



1. Project Data

Project ID P167959	Project Name Strategic Purchasing in Health
Country Cote d'Ivoire	Practice Area(Lead) Health, Nutrition & Population

L/C/TF Number(s) IDA-63870,WBTF-A9692	Closing Date (Original) 30-Jun-2025	Total Project Cost (USD) 214,396,286.29
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Bank Approval Date 22-Mar-2019	Closing Date (Actual) 14-Apr-2025
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	IBRD/IDA (USD)	Grants (USD)
Original Commitment	200,000,000.00	20,000,000.00
Revised Commitment	202,298,460.00	20,000,000.00
Actual	195,429,253.32	19,206,956.38

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2. Project Objectives and Components

a. Objectives

The project development objective (PDO) was “to improve the utilization and quality of health services towards reducing maternal and infant mortality in the Recipient’s territory” (Financing Agreement, April 19, 2019). The revised PDO was “to improve the utilization and quality of health services towards reducing maternal and infant mortality in the Recipient’s territory and to provide immediate and effective response to an eligible crisis or emergency in the Recipient’s territory”.



b. Were the project objectives/key associated outcome targets revised during implementation?

Yes

Did the Board approve the revised objectives/key associated outcome targets?

No

c. Will a split evaluation be undertaken?

No

d. Components

The project had four components:

Component 1: Scaling up of strategic purchasing (Appraisal: US\$116.39 million; Revised: US\$97.4 million; Actual: US\$112.54 million)

WHO defines Strategic purchasing as "the allocation of resources informed, at least in part, by provider performance and population health needs" (WHO 2021, 2019).

This component supported the scale up and operationalization of two key reforms that were piloted earlier in a smaller scale—Performance-based Financing (PBF) and expansion of National Health Insurance (CMU), focusing on maternal and child health. It had the following sub-components:

1.1 Extension of PBF in the context of strategic purchasing to all health districts in Cote d'Ivoire, including piloting of contracting, verification, quality evaluation and community-based counter-verification through a phased approach. It would also include building key stakeholders' capacity for the implementation of PBF and related structural improvements, and awareness raising. The PBF subcomponent had the largest allocation of funds under component 1 (US\$93 million). It was estimated that 80 percent of the funds for this subcomponent would be used for subsidy payments (56 percent) and verification (24 percent), and 20 percent of the funds will be used for capacity building-- training and M&E.

1.2 Scale up National Health insurance (CMU) program: Building on the experience of piloting the CMU in three districts, expand the insurance scheme to 19 districts, closely aligned with PBF rollout; provide technical assistance to support CMU conceptualization and implementation, support activities to improve the identification and targeting of vulnerable population, develop household management tool for implementing Single Social registry; provide social security cards to households and develop PBF/CMU indicators for health facilities.

1.3 Support Health Reforms and National Capacity. Activities to build capacity for program-based budgeting and to scale up strategic purchasing, such as developing and operationalization of strategic purchasing tools, providing technical support to the Ministry of Health and Public Hygiene (MSHP). It also included technical support to National Insurance agency (CNAM) to enable the agency manage the scale-up of CMU. This included building agency's capacity to execute the purchasing function, training national, district, and facility level stakeholders to use the tools of national health insurance mechanism.

Component 2: Health Systems Strengthening to improve Performance (Appraisal: US\$91.58 million; Revised: US\$70.7 million; Actual: US\$47.65 million)



This component included activities to improve the quality of care, expand coverage of RMNCAH services, increase patient satisfaction, strengthen health sector management and stewardship. It had the following sub-components:

2.1 Rehabilitation, Equipment and Environmental Sanitation: Development of a national infrastructure and equipment master plan to map needs and available financing, development of national health facility maintenance policy, strengthen the capacity of Directorate for Infrastructure, Equipment and Maintenance (DIEM), rehabilitation of 50 health centers and connection of 420 health centers to power grid and a piped water source; as well as implementation of the sanitary waste management plan, and environmental safeguards policies.

2.2 Reproductive Health and Nutrition: Establishment of health review committees in health regions and strengthening of referral system; strengthening of emergency obstetrical and newborn care services in health facilities and ensuring the availability of qualified personnel at the community level; piloting mobile pregnancy ultrasound clinics in three districts; in collaboration with UNICEF expanding nutrition activities, including equipment and supplies; demand-generating activities to increase contraceptive use in collaboration with regional SWEDD project and UNFPA.

