverage. Household payments as a percentage of total health spending have long been among the highest in the West African Economic and Monetary Union (WAEMU) region. The Government spends far more of its funds on tertiary care than on secondary or primary care facilities. The primary care level actually receives a very small share of public expenditures, especially compared to its utilization and disease burden. These budget allocations are particularly unfavourable to the very poor, who are more likely to use primary care. There is considerable inequality between Abidjan, which has the highest amount of per capita resources available, and districts in the periphery.
- The main health insurance organizations are non-profit groups. They include the Civil Servants and State Workers of Côte d'Ivoire Fund (MUGEFCI), the National Social Security Fund for private sector employees (*Caisse Nationale de Prévoyance Sociale* CNPS), the Military Social Security Fund (*Fonds de Prévoyance Militaire*, FPM), the National Police Social Security Fund (Fonds de Prévoyance de la Police Nationale, FPPN), Community-Based Urban Health Funds (*Formations Sanitaires Urbaines à base Communautaire,* FSUCOM) and small schemes run by various government institutions (such as the *Bureau National des Études Techniques et du Développement* (BNETD). In addition, the Government provides subsidies for specific groups and services. A budget line item for indigents, to cover the poorest who cannot afford care, is officially available within each public hospital[12].
- Public financial management (PFM) and governance are weak. However, the Government is committed to undertaking various PFM reforms, including launching a program-based budget to comply with the WAEMU rules. With this system, line ministries will have more autonomy over their

[10] DMA oversee the operational functions of collecting contributions, service delivery, and information management.

[11] Less than 5% of the of the total population according to the most recent Multiple Indicator Cluster Survey (MICS).

[12] In practice, these resources are often used for other purposes and thus are not available for indigent care.

budgets, moving from an input-based to an output and outcome-based approach[13]. The transition from output-based budgeting to program-based budgeting requires reformulating the current budget allocation methodology, ensuring appropriate financial management (FM) units are in place, and defining effective and accurate programs that are aligned with the sectoral priorities as defined by the PNDS. But significant reforms are also needed across revenue-raising, pooling, and purchasing, coupled with investments and policy changes in the health system, to improve quality and outcomes in the Ivorian health system.

Revenue Raising

- In terms of revenue-raising, there is an urgent need to increase the share of health in the Government budget, as well as to focus on a holistic approach to raise revenues. Within the existing fiscal space, the share of social spending remains low and health expenditure is about 5% of general Government spending, which is among the lowest in Africa and well below the Abuja target of 15%. The health sector receives a significantly lower budget than education and infrastructure. Over the past 10 years, Total Health Expenditure (THE) has stagnated, and Households OOPs payments account for over half of THE[14]. Households finance 50% of all spending at pharmacies and 35% of spending at hospitals, including high expenditures on maternal health and malaria even though these interventions are covered under the free services package. Elevated level of OOPs spending translates into poorer financial outcomes for the broader population.
- Development Assistance for Health (DAH) increased in recent years and represent more than 25% of THE in 2015[15]. Most donor spending in Côte d'Ivoire is also not channelled through the Government, leading to an even more limited fiscal capacity, prohibiting the Government's ability to plan effectively and ensure predictability[16]. The over-reliance of the health sector on household expenditure and DAH, which together represent more than 70% of THE, are a challenge to sustainability, ownership and efficiency of existing resources, especially as donor resources remain fragmented with many duplications, high administrative burden and limited alignment on national priorities.

[13] 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.

[14] People in Abidjan spent an average of 1.5 times more than those in the rural and urban areas respectively. Hospitalization is the highest expenditure item in terms of money spent, while drugs are the most common item of expenditure in terms of frequency, regardless of the place of residence. Female gender, high social economic status and large household size increase OOP health expenditure significantly in all areas of residence when insurance reduce it. To reduce the impact of the direct payments there is today a need to take into account social demographic factors in addition to economic factor in health policy development.

[15] Most external financing takes place at the primary level for the control of infectious disease : in 2016, 70% of all donor funding is allocated to HIV and malaria.

[16] It is crucial for most external funding to flow through Government systems, and to integrate disease programs on the Government budget across all health-financing functions.

