Report Number: ICRR0023843

1. Project Data

Project ID	Project Name
P156679	CM-Health System Performance Project
Country	**Practice Area(Lead)**
Cameroon	Health, Nutrition & Population

L/C/TF Number(s)	Closing Date (Original)	Total Project Cost (USD)
IDA-57900,IDA-62250,IDA-D3000,TF-A2177	31-May-2021	105,241,025.58
Bank Approval Date	**Closing Date (Actual)**	
03-May-2016	31-Dec-2022	

	IBRD/IDA (USD)	Grants (USD)
Original Commitment	127,000,000.00	27,000,000.00
Revised Commitment	133,000,000.00	27,000,000.00
Actual	105,241,025.58	14,606,386.44

Prepared by	Reviewed by	ICR Review Coordinator	Group
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2. Project Objectives and Components

a. Objectives

According to the Financial Agreement (dated September 14th, 2016), the project's development objective (PDO) was "to increase utilization and improve the quality of health services with a particular focus on reproductive, maternal, child and adolescent health and nutrition services".

The Additional Financing (AF) in May 2018 reformulated the PDO "to: (i) increase utilization and improve the quality of health services with a particular focus on reproductive, maternal, child and adolescent health, and

nutritional services for the population of Cameroon, including refugees and refugee host communities, and (ii) in the event of an Eligible Emergency, to provide immediate and effective response to said Eligible Emergency".

The project's AF during the first project restructuring widened the scope of the project's development objectives by i) adding an emergency response component, and ii) explicitly including refugees and host communities in the PDO statement, which were originally part of the project's direct beneficiaries (see PAD p.6). As a result, the project introduced additional indicators to the Results Framework to measure the new parts of the PDO. In addition, the project's closing date was extended to December 2022, and the indicators' targets were revised upwards for existing indicators to capture the additional 18 months of implementation. The project became more ambitious, encompassing refugee services, including an emergency response objective, and increasing indicators targets. Therefore, according to IEG guidelines, no split rating is needed.

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

Yes

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

No

c. Will a split evaluation be undertaken?

No

d. Components

Originally the project had two components.

Component 1: Strengthening of Health Service Delivery (planned US$89 million IDA, US$20 million Global Financing Facility (GFF); actual US$82.5 million). This component had three sub-components:

1.1: Payment of performance: supporting the implementation of the ongoing Performance-Based Financing (PBF) mechanism across the original 44 health districts financed by the previous operation, and the incremental rollout of the PBF to national coverage across all the ten regions (North-West, South-West, East, Littoral, Centre, West, South, Far North, North and Adamawa).

PBF payments were to be provided: (i) to health facilities quarterly conditional on the quantity and quality of Reproductive, Maternal, Newborn, Child, and Adolescent Health (RMNCAH) services delivered via in-clinic activities and/or via health-outreach activities, and verified (ex-ante and ex-post), and (ii) to community health workers for providing selected basic preventive, promotional, referral and curative health services, including Integrated Management of Childhood Illness (IMCI). This sub-component also aimed at introducing fee waivers for selected essential services as a mechanism for vulnerable households to increase the uptake of health services.

1.2: Support to the implementation and supervision of PBF: supporting Contract Development and Verification Agencies (CDVA) covering each region, using either the Regional Fund for Health Promotion or NGOs, through training and capacity-building activities related to best practices and implementation

approaches in PBF using a “snowball training” approach or “training of trainers” program at the central level, regional, district and health facility levels. This sub-component provided support for technical assistance in rolling out PBF to regional and tertiary-level hospitals in the Country, which are financed by public budget and internal revenue generation.

1.3: Additional support for improving access to a key package of RMNCAH and nutrition services: supporting non-PBF activities identified as priorities without current funding commitments within the GFF Investment Case, which includes critical inputs to reinforce the availability and quality of nutrition services.

Component 2: Institutional Strengthening for Improved Health System Performance (planned US$11 million IDA and US$7 million GFF; actual US$8.4 million). This component had three sub-components:

2.1: Strengthening institutional capacities for improved health system stewardship, including monitoring and evaluation (M&E): supporting the Ministry of Public Health (MoPH) through analytical work and policy dialogue on i) Enhancing pharmaceutical sector regulation ii) Implementing judicial reforms for decentralized decision-making and autonomy of health service providers and regulators iii) Reforming health workforce regulations to enhance service availability and quality, especially in rural areas iv) Creating a comprehensive community health strategy focused on practical results v) Engaging private and faith-based health sectors through strategic contracts. This sub-component will also support the development and implementation of the country’s national health financing strategy entailing a public expenditure review for the health sector, two rounds of national health accounts, and a study on public financial management (conducted jointly with WHO), other key studies, and trainings and workshops related to the design of the strategy. It included other investments related to improving reliable data systems for the PBF project through the District Health Information Software 2 (DHIS2) platforms and the national portal, as well as two rounds of Service Delivery Indicator Surveys (SDIs). Finally, this sub-component encompassed the ex-post verification activities to be conducted by an independent third party and the External Evaluation Agency (EEA) that the MoPH would contract to check the veracity of the information provided by the health facilities. The EEA’s roles will include ex-post fact verification of service volumes and quality delivered by health facilities contracted with the CDVA and for which PBF payments have been made.

2.2: Reinforcement of civil registration and vital statistics systems: supporting the building of the national civil registration and vital statistics systems, through the National Office of Civil Registration. CRVS systems would also be indirectly supported through activities included in other subcomponents such as those related to the expansion of DHIS2 systems and general support to PBF indicators linked to civil registration such as birth registration.

2.3: Program coordination: covering the operating costs of the PBF national technical unit (*Celulle Technique Nationale* or National Technical Unit - CTN) for activities related to the project and the PBF program, including internal performance contracts with other MoPH departments.

The AF in May 2018 included the addition of two components:

Component 3: Strengthening emergency, sexual and reproductive health services, and water, sanitation, and hygiene, and nutrition service delivery for refugees and host communities in the

Northern regions and East (planned US$0 million, first restructuring allocation US$10 million IDA18 RSW; actual US$0 million).

