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Report No: PAD1666

INTERNATIONAL DEVELOPMENT ASSOCIATION

PROJECT APPRAISAL DOCUMENT

ON A

PROPOSED CREDIT

IN THE AMOUNT OF SDR72.40 MILLION
(US$100 MILLION EQUIVALENT)

AND
A PROPOSED GRANT FROM THE MULTI DONOR TRUST FUND FOR THE GLOBAL FINANCING FACILITY
IN THE AMOUNT OF US$27 MILLION

TO THE

REPUBLIC OF CAMEROON

FOR A

HEALTH SYSTEM PERFORMANCE REINFORCEMENT PROJECT

April 12, 2016

Health, Nutrition and Population Global Practice
Africa Region

CURRENCY EQUIVALENTS

(Exchange Rate Effective February 29, 2016)

Currency Unit	=	XAF
XAF 604	=	US$1
US$1	=	SDR 0.72395045

FISCAL YEAR

January 1 – December 31

ABBREVIATIONS AND ACRONYMS

AEDES	European Agency for Development and Health
AIDS	Acquired Immunodeficiency Syndrome
AF	Additional Financing
ANC	Antenatal Care
CAD	Canadian Dollar
CAS	Country Assistance Strategy
CDVA	Contract Development and Verification Agencies
CENAME	Centrale d'Achat et d'Approvisionnement en Médicaments Essentiels *(National Supply Center for Essential Medicines and Medical Supplies)*
CHAI	Clinton Health Access Initiative
CHW	Community Health Worker
CORDAID	Catholic Organization for Relief and Development Aid
CPA	Complementary Package of Activities
CPF	Country Partnership Framework
CRVS	National Civil Registration and Vital Statistics
DA	Designated account
DALYs	Disability Adjusted Life Years
DHS	Demographic and Health Survey
DIB	Development Impact Bond
DLIs	Disbursement Linked Indicators
DP	Development Partners
DRC	Democratic Republic of Congo
DSCE	Document de Stratégie pour la Croissance et l'Emploi (*Growth and Employment Strategy*)
EA	Environmental Assessment
ECAM	Enquête Camerounaise Auprès des Ménages (*Cameroon Household Survey*)
EEA	External Evaluation Agency
EPI	Expanded Program on Immunization
FBO	Faith Based Organization
FM	Financial Management
GAVI	Global Alliance for Vaccines and Immunization

GCC	Grand Challenges Canada
GDP	Gross Domestic Product
GF	Global Fund
GFF	Global Financing Facility
GRS	Grievance Redress Service
HCWMP	Health Care Waste Management Plan
HD	Human Development
HIPC	Heavily Indebted Poor Countries Initiative
HIV	Human Immunodeficiency Virus
HRH	Human Resources for Health
HRITF	Health Results Innovation Trust Fund
HSS	Health Sector Strategy (*Stratégie Sectorielle de la Santé*)
HSSIP	Health Sector Support Investment Project
IB	Investment Budget
IC	Investment Case
IDA	International Development Association
IBRD	International Bank for Reconstruction and Development
IE	Impact Evaluation
IFR	Interim Financial Report
IMCI	Integrated Management of Childhood Illnesses
IMR	Infant Mortality Rate
IPP	Indigenous Peoples Plan
IPF	Investment Project Financing
IPPF	Indigenous Peoples Planning Framework
JICA	Japan International Cooperation Agency
KMC	Kangaroo Mother Care
LBW	Low Birth Weight
M&E	Monitoring and Evaluation
MDGs	Millennium Development Goals
MICS	Multiple Indicator Cluster Survey
MINMAP	Ministry of Public Procurement
MMR	Maternal Mortality Ratio
MoPH	Ministry of Public Health
MPA	Minimum Package of Activities
MWMP	Medical Waste Management Plan
NGO	Non-Governmental Organization
NHA	National Health Accounts
PBF	Performance Based Financing
PDO	Project Development Objective
PFM	Procurement and Financial Management
PHCPI	Primary Health Care Performance Initiative
PIM	Program Implementation Manual
PIM	Public Investment Management
PIU	Project Implementation Unit
PNDS	Programme National de Développement de la Santé (*National Health Development Plan*)

PPA	Performance Purchasing Agency
PPP	Purchasing Power Parity
RFHP	Regional Funds for Health Promotion
RMNCAH	Reproductive, Maternal, Neonatal, Child and Adolescent Health
ROC	Republic of Congo
SCD	Systematic Country Diagnostic
SDG	Sustainable Development Goals
SDI	Service Delivery Indicators
SORT	Systematic Operations Risk Rating Tool
TFR	Total Fertility Rate
TOR	Terms of Reference
UHC	Universal Health Coverage
UNFPA	United Nations Fund for Population Activities
UNICEF	United Nations Children's Fund
WB	World Bank
WBG	World Bank Group
WHO	World Health Organization

Regional Vice President:	Makhtar Diop
Country Director:	Elisabeth Huybens
Senior Global Practice Director:	Timothy Grant Evans
Practice Manager:	Trina S. Haque
Task Team Leader:	Paul Jacob Robyn

COUNTRY
Health System Performance Reinforcement Project

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Health System Performance Reinforcement Project (P156679)

PROJECT APPRAISAL DOCUMENT

AFRICA

Report No.: PAD1666

Basic Information			
Project ID P156679	EA Category B - Partial Assessment		Team Leader(s) Paul Jacob Robyn
Lending Instrument Investment Project Financing	Fragile and/or Capacity Constraints [ ] Financial Intermediaries [ ] Series of Projects [ ]		
Project Implementation Start Date 03-May-2016	Project Implementation End Date 31-May-2021		
Expected Effectiveness Date 05-Sep-2016	Expected Closing Date 31-May-2021		
Joint IFC No			
Practice Manager/Manager Trina S. Haque	Senior Global Practice Director Timothy Grant Evans	Country Director Elisabeth Huybens	Regional Vice President Makhtar Diop

Borrower: MINEPAT			
Responsible Agency: Ministry of Public Health			
Contact:	Andre Mamma Fouda	Title:	Minister of Public Health
Telephone No.:	237-22-22-35-25	Email:	andrmama@yahoo.fr

Project Financing Data(in USD Million)					
[ ]	Loan	[ ]	IDA Grant	[ ]	Guarantee
[X]	Credit	[X]	Grant	[ ]	Other

Total Project Cost:	127.00	Total Bank Financing:	127.00
Financing Gap:	0.00		

Financing Source	**Amount**
BORROWER/RECIPIENT	0.00

International Development Association (IDA)	100.00
Global Financing Facility (GFF)	27.00
Total	127.00

Expected Disbursements (in USD Million)

Fiscal Year	2017	2018	2019	2020	2021
Annual	10.00	30.00	35.00	40.00	12.00
Cumulative	10.00	40.00	75.00	115.00	127.00

Institutional Data

Practice Area (Lead)

Health, Nutrition & Population

Contributing Practice Areas

Cross Cutting Topics

[ ] Climate Change
[ ] Fragile, Conflict & Violence
[X] Gender
[ ] Jobs
[X] Public Private Partnership

Sectors / Climate Change

Sector (Maximum 5 and total % must equal 100)

Major Sector	Sector	%	Adaptation Co-benefits %	Mitigation Co-benefits %
Health and other social services	Health	80		
Public Administration, Law, and Justice	Public administration-Health	20		
Total		100		

☑ I certify that there is no Adaptation and Mitigation Climate Change Co-benefits information applicable to this project.

Themes

Theme (Maximum 5 and total % must equal 100)

Major theme	Theme	%
Human development	Health system performance	40
Human development	Child health	20
Human development	Population and reproductive health	20
Human development	Nutrition and food security	10

Human development	Other communicable diseases	10
Total		100

Proposed Development Objective(s)

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

Components

Component Name	**Cost (USD Millions)**
Strengthening of Health Service Delivery	109.00
Institutional Strengthening for Improved Health System Performance	18.00

Systematic Operations Risk- Rating Tool (SORT)

Risk Category	**Rating**
1. Political and Governance	Moderate
2. Macroeconomic	Moderate
3. Sector Strategies and Policies	Moderate
4. Technical Design of Project or Program	Substantial
5. Institutional Capacity for Implementation and Sustainability	Substantial
6. Fiduciary	Substantial
7. Environment and Social	Low
8. Stakeholders	Moderate
9. Security (Other)	Substantial
OVERALL	Substantial

Compliance

Policy

Does the project depart from the CAS in content or in other significant respects?	Yes [ ] No [X]
Does the project require any waivers of Bank policies?	Yes [ ] No [X]
Have these been approved by Bank management?	Yes [ ] No [ ]
Is approval for any policy waiver sought from the Board?	Yes [ ] No [X]
Does the project meet the Regional criteria for readiness for implementation?	Yes [X] No [ ]

Safeguard Policies Triggered by the Project	**Yes**	**No**
Environmental Assessment OP/BP 4.01	**X**	
Natural Habitats OP/BP 4.04		**X**

Forests OP/BP 4.36		**X**
Pest Management OP 4.09		**X**
Physical Cultural Resources OP/BP 4.11		**X**
Indigenous Peoples OP/BP 4.10	**X**	
Involuntary Resettlement OP/BP 4.12		**X**
Safety of Dams OP/BP 4.37		**X**
Projects on International Waterways OP/BP 7.50		**X**
Projects in Disputed Areas OP/BP 7.60		**X**

Legal Covenants

Name	**Recurrent**	**Due Date**	**Frequency**
Recruitment of Fiduciary Personnel		05-Nov-2016	

Description of Covenant

SCHEDULE 2. Section I.A.2.(b)(i)(B). The recipient will recruit not later than two (2) months after the Effective Date, an accountant, an assistant accountant, and an internal auditor all in accordance with Section III of Schedule 2.

Name	**Recurrent**	**Due Date**	**Frequency**
Implementation of External Verification		05-Jun-2017	

Description of Covenant

SCHEDULE 2. Section I.G.4.(a). The Recipient shall maintain or, as needed, in accordance with Section III of this Schedule 2, recruit not later that nine (9) months after the Effective Date and thereafter maintain, throughout Project implementation, external verification agents, with qualifications, experience, and terms of reference satisfactory to the Association, for purposes of the third-party verification of the Basic Health Services Package to be carried out under Part A.1 of the Project.

Name	**Recurrent**	**Due Date**	**Frequency**
Upgrading of Financial and Accounting System		05-Nov-2016	

Description of Covenant

SCHEDULE 2. Section II.B.4. The Recipient shall upgrade, not later than two (2) month after the Effective Date, the Project's computerized financial and accounting system to be fit for Project purpose, in a manner satisfactory to the Association.

Name	**Recurrent**	**Due Date**	**Frequency**
Recruitment of External Auditors		05-Feb-2017	

Description of Covenant

SCHEDULE 2. Section II.B.5. The Recipient shall engage external auditors for the purpose, not later than five (5) months after the Effective Date, in accordance with the provisions of Section III of this Schedule 2.

Conditions		
Source Of Fund	**Name**	**Type**
GFF	GFF Grant Agreement Effectiveness	Effectiveness
Description of Condition		
The Co-financing Agreement has been executed and delivered and all conditions precedent to its effectiveness or to the right of the Recipient to make withdrawals under it (other than the effectiveness of the Financing Agreement) have been fulfilled.		
Source Of Fund	**Name**	**Type**
IDA	Establishment of the Technical Working Group	Effectiveness
Description of Condition		
SCHEDULE 2. Section I.A.1. The Recipient has established the Technical Working Group in accordance with the provisions of Section I.A.1 of Schedule 2 to the Financing Agreement.		
Source Of Fund	**Name**	**Type**
IDA	Expansion of the mandate of the National PBF Technical Unit	Effectiveness
Description of Condition		
SCHEDULE 2. Section I.A.2. The Recipient has expanded the mandate of the National PBF Technical Unit in accordance with the provisions of Section I.A.2 of Schedule 2 to the Financing Agreement.		
Source Of Fund	**Name**	**Type**
IDA	Recruitment of personnel	Effectiveness
Description of Condition		
SCHEDULE 2. Section I.A.2.(b)(i)(A). The Recipient has recruited a financial management specialist, a procurement specialist, all in accordance with the provisions of Section I.A2 (b) (i) (A) of Schedule 2 to the Financing Agreement.		
Source Of Fund	**Name**	**Type**
IDA	Expansion of the mandate of the Tender Board	Effectiveness
Description of Condition		
SCHEDULE 2. Section I.A.3. The Recipient has expanded the mandate of the Tender Board in accordance with the provisions of Section I.A.3 of Schedule 2 to the Financing Agreement.		
Source Of Fund	**Name**	**Type**
IDA	Adoption of the Project Operational Manual	Effectiveness
Description of Condition		
SCHEDULE 2. Section I.C.1. The Recipient has adopted the Project Operational Manual in accordance with the provisions of Section I.C of Schedule 2 to the Financing Agreement.		

