# COMBINED PROJECT INFORMATION DOCUMENTS / INTEGRATED SAFEGUARDS DATA SHEET (PID/ISDS)
# CONCEPT STAGE

**Report No.**: PIDISDSC15281

**Date Prepared/Updated:** 19-Nov-2015

## I. BASIC INFORMATION

### A. Basic Project Data

| | | | |
|---|---|---|---|
| **Country:** | Cameroon | **Project ID:** | P156679 |
| | | **Parent Project ID (if any):** | |
| **Project Name:** | Health System Performance Project (P156679) | | |
| **Region:** | AFRICA | | |
| **Estimated Appraisal Date:** | 08-Feb-2016 | **Estimated Board Date:** | 03-May-2016 |
| **Practice Area (Lead):** | Health, Nutrition & Population | **Lending Instrument:** | Investment Project Financing |
| **Sector(s):** | Health (80%), Public administration- Health (20%) | | |
| **Theme(s):** | Health system performance (40%), Child health (20%), Population and reproductive health (20%), Nutrition and food security (10%), Ot her communicable diseases (10%) | | |
| **Borrower(s):** | MINEPAT | | |
| **Implementing Agency:** | Ministry of Public Health | | |

**Financing (in USD Million)**

| Financing Source | Amount |
|---|---|
| BORROWER/RECIPIENT | 0.00 |
| International Development Association (IDA) | 100.00 |
| Total Project Cost | 100.00 |

| | |
|---|---|
| **Environmental Category:** | B - Partial Assessment |
| **Concept Review Decision:** | Track II - The review did authorize the preparation to continue |
| **Is this a Repeater project?** | No |
| **Other Decision (as needed):** | |

## B. Introduction and Context

### Country Context

Cameroon has an estimated population of 21.7 million (2014) and the annual population growth rate is 2.7, with 41 percent of the population under 15 years old. Cameroon's average Growth Domestic Product (GDP) growth in real terms has stood between 3.5 and 4.5 percent over the last five years, with GDP per capita per year (PPP) estimated at US$2,400 in 2013. Cameroon is a lower middle income country, but poverty levels are high and social indicators remain low. It was ranked 152nd out of the 187 countries tracked in the 2013 Human Development Index (HDI) and is one of a group of countries whose HDI scores have deteriorated in the past two decades.

Despite significant natural resources, Cameroon's economic growth is lagging behind its potential and has not had a lasting impact on poverty. Cameroon is endowed with significant natural resources, including oil, high value timber species and agricultural products (coffee, cotton, cocoa). Poor infrastructure, an unfavorable business environment, and weak governance hamper economic activity and make it difficult to reach the growth rates needed to reduce poverty in a sustainable manner. After a significant decrease in poverty rates in the 1990s, the poverty rate has barely shifted between 2000 and 2007. Since 2001, it is estimated that around 40 percent of the population lives below the poverty line and chronic poverty stands at about 26 percent. These averages are high compared to other countries in the region with similar economic characteristics. Moreover, there are significant regional disparities in poverty and depths of poverty in Cameroon: poverty is predominant in rural areas and in the northern regions of the country. Existing data also highlight strong socioeconomic disparities and show that over time poverty has decreased in urban areas while continuing to increase in rural areas. The latest household survey in 2014 finds that 56.8 percent of rural families are poor, as opposed to 8.9 percent in urban areas. Approximately 87 percent of the poor live in rural areas; the poor – in terms of numbers and level of poverty - are concentrated in the three northern regions: Far North, North, and Adamaoua

### Sectoral and Institutional Context

While some progress has been recorded in the health sector, some indicators have also worsened. Cameroon has not achieved the Millennium Development Goals (MDGs). For example, in order to achieve MDG 4, the child mortality rate which was 122 deaths per 1,000 live births in 2011, would have to fall by 77 deaths per 1,000 live births by the end of 2015. MDG 5, related to maternal health, will also not be met, with the maternal mortality ratio (MMR) actually increasing since 2004 -from 690 to 782 deaths per 100,000 live births in 2011, ranking as the 18th highest MMR in the world. Over the past twenty years, Cameroonian women have experienced on average a decrease of one birth out of almost six per woman. The Total Fertility Rate (TFR) remains high at 5.1 children per woman on average in 2011, of which 4.5 were reportedly desired pregnancies.