- The extremely low priority given to health in the national budget reflects a perceived inefficiency of current spending in the sector as well as donor spending potentially crowding out domestic financing. The Government strong and sustained political leadership and commitment to the UHC agenda has not been accompanied by an increase in financial resources.
- Despite the country's economic growth, tax revenue mobilization remains limited[17]. Increasing efficiencies is one of the most important measures the Government should undertake to expand its fiscal space. In particular, the following critical issues have to be tackled: weak financial management, overreliance on disease-specific funds, low absorption rate of investments, inadequate use of data for decision making, and suboptimal budget planning and execution processes.
- The MSHP-CMU has launched several reforms and initiatives to mobilize additional resources and improve public financial management in health. Reforms focus on expanding protection of financial risk through the national health insurance scheme, increasing access to quality maternal and child services with critical medicines and supplies and strengthening health sector governance. Other recommendations include widening the tax base, improving the efficiency of administration, rationalizing tax legislation through reducing exemptions, and increasing tax revenues by modifying tax rates.

Pooling[18]

- Less than 25% of the health spending in Côte d'Ivoire is pooled through public pools, which is lower than the Sub-Saharan Africa (SSA) and LMIC average, indicating that the mix of financing is suboptimal and not designed to maximize health benefits. In addition to low levels of public spending, most donor spending in Côte d'Ivoire is also not channelled through the Government, leading to fragmentation and even more limited fiscal capacity. To remedy the high burden of OOP spending, there is a need to increase the size of prepaid risk pools and ensure that health insurance assures financial risk protection.
- The NHIF is a single national fund established to consolidate, manage, and regulate the existing health financing schemes. The NHIF is intended to manage risk and supervise operations for individual schemes. The NHIF offers two schemes : a contributory Basic General Scheme (*Régime Général de Base*, RGB) and a non-contributory Medical Assistance Scheme (*Régime d'Assistance Médicale*, RAM) for low income persons, those living in extreme poverty, e.g. indigents, pregnant women, and children under five years of age. The RGB is a contributory scheme based on the principle of third-party payment and co-payment. It is available to all residents who are not eligible for the RAM. Enrollment

[17] Overall tax revenue collection has however increased by an average rate of 12% every year since 2015, largely due to strong economic recovery post-conflict.

[18] Pooling is the accumulation of funds for health care on behalf of a population before they get sick. The main rationale for pooling of funds is that health care costs are unpredictable. Risk equalization between different pools and consolidating towards larger and more diversified pools is critical.

is mandatory for those who are subject to income tax[19]. The RAM is non-contributory, government-subsidized scheme based on the principle of national solidarity[20].

- The pilot phase for both programs has begun in 2015 with workers and retirees from the private and public sectors, and with agricultural workers from the rubber and palm oil sectors. The package of services focuses on primary health care (PHC)[21]. Introducing contributory health insurance schemes aimed at decreasing OOP payments at the point of care and was used as a primary policy instrument to reach UHC.
- 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.

Purchasing[22]

- In Côte d'Ivoire, the expansion of health insurance coupled with strategic purchasing is a real opportunity to harmonize disease programs within a single benefits package, and to pay providers for progress toward specific targets[23]. PBF, selective contracting, and the definition of benefits package are actually powerful strategic purchasing tools to improve the efficiency and quality of health spending.
- The Government now concentrates its efforts to 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. In addition, as part of the scale-up of

[19] The NHIS is primarily funded by member contributions under the RGB. A fee of 1,000 West African Franc (FCFA) per person per month is required for all those over the age of five years. Revenue for the RGB is provided through mandatory contributions, late penalties, investment income, government subsidies, donations, and other funding mechanisms.

[20] Persons living in extreme poverty are exempt from paying a monthly contribution. The RAM is funded by subsidies from the central Government and regional resources, investment income, donations, and earmarked taxes.

[21] In 2015, the Government, with the support of the World Bank, began implementation of the Health Systems Strengthening and Epidemic Preparedness Project (PRSSE/2015-2020). PRSSE is a standard Investment Project Financing (IPF) of US$80 million whose very purpose was initially to pilot the Performance-Based Financing (PBF) approach in 19 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); and (iv) supporting the further development of a robust health management information system (HMIS) and health system management.