3.1 PBF payments: financing PBF payments for carrying out activities to a) encourage development of norms, guidelines and training modules on i) emergency health services and life-saving sexual and reproductive services, including management of rape and GBV; ii) nutrition, deworming, water sanitation and hygiene at schools, health facilities, community level including refugee camps; iii) mental health and psychosocial support programs for refugees, internally displaced people and communities hosting refugees; iv) biomedical waste management; and b) strengthening institutional capacity building including i) provision of sensitivity training of frontline health professionals, and community health workers (CHW), and community-based organizations (including refugee population, community hosting refugees, and civil registration officers), ii) training to health professionals on basic and emergency obstetric and newborn care, and iii) training to health professionals and CHW on the management of GBV, mental health, nutrition, neglected tropical diseases, biomedical waste management and water sanitation and hygiene.

3.2 Program on water, sanitation, and hygiene: carrying out a program of water, sanitation, and hygiene, including support for a) analytical work, and b) strengthening health communication toward good sanitation and hygiene behaviors among refugees and host community populations (Financing Agreement for AF December 2018).

Component 4: Contingent Emergency Response Component (planned US$0 million; first restructuring allocation US$0 million; actual US$6 million). This sub-component was introduced at the first restructuring providing the project with a critical funding package to respond to emergency crises, including financing for the rehabilitation of health facilities, purchase of medical equipment, other commodities and supplies needed to increase the Government of Cameroon's (GoC) response capacity.

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

The project was approved in May 2016, became effective in December 2016, and the expected closing date was in May 2021. Total project costs were estimated at US$127 million at appraisal to be financed by an IDA credit (US$100 million) and a GFF grant (US$27 million). There was no borrower contribution to project costs.

The project was restructured three times:

The first restructuring in May 2018 involved an Additional Financing (AF) through an IDA credit (US$6 million) and an IDA18 Refugee Sub-Window Grant (RSW) (US$30 million) requested by the GoC in response to the worsening security crisis. The restructuring involved: i) the allocation of additional resources to Component 1 for PBF payments in refugee-affected areas (US$6 million IDA18 credit and US$15 million IDA18 RSW); ii) the allocation of additional resources under Component 2 to reinforce selected activities in refugee-affected areas (US$5 million IDA18 RSW); iii) the addition of Component 3 which was provided an allocation of US$10 million from IDA18 RSW; and iv) the addition of Component 4 with a zero-dollar allocation as a Contingency Emergency Response Component (CERC); v) the extension of project's closing date from May 2021 to December 2022. Due to delays in complying with legal covenants, the AF took 13 months to become effective eventually in June 2019.

The second restructuring approved on August 13, 2020, followed the activation of the CERC during the COVID-19 pandemic and included i) the extension of the project's GFF grant closing date to December 2022 to be aligned with the AF; ii) the reallocation of US$6 million from the IDA18 Credit added during the previous AF to support the country's national response plan to the pandemic; and (iii) the revision of Results Framework.

The third and final restructuring in December 2022 canceled the full undisbursed amount of the IDA18 RSW for SDR 20.8 million (see quality of supervision and efficiency sections for further details).

3. Relevance of Objectives

Rationale

The project's objectives were relevant to the country's needs. The country's context at the time of approval was characterized by:

i) a deterioration of the Human Development Index (HDI) and **suboptimal progress on health outcomes** (e.g., reduction in under-5 mortality from 138 per 1,000 live births to 88 between 1990-2015 were short of the target of 46 set under the Millennium Development Goals (MDGs), maternal mortality ratio had increased from 728 in 1990 to 782 per 1,000 live births in 2011, malnutrition remained a widespread challenge with 32 percent of children stunted);

ii) regional **disparities in access to health services and health outcomes** (e.g., institutional delivery rates in the North and Far North at 29 percent and 35 percent, respectively, were particularly lower than those observed in Douala (99 percent) or West and Northwest region (96 percent), high stunting rates predominantly affected the three Northern regions and the East);

iii) **low and inefficient public health expenditures** (e.g., public health expenditures represented 8.5 percent of total government expenditures in 2013 and had been stagnant since 2000, households bore the large share of health expenditure (52.2 percent) almost exclusively through out-of-pocket expenditures); and

iv) **low quality of health services** (e.g., in terms of human resources, Cameroon was far from the WHO standards with approximately 11 qualified healthcare personnel per 10,000 inhabitants, experiencing high levels of absenteeism and poor technical quality of personnel, the pharmaceutical sector and the public central medical store suffered from serious governance issues and poor planning capabilities, which compromised quality of supplies, cash flow issues and frequent stock-outs).

The revised PDO also reflected the heightened refugee crisis and emergencies in Cameroon. The **growing humanitarian crisis** exacerbated the existing health challenges and the revised project objectives continued to be relevant. The **deterioration of the security situation** in Northern Cameroon since 2014 resulted in displacements, and food insecurity and had a negative impact on health outcomes. It was estimated that 2.4 million people in the Far North region were food insecure and 250,000 persons suffered from malnutrition. The activation of the CERC responded to the COVID-19 pandemic.

In terms of country priorities, the GoC had identified the expansion of the PBF model as a key strategy for health system strengthening towards national universal health coverage goals, higher quality of health services, and reduced out-of-pocket expenditure. Supporting PBF was one of the priority strategies of the World Bank's Country Assistance Strategy for Cameroon 2010-2014, the 2015 Systematic Country Diagnostic, and the Country Partnership Framework FY17-FY21. In addition, the project objectives were relevant to Cameroon's Strategic Plan for the National Multisectoral Program for Combating Maternal, Newborn & Child Mortality in Cameroon (2014-2020), the Strategic Plan for Reproductive, Maternal, Neonatal and Infant Health (2014-2020), the National Strategic Plan for Adolescent and Youth Health in Cameroon (2015-2019), and the Health System Strategy (2016-2027) toward the vision of Cameroon being a country with universal access to quality health services by 2030. The revised PDO continued to be relevant and was coherent with National and World Bank priorities and the increased vulnerability and poverty of certain populations of regions of the country.

