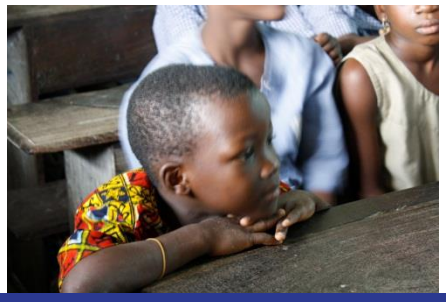

MEASURING AND MONITORING PROGRESS TOWARD UNIVERSAL HEALTH COVERAGE: A CASE STUDY IN CÔTE D'IVOIRE

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USAID's Health Finance and Governance (HFG) project will help to improve health in developing countries by expanding people's access to health care. Led by Abt Associates, the project team will work with partner countries to increase their domestic resources for health, manage those precious resources more effectively, and make wise purchasing decisions. As a result, this five-year, $209 million global project will increase the use of both primary and priority health services, including HIV/AIDS, tuberculosis, malaria, and reproductive health services. Designed to fundamentally strengthen health systems, HFG will support countries as they navigate the economic transitions needed to achieve universal health care.

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MEASURING AND MONITORING PROGRESS TOWARD UNIVERSAL HEALTH COVERAGE: A CASE STUDY IN CÔTE D'IVOIRE

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ACRONYMS

DHS	Demographic and Health Survey (*Enquête Démographique et de Santé*)
DIEM	*Direction des Infrastructures, de l'Équipement et de la Maintenance* (Department of Infrastructure, Equipment and Maintenance)
DIPE	*Direction de l'Information, de la Planification et de l'Évaluation* (Department of Information, Planning and Assessment)
HFG	Health Finance and Governance
HIS	Health Information System
NHA	National Health Accounts (*Comptes Nationaux de la Santé*)
MCI-SOGEM	Managed Care International-Société de Gestion Maladie (Health Management Company) (COLINA Group)
MICS	Multiple Indicator Cluster Survey
MOH	*Ministère de la Santé et de la Lutte contre le Sida* (Ministry of Health and the Fight against AIDS)
NHIF	National Health Insurance Fund (*Caisse Nationale d'Assurance Maladie*)
RAM	*Régime d'Assistance Médicale* (Medical Assistance Scheme)
RGB	*Régime Général de Base* (Basic General Scheme)
UHC	Universal Health Coverage
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WAEMU	West African Economic and Monetary Union
WHO	World Health Organization

EXECUTIVE SUMMARY

Developing simple and sound measures to monitor progress toward universal health coverage (UHC) is critical if this objective is to remain high on the global agenda and receive priority attention from country policymakers. While discussions on UHC measurement approaches have been occurring at the global level for a few years, less attention has been paid to country perspectives on this topic until recently. To advance discussion on the availability, feasibility, and relevance of various globally proposed candidate indicators for UHC measurement - especially in resource-poor contexts - the Health Finance and Governance Project, funded by the United States Agency for International Development, conducted a case study in Côte d'Ivoire, a low-income country engaged in UHC efforts.

The primary objective of this study was to gain a better understanding of Côte d'Ivoire's monitoring capacity in relation to the challenge of UHC. The specific objectives were the following:

1. To gain an understanding of how Côte d'Ivoire is conceptualizing and moving toward UHC;
2. To explore which indicators Côte d'Ivoire is already using or plans to use to measure progress toward UHC; and
3. To evaluate the country's capacity to collect data for and generate a set of proposed UHC indicators.

To satisfy these objectives, we conducted key informant interviews in Abidjan in August 2013 with the principal stakeholders responsible for implementing UHC initiatives in Côte d'Ivoire. We also used a review of secondary data sources to gather complementary data.

At the time of this study, the government of Côte d'Ivoire had begun the process of designing a strategy to achieve UHC and had already articulated some components of the strategy. The government aims to gradually expand protection against the financial risks associated with disease to the entire population. This will be achieved through risk pooling and increased coverage of quality health services throughout the country. UHC initiatives will be steered by a central structure known as the National Health Insurance Fund (NHIF), which will delegate responsibility for parts of its mission to "Delegated Management Authorities" - various existing public and private insurance institutions. These will oversee the operational functions of collecting contributions, service delivery, and information management. The proposed NHIF will have two programs: a compulsory contributory program for workers and retirees and a noncontributory medical assistance program for indigents, pregnant women, and children under five years of age. The pilot phase for both programs will begin in 2015 with workers and retirees from the private and public sectors, and with agricultural workers from the rubber and palm oil sectors. The package of services covered has not yet been defined, but it will likely focus on primary health care.

At this stage of designing the UHC strategy, formal measurement and monitoring indicators have not yet been defined. In reviewing the availability of proposed indicators for measuring progress toward UHC in Côte d'Ivoire, we found that a majority of service coverage indicators associated with communicable diseases are collected routinely or in surveys and are considered relevant for measuring UHC by the majority of stakeholders who were surveyed. The indicators associated with noncommunicable diseases are not routinely collected and, for the most part, are not considered relevant for monitoring UHC in Côte d'Ivoire. Proposed indicators of protection against financial risk are also not routinely collected in Côte d'Ivoire, but these are considered relevant for the UHC measurement in the future.

- According to key informants interviewed, data collection for management and monitoring of UHC initiatives will be carried out by the Delegated Management Authorities, while the NHIF will be responsible for collating and consolidating that information for decision-making. At this point, it is difficult to envision how coordination will be ensured between the health insurance system management indicators made available through the NHIF and the routine public health service coverage indicators that are mandated by the Ministry of Health and managed by its Department of Information, Planning and Assessment (*Direction de l'Information, de la Planification et de l'Évaluation*, DIPE).

Yet another basic challenge in the implementation process is that the concept of UHC is not well understood, which creates confusion for many stakeholders who understand UHC as *universal health insurance*, and are missing the extent to which this strategy will expand coverage of health services to the entire population.

The research team drew the following key conclusions from the interviews and literature and data review conducted for this case study:

1. It seems clear to the stakeholders interviewed that Côte d'Ivoire's planned UHC scheme will help to make progress toward the three aspects of UHC: service coverage, protection against the financial risks associated with disease, and equity in access to care. The way in which stakeholders will be informed about progress in achieving this goal did not seem to have yet been addressed.
2. Any proposed UHC information system should be able to provide information on financial protection; equity in access to care in relation to patient characteristics (residence, gender, age, economic status, nationality); and the quality of services offered by disease category (through measurement of deviations from average expenses by health facilities, prescriptions made by providers, and utilization of services by members).
3. However, if the Health Information System (HIS) currently managed by the Ministry of Health's DIPE should play a key role in monitoring progress toward UHC, additional investments will be necessary to ensure the quality of service coverage indicators. The HIS, in its current configuration, is judged to be of medium quality in terms of completeness and accuracy based on numerous assessments.
4. Key stakeholders would benefit from support in understanding the distinction between health insurance and UHC, as defined by the World Health Organization.
5. There also is a need to help identify and clarify the roles of each stakeholder in UHC monitoring efforts, as well as to emphasize the importance of standard indicators in the UHC process.