[22] Purchasing is the process of allocating prepaid resources from pooled funds to providers for service benefits. Closely linked to purchasing are decisions on benefits (what services, and at what level of cost coverage) and provider payment methods. The way purchasing arrangements are set up will have significant implications for provider behaviour and efficiency.

[23] Strategic purchasing in the Ivorian context refers more specifically to the use of performance contracts and the harmonization of PBF and CMU, with mechanisms to facilitate further harmonization and defragmentation such as *gratuité*, vertical programs, and complementary packages.

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 Human resources for health in remote areas. Districts and regions are contracted under strategic purchasing. Supporting decentralization activities to make strategic purchasing more effective is actually a core priority[24].

- Impact evaluations should be conducted regularly to assess the results of the strategic purchasing reform with the purpose to identify the links between strategic purchasing and health service quality and the reduction of maternal and infant mortality rates and to evaluate the cost-effectiveness of strategic purchasing as a strategy to improve service coverage and quality.
- The development objective of the strategic purchasing in Côte d'Ivoire is to improve the utilization and quality of health services towards reducing maternal and infant mortality. This implies the extension of PBF in the context of strategic purchasing, the scale-up of national health insurance (CMU) and support for health reforms and national capacity building.

2.4. Collaborative Challenges

- Côte d'Ivoire became a signatory to the IHP+ global compact in 2012 and since then has worked through a highly participatory process involving all the key health actors in the country to establish a country compact and new PNDS[25]. The compact constituted a useful accountability tool among actors in the health sector, demonstrating their mutual engagement in implementing the PNDS 2016-2020, which was the central strategic framework to guide interventions to improve health indicators.
- WHO fully assumes its coordinating role as the lead agency among technical and financial partners in the health sector in Côte d'Ivoire. WHO is currently in the process of strengthening coordination with national bodies and external partners through the health sector coordination mechanism and fully supports the Government on the basis of the strategic guidelines of the 2016-2020 Country Cooperation Strategy (CCS). In addition, within the framework of the Delivering as One initiative, WHO support helps to strengthen governance and the national priorities[26].
- Coordination mechanisms improved substantially with the appointment of a National Response Coordination Unit within the Prime Minister's Office. This Unit is in charge of coordinating the national COVID-19 response and overseeing the implementation of the Public Health Response Plan. The WHO coordination group with its 6 sub-groups are functional with the participation of UN agencies, Civil

[24] Through increased managerial autonomy e.g. hiring and firing, full control over both Government and strategic purchasing funds, strengthened facility and district-level management.

[25] Development Partners (DPs) involved include WHO, UNICEF, UNFPA, UNAIDS, UNDP, UNESCO, World Bank, European Union, African Development Bank, USAID, Japan International Cooperation Agency, and the Korean International Cooperation Agency. Several civil society organisations have been involved and include international organisations such as l'Agence de médecine preventive (AMP), the Red Cross, CARE, International Rescue Committee, Doctors of the World and Helen Keller International and a range of national health CSOs. IHP+ (now UHC2030) has worked with the WHO country office to support the process, help build consensus and draft documents around the compact development.

[26] The various international initiatives and partnership frameworks to which Côte d'Ivoire is a party (H4+, the Muskoka Initiative, IHP+, GAVI Alliance, Global Fund, Scaling Up Nutrition, Millennium Challenge Corporation, etc.) continue to be used as channels for mobilizing resources to achieve the goal of improving public health.

Society and partners under the lead of the MSHP-CMU. Reactivation of the WASH sector coordination mechanisms was also a strategic objective : coordination efforts were strengthened in nutrition, child protection, social protection, WASH and education and specific response plans were developed to operationalize the National Multisectoral Response Plan.

- In addition to these measures, there is a broader need for increasing efficiency through coordination between DPs to reduce duplication. More studies are however needed to identify the extent of duplication between different funding sources[27]. As it moves toward sustainability, the Government should also increase and coordinate its health spending. Alignment with DPs is critical to improve maternal, newborn, and child health outcomes, and to strengthen the health system. From this point of view, increasing dialogue with the Ministry of Finance, promoting broader advocacy with other social sectors, and developing innovative financing mechanisms such as earmarked consumption taxes for health appear to be key measures.

