Public Disclosure Authorized

Public Disclosure Authorized

Project Information Document/ Integrated Safeguards Data Sheet (PID/ISDS)

Concept Stage | Date Prepared/Updated: 10-Jul-2018 | Report No: PIDISDSC25099

BASIC INFORMATION

A. Basic Project Data

Country	Project ID	Parent Project ID (if any)	Project Name
Cote d'Ivoire	P167959		Strategic Purchasing and Alignment of Resources & Knowledge in Health Project (SPARK) (P167959)
Region	**Estimated Appraisal Date**	**Estimated Board Date**	**Practice Area (Lead)**
AFRICA	Sep 10, 2018	Feb 21, 2019	Health, Nutrition & Population
Financing Instrument	**Borrower(s)**	**Implementing Agency**	
Investment Project Financing	Government of Côte d'Ivoire	Ministere de la Sante et de l'Hygiene Publique (MSHP)	

Proposed Development Objective(s)

The PrPDO is to reduce Maternal Mortality by one-half and Infant Mortality by one-third over the next decade

PROJECT FINANCING DATA (US$, Millions)

SUMMARY

Total Project Cost	125.00
Total Financing	125.00
of which IBRD/IDA	100.00
Financing Gap	0.00

DETAILS

World Bank Group Financing

International Development Association (IDA)	100.00
IDA Credit	100.00

Non-World Bank Group Financing

Trust Funds	25.00

Global Financing Facility	25.00

Environmental Assessment Category	Concept Review Decision
B - Partial Assessment	Track II-The review did authorize the preparation to continue

Other Decision (as needed)

B. Introduction and Context

Country Context

1. **With a population of around 23.3 million in 2016, Cote d'Ivoire has about sixty ethnic groups and nearly seventy languages.** The country has a young population with a large number of dependents: one Ivorian out of two is under 20 years old and nearly two out of three Ivorians are under 25; women of childbearing age represent 24% of the population, compared to 16% for children under 5 years of age. The non-national population is estimated at around 25% of the total. Independent since August 1960, Côte d'Ivoire experienced a long period of instability between 2002 and 2011, marked by two civil wars respectively in 2002-2007 and 2010-11, which not only cost the lives of thousands of people but considerably slowed down the country's economic development. In 2011, GDP shrank to 4%.

2. **Côte d'Ivoire (CIV) is a lower-middle income country (LMIC)** with a GNI per capita of US$1,520 in 2016[1] and is the second largest economy in West Africa. After 10 years of economic stagnation accompanying civil unrest, economic growth picked up in 2011 and GDP has increased at more than 7% annually since. Since 2012, the country ranks among the top ten countries with the highest growth rate in the world (average estimated at 9.4% over the period 2012-2015). Inflation has also been lower than the regional average at 1% 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 IMF predicting growth at similar rates until 2020,[2] and continued low inflation.

3. **However, economic benefits remain concentrated in Abidjan and the benefits of development are poorly shared.** The proportion of the population living below the national poverty line was 46.3% in 2015 and 56.8% in rural areas. The Human Development Index (HDI) ranks the country 171st out of 187 countries. The literacy rate of people over 15 is estimated at 45%, including 53% for men and 36% for women. Côte d'Ivoire is among the 35 countries described as "fragile" by the World Bank in 2016. An acceleration of structural reforms is needed, in order to support GDP growth,

[1] WBG https://data.worldbank.org/country/cote-divoire, Atlas method, current US dollars.
[2] http://www.imf.org/en/Countries/ResRep/CIV#news

improve the living conditions of vulnerable populations and enable the transition of the Ivorian economy towards a more dynamic and wealth-creating economy.

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

5. **With strong economic growth, CIV's capacity to increase government spending, including on health, over time, is good.** Likely conditionalities linked to continued IMF support that imply a small reduction in the ratio of government debt to GDP will still allow the dollar value of government spending to increase as long as growth forecasts hold. However, tax revenue, at 15.3% of GDP in 2016, remains low and has shown only modest increases in the last 5 years. This will mean that Cote d'Ivoire may need to look at innovative ways to increase fiscal space for health, for example taxing natural resources instead of taxing labor in a narrow tax base environment[3]. If the efforts to increase government revenues as a share of GDP are successful, this will also provide more capacity to spend. The counter-balance is that continued structural reforms designed to improve efficiency are required and cocoa prices remain relatively low.