2.3 Strengthening Health Human Resources: Introducing incentives to retain qualified health personnel in remote areas, competency assessments, and trainings.

2.4 Governance and health management information services (HMIS). This entailed supporting the implementation of electronic medical record system in health facilities, integrating data from the PBF portal, CMU information system, and private facilities, preparing annual Health Statistics Report (RASS), strengthening operational capacities of regional and district health directorates (e.g. revised profiles, functions, and training needs).

Component 3: Project Management (Appraisal: US\$12.02 million; Revised: US\$12 million; Actual: US\$20.78 million)

3.1 Project coordination unit (UCO-Sante-BM).

3.2 Project monitoring and evaluation.

3.3 Knowledge sharing and dissemination of results.

Component 4: Contingent Emergency Response Component (CERC): rapid reallocation of project proceeds in the event of natural or man-made disaster or crisis that has caused or is likely to cause a major adverse economic and/ or social impact (Appraisal US\$0.00; Revised: US\$40 million; Actual: US\$33.74 million).

e. Comments on Project Cost, Financing, Borrower Contribution, and Dates

Project costs and Financing: At appraisal, project costs were estimated at US\$220 million, including US\$200 million IDA Credit and a grant from the Global Financing Facility of US\$20 million. The actual



disbursement amounted to US\$214,695,000, of which US\$195,429,000 was the IDA credit and US\$19,266,000 was the GFF grant.

Borrower contribution: There was no direct borrower contribution to the project. Nevertheless, as the project scaled up PBF, it was intended to be progressively funded through the national budget, with the Government providing 98 percent of financing in 2024 and 100 percent in 2025 (PAD, p.27).

Development partners: Additionally, the IsDB was expected to provide US\$80 million in parallel financing for project activities, specifically focusing on Components 2 and 3 (Table 9 in PAD) to support health system strengthening and project management. However, the ICR did not clarify if these funds were disbursed. Parallel financing was also anticipated from GAVI, GFATM, UNICEF, and UNFPA. The project also proposed to channel funding through key United Nations (UN) Agencies such as WHO, UNICEF, and UNFPA, aiming to support external services reform, nutrition, WASH and rural solar electricity, as well as obstetrical and newborn care. The ICR did not follow up on any of these partnerships.

Dates: The Project Financing Agreement was signed on April 19, 2019 and the project became effective on July 18, 2019. The project's original closing date was June 30, 2025. According to the ICR, the government decided to close the project one year earlier on June 30, 2024 (ICR, p.8). However, the project closed on April 14, 2025.

The Project had four level II restructurings:

First restructuring approved on September 29, 2020 to (i) update the PDO to include the CERC-related objective; (ii) reallocate funds to the CERC component, and (iii) adjust the results framework to reflect the expected CERC results. Four new intermediate indicators for the revised PDO were added to the project's results framework to monitor the progress. Two years later, after project's mid-term review in May 2022, one of those intermediate indicators, "health district receiving personal protection equipment (PPE) and/ or drugs financed by the project", was categorized as an outcome indicator for PDO (PDO indicator 5) to measure the progress of the newly added Covid-19 response objective (ICR, p.52).

Second restructuring approved on December 15, 2021 to (i) include a new project activity, the purchase of a building to house the Department of Health Information and Information Technology (DIIS); (ii) extend the closing date of the GFF grant by 18 months to June 30, 2023. The ICR argues that during 2021 restructuring the results framework was modified as well. However, the restructuring paper does not contain anything related to the results framework.

Third restructuring approved on June 16, 2023 to (i) reallocate IDA unused resources from the CERC to continue supporting the implementation and scale-up of the performance-based financing activities under the project; and (ii) to extend the closing date of the GFF grant for an additional six months to December 2023.

Forth restructuring approved on May 11, 2025 to [retroactively] advance the closing date to 14 April 2025 instead of the original closing date of June 30, 2025.

Mid-term review: The project also had a mid-term review in November 2023, which, according to the ICR, was used to revised project's baselines and end of project targets. This change does not seem to be part of the Mid-term review report, however. The ICR stated the following reasons for the revisions: (a) full



commitment and use of all project funds by the end of 2023 [by the government]; and (b) the decision not to proceed with the additional financing (AF) to complete the originally planned project activities, which would have required more funds. While the reallocation of US\$40 million for the COVID-19 response would have justified an AF, the Government instead focused its efforts on preparing a 10-year Health, Nutrition, and Early Childhood Development Program which launched its first phase in 2023, building on the foundations of Strategic Purchasing and Alignment of resources and Knowledge in Health - SPARK project and the prior Health System Strengthening and Epidemic Preparedness Project- PRSSE. The Government also agreed to close the project a year earlier by June 30, 2024. In this context, in November 2023 most end-of-project targets were revised downwards to reflect the diversion of substantial resources and efforts toward the COVID-19 pandemic response and a shortened project implementation period. In the end, the project closing date was changed to April 14, 2025 (ICR, p.8).

