Rapid Gender Assessment: Côte d'Ivoire *Couverture Maladie Universelle* (CMU)

Version: June 30, 2023

Introduction

In its pursuit of expanding healthcare access to quality health services, the government of Côte d'Ivoire has introduced the *Couverture Maladie Universelle* (CMU) system, a mandatory health risk coverage program that aims to guarantee access to quality health care for the general population. [1] Given the high maternal mortality, child mortality, fertility, and adolescent fertility rates in the country, the World Bank Group (WBG) and the Global Financing Facility (GFF) have supported the government in prioritizing CMU as a key reform measure for improving basic services related to women's, adolescents', and children's health. It is hoped that insurance access would incentivize improved utilization of health services, including maternal and newborn care as well as family planning services, ultimately improving Côte d'Ivoire's health outcomes. [2]

While at its core, UHC sets out to achieve equity and provide financial protection to all segments of the population, gender inequality is often overlooked in general financing reforms that aspire to achieve universal access, an omission that undermines the full potential of the intended reforms and often contributes to continued disparities in health outcomes and service coverage rates.[3, 4] For Côte d'Ivoire, some elements of a just-completed evaluation of the CMU system suggest that inadequate consideration of gender inequality concerns in the program design and rollout may be both reflective of, and contributing to, the overall challenges encumbering the program and undermining it success.

To shed further light on some of the gender related issues in the CMU rollout and utilization, the Monitoring and Action for Gender and Equity (MAGE) partnership at the GFF and Johns Hopkins University (JHU) in collaboration with the World Bank undertook a rapid gender assessment of the CMU system in Côte d'Ivoire. This rapid gender assessment involved further analysis of the gender related data in the recent CMU evaluation and incorporated other available relevant data to highlight key concerns that could help the government of Côte d'Ivoire improve equity in the CMU implementation and track progress in the next phase of Côte d'Ivoire's Health, Nutrition, and Early Childhood Development Program for UHC.

This report captures the key findings from the rapid gender assessment of the CMU implementation. Although providing only a preliminary set of findings limited by available secondary data sources, the analysis points to important gender-related bottlenecks with respect to how the program is financed, how funding for the CMU is pooled, and how purchasing of services is undertaken. Combining both a gender and equity lens, the findings highlight that the design and implementation of the CMU are especially challenging for uptake and utilization by poor women whose financial and logistical barriers as well as health care needs will have to be specifically targeted in the next stage reforms of the insurance system. Additionally, the reach, relevance, and impact of the reforms will have to be tracked not just in terms of economic or geographic equity, but also gender equity, if improvements are to trend toward the desired positive outcomes.

Methodology

This rapid gender assessment leverages available gender relevant data collected and/or compiled for a WBG-financed evaluation of the CMU in Côte d'Ivoire completed by (R4D) in late 2022. The analysis further incorporates secondary data from *Caisse Nationale de l'Assurance Maladie* (CNAM) and publicly available gender data for Côte d'Ivoire from such sources as World Bank and UN data portals. In addition to the document and secondary data analysis, an interview with members of the R4D CMU evaluation team was conducted to get a better understanding of the CMU organization and implementation processes, and to triangulate and contextualize the findings. The analysis applies a gender and intersectionality lens to the four key functions of the health insurance system: financing, pooling of resources, purchasing, and provision.

Key Findings

1. There are significant gender disparities in CMU coverage and utilization.

The findings on CMU coverage and utilization indicate that women are insured at lower rates (48%) than men (52%) for the overall period from 2015-2020 and particularly after the program took off in 2019. Beyond the gender gap in population coverage there is a much larger gender gap in CMU utilization with almost two-thirds (65%) of service utilization being accounted by men, and only one-third (35%) by women. For example, according to the 2020 CNAM report, men were the beneficiaries of 64% of consultations, 63% of drugs, and 67% of procedures through the CMU. [5]

This gender imbalance in utilization is especially jarring given that data in most settings indicate that in general, women have both greater need for and greater utilization of healthcare services compared to men.[2, 6] For example, women have specific health needs related to their sexual and reproductive health, and they bear the biological burden of human reproduction - from pregnancy to childbirth, postnatal care, and breastfeeding. Women in Côte d'Ivoire, with an average of 4.5 live births throughout their lifetime and a maternal mortality rate of 385 per 100,00 births, have extensive maternity care related needs and risks. [7, 8] Additionally, to the extent that family planning options are utilized, they are largely for female specific methods such as injectables and intrauterine contraceptive devices (IUD). [22] More broadly, in Côte d'Ivoire, women are not only subject to the same diseases that affect men but are also at high risk of several socially determined health risks and injuries, such as female genital mutilation and sexual and domestic abuse.[9] Thus, women's lower enrollment in and use of the CMU related health care signal that the program and related services may be both less accessible and/or less applicable to the most relevant health needs of women. [5]