There are also major disparities in health outcomes and access to health services. Significant progress has been made to reduce infant and under-five child mortality in many regions of the country, but major geographic discrepancies remain, particularly between the three northern regions (Far North, North and Adamaoua) and the rest of the country. Child mortality remains extremely high in the poorest parts of the country, such as the North and the Far North, where close to 20 percent of the children born die before their fifth birthday (191 deaths and 168 deaths per 1,000 live births in the North and the Far North, respectively, in comparison with the national average of 122 deaths per 1,000 live births) .

Geographically, the northern regions also have the fewest assisted deliveries. Between the two most recent Demographic and Health Surveys (2004 and 2011), the percentage of deliveries that were assisted by a health professional increased at the national level from 61.7 percent to 63.6 percent. In the Far North, however, only 21.8 percent of births were attended by skilled personnel, compared to 93.0 percent in the Littoral and 91.6 percent in the West. Furthermore, people in the lowest income brackets have the lowest coverage and access to health services. The main factors contributing to these poor health outcomes include: mothers not availing themselves of prenatal services due to lack of education and awareness; financial barriers to health services, and insufficient local infrastructure and lack of skilled personnel, leading to poor quality of the services that are actually provided.

Malnutrition is an important – and increasing – problem. The northern regions are hardest hit, and in addition, malnutrition rates in these regions are on the rise. Between 2004 and 2011, all aspects of infant and child malnutrition worsened, especially emaciation. The overall percentage of emaciation among the population of children under five years of age doubled during that period and more than quadrupled in the fourth quintile . Being underweight, which is a composite of acute and chronic malnutrition, affects 15 percent of children, of whom 5 percent are severely affected. Four regions are especially affected by high rates of children being underweight: the Far North (32 percent), the North (24 percent), Adamawa (21 percent), and the East (15 percent). Growth retardation, which is a clear sign of chronic malnutrition, has increased by 10 percent in Cameroon over the past 20 years. Cameroon is also one of the countries that have made the least progress in reducing growth retardation; with 36.4 percent of children under five suffering. Malnutrition is identified as an underlying cause in 48 percent of deaths of children under five years of age .

Health System Challenges

While Cameroon has an overall high level of health spending of US$138 per capita per year (PPP) (2013), its epidemiological profile corresponds to countries with much lower per capita spending, as described above. Public expenditures for health are relatively low, representing only 33% of total health expenditures (National Health Accounts 2011) and 8.5% of total government expenditures in 2013 (stagnant at the same level since the early 2000s). Budget execution is poor as well, with only 36% of the planned Ministry of Budget Health Investment Budget (IB) for 2013 actually being spent (with the average execution rate for the Ministry of Health IB between 2007 and 2013 being 53%). Households are bearing a large share of health expenditures (52.2% of total health expenditures, NHA 2011), and almost exclusively through out-of-pocket expenditures as coverage with risk-pooling mechanisms is very low (1.2%, NHA 2011), leading to a greater risk of impoverishment and vulnerability for poor households.. Moreover, health funds are not allocated efficiently to high-impact interventions targeted at the neediest groups, in line with the country’s health care priorities (for example, only 2.9% health resources are dedicated for preventive services, NHA 2011). Additionally, financial governance is a main issue in the health sector: informal payments, corruption, and rigidity of public spending procedures. This health financing situation is leading to significant geographic and socio-economic inequities in access to essential health services. Consequently, there is a need to increase efficiency and prioritization in public spending to improve health outcomes.