1. INTRODUCTION

Universal health coverage (UHC) as a goal of health policy development has gained wide acceptance at country and global levels since the publication of the World Health Report 2010 (World Health Organization 2010) and is now also seen as a critical component of sustainable development (Brearly et al. 2013). UHC has also been listed as one of the possible goals of the post-2015 development agenda (World Health Organization and World Bank 2013). Discussions on the suitability of UHC as a goal are often reduced to two questions: how should UHC be defined, and how can it be measured and monitored? The World Health Organization (WHO) has defined UHC as a situation in which all people who need health services receive them, without incurring financial hardship (World Health Organization 2010). This definition has two interrelated components: coverage with needed quality health services and access to financial risk protection, for everyone. The level and distribution of (effective) coverage of interventions and financial risk protection have been proposed as the focus of monitoring progress toward UHC (Evans et al. 2012).

Developing simple and sound measures to assess country, regional, and global situations and monitor progress toward UHC is critical if UHC is to remain high on the global agenda and receive priority attention from country policymakers. While the basic definition of UHC is conceptually straightforward, developing feasible metrics of UHC is less so. Variations in countries' epidemiology, health systems and financing, and levels of socioeconomic development imply both different approaches to UHC implementation as well as a potential range of relevant metrics. Many countries working toward UHC already rely on locally specific, routinely collected service statistics to measure their health system's performance and standard demographic and economic surveys contribute occasional snapshots of trends in health status measures and economic development. At the same time, establishing new global goals, indicators, and targets could have a critical impact on governments' commitment to successful implementation of global declarations, such as the December 2012 United Nations Resolution making UHC a key global health objective.

To advance discussion on the availability, feasibility, and relevance of various candidate indicators for UHC measurement, the Health Finance and Governance Project (HFG), funded by the U.S. Agency for International Development (USAID), conducted a case study in Côte d'Ivoire. The objective of this assessment was to compile existing information and conduct primary research on the country's approach to monitoring its progress toward UHC. The case study described in this article will: (i) explore which indicators Côte d'Ivoire is already using or plans to use to measure progress toward UHC; (ii) evaluate its capacity to collect data for and generate a set of proposed UHC indicators; and (iii) issue recommendations based on findings. After a brief presentation of the methodology, we will present some background about the Ivoirian health system followed by our findings. Recommendations addressed to the actors involved in the process of monitoring UHC indicators will be then provided, followed by the concluding section of this report.

2. METHODOLOGY

The HFG Project compiled a list of indicators that are under consideration for global UHC monitoring from two primary sources: a WHO working paper by Evans et al. (2012)[1] and an unpublished workshop report prepared as an output of a WHO- and Rockefeller Foundation-sponsored meeting in Bellagio in September 2012 (World Health Organization 2012). The list of indicators referenced is attached as Annex A; it includes tracer indicators of service coverage and financial protection coverage that are expected to correlate with or proxy for a wider range of direct coverage measures.

The case study employed three methods: key informant interviews, review of available literature, and secondary data analysis. A set of key research questions was developed by the HFG team and these questions formed the basis for interviews with key informants (Annex B). Key informants representing major stakeholders in Côte d'Ivoire's UHC efforts were interviewed, including multiple government ministries and agencies, development partners, and implementing partners. The key informant interviews were critical for preparing this report mainly because UHC initiatives in Côte d'Ivoire were still being conceptualized at the time of this study. A list of key informants interviewed for this study is available in Annex C.

The team referenced available documents on the topic of UHC in Côte d'Ivoire. The documents, mainly Ivorian government but also some development partner publications provide legal and political definitions and describe the context and structure of the reforms. The study team also obtained and analyzed available secondary data from sources such as Health Information System (HIS) annual reports, health care utilization survey reports, Demographic and Health Survey (DHS) reports, household income, consumption, and expenditure survey reports, and other survey data and reports relevant to UHC indicators.

The scope of these data collection efforts was limited by the constrained time period in which this research was undertaken (August-September 2013). Readers should thus consider the recommendations from this paper cautiously. While the data can inform the discussion on measuring progress toward UHC in low-income contexts, additional information on UHC indicators and health system constraints could fill in existing gaps.

[1] Evans et al. also drew heavily from the 2011 WHO report *Monitoring, evaluation and review of national health strategies: A country-led platform for information and accountability*.

3. BACKGROUND: CÔTE D'IVOIRE'S HEALTH SYSTEM

This section presents an overview of relevant aspects of the health system in Côte d'Ivoire, highlighting service delivery and risk pooling structures that are key to UHC dimensions of access and financial risk protection as well as equity and quality.

3.1 Service Delivery

In Côte d'Ivoire, the provision of health care is dominated by the public sector. There are 1,870 public primary health care institutions; 66 general hospitals, 17 regional hospitals, and 2 specialized hospitals at the secondary level; and at tertiary level, 4 university teaching hospitals and 9 specialized health institutes (Department of Infrastructure, Equipment and Materials 2011).

However, for several years, the supply of private health care has been increasing, including nonprofit, for-profit, and traditional medicine providers. In 2011, the for-profit sector included 821 pharmacies and 2,036 private health facilities of all categories (polyclinics, clinics, medical offices, and private infirmaries). These structures are mainly present in large cities. With more than 800 beds out of a total of about 3,000 beds in Côte d'Ivoire, private for-profit health facilities represent over one-quarter of the supply of health care and contribute significantly to the population's access to care. In the nonprofit sector, 49 health facilities run by religious organizations and community-based organizations provide care. There were also about 8,500 individual traditional medicine providers identified by the Ministry of Health and Public Hygiene (*Ministère de la Santé et de l'Hygiène Public*) in 2007.[2] Care provided by traditional healers and self-medication are also common.

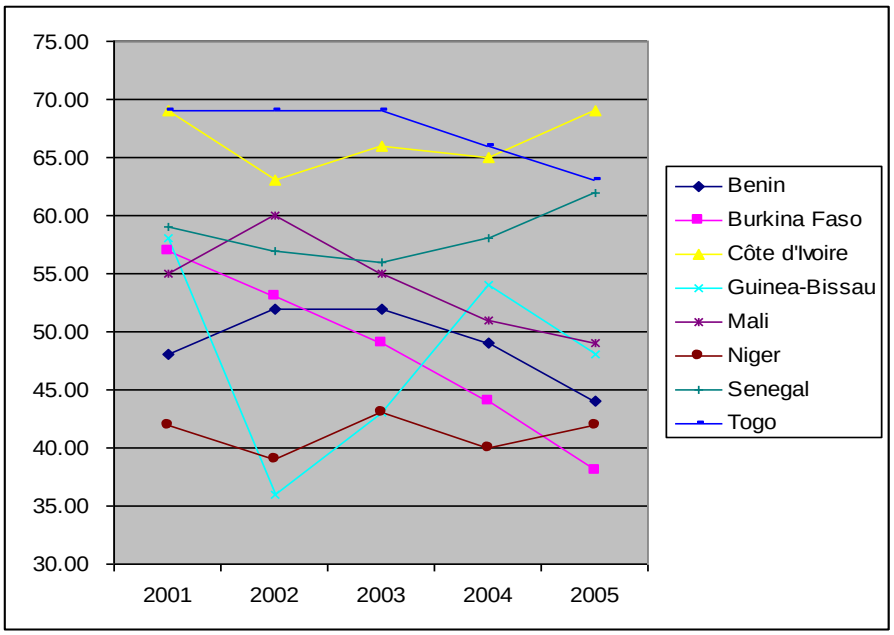
3.2 Health Financing

The WHO's Global Health Observatory estimates that Côte d'Ivoire's total health spending was PPP$120 per capita in 2011. Of this, 69 percent was paid out-of-pocket by households, while 27 percent was funded by the government. In fact, in Côte d'Ivoire, household payments as a percentage of total health spending have long been among the highest in the West African Economic and Monetary Union (WAEMU) region (Figure 1). Total expenditures by various social and private health insurance schemes ranged from 20 to 28 billion CFA francs between 1996 and 2005 – less than 2 percent of total health spending.