Sectoral and Institutional Context

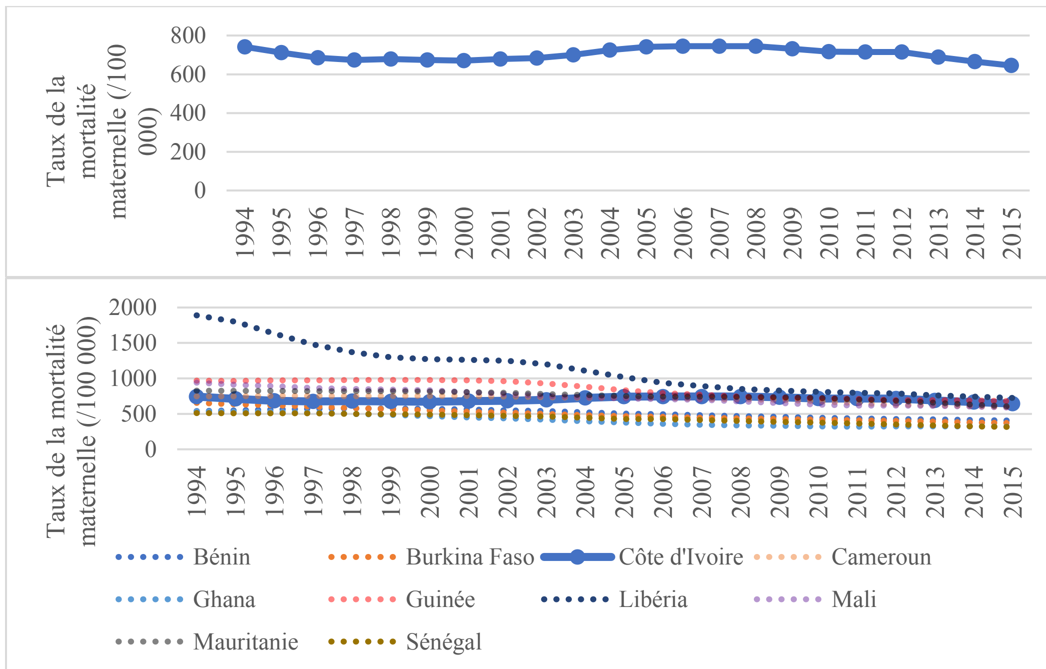
Health Status

6. **Given its income level, health and nutrition indicators in Côte d'Ivoire are among the lowest in the region and globally.** The events of 2002-2011 affected the health sector significantly and, despite relative stability and strong economic growth since 2012, the recovery in the health sector has been slow. The maternal mortality rate is among the lowest in the world compared to the country's level of development. Children continue to die for reasons that can be avoided. One of the causes identified is the lack of infrastructure and human resources to meet the growing needs of the population; the fact that resources are concentrated in the city of Abidjan and the big cities of the country; the focus of the budget on the tertiary level which treats a small proportion of the population; lack of access to certain geographical areas and funding; limited ownership and participation of beneficiary communities; as well as limited collaboration with the private sector.

7. **The maternal mortality ratio is 645 deaths per 100,000 live births** (Figure 1). The main causes of maternal mortality are hemorrhage (25%); hypertension (16%); sepsis (10%); and abortion (10%). Those of under-five mortality are malaria (25%); pneumonia (15%); diarrhea (9%); premature births (13%); and asphyxiation (10%). 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