Rating
High

4. Achievement of Objectives (Efficacy)

OBJECTIVE 1

Objective
To increase utilization of health services with a particular focus on reproductive, maternal, child and adolescent health, and nutritional services for the population of Cameroon, including refugees and refugee host communities.

Rationale
PBF was a key strategy to strengthen health service delivery and increase access to essential reproductive and nutrition services by the population. From the supply side, performance-based payments to health facilities were central for incentivizing both the quantity of services delivered and the quality of health services.

From the project's activities depicted in the theory of change, it was reasonably expected that PBF payments to health facilities and community health workers combined with efforts toward reforming health workforce regulations to enhance service availability, strengthening health data stewardship, and improving contract management capacity would lead to the increased supply of quality services. Previous empirical evidence shows that paying for results can contribute to improving service utilization. A rigorous impact evaluation covering the PBF program from 2012 to 2015 highlights the positive impacts of the PBF on some service utilization indicators, namely child and maternal vaccinations, and the use of modern family planning (De Walque et al., 2021).

On the demand side, it was plausible to expect that the introduction of fee waivers for selected essential services would reduce financial barriers to access and increase the uptake of health services. In addition, community-based approaches for preventive, promotional, and referral services would reasonably lead to

improved access to reproductive health and nutrition services. Interventions under the GFF investment case, such as social communication and behavioral campaigns in health and nutrition; and the pilot of Kangaroo mother care would also contribute to reducing socio-cultural barriers and improve utilization and health outcomes.

Outputs

- The project contributed to the successful **expansion of the PBF program**, increasing coverage from 25% of the national population in 2016 to 100% by the project's closure, thereby surpassing the 95% coverage target. A total of 4,009 health facilities were gradually enrolled in the PBF model across 194 health districts.

Intermediate Outcomes

- The corporate results indicator, measuring the **number of people who received essential health nutrition and population (HNP) services,** reached a total of 7.77 million (including 4.28 million women), surpassing both the original target of 5,520,987, and the revised target of 6,020,987 people. Despite the indicator description not specifying the geographical coverage, the ICR assumes it is limited to the beneficiaries of the four most vulnerable regions (Adamawa, North, Far North, and East). The increased delivery of services from the beginning of the project remains uncertain, as the baseline value set at appraisal was zero, even though the PBF had already been functioning in some of these regions since 2012. According to Table 4 in PAD p.50, the percentage population covered by the PBF in 2015 was 35% in Adamawa, 29% in the North, 42% in the Far North, and 98% in the East. Additional evidence provided by ICR (p.16) from the PBF portal, which was not accounted for in the results framework, shows that the provision of HNP services in the six remaining regions (i.e., Center, Littoral, North-West, West, South, South-West) increased from 423,000 in 2018 to 5.10 million people at project closure.
- **Referrals to the health facilities by community health workers** also proved successful, reaching 1,480,159 patients against original and revised targets of 243,890 and 1,403,217 patients, respectively. However, this indicator does not specify whether it covers all or just the four more vulnerable regions.
- In terms of affordability, the **number of consultations provided to the poor and vulnerable free of charge** partially met the target, reaching 1,224,221 people. However, this achievement falls below both the original target (1,302,057 people, achieving 94%) and the revised target (1,502,057 people, achieving 81%).

Outcomes

The project’s achievements in terms of **reproductive health services** were positive:

- The new indicators added in 2020 to capture the reproductive health dimension show that the **number of acceptors of modern contraception** in the three Northern regions (Adamawa, North, Far North) and the East reached 1,307,472 women of reproductive age, surpassing the target of 1,292,020. Furthermore, acceptors of modern contraception among adolescents reached 103,337 adolescents, against a target of 100,865. The ICR’s estimated modern contraceptive prevalence rate in 2021 shows modest increases for Adamaoua, North and Far North (i.e., from 9% in 2018 to 10% in 2021 in Adamaoua; from 12% to 15% in Nord; from 4% to 8% in Far Nord; and from 11% to 25% in East).

- The **number of pregnant women receiving at least 4 antenatal care visits** in the three Northern regions (Adamawa, North, Far North) and the East increased to 840,517, surpassing the target of 814,656. It is worth noting that this indicator was originally measured in percentages, expressing coverage rates, but was modified in the 2020 restructuring. The ICR does not offer estimated coverage rates, unlike other utilization indicators.
- The **number of deliveries attended by skilled health personnel** in the three Northern regions and the East reached 868,025, surpassing the target of 713,379 attended deliveries. The ICR's estimated skilled birth attendance rate in 2021 for these four regions is 49.75%, which is about 90 percent of the original project target (55 percent). Estimates show, however, large disparities amongst the four regions: Adamaoua 59%, North 44%, Far North 36%, and East 60%). Increases in skilled birth attendance rates compared to MIC survey data in 2014 (provided by the PAP p.3, and ICR p.6) seem substantial considering that the northern regions also have the fewest assisted deliveries (North 35% of births, Far North 29% of births). Additional evidence provided by ICR (p.16) from the PBF portal, which was not accounted for in the results framework, shows that assisted birth deliveries in the six remaining regions also increased from 95,000 in 2018 to 920,000 at the project closure.
- The **number of children immunized** (aged 1 to 11 months old that received the third dose of the Pentavalent vaccine) in the three Northern regions and the East reached 1,393,670, surpassing the target of 737,048. ICR's estimates show that immunization rates increased from a baseline of 68% to 78.5% in 2021 slightly below the original target of 80% stated at the PAD. These estimates are relatively consistent with the official statistics for Cameroon for 2021 (81 percent). There were, however, large disparities across the four regions: vaccination rates were 79% in Adamaoua, 66% in Nord, 73% in Far North, and 96% in the East region. Additional data from ICR also shows that over 740,000 children were immunized in the six remaining regions at the end of the project, against an initial 102,000 children in 2018.