Team Composition

Bank Staff

Name	Role	Title	Specialization	Unit

Paul Jacob Robyn	Team Leader (ADM Responsible)	Health Specialist	Health	GHN07
Mohamed El Hafedh Hendah	Procurement Specialist (ADM Responsible)	Senior Procurement Specialist	Procurement	GGO07
Celestin Adjalou Niamien	Financial Management Specialist	Senior Financial Management Specialist	Financial Management	GGO13
Abel Paul Basile Bove	Team Member	Governance Specialist	Governance	GGO13
Aissatou Chipkaou	Team Member	Operations Analyst	Operations	GHN07
Christophe Rockmore	Team Member	Senior Economist	Service Delivery Indicators	GHN07
Defa Wane	Team Member	Consultant	Reproductive Health	GHNDR
Emanuela Di Gropello	Team Member	Program Leader	Human Development	AFCC1
Emeran Serge M. Menang Evouna	Safeguards Specialist	Senior Environmental Specialist	Environment	GEN07
Eric Christian Thibaut Mallard	Team Member	Senior Health Specialist	Health	GHNGE
Francis Tasha Venayen	Team Member	Financial Management Analyst	Financial Management	GGO13
Hamadou Saidou	Team Member	Consultant	Impact Evaluation	GHNDR
Helene Simonne Ndjebet Yaka	Team Member	Operations Analyst	Operations	AFCC1
James Dunaway Long	Team Member	Consultant	Impact Evaluation	GHN07
Jean Claude Taptue Fotso	Team Member	E T Consultant	Performance Based Financing	GHN07
Jeremy Henri Maurice Veillard	Team Member	E T Consultant	Primary Health Care	GHNGE
Kolie Ousmane Maurice Megnan	Team Member	Sr Financial Management Specialist	Financial Management	GGO13
Kristyna Bishop	Safeguards Specialist	Senior Social Development Specialist	Social Development	GSU01
Luis M. Schwarz	Team Member	Senior Finance Officer	Finance	WFALA

Maria Ward Steenland	Team Member	Consultant	Impact Evaluation	GHN07
Maud Juquois	Team Member	Economist (Health)	Health Financing	GHN07
Mbah Okwen Patrick	Team Member	Consultant	Community Health	GHN07
Menno Mulder-Sibanda	Team Member	Sr Nutrition Spec.	Nutrition	GHN07
Moulay Driss Zine Eddine El Idrissi	Team Member	Sr Economist (Health)	Health Financing	GHN07
Natalie Tchoumba Bitnga	Team Member	Program Assistant	Operations	AFCC1
Nneoma Veronica Nwogu	Counsel	Senior Counsel	Legal	LEGAM
Norosoa Andrianaivo	Team Member	Senior Program Assistant	Operations	GHN03
Robert Anthony Soeters	Team Member	Consultant	Performance-Based Financing	GHN07
Tazeem Mawji	Team Member	Consultant	Operations	GHN07

Extended Team

Name	Title	Office Phone	Location
Toby Kasper	GFF Core Team Member		

Locations

Country	First Administrative Division	Location	Planned	Actual	Comments
Cameroon	South-West Province	South-West Province	X	X	
Cameroon	South Province	South Province	X		
Cameroon	West	West	X		
Cameroon	North-West Province	North-West	X	X	
Cameroon	North Province	North	X	X	
Cameroon	Littoral	Littoral	X	X	
Cameroon	Far North	Far North	X	X	
Cameroon	East	East	X	X	
Cameroon	Centre	Centre	X	X	
Cameroon	Adamawa	Adamawa	X	X	

Consultants (Will be disclosed in the Monthly Operational Summary)

Consultants Required? Consulting services to be determined

I. STRATEGIC CONTEXT

A. Country Context

1. **Cameroon has an estimated population of 22.8 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 3.3 (2010) and 5.9 percent (2014) over the last five years, with GDP per capita per year (Purchasing Power Parity (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 153rd out of the 188 countries tracked in the 2014 Human Development Index (HDI) and is one of a group of countries whose HDI scores have deteriorated in the past two decades.

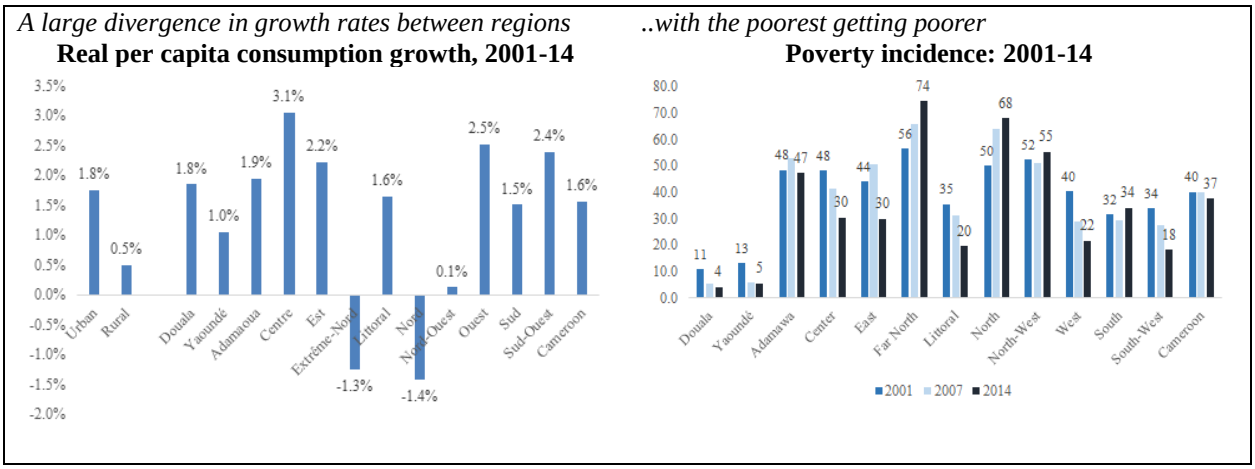
2. **Despite great development potential (significant natural resources, a relatively educated work force and a capable bureaucracy), Cameroon's economic growth is lagging behind its potential and has not had a lasting impact on poverty.** Cameroon is endowed with significant natural resources, including 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. In 2014, poverty incidence was 38 percent (using the national poverty line). These averages are high compared to other countries in the region with similar economic characteristics.

3. **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, compared to 8.9 percent of urban families. 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 Adamawa. Fifty six percent of all poor are found in the Far North and North regions, this reflects a rapid increase (in 2001, it was 34 percent). Changes in poverty between 2001 and 2014 show an unambiguous regional pattern, with northern Cameroon becoming poorer and southern Cameroon becoming better-off. Poverty declined continuously in the center-west of the country, in the Littoral, Center, West and South-West regions, as well as in Douala and Yaoundé. By contrast, poverty continuously rose in the North and Far North regions. The regions of Adamawa, North-West and South are characterized by stagnation while the East region initially experienced an increase in poverty followed by a sharp decline.

4. **The rapid increase in poverty in northern Cameroon occurred before insecurity increased due to Boko Haram activities in the region.** The deterioration of the security environment in northern Cameroon occurred largely after the completion of data collection for the 4th round of the Cameroon Household Survey (ECAM). The poverty estimates for the northern regions should, thus, be considered the lower bounds, since the consequences of the

increased influx of refugees, closure of markets, roads and frontiers has not been taken into account. Latest updates suggest that as the result of the interruption of agricultural activities and trade, as well as displacement, vulnerability and food insecurity in the Far North are acute with 2.4 million people considered food insecure and 250,000 people suffering from acute malnutrition.

Figure 1: Changes in consumption and poverty, 2001-2014



Source: ECAM2 and ECAM4; inflation rate: WDI 2015.

B. Sectoral and Institutional Context

Poor Progress on Health Outcomes

5. **While some progress has been recorded in health outcome, some indicators have also worsened.** Cameroon has not achieved the Millennium Development Goals (MDGs). For example, with respect to MDG 4, "*Reduce by two-thirds, between 1990 and 2015, the under-five mortality rate*" Cameroon's target was to reduce the under-five mortality rate (U5MR) from 138 deaths per 1,000 live births in 1990 to 46 in 2015. Cameroon was only able to reduce its U5MR to 88 by 2015 target. Similarly for MDG5, "*Reduce maternal mortality by three quarters between 1990 and 2015*", the target was also not met, with the maternal mortality ratio (MMR) for Cameroon actually increasing from 728 maternal deaths per 1,000 live births in 1990 to 782 in 2011[1]. Over the past twenty years, the Total Fertility Rate (TFR) has decreased by almost one birth per woman, from almost 6 to 4.9 births per woman according to the 2014 Multiple Indicator Cluster Survey (MICS).

6. **There are also major geographic 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 Adamawa) 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 (173

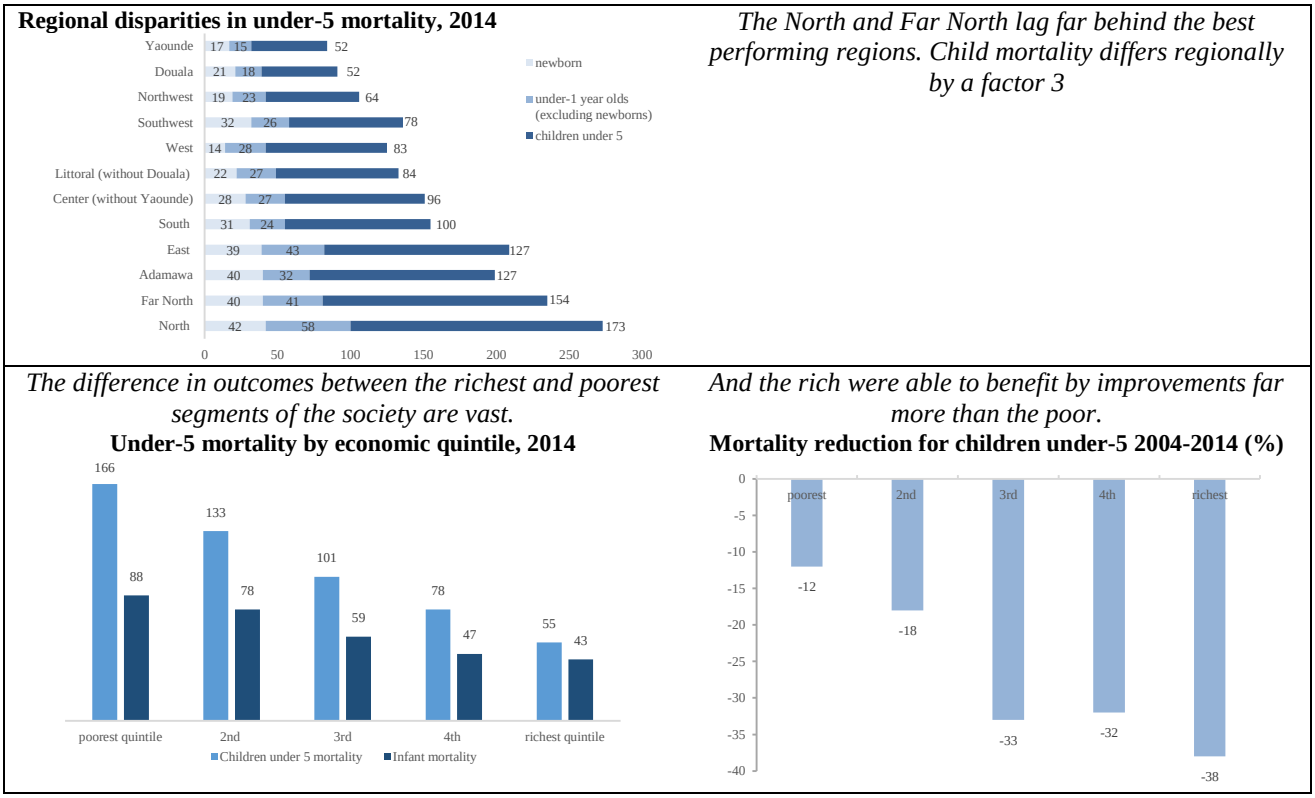
[1] Estimates based on the 2011-DHS MICS. The next DHS round is planned for 2016

deaths and 154 deaths per 1,000 live births in the North and the Far North, respectively), in comparison with the national average of 103 deaths per 1,000 live births).

7. **The northern regions also have the fewest assisted deliveries.** Between the two most recent MICS surveys (2011 and 2014), the percentage of deliveries that were assisted by a health professional increased at the national level from 63.6 percent to 64.7 percent. In the Far North and North, however, only 29 percent and 35 percent of births, respectively, were attended by skilled personnel, compared to 99 percent in Douala, and 96 percent in the West and North-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 the provision of poor quality services.