2. The financing mechanisms of the CMU have important gendered implications that put women at a disadvantage

The CMU has been structured as a two-tier insurance system aimed at achieving universal health coverage. The pre-existing *Régime général de base*, a contributory scheme open to all Ivorian citizens, is supplemented with the *Régime d'assistance médicale (*RAM*),* a government-subsidized non-contributory scheme aimed at the unemployed and the indigent. The premiums and co-payments for the RAM are intended to be paid entirely by the State, but fiscal constraints have meant that the government contributions pledged and collected for this part of the scheme have thus far not materialized in line with expectations. [5] In contrast, for formal and government workers, premiums

for the *Régime général de base* are paid by employer (50%) and workers (50%) and among informal workers and the self-employed, premiums are paid by the enrollee (100%).

Women are considerably more disadvantaged than men with regard to poverty levels as well as employment and wages, factors which make both tiers of the insurance schemes less accessible to them. Overall labor force participation rates for women are only 57.5% compared to 73.2% for men, and on average, women earn half the salary of men and have much lower access to better paid jobs that come with benefits in the private and public sectors. [10, 11] As in many other countries, female workers in Côte d'Ivoire are disproportionately relegated to the informal sector. According to ILO estimates, 80.4% of employed Ivorian women are in vulnerable employment compared to 61.5% of employed Ivorian men, thus having lower access to formal work arrangements and employment based social protection coverage. [10] Additionally, female headed households are especially likely to be in poverty, and even when women are living in male headed households, the lack of assets, responsibility for children, and lack of decision-making power puts more women in the effectively indigent category than men. [11]

Thus, first and foremost, the CMU financial structure offers clear advantages to employees of the formal sector, who are predominantly male, compared to those in the informal sector, who are predominantly female. CMU enrollees from the formal (public and private) sector benefit from the mandated contributions made by their employers, who are required to contribute 50% of the premium amount. [5] The employer contribution lightens the financial burden on families whose household heads are in the formal sector. Moreover, the income for formal sector employees tends to be more stable and reliable compared to those in the informal sector, putting the disproportionate share of female workers in the informal sector at greater risk of intermittent loss of coverage. Thus, the gendered nature of the labor force structure means women are less likely to get subsidized coverage and are at greater risk of discontinued coverage. It is likely that the largest share of women in the advantageous position of benefitting from the contributory scheme are doing so as acknowledged dependents of male formal sector workers, a pattern that should be more fully assessed from the more detailed data on the marital and dependent status of women and men in the contributory scheme. Without such data, it is also not clear how the significant share of women who are in informal or polygamous unions fare with regard to dependent coverage for themselves and their children, especially as enrolment processes require formal papers (see point 4 below).

Second, the revenue collection for CMU's contributory tier is regressive because employee contributions do not vary by salary level. As lower-level wage earners, women have to contribute at the same level as men who are typically higher-level wage earners. The CMU relies on equal contributions as well as pre-payments regardless of income level. The monthly contribution is set at 1,000 FCFA per person and 70% of the costs for certain consultations, procedures, and medications are covered. The insured person, within the framework of the basic scheme, assumes the co-payment of 30%. [5, 12] Neither changes based on income or salary, and for the formal sector, the contributions of the employees are deducted on a mandatory basis from their salary.

In summary, the CMU's financing mechanisms have important implications resulting from the gendered nature of the labor force and higher unemployment rates among women. This has resulted in the following: 1) women in the formal sector are more likely to be at a disadvantage compared to their male counterparts because they are more likely to make lower wages and yet are expected to pay the same contributions under the CMU; 2) women are more likely to have to pay 100% of the contributions themselves compared to males in the formal sector who benefit from employer subsidies because more women are in the informal sector compared to men who are mostly in the formal sector; and 3) women

are not benefiting from the RAM scheme, despite being more likely than men to fall in the indigent group, because government pledges and contributions have not been as expected .