Split rating: Even though outcome targets were reduced at a late stage of implementation thus inflating perceived achievements, this ICR Review (ICRR) did not apply a formal split rating, as the ICRR's assessments with or without a split rating methodology were similar in deriving efficacy and outcome ratings.

3. Relevance of Objectives

Rationale

The objectives of the project reflected Cote d'Ivoire's context and national priorities at appraisal. Country's epidemiological profile and health outcomes were among the lowest in the West Africa region. The country lagged in access and quality of health service with negative impact on maternal and child health; high out of pocket spending affected the poor and vulnerable disproportionately, exacerbating the regional disparities in the country. This project aligned well with the government's priorities to address Cote d'Ivoire's health sector challenges and was designed to deepen and scale up the successful results of its predecessor, P147740 project (PRSSE). The latter was implemented in 2015-2019 to pilot the Performance-based financing approach in the health sector in a few health districts in the country.

The project also adapted and remained highly relevant during COVID-19, when its PDO has been revised to activate the emergency response component. Additionally, the project complemented well other Bank country and regional operations in the country related to reproductive health (e.g., SWEDD), nutrition, as well as public sector governance.

At closing, the development outcomes of the project remain highly relevant to country priorities reflected in Cote d'Ivoire's 2030 vision of strengthening human capital which, among other priorities, included raising the quality of education and health care, empowering women, and reducing rural and urban disparities in access to health and education.

The outcomes of the project are also fully aligned with the WBG's CPF 2023-2027 and contribute to CPF's high level outcome 1 (HLO) of "Improving human capital and living standards" and its three objectives to (i) Strengthen public financial and debt management and accountability for improved service delivery; (ii) expand equity of, and access to, improved quality basic services, particularly for youth and women; (iii) Strengthen productive social protection systems.



Rating

High

4. Achievement of Objectives (Efficacy)

OBJECTIVE 1

Objective

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

Rationale

The project's theory of change for objectives 1 and 2 highlights critical strategies to strengthen the health system, with the ultimate goal of improving access, utilization, and quality—especially for women and children's health. The approach assumes that expanding national universal insurance and implementing performance-based financing will increase accessibility and affordability of basic health services. These strategies were expected to raise service quality and encourage greater utilization. Enhanced workforce capacity, improved management, robust information systems, upgraded infrastructure, and targeted outreach for RMNCAH, combined with stronger community engagement, were anticipated to further boost service utilization and elevate the overall quality of care.

While logical, the theory of change outlined in the PAD and the ICR oversimplifies the connection between project inputs and the anticipated improvements in health service quality and usage. It presumes that updating facilities, training staff, implementing PBF mechanisms, or running community campaigns will directly result in better care and increased service use, without considering essential intermediate behavioral changes—such as applying new skills on the job, retaining staff in remote areas, processing claims promptly, or ensuring services are used effectively. This weakness also further cascades down in the project's results framework, where the choice of outcome and intermediate result indicators are not always at the right level and missing to capture important intermediate results related to behavior change.

Project's theory of change is also missing some critical assumptions about the pathway from better service quality/utilization to “sustainable UHC” and “reduced maternal & child mortality”, omitting external factors like public-finance commitments, political support, or macro-fiscal shocks. These assumptions remain unarticulated, making the logic on impact of the project vulnerable.

Since health service access, utilization, and quality are interconnected and reinforce each other, most of the outcomes, intermediate results, and outputs for these two objectives are relevant to both areas and in some cases overlap.



Outputs

To expand national health insurance:

- Surveys and field work were carried out to identify 'non-contributory' beneficiaries of the CMU (poorest households).
- Health insurance enrollment cards were produced and distributed; advocacy campaigns were carried out to encourage enrollment among population.
- As of 2021, 519,043 of the 608,000 poor and vulnerable individuals that were surveyed, were enrolled in the National Health Insurance with the project's support (ICR, p.13).