8. **Low birth weight (LBW)** is a pressing issue in Cameroon, where the neonatal mortality rate is about 28 per 1000 live births, according to World Health Organization statistics, but even higher in some regions. Low birth weight is a leading risk factor for neonatal mortality. As with the majority of other health challenges in Cameroon, there remains a higher prevalence of low birth weight in the three northern regions than the rest of the country.

Figure 2: Inequalities in health outcomes



Source: Hodges (2015) and World Bank staff calculations (from Cameroon SCD)

9. **Childhood malnutrition remains widespread, has stagnated for over 20 years and is characterized by enormous disparities. The northern regions are hardest hit, and malnutrition in these regions is on the rise.** The overall percentage of wasting among the population of children under five years of age doubled between 2004 and 2011 and more than quadrupled in the fourth quintile[2]. Stunting, which is an indicator of chronic malnutrition, was 36 percent in 1991 and 32 percent in 2014. The difference between urban (22 percent) and rural (41 percent) areas is significant and four regions are especially affected by high rates of stunting: the Far North (44 percent), the North (40 percent), Adamawa (40 percent), and the East (38 percent). As a result, Cameroon is one of the countries that have made the least progress in reducing stunting. Micronutrient deficiencies are equally rampant; vitamin A deficiency, associated with child mortality and blindness, was found in 39 percent of children aged 1-6 years; and early childhood anemia, associated with impaired cognitive and physical development, affects 60 percent of children 6-59 months. Malnutrition is identified as an underlying cause in 48 percent of deaths of children under five years of age[3]. Among the survivors, undernourished children have lower cognitive and school performance, and 10-17 percent lower income potential as adults.

Table 1: Summary of health indicators

Indicator	Value	Unit of Meas.	Year	Source
Maternal and reproductive health				
Women of ages 15-49 having taken basic prenatal health tests	73	%	2014	MICS
Women of ages 15-49 having had qualified assistance during child birth	65	%	2014	MICS
Women having had postnatal consultation after child birth	69	%	2014	MICS
Maternal mortality	782	per 100,000 live births	2011	DHS-MICS
Child mortality and child health				
Under-2 full vaccination coverage	64	%	2014	MICS
Under-5 mortality	103	% live births	2014	MICS
Under-5 malaria infection	30	%	2011	DHS-MICS
Under-5 diarrhea	20	%	2014	MICS
Exclusive breastfeeding in children 0-6 months	28	%	2014	MICS
Under-5 stunting (low height for age)				
a) Moderate to severe	32	%	2014	MICS
b) Severe	13	%	2014	MICS
Under-5 wasting (low weight for height)				
a) Moderate to severe	5	%	2014	MICS

Source: DHS-MICS 2011, MICS 2014

[2] Idem.
[3] Idem.

10. **General health issues facing the population.** Life expectancy at birth was 55 years in 1990 and 53 years in 2008, it has since declined to 51 years in 2011. This outcome is nearly the same as the rate for the sub-region as a whole (52 years), but well below the overall world average (68 years). Life expectancy is the same for men and women. The mortality rate of the population (15–60 years of age) rose from 321/1,000 in 1990 to 403/1,000 in 2008. According to the latest estimate of the WHO's Global Health Observatory (2012), the mortality profile in Cameroon continues to be dominated by infectious diseases**,** although cancer and cardiovascular diseases are on the rise. Diarrhea, respiratory infections, and malaria are still far more prevalent than other diseases. The malaria-induced mortality rate (116/1,000) is also higher than the African region's overall average (104/1,000) and certainly higher than those of its neighboring countries. Malaria remains the leading cause of morbidity and mortality, particularly among children under five years of age and pregnant women. It accounts for 40–50 percent of medical consultations, 40 percent of deaths among children 0–5 years of age, and 23 percent of hospitalizations. Despite a steady decline, HIV prevalence remains high (4.3 percent) and exceeds that of most western and central African counties. The Tuberculosis (TB) burden remains significant in Cameroon with mortality rates of 14 per 100,000 in 2010, prevalence rates of 195 per 100,000, and incidence of 177 per 100,000 respectively.

Growing disparities for other human development outcomes

11. **Regional inequalities in education outcomes are also significant.** The net enrollment rate for primary education in 2014 was 63, 74 and 74 percent in the Far North, the North and Adamawa regions respectively, versus 85-95 percent in the other regions. At the secondary level, in 2011 gross enrollment was 22 and 29 percent and net enrolment only 14 and 18 percent in the Far North and North regions respectively.

12. **Disparities in secondary schooling widened between North and Far North and the other regions, as well as between the bottom wealth quintile and the other wealth quintiles**. Even though every region experienced increases in secondary school enrolment between 2004 and 2011, the North and Far North regions experienced less of an increase than the other regions. At the secondary level, gross enrolment is only 22 and 29 percent, and net enrolment is only 14 and 18 percent in the Far North and North regions, respectively. This implies a negative gap of about 80 percentage points in gross enrolment and a negative gap of about 50 percentage points in net enrolment, compared to Douala and Yaoundé. The North and Far North are the only two regions in which gross enrollment rates for secondary education grew by less than 10 percent during 2004-2011.

13. **Girls remain discriminated against, particularly those from the most socioeconomically disadvantaged groups and from northern Cameroon.** While overall gender parity in secondary schooling is around 0.9, implying that girls enroll in secondary school at a rate only slightly lower than boys, only about 30-40 percent of gross and net enrolment in the poorest quintile is female and only 30 percent in the Far North and 32 percent in the North region. These inequities in girls' education are then reflected in inequities in women's education and ultimately, maternal and child health and mortality. The median number of years of schooling of women of ages 15-49 in the North and Far North regions and in the poorest quintile is 0, implying that the majority of these women have no schooling at all. Meanwhile, the median number of years of schooling of their peers in the other regions is more than 5 years; it is 9

years in Yaoundé and 9.5 years for the wealthiest quintile. Evidence on Cameroon shows that women's educational attainment is a strong determinant of fertility, access to reproductive health services, and child survival and child nutrition,[4] highlighting the critical constraint that low girls' education levels represent for the North and Far North.

Fertility and demographic trends are an important policy concern in Cameroon

14. **The demographic transition (the shift from high to low mortality and fertility levels) and demographic dividend are central to the discussion on both health and economic growth in Cameroon. While Cameroon has started its demographic transition, the pace is too slow and is at high risk of not harvesting the demographic dividend**. The demographic dividend is characterized by a period in a country's demographic transition when the proportion of working age population is higher compared to the number of dependents. This period corresponds to an extra economic boost through increased savings and private investments. Triggering such a demographic dividend requires two ingredients: (i) a decreased dependency ratio which is made possible only when fertility is declining more rapidly than mortality, and (ii) adequate policies to foster human capital, employment and investments to ensure that the additional working-age population can get good jobs. According to the 2015/2016 Global Monitoring Report classification,[5] Cameroon is a pre-demographic dividend country.

15. **One key trigger to open the demographic dividend window is a rapidly declining fertility, which has yet to be achieved in Cameroon**; **total fertility and adolescent fertility remain very high.** The Total Fertility Rate (TFR) is 4.9[6] with only minor reductions over the past 25 years (the TFR was 5.8 in 1991). Because of its persistently high fertility Cameroon has a population age structure that is heavily concentrated towards dependent children (42.9 percent of the population is less than 15 years old), which negatively affects its prospects for human development and economic growth. Annual population growth is 2.6 percent which means that the population is expected to double in approximately 27 years. The unmet need for contraception among married women is high (18 percent). Thirty-one percent of young women aged 20 to 24 were married by age 18, which suggests some progress in reducing child marriage but still a very high prevalence.

16. **The adolescent fertility rate is high with 21 percent of female adolescents aged 15 to 19 who already had given birth in 2014**. The regional disparities are significant: in the East and Far North, respectively, 44.2 percent and 23.4 percent of young women 15 to 19 years of age had already had a child in 2014, while in Yaoundé this rate was only 7.6 percent. Here too, education and poverty are determining factors: 48.8 percent of adolescents aged 15 to 19 without any education were pregnant or already had a child, a rate that is three times higher than among girls with a secondary education (17.9 percent). Similarly, 31.3 percent of young

[4] For instance, as of 2011, women who completed secondary education on average have almost one child fewer than those who did not complete any level of education. Women's primary and secondary education are also significantly associated with the under-5 mortality rate, use of pre-natal care, and child stunting.
[5] http://pubdocs.worldbank.org/pubdocs/publicdoc/2015/10/503001444058224597/Global-Monitoring-Report-2015.pdf
[6] 2014 MICS

women aged 15 to 19 in the poorest quintiles had begun their reproductive life, whereas only 8.6 percent of young women in the richest quintile had done so.[7]

Health System Challenges and Sectoral Strategies

17. **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. Households are bearing a large share of health expenditures** (52.2 percent of total health expenditures, National Health Accounts (NHA) 2011), almost exclusively through out-of-pocket expenditures as coverage with risk-pooling mechanisms is very low (1.2 percent, NHA 2011), leading to a greater risk of impoverishment and vulnerability for poor households.

18. **Public expenditures for health are relatively low, their execution is weak, and they are not efficiently allocated**. They represented only 33 percent of total health expenditures (National Health Accounts 2011) and 8.5 percent of total government expenditures in 2013 (stagnant at the same level since the early 2000s). Investment Budget (IB) execution is poor as well, with only 36 percent of the planned Ministry of Health Investment Budget for 2013 actually being spent (with the average execution rate for the Ministry of Health IB between 2007 and 2013 being 53 percent). 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 percent of health resources are dedicated for preventive services, NHA 2011).

19. **Additionally, financial governance is a main issue in the health sector**: informal payments, corruption, and rigidity of public spending procedures are prevalent. This contributes 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.

20. **Cameroon is one of the African nations experiencing a crisis in human resources for health**, due to the paucity of health workers, high absenteeism rates, and 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 (Human Resources for Health (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.[8] Finally, it appears that the level of competence

[7] 2014 MICS
[8] Cameroon Health Country Status Report, 2013.

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 Performance Based Financing (PBF) impact evaluation baseline survey was conducted.

21. **Serious challenges remain in the pharmaceutical sector compromising availability of high quality medicines in the country.** Although Cameroon exhibits a few features from a maturing economy (largest pharmaceutical market of sub-Saharan francophone Africa, developed private retail market, relatively robust distribution system), the quality of medicines purchased by patients in the public and private sector is not assured. The governance of the CENAME (the public central medical store) and in particular suppliers and product selection raises serious questions. Its financial situation is disastrous, with long-standing government receivables contributing to cash flow issues and ever growing debt to suppliers. Poor organization and planning capabilities, together with these financial issues, cause frequent stock outs at the central level with order fill rates around or below 60 percent. As in most Sub-Saharan African countries, the pharmaceutical regulatory authority focuses more on technical expertise work to the detriment of developing a strategic vision for the pharmaceutical sector.

22. **There is a substantial lack of coordination between the different programs of the Ministry of Health engaged in the pharmaceutical sector, each of them operating their supply chains in a silo.** Not only synergy and savings opportunities are missed, but it also weakens the performance of these supply chains as testified by the significant cold chain issues the Expanded Program for Immunization (EPI) faced last year. The registration process of medicines is vulnerable to fraudulent practices, lacks adequate funding and does not guarantee the quality of generics available in the private sector. The General Inspection of pharmaceutical services has inadequate resources that hinder its mission. Its influence is also limited by the weakness of sanctions which provide little deterrence as they are rarely applied. Overall the governance and the transparency of the pharmaceutical sector can largely be improved. Besides these issues, the informal and illicit pharmaceutical market is growing, opening the door to counterfeit and substandard medicines. As a result, there is a need to develop a multi-pronged approach, tackling governance and performance issues and focusing on quality assurance of public procurement, medicines registration, pharmaceutical inspection and market surveillance in order to ensure the quality of products prescribed to the population.

23. **In 2015 the Government of Cameroon developed a new 12-year HSS 2016-2027 that was developed through a participatory process and validated in December 2015.** The strategic vision is for Cameroon to be "a country with universal access to quality health services ensured for all social strata by 2035, with the full participation of communities". The general objective of the strategy is "to contribute to the development of healthy human capital, productive and capable of contributing to strong, inclusive and sustainable growth". The strategy has four strategic axes: (1) health promotion; (2) illness prevention; (3) health service delivery; (4) health system strengthening; and (5) governance and stewardship. The 5-year National Health Development Plan is currently in development and is expected to be finalized during the first half of 2016.