According to the data reported in the National Health Development Plan (*Plan National de Développement Sanitaire*) 2009-2013 (*Ministère de la Santé et de l'Hygiene Public* 2008), the government spends far more of its funds on tertiary care than on secondary or primary care facilities. National Health Accounts (NHA) estimates using 2007 and 2008 health expenditure data also found that 27 to 29 percent of government health spending is on tertiary care facilities (most of them located in Abidjan), while only 7 percent of spending is on secondary and primary care facilities combined (*Ministère de la Santé et de l'Hygiene Public* 2010). These budget allocations are particularly unfavorable to the very poor, who are more likely to use primary care.

[2] The ministry is now referred to as the Ministry of Health and the Fight Against AIDS (MOH).

Figure 1: Percent of Health Spending Financed by Households in WAEMU Countries, 2001-05



Sources: World Bank Group 2010

Very few people in Côte d'Ivoire have health insurance (3-4 percent of the of the total population according to the most recent Multiple Indicator Cluster Survey (MICS) (*Institut National de la Statistique et ICF International 2013*). The insured are mainly private sector employees, civil servants, and members of the military; the large portion of the population that lacks a stable income (those in the agricultural and informal sectors, the self-employed, and the indigent)[3] is excluded from coverage (*Ministère de la Famille, de la Femme et des Affaires Sociales* 2006). The 2008 Living Standards Measurement Survey (*Institut National de la Statistique* 2008) indicated that only 8 percent of households benefited from a partial or total coverage of their health costs, whether through insurance, the government, or a nongovernmental organization. This coverage varied substantially based on income level: only 5.2 percent of households in the poorest quintile benefited from such subsidies compared to 13.5 percent among the households in the most affluent quintile.

In Côte d'Ivoire, the main health insurance organizations are nonprofit groups; they include the following:

- Civil Servants and State Workers of Côte d'Ivoire Fund (MUGEFCI);
- National Social Security Fund for private sector employees (*Caisse Nationale de Prévoyance Sociale* CNPS);
- Military Social Security Fund (*Fonds de Prévoyance Militaire*, FPM);
- National Police Social Security Fund (*Fonds de Prévoyance de la Police Nationale*, FPPN);
- Community-Based Urban Health Funds (*Formations Sanitaires Urbaines à base Communautaire*,

[3] Mainly individuals in rural areas where the need is greater and the poverty rate (62.5 percent) is twice that in urban areas (29.5 percent) (*Institut National de la Statistique* 2008).

FSUCOM); and

- Small schemes run by various government institutions (*Bureau National des Études Techniques et du Développement* (BNETD), financial authorities, etc.).

There also are small private for-profit health insurance schemes.

The government also aims to provide subsidies for specific groups and services. A budget line item for indigents, to cover the poorest who cannot afford care, is officially available within each public hospital. In practice, these resources are often used for other purposes and thus are not available for indigent care. Some subsidy initiatives were also created and implemented during the first few months of 2002, when a period of political and military crisis began to ravage the country, providing coverage for war refugees and for emergency care at certain hospitals.

In May 2011, at the end of the political crisis, the Ivorian Government instituted a temporary free care policy within public health establishments and authorized community-based health facilities. This was for a limited period – initially, 45 days, later extended to 10 months – in order to assist populations that were most affected by the deterioration of the country's socioeconomic environment. This measure was replaced on February 20, 2012 by a free care policy targeting pregnant women and children under five, in order to accelerate improvements in maternal and child health indicators associated with the Millennium Development Goals. The new policy also provided for free care for diagnosed cases of malaria and medical and surgical emergencies for the entire population.

By 2013, the government began to further redefine this policy in order to ensure the population's access to quality health services at an affordable cost, and to enhance sustainability and reduce reliance on government subsidies. This ideal was at the heart of the development of a UHC strategy in Côte d'Ivoire.

4. UHC INITIATIVES IN CÔTE D'IVOIRE

This section looks at how UHC is conceptualized in Côte d'Ivoire and at the vision for UHC reforms, including the rationale for and status of these reforms, and their components.

4.1 Conceptualization of and Rationale for UHC

According to key informants as well as UHC-related government documents, the government of Côte d'Ivoire has adopted a practical definition of UHC that is in line with the WHO's definition. For Ivorian health sector stakeholders, UHC embodies the principles of national solidarity and equity, according to the "Draft decree establishing the Social Insurance Institution named the National Health Insurance Fund": "Regardless of the system under which individuals are insured, they shall be covered without discrimination in relation to age, gender, religion, history of illness or residential areas. The entire population of Côte d'Ivoire shall accordingly be subject to UHC" (*Présidence de la Republique*, no date). UHC aims to "make it possible for all people living in Côte d'Ivoire (nationals and non-nationals) to benefit from basic health coverage, the benefits of which shall be defined in a basic package."

Between 1985 and 2008, the incidence of poverty nearly quadrupled in Côte d'Ivoire, rising from 10 to 49 percent, and the depth of poverty worsened (*Institut National de la Statistique* 2008). As mentioned above, the country experienced political and military instability between 2002 and 2011, resulting in, among other problems, disruptions in the delivery of public health services and large numbers of refugees as people fled the fighting. Traditional informal coping mechanisms were weakened. In response, in 2013 the government developed a comprehensive National Social Security Strategy that has five major priorities (*République de Côte d'Ivoire* 2013):

1. Improving living standards of the very poor;
2. Improving access to basic social services and investment in human capital (such as health services for children under five and pregnant women, and basic education) by reducing financial barriers to access
3. Reducing vulnerability to the risks of abuse, violence, exploitation, discrimination and exclusion;
4. Gradually increasing levels of social security coverage; and
5. Strengthening the legal and institutional framework, capacities and resources.

UHC efforts in Côte d'Ivoire are rooted in this broader strategy, but especially in priorities 2 and 4.

4.2 Proposed Institutional Arrangements for Expanding Coverage

In Côte d'Ivoire, the term UHC is often used interchangeably with national health insurance. The UHC strategy in Côte d'Ivoire is being led by a working group that includes representatives from the government, the National Social Security Fund and the Civil Servants and Government Workers Pension Fund, a civil society advisory group, and trade unions. They have created a Permanent Technical Secretariat responsible for the operational management of the UHC process. Secretariat members include a health adviser for the Presidency of the Republic; the Director of Social Security and of the Mutual Insurance System in the Ministry of Social Affairs, Employment and Solidarity; representatives

from line ministries (social affairs, finance, and health); an expert actuarial consultant; the Director-General of Managed Care International-Société de Gestion Maladie (MCI-SOGEM), a private health management company; and a technical inspector from the National Social Security Fund.