As for targeted Reproductive Health and Nutrition services:

- Mobile ultrasound clinics were implemented in 10 health districts.
- 1,382 health establishments received complete nutritional package supplies.

Intermediate Results

- The project supported the building of the database of poor and vulnerable population and developed costing tools.
- 8,867 individuals from poor and vulnerable population had accessed health services using the Universal health insurance cards, surpassing the revised target 8,200. While this intermediate outcome indicator was at a more appropriate level and replaced a more output-level indicator (Number of beneficiaries enrolled in CMU), after the mid-term review in 2023, the ICR does not provide any explanation why the national health insurance scheme utilization rate was so low compared to the number of individuals actually enrolled in the insurance scheme.
- The project expanded community-based nutrition services within covered regions, complementing the activities of the World Bank's "Multi-sectoral Nutrition and Child Development" project. According to the ICR, the percentage of public health facilities offering severe acute malnutrition management rose from 46.45 percent to 83 percent.
- 684,112 pregnant women were consulted for prenatal care at least 4 times during pregnancy, falling short of its revised target 863,103 (target was lowered; partially achieved).
- Nearly 800,000 pregnant women made at least three visits to CPoN according to the schedule (achieved).
- Over 1.6 million 'healthy' 12-59 months old children received nutritional consultations, surpassing its revised target of 1.4 million, surpassing the revised target but below the original target.
- A complete package of nutrition services was offered in 1,382 health centers.

Outcomes

- The project directly benefited 18,618, 871 people of which 73 percent were female beneficiaries (ICR, p. 28). These numbers are drastically different from the original targets in the PAD as well as the revised targets in the ICR due to incorrect definition and calculation methods that were noted in the ICR. Alternatively, the ICR also reported that 32,773,733 services were used by people (excludes COVID-19 response component) surpassing its revised target of 32,493,668.



- The share of population utilizing health services in areas covered by PBF, which was measured by the percentage of population in the health area who consulted for a first episode of illness during a given period in a health facility, increased by 10 percent, from 39 percent baseline to 49 percent, achieving its revised target (original target 60 percent).
- At project closure, more than 1.3 million children received vaccinations and skilled health professionals were present for 1.7 million deliveries. Between 2021 and 2023, Therapeutic Nutrition Units (UNTAs) treated 136,000 children suffering from acute malnutrition, achieving a cure rate of 89 percent by 2023 (ICR, p.13). Despite these impressive achievements, there is an attribution issue regarding nutrition and vaccine support data. Outcomes in these areas are likely shared with organizations such as UNICEF, GAVI, GFATM, and another Bank project, P161770.

Efficacy of Objective 1 is assessed as Modest, due to limited evidence regarding the achievement of certain outcomes, and insufficient attribution of key results—such as nutrition and vaccine-related impacts—to the project interventions.

Rating
Modest

OBJECTIVE 2

Objective

Improve the quality of health services in the Recipient's territory toward reducing maternal and child mortality.

Rationale

Objectives 1 and 2 share the same TOC described under Objective 1.

Outputs

- The PBF roll out in 2577 primary and secondary health facilities nationwide.
- Additionally, 6000 individuals in health facilities at different levels were trained to use PBF tools.

Some other institutional capacity-building focused outputs that contributed to quality of health care were:

- 1,679 health facilities were rehabilitated or equipped, exceeding the project target of 1,200, although this indicator conflates equipment purchases with infrastructure rehabilitation.
- The Ministry of Health developed a strategic document and operational plan to better align human resources with government priorities.
- Improvements were made to e-training programs and training infrastructure.
- 201 national and regional trainers provided staff training in nutrition for newborns, young children, and pregnant women.
- Furthermore, standardized protocols for neonatal and obstetric care were updated to include directives from the WHO and West Africa Health Organization.
- Electronic records management at the facility level, which was initiated with predecessor Bank project, was improved and expanded to cover all health districts.



- The National Medical Waste Management Plan (NHMMP) for 2021-2025 was created.
- Twenty-five general practitioners were trained as OBGYNs to perform emergency obstetric care.
- The completeness and timeliness of health data reporting (RASS-Health Statistics report) improved.

Intermediate Results

The project gradually expanded the PBF program from the baseline of 17 'health districts' to all 113 departmental health directorates, thus achieving its target. The project helped expand and strengthen the entire chain of PBF, including setting up verification mechanisms for the services provided by health facilities, and improving the PBF portal, which also served as a data source to report on most of project results.

