

**PROJECT INFORMATION DOCUMENT (PID)
APPRAISAL STAGE**

Report No.: PIDA14766

Project Name	Health Systems Strengthening and Ebola Preparedness Project (P147740)
Region	AFRICA
Country	Cote d'Ivoire
Sector(s)	Health (100%)
Theme(s)	Health system performance (30%), Population and reproductive health (25%), Child health (25%), Nutrition and food security (20%)
Lending Instrument	Investment Project Financing
Project ID	P147740
Borrower(s)	Government of Côte d'Ivoire
Implementing Agency	Ministry of Public Health
Environmental Category	B-Partial Assessment
Date PID Prepared/Updated	22-Oct-2014
Date PID Approved/Disclosed	23-Oct-2014
Estimated Date of Appraisal Completion	20-Oct-2014
Estimated Date of Board Approval	25-Nov-2014
Decision	

I. Project Context

Country Context

A. Country Context

1. After almost two decades of strong economic growth, Cote d'Ivoire's economy experienced a series of economic and political crises (2002 – 2007, 2010 - 2011) which culminated in a short war following the 2011 elections. The successive crises resulted in widespread deterioration of living standards. Economic growth was among the lowest in Sub-Saharan Africa (SSA) (on average -1.6% between 1999 and 2003; 1.3% between 2004 and 2008, and -0.8% from 2009 to 2011), and per capita Gross Domestic Product (GDP), fell to 1960's levels. Since mid-2011, stability has been restored and economic growth has resumed with GDP growth of 9.8% in 2012, and a government estimate of 8.7% in 2013. Continued strong economic growth is expected in the coming years as a result of: (i) recovery in key agricultural sectors; (ii) improved fiscal performance; and, (iii) debt sustainability achieved following Heavily Indebted Poor Countries (HIPC) completion point.

2. Cote d'Ivoire's economic development has been built on agriculture, but it is also emerging

as an oil-rich country. Agriculture accounts for 22% of GDP, over three quarters of non-oil exports, and provides incomes for two thirds of all households. The sector, especially cashew, cotton, rubber and oil palm, has an enormous potential for growth. Since 2002, however, crude oil production has quadrupled, and the value of petroleum products dramatically increased; the value of exports reached US\$900 million in 2010.

3. Despite economic growth, poverty remains high, and some instability remains. Since the 1980's, and following successive economic shocks and political instability, poverty has continued to increase. In 2008, about 49% of the population was classified as poor compared to 10% in 1984. A large proportion of the population lives in high vulnerability without any social protection. According to the 2013 UNDP Human Development Report, the incidence of poverty declined marginally between 2008 and 2011, but the depth increased and the incidence increased in a number of regions, including the North, Center North, and North East. The Human Development Index (HDI) showed Cote d'Ivoire ranked 168th out of 186 countries, with a value of 0.432; well below the average of 0.475 for countries in SSA. In addition, despite significant improvements since the end of the last crisis in 2011, the country's social and political situation remains somewhat fragile. National elections, which are scheduled for 2015, will be the true test of the extent to which fragility has been reduced.

4. In recent months, the Ebola outbreak in neighboring Liberia, Guinea and Sierra Leone have been of great concern, especially since there is over 800 miles of border between Cote d'Ivoire and both Guinea and Liberia, and since the epicenter of the epidemic is in the eastern part of these countries (i.e. near Cote d'Ivoire's western border). The Government of Cote d'Ivoire (GCI) has taken steps to guard against Ebola entering the country, such as closing the border and cancelling direct flights with the neighboring countries. Concerns, however, remain, over the country's level of preparedness to respond effectively to an Ebola Virus Disease (EVD) Outbreak.

B. Situations of Urgent Need of Assistance or Capacity Constraints

5. Political and social crises have taken a heavy toll on the health system. In the first phase of the crisis (2002-2010), most of the health centers were closed in the central and northern part of the country (over 52% of health centers nationally), and only Non-Governmental Organization (NGO) facilities remained open. During the post electoral crisis (2011-2012), all health centers in the western part of the country and in the city of Abidjan (the communes of Yopougon and Abobo) were closed. Nationwide many hospitals and health centers were looted and remain in dire shape.