3. Low financial and digital literacy constrains women's enrollment and utilization of the CMU.

For the contributory tier, CMU coverage requires timely and regular payments, which for informal sector wage earners can be made solely via mobile telephone operators and banks, and cash payments are not allowed. The gender digital divide and imbalance in accessing banking services thus presents another challenge for the female workers in the informal sector in their effort to access CMU coverage. Fewer women (64.34%) own smart phones compared to men (71.03%) in the country,[13]and internet access is very constrained in the country. [13] In 2019, only 36.0% of the total Ivorian population used the internet. [14] While Côte d'Ivoire is making progress in increasing financial inclusion, women have less access to bank accounts or use digital financing services compared to men (women 35.6% vs men 46.6%) which makes the digital contribution option a greater challenge for them.[10]

4. Lack of identity papers and administrative processes hamper enrollment of women into the CMU

An important contributing factor to low overall CMU enrollment, and especially among the indigent population, is the combination of administrative processes and identity-related requirements, both of which place extra burden on women in getting coverage for themselves and their children. The registration process for the CMU is complex, with multiple identity documents required, including the national identity card or the identity certificate, the consular card for non-Ivorians, certificate of presence at work or work certificate for civil servants or employees, the marriage certificate for entitled spouses, pension certificate if retired, and birth certificate or student card for children under 18.[15] The requirement to provide a range of identity documents is more onerous for women who are not only less likely to possess official documentation for themselves and their children, but also typically have lower literacy levels and less experience navigating administrative processes than men. For example, 70.9% of women have complete birth registration compared to 75.2% of men, with women in older cohorts more heavily disadvantaged.[16] For coverage as dependents of male beneficiaries, the significant proportion of women in informal unions (23.4% of women aged 15-49 according to the latest DHS data) or polygamous marriages (16.5% of marriages according to the latest DHS data) are unable to produce marriage certificates. [17] Rural, indigent women in particular are likely to be illiterate and without the necessary official documents. [10]

Furthermore, enrollment and registration are especially burdensome for women because of their caregiving responsibilities and lack of access to transportation and mobility. While the male-dominated public sector is exempt from the requirement to present family members at an agency in order to obtain coverage for them, the female-dominated informal sector is required to bring identity papers and each accompanying family member, including children and infants to queue and register at an agency. For informal female workers not only is the cost in terms of time and transportation a barrier, but the opportunity cost of lost earnings by taking so much time off to register for the CMU is substantial.

Particularly, a barrier for the many women working in agriculture, especially the cocoa and cashew industries; and in the poultry and fish industries is the collection of biometrics for the CMU cards which

have been integrated to confirm patient identity when accessing services at health facilities. Work in these industries can damage fingerprints which then makes biometric identification for CMU coverage problematic.

5. Coverage for reproductive and maternal health services—which are an overwhelmingly disproportionate female need—is not a mainstay of the CMU and is confusingly distributed across multiple payment and service schemes.

Currently, women's health services are covered under several other quasi-vertical schemes that provide free ANC care, childbirth, and child health, and medication for pregnant women. At the same time, gynecologic and obstetric services are part of the CMU care basket with pregnancy, childbirth, and puerperal conditions listed as pathologies covered by the CMU. [18] There is thus both potential duplication as well as confusion because pregnancy, childbirth, and postnatal services are listed in both the targeted free programs and CMU care baskets, but in effect, the CMU does not reimburse maternal and child health services because of the overlap with the targeted free program for pregnant women. [5] At the same time, there are currently data gaps on the exact level of financing and utilization of the targeted programs that are supposed to offer free services.

The existence of multiple schemes and coverage channels creates not only confusion and potential duplication, but also highly fragmented risk pools, which in turn fail to generate cross-subsidies, thus undermining financial sustainability for any of the schemes as well as the CMU. The continuation of various funding streams may mean lost opportunity to pool and distribute risk across the population. Vulnerable groups, such as women and the indigent could benefit from the cross-subsidies that would have been generated by the consolidation of financing across risk pools. However, any efforts to consolidate multiple schemes and financing would have to extra cautious in ensuring that women do not lose access to essential health services that are currently available to them—theoretically at least--at no cost.

Access to quality essential health services by women is key in achieving the CMU's goal of extending coverage to the whole population, and in achieving some of the most critical targets on lower maternal and child mortality levels as well improvements in nutrition and early childhood development outcomes. Moreover, under Universal Health Care (UHC) and international frameworks such as Every Woman Every Child (EWEC), cost-free services for maternal, reproductive, and child health is a basic right and global commitment. Thus, clarity on whether, how, and which government subsidized mechanism women are accessing for essential reproductive, maternal and child health services, and at what out of pocket cost is a critical step toward a more successful CMU system that serves Cote D'Ivoire ultimate goals of improved maternal and child health outcomes.