A new umbrella institution, known as the National Health Insurance Fund (NHIF), is to be established to consolidate, manage and regulate existing individual health financing schemes. The NHIF is intended to manage risk and supervise all operations for individual schemes. It will receive contributions and ensure the pooling of resources; ensure that the individual registration process is functioning and manage the central file of insured individuals and employers; enforce contractual agreements with and manage health service providers in its network; and reimburse providers for services provided. Some operational functions will be contracted out to selected "Delegated Managing Authorities" (*Organismes de Gestions Délégués*) existing public and private sector institutions that are experienced in the management of health insurance. These include the public sector health insurance entities listed in Section 3.2 as well as private sector associations and organizations such as MCI-SOGEM, Grasoye, and *Assurance Maladie de Monaco* (ASCOMA). The Medical Assistance Board (*Régie d'Assistance Médicale*, REAM) will provide technical management of the scheme for the indigent.

The Delegated Managing Authorities will be responsible for tasks such as the following:

- Identifying and pre-registering formally employed workers and employers in their respective sectors;
- Identifying and enrolling those not formally employed;
- Collecting contributions from workers and those not employed;
- Transferring these contributions to the NHIF;
- Doing medical supervision of clinical service quality and reviewing service providers' invoices;
- Authorizing payments to service providers; and
- Doing overall management of information systems to monitor and update subscribers', employers', and health care providers' accounts.

The proposed institutional arrangements largely build on existing institutions, in the hopes of facilitating rapid and low-cost implementation. Contracts between the NHIF and the Delegated Managing Authorities are intended to strengthen oversight, and competitive procurement of those contracts is hoped to promote competition on quality and cost among health insurance organizations. However, this approach may encounter challenges in coordinating multiple, complex organizational and electronic systems and weaker medical supervision.

In 2015, the UHC strategy will be piloted among the following groups using existing organizations: the formal private sector workforce; public sector workers; retirees from the public and private formal sectors: and agricultural workers from the palm oil and rubber industries.

4.2.1 Proposed Schemes within the NHIF System

The NHIF will offer two schemes: a contributory "Basic General Scheme (*Régime Général de Base*, RGB)" and a non-contributory "Medical Assistance Scheme (*Régime d'Assistance Médicale*, RAM)" for low-income or destitute persons, as defined by law.

The RGB will be a contributory scheme based on the principle of third-party payment and co-payment. It will be available to all residents, whether nationals or non-nationals, who are not eligible for the RAM. Enrollment will be mandatory for those who are subject to income tax, and coverage will be provided either by the National Social Security Fund, the Civil Servants and State Workers Pension Fund, or another health insurance organization of the worker's choice. Agricultural and informal sector workers

will have to organize and join *mutuelles* (community-based health insurance schemes) for their professions; these schemes will be able to join one of the larger health insurance organizations. All members will have to pay a flat premium of 1,000 CFA francs per month per person, and will have access to the same benefits package, which will include coverage of outpatient care, inpatient care, maternity care, and generic drugs. Networks of health care providers, both public and private, will be organized, and payment rates will be negotiated between the NHIF and providers.

RAM will be a non-contributory, government-subsidized scheme based on the principle of national solidarity. This will provide free care to targeted vulnerable groups (pregnant women, children under five years old, indigents). The scheme will cover safe delivery kits, caesarean delivery kits, and selected free medications (anti-malaria drugs, antibiotics for children, oral rehydration salts, 20-mg zinc tablets, acetaminophen, malaria test kits, and essential generic drugs provided by an in-network provider). Indigents will have access to covered curative and maternity care provided in in-network public and community facilities and hospital care with a referral from the lower-level facilities. Some endemic tropical diseases, such as Buruli ulcers, onchocerciasis (river blindness), schistosomiasis, and trypanosomiasis, will also be covered.

Individuals covered under the above schemes will be able to buy additional health insurance through a Supplementary Scheme. The scheme will be a separate marketplace of private insurance companies and *mutuelles*. It will not be regulated under the government UHC strategy.

4.2.2 Planned Funding for the NHIF System

Revenue for the RGB will be provided through contributions (voluntary or mandatory), late penalties, investment income, government subsidies, donations and bequests, and other funding mechanisms (for example, taxes on coffee and cocoa products).

The RAM will be funded by subsidies from the central government and regional resources, investment income, donations and bequests, and earmarked taxes. The funding from the central government is projected to be 30 billion CFA francs (US$63 million) per year, equivalent to the amount spent on the free care policy since 2011. It is hoped that the scheme can be funded from existing health care resources and not require either new revenue streams or funding from another part of the central government budget.

4.2.3 Planned Infrastructure Improvements

To ensure its success with UHC, Côte d'Ivoire's UHC strategy recognizes that the technical capacity of public health facilities will have to be improved to enable them to meet quality standards. According to a member of the UHC working group in the Ministry of the Economy and Finance, the annual budget for fiscal years 2013 and 2014 will include 110 billion CFA (US$230 million) to upgrade technical capacity, specifically the renovation and re-equipping of 37 primary health care facilities, 18 urban health centers, 10 regional hospital centers, 29 general and district hospitals, and the neonatal and gynecological wing of the Yopougon teaching hospital. In the medium term, this will also involve the construction of specialized centers (radiotherapy and medical oncology centers, Bouaké Institute of Cardiology, and an operating room in the Guitry General Hospital).

Private facilities that have chosen to be part of the UHC system will have to meet the same technical standards as the public facilities to avoid penalties imposed on their reimbursements by the NHIF.

5. UHC MEASUREMENT FINDINGS

5.1 Information Systems to Monitor UHC Initiatives

5.1.1 Profile of the Current Health Information System

The MOH collects data through the routine health information system (HIS) as part of its overall management of the health system. HIS data are published in Annual Health System Reports and Health Statistics Directories. Government financial data on the health sector is available from the Ministry of the Economy and Finance. Other national surveys and studies are also produced for information about household financial protection and service access indicators. The DHS, the MICS, other surveys on household living standards, and NHA estimations have all been conducted in recent years.

In 2013, the MOH established an internal technical committee with several subgroups to help prepare for the roll-out of the NHIF. The committee has begun collecting information on health services and financing at every level of care as part of this preparatory process. One goal is to map all health facilities in the country, assessing whether they meet basic technical standards and if their information system is in place. To carry out the assessment, the MOH developed data collection templates for all regional and district health departments, and health inspectors have been charged with reaching out to the regional and district health directors to gather this information.

5.1.2 Strengths and Challenges of the Health Information System

Several strengths in the current routine HIS should be recognized. The very existence of a working system with defined procedures and rules is a strength, given that the country is emerging from a long period of crisis. At the regional and district management levels, the personnel in charge of the HIS are well-trained professionals with proven experience in compiling health facility data. HIS staff generally have the technical equipment they need to perform their tasks. At the health facility level, the staff responsible for data collection are strongly motivated, despite the need to strengthen their capacities. Data generated from programs that are supported by development partners – HIV/AIDS, tuberculosis, immunization, and reproductive health – are generally considered to be of good quality in terms of completeness, promptness and accuracy, because of the partners' involvement in program implementation and requirements for monitoring. The data collection systems developed by partners can be a model for improving data quality of the entire system.