6. Governance and management of the health system is also problematic. The central level lacks effective control mechanisms and strategic planning capability, with overlap between different parts of the Ministry of Health and the Fight against AIDS (MSLS). Despite the generally high competence of managers, technical capabilities were greatly blunted during the civil war period. At the sub-national level, Cote d'Ivoire is one of the last countries in SSA to develop a district model. In part due to the various crises, this process is incomplete, with a large number of districts still not operational. Effective control and management of the health system is hampered by two key factors. Firstly, the quality and timeliness of the information system, which suffered greatly during the civil war, and has been further hampered by the delay in the decentralization, is weak. Second, funding is highly centralized, with the central administrative budget (including salaries and utilities for all public structures), comprising about half of total MSLS expenditures. A further quarter or more of the budget goes to tertiary care and one-tenth to public health, leaving

less than 5% each for secondary and primary care.

7. Government expenditures in the health sector have consistently been less than half of the Abuja target. At 6.8%, the Government of Cote d'Ivoire's health expenditure is on par with Guinea, and is the lowest in West Africa. As a percent of GDP, Cote d'Ivoire (1.8%) ranks the third lowest, just above Guinea-Bissau and Guinea (1.7% and 1.6% respectively). Finally, public expenditure on health as a percent of total health expenditure is just 26.6%. This is the lowest in West Africa, and fall far-behind the SSA average of 45.1%. These indicators show that to date, health has not been a high government priority in terms of funding.

8. Barriers to health service utilization can be grouped into four key factors: access, affordability, availability, and acceptability. Access issues include where health facilities are located, and whether health services are delivered in the community. In Cote d'Ivoire, less than 45% of the population lives within 5 km of a health center, with a large share of the poor not having access to a health center (12%) or to a general hospital (26%) in 2008. The 2012 DHS indicated that 60% of women in the poorest quintile mentioned distance to health services as a major barrier to maternity care, compared to 25% for women in the wealthiest quintile. Issues of access are currently being partially addressed by the President's Emergency Fund (PPU) and through development partners via interventions such as the World Bank's Emergency Infrastructure Project, although these facilities are missing funds for necessary equipment.

9. Affordability clearly poses a key barrier to the use of services. According to the 2012 DHS, 91% of women in the wealthiest quintile delivered with skilled health personnel, compared to 35% of women in the poorest quintile. Similarly, almost 75% of women in the poorest quintile indicated that a lack of money was a major barrier to maternity care, compared to 55% of women in the wealthiest quintile.

10. Affordability is currently being addressed through initiatives such as "Targeted Free Services" and the proposed "Couverture Maladie Universelle" (CMU) program, which aims to improve pre-paid health insurance coverage (see Annex 6 for details of the health insurance landscape). In April 2011, the Government of Cote d'Ivoire (RCI) declared that health care would be provided free of charge in all public facilities as a means of mitigating the consequences of the post-election crisis. This declaration was revised in February 2012, with free care targeted to pregnant women, children aged 0-5 years, emergency care and malaria. Despite this targeted free health care initiative (TFHCI), the cost is high since a large proportion of the patients in public facilities are covered.