24. **Additionally, Cameroon has been selected as one of the second wave countries for the Global Financing Facility (GFF).** The country launched the GFF process in a high-profile

event in October 2015, demonstrating significant political commitment. A governance structure has been established to oversee the preparation of an Investment Case for reproductive, maternal, newborn, child, and adolescent health (RMNCAH), and of a health financing strategy. The GFF presents considerable opportunities for the country, on several fronts. First, the country's response to RMNCAH has been fragmented, with separate analytical work and strategies for various aspects of the RMNCAH continuum. Second, some key technical elements that the GFF emphasizes – such as equity and efficiency – have been under-addressed in Cameroon. Third, progress on health financing in Cameroon has been limited, with no national strategy having been developed to date.

25. **The Investment Case is being developed through a collaborative multi-stakeholder process anchored at the National Multisectoral Program for Combating Maternal, Newborn and Child Mortality,** which is composed of representatives from the ministries of health, education, youth and gender, finance, and planning, as well as civil society and development partners engaged in the heath sector. The preparation of the Investment Case began in December 2015 and is expected to be completed by April 2016. It will identify an evidence-based set of priorities for improving RMNCAH outcomes in Cameroon, linked to priority interventions identified in the HSS. The initial discussions around priorities for the Investment Case have informed the development of this document, and the project document is expected to make a significant contribution to supporting the Investment Case. The Investment Case will only be partly financed by the project. Dialogue is already underway with potential financiers, including the Global Fund to Fight AIDS, Tuberculosis and Malaria, GAVI (the Global Alliance for Vaccines and Immunization), UNICEF, and UNFPA.

26. **On the health financing strategy, discussions have begun in 2015 and its development is one of the objectives of the 2016-2027 HSS.** A technical committee, including the Universal Health Care (UHC) technical group, will lead the process. Additional analytical work to inform the health financing strategy will be conducted during the first semester of 2016, and it is expected to be available in 2017. Different partners are supporting the process (WHO, Clinton Health Access Initiative (CHAI), World Bank, etc.).

27. **PBF has been identified as a central strategy for health system strengthening that will contribute towards achieving UHC goals.** PBF is implemented to address critical impediments confronting the delivery of services at frontline health facilities. These challenges include the (i) shortage of funds to meet operating expenses, (ii) lack of autonomy to manage resources to procure drugs and attract and motivate qualified human resources; (iii) lack of focus on results and limited use of performance data at all levels (health facility, district; regional and national) (iv) lack of accountability and transparency of the health system; and (v) weak managerial capacity at all levels. Instead of allocating physical and human resources (physical inputs) through central planning, PBF is addressing the above mentioned challenges by allocating financial resources to frontline health facilities based on results achieved in order to enhance the availability, the accessibility and the quality of essential services. In addition, PBF leverages existing sunken investments (building, equipment, and centrally planned human resources), vertical program investments and other resources.

28. **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 exceed the expectations given to them via their assigned designations and roles within the health facility.

29. **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.

30. **The project 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. Since the launching of PBF, the quality and utilization of maternal and child health services has increased substantially. 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, and the majority of Results Framework indicators have already met their targets or are on track to meeting them before project closing.

31. **After five years of experience with PBF in Cameroon, the government has identified PBF as a key strategy** to (i) improve the efficiency of the allocation and use of resources; (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 technical and financial support for making PBF a national program and has committed to increasing over time its financial contribution to the PBF program through the public budget (the MoPH has been financing PBF in the Littoral region since 2014 with an annual contribution of approximately US$1.5 million, about 75 percent of the annual PBF budget for the region). The proposed operation will support the country's objective of scaling-up PBF nationwide by 2020.

C. Higher Level Objectives to which the Project Contributes

32. **The proposed project is fully in line with the Sustainable Development Goals (SDG), in particular *Goal 3*: Ensure healthy lives and promote well-being for all at all ages.** Goal 3 of the SDGs has several targets for which the proposed project directly supports: reduction of

maternal mortality (Target 3.1), reduction of under-5 and neonatal mortality (Target 3.2), achieving universal access to sexual and reproductive health-care services (Target 3.7), achieving Universal Health Coverage (Target 3.8), and increasing health financing and the recruitment, development, training and retention of the health workforce (Target 3.c). The project also supports achievement of *Goal 1*: End poverty in all its forms everywhere through its links with social safety nets programs and improved financial protection from health expenditures among the poor and vulnerable; and *Goal 2:* End hunger, achieve food security and improved nutrition and promote sustainable agriculture, through its activities related to scaling-up high impact nutrition interventions.

33. **The proposed project is also fully in line with the World Bank Group's (WBG) twin objectives of reducing poverty and promoting shared prosperity, and with the Africa Regional Strategy which focuses on strengthening governance and public sector capacity.** The project responds to the urgent need for addressing health issues, especially in the North, as underlined in the Country Assistance Strategy (CAS) for Cameroon 2010 – 2014, and the new Systematic Country Diagnostic (SCD) which was finalized in December 2015. The new Country Partnership Framework (CPF) is currently under preparation and providing continued support to the PBF program has been identified as one of the priority strategies of the framework. The proposed operation is also aligned with the Government's 2010-2013 Growth and Employment Strategy (*Document de Stratégie pour la Croissance et l'Emploi* – DSCE) and 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. 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.

34. **In addition to linking to the human development objectives in the CAS and the forthcoming CPF, the project will complement other IDA-financed projects**. The project builds upon the Cameroon Social Safety Nets Project (P128534) by scaling-up 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 will build on both experiences from the Health Sector Support Investment Project and the Social Safety Nets project. In the zones covered by both the health and safety nets project, the methodology for identification will use a combination of community-based targeting and proxy-means testing. In the zones covered by both projects, the project will also help maximize the impact of the safety nets project by supporting higher awareness for and better quality of primary health care services.

II. PROJECT DEVELOPMENT OBJECTIVES

A. PDO

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

B. Project Beneficiaries

36. **The project will support the ongoing implementation of PBF in the 26 health districts covered by the original operation, the 18 health districts recently added through the Additional Financing, and an incremental roll out of PBF to national coverage.** With coverage at 25 percent of the population in 2016, the operation would support a gradual scale-up of approximately an additional 20 percent of the population 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 36 districts in the three northern regions of Cameroon (Far North, North, and Adamawa) to address the urgent and growing needs in those regions. In total, the three northern regions include 54 health districts with a population of 7,614,882 (2016). The direct beneficiaries of the supported interventions include women, adolescents and children under 5, as well as displaced and refugee populations affected by the insecurity in the region.

37. **Once HSSIP funds have been fully disbursed, the original 44 districts will be financed by the new operation and their results will then be integrated into the Results Framework of the new operation.** Results from PBF will be captured for the proposed operation by disaggregating results achieved in the newly targeted districts from the 44 districts originally covered by the HSSIP. Once full disbursement of the HSSIP is achieved, implementation of PBF in the original 44 districts will then be supported by financing from the new operation and thus results achieved in these districts will be linked to the new operation and captured through the Results Framework indicators.

C. PDO Level Results Indicators

38. **The following key indicators will be used to track progress towards the PDOs:**

    1. People who have received essential HNP services (number)
    2. Children 12-23 fully immunized in the 3 Northern regions and East (percentage)
    3. Births attended by skilled professional in the 3 Northern regions and East (percentage)
    4. Average score of the quality of care checklist (percentage)
    5. Children under 24 months being weighed for growth monitoring in the 3 Northern regions and East (number)

39. **The number of direct project beneficiaries of which female (percentage) would also be part of the PDO level indicators covering both components 1 and 2.**

III. PROJECT DESCRIPTION

A. Project Components

40. **The project will have two components.** Component 1: Strengthening of Health Service Delivery, and Component 2: Institutional Strengthening for Improved Health System Performance.

41. **The IDA allocation for this project is US$100 million. A grant of US$27 million from the Global Financing Facility (GFF) Trust Fund will support investments in RMNCAH and nutrition (US$25 million) and civil registration and vital statistics (CRVS) systems (US$2 million).** The proposed project would support the progressive national scale-up of the PBF program as well as implementation of other high-impact interventions supported by the GFF and nutrition trust funds. The GFF-supported interventions will have a multi-sectoral approach and conjointly improve health outcomes through investing in social protection and education as well as health. The project is comprised of two components that aim to improve performance of the health sector: (i) Strengthening of Health Service Delivery; and (ii) Institutional Strengthening for Improved Health System Performance. Both components address key strategies identified in the new national HSS (2016-2027), as well as other strategic plans such as the National Strategic Plan for Adolescent and Youth Health in Cameroon (2015-2019), the Strategic Plan for the National Multisectoral Program for Combating Maternal, Newborn & Child Mortality in Cameroon (2014-2020) and for the Strategic Plan for Reproductive, Maternal, Neonatal and Infant Health (2014-2020).

42. **Component 1 includes continuing support to the ongoing PBF intervention that currently 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.** While the project will support the national scale-up of PBF, which has been identified as a key objective of the Government of Cameroon, the extent to which national coverage can be achieved by 2020 will depend on financial commitments realized by the government and development partners engaged in the health sector. The progress toward national coverage will be assessed at the Mid-Term Review of the project. Component 2 includes strengthening institutional capacity at the national level to foster the development of equitable, efficient, and sustainable national health financing strategies to achieve the national health goals. It also focuses on increasing 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 of Health Service Delivery (US$109 million (US$89 million IDA, US$20 million GFF)

43. **Sub-Component 1.1: Payment of performance (US$70 million IDA):** In the 44 districts in the North-West, South-West, East and Littoral regions currently covered by the HSSIP and the additional health districts where PBF will be scaled-up, this sub-component will provide PBF payments: (i) to health facilities 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 health services as well as ensuring community organization to support positive health behavior.

44. **After the establishment of Contract Development and Verification Agencies (CDVAs) 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)**.

45. **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 - Integrated Management of Childhood Illness (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.

46. **The project will also introduce financial mechanisms to improve access among poor and vulnerable households to essential health services at the community and health facility levels.** The mechanism used to identify the poor that will be applied will build on both the experiences from the Health Sector Support Investment Project (P104525) and the Cameroon Social Safety Nets Project (P128534). In the zones covered by both the health and safety nets project, the methodology for identification will use a combination of community-based targeting and proxy-means testing, while in zones that are not covered by the Social Safety Nets Project, identification will rely on a combination of community-based targeting and identification at the point of service delivery by service providers.

47. **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.

48. **A quantified quality checklist will be designed for each level of the service package and will provide the foundation for measuring results (with increased weights given to process measures).** The quality checklist will introduce measures related to rational prescribing of generic drugs, essential drug management and availability of tracer drugs. Facility payments will be made quarterly: (i) on the basis of a set of incentivized indicators (defined by the Ministry of Health) emphasizing reproductive, maternal and child health (see Annex 2 for complete list of targeted services); and (ii) after quantity and quality of services have been declared and verified (ex-ante and ex post).

49. **Sub-Component 1.2: Support to the implementation and supervision of Performance-Based Financing (US$11 million IDA, US$8 million GFF):** To support PBF implementation and supervision (capacity building, verification and counter verification, IT system, etc.), the project will support Contract Development and Verification Agencies (CDVA) covering each region, using either the Regional Fund for Health Promotion or NGOs. Given the large sizes of certain regions (both in terms of geography and population), agency annexes will be established in each district (or batches of districts, depending on the size of each district and logistical considerations). The contract management and verification for PBF implementation is estimated to be at 18 percent of the total PBF budget, which is in-line with international experience.

50. **Capacity building and training programs.** Sub-Component 1.2 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 Rwanda, Burundi, Nigeria, Zambia, the Republic of Congo (ROC) and the Democratic Republic of Congo (DRC). 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. The "snowball" approach begins with a "training of trainers" program at the central level, who will be trained on how to conduct trainings at the regional, district and health facility levels on PBF best practices and implementation approaches for the PBF program in Cameroon.

51. **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. In order to avoid incentivizing overproduction of services as a means to increase hospital revenue, the main function of the PBF program in the tertiary hospital is to redistribute revenue based on performance outcomes linked to quality improvements. 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 CDVAs in each region. No resources from the proposed project will finance the actual payment of PBF subsidies for tertiary facilities.

52. **Sub-Component 1.3: Additional support for improving access to a key package of RMNCAH and nutrition services (US$8 million IDA, US$12 million GFF):** It is anticipated that PBF will feature prominently in the country's Investment Case. However, there will also be other priorities identified through the evidence-based and consultative processes now underway. Sub-Component 1.3 will support non-PBF activities identified as priorities without current funding commitments within the GFF Investment Case. In line with the general GFF approach, this includes both RMNCAH interventions and health systems approaches, and includes critical inputs to reinforce the availability and quality of nutrition services.