Cameroon is one of the African nations experiencing a crisis in human resources for health, due to the paucity of health workers and their highly uneven distribution across the country. Cameroon has lower per capita ratios of doctors than neighboring countries, and an alarming lack of

midwives. With approximately 11 qualified health care personnel per 10,000 inhabitants (0.9 doctor, 11 nurses and 0.06 midwife per 10,000 inhabitants), Cameroon is far from the 'high' WHO standard of 22.3 health care personnel per 10,000 inhabitants (HRH census, 2011). Moreover, the geographic distribution of health personnel in Cameroon is uneven, with higher densities in urban areas and in some regions: the Centre region (Yaoundé) contains almost 24% percent of the country's qualified health workers who serve only 18 percent of the population, while the Far North region, which has the same proportion of the population, has only 9% of health workers. The main reasons for the 'desertion' of rural areas by healthcare personnel are the difficult environment, the low level of remuneration, poor working conditions, and limited opportunities for professional advancement . Finally, it appears that the level of competence of personnel (i.e., technical quality) is weak and high levels of absenteeism are observed. Approximately 55% of staff were absent on the day of the survey when the 2012 PBF impact evaluation baseline survey was conducted.

The 15-year Health Sector Strategy (HSS), adopted in 2001, has set the guidelines for Cameroon's health policies for the past decade and a half. Five strategic phases were chosen to achieve the HSS targets: (i) strengthening the health system; (ii) extending implementation of the Minimum Package of Activities (MPA) and the Complementary Package of Activities (CPA) in health districts; (iii) strengthening the referral-treatment system; (iv) strengthening partnerships; and (v) boosting demand for health services. The 2007 midterm review of the HSS noted that little progress had been made in achieving the HSS targets, identifying several key constraints impeding achieving better results. These issues remain fundamental challenges today, with little progress being made since 2007:

1) Geographical barriers to accessing health services, geographical inequities in the availability of health services (a direct result of having no National Health Map to improve allocative efficiency), and obsolescence of most of the health infrastructure and equipment, despite efforts to build and equip health facilities;
2) An inefficient and worsening geographic distribution of trained health professionals, despite recruitment efforts;
3) A legislative and regulatory framework that did not allow the Health Sector Strategy (HSS) to become fully operational, particularly with regards to decentralization;
4) Despite considerable support from international aid, the household contribution to financing health care had only increased over time and government financing had stagnated at around 5 percent of the government's budget, largely below the 15 percent Cameroon committed to contribute in signing the Abuja Declaration; and
5) Very little progress with the introduction of social protection measures for vulnerable populations, including targeted subsidies for the poor and the establishment of risk protection mechanisms such as health insurance.

The next 10-year HSS (2016-2025) is currently in development and is expected to be finalized by the end of 2015. Performance-Based Financing (PBF) has been identified as a central strategy to address the above-mentioned health system challenges and contribute towards achieving Universal Health Coverage (UHC). PBF is being implemented to address critical impediments confronting the delivery of services at the decentralized levels. These challenges include the (i) scarcity of funds to meet operating expenses, (ii) lack of focus on achievement of results and lack of accountability mechanisms of the district health system; and (iii) modest managerial capacity at the district and regional levels. As opposed to the traditional method of allocating funding or material on an input basis, PBF in Cameroon is addressing the abovementioned challenges by

allocating financial resources according to the results achieved (paying for performance) in order to improve the availability, the accessibility and the quality of key services in health facilities.

The foundation of PBF is based on a contractual relationship between the different actors of the health system. Health care providers and regulatory bodies are paid based on their performance, as measured against predetermined targets, and formalizing this financing by a contract between the service provider and a purchaser. The intervention aims to increase providers' accountability with regard to their mission and give them the autonomy and financial incentives necessary to achieve these targets, in particular by enhancing motivation among health personnel. This improvement in staff attitude and morale is closely linked to the increase in resources, goods and equipment acquired through PBF funds. The financial bonuses received by health facility staff serves as a strong motivator for staff members to meet and work to exceed the expectations given to them via their assigned designations and roles within the health facility.

After five years of experience with PBF in Cameroon, the government has identified PBF as a key strategy to (i) improve the efficiency of how resources for the health sector are allocated and used; (ii) improve health worker performance through increased motivation, satisfaction and autonomy for decision-making at the point of service delivery; and (iii) increase the population's use of essential health services through an increase in the quality of health services and reduction in the out-of-pocket costs for these services. As such, the government has recently requested for technical and financial support for making PBF a national program. The proposed operation will support the country's objective of scaling-up PBF nationwide by 2020.