11. Despite an increase in the use of public health services, many problems persist, and hinder the successful implementation of the TFHCI. Challenges include: (a) only 1-5% of first level health facilities, and about 25% of health facilities in the second and third levels are reimbursed for free health care services; (b) all facilities are not reimbursed at the same level, with some receiving 15% and others 80%, and repayment favoring tertiary facilities and in so doing, discouraging primary care facilities; (c) reimbursement is based on the invoices submitted and there is no pre-payment verification, creating opportunities for over-billing; (d) no or inadequate repayment and a lack of monitoring, result in disruptions in the flow of inputs to health facilities, thereby effectively limiting utilization, as the patient is obliged to fill and pay for prescriptions, for example, in order to take advantage of "free care"; and, (e) an increase in the workload, arising from increased utilization, coupled with a decline in revenue, tends to demotivate staff. These challenges, together

with the annual free health care costs of nearly 50 billion CFA francs (\$100 million or \$5 per capita), suggest that results-based financing (RBF) approaches, including performance-based financing (PBF) may be more cost-effective. A PBF approach operates through decentralizing health financing to front-line providers. As such, it can remedy a large source of health system inefficiency, that is, an extremely limited share of financial flows to operational costs (less than a 15% in Cote d'Ivoire).

12. Availability constraints exist on both the supply and the demand sides. Supply side issues include staffing, equipment, and drugs and medical supplies, while demand side issues relate to constraints that might hinder patient utilization of available health services. These constraints could factors such as whether the patient is able to get to the facility, whether drugs are available once a patient arrives, and whether the staff is perceived by the patient to have the technical capacity and/or the motivation of staff to provide high quality services.

13. Acceptability includes the attitude of providers (supply side) and the perceived value or quality of services from the perspective of the patient (demand side). While quality is objectively measurable, and clearly has an impact on the "real" availability of services (services of low quality may be provided but have no therapeutic value), perceived quality also has an impact on patient demand and acceptability. In this regard, many countries have found that RBF can have a positive impact on both the availability and acceptability of services, including both the quality and quantity of services delivered.

14. The government has developed a National Health Policy, which is accompanied by a National Health Development Plan (PNDS) covering the 4-year period, 2012-2015. Its main goal is to guarantee access to quality health care for all citizens, especially the most vulnerable.

15. There are many donors active in Cote d'Ivoire, with existing programs in various areas. These programs have a heavy emphasis on human resources development (training and capacity building); supply chain development and provision of drugs and medical supplies; reproductive, maternal, newborn and child health (RMNCH); nutrition, and HIV/AIDS, TB and malaria. Most of these programs focus on providing inputs. There are also several Bank-financed interventions outside the health sector per se which have also informed the selection of project interventions. For example, the Emergency Infrastructure project has already been mentioned, where renovations have been done but essential equipment is still needed. Another important intervention under development is the Social Safety Net Project, which will provide cash transfers to poor households in rural areas and provide both regular payments and encourage regular health check-ups, proper nutrition and school attendance for children. The program will include measures to sensitize households about the importance of sending children to school, registering children in the civil registry, completing vaccination schedules, and ensuring proper nutrition especially in the first 1,000 days of child's life. The project will assist in designing and developing the operational building blocks that are essential to coordinate safety net programs and increase their effectiveness through a systemic approach, with a view to establishing a long-term effective and sustainable (institutionally, politically and financially) system of safety nets anchored in the national social protection strategy.

16. The implementation of CMU will require linkages to other parts of government outside of the health system, especially the Ministry of Social Affairs and Employment, with regard to targeting the poor and indigent in terms of premium subsidies. The proposed project activities

would therefore be closely aligned with similar projects in the social protection area. The ability to share information between the health, social affairs and the CMU systems will be critical. This will therefore be an essential element of the HMIS activities.

17. The support to CMU will help to address issues of affordability, since the services covered under the CMU will be free at the point of use. Challenges in physical access, that is, distance from a health facility will be addressed through community-based elements of the proposed PBF intervention. Specifically, this will involve bringing selected services directly to the community, thereby enhancing the overall level of physical access and utilization of health services. In the area of availability, the infrastructure investments proposed for the project should improve the ability of selected health centers and hospitals to provide high quality services.

18. Through the incentives inherent in a PBF approach, both the availability and the acceptability of services should be enhanced, since health facility staff will have incentives (and by extension, improved motivation) to provide high quality care and encourage patients to return. This will be particularly important in further supporting the implementation of the “Targeted Free Health Care” initiative, which is currently acknowledged as having operational issues in terms of the provision of services. In addition, the clear guidelines that will be established in paying for services incentivized through PBF, as well as the focus on “Targeted Free Health Care” services, should improve the overall affordability of services.