The project's achievements in terms of **nutrition-related results** were mixed:

- Overall, the **number of women and children who have received basic nutrition services** in the four vulnerable regions reached 5,509,371, surpassing the target of 4,570,560.
- The **number of children and pregnant women dewormed** reached 2,113,253, about 60% achievement from the target of 3,520,000.
- The **number of children under 24 months being weighed for growth monitoring** in the three Northern regions (Adamawa, North, Far North) and the East reached 2,342,533 children, exceeding the original target of 1,608,480, but falling below the revised target of 3,689,641.
- The **number of children aged 6-59 months who received Vitamin A** (in the last six months) increased to 3,708,867, surpassing both original (474,286) and revised targets (3,128,788 children). The ICR's estimated coverage rates show that within nutrition services for children, Vitamin A coverage in 2021 continued to be low in the Northern regions: by the end of the project, coverage was 21% in Adamaoua, 32% in Nord, 22% in Far Nord, and 61% in East regions. Without baseline rates or additional data points, it is not possible to determine appropriate increments for Vitamin A coverage rates.

The project's achievements in increasing the **utilization of healthcare services by refugee communities** were negligible:

- The target for the **number of refugees who have received healthcare (curative and preventative) at health facilities** in the three northern (Adamawa, North, Far North) and the East was not met. No

data was reported and no activities were carried out toward the improvement of healthcare services by refugees and hosted communities. This is because about 85 percent of the financing from the AF (the full amount for the RSW financing) for activities targeting refugees and hosted communities was canceled. The remaining funds (US$6 million from the IDA credit) were utilized under Component 1 and contributed to covering the overrun of verification costs under Sub-Component 2.1. The GoC request for fund cancellations in December 2022 was not followed by a change in the PDO.

- As mentioned in the M&E section below, the indicators for utilization reported under the project had a focus on the four more disadvantaged regions (i.e., Adamaoua, North, Far North and East), although the project rollout the PBF model nationwide. Furthermore, increments from baseline cannot be established in most cases since baselines were set to zero even though the PBF has been implemented since 2012 in some health districts across regions. ICR's efforts to overcome the project's M&E shortcomings are commendable. However, estimated coverage rates cannot be compared in most cases with target values or increments from baselines, as they represent single data points at the end of the project.

Rating
Modest

OBJECTIVE 2
Objective
To improve the quality of health services with a particular focus on reproductive, maternal, child and adolescent health, and nutritional services.

Rationale
As mentioned before, PBF to health facilities was central to incentivizing the quality of health services delivered. Implementing performance-based payments requires defining clear and measurable quality metrics. The design of the quality checklist provided the foundation for measuring results related to the rational prescribing of generic drugs, essential drug management, and availability of tracer drugs, among others, with increased weights given to process measures. By tying payment directly to quality metrics, service providers are incentivized to continuously improve their processes, skills, and resources.

Unlike service utilization indicators, project indicators measuring the quality of services had a national coverage to account for the expansion of the PBF model throughout the project.

Outputs

- The **percentage of facilities with 100 percent tracer drugs** (available in targeted health facilities on the day of the visit) increased from 20% in 2016 to 59%, surpassing the target of 40%.

Intermediate Outcomes

- The **percentage of reported maternal deaths audited** in PBF districts increased to 53.9%, surpassing the target of 25%.

Outcomes

- The **average score of the quality-of-care checklist** across regions increased from 30% at baseline to 76.84%, surpassing the target of 50% at the end of the project.

Nevertheless, this ICRR highlights three shortcomings regarding the evidence provided:

Lack of meaningful targets: As detailed in the M&E section below, the project set a baseline value of 30% for the quality score. However, this baseline aligns closely with the average scores recorded in 2012 (33%), and the anticipated target for 2021, set at 50%, falls below the average recorded in 2015 (65%). This discrepancy raises questions about the ambition of the target-setting process.

Insufficient details on Quality Checklist: Neither the PAD nor the ICR offers the specific measures included in the quality checklist, nor do they provide insights into the weighting applied during the score calculations. The IEG's 2018 Health Services evaluation recommended a shift towards incorporating more process or outcome quality indicators instead of solely relying on structural quality indicators, which typically measure outputs. The absence of clarity underscores the insufficiency of evidence for conducting a thorough assessment of the enhancement in service quality, and hence this objective is rated substantial instead of high. ICR p.18 also acknowledges that there was limited attention paid to unpacking results, such as the quality-of-care scores, in supervision documentation such as aide-mémoires and ISRs, which predominantly focused on fiduciary and project management issues.

Insufficient evidence on completion of activities for Component 2: According to the project's Theory of Change efforts toward reforming health workforce regulations to enhance service availability, strengthening health data stewardship, and improving contract management capacity would contribute to increasing the quality of services. However, neither the Results Framework nor the ICR provided evidence on the progress of such activities funded by Component 2.

Rating
Substantial

OBJECTIVE 3
Objective
In the event of an Eligible Emergency, to provide immediate and effective response to said Eligible Emergency.

Rationale
The addition of the CERC as Component 4 gave the project more flexibility to respond to unforeseen crises. The COVID-19 crisis in 2020 triggered the need to activate the CERC and support the country's limited capacity to respond to and deal with the effects of the pandemic.

The first batch of medical equipment which included ventilators, thermoflash, defibrillators, COVID-19 testing kits, and protective equipment was delivered to the GoC in April and May 2020 through a UNDP procurement

funded by the World Bank and the Global Fund. Additional batches would be ordered and delivered in the following weeks (Restructuring paper NO.: RES42463).

The CTN carried out a supervision mission in December 2022 before project closure confirming the distribution of health equipment to health facilities in 10 regions of Cameroon. Material included respiratory equipment, sterilization equipment, and personal protective equipment.

Output

- A total of **11 COVID-19-designated healthcare facilities had the required equipment for the treatment of critical patients as per the approved national protocol**, meeting the target, and contributing to a swift response to mitigate the impact of the COVID-19 pandemic in terms of treatment aspects of the response.