Recommendations

The assessment of the CMU underscores the importance of explicitly and deliberately integrating gender equality considerations and measurement in the next phase of implementation and assessment of the CMU in Côte d'Ivoire. For the next phase of the CMU to be successful, it will be critical to address the gender related challenges and distortions identified above in three key areas of CMU reform: 1) coverage related; 2) financing related; and 3) service utilization related.

1. **CMU coverage-related reforms need to address the gender gap in insurance coverage while using implementation research to track ongoing progress and undertake course correction.**

The gender imbalance in CMU enrollment and participation will require enhanced outreach efforts to enroll women along with regular assessment of the effectiveness of specific approaches. In the next phase an outreach strategy accompanied by regular tracking and adjustment is needed to successfully identify and enroll women—especially indigent women--as a vulnerable group being left behind. For example, mass or innovative digital communications campaigns with gender-tailored messaging might be able to increase awareness among women of the CMU and its benefits. Increasing the number of enrollment sites and card distribution centers could bring them closer to rural and indigent women. Similarly, strengthening the workforce and resources at the many social centers across the country as a first line of contact with women would also be an option that would require testing for feasibility and success.

Gender barriers in administrative processes and identity requirements will need to be redressed. In order to reach more women, especially indigent women, it will be important for the CNAM to simplify the enrollment processes and track which steps are most effective and affordable. This includes creating solutions for women and children (and men) without identity papers and expanding biometric identifiers for those with physical deformities. Removing barriers related to timely card delivery is especially important in rural settings, for the informal workforce, and for indigent women. Concurrently alternatives to physical insurance cards as well as paper identity verification should also be considered so that essential and life-saving health services that women need—such as emergency maternity care--are not delayed or denied due to the lack of a piece of paper. Shifts in these requirements will require tracking and adjustment so that scaled up options are viable for the long term.

Sex disaggregated and gender-sensitive data on enrollment for both the contributory and non-contributory schemes should be collected, analyzed, and reviewed on a quarterly basis. A gender-equity focus in the routine assessment of CMU enrollment and utilization rates is critical to improving, expanding, and institutionalizing the program and ensuring that it addresses rather than creates inequalities. Currently, important data on the distribution of CMU beneficiaries across gender, income level, and schemes (RAM vs. RGB) is lacking. There is also currently no data on the percentage of women who are primary beneficiaries or dependents under the CMU, nor on distribution of formal vs. informal employees, those in monogamous vs polygamous marriages, number of female-headed households, or the number of dependent children. Routine collection and tracking of sex-disaggregated and gender sensitive data has important implications for understanding whether women's underrepresentation in the program is rectified and whether the corrective measures to increase coverage are working.

2. **Plans to reform CMU financing by harmonizing subsidized programs should assess both the potential positive and negative impact on women's service utilization and out of pocket costs.**

Harmonization of the CMU basket of services and with other schemes, especially those for reproductive, maternal, and child health, may help to overcome confusion among female beneficiaries about their entitlements under different schemes. It may maximize efficiency, prevent duplication and waste, and increase the viability and sustainability of CMU financing by harnessing subsidies across schemes. Consolidation of programs may also lead to greater utilization of the CMU and improvement in quality of services by leveraging funds that are currently being used to finance parallel programs. Financing and

consolidation reforms, however, need to be based on a careful assessment of the potential unintended consequence of reducing women's access to basic maternal and child health services by making them more unaffordable. As such, it would be advisable to pilot test harmonization efforts while tracking both women's utilization of RMNCAH-N services and their out of pocket costs.

3. Eliminating the gender gap in CMU service utilization can be assisted by assessing and reforming health service delivery to meet women's needs and preferences.

Assessing the extent to which current government schemes are meeting the goal of no-or-low-cost essential health services for women and children should be a first step in addressing the gender gap in CMU service utilization. While sex-disaggregated or sex specific data on the utilization of CMU covered services is collected, it is currently not analyzed based on geographic regions, public vs private sector providers, or insurance scheme. An analysis of these data with regard to provider options, service quality, and cost barriers faced by women would facilitate identification of targeted areas for service. improvement. Moreover, considering the RMNCAH domain of health a barometer for women's ability to access essential health services, some key analysis would include:

- An assessment of RMNCAH service delivery—including access to and utilization of emergency obstetric and neonatal care--by wealth quintile and by geography.
- Analysis of Results-Based Monitoring (RBF) quality score data for facilities with MNH services to identify quality gaps for facilities providing core reproductive and maternal health services.
- Analysis of PMA (Performance Monitoring for Action) or similar data on coverage of family planning services to assess women's unmet need for family planning, by geography, age, and wealth.
- Support to the MOH Direction de l'Informatique et de l'Information Sanitaire (DIIS) in strengthening data and analysis on adolescent reproductive and maternal health service coverage.