World Bank engagement in Cameroon's health sector
The original Cameroon Health Sector Support Investment Project (HSSIP, P104525) is a US$25 million project (approved in 2008), which aims to provide key maternal and child health services to target populations in their vicinity through PBF. The Project Development Objective is to increase utilization and improve the quality of health services with a particular focus on maternal and child health and communicable diseases.

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The HSSIP project (P10425) began implementing PBF in the Littoral region in 2011, followed by a scale-up to the North-West, South-West and East regions in 2012. The project is currently implementing PBF in public, private and faith-based organization (FBO) facilities across 26 districts in the four regions, covering a total population of approximately three million people. The quality and utilization of maternal and child health services has increased substantially since the launching of PBF. The number of health facilities achieving an average score of 75 percent of the quality index of services has increased by almost seven times since the third quarter of 2012, from 9.3 percent to 71.6 percent in the first quarter of 2015. The number of children completely vaccinated has more than doubled, and the number of children who received one dose of vitamin A by their first birthday has also more than tripled. Key maternal health indicators have substantially increased in volume. The majority of Results Framework indicators have already met their targets or are on track to meeting them before project closing.

An Additional Financing (AF) of the HSSIP of US$40 million was approved in June 2014 (P146795). The IDA AF of US$20 million is being supported by a grant from the Health Results Innovation Multi Donor Trust Fund (HRITF) of US$20 million. Together, the IDA and HRITF resources are supporting continuation of PBF in the original 26 health districts, as well as the extension of the project to departments with high levels of chronic poverty in the regions of

Adamaoua, North and Far-North. An additional 3 million people will be covered through this extension. An official launching of PBF in these regions is planned for November 2015, upon completion of the baseline survey and recruitment of firms including NGOs, who will provide technical assistance for contract development and verification activities.

Since late-2014, the project has engaged in a reform process to better integrate PBF into the national he alth system and prepare for an eventual national scale-up. The international NGOs (Cordaid in the East region and AEDES in the North-West and South-West regions) that were contracted by the Government to pilot PBF in Cameroon in 2012 completed their contracts in December 2014 (AEDES) and June 2015 (Cordaid). In April 2015, the Ministry of Public Health successfully transferred contracting, verification and payment responsibilities to the Regional Funds for Health Promotion (RFHP), which are regional-level civil society organizations with the legal status of Public Interest Groups. The RFHP have subsidiary agreements with the Ministry of Public Health to execute public health interventions on behalf of the government, including PBF-related activities.

In the regions where the RFHP have been in existence for some time (North-West, South-West, and Littoral), they are in charge of medicines management and consign stocks at the facility level. In the regions where the RFHP are not yet functional, the regional distribution of essential drugs is organized around regional monopolistic warehouses of the unique public central medical store (Centrale d'Achat et d'Approvisionnement en Médicaments Essentiels - CENAME). In these regions public health facilities are independent and buy medicines from the regional warehouse. The RFHP approach is being scaled-up and as of 2015 they have been created in nine of the 10 regions, with the process ongoing in the Far North. The expectation is that as PBF scales-up to additional regions, the RFHP will act as Contract Development and Verification Agencies (CDVA) in all regions where they are deemed sufficiently functional to play this role.

The Government of Cameroon has begun providing counterpart financing for PBF. Since 2014 the Ministry of Public Health (MOPH) has financed PBF through direct budget support in the Littoral region, including implementation costs for the Purchasing Agency and direct payments of PBF subsidies to providers through the Public Treasury. Expenditures reached US$1.5 million in 2014, about 75 percent of total costs for the region. The same financial envelope is committed for 2015 and a higher envelope (at least US$2.2 millions) for 2016. The MOPH has recently requested support to conduct fiscal space analysis within their current budget to identify opportunities for channeling resources that are currently being wasted/poorly spent towards the PBF budget line, while also, down the line, revisiting their overall health budget to align it to the PBF approach.