53. **While the final list of interventions and strategies to be supported by the GFF trust fund will be validated at the national level in mid-2016, the GFF Investment Case prioritization workshop that was held in February 2016 identified several key areas for which support will be provided.** These include:

    i. Support to a multisectoral approach to address adolescent health, education and demographic challenges in the northern regions of Cameroon;
    ii. Providing support to reinforcing nutrition services to ensure that services supported through PBF payments are of high quality and high impact;

iii. Support to the development and implementation of a communication and behavior change strategy including formative research, identification of priority behaviors, key message development, development of communication tools and training manuals for health and nutrition;
iv. Support to the piloting of Kangaroo Mother Care (KMC) to reduce risks related to low birth weight; and
v. Providing critical support for maternal health, neonatal health and family planning services, family planning and adolescent health services, responding to gaps in financing of the Strategic Plan for the National Multisectoral Program for Combating Maternal, Newborn & Child Mortality in Cameroon (2014-2020).

54. **The final set of activities and allocations to each of them will be determined based on the consultative process for the development of the Investment Case and the discussions about complementary financing that are underway with key financiers.** The amounts listed below are indicative and may change as the Investment Case is finalized.

55. **Support to improve health outcomes by addressing the multi-sectoral determinants of health, with a particular focus on the economic, education, and demographic challenges in the northern regions of Cameroon, especially for adolescent girls (US$ 4 million IDA, US$3 million GFF Trust Fund).** Potential activities include a comprehensive Human Development (HD) program that builds on preexisting programs for a comprehensive approach to addressing the highly interrelated health, education, and fertility challenges prevalent in the northern regions in Cameroon. Investments will focus on underutilized and highly cost effective interventions. This includes, in addition to the health sector PBF program, (i) additional awareness/ sensitization modules on adolescent girls, and a conditional cash transfer program for adolescent girls linked to education outcomes and providing life skills coaching (building on the existing Social Safety Nets Project's implementation arrangements); (ii) adolescent girls health module in school curriculum, and an education sector PBF pilot (building on the outcomes of a feasibility study and pre- pilot launched in 2016 by the World Bank and the Ministry of Education and on the experience of the health sector PBF program) and (iii) additional cash transfer support for health, sanitation and nutrition outcomes for the safety net program's target population (also building on the Social Safety Nets Project). During its first phase, the project will support the design of the multi-sectoral program, including further policy dialogue related to the education PBF pilot (in particular related to sharing the health experience and multi-sectorial dimensions) and awareness and cash transfer program for adolescent girls. Implementation of the joint program is expected to begin prior to the mid-term of the project, in coordination with the Safety Net Project and Ministry of Education's program, and will include a prospective impact evaluation, as well as an overall learning agenda. The specifics of the GFF learning agenda will also be defined during the GFF Investment Case preparation process and be defined in the final Investment Case.

56. **Providing additional support to reinforcing nutrition services to ensure that services supported through PBF payments are of high quality and high impact (US$5 million GFF Trust Fund).** In addition to the financial resources mobilized for paying performance subsidies for nutrition services under Component 1.1, resources will also be earmarked for the provision of essential inputs for nutrition services. The mobilized resources for provision of inputs would

include micronutrients for community-based distribution (through the Community PBF program), development of protocols and guidelines, and training of facility-based health workers and community health workers (CHW). Priority areas include guidelines on the promotion of infant and young child feeding practices, the management of acute malnutrition, promotion of exclusive breastfeeding during prenatal, delivery and postnatal care, and promotion of women's nutrition, notably adolescents and pregnant women. The management of moderate acute malnutrition will use locally available foods and will be initially done at the health facility level. Mothers will be encouraged to make in-kind contributions, but the center may need additional resources to complement the ingredients.

57. **Support to the piloting of Kangaroo Mother Care to reduce risks related to low birth weight (US$1 million IDA, US$1 million GFF Trust Fund).** KMC involves continuous skin-to-skin contact between caregivers and Low Birth Weight (LBW) infants and exclusive or near-exclusive breastfeeding. KMC allows infants to spend less time – if any – in incubators, leading to more efficient use of limited resources. A Cochrane Review of 16 randomized control trials concluded that KMC significantly reduces LBW neonatal mortality, infection and hypothermia, as well as the number of days in hospital. KMC has also been shown to improve parent-infant attachment, and infant growth and development. Preliminary results from a Grand Challenges Canada (GCC)-funded study indicate that KMC has a positive impact on cognitive development that lasts into adulthood (measured at 18-20 years), and is associated with improved school and wage earning outcomes.

58. **GCC plans to launch a CAD$6-9 million (Canadian dollar) Development Impact Bond (DIB), in cooperation with partners, in 2017, which would fund KMC scale-up in Cameroon until about 2020.** The GFF trust fund will support the KMC DIB by contributing US$2 million to leverage an additional CAD$4-7 million in outcomes funding commitments from donors, as well as an equivalent amount from private investors. A DIB could fund KMC rollout to as many as ~25 national/regional hospitals and ~30 district hospitals in Cameroon, depending on the scale-up plan, delivering improved health outcomes for roughly 4,000 LBW infants per year. Funders – for example, GCC, the MoPH, and other donors – would only pay for the delivery of agreed target outcomes. Target outcomes could include: increase in access to quality KMC for LBW infants; weight gain as an indicator of quality KMC; and reduction in mortality for LBW infants. Private investors would provide upfront working capital for the program, and would take on the financial risk, in an innovative example of how the GFF approach can be used to draw new actors into the financing of development activities.

59. **Providing critical support for maternal health, neonatal health, family planning, and adolescent health services, responding to gaps in financing of the Strategic Plan for the National Multisectoral Program for Combating Maternal, Newborn & Child Mortality in Cameroon (2014-2020) (US$3 million IDA, US$3 million GFF).** The selection of activities to be supported under this component of the Investment Case will be confirmed upon completion of the resource gap for priority interventions included in the Investment Case.

Component 2: Institutional Strengthening for Improved Health System Performance (US$18 million (US$11 million IDA, US$7 million GFF (US$5 million RMNCAH and US$2 million for CRVS))

60. **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 health reforms, as well as implementation support for 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, this 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.

61. **Sub-Component 2.1: Strengthening institutional capacities for improved health system stewardship, including monitoring and evaluation (US$4 million IDA, US$3 million GFF):** Sub-Component 2.1 will provide support at the central level of the MoPH through analytical work, policy dialogue and institutional strengthening 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; and (v) harnessing the private and faith-based health sectors through strategic contracting.

62. **This sub-component will also support the development and implementation of the country's national health financing strategy (US$1 million IDA**), which is to be developed within the GFF implementation framework. Given the dearth of information on health financing in Cameroon, the project will support the various pieces of analytical work necessary for the development of the national health strategy. These include 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), and other key studies that were identified during the national health financing strategy workshop that was held during the February 2016 appraisal mission. The sub-component will also provide support to trainings and workshops related to the design of the strategy.

63. **Addressing critical bottlenecks and constraints in the pharmaceutical sector for improved regulation and availability of essential medicines and RMNCAH products (US$2 million IDA, US$2 million GFF Trust Fund).** Access to quality pharmaceuticals is a significant constraint to improving RMNCAH outcomes in Cameroon, and so the GFF Investment Case is likely to cover interventions that would improve the quality of RMNCAH products circulating in Cameroon. There are four potential areas for interventions:

i. Strengthening the Medicines regulatory authority and the medicines registration process, to make sure that only high quality generic medicines are approved by the country (US$1 million);
ii. Fostering pharmaceutical inspection capabilities to better regulate the wholesale/distribution sector and to scale up the fight against counterfeit and illicit medicines which is a prominent issue in the country (US$1 million);
iii. Strengthening the quality assurance system of the Central Medical Store to improve the performance of the national procurement system (US$1 million); and
iv. Continuing the reform of the governance of the pharmaceutical sector based on the WHO assessment conducted two years ago (US$1 million).

64. **Sub-component 2.1 will also support institutional strengthening of information systems monitoring and evaluation, and performance measurement mechanisms for the health system (US$1 million IDA, US$1 million GFF Trust Fund).** Given the fragmentation, unreliability, and inaccuracy of the existing routine reporting system for the health sector, challenges exist in using results from this system as the basis for measuring health facility performance. As such, the project will contribute to building a reliable health information system for tracking key performance indicators by providing resources to support the ongoing rollout of the DHIS2 platform and the national PBF portal and the linkages between the two. Use of mobile technology for activities such as community verification, beneficiary feedback and community reporting, will be integrated into an upgraded version of the PBF portal.

65. **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.** For instance, two rounds of Service Delivery Indicators (SDI) surveys will be implemented to fill an information gap left by other data collection activities in Cameroon. As PBF will be rolled-out nationally in the health sector and piloted for the education sector, SDI data (collected both at health and education facilities) will provide the user perspective on service provision by looking at the facility's resources and its clinicians'/teachers' effort and competence. This information fills a gap in the results chain between inputs and outcomes, thus broadening and refining policy options. Moreover, to the extent possible, the analysis will be done with local partners. For Cameroon, two rounds of SDI surveys for health and education will be conducted, with the first in early 2017 soon after the project becomes effective. Results will be released to various stakeholders in content formats that are adapted to their ability to use the information.

66. **The project will also work with the Primary Health Care Performance Initiative (PHCPI), a global initiative led by the World Bank, the Bill and Melinda Gates Foundation and the World Health Organization to track key performance indicators for Cameroon's primary health care system.** The policy dialogue surrounding this, including benchmarking Cameroon's performance with the performance of other countries, will help identify which parts of the system are working well, which ones aren't, and it will enhance accountability and provide decision-makers with essential information to drive improvements. PHCPI began contributing to this dialogue by holding a workshop during the project identification mission in October 2015 that reviewed the trends of Cameroon's primary health

care key performance indicators. Further analytical work by PHCPI on primary health care bottlenecks was presented in February 2016 during the GFF Investment Case prioritization workshop.

67. **Finally, since PBF payments are to be made based on service volumes and quality, external reviews will assess the declared results, ex post verification activities will be conducted by an independent third party and an External Evaluation Agency (EEA) will be contracted by the MoPH to check the veracity of the information provided by health facilities.** 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 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. An assessment of these agencies is being conducted to assess if these universities can continue to play the role of EEAs, or if a new national structure should be identified/developed.

68. **Sub-Component 2.2: Reinforcement of civil registration and vital statistics systems (US$2 million IDA, US$2 million GFF):** This sub-component will support the building of the national civil registration and vital statistics systems. The National Office of Civil Registration (*BUNEC-Bureau National de l'Etat Civil*) has been recently created and its role is to coordinate interventions from different Ministries related to civil registration. Its partnership with the Ministry of Public Health will support investments to improve data collection and quality for mothers and children. The prioritization, costing and planning of interventions will be outlined in a specific chapter in the GFF Investment Case, which will be finalized in mid-2016.

69. **In addition to the direct support IDA financing will provide to CRVS under this sub-component, approximately US$7-10 million of IDA financing in the proposed operation across various sub-components supports strengthening of CRVS systems in Cameroon through various channels:** (i) increasing birth registration rates through PBF indicators at the community, health facility and district levels through ensuring registrations are made for each delivery and maternal death audits are conducted; (ii) reinforcing the HMIS system through piloting and scaling-up DHIS-2 and linking data with the CRVS system and PBF portal; (iii) training and capacity-building activities for the PBF program at all levels of the health system that will include components on birth registration, death registration and maternal death autopsies; and (iv) piloting mobile technology (smart phones and tablets) for enhanced and more efficient community verification, linking verification results to the online platforms and identifying geographical areas where birth registration remains low.

70. **Sub-Component 2.3: Program coordination (US$5 million IDA, US$2 million GFF):** The project will support operating costs for the PBF Technical Unit and Project Implementation Unit (now housed within the PBF Technical Unit) for activities directly related to the project and the PBF program, including internal performance contracts for the PBF Technical Unit and other central departments at the Ministry of Public Health (Direction of Family Health, Direction of Health Promotion, Direction of Human Resources, Direction of Financial Resources and Planning, etc.) and programs playing a coordination role in the GFF (National Program for the reduction of Maternal and Child Mortality). These performance contracts are

a tool to enhance governance and stewardship in the central Ministry of Public Health departments and are an essential part of the project.

B. Project Financing

71. **The lending instrument will be Investment Project Financing (IPF), financed under an IDA credit of US$100 million, and a GFF grant of US$27 million for RMNCAH (US$25 million) and CRVS (US$2 million).** The government has financed the payment of PBF subsidies at approximately US$2 million annually since 2014 and has committed to increasing its contributions substantially over the next few years, with approximately US$8 million budgeted for 2016. With the elaboration of the new national health sector strategy, 5-year national health development plan (*Plan National du Développement Sanitaire* – PNDS) and the development of a national health financing strategy (supported by this operation and the GFF process in-country), the Ministry of Public Health, Ministry of Finance and Ministry of Economy and Planning aim to develop a sustainable financing approach for both the PBF program and other high-impact interventions supported by the GFF Investment Case, with the majority of financial resources being provided by the government in coming years. As mentioned above, co-financing of the PBF program is being provided by UNFPA and UNICEF (US$300,000 for 2015 with an increase expected for 2016); additionally, both GAVI and Global Fund resources will be used to support the program.