In addition, the consultations as part of the visit confirmed that the training of trainers of field personnel in the use of respiratory equipment managed by UNDP that was meant to take place had been delivered.

At the same time, it is understood that the quick provision of equipment to 11 health facilities to treat COVID-19 patients cannot, on its own, reflect the full achievement of an effective response to the pandemic.

Rating
Substantial

OVERALL EFFICACY
Rationale
The first objective to increase utilization of maternal and child health services was modestly achieved, due to shortcomings in indicators' geographic and population coverages and negligible achievements for refugee communities. The second objective of increasing the quality of services was substantially achieved taking into account the shortcomings in the target-setting process, insufficient details on the quality score measure, and insufficient evidence toward efforts undertaken by Component 2. The third objective to provide an immediate and effective response in case of an Eligible Emergency was substantially achieved. The aggregation of achievements under the three objectives is consistent with a substantial rating for overall efficacy.

Overall Efficacy Rating

Substantial

5. Efficiency

The economic and financial analysis provided in both the PAD and the ICR focused on incremental cost-effectiveness ratios and cost per disability-adjusted life year (DALY) saved, concentrating solely on interventions funded through Component 1 of the project, which constituted 86% and 85% of total project funding at appraisal and closing, respectively.

During the appraisal phase, the cost-effectiveness analysis drew upon results from a 2016 impact evaluation assessing the impact of the PBF pilot (financed by a preceding project) on the quality and utilization of services. Cost calculations for RMNCAH services included in the package funded by PBF were based on operational and payment data from 2015 across treatment facilities in four regions: North-West, South-West, East, and Littoral. Projections for these indicators were derived from the baseline figures, observed trends during the PBF pilot, and the project's four-year duration. At appraisal, the estimated incremental cost-effectiveness ratio was US$10 per beneficiary, with a slightly higher figure of US$15.5 for female beneficiaries. These estimates were consistent with comparable maternal and neonatal health initiatives in developing countries, where cost-effectiveness ratios ranged from US$1 to US$223 per beneficiary.

Additionally, the set of interventions for RMNCAH included in the PBF package was deemed highly cost-effective, with cost per DALY saved ranging between US$82 to US$142, as supported by various studies across countries.

However, the efficiency analysis at the appraisal stage exhibited inconsistencies in parameters compared to baseline and target beneficiary figures as highlighted by the ICR. This discrepancy was likely due to the preliminary nature of efficiency analysis, often conducted before the finalization of the PAD, leading to the oversight in capturing adjustments in the results framework. Notably, assumptions on the total number of beneficiaries (990,606 people) were underestimated considering the different population sub-groups targeted for each intervention (ICR p.51). The ICR's subsequent estimations of the incremental cost-effectiveness ratio at project appraisal revealed lower costs per beneficiary (US$7.90 for all beneficiaries and US$11.80 for female beneficiaries) compared to the PAD. At project closing, the efficiency improved, with the incremental cost-effectiveness ratio dropping to US$5 per person for all beneficiaries, marking a 37% decrease from the baseline estimate.

However, the project faced operational and implementation inefficiencies, ranging from significant to major, and evident in several areas, indicating that project efficiency was barely realized:

(i)The project took nearly 8 months to become effective after its approval. The first disbursement occurred in January 2017, nearly 9 months after its approval, which resulted in a downgrade in implementation progress just 5 months after project approval. The delay in effectiveness was due to the time taken to satisfy the project's effectiveness conditions, and the inability to cope with an ambitious pace of PBF expansion, aggravated by the introduction of a new institutional setup that transferred the project management responsibilities from a dedicated PIU to the CTN.

(ii)Despite an available envelope of US$133 million, the project disbursed only US$105.5 million, and in the last 18 months, disbursements significantly decreased, indicating an underutilization of resources. In particular, the project failed to utilize a US$30 million grant allocated for assisting vulnerable refugees in at-risk regions, primarily due to (a) insufficient technical readiness on the part of CTN to implement the AF within the existing PBF program, (b) governance and fiduciary concerns surrounding the PBF, which hindered the World Bank's approval for disbursements via CTN and the PBF mechanism, and (c) the absence of backing from the MoPH to

reconsider implementation arrangements, transitioning from CTN to specialized NGOs, compounded by ambiguity regarding the role of the UN Refugee Agency (UNHCR).

(iii) A significant portion of the project's budget, amounting to US$30 million or one-third of total expenditure, was allocated to verifying payments disbursed to health facilities. This verification cost exceeded initial budget projections by 66.8%. While the GoC contributed minimally to these verification costs through the project, their substantial direct payments to health facilities were verified using project-supported resources. When factoring in both project and GoC PBF payments, verification costs represented 20% of PBF expenses. Despite comparable instances in other Sub-Saharan African countries, the high verification costs in Cameroon were deemed excessive, considering the context's fiduciary and governance standards.

(iv) An audit of verification agencies conducted between July and September 2023 revealed inefficiencies and a lack of transparency in their work, significantly impacting project efficiency. While there has been no official response from the CDVAs, the audit report uncovered a significant amount of ineligible expenditure related to supervision mission costs, salaries exceeding established salary grids agreed upon for agents, as well as irregular procurement processes and incomplete financial management documentation, such as annual financial statements.

(v)Moreover, the findings from the impact evaluation on the pilot of the PBF model showed that outcome differences between the PBF (treatment group) and the increased financing group (control group where no PBF verification mechanisms were included) were not statistically significant (De Walque et al., 2021). This suggests that verification mechanisms do not provide added value but rather increased costs, thereby reducing the cost-effectiveness of the PBF model with verification mechanisms.