2.5. Human Resources Challenges

- Lack of infrastructure and adequately distributed human resources for health to meet the growing needs of the population as well as paucity of skilled and motivated personnel, leading to the provision of poor quality services, is concerning. If Côte d'Ivoire satisfies WHO norms for generalists, nurses, and midwives per capita[28], overall a shortage of specialists is a key problem with many regional hospitals lacking gynaecologists, surgeons, anaesthesiologists etc. Besides, these specialists, as well as other cadres such as midwives, remain concentrated in Abidjan and urban areas[29].
- Other challenges identified with human resources include low quality of training for midwives and other health workers, lack of a national information system/tools to identify distribution of health workers, issues with retention, especially in rural, hard-to-reach and remote areas[30], low institutional capacity of the MSHP-CMU in terms of regulating and governing the health workforce; and limited financing.
- Côte d'Ivoire has a three-tiered health service delivery system, with each tier providing a different set of services. The primary level of the Ivorian health system consists of an urban health center (*Centre de santé urbaine*, CSU) and a rural health center (*Centre de santé rurale*, CSR). Although CSU and CSR both constitute the primary care level, they differ significantly in the services they provide. In addition, the CSU and CSR designation does not always correspond with the geography : for example, certain

[27] A newly instituted resource mapping process collecting financing data from donors would assist in closing this evidence gap.

[28] All regions surpass the norms for midwives and nurses per capita although with significant inequalities between regions.

[29] 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.

[30] There is a lack of implementation of financial and non-financial incentives targeting retention, resulting in an unequal distribution of staff across the country.

urban health centers can be in rural areas[31]. The secondary level consists of regional hospitals that offer every service offered at an urban health center, as well as treatments for more complications. In reality, many of the district hospitals were recently upgraded from urban health centers and do not have the equipment or staffing levels that are required with a secondary level facility. Finally, the tertiary level offers specialized care for conditions that are not treated at primary and secondary levels.

- Strengthening human resources for health is today critical. Key priority actions include supporting the development and implementation of relevant policies such as the update of guidelines around staffing needs[32], and to increase district and health facility autonomization for hiring and firing[33]. Better decision-making is also needed to increase accountability and efficiency and improve capacity and quality for health workers. To this end, scaling-up coaching, mentoring and supervision is essential. Introducing incentives to improve retention in remote areas should also be core to any substantial reform[34].

2.6. Health Information Challenges[35]

- MEASURE Evaluation, a program funded by USAID, has been working in recent years with the MSHP-CMU to strengthen Côte d'Ivoire's monitoring and evaluation system through integration of multiple data collection systems for routine data, HIV/AIDS data, malaria data, and community-based data[36]. MEASURE Evaluation has contributed in particular to strengthen the country's HMIS, especially related to HIV, to assist the Ministry of Women, Children and Social Affairs to improve the reporting of monitoring and evaluation (M&E) on programs for orphans and vulnerable children, to improve in-country use of information for decision-making, and to support the National Institute for Public Hygiene to strengthen surveillance systems to detect and rapidly report on Ebola and other epidemic-prone diseases.
- The program helped to harmonize health indicators, standardize data collection tools, increase the availability and quality of data, and increase the use of information for decision making at district and

[31] Rural health centers consist of one maternity and one dispensary wing, and usually have one to two nurses and one to two midwives, and they offer the most basic maternal and child health interventions as well as basic outpatient treatment for infectious disease. In contrast, urban health centers can be significantly larger, have more than five nurses and midwives each, at least one generalist physician, and offer everything that rural health centers offer as well as more laboratory tests and diagnoses, and basic surgery and noncommunicable disease interventions.

[32] Specifically on increasing the availability of nurses and midwives.

[33] The health workforce is not directly managed by the MSHP-CMU 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.

[34] The increase in availability of key inputs in rural health centers, as well as the increase in provider pay through incentives should contribute to retention of HHR in remote areas.

[35] Health information is one of the six core functions of a health system, along with service delivery; human resources for health; medical products, vaccines, and technologies; financing; and leadership and governance.

[36] MEASURE Evaluation has developed a model for strengthening health information systems (HIS) in low-and-middle income countries (LMICs).

regional levels[37]. Côte d'Ivoire now has a national health data management system DHIS 2 deployed and used nationwide, and an electronic logistics management and supply chain system (eLMIS) used by clients of the new public health pharmacy.