72. **The Government and the Bank considered the option of using Disbursement Linked Investment (DLI).** However, the Bank's assessment is that given the country context and the experience so far with DLIs in other sectors this approach will not be utilized for this project. The Project will strive to strengthen the MoPH capacities (especially regarding financial management, M&E and a culture of performance management) so that use of DLIs may be an option for future operations.

C. Project Cost and Financing

73. The proposed budget breakdown for the project is the following:

Table 2: Proposed budget breakdown

Project Components	Project Cost (US$ million)	IDA Credit/Grant Financing	GFF Financing
Component 1: Strengthening of Health Service Delivery	**109**	**89**	**20**
- Subcomponent 1.1: Payment of performance	70	70	0
- Subcomponent 1.2: Support to the implementation and supervision of Performance-Based Financing	19	11	8
- Sub-component 1.3: Additional support for improving access to a key package of RMNAC health and nutrition services	20	8	12

Component 2: Institutional Strengthening for Improved Health System Performance	**18**	**11**	**7**
- Subcomponent 2.1: Strengthening institutional capacities for improved health system stewardship, including monitoring and evaluation	7	4	3
- Subcomponent 2.2: Reinforcement of civil registration and vital statistics systems	4	2	2
- Subcomponent 2.3: Program coordination	7	5	2
Total Project Costs	**127**	**100**	**27**

Note: Disbursements for all project activities will be made against two categories 1) for PBF and cash transfer expenses; and 2) for goods, commodities, consultant services, non-consultant services, operational costs, and training.

D. Lessons Learned and Reflected in the Project Design

74. **Lessons learned from the implementation of projects such as Health Sector Support Investment Project (HSSIP) are taken into account in this project**. Additionally, the project design has also taken into account the experiences of other countries implementing similar projects.

75. **Effective leveraging of investments from other development partners can enhance results.** The project was developed in close coordination with the development partners that are investing in human development. The interventions were chosen to complement current and expected investments by other development partners.

76. **Strengthening management capacity, a focus on results and promoting innovation are essential to achieving results in low-capacity environments.** Given that PBF was a new approach when first introduced under the HSSIP, the overall project management capacity was expected to be weak at the outset of the project. The recruitment of dedicated staff at central and regional levels, the sub-contracting of specific technical and managerial functions to capable agencies and non-governmental organizations (NGOs), and the focused investment on capacity-building over the initial years of project implementation resulted in increased capacity at all levels. These lessons will be taken into account in the design of the proposed new project and will ensure that those responsible for planning, managing, and delivering services will be fully trained and equipped to perform their functions. The fiduciary and technical capacity of the implementing agency will be strengthened as well, with the majority of skills and experience (and staff) from the HSSIP PIU being transferred to the National PBF Technical Unit.

77. **A community-based health strategy must combine increased accessibility to services with improved facility level delivery of services and ensure that appropriate incentive mechanisms are in place at all levels.** Though implemented in different districts, the pilot experiences for both community-based service delivery and facility-based Performance-based Financing have demonstrated the potential benefits of these individual initiatives. The

proposed project would combine these complementary service delivery modalities in the same districts to: (i) enhance service accessibility (through community outreach) and affordability (by expanding free antenatal and family planning services and subsidizing emergency obstetrical care); and (ii) improve facility performance (by increasing the quantity and quality of outputs). Community health workers will be contracted by health centers and paid based on their performance (quantity and quality of services provided) upon verification.

78. **The following are lessons learned from the design and implementation of both Bank and non-Bank operations in Africa. PBF leads to**:

a) Improved alignment between resources and a focus on maternal and child health priorities by purchasing priority service delivery indicators at higher rates;
b) Improved quality of health services by purchasing services conditional on quality;
c) Creating incentives for health facility managers and health workers to expand the coverage of essential public health interventions and improve their quality by linking facility payments to service delivery and quality indicators, and offering health workers bonuses that are linked to facility performance;
d) Improved governance through better verification and oversight of performance by providing incentives for good performance, by involving the communities for verification of the health facility quality, and by involving civil society in assessing health service delivery results and by publishing results on a public website;
e) Reduced financial barriers to the access of quality health services by the poor; and
f) Enhanced functioning of the public health administration at all levels.

IV. IMPLEMENTATION

A. Institutional and Implementation Arrangements

79. **At the central level of the Ministry of Public Health, the Health Sector Strategy Steering Committee (created in 2005), chaired by the Minister of Public Health, will oversee the achievement of the project's objectives.** Under the authority of the Health Sector Strategy Steering Committee, a specific project technical committee will be created to provide direct oversight and support to the project. To ensure institutional memory, the current steering committee of the HSSIP project will be converted into the technical committee for the new project. Chaired by the Director of the Division of Cooperation and Partnerships, the technical committee will include: (i) the most pertinent directorates of the MoPH; and (ii) key ministries whose support is needed for successful implementation and sustainability of PBF in Cameroon (Ministry of Economy and Planning and Ministry of Finance). The technical committee will be tasked to: (i) validate the overall strategic direction of the PBF program; (ii) validate the overall strategic direction of other interventions supported by the Project; (iii) ensure that the procedures set forth in the project implementation manual are followed; (iv) examine the different contracts and intervene where necessary to resolve issues; (v) monitor PBF and other activities' implementation and intervene where problem resolution may require the support of committee members; and (vi) disseminate the results of the evaluations with a view toward mobilizing additional resources and expanding the PBF approach in the country.

80. **Also, as part of the GFF process, the national GFF coordination will oversee achievement of interventions related to the GFF Investment Case and Health Financing Strategy.** National coordination of the GFF will be led by Health Sector Strategy Steering Committee, under the leadership of the Minister of Public Health and Secretary General of the Ministry of Public Health. Representatives from the Ministry of Economy and Planning, the Ministry of Finance, the private sector and civil society are all part of the HSS Steering Committee. Under the HSS Steering Committee, the National Program for the reduction of Maternal and Child Mortality will lead the development of the GFF Investment Case. For development of the national health financing strategy, a multi-sector committee composed of representatives of the Ministry of Public Health, Ministry of Economy and Planning, and the Ministry of Finance is being created. Within the Ministry of Public Health, the Director of Financial Resources and Planning will lead the process of designing the strategy.

81. **Under the HSSIP, a dedicated PIU was established for day-to-day management of the project.** To institutionalize leadership and coordination of the PBF program within the government and across partners, in 2014 the MoPH established a National PBF Technical Unit (*Cellule Technique Nationale PBF*) responsible for day to day implementation of the program and for informing the HSS Steering Committee of the progress achieved in implementing the PBF approach. The PBF Technical Unit is currently staffed with four full-time staff recruited from various directorates of the MoPH and is tasked with: (i) developing norms and procedures for the PBF program; (ii) coordination and leadership of development partners, vertical programs and departments within the MoPH involved in the PBF program; (iii) conducting performance evaluation and coaching activities for decentralized actors such as the Regional Health Delegations, Contracting and Verification Agencies, and Regional Funds for Health Promotion; (iv) preparing and implementing PBF training programs; and (v) developing the scale-up plan for national coverage. The Coordinator of the PBF Technical Unit, co-Coordinator of the Unit, M&E expert and Judicial Services expert have all been appointed by the Minister of Public Health through a merit-based internal competitive process.

82. **Under the proposed operation no dedicated PIU external to the ministry will be created, as was the case for the HSSIP**. As such, the National PBF Technical Unit will be tasked with overseeing both the coordination of the overall PBF program, as well as, specific project implementation for activities supported by the GFF trust fund. As such, the fiduciary requirements of the PBF Technical Unit will increase substantially as the entirety of responsibilities from the HSSIP PIU will be transferred to the PBF unit. The four staff will remain under the proposed operation and will be reinforced through the recruitment of additional staff and experts. As the experience with the HSSIP staff was highly satisfactory and they hold invaluable experience and knowledge in implementation of the PBF program, the majority of staff from the HSSIP PIU will be transferred to PBF Technical Unit. These include the Financial Management Specialist, the Procurement Specialist, the Accountant and Assistant Accountant, and Internal Auditor. Other technical experts may be recruited based on the evolving needs of the project. These additional staff will be recruited in accordance with IDA guidelines for the selection of consultants.

83. **The project will also support the recruitment of additional technical staff to support the programs and departments involved in GFF-related processes**. These include a

Monitoring and Evaluation Specialist for the National Program for the reduction of Maternal and Child Mortality and a Health Economist/Health Financing Expert for the Department of Financial Resources and Planning within the Ministry of Public Health.

84. **The project policies and procedures will be incorporated in a project implementation manual.** It will be complemented by a national PBF manual prepared by the PBF Technical Unit. The PBF Technical Unit and the Bank will ensure that implementation manuals prepared by the CDVAs are consistent with each other and with the project implementation manual and the national PBF manual. A more detailed description of the implementing arrangements is presented in Annex 3.

85. **As mentioned above, the project will continue to use Contract Development and Verification Agencies in the seven regions currently covered by the HSSIP, and will establish agencies in the remaining three regions.** CDVAs will be tasked with contracting and coaching health service providers and regulatory agents (Regional Health Delegations and District Medical Teams), contracting community-based organizations for community verification, and verification of declared results by contracted agents. Upon verification, CDVAs will send payment requests through the PBF portal (www.fbrcameroun.org), which will be received, validated and processed by the National PBF Technical Unit. Payments will be made directly to health facilities and regulatory bodies, each of which will have their own independent bank account. CDVAs will pay Community-Based Organizations directly for community verification activities.

86. **Counter-verification of the program's results will be conducted by an independent third party.** The independent External Evaluation Agency (EEA) will be contracted by the Ministry of Public Health. 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.

87. **Performance contracts will be established with technical departments and vertical programs at the central level of the MoPH**. A multi-stakeholder committee composed of the PBF Technical Unit, representatives from the Ministry of Economy and Planning, and the Ministry of Finance, and development partners will be created to evaluate these departments and verify results achieved prior to payment. The national PBF manual will be the key strategic document providing operational guidelines for implementation of PBF-related activities.

B. Results Monitoring and Evaluation

88. **The Results Framework focuses on accountability for results in the delivery of RMNCAH and nutrition services.** The project approach to results monitoring aims at extending beyond tracking of inputs and outputs by placing a strong emphasis on intermediate outcomes. When possible, the proposed results framework will use existing indicators and data to measure the progress of both the project and its contribution to the overall national program; this will benefit the program by strengthening and increasing the efficiency of existing data collection mechanisms.

89. **Routine monthly and quarterly data collected via the web-based PBF system will be aggregated for the project's quarterly and annual indicators and be linked to the national HMIS system (currently being reinforced by the introduction and scale-up of DHIS-2).** The project monitoring system will include (i) identification and consolidation of M&E indicators; (ii) training and capacity building initiatives at the national, regional, and local levels; (iii) standardized methods and tools to facilitate systematic collection and sharing of information; (iv) an independent review by external technical consultants (External Evaluation Agency); and (v) annual program evaluations and strategic planning exercises for each component.

90. **The GFF Investment Case will include both a Results Framework with key indicators to track progress in achieving objectives as well as a clearly defined learning agenda.** The content of the learning agenda, which may include impact evaluations, qualitative research, specific surveys, process evaluations, will be defined in early 2016 during the process of developing the Investment Case.

91. **In addition to the ongoing Community PBF impact evaluation, the project will also include a prospective evaluation for the Multisectoral program in the northern regions, plus several rounds of SDI surveys and national health accounts**.

C. Sustainability

92. **Technical sustainability will be ensured by capacity building and knowledge transfer activities throughout the project.** While capacity already exists for implementing Component 1 through previous experience with PBF and an extensive training program which continues to build in-country capacity, capacity in the National PBF Technical Unit will be strengthened during project implementation through trainings and on-the-job coaching. A training of trainers program for PBF is currently being developed and will create a pool of knowledgeable PBF trainers who will then train additional trainers using cascade training to ensure capacity at all levels of the health system.

93. **Financial sustainability of PBF can be reasonably achieved given the limited cost of this mechanism and the current low level of financing the Government is investing in the health sector.** The project will help improve the efficiency of health spending by improving the outcomes obtained from the current total health expenditure of US$138 per capita per year (PPP). By spending US$4-5 per capita per year (including overhead costs) and less than US$100 million per year for national coverage, given current expenditure patterns the cost is likely to be affordable and sustainable in the long term. Additionally, by integrating an ongoing policy dialogue on reforming the financing structure of the MoPH, including the replacement of the budget for health facility operational costs that is managed by a centralized decision-making approach with budget lines for PBF subsidies (with which health facilities have autonomy to plan and use) and making sure PBF is embedded in the broader health sector national financing strategy, the project is expected to institutionalize these PBF reforms.