Outcomes

- Average Health facility quality score contracted under PBF was improved from 48 percent baseline to 69 percent at completion, meeting its revised target of 70 percent.
- Health sector governance has also been strengthened through strategic purchasing, such as gradual autonomy of health establishments, strengthening of planning skills, strengthening of community involvement in the management of health issues (e.g., community survey), strengthening of governance at the level of health structures.

Rating

Substantial

OBJECTIVE 3

Objective

Provide immediate and effective response to an eligible crisis or emergency in the Recipient's territory.

Rationale

For project's objective 3, it was plausibly assumed that providing prompt support for obtaining essential drugs and surveillance equipment, improving infrastructure, and raising awareness for better hygiene and prevention will strengthen the country's capacity for effective immediate pandemic emergency response and help save lives.

Outputs and intermediate results

- The project supported 100 rapid response teams and provided 19,000 units of disinfectants, medications, disposable medical supplies, testing kits, and PPE such as masks to health districts.
- Lodging and meal costs were covered for individuals testing positive at four designated sites from March 2020 to December 2021.
- Handwashing stations were established across the country.
- Vehicles and ambulances were purchased to facilitate the transportation of medical staff and medicines, enabling timely delivery of medical samples to laboratories for analysis and swift patient transport for treatment.
- Additionally, awareness campaigns were conducted to inform the public about virus prevention.



Outcomes

Nearly 13 million people benefited from the project's COVID-19 activities, which fell short of the 20 million target. All health districts received personal protective equipment and essential medications as planned (target achieved). The project enhanced epidemiological surveillance, early detection, data analyses, and case monitoring across the country. Although the number of beneficiaries was lower than anticipated, the outcomes were viewed favorably, especially considering that nearly US\$6 million less was spent than originally budgeted. The Efficacy of this objective is rated Substantial.

Rating

Substantial

OVERALL EFFICACY

Rationale

Efficacy of Objective 1 is rated Modest; Efficacy of Objective 2 is rated Substantial; and Efficacy of Objective 3 is rated Substantial. Based on these, the overall Efficacy is rated Substantial.

Overall Efficacy Rating

Substantial

5. Efficiency

While the appraisal team did not conduct a cost-benefit analysis at appraisal, they used international literature references to demonstrate that strategic investments in health reap significant economic and social benefits. However, the assessment focused only on the PBF scale-up component (about 52 percent of disbursements). Using the Lives Saved Tool they projected annual decline of 7 percent in maternal mortality with the project (versus 1 percent without) and 10 percent decline in infant mortality (versus 2 percent without). No economic analysis was undertaken at restructuring when the COVID-19 response component was added. The ICR's ex-post CBA monetized DALYs averted, discounting costs at 3 percent (with sensitivity at 5 percent), and estimated very high economic returns—US\$76 per US\$1 invested at 3 percent discount rate and US\$72 per US\$1 at 5 percent—though reported NPVs (US\$12,114.35 at 3 percent and US\$11,497.63 at 5 percent) show discrepancies between the main text and Annex 4 that require reconciliation.

Implementation and administrative efficiency were mixed. Early delays stemmed from opening bank accounts for PBF facilities, procurement processing bottlenecks, government adaptation of the pilot PBF model (including



tool and manual revisions), expansion from 86 to 113 districts that increased complexity and costs, and a mid-course shift of institutional responsibility from the National Technical Commission to the Technical Secretariat for Strategic Health Purchasing. External disruptions during the 2020 presidential elections and the COVID-19 pandemic further slowed progress (e.g., halted field trainings and reduced patient visits). Over time, efficiency gains materialized, notably a significant reduction in the time required to pay PBF subsidies.

Project management costs exceeded estimates (US\$20 million actual, US\$12.8 million planned). The government proposed to close the project early on June 30, 2024 instead of June 30, 2025. The last ISR reported that the project disbursed nearly fully already by December 2024. Nevertheless, the project ultimately closed in April 2025. The ICR provides no explanation about this significant discrepancy in the timeline and disbursement of the project, except indicating that the "World Bank and the Borrower took time to formally advance the credit closing date" (ICR, p.23). Overall, efficiency appears positive given strong ex-post returns and later operational improvements, but is tempered by analytical gaps, administrative inefficiencies, and cost overruns.