Recently development partners (DPs) in Cameroon's health sector have begun to align their activities with the PBF program. The Ministry of Public Health, UNICEF, UNFPA and the World Bank have prepared a joint financing strategy for PBF (launched on September 18, 2015). UNICEF and UNFPA have signed subsidiary agreements with the Project Implementation Unit (PIU) of the Health Sector Support Investment Project to purchase reproductive health and child health indicators directly through the PIU. The joint-financing is being piloted in the East region for the second half of 2015. This is seen as an initial pilot for them in order to mobilize substantially more resources in 2016. Discussions with other partners (GAVI, Global Fund, WHO, and JICA) regarding their engagement in PBF are ongoing.

The AF (P146795) is already disbursing well ($US22 million in the first year) and additional resources will be necessary to ensure provision of the complete package of services until closing (December 2017). The project has introduced a “Community PBF” component in the northern regions designed to improve health-seeking behavior and geographical access to health services through contracting and training community health workers (CHW) for the provision of a packa ge of referral, preventive and promotional health services. The Community PBF approach developed for Cameroon is currently being piloted in the North-West region, allowing for adjustments prior to its introduction at scale in the northern regions at the end of 2015.

Impact evaluation: The World Bank team and the Government of Cameroon are jointly conducting an impact evaluation linked to the project, with the policy objectives of (a) identifying the impact of PBF on maternal and child health service coverage and quality, (b) identifying key factors responsible for this impact, and (c) assessing the cost-effectiveness of PBF as a strategy to improve coverage and quality. The impact evaluation uses an experimental design to test whether PBF leads to improved maternal and child health outcomes. The results of the impact evaluation are expected to be disseminated in early 2016. A second impact evaluation will be implemented in the northern regions, studying the impact the Community PBF intervention, combined with various formats of “community monitoring”, on key health service delivery outcomes.

At the global level, the WBG and the key DPs launched a Global Financing Facility (GFF) for Every Woman Every Child initiative in September 2014 in order to mobilize and channel additional resources to scale-up delivery of effective and efficient reproductive, maternal, neonatal, child, and adolescent health (RMNCAH) services. Cameroon is one of the second-wave countries selected in July 2015. During project preparation, the level of grant financing from the GFF will be determined, although allocations are expected to follow the matching protocol noted in the GFF guidelines. The GFF consultations and preparation of the GFF Investment Case will be initiated during the October 2015 project preparation mission.

### Relationship to CAS/CPS/CPF

The proposed operation is fully aligned with the Country Assistance Strategy (CAS) for Cameroon 2010-2014, as well as with the new Systematic Country Diagnostic (SCD) and Country Partnership Framework (CPF) under preparation, and aligned with the 2010-2013 Growthand Employment Strategy (Document de Stratégie pour la Croissance et l’Emploi – DSCE) as well as the country’s stated vision and priorities for development. The CAS has two pillars of engagement; enhancing competiveness and enhancing service delivery, with a cross cutting governance lens. The SCD identifies opportunities for achieving the twin goals of ending poverty and improving shared prosperity by 2030, with particular focus on addressing human capital constraints to achieve those goals. This project is fully in line with improving service delivery and stimulating demand-side governance and transparency through the strengthening of civil society organizations and the delivery of quality health services with a particular focus on child and maternal health and communicable disease. It will also support the Government’s commitment to improve access to services in rural areas with a focus on the poor.

## C. Proposed Development Objective(s)

### Proposed Development Objective(s) (From PCN)

The Project Development Objective (PDO) is to increase utilization and improve the quality of health services with a particular focus on reproductive, maternal, and child health and nutrition services.

### Key Results (From PCN)

The key result (outcome) indicators will include:

- Pregnant women receiving antenatal care during a visit to a health provider (number)
- Births attended by skilled professional (number)
- Children 12-23 months fully immunized (number)
- Nutrition services provided (number)
- Average score of the quality of care checklist

The key results including intermediate outcome indicators will be refined during the preparation, and a detailed description of how PDO and intermediate indicators will be used to measure progress in achieving the project's development objectives, will be provided in the Project Appraisal Document (PAD).