- Priorities include developing an integrated health information system to secure higher quality health data, e.g. availability, accessibility, and validity[38]. 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 Civil Registry and Vital Statistics database for the registration of births and deaths.
- Adequate preparation of the Annual Health Statistics Report (RASS) is also a key challenge to enhance accountability at each level of the health system. To this end, health data will be harmonized and validated in a series of workshops with health programs and directorates. Other actions include development of a master plan to guide the implementation of digital health interventions, 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, 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 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.

3. WHAT IS NEEDED?

3.1. Strengthening policy frameworks by

Adopting conducive policies and strategic plans and promoting equity in health system financing[39]

- The government has finalized a set of new documents to guide the health sector's vision through 2020, including a PNDS, a national quality of care policy and improvement strategy, a hospital decentralization strategy, and a PBF strategy. These strategies are to be implemented in the context of

[37] For a long period, the national health strategic plan was not aligned to a monitoring and evaluation framework, health providers could not reliably track clients from one service to another, health districts could not measure disease trends and national policy makers could not know health service quality or coverage. In part, this situation was due to non-standardized data collection tools and the lack of checks on data quality and completeness. It was also due to fragmented data management systems that served one aspect of healthcare but not the full spectrum of health services.

[38] The implementation of the electronic medical record (EMR) system in referral hospitals, and the creation of electronic patient registries in primary care facilities are key actions in this regard.

[39] It is generally accepted that the burden of health financing should be distributed according to an individual's ability to pay, that is, the burden should increase as household income increases.

a limited financial capacity : while external spending has steadily been rising, there will be changes to donor assistance levels and modalities, given Côte d'Ivoire's economic growth and disease burden, and solidified LMIC status.

- Crisis 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. During the conflicts, the supply chain was seriously disrupted, almost all hospitals were closed due to looting or occupation, and 800,000 people were internally displaced with more than 70% of the population lacking access to health services.
- Accessibility still poses a major barrier to service utilization. Long distances from the nearest facility and weak referral systems jeopardize an equitable and affordable access to health care, with more than 30% of the country's population living outside a five-kilometer radius from a health facility, and an average of 0.22 ambulances per health facility, although with wide variation across the country.

Ensuring financial sustainability and the efficient use of resources

- PBF in Côte d'Ivoire 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 are used to support increased utilization of targeted services related largely to MNCH[40]. PBF has increased data availability and quality, facility-wide and disease-specific inputs, provider motivation and management practices in contracted facilities, but has had limited success in improving process and outcome measures of quality, as well as community involvement and the provision of non-incentivised services.
- Performance payments are now used for health facility operational and capital costs[41], outreach activities[42] and financial and non-financial incentives for health workers according to defined criteria[43]. And an analytical framework has been developed to identify financial incentives that can influence the quality of primary care[44]. However, limitations in the efficient use of resources for health

[40] In order to improve the quality of primary care, health sector reforms such as PBF should incorporate the organisational and service delivery context more broadly into their design and implementation.

[41] Including maintenance and repair, drugs and consumables.

[42] Transport and performance payments to community workers to stimulate demand.

[43] Performance-based incentives are additional to existing financial resources at target facilities and fully harmonized with the planned scale-up of CMU:

[44] Namely earmarking, conditioning, provider behaviour, community involvement and management. Conditioning refers to the transfer of funds to health facilities given the achievement of a predefined set of requirements; provider behaviour pertains to how the satisfaction, motivation and autonomy of health workers would respond to financial incentives and improve provider effort, absenteeism and their know/do gap; earmarking and the flexibility associated with using the funds once they come in to the facility has the potential to give providers more autonomy to be responsive to issues at the service delivery level; improving accountability and community involvement can take place through involving the community in quality of care improvement either as a direct condition for providing payment or through supplemental activities related to PBF projects; and finally, management and institutional reform pertains to the increase in the ability of providers to proactively plan and execute funds due to the improvement of data availability, supervision visits and flexibility of funds associated with financial incentives.

are still to be pointed out. They are mainly attributable to a centralised health system structure constraining the decision space of health providers.