Sectoral and institutional Context

C. Sectoral and Institutional Context

19. Given its income level, health indicators in Cote d’Ivoire are amongst the weakest in the region, and the country is unlikely to reach most of the Millennium Development Goals (MDGs). With around the same Gross National Income (GNI) per capita, Senegal has a much lower under-5 mortality rate; Benin, Togo, Mauritania and the Gambia, have equivalent or lower child mortality with lower GNI per capita.

20. The maternal mortality ratio, for example, has increased from 543 deaths per 100,000 births in 2005 to 614 in 2012. Approximately 80% of maternal mortality is due to direct medical causes, such as hemorrhage, obstructed labor, high blood pressure, and abortion complications; reflecting a lack of coverage and inadequate obstetric care in the prevention and management of complications during pregnancy, childbirth and postpartum. Under-5 mortality is also still high at 108 deaths per 1,000 live births; down just 14% from 2005. An estimated 60% of these deaths are due to communicable diseases and perinatal causes, and the use of anti-malarial drugs has remained around 20%, again suggesting issues with regard to the availability, use and quality of basic health services. Basic immunization rates have declined—for example, measles immunization decreased from 66% in 1999 to 65%—and recent years have seen outbreaks of several communicable diseases such as polio and cholera. Finally, adult HIV prevalence among 15 – 49 year olds is 3.7%, including 4.6% for females and 2.9% for males, one of the highest in West Africa.

21. Notwithstanding ongoing challenges, there has been some improvement across a number of health indicators since the 1990s, although progress is skewed towards urban populations. Skilled birth attendance, for example, has increased from 47% in 1994 to 59% in 2012; there are, however, significant geographic disparities (27% in the North-West region, versus 92% in Abidjan). In 2012,

44% of women (33% in rural areas and 61% in urban areas) had at least four antenatal visits compared to 36% in 1999. Use of long-lasting insecticide treated bed nets in 2012 was estimated to be 37% for children under-5 and 40% for pregnant women (DHS 2012), with higher use in the north and lower use in the south and in Abidjan. This compares to 28% and 14% for children under-5 and pregnant women respectively in 2009. Despite these improvements, bed-net use is still well below other countries in SSA.

22. Rates of child malnutrition have declined somewhat, from 34% chronic and 16% severe in 2006 to 30% chronic and 12% severe in 2012, while Vitamin A supplementation has increased from 55% in 2006 to 61% in 2012. Only 12% of women exclusively breastfeed until 6 months, suggesting that there may be quality issues in ante-natal, maternity and post-natal care.

23. As with most of SSA countries, Cote d'Ivoire has a rapidly growing and young population. According to the National Institute of Statistics, the annual growth rate was estimated to be 2.6% per year in 2013, down from 3.1% in 2009, but still one of the highest in the world. This is due to the combined effects of lower mortality, high fertility (5.0 children per woman on average, with fertility rates reaching 6.8 in the North-West and just 3.1 in Abidjan – DHS 2012) and high levels of international migration.

24. The contraceptive prevalence remains very low, with the 2012 DHS showing that only 14% of women use modern methods (up from 8% in 2006). With about half of all women of childbearing age, it is likely that the population will continue to grow, and remain young in the coming decades. This growth, allied with rapid urbanization, will put significant pressure on basic social infrastructure.

25. The health system in Cote d'Ivoire was modelled on the French system, with heavy reliance on physicians and secondary and tertiary care institutions. There is a relative abundance of doctors, especially in urban areas, but generally fewer nurses and midwives country-wide, with the greatest shortages occurring in the rural areas and in the north.