Efficiency Rating

Modest

a. If available, enter the Economic Rate of Return (ERR) and/or Financial Rate of Return (FRR) at appraisal and the re-estimated value at evaluation:

	Rate Available?	Point value (%)	*Coverage/Scope (%)
Appraisal		0	0 <input type="checkbox"/> Not Applicable
ICR Estimate	✓	0	52.60 <input type="checkbox"/> Not Applicable

* Refers to percent of total project cost for which ERR/FRR was calculated.

6. Outcome

The project remains Highly relevant within Côte d'Ivoire's national context and is closely aligned with both the nation's priorities and the WBG country program. Overall Efficacy is rated Substantial, while also noting that one of the objectives used in the assessment of the overall efficacy had modest achievement. Efficiency is Modest, due to considerable administrative and operational inefficiencies. The overall Outcome rating is Moderately Satisfactory.

a. Outcome Rating

Moderately Satisfactory



7. Risk to Development Outcome

The project played a pivotal role in rolling out and institutionalizing PBF nationwide. It also contributed to the expansion of the National Health Insurance Program. Through these efforts, the necessary structures were established to support the proper functioning of the PBF, including building health sector's capacity to support these achievements.

According to the ICR, at project's completion, 52 percent of population was covered by the national health insurance program. The World Bank Group launched a comprehensive 10-year multi-phase program in 2023, to further boost the utilization of basic health and nutrition services and this project will reinforce the achievements of the current project. Furthermore, other development partners remain actively engaged in this sector, providing continued technical and financial support. In this context, the risks to development outcomes of the project are low in a medium term.

Despite these positive developments, sustaining the institutionalization of PBF and the national health insurance program in a long term requires a strong commitment from the government and adequate allocation of resources in the national budget. While the PAD noted that the government planned to progressively finance PBF from the national budget, it is unclear from the ICR whether this commitment was fulfilled. The continued and increased utilization of the national health insurance program, which was supported by the project, will depend on the government's dedication and ability to maintain and increase its support to the sector as intended. This also includes improvements in infrastructure, ongoing training, and the retention of skilled health workers to ensure that the population receives high-quality care. In sum, consistent focus on fiscal sustainability, service quality, and governance will be necessary to ensure the long term sustainability of the gains of the project.

8. Assessment of Bank Performance

a. Quality-at-Entry

The project was designed to expand the outcomes of a previous PBF initiative and complement existing vertical HNP projects, and its design was guided by lessons learned from the predecessor pilot PBF project. The arrangements for project implementation were adequate, and the Project Implementation Unit (PIU) had sufficient capacity to manage the project and support the synergies with other relevant Bank projects under its purview. However, there were critical flaws in the project's theory of change and the results framework, particularly regarding the selection and definition of PDO indicators. Additionally, the project team did not conduct a comprehensive economic analysis during the appraisal phase, which limited the understanding of potential impacts and cost-effectiveness.

Quality-at-Entry Rating
Moderately Satisfactory



b. Quality of supervision

The World Bank conducted regular supervision missions and carried out a comprehensive mid-term review in 2023. Project fiduciary aspects and safeguards were adequately supervised, and the Bank provided additional training on fiduciary matters as needed to strengthen capacity. The Bank was generally responsive to evolving client needs, demonstrated by timely project restructurings, including an early adjustment that enabled prompt access to funding for the COVID-19 response. Despite these efforts, critical issues related to project design, such as outcome targets and PDO indicator definitions—some of which had been flagged during supervision missions and ISRs—remained unresolved throughout implementation. In the same way, the agreement with the counterpart to close the project one year early (in June 2024) did not materialize formally until April 2025, although the funds were already disbursed. The project had three TTLs, and it is likely that their succession affected the proactivity to act on the challenges flagged in supervision reports. The ICR notes the following shortcomings: "(a) the World Bank and the Borrower agreed to adjust the results framework during the November 2023 supervision mission, once it was agreed that a new operation would support the implementation of the national 10-year health program. This agreement was not reflected in a formal restructuring; (b) the World Bank and the Borrower took time to formally advance the credit closing date, after the decision not to request additional financing after the CERC activation" (p.23). These gaps underscore the need for more proactive and decisive action in addressing project adjustments and formalizing agreements.

Quality of Supervision Rating

Moderately Satisfactory

Overall Bank Performance Rating

Moderately Satisfactory

9. M&E Design, Implementation, & Utilization

a. M&E Design

The project's objectives were clearly defined. The theory of change, while generally encompassing all aspects of the PDO, had notable gaps in the results chain, as already noted in the Efficacy section.