Figure 1 – Maternal Mortality in Cote d'Ivoire and Francophone West Africa

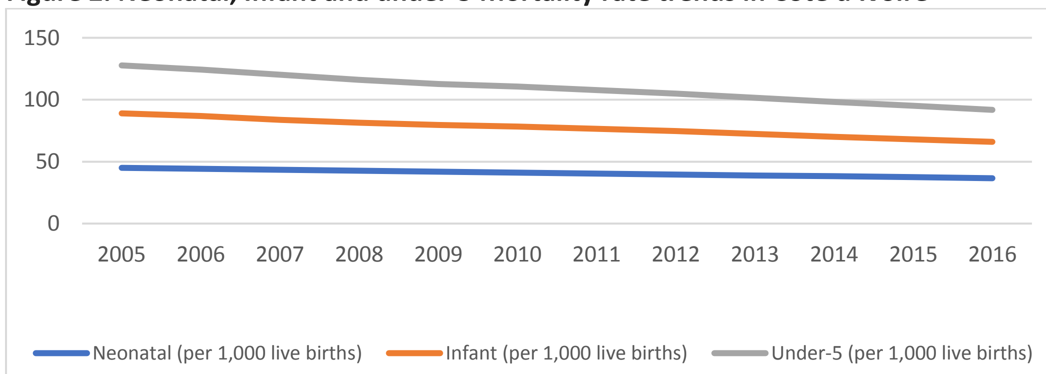
[3] A recent study by the World Bank assessed options for increasing fiscal space for funding Social Health Insurance



Source : WDI, 2017

8. **The infant mortality rate is 60 and the neonatal mortality rate is 33 per 1,000 live births[4].** The under-five mortality rate is 96 deaths per 1,000 live births. These three measures represent declines of 26%, 19%, and 28% from 2005 respectively (figure 2). 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 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.

Figure 2. Neonatal, Infant and under-5 Mortality rate trends in Cote d'Ivoire



9. **Accessibility poses a major barrier to service utilization:** in the richest quintile, 91% of women give birth with the assistance of qualified health personnel, compared to 35% of women in the poorest quintile. Seventy-five percent (75%)

[4] MICS 2016

of women in the poorest quintile indicated that lack of money was a major impediment to maternity care, compared to 55% of women in the richest quintile[5].

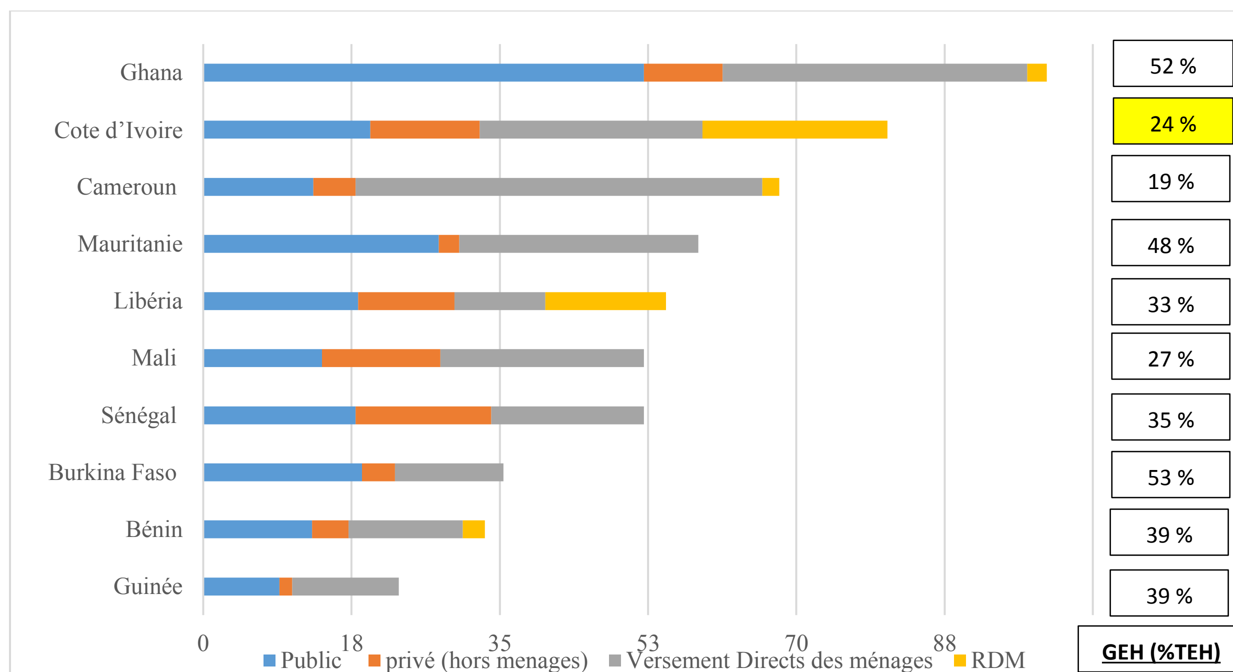
10. **Overall, country averages mask large regional disparities,** with significantly worse indicators in the northern and western regions of the country. Regional disparities in child mortality are virtually the same regardless of target, with all three measures higher in the northern, western and central parts of the country. Child mortality is also higher in rural than in urban areas. The gap in mortality rates between rural and urban areas increases as the child's age increases. Thus, at the neonatal level, this difference is 5 points to the detriment of the rural environment, 16 points at infant, and 25 points for the under-5s.