26. The 2010 Country Status Report (CSR) shows that in 2008, the number of physicians per 10,000 population ranged from 1.31 to 0.3 depending on the region, with a dispersion of 4.28:1 between the highest and lowest density regions. In 2010, the overall level for Cote d'Ivoire was 1.44 physicians per 10,000 population, which was the highest in West Africa. Moreover, the ratio of nurses and midwives per physician was the lowest, at 3.4:1, compared to 5.2:1 for the next lowest group of countries (Mauritania, Togo and Mali), around 7:1 for Senegal, Niger and Sierra Leone, and over 12:1 in Benin, Ghana, and Burkina Faso. Looking ahead, it would be wise to train fewer doctors and use the funds to increase the training of paramedical personnel instead. It would also be important to develop and implement strategies to attract and retain staff in rural or difficult areas. The performance of staff could be improved with a combination of real decentralization of the health system (including HRH management) and the implementation of a payment scheme based on the achievement of results, as other countries have done successfully and as is currently being piloted by other donors.

27. Unlike other countries in West Africa, Cote d'Ivoire does not currently use community health workers or other lower-level clinical staff, increasing the over-reliance on physicians and nurses. In terms of competence, a 2010 study showed that the health worker training does not prepare them for the realities on the ground in terms of care and treatment because training

institutions offer a range of materials, equipment, and drugs that are not found in the vast majority of health facilities. This results in a mismatch between the competence of health workers, and their capacity to perform.

28. RCI has made a decision to move towards PBF in - as noted in the PNDS, and the SNFBP which was finalized in April 2014. This decision is based on: (a) the encouraging results obtained by two pilot projects lead by Abt Associates and the Elizabeth Glaser Pediatric AIDS foundation (EGPAF); and (b) the experiences of a number of countries including Benin, Burundi, Rwanda, and Senegal. The results of these pilots, and global experience – both in SSA and elsewhere- show that PBF has the potential to: (1) improve utilization and quality of health services; (2) stabilize or reduce the costs of these services; (3) promote the efficient use of scarce resources; and, (4) improve staff motivation.

29. With regard to Ebola, there is a clear link between an effective response to an EVD outbreak and an effective and well-functioning health system. As of October 12, 2014, there were almost 9,000 Ebola cases, of which 4,492 or 50% have died. More disconcerting is the fact that the number of cases has increased sharply in recent weeks, with an increase 68% in the number of cases and 71% in the number of deaths in less than a month. The World Health Organization (WHO) has estimated up to 20,000 cases before the epidemic is brought under control. Faced with this situation, the GCI has asked the international community to assist in efforts to increase the country's overall level of preparedness.

D. Higher Level Objectives to which the Project Contributes

30. The proposed project is completely aligned with the PNDS, and will support two of the four pillars of the current Country Partnership Strategy (CPS), namely: (1) Strengthening governance and institutions; and (4) Renewing infrastructure and basic services. By improving utilization of high quality health services, through PBF, the project will promote “continued progress in crisis recovery and improved prospects for sustained peace”, while both the PBF and CMU components will contribute to “More efficient and transparent management of public financial resources”. The support for essential medical equipment will contribute to ensuring that “essential basic infrastructure is rehabilitated, expanded or upgraded”, while both the PBF and CMU activities will promote “improved basic social services”, especially for the poor and vulnerable, with due regard to both the quantity and the quality of the services provided.

31. The project will also contribute directly to the Bank's twin goals of eliminating extreme poverty reduction, and promoting shared prosperity. Specifically, the project will focus on increasing the access to essential services, especially by the poorest groups in the population, and improving the level of financial health protection for these groups. This is also consistent with the focus of the HNP global practice, which emphasizes the provision of services to the poorest segment of the population and increase financial protection for the poor. The RBF component will track the utilization of the poor relative to the general population, and the CMU component will focus on ensuring that the poor are adequately identified and enrolled in the UHC scheme, which should contribute towards both poverty reduction and shared prosperity.

II. Proposed Development Objectives

To strengthen the health system and improve the utilization and quality of health and nutrition services in selected regions.