However, some challenges have been identified as well. According to information from interviews with several key informants from the MOH and development partners, the MOH Department of Information, Planning and Assessment (DIPE), which is responsible for the gathering and management of routine health information, is insufficiently equipped to properly manage information in the context of moving toward UHC. The computerization of the health system is a real challenge, particularly in health facilities where there is little use of new technologies for gathering and managing data. The DIPE relies instead on multiple paper-based templates. Primary care facilities lack human resources dedicated to health information, increasing the difficulty of getting data from those facilities, especially in rural areas. The nature of the data collection process itself leads to chronic breakdowns along the reporting chain from

rural areas all the way to the central level. The lack of an organizational link between the central level (DIPE) and the health facilities in terms of governance, planning, and supervision adds to the challenge. Moreover, the DIPE does not have formal ties to the University-Affiliated Hospitals (CHU),[4] and those hospitals do not use the MOH templates created for routine data collection; they provide data upon request from the DIPE.

Key informants reported that the information gathered routinely in health facilities is considered to be of inadequate quality in terms of completeness, promptness, and accuracy. A DIPE assessment (DIPE 2012) conducted in April 2012 with the MEASURE Evaluation project using PRISM tools confirms these opinions. However, it should be noted that data quality varies by the level of the health facility: data from primary care facilities are of better quality than data from general and regional hospitals.

Finally, the routine HIS contains only data from public and nonprofit health facilities, excluding data from the growing for-profit health sector.

5.1.3 Planned UHC Monitoring System

The NHIF, which will oversee the various financing schemes under the new system, will have its own information system. It will provide information from this system to the MOH as needed for tracking progress on the financial dimension of UHC.

Responsibility for day-to-day information management will rest with the Delegated Managing Authorities. They will report information on insurance beneficiaries and service providers in accordance with the terms of reference defined by them and the NHIF. The Delegated Managing Authorities will also be responsible for medical supervision – ensuring the appropriateness and quality of the health services they purchase from health facilities on behalf of their beneficiaries – which will be carried out by their medical consultants. This information will also be reported to the NHIF, which will consolidate it.

The data collected through the NHIF information system will enable monitoring of some financial risk protection indicators. For example, the proportion of the population with insurance could be easily generated and disaggregated by urban/rural residence, work in formal/informal sector, or belonging to a vulnerable group. More detailed estimators in terms of type of benefits received (in volume and cost) could also be obtained.

For now, a system for monitoring progress toward UHC is yet to be defined in greater detail. However, the UHC working group's Secretariat has engaged an accounting firm for technical assistance in designing and implementing the information system. Currently, the Secretariat is gathering and using a wide range of economic, social, and health data from various public and private organizations and through special studies. These data are intended to support a better understanding of the socioeconomic and health profile of Côte d'Ivoire's population and to help make the best strategic choices for UHC monitoring. Ultimately, the government aims to define standard treatment protocols and associated expected costs for each condition covered by insurance, in order to establish appropriate reimbursement rates and ensure the most efficient use of financial resources. Because this could be a very long process and the government wishes to roll the system out soon, the Secretariat is starting by creating general profiles for insured individuals, health professionals, and health facilities (by level). For each condition, average health care consumption profiles per insured will be defined, as well as average prescription profiles per prescriber and average invoice profiles by facility level.

[4] There probably will be a need to coordinate the data collection from a higher number of services, which will require greater involvement of health workers.

One particularly challenging technical topic is developing the criteria that will define "indigence," that is, how poor citizens will be identified. This is particularly important for the design of the RAM. The Secretariat of the UHC working group is currently defining the criteria. Once these criteria have been validated, the Secretariat will be able to estimate how many indigent Ivorian citizens the RAM can cover. The current thinking is to use relative deprivation criteria rather than absolute income thresholds. The working group seeks to develop two or three approaches for the urban, semi-urban, and rural sectors.

5.2 Relevance of Globally Proposed Indicators in Côte d'Ivoire

5.2.1 Health Services Coverage Indicators

The researchers asked key informants their views about the relevance and usefulness of the WHO indicators to the Ivorian system. The consensus was that most of the service coverage indicators regarding communicable diseases already are collected routinely or through surveys and are considered relevant. However, information on the indicators associated with noncommunicable diseases is not routinely reported, and informants had varying opinions about their relevance in Côte d'Ivoire. Table 1 summarizes availability of the service coverage indicators in the current information system.

Table 1: Availability of Service Coverage Indicators Proposed by the WHO in Côte d'Ivoire

Service Coverage Indicators	Number of Indicators	Number Available		Number Unavailable	Comments
		Survey	Routine		
Communicable Disease Indicators					
Maternity care	5	5	4	0	
Child undernutrition	6	6	2	0	
Child vaccination	5	4	4	1	Hepatitis B is not tracked within the standard immun. program framework
Treatment of sick children	3	3	1	0	
Family planning	2	2	1	0	
Malaria	3	3	0	0	
Tuberculosis	2	2	0	0	
HIV/AIDS prevention/treatment	5	3	2	0	
Subtotal	31	28	14	1	97% available
Noncommunicable Disease Indicators					
Cancer	5	1	0	4	Tobacco use indicator available through surveys
Cardiovascular diseases	8	0	1	8	Only high blood pressure incidence is available through routine data
Diabetes	1	0	0	1	
Chronic pain (terminal disease, musculoskeletal etc.)	1	0	0	1	

Service Coverage Indicators	Number of Indicators	Number Available		Number Unavailable	Comments
		Survey	Routine		
Chronic respiratory conditions	1	0	0	1	
Musculoskeletal conditions	1	0	0	1	
Mental health	1	0	0	1	
Vision problems	2	0	0	2	
Hearing problems	1	0	0	1	
Dental/ Oral	1	0	0	1	
Other Noncommunicable Diseases (NCDs)	2	0	0	0	
Injuries	1	0	0	1	
Subtotal	25	1	1	23	8% available
TOTAL	56	29	15	24	57% available

Source: Case study interviews and review of data, August 2013

5.2.2 Financial Protection Indicators

Among the key informants interviewed, the general consensus was that indicators of protection against financial risk are relevant, even though they are not systematically calculated (see Table 2).

National household surveys are conducted every five years to collect information on living standards. Those surveys gather information about household health expenditures that is difficult to collect routinely, and enable calculation of indicators such as the share of total health expenditures made by households or the incidence of catastrophic health expenditure.

Table 2: Availability of Financial Risk Protection Indicators Proposed by the WHO in Côte d'Ivoire

Type of Financial Risk Protection Indicator	Number of Indicators	Number Available		Number Unavailable	Comment
		Surveys	Routine		
Direct indicators	4	1	0	3	
Indirect indicators	6	0	5	1	Some indicators collected by MOH Department of Finance as part of NHA estimations
TOTAL	10	1	5	4	

Source: Case study interviews and review of data, August 2013

5.2.3 Quality and Health Systems Indicators

Key informants stated that information on the quality of care is not currently gathered in Côte d'Ivoire either routinely or through surveys. One of the few existing studies was conducted under the Urban Health Project in public and community-based health centers in Abidjan; it was financed by French Cooperation and focused particularly on the issue of emergency obstetrical care. UNICEF has funded other anthropological studies on the quality of services as part of the Urban Health project. Studies by Jaffré and de Sardan (2003), and the USAID-funded Health Systems 20/20 project[5] have assessed the quality of human resources for health in Côte d'Ivoire's public health system. The key informants generally considered that it would useful to monitor quality indicators routinely in the context of UHC.