Health Financing

11. **Current health expenditure per capita has not increased substantially in US dollar terms since 2008,** generally somewhere above $70 per capita.[6] In 2015, the latest year for which data are available, it fell from $79 to 75$ in US dollar terms, partly because of a depreciation in the local currency. Government expenditures to health (GEH) remained low at around 24% of the total and out of pocket payments (OOPs) exceeded 50% of all health expenditures until 2014. While there was an apparent fall in 2015 to 36% (figure 3), this is an artefact of the increase in total expenditures in health (THE) due to a sharp increase in the share of external expenditure (DAH) in total recurrent health expenditures, which increased from 9% in 2013, to 19% in 2014, to 26% in 2015. There is no evidence that current external partners to health are reducing their contributions, and new partners are entering the country but there is evidence of a rapid decline in the proportion of DAH that is on-budget. The poor outcomes relative to high total spending also indicate significant inefficiencies in the system, with recent WHO study estimating potential efficiency gains of up to 51% in the health sector.

[5] DHS 2012
[6] Most of the data in this section are taken from WHO's Global Health Expenditure Database http://apps.who.int/nha/database/ViewData/Indicators/en

Figure 3 – Health expenditure in Cote d'Ivoire Select West African Countries (2015)



Source : WHO CNS, 2015

12. **The health share of total government spending, at around 5%, is one of the lowest in Sub-Saharan Africa** (table 1)**.** While the share of Government expenditure GGE domestic (GGEd) in GDP is also low by the standards of LMICs, the extremely low priority given to health in the national budget reflects, in part, a perceived inefficiency of current spending in the sector. 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 SDG – over $80 per capita annually.

Table 1. Total and Domestic government spending Cote d'Ivoire (2015)

Variable	TOTAL	DOMESTIC – NET OF EXTERNAL*
GGE/GDP 2015	22.8%	20.7%
GGE/capita constant 2015 US$, 2018	$370.11	$335.46
Government health/total government 2015	13.4%	5.0%
Recurrent government health expenditure per capita 2018	$22.20	$16.89