III. Project Description

Component Name

Results-based Financing

Comments (optional)

This component aims to increase the volume and quality of health services, with a specific focus on maternal and child health and nutrition interventions, through PBF in selected regions.

Performance-based incentives will be used to support: (a) increased utilization of targeted services; (b) improved clinical practice and health worker motivation; (c) structural improvements; 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; and, (ii) financial and non-financial incentives for health workers according to defined criteria. Performance based incentives will be additional to existing financing at target facilities.

Component Name

Health System Strengthening

Comments (optional)

This component will finance areas that are critical to the effective operation of the health system generally, and RBF in particular: (i) improved health insurance coverage; (ii) essential infrastructure and rehabilitation, including rehabilitation of selected health centers and the bulk purchase of essential equipment; (iii) Health Management Information Systems; (iv) improvements in health system management, including support to hospital reform and the development of a strategy for community health; (v) Ebola preparedness, using UNICEF to rapidly provide essential equipment, supplies, drugs and vehicles that are essential in ensuring that the country is prepared for a potential Ebola outbreak in Cote d'Ivoire; and (vi) Project Management.

IV. Financing (in USD Million)

Total Project Cost:	75.00	Total Bank Financing:	70.00
Financing Gap:	0.00		
For Loans/Credits/Others			Amount
BORROWER/RECIPIENT			5.00
International Development Association (IDA)			70.00
Total			75.00

V. Implementation

Institutional and Implementation Arrangements

32. The MSLS has a long track record in implementing Bank-financed projects, with the most recent project closing in 2012. As noted above, a PIU will be established for the project, as is common practice in the country, and the staff of the PIU will be recruited with the necessary qualifications to ensure appropriate fiduciary control and project management. The deputy director of the Minister's Cabinet was assigned the lead role during project preparation, and will continue to serve in this capacity during project implementation, supported by key personnel from the major departments affected by the project (Policy and Planning; Infrastructure, Equipment and Maintenance; Information, Planning and Evaluation). Two steering committees have been constituted, one for the Bank-financed project, and one to guide the overall development of PBF in Cote d'Ivoire. These two committees will work closely together to ensure that PBF activities

remain consistent with the National PBF Strategy. The Project Steering Committee will have overall responsibility for project implementation, and will be supported by the PIU.

33. To support the PBF Steering Committee, as well as to coordinate and provide technical leadership for PBF activities, the MSLS has established a National Technical Unit (CT-PBF). The CT-PBF will be responsible for: (i) preparing PBF Steering Committee meetings and supporting implementation of the decisions made by the PBF Steering Committee; (ii) supporting the regulatory function of the Ministry in the implementation of PBF; (iii) monitoring the progress of PBF implementation in the field, and promoting ownership of PBF by the Ministry; and (iv) exploring ways and mechanisms to both institutionalize PBF as a national policy in Cote d'Ivoire, and progressively expand the PBF approach.

34. The PIU will include a project coordinator, fiduciary staff and MSLS-appointed technical staff and be responsible for managing non-PBF activities of the project, and working with the CT-PBF on the implementation of the PBF activities.

VI. Safeguard Policies (including public consultation)

Safeguard Policies Triggered by the Project	Yes	No
Environmental Assessment OP/BP 4.01	x	
Natural Habitats OP/BP 4.04		x
Forests OP/BP 4.36		x
Pest Management OP 4.09		x
Physical Cultural Resources OP/BP 4.11		x
Indigenous Peoples OP/BP 4.10		x
Involuntary Resettlement OP/BP 4.12		x
Safety of Dams OP/BP 4.37		x
Projects on International Waterways OP/BP 7.50		x
Projects in Disputed Areas OP/BP 7.60		x

Comments (optional)

Since Cote d'Ivoire is classified as a fragile state, per OP10.00 para. 11, the completion of the safeguards instruments will be deferred to project implementation, subject to approval by the Regional Vice-President.

VII. Contact point

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