5.2.4 Indicators Prioritized by Local Stakeholders

Among the indicators prioritized by local stakeholders to monitor the implementation of UHC initiatives, particular attention was given by the interviewees to the indicators in Table 3. For analysis of equity in coverage, socioeconomic status (measured through wealth quintiles) and place of residence (region, urban/rural) were prioritized.

Table 3: List of Service Coverage Indicators Recommended by Key Informants for UHC Monitoring in Côte d'Ivoire

Service Coverage Indicators	Financial Risk Protection Indicators	Additional Topics of Interest
General population rate of health services utilization (percentage of population seeking any health care)	Percentage of the population covered by a UHC scheme	Measures of the quality of health services delivered
Consultation rate (number of consultations per person per year)	Percentage of the indigent covered by a UHC scheme	Measures of patient satisfaction
Rate of assisted deliveries	Percentage of public expenditure allocated to health	Rate of health budget execution
Percentage of pregnant women who have at least 4 antenatal care visits	Household out-of-pocket expenditures as a percentage of total health expenditures	Operating expenses of managing entities as a percentage of total expenses
Percentage of children who are fully immunized	Household incidence of catastrophic health expenditures	Average time for payment of services
Coverage of malaria services		
Percentage of newborns receiving priority interventions		
Population residing less than 5, 10 and 15 km from a health facility		
Number of health personnel per 10,000 inhabitants		

Source: Case study interviews and review of data, August 2013

[5] For the Health Systems 20/20 study reports, see http://www.healthsystems2020.org/content/resource/?topic=26&country=43&type=&source=

6. RECOMMENDATIONS

This chapter recommends steps that Côte d'Ivoire should take in order to improve the measurement of its progress toward UHC and the strengthening of health system governance.

6.1 Clear and Inclusive Communication on UHC among Stakeholders

Based on key informant interviews, it appears that stakeholders who are knowledgeable about monitoring constitute only a small number of the people involved in the UHC working group's Permanent Technical Secretariat. Other stakeholders, including those directly engaged in the development of health insurance, were unfamiliar with the global definition and objective of UHC – widespread access to quality health services and protection from medical impoverishment – and its terminology, and with ongoing UHC reforms in Côte d'Ivoire. Indeed, many respondents used the terms UHC and national health insurance interchangeably. Therefore, priority should be given to more inclusive communication (explaining strategic choices and specific implementation steps) to the variety of stakeholders across the ministries and other institutions involved in the UHC process.

6.2 Leverage Development Partners' Expertise in HIS

The implementation of UHC will likely influence the intervention strategies of the development partners currently working in Côte d'Ivoire. As noted earlier, key informants recognized partners' expertise in data collection and rigorous indicator measurement. As the UHC Secretariat works to design the UHC monitoring framework, it would be appropriate to leverage the technical expertise of development partners and enable them to integrate the new opportunities that UHC represents into their future plans for the country.

6.3 Promote Better Coordination among the Institutions Responsible for UHC Monitoring

Although the individual insurance institutions managed by the NHIF will be responsible for the gathering and managing health insurance information, it would be prudent to have from the very beginning a framework for communication between these institutions and the DIPE, the entity responsible for information management at the MOH. Linkages could be direct or through the NHIF. The potential role of each of these two main actors (MOH and NHIF) in the monitoring process has been partially defined, but no official communication channels have yet been established between them. This kind of framework for communication would ensure that the MOH's health information requirements are considered within the configuration of the overall UHC information system, especially for health service coverage and quality of care.

7. CONCLUSION

The objectives of this case study were the following: (i) to understand how Côte d'Ivoire is conceptualizing UHC and the initiatives it is implementing to achieve this goal; (ii) to identify the indicators that the country is using to measure its progress toward UHC; (iii) to assess the country's capacity for gathering data as well as producing the standard measurement indicators recommended by the WHO; and (iv) to make recommendations.

Côte d'Ivoire is at the very beginning of implementing financial protection mechanisms for health risks and extending coverage through a UHC system. Not surprisingly, given the stage that the country is at, it has not yet defined all of the parameters for implementing the new system. The monitoring system, the main focus of this exercise, is not entirely defined, and the interpretations in this report should be understood relative to that context.

Based on this assessment, the following conclusions can be formulated regarding measuring and monitoring progress toward UHC in Côte d'Ivoire:

- The majority of the WHO's recommended UHC service coverage indicators that are associated with communicable diseases are gathered routinely or through surveys and are considered relevant for measuring UHC by the majority of the stakeholders interviewed. The indicators associated with noncommunicable diseases are not gathered routinely and, for the most part, are not considered relevant for monitoring UHC currently. On the other hand, the financing indicators and those of protection against financial risk, while not systematically available, are considered relevant for the measurement and monitoring of UHC.
- At this stage of designing UHC initiatives, official measurement and monitoring indicators have not yet been defined. However, it is envisioned that data collection for management of the NHIF will be carried out by the "Delegated Managing Authorities" – the numerous individual insurance institutions that will fall under the NHIF's umbrella. The NHIF will be responsible for centralizing and consolidating information from those various entities for decision-making.
- One source of concern is that no "bridges" or cross-walks have been envisioned to link these insurance system management indicators (which will be made available through the NHIF) and existing public health indicators associated with the coverage of health services (which are properly the mandate of the DIPE at the MOH). The routine HIS, which is managed by the DIPE, could become the platform for compiling service coverage indicators, but linkages with the NHIF have not been made. Moreover, assessments show serious weaknesses in data completeness and accuracy in the HIS. There is a clear need for investment in the HIS as well as capacity building for the staff in charge of its management, in order to improve the data it compiles.

ANNEX A. SUMMARY OF WHO AND COUNTRY INDICATORS IN CÔTE D'IVOIRE

Service Coverage Indicators: Maternal and Child Health

Core Tracer Indicators	Specific indicator definition (numerator, denominator, timeframe)	Data Sources (citation of reports)	Indicator Value by Year											
			2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
ANC 4 or more visits	Proportion of women who went for at least the 4 required antenatal visits during pregnancy (once for each trimester and one for the 9th month)	DHS, MICS, 2005 Survey on AIDS Indicators (EIS), Country Annual Health Statistics Report		30.69%	33.00%	34.22%	34.79%	32.46%	33.51%	20.45%	23.14%	17%		23.00%	
ANC 1+ visit	Proportion of women who went for at least the 1 antenatal visits during pregnancy	DHS, MICS, 2005 Survey on AIDS Indicators (EIS), Country Annual Health Statistics Report								52.29%	66.33%	55%		69%	
Postnatal care	Number of babies who received postnatal care within two days of birth, regardless of place of delivery	Country Annual Health Statistics Report								39,752	237,378	61,542		56,294	
Children under 5 who are stunted	Proportion of stunting (height-for-age less than -3 standard deviations of the WHO Child Growth Standards median) among children aged 0-5 years	DHS, MICS	NA						34%						12% for 6-8 months; 19% for 9-11 months; 39% for 24-59 months