- At the facility level, the most significant benefit of PBF was an increase in non-earmarked financing resulting in improved inputs and innovation[45]. Providers were actually in a position to use funds for improving the availability of medical equipment, water, electricity as well as improved stock and waste management[46].

3.2. Strengthening legal and regulatory frameworks by

Adopting robust legislations

- Key challenges regarding quality of care are lack of a governance structure to ensure high quality of care, lack of an adequate institutional framework, including accountability mechanisms and lack of adherence to protocols as well as limited implementation of evidence-based guidelines.
- The legal and regulatory framework should also be strengthened concerning direct transfers to facilities for their operating costs. There are actually problems with the adequacy and efficiency of these transfers and delays in reimbursements of salaries and operating budgets of facilities.
- Institutional arrangements focusing on defining the benefits package and provider payment modalities are also essential to ensure that insurance is introduced in a sustainable way, balancing the premium costs as well as payments to providers for the costs of interventions.
- Although the private sector plays a significant role in the provision of care in Côte d'Ivoire, governance structures overseeing the provision of private care are not well defined or well-regulated[47]. The lack of official contracting and accreditation arrangements between the private and public sectors in particular is an obstacle to better integrating the private sector in the provision of quality healthcare. The Government is now seeking to organize and increase the private sector's involvement in the health system, through mechanisms such as public private partnerships PPPs. Establishing a specific legal and regulatory framework in this regard is necessary.

Adopting implementing/regulatory measures

- In order to facilitate the operationalization of the Medical Assistance Scheme - RAM, regulatory measures should be adopted to extend enrolment and coverage to vulnerable households and the informal sector. For poor households, this implies to carry out beforehand the targeting and

[45] In a context where most funds are earmarked, PBF is the most significant source of flexible funding at the health centre level.

[46] The improvement in resources is also associated with higher provider motivation, especially compared with health centres without PBF which lack inputs to deliver the services they are mandated to provide.

[47] The private health sector follows the three-tier pyramid structure of the public health system. Private paramedical and medical centers operated by nurses or providers are the first point of care. The secondary level consists of specialist medical offices and centers, including medical imageries and diagnostic laboratories. Finally, polyclinics and hospitals providing consultations and hospitalizations offer a range of specialized care, such as general surgery and obstetrics and gynaecology among other specialties, are found at the third level of the pyramid.

enrollment of vulnerable and low-income households. For the informal sector, of the utmost importance is the identification and enrollment of segmented groups to ensure its full integration. Electronic payment innovations should be further developed as part of social protection and cash transfer programs[48].

- To begin the process of strengthening health sector governance, the MHPH and the Inspector General's office jointly conducted a first self-assessment of health sector governance in 2014[49]. Standardized financial controls and audit tools used by the Inspector General at local levels are now critical component to improve accountability and emergency preparedness. In particular, internal audits can verify that resources are effectively and efficiently deployed and soundly managed where they are most needed. The MSHP has trained national-level inspectors, established a new audit process, and revised regulations to allow inspectors to conduct audits at the local level.

3.3. Strengthening institutional frameworks by

Creating supportive environments and advocating for new investments

- Several implementing entities of the MSHP-CMU (central departments, health regions and districts, national program, health centers) and the CNAM serve as implementing agencies and are responsible for the operational implementation of the UHC strategy. Given that PBF development covers all pillars of the health system, the ministry departments, in accordance with their respective mandates, help implement the reforms or actions for which they are responsible. For example, the CNAM is tasked with implementing the CMU scale-up interventions.
- Increased investments are necessary in different building blocks of the health system, particularly within the primary care level, to ensure equitable and high quality care. There is also a need to determine smart and cost-effective interventions, focusing on harmonization and integration of existing supply chain and information systems, financing last kilometer distribution of commodities, moving away from a disease specific supply chain towards an integrated community-based model, and redistributing the health workforce to areas with the largest gaps.
- There is an urgent need for allocating investments based on need. An expanded information system would assist in moving toward evidence-based budgeting and decision-making, particularly for large-scale health systems investments such as infrastructure.

[48] In addition, 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 should be established.

[49] It revealed conflicts of interest, informal payments, and a lack of transparency, monitoring, community participation, and accountability.