*on budget external is removed from both numerator and denominator

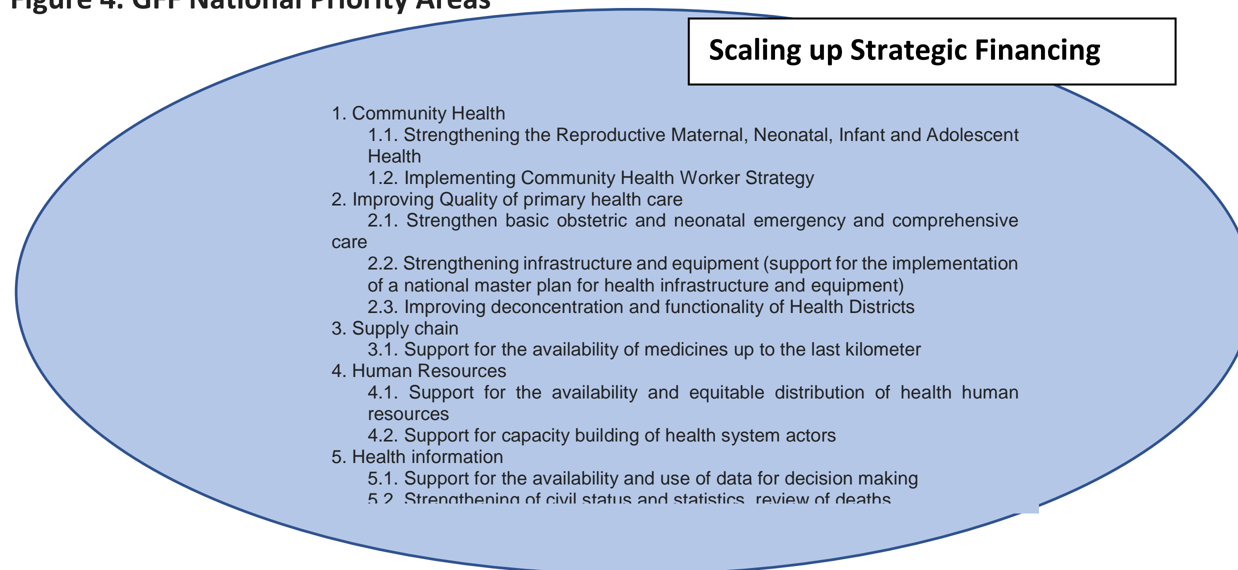
13. **The government has launched the Social Health Insurance Scheme (*Couverture Medicale Universelle*, CMU)** in 2011 which aims to improve pre-paid health insurance coverage. A Health Insurance Agency (CNAM) has been set up that will gradually take on the role as purchaser of an essential package of services, starting with the formal sector and the poor. The World Bank is supporting this process (see below) through targeted technical assistance (TA), identification of the poor through proxy means testing, and planned piloting of the CMU in 3 Performance Based Financing (PBF) districts.

Relevant Sectoral & Multisectoral Initiatives & Engagements

14. **The Global Financing Facility in support of Every Woman Every Child (GFF) Trust Fund will provide a grant to the government in Côte d'Ivoire between US$ 15-25 million, linked to the future IDA project (the MPA under proposal).** Cote d'Ivoire joined the GFF In November 2017, which will additionally provide funding for the preparatory work and technical assistance required to identify priorities and bring partners together. Beyond direct funding, the GFF aims to mobilize additional resources from partners, the private sector, and at national level, for a concerted effort towards the achievement of the health-related SDGs. A platform is in the process of actualization, six priority areas have been identified under the overall priority reform of scaling up strategic financing (figure 4). A roadmap is being finalized and the investment case written, with a target date of November 2018.

15. **Cote d'Ivoire is one of 4 pilot countries globally for the 4G initiative**, which formalizes intensified collaboration on sustainable financing collaboration between the World Bank, The Global Fund, GAVI, and the GFF. In the medium term, the 4G will develop joint work plans that aim to support national health policies, strategies, plans, and UHC roadmaps. This includes exploring opportunities for co-financing beyond technical assistance, for example through loans\ buy-down, or the results-based financing platforms that exist in several of the proposed countries and coordinating communication and advocacy efforts to promote a shared vision of the health sector.

Figure 4. GFF National Priority Areas



16. **The Health Systems Strengthening and Pandemic Preparedness project** (PRSSE, P147740) currently pilots a PBF approach in 17 (out of 82) districts, covering ~5 million people (1/5 of the population), with Global Fund (GF) parallel financing. The project is a standard investment project financing (IPF) credit, with a total cost of US$77 million. This includes US$70 million IDA Financing (Credit of US$35 million and Grant of US$35 million), US$3 million GF and US$7 million in Government contributions. PRSSE addresses several constraints in the sector on different levels and supports increased access to quality health care for all citizens, especially the most vulnerable through: (i) provision of technical assistance to develop and help with the implementation of the CMU; (ii) piloting of PBF as an approach to increase the volume and quality of services provided to the population, with a specific focus on improving the effectiveness of "Targeted Free Care" (*gratuité ciblé*) and other RMNCH interventions, and specifically addressing linkage to CMU; (iii) rehabilitating and providing

equipment for rehabilitated 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.