## D. Concept Description

The proposed new project would support the progressive national scale-up of the PBF program. It is to be comprised two components that aim to improve performance of the health sector: (i) improving the quantity and quality of preventive, curative and promotional health services through Performance-Based Financing; and (ii) strengthening stewardship and regulatory functions of the Ministry of Public Health. Both components address key strategies identified in the draft national Health Sector Strategy (2016-2025), which is currently under development. Component 1 includes continuing support to the ongoing PBF intervention that covers approximately 25 percent of the country, as well as incrementally increasing coverage, first focusing on scaling-up to full coverage in the three northern regions, to reach national coverage by 2020. The extent to which national coverage can be achieved by 2020 will be assessed at the Mid-Term Review of the project. Component 2 includes strengthening institutional capacity at the national level to foster development of equitable, efficient, and sustainable national health financing strategies to achieve the national health goals, and increase the capacity at the county level to plan, budget, implement, and monitor the effective delivery of an essential package of health services.

Component 1: Strengthening health service delivery through Performance-Based Financing (initial estimation: US$90 million IDA, US$20 million GFF, US$87 million counterpart financing (initial estimate))

Component 1 will support the ongoing implementation of PBF in the 26 health districts covered by the original operation, the 17 health districts newly added through the Additional Financing, and an incremental roll out of PBF to national coverage. With coverage at 25 percent of the population in 2015, the operation would support a gradual scale-up of an additional 20 percent per year between 2017 and 2020. During the first phase of the extension (2016-2018), the operation will focus on scaling-up to the remaining districts in the three northern regions of Cameroon to address the urgent and growing needs in those regions.

In addition, the operation will support the establishment of CVDAs in the three regions currently not covered by the operation: the Center, South and West, with approximately 2-4 health districts in each new region. The operation would subsequently scale-up coverage to additional districts within the seven southern regions (North-West, South-West, East, Littoral, Center, West and

South).

As per the current project design, Component 1 will provide PBF payments: (i) to health facilities in the targeted regions conditional on the quantity and quality of services delivered via in-clinic activities and/or via health-outreach activities, and (ii) to community health workers for providing selected basic preventive, promotional, referral and curative health services (community IMCI). Contracted health facilities will use PBF payments to (i) increase the quality and the quantity of health services provided at the facility and community levels; and (ii) provide financial incentives to health facility staff and community health workers based on performance achieved.

The project will also introduce mechanisms to improve financial access to essential health services at the community and health facility levels among poor and vulnerable households. The mechanism used to identify the poor that will be applied will build on both experiences from the Health Sector Support Investment Project in other regions of Cameroon and the Cameroon Social Safety Nets Project (P128534). Exemption mechanisms for the poor will be put in place to cover health care provided at the community and health facility levels. The project will also introduce fee-waivers for certain essential services for systematically identified vulnerable households as a further demand-side mechanism to boost households' use of health services. In order to fill the financial gap caused by this loss in facility revenue through the absence of direct payments, facilities will be reimbursed for free services provided to vulnerable populations. In the districts also covered by the Cameroon Social Safety Nets Project, access to health services will be further facilitated through joint sensitization activities and the household transfers operated through the Safety Nets Project.

In addition to increasing the geographical coverage of PBF, Component 1 will provide technical assistance in rolling-out PBF to regional and tertiary-level hospitals in the country. A pilot is currently ongoing at the national pediatric hospital in Yaoundé to test PBF at the tertiary level. Within this pilot, PBF subsidies are being paid by revenue generated internally within the hospital. While the implementation of PBF at tertiary hospitals, including payment of subsidies, will be supported by both the public budget and internal revenue generated at these hospitals, the project will provide the necessary technical assistance to design and implement these interventions, as well as support the contract management and verification activities to be conducted by the CVDAs in each region.