Efficiency Rating

Negligible

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

	Rate Available?	Point value (%)	*Coverage/Scope (%)
Appraisal		0	0 ☐ Not Applicable
ICR Estimate		0	0 ☐ Not Applicable

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

6. Outcome

The relevance of objectives is rated high, as the objectives were responsive to maternal and child health priorities and were consistent with country and Bank strategies. Overall Efficacy is rated substantial, as the

aggregated objectives were almost fully achieved. Efficiency is rated negligible given considerable shortcomings in the efficiency of implementation, despite the cost-effectiveness estimates of the package of interventions funded by the PBF. The overall outcome is rated Unsatisfactory, indicative of major shortcomings in the project's overall preparation, implementation, and/or achievement.

a. Outcome Rating
Unsatisfactory

7. Risk to Development Outcome

While the PBF model experienced a short-term setback following the project's conclusion, with the country reverting to an input-based approach for health facility and service financing, the ICR affirms the GoC's enduring commitment to the PBF approach. The CTN has been retained, with ongoing efforts to redefine the model, including enhancing institutional arrangements at the regional level, bolstering the CTN, transitioning to quarterly verification of health facilities and bi-annual assessment of community satisfaction, and instituting direct payments to Associations Locales (ASLOs) by the CTN.

In terms of financial sustainability, throughout the project's implementation phase spanning 2017 to 2022, PBF costs accounted for an average of 13 percent of domestic government spending on health. Considering projections for GDP growth, population expansion, and the trajectory of domestic government spending on health, sustaining the PBF will necessitate the GoC's commitment to allocating at least 10 percent of its annual domestic government health expenditure over the next four years (ICR p. 28).

8. Assessment of Bank Performance

a. Quality-at-Entry

Government commitment and momentum: The MoPH identified the PBF approach as a central strategy for the health system. The project was developed with strong political support and during a period of significant momentum within the Cameroon health sector.

However, insufficient internalization of the lessons learned from the previous operation resulted in an overambitious project design. While the project's design built up on the positive experience of the PBF model from the previous operation, including as well other regional experiences with performance-based approaches in Sub-Saharan Africa, the preparation of the project seemed to overlook important factors that affected the previous operation:

Adding complexity through the institutionalization of the PBF model. A dedicated project implementation unit (PIU) was identified as a key factor of the success of the previous operation. This project proposed new arrangements to institutionalize the PBF model and facilitate its expansion. These were reflected primarily in the transfer of project management responsibilities from a dedicated PIU to the CTN. The creation of a new CTN entailed (i) the expansion of the CTN's mission to implement both the previous operation and this project; (ii) the setup of a project technical committee within the Health Sector

Strategy Steering Committee; (iii) the expansion of responsibilities for the procurement tender committee at the Ministry of Public Contracts to cover this project as well; (iv) the transfer of appropriate fiduciary experts from the original PIU to the CTN); and the need to establish new CDVAs instead of using PBF-specialized international NGOs for the management of the payments and verification of services. The introduction of this new institutional setup led to delays in disbursement conditions, as evidenced by an 8-month delay until effectiveness and a downgrade in implementation progress just 5 months after project approval.

Overambitious scaling up. The paced scale-up was also a key factor of success in previous operation. The strong focus on the massive expansion of the PBF coverage from 25 percent of the population in 2016 to a target of 95 percent in 5 years underestimated the effort required to establish the PBF systems. The pace of scale-up that the project proposed had in retrospect been too ambitious and did not enable the country to keep up with the necessary reforms to make it a success.

Insufficient mitigation measures for similar identified risks. The new financial management and procurement responsibilities attributed to the new CTN called for specific actions to mitigate fiduciary risks that had also been identified in the previous operation. These challenges included the accumulation of debts, the lack of routine contract management at the project level, and the encounter of over US$200,000 in ineligible expenditures in the earlier PBF project (SWAP), all meticulously documented in the ICR, which rated the Financial Management aspect as Moderately Unsatisfactory. Fiduciary assessments and action plans during project preparation in high-risk settings should include more nuanced and realistic mitigation measures. As acknowledged by the ICR, no concrete actions or measures to specifically address the enhanced fiduciary challenges were recommended in the PAD in the light of previous experience.

The activities to support the GFF Investment Case created additional complexity to what was already an ambitious expansion of the PBF project. The project committed (primarily under Subcomponent 1.3 for US$20 million) to supporting a wide range of areas of intervention under the GFF investment case that was being developed and which were mainly to be led by the National Multisector Program To Combat Maternal Newborn and Child Mortality (PLMI). The project design did not clarify whether these activities would be performance-based vs. inputs-based financed hindering the approval of activities proposed by the PLMI.

A missed opportunity to leverage the functionality of the PBF portal for M&E design. According to the ICR, the project relied on data reported through the web-based PBF portal which included key indicators and project results. The Project did have a considerable amount of data that was accessible through the PBF portal and was consolidated for reporting against the project's Results. Considering the previous experience in PBF and the functionality of the PBF web-based platform, the project's M&E framework could have been better designed (see M&E section).

Quality-at-Entry Rating
Moderately Unsatisfactory

b. Quality of supervision

Supervision of the project was well documented through regular aide memoires and ISRs. The aide memoires provided a very detailed description of the challenges and concrete recommendations for project performance to improve. The Bank team was thorough in their follow-up of agreed actions and in setting clear milestones for the improvements of ratings.

The Bank team invested significant efforts in leveraging the RSW grant resources from 2019 until its closure in 2022. Regrettably, these efforts did not yield any tangible results. In 2020, collaborative endeavors between the World Bank, the CTN, and the UN Refugee Agency (UNHCR) aimed to incorporate UNHCR into the existing MOU for technical assistance (TA) between UNHCR and MoPH. However, the lack of clarity regarding actual deliverables hindered progress. Similarly, efforts were made to directly contract NGOs for implementation by the CTN. Although a call for proposals was initiated and proposals were duly reviewed and accepted by the Bank team, the MoPH did not find this approach acceptable. The onset of the COVID-19 crisis in 2020 likely diverted attention from utilizing these funds, as the focus shifted toward activating the CERC and bolstering the country's limited capacity to manage the pandemic's repercussions. Ultimately, with less than six months remaining for implementation, a viable mechanism for utilizing the RSW funds remained elusive.