The PAD suggested to develop a comprehensive M&E system to track project progress. This system was to utilize the existing Health Management Information System (HMIS), which had been supported by the preceding pilot project and other development partners, along with regular household surveys. The PAD also envisaged an impact evaluation of the national scale-up of PBF and National Health Insurance, which did not seem to materialize.

The Results Framework contained numerous inconsistencies, particularly regarding the definitions and targets of several key PDO indicators. These inconsistencies not only complicated the assessment of project outcomes but also undermined the credibility of the project's M&E. More specifically,

- PDO Indicator 1: "People receiving essential health, nutrition, and population services" initially included only two sub-indicators: 1.1 "Number of children immunized", and 1.2 "Number of



deliveries attended by skilled personnel", missing a sub-indicator that would capture the outcomes related to nutrition. Moreover,

- The definition for PDO 1.1, "Number of children immunized", was not provided in the PAD or during project implementation and appeared only in the ICR. Additionally, measuring the percentage of vaccinated children among all eligible children would have been more appropriate outcome-level indicator, offering a more meaningful assessment than simply reporting the number of children immunized.
 - Similarly, for PDO sub-indicator 1.2, tracking the share of deliveries attended by skilled personnel out of all deliveries would have provided more informative data at outcome level, than recording just the number of deliveries.
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- PDO indicator 4 was to measure "the number of people, including health personnel, who benefited from a project intervention in a given period of time", as per PAD. However, the final project target for this indicator greatly exceeded the total population of Côte d'Ivoire. According to the ICR the indicator was meant to track the number of services delivered, rather than the number of beneficiaries, thereby encompassing health services and other interventions (such as training) that supported both health and project staff.
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- With regard to PDO indicator 4, the ICR also indicated that the results framework was revised during the second restructuring in December 2021 to correct an error in the calculation of beneficiaries for that indicator as well as one of the intermediate outcome indicators, "Number of poor and vulnerable supported by CMU" (national health insurance supported by the project) (p.8) However, this seems to be inaccurate, as there is no mention of these changes in the restructuring paper. The revised targets for PDO 4 were only implemented in late 2023. The same applies to the changes in the definition and metrics of health insurance related intermediate indicator.
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- PDO indicator 5, which was introduced during the project's first restructuring, was an output-level indicator and was inadequate for measuring outcomes related to the COVID-19 response.

b. M&E Implementation

The PBF portal was used as a primary tool for data collection throughout the project, albeit inconsistencies and gaps in the data captured by this system. Importantly, the PBF portal operated in parallel to the Health Management Information System (HMIS) rather than being fully integrated with it. In addition to the PBF portal, the project also relied on household surveys and Annual Health Statistics reports as supplementary sources of data.



While the project team was aware of the caveats and gaps in the measurement and definition of several outcome and IRI indicators at early implementation stage, and these issues were repeatedly flagged in ISRs, the project team did not take adequate measures to update the project's results framework, despite numerous restructuring opportunities. Eventually, in some cases, such as for PDO indicator 4, and the indicator on insurance coverage, the project team reported revised definitions or targets under the original indicators without formal revisions of the indicators, and targets, and proper documentation of their actions. Although the ICR mentions that certain revisions related to indicators and targets were addressed through project restructuring, there is no evidence of these changes in the official restructuring documents.

Another example is reporting on 'nutrition services' under PDO 1. The ICR introduced a sub-indicator "Number of children diagnosed with acute malnutrition", (IRI 10) in the results framework to provide a more comprehensive reporting on PDO indicator 1. According to the ICR, this indicator was added in 2023 to measure PDO achievement. Nevertheless, there is no evidence in the project's supervision documents to confirm the official inclusion of this indicator and collection of data on it.

c. M&E Utilization

The project tracked progress by utilizing data recorded in the PBF portal. Although incomplete, these data served as a primary tool for monitoring project's progress. According to the ICR, the PIU also incorporated data collected from relevant maternal and child health programs to assess progress toward the intended outcomes. However, there was a notable lack of attention to the significant limitations identified in the project's results framework that were left unaddressed throughout the project implementation. As a result, it is likely that the monitoring and evaluation (M&E) data were not sufficiently leveraged to collect robust evidence on the achievement of project outcomes or to inform necessary course corrections.

Considering the weaknesses in the design, implementation, and utilization of the project's M&E system, the overall quality of M&E is rated as Modest. This rating reflects shortcomings especially in the M&E design and implementation, which ultimately limited the effectiveness and utility of data.