Core Tracer Indicators	Specific indicator definition (numerator, denominator, timeframe)	Data Sources (citation of reports)	Indicator Value by Year												
			2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Children under 5 who are underweight	Proportion of underweight (weight-for-age less than -2 standard deviations of the WHO Child Growth Standards median) among children aged 0-5 years	DHS, MICS, Country Annual Health Statistics Report	NA						7%	7.48 %	7.54 %	20.52 %	12.49 %	9.10 %	8%
Proportion of wastage in children under 5 years of age	% of wastage among children aged five years or younger	DHS, MICS							20%						15%
Low birth weight among new born	Proportion of live births that weigh less than 2,500 g out of the total of live births during the same time period	DHS, MICS, Country Annual Health Statistics Report		6.2% / 7.27	6.8% / 7.49	6.9%/ 7.68	7.3%/ 7.39	6.45% / 7.5	7.05%/ 7.75	NA	NA	13%	13%	5.58%	14.12%
Measles	% of children aged 12-23 months who have received at least one dose of measles-containing vaccine in a given year	DHS, MICS, Country Annual Health Statistics Report		44.02%	42%	42.34%	37.95%	36.20%	38.03%	69.33%	59.74%	67%		67%	
Polio	% of one-year-old who have received three doses of poliovaccine in a given year	DHS, MICS, Country Annual Health Statistics Report		42.82%	43.90%	46.97%	41.34%	43.01%	46.86%	78.77%	77.08%			77%	
Suspected pneumonia taken to health facility	Proportion of children aged 0–59 months who had acute respiratory infection (ARI) or presumed pneumonia in the last two weeks and were taken to an appropriate health-care provider	DHS, MICS, Country Annual Health Statistics Report		86.5‰	87.40‰	92.00‰	107.40‰	98.80‰	99.00‰	88.02‰	82.53‰	84.57‰			40‰

Core Tracer Indicators	Specific indicator definition (numerator, denominator, timeframe)	Data Sources (citation of reports)	Indicator Value by Year												
			2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Unmet need for Family Planning	The proportion of women of reproductive age (15-49 years) who are married or in union and who have an unmet need for family planning, i.e. who do not want any more children or want to wait at least two years before having a baby, and yet are not using contraception	MICS							29%						27%
Contraceptive use	Proportion of women aged 15-49 years, married or in-union, who are currently using, or whose sexual partner is using, at least one method of contraception, regardless of the method used	DHS, MICS, Country Annual Health Statistics Report							13%	5.37%	9.39%	9.58%	7.55%	5.80%	18%

Data for institutional delivery were not obtained. Hepatitis B vaccine is part of Penta vaccine and is not tracked separately.

Service Coverage Indicators: Disease Specific

Core Tracer Indicators	Specific indicator definition (numerator, denominator, timeframe)	Data Sources (citation of reports)	Indicator Value by Year												
			2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Communicable diseases : Malaria, Tuberculosis, HIV/AIDS															
Fever treated with antimalarials/ artemisinin combination therapy	Percentage of children aged 0–59 months who had fever in the two weeks preceding the survey who received anti-malarial drugs	DHS, MICS	57.50%						36%						18%
Housholds with IRS	Proportion of houses in IRS targeted areas that were sprayed in the last 12 months	DHS, MICS													2%
Detection rate	Number of new cases of tuberculosis per 1,000 at risk population	Country Annual Health Statistics Report		1.3 ‰	1.29 ‰	0.9‰	0.83‰	0.74 ‰	0.77 ‰	1.17‰	1.17 ‰	1.08 ‰	1.06 ‰	1.06 ‰	
Treatment success rate	Percentage of tuberculosis cases detected and cured under DOTS	National Strategy Against Tuberculosis Report	52%	56%	54%	61%	63%	63%	62%	67%	69%	67%	78.40%		
ARV therapy among those in need	% of population with advanced HIV infection with access to ART drugs	UNDP National report on the MDGs, UNAIDS National GARP Report							21.30%	29.70%	31.60%	43.90%			
ARV prophylaxis among HIV+ pregnant women	Proportion of HIV-infected pregnant women who received antiretroviral medicines among the estimated number of HIV-infected pregnant women	Country Annual Health Statistics Report								65.40%	62.40%	61.50%	59%	60%	
ART	Number of people under ART	Country Annual Health Statistics Report			2,473			15,722		37,603	51,820	72,011	82,347	88,153	

Core Tracer Indicators	Specific indicator definition (numerator, denominator, timeframe)	Data Sources (citation of reports)	Indicator Value by Year												
			2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Male circumcision rate	Proportion of men 15-49 years who are circumcised	DHS, MICS, 2005 Survey on AIDS Indicators (EIS)						96%							97%
Non communicable diseases*															
High blood pressure prevalence	High Blood Pressure prevalence among those 15+ years	Country Annual Health Statistics Report								4.66 ‰	4.03 ‰	4.76 ‰	4.36 ‰	3.44 ‰	

*None of the detailed NCD indicators proposed were obtained for Côte d'Ivoire. The only NCD indicators found were related to tobacco use and High blood pressure prevalence

Financial Coverage Indicators

Core Tracer Indicators	Specific indicator definition (numerator, denominator, timeframe)	Data Sources (citation of reports)	Indicator Value by Year												
			2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Out-of-pocket payments as a share of total health expenditure	Level of out-of-pocket expenditure expressed as share of total health expenditure	NHA data								70%	66.30%	57%	56%		
Legal entitlement to health services through insurance or direct government funding/provision		DHS, MICS, NHA data								4%	4%	4.04%	4.03%		
Government health expenditure as a share of GDP	Level of total expenditure on health (THE) expressed as a percentage of gross domestic product (GDP)	Country Annual Health statistics Report, NHA data	1.31%	0.91%	0.91%	0.88%	0.93%	0.77%	0.84%	0.86%	0.88%	0.99%	1.05%	0.95%	
Government health expenditure as a share of general government expenditure	Level of general government expenditure on health (GGHE) expressed as a percentage of total government expenditure	Country Annual Health statistics Report, NHA data	5.18%	5.62%	4.02%	4.95%	4.06%	3.96%	3.95%	4.05%	4.03%	4.37%	4.05%	3.52%	4.06%
Percentage of government health expenditure for fixed costs compared to medication and equipment costs		NHA data								55%	52.00%	51.35%	51.31%		
Total health expenditure per capita (FCFA)	Per capita total expenditure on health (THE)	NHA data								27,941	29,826	34,576	35,552		

None of the direct financial protection indicators proposed was obtained for Côte d'Ivoire. Those indicators are mostly related to catastrophic out of pocket expenditure on health and their impact on impoverishment