17. **The Ministry of Health has requested the World Bank's support to scale up of PBF nationally and to it integrate into the national provider payment system.** This builds upon based on the success of the PBF methodology, as evidenced by quantitative and qualitative analysis in recent MTR showing improved quality, improved utilization of key services, improved health worker and patient satisfaction, and improved quality of routine reporting data.

18. **Other World Bank projects include:** Multisectoral Nutrition and Child Development (HNP, $US 60.4 million) (2018-23); Enhancing Government Effectiveness for Improved Public Services P4R (GOV, $US 100 million, pipeline); Productive Social Safety Nets (SPL, $US 150 million); Sahel Women's Empowerment and Demographic Dividend (HNP, regional, $US 172 million, of which $30 million for CIV); West Africa Regional ID4D MPA (SPL, Regional, $US 90 Million, pipeline); Regional Disease Surveillance Systems Enhancement (HNP, $40 million, distant pipeline); Pandemic Emergency Facility (HNP, CERC in proposed MPA).

19. **Several high-quality ASAs are setting the stage for the proposed MPA**, including a health sector Public Expenditure Review (PER); a Health Financing Systems Assessment (HFSA) with Vaccine and HIV transition and PFM deep dives; and a regional piece on Covering the Informal Sector in Francophone West Africa. Further studies financed through the PRSSE include costing of CMU; a study on population capacity to pay for health insurance premiums; a study on cost of service provision in public and private facilities; infrastructure and equipment needs of all facilities in 25 districts; health human resources training and distribution assessment; and a fiscal space for UHC analysis.

Relationship to CPF

20. **The proposed MPA is strongly linked to country priorities, as outlined in the CPF** including (1) Accelerating Economic Growth, with focus on Private Sector; (2) Strengthening Human Development toward economic development and social cohesion and (3) Strengthening public financial management and governance, more comprehensively and in a way, that would not be possible in a traditional project. The MPA 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), 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.

21. **The proposed MPA is strongly linked to IDA18 and Regional priorities,** namely Gender; Fragility; and Governance and Institutions, under IDA 18 and Operationalizing UHC; Scaling up pilots; MFD and PPPs; and Hospitals and equipment, under regional priorities.

22. **The proposed MPA is fully in support of the Government's efforts and strategies**. It is aligned with pillars one, two and four of the National Development Plan (PND 2016-2020); the National Health Development Plan (PNDS 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 National Health Development Plan (PNDS 2016-2020): (i) Governance and leadership; (ii) Internal and external financing; (iii) Availability and utilization of quality health services;(iv) Morbidity and mortality from major diseases reduced by 50%; (v) Health of mothers, newborns, children, adolescents and young people; and (vi) Prevention and health promotion In fact, the GFF priority framework provides an opportunity for the operationalization and financing of the key priority areas under the PNDS as well as the operationalizing of the Compact, signed by donor partners in 2017, but which lack formal enforcement or coordinating mechanisms. The proposed MPA will, by definition, be supporting nationally defined highest priorities since it will map onto these priorities as defined under the country-led GFF framework.

C. Proposed Development Objective(s)

23. **The PDO of Phase One**, is to Strengthen the health system and improve the utilization and quality of health and nutrition services in Cote d'Ivoire.

Key Results (From PCN)

24. The following key results, related to the PDO and PrPDO, will be supported through the project. Results will be measured Nationally. A detailed results framework will be derived during preparation stage.

i. Deliveries in a health facility by trained health personnel (number);
ii. Vaccination coverage: DTC (percentage);
iii. Average quality score for facilities covered (percentage);
iv. Per capita utilization of services (number);
v. Citizen satisfaction score (percentage).

D. Concept Description

25. **Phase 1 proposes to integrate strategic purchasing into the national system and scale up nationally, drawing lessons from the PBF and CMU pilots implemented to date.** It will additionally finance and support other areas of the GFF investment case, determined with key donors and stakeholders. Key focus areas include rehabilitation and equipment; health information systems; and quality of health services. The component will additionally provide a conduit for the PEF.