Component 2: Strengthening institutional capacity for improved health system performance (initial estimation: US$10 million IDA, US$5 million GFF, US$3 million counterpart financing (initial estimate))

Component 2 will support institutional strengthening at national, regional, and district levels for improved health system performance. In addition to providing institutional support for moving PBF from a pilot project to a national program, Component 2 will also support analytical work, and policy dialogue to facilitate the development of these reforms, as well as implementation support for a few key reforms that address system bottlenecks for achieving more efficient use of health sector resources and improved health outcomes. While PBF is seen as a systemic reform in itself, affecting a large array of factors that contribute to health outcomes, the component will also support the broader reform agenda that is seen as necessary by the Government of Cameroon in order to make progress towards achieving UHC. The identification of these bottlenecks and reforms to be supported by the project will be guided by the new national health strategy and

agreed upon during the GFF consultation process.

As such, Component 2 will provide additional support at the central level of the Ministry of Public Health through analytical work and policy dialogue related to several of the main challenges the health system is facing: (i) improving regulatory functions of the pharmaceutical sector, (ii) addressing necessary judicial reforms related to decentralized decision-making and financial and managerial autonomy of health service providers and regulatory bodies; (iii) health workforce regulatory reforms needed to improve the availability and quality of health services by skilled providers, particularly in rural areas; (iv) the development of a coherent, practical and results-oriented community health strategy; (v) harnessing the private and faith-based health sectors through strategic contracting; and (v) supporting the strengthening of national civil registration and vital statistics (CRVS) systems. The component will also support the development and implementation of the Government's national health financing strategy, which is to be developed within the GFF implementation framework.

The specific activities will be identified during the project preparation process. The approach to addressing regulatory reforms will be based on evidence, take into account the specificity of the country and its regions and favor an inclusive policy dialogue with the government, donors and technical partners and the private sector.

Specifically for PBF, Component 2 will support the strengthening of monitoring and evaluation capacity for high-quality, real time data, through the creation of an independent national External Evaluation Agency (EEA) for verification of results achieved through the program. Currently external evaluation activities are being conducted by the faculties of medicine at the University of Yaoundé and University of Douala. During project preparation a performance assessment of these agencies will be conducted to assess if these universities can continue to play the role of EEAs, or if a new national structure should be identified/developed.

Component 2 will also support training and capacity building activities related to PBF. A "snowball training" approach for key implementation and regulatory actors in PBF has been developed and implemented in neighboring countries such as Nigeria, the Republic of Congo and the Democratic Republic of Congo. Given the task of scaling-up PBF over the lifetime of the project, a similar approach will be designed and implemented under the new operation to ensure that an efficient and high-quality training program is in place for new geographical areas that will be targeted.

Finally, the component will also cover operational costs for the Project Implementation Unit (PIU) and National PBF Technical Unit within the Ministry of Public Health, as well as performance contracts for central-level regulatory bodies such as the Department of Family Health and the Department of Health Promotion.

Although the research portfolio on PBF in Cameroon is already quite extensive (two impact evaluations, several process evaluations, etc.), the project will continue to build the knowledge base and strengthen the evidence base on high-impact interventions within the Cameroonian context. The learning and research agenda will be developed during project preparation.

The project will be also conceived in synergy with the Public Financial Management for Service Delivery Reform Project (P151155) currently in preparation, which aims to improve effectiveness

and transparency in the management of public finances and contribute to improved service delivery in selected sectors. This project will target specific line ministries, including the Ministry of Public Health, to review and improve their (i) program-budget and indicators, (ii) Investment Budget execution, and (iii) information management systems. The health project will provide knowledge, expertise and potentially the framework for piloting PBF-type approaches in line ministries for civil servants involved in Public Investment Management (PIM) to provide the right incentives for the enforcement of the new PIM system.

## II. SAFEGUARDS

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

The project will be implemented in all ten regions of the country. Indigenous Peoples live in the East region and OP/BP 4.10 has been triggered in order to ensure that these populations will be effectively included in project benefits.