Other Indicators

Core Tracer Indicators	Data Sources (citation of reports)	Indicator Value by Year													
		2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
Access to Health workers	National Strategy for HRH development report						1 doctor for 9,454 inhabitants; 1 nurse for 2,805 inhabitants; 1 midwife per 2,235 pregnant women	1 doctor for 8,039 inhabitants; 1 nurse for 3,833 inhabitants; 1 midwife per1,866 pregnant women	1 doctor for 5,909 inhabitants; 1 nurse for 2,900 inhabitants; 1 midwife per 2046 pregnant women			1 doctor for 5,245 inhabitants; 1 nurse for 2,916 inhabitants; 1 midwife per 2,159 pregnant women			
Access to Health facilities	Country Annual Health Statistics Report							11,714 inhabitants per health facility	12,492 inhabitants per health facility	12,752 inhabitants per health facility	8,203 inhabitants per health facility	10,452 inhabitants per health facility	9,140 inhabitants per health facility		
Hospital beds per 10,000 population	Country Annual Health Statistics Report								2.78	2.72	2.60	2.60	2.51		
Percent of births registered	DHS, MICS							55%						65%	
Access to safe water	DHS, MICS	81.70%						76%							
Access to improved sanitation	DHS, MICS	59.10%						57%							
Life expectancy at birth	DHS, MICS	50.9					46					46			
Child mortality rates (under 5) (perinatal, neonatal, infant)	DHS, MICS						44 per 1,000							43 per 1,000	
Maternal mortality ratio	DHS, MICS						543 per 100,000				569 per 100,000			614 per 100,000	
HIV prevalence among young people (15-24)	Survey on AIDS Indicators (EIS)						15-19 years: 0.3/20-24 years: 2.5							15-19 years: 0.5/20-24 years: 2.2	

Core Tracer Indicators	Data Sources (citation of reports)	Indicator Value by Year													
		2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
Notifiable disease incidence (measles, neonatal, tetanus)	DHS, MICS		0.004/15	1.38/12	1.01/11	0.79/10	0.82/12	0.04/41	374/268	334/220	0.06/31		0.10/232		

ANNEX B. KEY RESEARCH QUESTIONS

Overview of the country's understanding of UHC and monitoring progress toward it

- How would key stakeholders define UHC? How would they define service coverage and financial coverage (or financial protection)? What dimensions of equity do stakeholders consider important (by wealth/income, region, gender, ethnic group, immigration/citizenship status)?
- To what extent has the country considered and/or prepared a plan for measuring service coverage and financial protection as well as equity in the distribution of services and financial resources?

Current status of monitoring progress toward UHC measured against internal and WHO standards

- What indicators do key stakeholders consider relevant for tracking progress toward UHC? Which of these is the country's government currently tracking? Assess the availability, frequency, timeliness, and quality of these indicators. Are these data used by policy makers? What would the government like to measure, but does not currently have resources or capacity to measure?
- Which of the WHO's proposed UHC indicators [to be provided] does the country currently measure through its existing health information system (from the routine HIS, surveys, vital statistics, surveillance, etc.) to monitor progress toward UHC? How are the data collected? To what extent are the WHO UHC indicators compatible with those captured by the country's routine HIS? Assess the availability, frequency, timeliness, and quality of these indicators.
- How do the indicators that the government currently tracks or has identified compare to the WHO's proposed UHC indicators? Do government officials find the WHO UHC indicators relevant/helpful?
- Is the country capturing measures of equity in financial protection and in service coverage? If so, how is equity being measured - along what dimensions?
- The WHO is interested in measuring "effective coverage," the percentage of the population who receive services that are of adequate quality to improve health or well-being. Information about the quality of services received is important in assessing the real health implications of service coverage statistics. How does the country currently measure the quality of service provision?

Country's capacity to monitor progress toward UHC

- Assess the country's capacity to produce the set of WHO indicators based on core HIS dimensions, including: sufficient human resources with relevant technical knowledge and skills, sufficient financial resources, conducive legal and regulatory policies, adequate organizational capacity, adequate IT and management systems strength.
- What investments to improve or build capacity for monitoring progress toward UHC have been made already, if any?
- What other investments would the country need to strengthen its capacity to track the WHO indicators? Possible examples include:
    - Ensure adequate staffing of technical positions; recruit additional staff
    - Improve technical skills and knowledge of available key staff through technical assistance and training (e.g. topics: surveys development and implementation, statistics, routine monitoring, producing indicators from raw data, basic data analysis skills)
    - HIS strengthening, including IT infrastructure
    - Organizational development and management skills building (e.g., professional development for senior-level people

ANNEX C: KEY INFORMANTS

Ministry of State, Ministry of Employment, Social Affairs and Solidarity (3): Representatives of the Permanent Technical Secretariat for the UHC working group

Ministry of Health and the Fight against AIDS (8): Representatives of the UHC Technical Committee, the DIPE, the Directorate of AIDS Planning, Monitoring and Evaluation, and the Directorate of Forecasting and Strategic Planning

Ministry of the Economy and Finance: Representative of the Permanent Technical Secretariat for the UHC working group

Development partners (3): Representatives from the USAID-funded MEASURE Evaluation project, WHO, and UNICEF

ANNEX D: AVAILABILITY OF ADDITIONAL HEALTH SYSTEMS INDICATORS

Additional Indicators	Number of WHO Indicators	Available		Unavailable	Comment
		Survey	Routine		
Health financing	1	0	1	0	Indicator collected from MOH Department of Finance as part of NHA estimations
Health workforce	2	1	1	0	
Infrastructure	2	0	2	0	
Information	2	0	0	2	
Governance	7	0	3	4	The National Health Plan includes some of these indicators
Service access and readiness	3	0	1	2	
Service quality and safety	3	0	0	3	
Risk factors and behaviors	4	2	0	2	
Health status	8	4	1	3	
Responsiveness	1	0	0	1	
TOTAL	26	7	9	10	

ANNEX E: SOURCES OF SECONDARY DATA ANALYZED FOR CASE STUDY

1. DIPE, MOH, 2011, Free health care in Côte d'Ivoire (April 16 to May 30, 2011): Assessment report, mimeographed report, 17 p.
2. DIPE, 2008, Health Statistics Directory 2001-2006, mimeographed document, December, 73 p.
3. DIPE, 2009, Health Statistics Directory 2007-2008, mimeographed document, December, 239 p.
4. DIPE, 2010, Health Statistics Directory 2009, mimeographed document, November, 258 p.
5. DIPE, 2011, Report on the Status of Health (RSS 2007-2009), mimeographed document, September, 256 p.
6. DIPE, 2012, Health Statistics Directory 2011, mimeographed document, 222 p.
7. DIPE, 2012, National Routine Health Information Assessment by the PRISM's methodology, mimeographed document, March, PEPFAR/Measure Evaluation, 46p.
8. DIPE, undated, Free health care in Côte d'Ivoire (16 April to 30 May 2011), mimeographed document, 17p.
9. Draft decree on the creation of the social security institution named "Caisse Nationale d'Assurance Maladie" ["National Health Insurance Fund"] (Institut de Prévoyance Sociale-NHIF)
10. Draft legislation on the institution, organization and operation of Universal Health Coverage
11. ENSEA, Health Systems 20/20 (2010), Characteristics of the skills of newly qualified health providers to support the most common diseases in Côte d'Ivoire- Report, mimeographed document, May, 57p + annexes.
12. Y. Jaffré et J. Olivier de Sardan (2003), Un diagnostic socio-anthropologique des centres de santé malades …, extrait de La médecine inhospitalière- les difficiles relations entre les soignants et les soignés dans cinq capitales d'Afrique de l'Ouest, Karthala, p52.
13. Institut National de la Statistique (INS), 2007, Survey MICS Côte d'Ivoire 2006 (MICS 2006), UNICEF/UNFPA/UNDP/UE/INS, mimeographed document, March, 204p.
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