26. **The Government of Cote d'Ivoire is interested in scaling up the PBF and linking it to the rollout of the national health insurance scheme (CMU).** A Health Insurance Agency (CNAM) has been set and has piloted CMU, with World Bank support, on a cohort of students. The first phase of the scaling up of CMU will be piloted in 3 districts in 2018, all of those also implementing the PBF, again with World Bank financial and technical support. 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 exactly to set up the payment function and link the fund flows. The prosed phase one will therefore adress key question such as how to compensate providers adequately such that insured people are receiving the services they are entitled to while keeping the system on a budget and avoiding fragmentation. Specific questions to be addressed in Phase 1 inculde: How to integrate the fund flow from the PBF with that from the CNAM? Which combination of fee-for-service and capitation ensures most efficient use of resources? How to move towards a unified data reporting system? How to

ensure sustainable verification? What is the most efficient strategy to cover the informal sector (identification, premium collection and coverage) ?

27. **The proposed project will achieve its objectives through three complementary components**: (a) Scaling up Strategic Purchasing (Component 1); (b) Financing the GFF Investment Case for Improved Performance (Component 2); and (c) project management and capacity building for sustainability (Component 3) which are essential for achieving the PDO and PrPDO. Component 1 will develop a new approach to financing health services at the health facility level and increase the overall level of health services provision, while Component 2 addresses key national priorities which are needed to ensure the overall success of the Strategic Purchasing approach and to improve the management and operation of the health system generally. Component 3 ensures the functioning of the project elements while at the same time step-by-step preparing for transfer to a national entity. The project interventions complement the government's goal of achieving Universal Health Coverage (UHC), since it will focus on improving: (i) the quality of care; (ii) the utilization of health services; and (iii) financial protection for the entire country, with focus on the poor/ vulnerable/ and marginalized, thereby improving their use of essential services. The details are as follows:

28. **Component 1 (estimated $US 60 million) proposes to put an architecture in place for step-by-step progress toward UHC** that can avoid some of the challenges faced by other countries that introduce national or social health insurance on top of budget-funded public health services. In these countries (such as Ghana, Indonesia, Kenya, and Vietnam), fragmentation in funding sources is carried through to fragmentation in the benefits or service packages, provider payment systems, and data and monitoring systems. In fragmented systems, the power of strategic purchasing is limited, creating unclear signals to providers and limited incentives for quality and efficiency (figure 8). This component includes all of the tools and trainings required for the scale up; analytic components related to optimal pricing and contracting; covering of the formal, informal, and poor sectors; and the national scale-up of strategic financing (which may be progressive) including to contracting deconcentrated and central MSHP units and to private sector providers.

29. **Component 2 (estimated $US 38 million) proposes to fund a portion of the GFF investment case.** Key focus areas include rehabilitation and equipment; health information systems; and quality of health services. Precise components to be funded will derive from an ongoing process that includes detailing Priority area content and cost; a resource mapping analysis; and a health financing round table, to be held in December 2018, where the government and donor partners will agree on the resource envelope and the financial and operational division of labor. It is hoped that, at this stage, significant co- and parallel financing of Phase 1 may be achieved and that initial commitments towards DRM as well as strategies for MFD are obtained.

30. **Component 3 (estimated $US 2 million) proposes to finance project management,** with a focus on building national capacity and transfer of knowledge. The current PIU supports project management and procurement and financing activities while technical tasks are divided with the CTN-PBF. Given the newness of strategic purchasing in Cote d'Ivoire, the PIU will continue this role for the scale up, while planning the full transfer to national entities for phase 3. This budget will include not only the functioning of this unit but also its capacity building and knowledge transfer activities.

31. **Component 4 ($US 0) proposes to establish a Contingency Emergency Response Component (CERC).** A 0-dollar component will be added to the project to serve as a potential conduit for the Pandemic Emergency Facility (PEF). The CERC may furthermore be activated in case of any state of emergency and provides for a request from Cote d'Ivoire to the Bank to support mitigation, response, and recovery in the district(s) affected by such event.