The institutionalization of the PBF revealed significant technical and leadership shortcomings within the new CTN, particularly a lack of expertise in PBF for a considerable portion of the project's duration. According to the ICR, the Bank could have taken a more proactive approach in addressing these capacity gaps, such as providing technical assistance (TA), offering greater guidance from the Bank team, or initiating a thorough restructuring as early as 2019. Although the World Bank team acknowledged the necessity for project restructuring, these actions were often delayed or not implemented at all. Notably, the final request for project restructuring was submitted in December 2022, despite discussions dating back to a mission in March 2021 (ICR, p.26). Measures concerning staff management and performance, as agreed upon during missions and documented in the project's aide memoires, remained largely unaddressed. Furthermore, the significant expenditure on verification and the performance of verification agencies should have been scrutinized earlier. An audit of verification agencies was conducted between July and September 2023.

Furthermore, significant gaps were identified in the monitoring and reporting of Results Frameworks throughout the implementation phase. Despite the presence of a functional PBF platform, there were prolonged periods during which no data was reported. Notably, the project failed to report on PDO indicators from November 2019 to June 2022 (ICR p.26). This lapse can be attributed in part to issues inadequately addressed in earlier restructuring efforts, such as: (i) the delineation of specific data points from DHIS2 and the PBF portal; and (ii) the ambiguity surrounding the coverage of certain indicators (e.g., whether they applied to four regions or nationwide), which was eventually clarified during the comprehensive review of the Results Framework in March 2021.

The quality of supervision was further compromised by frequent team changes. The transitions in late 2018, including the shift to a new Task Team Leader (TTL), seemed to have occurred with limited handover processes. This coincided with changes within the CTN and the departure of the PBF expert, resulting in a significant loss of expertise in PBF both within the World Bank team and the CTN, which persisted until the project's conclusion. Moreover, a final TTL transition just five months before project closure significantly impacted the project's final phase. The new TTL had to lead the final supervision mission, manage a cancellation process, and ensure the financial closure of this intricate operation.

Furthermore, these transitions were compounded by the impact of the COVID-19 pandemic, which diverted attention away from addressing the recommendations made during a mission in late 2019 aimed at enhancing project performance. These recommendations, issued by the new TTL, including the imperative for restructuring, were sidelined due to the pandemic's exigencies. Both the Bank team and the GoC experienced bandwidth constraints due to the demands of processing various COVID-19 operations, such as the COVID-19 project approved in May 2020 and effective in September 2021, as well as its AF approved in December 2021, and slated for implementation in July 2023.

Quality of Supervision Rating
Moderately Unsatisfactory

Overall Bank Performance Rating
Moderately Unsatisfactory

9. M&E Design, Implementation, & Utilization

a. M&E Design
At appraisal, the M&E design appeared to be strong on the basis of past experience with the PBF system. Objectives were clearly stated and the original results framework contained 7 PDO indicators and 11 intermediate results indicators (IRIs) in the areas of PBF coverage, affordability, utilization of reproductive health and nutrition services, and quality of health services, and most of them were expressed in percentages reflecting coverage rates. All indicators had baseline values, description, data collection frequency, data sources (mostly from the PBF portal), and responsible unit for data collection.

However, the following shortcomings impacted the quality of M&E at design:

(i) In most cases, baselines were set to zero even though the PBF has been implemented since 2012 in some health districts across regions.

(ii) Many indicators reflected achievements of the four vulnerable regions only, although the project rolled out the PBF model nationwide.

(iii) Data on the quality of scores from previous years reported in the PAD shed some doubts about the meaningfulness of baselines and target values. According to the PAD (p.42 and figure 3), the average quality of care scores for primary healthcare centers increased from an average score of 33% in the third quarter of 2012 to an average of 65% in 2015. Therefore, the baseline value of 30% was consistent with average scores in 2012 but the expected target in 2021 of 50% was below the average of 2015. In addition, the main indicator measuring the quality of services was based on a checklist administered at the facility every quarter. Despite having the PBF system running since 2011, the quality checklist was yet to be designed for each level of the service package at project appraisal. According to the PAD (p. 14), the quality checklist aimed at introducing measures related to rational prescribing of generic drugs, essential drug management and availability of tracer drugs, but there was no clear information on what quality measures were indeed taken into account in such a checklist.

(iv) In addition, the Results Framework was not designed to track progress on activities supported by Component 2. According to the project's Theory of Change, efforts toward reforming health workforce regulations to enhance service availability, strengthening health data stewardship, and improving contract management capacity would contribute to increasing the quality of services.

b. M&E Implementation

The relatively large number of PDO indicators was narrowed down during subsequent restructurings. Despite adding two indicators to measure utilization by refugees in alignment with the expansion of the PDO, some indicators were dropped due to a lack of national survey data to track it regularly; others were re-created by the Corporate Results Indicator that included a subset of four indicators related to: (i) institutional deliveries; (ii) immunization; (iv) provision of nutrition services; (v) female beneficiaries, and most were turned into outputs by measuring the number of people using services instead of coverage rates.

Therefore, there was a missed opportunity to exploit the functionality of the PBF portal by the CTN, as acknowledged by the ICR. The lack of clarity regarding the definition of data points from the PBF portal for some indicators in the Results Framework hindered the project's ability to report during ISRs, which reflected negatively on the project's M&E rating for prolonged periods of time, although ratings were improved in 2021 after an in-depth review of portal data. In addition, some of the data quality assurance processes envisaged in the PBF manual such as the counter-verification of results were not consistently implemented throughout the project's cycle.

The PAD envisioned that once the HSSIP funds (from the previous operation) had been fully disbursed, the original 44 districts would receive financing from this project, and their results would subsequently be integrated into the Results Framework of this project, disaggregating results achieved in the newly targeted districts from the 44 districts originally covered by the HSSIP. However, this scenario did not unfold as anticipated. The indicators for utilization reported under the project primarily focused on the four more disadvantaged regions (Adamaoua, North, Far North, and East), despite the nationwide rollout of the PBF model by the project.

c. M&E Utilization

As acknowledged by the ICR, the project could have made better use of the project data to showcase achievements and tell the project's story during its implementation. There was limited attention to data monitoring and use toward improving the performance of indicators that lagged behind. This was for instance the case of the IRI related to emergency services, for which data were available outside of the PBF platform but never reported.