94. **Financial sustainability following the close of the project will be a continuing process, but the Government has already demonstrated its commitment to increasing the budget**

line for maternal and child health and establishing a dedicated budget line for PBF. This signals government's recognition of the importance of continuing to deliver results post-Bank support. These efforts will also require continued capacity building at all levels of the system (from civil society upwards) and close collaboration with other development partners. Collaboration with all development partners, including those who do not necessarily support PBF, has improved through the GFF's highly consultative and participatory process, the launch of an inclusive national health financing strategy, and focus on the common goal of Universal Health Coverage.

V. KEY RISKS

Systematic Operations Risk- Rating Tool (SORT)

Risk Category	Rating
1. Political and Governance	Moderate
2. Macroeconomic	Moderate
3. Sector Strategies and Policies	Moderate
4. Technical Design of Project or Program	Substantial
5. Institutional Capacity for Implementation and Sustainability	Substantial
6. Fiduciary	Substantial
7. Environment and Social	Low
8. Stakeholders	Moderate
9. Security (Other)	Substantial
OVERALL	Substantial

A. Overall Risk Rating and Explanation of Key Risks

95. **The overall risk of the project is considered to be Substantial as discussed in the Risk Template.** The project is expanding in scope from 25 percent of total districts covered by the original project to national coverage by 2020. This project presents four types of risks: (i) technical and institutional complexity; (ii) sustainability; (iii) insecurity and challenging context of the northern regions; and (iv) fiduciary aspects.

96. **Technical and Institutional Complexity:** Although PBF has been piloted in the country since 2011, there is a substantial risk involved in implementing and rolling out PBF to national scale. Both the technical and institutional capacity are considered substantial. To mitigate the risk of the technical complexity of the scale-up, the rollout out will be done in a phased manner, targeting approximately an additional 20 percent of the population per year. Significant implementation support will be provided throughout the process and at each stage assessments will be made to identify and address any bottlenecks for successful scale-up. In order to strengthen institutional capacity and ownership, anchoring the project within the

MoPH under a National PBF Technical Unit, which is responsible for day to day implementation of the program and for informing the HSS Steering Committee of the progress achieved in implementing the PBF approach, is expected to minimize implementation delays and mitigate risks.

97. **Sustainability:** The risk of sustainability is considered substantial. Piloting PBF has been successful and there is broad support for a national expansion, but financial and institutional sustainability remain a risk. To mitigate this risk the Bank project includes a solid capacity building and training component into the project; this will allow not only strengthened stewardship of the program at the national level, but also allow for areas that are successfully implementing PBF to share their experiences with new zones beginning implementation. Additionally, the government is expected to progressively increase co-financing of the program over the lifetime of the project, and the development of the national health financing strategy will contribute to designing a sustainable and smart health financing in the country, including increasing government contributions for the PBF program.

98. **Insecurity and challenging context of the northern regions:** The risk of implementing PBF in the northern regions is substantial. The northern regions face high levels of chronic poverty, have the poorest health outcomes in the country and face an acute shortage of health personnel to deliver health services. At the same time, instability and displacement of populations has increased in recent years due to violent attacks by Boko Haram in Cameroon and neighboring Nigeria. This has also resulted in a reduction in the availability of health services due to staff of health facilities in affected areas fleeing to safer areas. At the same time, there is an increase in need for health services for these displaced populations affected by the instability. As such additional challenges will exist to provide support to health service delivery through the PBF program, ensure appropriate monitoring and verification of service delivery is conducted, and that sufficient implementation support is provided to the project. To mitigate these risks and address these challenges, the project will partner with other development partners working in the area and will contract well-functioning NGOs already based in the regions for contracting, verification and coaching activities.

99. In addition, to respond to the health needs of population groups affected by the insecurity, the PBF program in Cameroon has an innovative design component that includes both geographical equity bonuses for areas affected by the instability, as well as the provision of higher subsidies for services that are provided at reduced cost or free of charge to refugees and displaced populations. This approach will provide greater resources to health service providers in areas affected by the instability, including additional incentives for staff to continue providing services at these health facilities. The project will also take advantage of the Community PBF platform of contracting community health workers to use them to help identify, sensitize and refer displaced people in communities served by contracted health facilities.

100. **Fiduciary:** The fiduciary risk for this project is substantial. Lack of transparency in the allocation and use of resources in the health sector in Cameroon remains a challenge and the proposed project will allocate high levels of financial resources through both the PBF and non-PBF activities. However the pilot areas that have been implementing PBF show that the

program itself has led to improved accountability at the point of service delivery and among regulatory bodies in the health system. To address these risks, the project includes a very strong training/capacity building program, which will ensure that all actors implicated in the program are well versed in the details of PBF and PBF implementation. Another risk is fiduciary capacity of the implementation agency. To address this, the new operation will build upon the experience and skills of the PIU developed under the HSSIP by transferring the existing financial management from the original HSSIP project to the PBF unit. In addition, close supervision of the project will take place by the team; including an experienced full-time PBF expert based in Yaoundé.

VI. APPRAISAL SUMMARY

A. Economic and Financial Analysis

101. **The overall development impact of the proposed Project will be the improvement of the health of women, children and adolescents.** Specifically, the development objective of the Project is to increase utilization and improve the quality of health services with a particular focus on reproductive, maternal, child and adolescent health and nutrition services. To achieve this objective, the Project investments will contribute to strengthening the performance of the health system through continued scaling-up Performance-Based Financing that has been successfully piloted in Cameroon (with support of an ongoing World Bank health operation). Through the PBF mechanism, coverage and quality of RMNCAH services for the population will be increased, especially in the poorest and most disadvantaged provinces of Cameroon.

102. **Component 1 of the Project aims at strengthening health service delivery through PBF and Component 2 at strengthening institutional capacity for improved health system performance.** The rationale for public sector engagement for this Project is based on the role of the government to promote economic and social goals and their spillover effects. Investments funded through the Project will strengthen health services delivery and institutional capacity through PBF thus improving health system performance (thus increasing utilization and quality of health services, and for the most vulnerable), and contributing to Universal Health Coverage. Public sector investment is also key to providing and promoting preventive health services and supporting equity improvements to access good quality RMNCAH services. Moreover, these interventions have positive externalities and important spillovers (societal returns of investing in women's and children's health for economic growth) which justify the role of the government.

103. **The value added of the World Bank support to Cameroon on health system performance is:** (i) its technical input based on international experience on health systems strengthening, specifically on Performance-Based Financing and its capacity to mobilize a wide-range of technical expertise to support key strategies and reforms (e.g., RMNCAH investment case, health financing strategy) but also (ii) its convening role to support the mobilization and channeling of additional resources to scale-up delivery of effective and efficient RMNCAH services, as Cameroon is now part of the GFF in support of Every Woman Every Child (initiative launched by the World Bank and key development partners in September 2014). Additionally, the ongoing Cameroon Health Sector Support Investment Project has been

successfully supporting the Government to implement key reforms such as the introduction of Performance-Based Financing. The World Bank is playing a key role to promote innovative approaches in the health sector (for example, Community PBF) and overall for human development by promoting a multisector approach (component 1.3 will support innovative interventions through a comprehensive program to address education, health and fertility challenges).

104. **The economic analysis of the Project draws on empirical evidence, including results from operational data of the PBF pilot and the PBF impact evaluation in Cameroon, to demonstrate that the expected benefits outweigh the costs of the proposed interventions in terms of health, poverty and social impacts.** Detailed economic and financial analysis conducted during project preparation includes: (i) a cost-effectiveness analysis of the project (what is the incremental cost effectiveness ratio?); (ii) a cost-benefit analysis of the project (how much does the project cost per saved life year?) and (iii) a financial analysis (how financially sustainable is the project?). In addition, the development of the Cameroon RMNCAH investment case and prioritization of interventions as part of the GFF process is built on an evidenced-based approach.

105. **The cost-effectiveness analysis focuses only on interventions funded through Component 1 of the Project** (mainly strengthening health service delivery through Performance-Based Financing), representing 86 percent of Project's investments as activities under Component 2 (Strengthening institutional capacity for improved health system performance) deal mostly with capacity building activities and it is more complex to assess their impact and benefits. The analysis estimates an incremental cost-effectiveness ratio of US$15.50 specifically for women beneficiaries. From this preliminary estimation, the project appears to be cost-effective and comparable to similar interventions in developing countries.

106. **The set of interventions on RMNCAH included in the PBF package have proven to be cost effective in a variety of studies and across many countries and evidence suggests that providing this package to mothers and children is highly cost-effective (US$82-142 per DALY averted).** Average costs of health and interventions funded by the Project per benefit (cost per disability-adjusted life year, DALY, averted) are detailed in Annex 5. Health interventions that cost less than US$100 per DALY are considered highly cost-effective by international standards. Thus, interventions funded by the Project can be considered highly cost-effective. Moreover, preliminary results from the PBF impact evaluation demonstrate significant improvements in utilization and quality of care in facilities receiving the PBF intervention, in comparison with facilities in the control group. The Project will contribute to improved allocative efficiency in the health sector which is a major issue in Cameroon. Total health expenditures have increased since 2000, from US$81 per capita to US$138 per capita in 2013, but health outcomes are still poor considering investments and the GDP of Cameroon (in comparison with similar countries).

107. **Financial sustainability. A preliminary fiscal sustainability analysis of the investments of the Project demonstrates that activities funded by the Project are sustainable.** Project investments focus mostly on strengthening the performance of the health system (strengthening service delivery and efficiency) by scaling-up PBF. Moreover, funding for

interventions under the Project represents a limited share of the national budget dedicated by the country for health (even if the public expenditures for health are low in the general budget).

B. Technical

108. **The project is comprehensive and technically sound.** It encompasses service delivery at different levels of care through the support of a basic package and complimentary health services aimed at improving maternal and child health indicators. It includes all the relevant support systems and is accompanied by a sound implementation plan and monitoring framework. The design of this project builds on several years of World Bank investment in Cameroon's health sector. The project will build on the current health sector project (HSSIP) which is scheduled to close in December 2017. The approach of continued investment in maternal and child health and nutrition interventions through PBF is endorsed by the MoPH. The MoPH is concerned about the high levels of infant, child, maternal mortality, and TFR and malnutrition rates. This project will reinforce the government's priorities and aim to strengthen the health system and focus on maternal and child health interventions through PBF.

109. **The design of PBF arrangements in Cameroon is based on best practices and experiential knowledge gained through HSSIP, as well as other successful PBF projects in the region.** For instance, the project will support Contract Development and Verification Agencies) covering each region, using either the Regional Fund for Health Promotion or NGOs. Close collaboration with non-state actors such as UNICEF, UNFPA, WHO, the Global Fund, GAVI and bilateral organizations (particularly the US, France and Germany) will help greatly in promoting and monitoring PBF results. Similarly, the mechanism to determine PBF credits is a "fee-for-service conditional on quality" system, which has been applied with successful results in other PBF projects such as in Rwanda, Burundi, ROC, Zambia, Zimbabwe, Nigeria, Benin, DRC and Chad. Such a system ensures that (i) the PBF mechanism is clear and can easily be understood by health workers and communities and (ii) the increase in the quantity of care is not detrimental to quality.

C. Financial Management

110. **The proposed FM arrangements under the project satisfy the Bank's minimum requirements under OP/BP10.00**, and therefore are adequate to provide, with reasonable assurance, accurate and timely information on the status of the project as required by IDA. With regards to the complexity of the project that will include performance-based rewards and will involve many implementing agencies and stakeholders, the preliminary FM risk is assessed as substantial.

111. **The new operation will transfer fiduciary and coordination responsibilities of the project from the PIU under the HSSIP to the National PBF Technical Unit.** That being said, the new operation will build upon the experience and skills of the PIU developed under the HSSIP by transferring the existing financial management from the original HSSIP project to the PBF unit. The Project Implementation Unit comprises one Finance and Administrative Officer, one Accountant, one Assistant Accountant and one Internal Auditor. They are well qualified and experienced in World Bank financed projects and have been adequately managing the

ongoing operation as substantiated by the last FM supervision rating which was assessed as Satisfactory.