SAFEGUARDS

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

This new operation will be nationwide.In terms of safeguard matters, the first analysis' findings show moderate potential safeguard impacts. in other words , no safeguards matters were identified so far regarding the project location.

B. Borrower's Institutional Capacity for Safeguard Policies

The Recipient has considerable legal, regulatory and institutional frameworks to ensure compliance with World Bank safeguards policies triggered by this new operation. In Cote d'Ivoire, the Ministry of Sanitation, Environment, and Sustainable Development (MINSEDD) is responsible for setting policy guidelines on environmental issues and ensuring compliance with national environmental standards. It has different departments among which the National Agency of Environment (ANDE, Agence Nationale de l'Environnement) in charge of safeguards compliance of all projects in the country. The unit is well staffed and its capacities are acceptable. However, it faces the lack of financial resources and vehicles to ensure the supervision of the Environmental and Social Management Plans(ESMPs) implementation on the ground. With regard to the PIU, capacity building efforts to support project implementation will be done by implementing recommendations contained in the safeguards instruments to be prepared for the project. The project will also receive guidance from the Bank's environmental and social specialists in the Project team.
Lastly,the borrower has successfully implemented a number of World Bank financed projects over the years and is well aware of the Bank's safeguards requirements.

C. Environmental and Social Safeguards Specialists on the Team

Abdoul Wahabi Seini, Social Safeguards Specialist
Abdoulaye Gadiere, Environmental Safeguards Specialist

D. Policies that might apply

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

Performance Standards for Private Sector Activities OP/BP 4.03	No	This policy is not triggered by the operation.
Natural Habitats OP/BP 4.04	No	The project does not involve or affect natural habitats.
Forests OP/BP 4.36	No	It is not anticipated that forests will be impacted by the project.
Pest Management OP 4.09	No	The project does not finance activity that may induce the use of pesticides .
Physical Cultural Resources OP/BP 4.11	Yes	Activities supported by the proposed project such as rehabilitations could involve excavations with possibilities to discover physical cultural resources. However, the triggering of this policy does not entail the preparation of a specific safeguard instrument. A specific section will be included in the ESMF to provide guidance in case physical cultural resources is discovered.
Indigenous Peoples OP/BP 4.10	No	There are no Indigenous People as defined by the policy in the project areas.
Involuntary Resettlement OP/BP 4.12	No	
Safety of Dams OP/BP 4.37	No	The project will not finance dams nor rely on dams.
Projects on International Waterways OP/BP 7.50	No	The project is not expected to affect international waterways.
Projects in Disputed Areas OP/BP 7.60	No	The project will not be located in a Disputed Area.

E. Safeguard Preparation Plan

Tentative target date for preparing the Appraisal Stage PID/ISDS

Oct 15, 2018

Time frame for launching and completing the safeguard-related studies that may be needed. The specific studies and their timing should be specified in the Appraisal Stage PID/ISDS

The following safeguard instruments are expected to be prepared during the preparation phase: i) an Environmental and Social Management Framework (ESMF), (ii) a Medical Waste Management Plan (MWMP) and,(iii) a Resettlement Policy Framework (RPF). All these safeguard documents will be reviewed consulted upon and disclosed by the Government of the Republic of Cote d'Ivoire, and at the World Bank's Website prior to the Decision Meeting.

CONTACT POINT

World Bank

Emre Ozaltin
Sr Economist (Health)

Borrower/Client/Recipient

Government of Côte d'Ivoire
Raymonde Goudou-Coffie Goudou-Coffie
Minister of Health
raymcoffie@yahoo.fr

Implementing Agencies

Ministere de la Sante et de l'Hygiene Publique (MSHP)
Clovis Konan
Project Coordinator
clovisko@yahoo.fr

FOR MORE INFORMATION CONTACT

The World Bank
1818 H Street, NW
Washington, D.C. 20433
Telephone: (202) 473-1000
Web: http://www.worldbank.org/projects

APPROVAL

Task Team Leader(s):	Emre Ozaltin

Approved By

Practice Manager/Manager:	Gaston Sorgho	18-Jul-2018
Country Director:	Pierre Laporte	20-Jul-2018