M&E Quality Rating

Modest

10. Other Issues

a. Safeguards

The project was designated Category B and triggered two safeguard policies: Environmental Assessment OP/BP 4.01 concerned primarily about rehabilitation activities and medical waste management, and Physical Cultural Resources OP/BP 4.11, again triggered by expected rehabilitation work. The ICR reported that relevant mitigation measures were developed and applied (p. 35). Medical Waste Management Plan (MWMP) was developed, alongside other social and environmental safeguard tools, with



training provided to 47 stakeholders on waste management and incinerators. The ICR reported that compliance with environmental and social safeguards 'is deemed adequate'. This conclusion was in line with the Moderately Satisfactory Overall Safeguards Rating recorded in the Operations Portal (pp. 21-22).

b. Fiduciary Compliance

The project relied on FM mechanisms established under its predecessor pilot project, benefiting from adequate staffing and experience. At appraisal, the project's FM risk was rated as substantial due to the involvement of multiple actors, the expected high volume of small and dispersed across the country financial transactions (subsidy payments), which would have created challenges for effective verification. To address these risks, several mitigation measures were introduced over time, notably the appointment of "regisseur"—civil servant focal points in the Ministry of Finance tasked with verifying and approving subsidy disbursements, as well as the trainings of large number of people at different levels involved in the chain of subsidy payment. As a result, the PBF financial management system was significantly strengthened. Audit reports also were consistently completed on time and without qualifications. Initially there were delays in procurement, also noted by the Borrower, which were due to initial delays in hiring of Contracting and Verification Agencies. The ICR also noted the challenges in procurement due the limited capacity of companies to implement project activities across the country, as well some delays due to the pandemic.

c. Unintended impacts (Positive or Negative)

n/a

d. Other

11. Ratings

Ratings	ICR	IEG	Reason for Disagreements/Comment
Outcome	Satisfactory	Moderately Satisfactory	Shortcomings in Efficacy, including Modest achievement of one of the objectives used in the assessment of overall Efficacy, and Modest Efficiency.
Bank Performance	Satisfactory	Moderately Satisfactory	Shortcomings in Quality at Entry and Supervision.
Quality of M&E	Substantial	Modest	M&E weaknesses, notably in M&E design, that were not



adequately addressed during implementation. Also, the impact evaluation of PBF was not undertaken.

Quality of ICR --- Modest

12. Lessons

Lessons from the ICR summarized by IEG include:

- **Scaling up health reforms based on the evidence from relevant pilot program are effective ways to support the development and implementation of national health and social protection policies over time.** The evidence from the pilot helped Government identify priorities in health reforms, define scope of scale up, and take ownership in the process. However, expanding the successfully piloted activities in two major health reform areas nationwide requires more caution in terms of its scope and project boundary. The project experience showed that not all reforms could be implemented under SPARK’s umbrella, despite reform momentum and political support. Explicit recognition of these limits would have helped avoid overextension while still launching key reform dynamics.
- **Effective implementation of PBF is facilitated by capacity building and continuous staff support at all levels.** By project completion, the country had developed a strong pool of PBF experts nationwide. Recognizing the implementation challenges, the project prioritized support to stakeholders during the transition to full implementation at regional, district, and facility levels. In terms of financial management, the project provided ongoing support to help health centers manage PBF and CMU funds independently.

An additional lesson offered by IEG is:

Scaling up a successful pilot project nationwide requires more than simply replicating its design. A strategic approach is necessary, involving careful sequencing of activities, refining the theory of change, and developing a robust results framework. Additionally, being more selective in the choice of activities and indicators is essential for achieving meaningful impact.

13. Assessment Recommended?

No

14. Comments on Quality of ICR

The ICR collected evidence from diverse sources to present a comprehensive account of the project's progress. However, the report had several shortcomings:



- Greater transparency about design limitations, gaps in the theory of change, and results framework would have enhanced the assessment.
- The report would have benefited from a candid discussion about implementation or effectiveness challenges due to the project's broad scope.
- For some activities, like nutrition, the link between actions and results was unclear. The roles of other development partners and attribution were not addressed.
- Additionally, lessons such as restored public confidence due to PBF were stated without supporting evidence from the report (ICR, p.25).
- The report also contains a number of factual errors and data inconsistencies affecting its candor.

a. Quality of ICR Rating

Modest