Establishing close monitoring and accountability for results

- There is a need to increase accountability and governance mechanisms at all levels of the health system. Accountability mechanisms must be designed from the bottom up[50]. In terms of procurement, it is important to increase accountability and oversight mechanisms at the district level and devolve more procurement authority to districts at the same time. Likewise, contracting of facilities within health insurance and strategic purchasing should be based on the performance of facilities, in such a way that facilities that do not meet a minimum set of quality standards would not receive government subsidies or reimbursements.
- In order to improve the quality of care through citizen monitoring, two key actions have been identified: information and participation. Information means incorporating the dissemination of information to the community regarding the performance of the health facilities serving them. Participation supposes that the community and the health workers meet regularly and prepare a specific plan of action based on concrete propositions.

Transferring powers and resources to local authorities (decentralization)[51]

- In Côte d'Ivoire, new forms of community healthcare organizations have emerged recently. These decentralized structures enjoy a kind of autonomy, with characteristics closer to those of devolution.
- If decentralization laws exist, they are not implemented. As a result, district health development plans are not aligned with the PNDS, decentralized entity budget structures are different compared to MSHP-CMU budget structure and complex funding flows should be pointed out, with facilities having to transfer a certain part of their budgets to central government and districts.
- There is considerable inequality between Abidjan, which has the highest amount of *per capita* resources available, and districts in the periphery. More rural districts in the west and the north have fewer resources available compared to those in the center and south. And the allocation of resources does not necessarily correspond to the disease burden, which creates inequities and inefficiencies. The incomplete implementation of the decentralization strategy is actually a bottleneck in rationalizing and improving resource allocation flows across decentralized entities.

[50] For example, facility managers and district health offices should have the power to hire and fire and district health offices should have greater oversight over health facilities.

[51] Decentralization is a process by which political, administrative and fiscal authority, responsibilities and functions are transferred from the central government to the state/region governments. There are at least three aspects of decentralization: devolution, deconcentration and delegation. Devolution is the transfer of authority and responsibility from central government ministries to lower-level, autonomous units of government through statutory or constitutional provisions that allocate formal powers and functions. Deconcentration is the transfer of authority and responsibility from central government ministries in the country's capital city to field offices of those ministries at a variety of levels (region/state or local). Delegation is the transfer of authority and responsibility from central government ministries to organizations not directly under the control of those ministries, for example, non-governmental organizations, and/or autonomous region/state and township governments. In Myanmar, devolution should be sought rather than deconcentration or delegation.

Developing Public-Private Partnerships (PPP) and "contractual arrangements"

- The private sector constitutes a large sector of visits and service utilization, particularly for the wealthiest quintiles. To better engage private sector in service delivery is a key priority in Côte d'Ivoire.
- Increasing Anti-Retroviral Therapy (ART) coverage and ensuring access to HIV services in a sustainable way largely depends on the private for-profit health sector[52]. Throughout SSA, Governments have established public-private partnerships or subcontracting relationships for referrals in ways that have maximized the contributions of public and private entities involved in the HIV response.
- In Côte d'Ivoire, approximately half of the facilities are for-profit, making the private sector a key partner to the country's HIV response. The Governments needs to take advantage of the opportunities that the private sector offers, e.g. innovations for health care delivery, networks for extending service coverage and access to medicines and other medical commodities and financial protection. Developing new PPPs in order to improve access and quality of care should thus be prioritised, in particular based upon the experience the country already has in public private partnerships in other field, for instance water[53].

[52] Private Health Sector Composition: The non-profit sector consists of: Faith-based organizations; Charities; NGOs; Community-based organizations The for-profit sector consists of a wide range of
commercial entities, including: Medical facilities; Pharmacies and pharmaceutical wholesalers; Laboratories; Consultation and ambulatory care centers

[53] The PPP for the national water utility of Côte d'Ivoire is the oldest and largest water PPP in LMICs. In place since 1960 and today serving more than 7 million people, this PPP has provided quality service for decades and made remarkable progress in expanding access in the 1990s. It even proved resilient to civil strife and the *de facto* partition of the country in 2002. This African success story shows that a pragmatic partnership between a committed government and an efficient private operator can produce tangible and sustained benefits for the population.