### B. Borrower's Institutional Capacity for Safeguard Policies

The Ministry of Public Health has a unit that is responsible for environmental issues which works in close collaboration with the Ministry of Environment, Nature Protection and Sustainable Development (MINEPDED). The Unit has well trained staff and when necessary seeks support from MINEPDED or external consultants. It was agreed that the same arrangement will be maintained during the implementation of the Additional Financing period of the original HSSIP project (P104525). The Indigenous People's Plan (IPP) was prepared and published in the Infoshop in 2008 during the preparation of the original HSSIP project. The IPPF was successfully applied under the HSSIP project (P10425), including an assessment by the implementation agency to assess to what extent indigenous peoples have benefitted from the project since the launching of Performance Based Financing. The Performance Purchasing Agency in the East has introduced specific measures to ensure indigenous peoples in the region are benefitting from the improved availability and quality of health services in their areas.

### C. Environmental and Social Safeguards Specialists on the Team

Emeran Serge M. Menang Evouna (GENDR)

Kristyna Bishop (GSURR)

### D. POLICIES THAT MIGHT APPLY

| Safeguard Policies | Triggered? | Explanation (Optional) |
|---|---|---|
| Environmental Assessment OP/BP 4.01 | Yes | This policy was triggered due to the potential increase in production of medical waste, resulting from an increase in use of health services as an impact of the proposed project. An new Medical Waste Management Plan will be prepared as an instrument to identify mitigation measures for these potential impacts. |
| Natural Habitats OP/BP 4.04 | No | The project is not expected to impact on natural habitats. |
| Forests OP/BP 4.36 | No | The project is not expected to impact on forests. |

| | | |
|---|---|---|
| Pest Management OP 4.09 | No | The project is not expected to impact on pests. |
| Physical Cultural Resources OP/BP 4.11 | No | The project is not expected to impact on physical cultural resources. |
| Indigenous Peoples OP/BP 4.10 | Yes | This policy has been triggered as indigenous peoples are present in the East region. The PIU will contract a consultant to undertake a social assessment that will review the implementation of the IPPF for the previous Health Sector Support project and evaluate the current health status and concerns of these communities in order to inform the preparation of an IPPF/IPP for this project. The appropriate safeguard instrument will be prepared and disclosed prior to appraisal per the requirements of |
| Involuntary Resettlement OP/ BP 4.12 | No | The project will not include any involuntary resettlement. |
| Safety of Dams OP/BP 4.37 | No | The project will not include construction or rehabilitation of dams, nor rely on dams. |
| Projects on International Waterways OP/BP 7.50 | No | The project is not expected to impact on any international waterway. |
| Projects in Disputed Areas OP/ BP 7.60 | No | The project will not be located in a disputed area. |

## E. Safeguard Preparation Plan

### 1. Tentative target date for preparing the PAD Stage ISDS

30-Nov-2015

### 2. Time frame for launching and completing the safeguard-related studies that may be needed. The specific studies and their timing should be specified in the PAD-stage ISDS.

The MWMP prepared for the original project was implemented as planned (purchase/installation of generators). The PIU is in the process of recruiting a consultant to update the MWMP for the new operation (new technical and geographical scope). During the update process, all relevant stakeholders will be consulted. The PIU is also in the process of recruiting a consultant to undertake the social assessment and prepare the IPPF/IPP as required. The TORs will be cleared prior to implementation.

# III. Contact point

**World Bank**

Contact: Paul Jacob Robyn
Title: Health Specialist

**Borrower/Client/Recipient**

Name: MINEPAT
Contact: Mr. Louis Paul Motaze
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**Implementing Agencies**

Name: Ministry of Public Health
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## IV. For more information contact:

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## V. Approval

| | | |
|---|---|---|
| Task Team Leader(s): | Name: Paul Jacob Robyn | |
| ***Approved By*** | | |
| Safeguards Advisor: | Name: Johanna van Tilburg (SA) | Date: 02-Dec-2015 |
| Practice Manager/ Manager: | Name: Trina S. Haque (PMGR) | Date: 02-Dec-2015 |
| Country Director: | Name: Elisabeth Huybens (CD) | Date: 03-Dec-2015 |

1 Reminder: The Bank's Disclosure Policy requires that safeguard-related documents be disclosed before appraisal (i) at the InfoShop and (ii) in country, at publicly accessible locations and in a form and language that are accessible to potentially affected persons.

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