M&E Quality Rating

Modest

10. Other Issues

a. Safeguards

The project was classified under Environmental Category B, as it triggered Environmental Assessment OP/BP 4.01 given the potential negative environmental impacts related to the handling of medical waste in health facilities. As a consequence, a Hygiene and Sanitation Plan was developed. Despite the hiring of a qualified environmental specialist by the CTN, reporting on compliance was generally substandard and prone to delays according to the ICR (p.24). Assessing whether all planned environmental safeguard activities were fully carried out by project closure proved challenging based on the available reporting documents.

Concerning social safeguards, the Indigenous Peoples Policy OP/BP 4.10 was activated during project preparation, leading to the development and implementation of an Indigenous Peoples Action Plan by the MoPH. The ICR highlights that safeguards-related endeavors in the East region aimed to disseminate information to target groups, encompassing the implementation of community risk engagement strategies, particularly pertinent in the context of the COVID-19 pandemic. Furthermore, a grievance redress mechanism system was established as of November 2020. However, its functionality appeared sporadic, and a significant number of complaints towards the project's conclusion were linked to delays in payments to implementing partners. Regrettably, initiatives concerning Gender-Based Violence (GBV) prevention were not carried out due to reliance on funding from the RSW18 grant, which was not executed. Additionally, the recruitment process for a GBV expert was protracted and ultimately incomplete.

As recorded in the Operations Portal the overall Safeguards Rating was moderately satisfactory.

b. Fiduciary Compliance

The project's Financial Management (FM) was consistently deemed moderately unsatisfactory or unsatisfactory throughout its lifecycle. Persistent delays in financial monitoring, providing up-to-date accounting and financial information, and absent audit reports contributed to recurring issues such as arrears in PBF transfers to health facilities and overdue payments to verification agencies. Additionally, the project struggled to effectively manage and utilize the RSW18 window funds. The use of these funds would have required readiness and capacity enhancements in FM systems to facilitate additional PBF payments to selected facilities.

A comprehensive review of financial management conducted in the project's final year identified weaknesses in operationalizing annual work plans and budgets, managing designated accounts, and disseminating and implementing the Project Operations Manual. The review also highlighted organizational deficiencies, including inadequacies in justifying expenditure for PBF transfers, payments to verification agencies, identifying over US$1.5 million in ineligible expenditures, and significant advances to project personnel lacking proper documentation.

Procurement management was also deemed inadequate during the project with an unsatisfactory rating. Poor procurement practices, including deviations from procurement methods, lengthy delays in contract award processes, incomplete information, and inadequate tracking of procurement exchanges, were observed throughout the project.

Substandard performance management further exacerbated issues, particularly in contract management with verification agencies, leading to substantial payment delays. The project exceeded allocations for verification and accrued significant debts with these agencies (amounting to US$5.3 million six months before the project ended).

c. Unintended impacts (Positive or Negative)

The ICR reported no unintended impacts.

d. Other

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11. Ratings

Ratings	ICR	IEG	Reason for Disagreements/Comment
Outcome	Unsatisfactory	Unsatisfactory	
Bank Performance	Moderately Unsatisfactory	Moderately Unsatisfactory	
Quality of M&E	Modest	Modest	
Quality of ICR	---	Modest	

12. Lessons

The ICR (p. 28) offered several lessons and recommendations, including the following lessons, partially re-stated by IEG:

Despite positive momentum, scaling up too quickly can limit the ability to adopt previous learning and build from experience. The project seized momentum and government commitment to prioritizing the PBF model. However, the pace of scaling up the project proved to be overly ambitious, given capacity constraints and the lack of PBF experience of the new national implementation unit. A more sequential approach would have also helped to fully internalize the lessons from the previous operations: the conclusions of the ICR and the impact evaluation of the PBF model of the previous operation were not shared until well into the implementation of this project, limiting the adoption of recommendations made.

Alternative approaches for PBF verification mechanisms, such as using representative samples, can offer a more cost-effective solution, especially in resource-limited contexts. Verification mechanisms may entail trade-offs between effectiveness and efficiency when including all health facilities. While it potentially contributed to improved health services utilization and quality, findings from a recent impact evaluation suggest its effectiveness may not be significant. De Walque et al. 2021 showed that outcome differences between the PBF (treatment group) and the increased

financing group (control group where no PBF verification mechanisms were included) were not statistically significant using data from the PBF pilot phase. The project incurred significant overrun costs for verification, with a large portion of the budget allocated to this process. Moreover, an audit of verification agencies revealed inefficiencies and a lack of transparency, further questioning the value of such verification mechanism. Instead of implementing costly verification arrangements for all health facilities, the project could have opted for a more targeted approach, that strategically allocates resources to achieve effective oversight while minimizing costs.

Maintaining continuity within project teams and implementing sound handover arrangements are critical to ensure effective project implementation and supervision. Implementation suffered from frequent team changes, notably TTLs from the Bank side and also the departure of the PBF expert in the CTN, resulting in a significant loss of expertise and continuity in PBF both within the World Bank team and the CTN, which seemed to have occurred with limited handover processes, and persisted until the project's conclusion.

13. Assessment Recommended?

No

14. Comments on Quality of ICR

The ICR provided a clear and consistent narrative, effectively documenting the project's implementation experience and challenges. Moreover, it addressed deficiencies in the results framework by calculating coverage rates for selected service utilization indicators.

However, the report had several shortcomings, including:

i) Failure to describe the activities included in additional components 3 and 4 introduced by the AF;

ii) Inconsistent data regarding restructuring dates and end values of results framework indicators throughout the document;

iii) Lack of evidence demonstrating progress on activities within component 2 focused on institutional strengthening, which is expected to contribute to increasing service quality;

iv) Insufficient details on measures included in the quality checklist and their weighting for score calculation.

a. Quality of ICR Rating

Modest