REFERENCES

1. IPSCNAM. *Universal Health Coverage*. [Internet] 2021 2021; Available from: https://www.ipscnam.ci/.
2. Bertakis, K.D., et al., *Gxender differences in the utilization of health care services.* J Fam Pract, 2000. **49**(2): p. 147-52.
3. Sen, G., V. Govender, and S. El-Gamal, *Universal Health Coverage, Gender Equality and Social Protection: A Health Systems Approach*. 2020, UN Women.
4. Morgan, R., et al., *Gendered health systems: evidence from low- and middle-income countries.* Health Research Policy and Systems, 2018. **16**(1): p. 58.
5. R4D, *Evaluation of the Universal Health Coverage program in Côte d'Ivoire*. 2022, The World Bank, R4D, UCP Sante.
6. Tecco, H. and J. Cheek, *Women's Health is More than Female Anatomy and Our Reproductive System - It's About Unraveling Centuries of Inequities Due to Living in a Patriarchal Healthcare System*, in *Health Supplement*. 2022, Harvard Business School.
7. The World Bank Group. *Fertility rate, total (births per woman) - Cote d'Ivoire*. [Internet] 2023 2023; Available from: https://data.worldbank.org/indicator/SP.DYN.TFRT.IN?locations=CI.

8. GFF. *Cote d'Ivoire*. [Internet] n.d.; Available from: https://data.gffportal.org/country/cote-divoire.
9. Fathalla, M., *Issues in Reproductive Health: Health and bieng a woman*, in *Expert Group Meeting on Women and Health: Mainstreaming the Gender Perspective into the Health Sector*. 1998, United Nations Division for the Advancement of Women: Tunisia.
10. The World Bank Group. *Country Profiles: Cote d'Ivoire*. Gender Data Portal [Internet] 2023 2023; Available from: https://genderdata.worldbank.org/countries/cote-d-ivoire/.
11. Kalsi, K. and F. Memon, *Women's Economic Empowerment in Cote d'Ivoire: WOW Helpdesk Query 55*. 2020, UK AiD, Work and Opportunities for Women.
12. CLEISS. *Le régime ivoirien de sécurité sociale*. 2021; Available from: https://www.cleiss.fr/docs/regimes/regime_cotedivoire.html.
13. UN Women. *Cote d'Ivoire*. [Internet] n.d.; Available from: https://data.unwomen.org/country/cote-divoire.
14. The World Bank Group. *Individuals using the internet (% of population) - Cote d'Ivoire*. [Internet] 2023 2023; Available from: https://data.worldbank.org/indicator/IT.NET.USER.ZS?locations=CI.
15. IPSCNAM. *Documents Required*. [Internet] 2021 2021; Available from: https://www.ipscnam.ci/pieces-a-fournir/.
16. The World Bank Group. *Completeness of birth registration, female (%) - Cote d'Ivoire*. [Internet] 2023 2023; Available from: https://data.worldbank.org/indicator/SP.REG.BRTH.FE.ZS?locations=CI.
17. DHS. *Statcompiler*. [Internet] n.d.; Available from: https://www.statcompiler.com/en/.
18. IPSCNAM. *Pathologies Covered by the CMU*. [Internet] 2021 2021; Available from: https://www.ipscnam.ci/pathologies-couvertes-par-la-cmu/.
19. WHO, *Making fair choices on the path to universal health coverage: Final report of the WHO Consultative Group on Equity and Universal Health Coverage*. 2014, WHO.
20. GFF, *Background note: GFF grant program for social protection and social safety nets in the CIV*. n.d.
21. Fenny, A.P., R. Yates, and R. Thompson, *Strategies for financing social health insurance schemes for providing universal health care: a comparative analysis of five countries.* Glob Health Action, 2021. **14**(1): p. 1868054.
22. Cote d'Ivoire. *Rapport Annuel sur la Situation Sanitaire (RASS).* [Internet] 2020; Available from: https://www.snisdiis.com/wp-content/uploads/2022/03/Rapport-Annuel-sur-la-Situation-Sanitaire-RASS-2020-VF.pdf