112. **The financial roles of the PPAs/CDVAs contracted will change under the new operation.** Under the original operation and AF, PPAs main activities were contracting, verification and subsidy payments to contracted providers upon validation by the PIU. Under the new project design, the payment component of the agency will be removed, allowing them to focus efforts on their other responsibilities (contract management, verification and coaching). Upon validation of payment requests by the National PBF Technical Unit, the fiduciary arm of the unit will make direct payments to health centers, bypassing the transitory PPA bank account that existed under the current operation. As each provider is obligated to have an independent bank account, direct payment transfers between the PIU and providers is possible. As such, PBF implementation agencies will no longer be called Performance Purchasing Agencies (PPA) but Contracting and Verification Agencies. An example of this model is the Burkina Faso PBF program. It is expected that the new model will: (i) reduce transaction time between validation of results and reception of PBF subsidies, (ii) reduce operational costs of agencies as their fiduciary role will be substantially reduced, and (iii) allow the PIU to focus on its main task in the new national model, which is to be primarily one payer of PBF subsidies among various payment sources (other partners and the government). However, the accounting role of the PPAs/CDVAs will be maintained for verification and record of financial transactions in the PBF portal. It is foreseen that the accounting team will comprise an accountant, an assistant accountant and a pool of two (2) to five (5) accountants (depending on the workload) dedicated to record purposes in the PBF portal.

113. **The assessment revealed that the new role assigned to the National PBF Technical Unit will increase the scope and breadth of work previously performed by them.** Consequently there will be an increased workload for the FM team who will perform additional and substantial amounts of prior review tasks. In addition the current HSSIP manual of procedures as it stands cannot be fully utilized for the implementation of the new project, the accounting software is not adequately customized to fit the new project accounting and reporting needs and the current external audit arrangements might not be adequate enough to ensure timely submission of acceptable audit reports as the scope of the new project encompasses all the ten (10) regions of the country. As a result, the following measures should be taken as part of the FM action plan:

(i) a progressive approach will be taken for the competitive recruitment of additional accountants i.e. four (4) accountants earlier in 2017 and two additional (2) in 2018. Such team reinforcement will be assessed with accuracy during implementation;
(ii) a new manual of procedures will be developed taking into account the specificities of the new project and building upon the existing procedures manual under the current health project;
(iii) the accounting software will be customized to fit the new project needs and
(iv) five (5) external auditors will be recruited, each of them dedicated to two regions. One of them will conduct audit activities at the PBF technical unit in addition to his affected regions. The external audit arrangements will be reviewed with accuracy within the first month of effectiveness.

114. **In addition, it is recognized that governance and corruption are issues in the health sector in Cameroon.** Therefore, the proposed project design will include some measures aimed at mitigating the related risk: (i) CDVA contracts will be performance-based with performance assessments occurring on an annual basis by the National PBF Technical Unit and development partners involved in the PBF program, (ii) the Internal Audit unit will conduct ex-post reviews that will aim at ensuring that CDVA and NGO activities are compliant with their contracts, payments are effective and made to the correct beneficiaries and that transactions are processed in a timely manner.

D. Procurement

115. Recent changes in the Cameroon legislation have modified the institutional architecture for public procurement in the country via three decrees issued on March 8, 2012, and on August 5, 2013. No special exceptions, permits or licenses need to be specified in the Financing Agreement since the procurement code, approved by the President of the Republic in September 2004 allows IDA procedures to take precedence over any contrary provisions in local regulations. Procurement will be the responsibility of the PFB Technical Unit with the technical support of the special tenders board placed under authority of the original HSSIP project (P104525) and set up by MINMAP Decree 006/A/MINMAP on May 8th 2013 modified by Decree 00000181/A/MINMAP on August 17th 2015. The mandate of this body should be broadened to cover the procurement of this project (Cameroon Health System Performance Reinforcement Project - P156679).

116. The new operation will transfer fiduciary and coordination responsibilities of the project from the PIU under the HSSIP (P104525) to the National PBF Technical Unit, including compliance with procurement procedures. That being said, the new operation will build upon the experience and skills of the PIU developed under the HSSIP. An assessment of these procurement arrangements of the project has been carried out and the procurement assessment recommended the following mitigation measures for PFB Technical Unit: (i) recruitment of qualified procurement specialist, (ii) establishment of an administrative and financial manual to include procurement arrangements related to this project, and (iii) installation of a comprehensive record keeping system. Details are provided in a mitigation action plan. Furthermore, while acknowledging the motivation of the institutional reform transferring responsibilities to MINMAP (December 2011), several concerns have been raised by the World Bank on the technical and legal responsibility and related regulatory issues (see Procurement Environment).

117. The overall procurement risk for the project is rated as *High.* This is due to, among other factors, the country environment risk of corruption in procurement, especially in public contracts, the relatively limited experience in the implementation of Bank-financed projects for PBF Technical Unit and MINMAP, the potential conflict of interest for MINMAP in relation to the management of complaints linked to contracts directly handled by MINMAP. Mitigation action plans have been agreed upon, which, if properly implemented and monitored, will bring this risk down to *Substantial.*

E. Social (including Safeguards)

118. **The project is expected to have a positive social impact by improving access to health care services for the poorest households, particularly in zones where the Social Safety Nets Project is also being implemented.** Component 1 (through the payment for performance) will provide incentives for health facilities to reduce staff absenteeism and to improve staff responsiveness with patients, as well as provide free care to the poor and vulnerable.

119. **Indigenous Peoples live in the East and South region and therefore OP/BP 4.10 has been triggered by the project in order to ensure that these populations will benefit from the project in culturally appropriate and effective ways.** A social assessment was undertaken during preparation in order to evaluate the accessibility and quality of health care provided to indigenous peoples under the original project as well as identify ways in which the project design could be improved in order to increase the coverage and effectiveness of the services being supported under this project. The social assessment found that Performance Purchasing Agency in the East introduced specific measures to ensure indigenous peoples in the region are benefitting from the improved availability and quality of health services in their areas. The assessment also identified several key areas in which adaptations should be made and these have been included as specific measures in the Indigenous Peoples Action Plan that has been prepared and disclosed per the requirements of the policy. As such an IPPF/IPP was also prepared for this project and disclosed on February 25, 2016. The Action Plan also includes indicators and budget that will be used during project implementation to evaluate progress and results.

120. **The project is expected to have a positive impact for women in Cameroon.** Given that the project's main objectives are to improve reproductive, maternal and child and nutrition services, improving women's health is an essential component of this intervention. Particular attention will be given to ensuring active participation of women in project implementation especially as it relates to health choices and care at the community level.

F. Environment (including Safeguards)

121. **The project is rated as Environmental Assessment (EA) category B**. Activities related to the proposed project may lead to an increase in medical waste, which may lead to adverse environmental impacts of the project.

122. **The OP/BP 4.01 Environmental Assessment safeguard has been triggered by this project due to the potential negative environmental impacts related to the handling and the disposal of medical waste (such as placentas, syringes, and material used for delivery of pregnant women) in health facilities covered by the project**. In accordance with OP/PB4.01, the Medical Waste Management Plan (MWMP) was prepared for the original project and was implemented as planned (purchase/installation of generators). The PIU has recruited a consultant to update the MWMP for the new operation (new technical and geographical scope), which was finalized prior to appraisal and disclosed on February 25, 2016.

123. **The World Bank's supervision missions will include environmental and social safeguards specialists in order to assist the project implementation unit by** (i) providing regular implementation support, (ii) carrying out field reviews of safeguards implementation, and (iii) monitoring safeguards implementation based on periodic progress reports.

124. **Two safeguard policies were triggered, as follows**:

Safeguard Policies Triggered by the Project	Yes	No
Environmental Assessment (OP/BP 4.01)	[X]	[ ]
Natural Habitats (OP/BP 4.04)	[]	[X]
Pest Management (OP 4.09)	[ ]	[X]
Physical Cultural Resources (OP/BP 4.11)	[]	[X]
Involuntary Resettlement (OP/BP 4.12)	[]	[X]
Indigenous Peoples (OP/BP 4.10)	[X]	[]
Forests (OP/BP 4.36)	[]	[X]
Safety of Dams (OP/BP 4.37)	[ ]	[X]
Projects in Disputed Areas (OP/BP 7.60)*	[ ]	[X]
Projects on International Waterways (OP/BP 7.50)	[ ]	[X]

* By supporting the proposed project, the Bank does not intend to prejudice the final determination of the parties' claims on the disputed areas.

G. World Bank Grievance Redress

125. **Communities and individuals who believe that they are adversely affected by a World Bank (WB) supported project may submit complaints to existing project-level grievance redress mechanisms or the WB's Grievance Redress Service (GRS).** The GRS ensures that complaints received are promptly reviewed in order to address project-related concerns. Project affected communities and individuals may submit their complaint to the WB's independent Inspection Panel which determines whether harm occurred, or could occur, as a result of WB non-compliance with its policies and procedures. Complaints may be submitted at any time after concerns have been brought directly to the World Bank's attention, and Bank Management has been given an opportunity to respond. For information on how to submit complaints to the World Bank's corporate Grievance Redress Service (GRS), please visit http://www.worldbank.org/GRS. For information on how to submit complaints to the World Bank Inspection Panel, please visit www.inspectionpanel.org.

Annex 1: Results Framework and Monitoring

Country: Cameroon

Project Name: Health System Performance Reinforcement Project (P156679)

Results Framework

Project Development Objectives

PDO Statement

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

These results are at | Project Level

Project Development Objective Indicators

		Cumulative Target Values				
Indicator Name	Baseline	2017	2018	2019	2020	End Target (2021)
People who have received essential HNP services (Number)	0	910,509	2,279,431	3,704,788	5,182,384	5,520,987
Children 12-23 fully immunized in the 3 Northern regions and East (Percentage)	68	70%	74%	77%	80%	80%
Births attended by skilled professional in the 3 Northern regions and East (Percentage)	37.6	40%	45%	50%	55%	55%
Average score of the quality of care checklist (Percentage)	30	35	40	45	48	50

Children under 24 months being weighed for growth monitoring in the 3 Northern regions and East (Number)	0	212,107	565,619	989,834	1,484,751	1,608,480
Direct project beneficiaries (Number) - (Core)	0	1,120,792	2,839,664	4,652,612	6,532,621	6,973,044
Female beneficiaries (Percentage - Sub-Type: Supplemental) - (Core)	0	743,523 (66%)	1,898,483 (67%)	3,111,170 (67%)	4,366,360 (67%)	4,661,169 (67%)

Intermediate Results Indicators

		Cumulative Target Values				
Indicator Name	Baseline	2017	2018	2019	2020	End Target (2021)
Pregnant women receiving at least 4 antenatal care visits in the 3 Northern regions and East (Percentage)	42.8	45	50	55	60	60
Adolescent girls aged 10-19 years benefiting of multisectoral services supported by the GFF IC (number)	0	0	30,000	80,000	130,000	150,000
Women 15-49 using modern contraceptive methods in the 3 Northern regions and East (Percentage)	12.8	14	16	18	22	22
Children aged 6-59 months who received a vitamin A supplement in the last six months (Number)	0	79,199	193,907	316,661	444,539	474,286

Percentage of facilities with 100% tracer drugs available in targeted health facilities on the day of the visit (Percentage)	20	25	25	30	35	40
Number of consultations provided to the poor and vulnerable free of charge (Number)	0	210,283	530,233	867,824	1,220,237	1,302,057
Patients/people referred to the health facilities by community health workers (Number)	0	22100	67663	117954	195379	243890
Percentage of reported maternal deaths audited in PBF districts (Percentage)	0	10	15	20	25	25
Percentage of health facilities conducting community interface meetings (Percentage)	0	20	30	40	50	60
Percentage of the national population covered by the PBF program (Percentage)	25	35	50	70	90	95
Percentage of the total budget for family planning needs funded by the Ministry of Public Health budget (Percentage)	0	10	30	40	50	50

Indicator Description

Project Development Objective Indicators				
Indicator Name	Description (indicator definition etc.)	Frequency	Data Source / Methodology	Responsibility for Data Collection
People who have received essential HNP services	Health services provided to the target population as defined by the package of services supported by the project : • Children immunized (number) • Pregnant women receiving; antenatal care during a visit to a health provider (number); • Pregnant/lactating women, adolescent girls and/or children under age five reached by basic nutrition services (number); • Births (deliveries) attended by skilled health personnel (number).	Annually	Report from PBF Statistics	MoPH
Children 12-23 fully immunized in the 3 Northern regions	Children under 1 year who received PENTA3 in Adamawa, Far-North, North and East regions	Annually	Report from PBF Statistics Households survey	MoPH
Births attended by skilled professional in the 3 Northern regions	Deliveries attended by a qualified health professional in Adamawa, Far-North, North and East regions	Annually	Report from PBF Statistics Households survey	MoPH
Average score of the quality of care checklist	Average of the quarterly quality score (%) of all PBF health facilities	Annually	Report from PBF Statistics	MoPH
Children under 24 months being weighed for growth monitoring in the 3 Northern regions	Children under 24 months being weighed for growth monitoring in Adamawa, Far-North, North and East regions	Annually	Report from PBF Statistics	MoPH
Direct project beneficiaries	Direct beneficiaries are people or groups who directly derive benefits from an intervention (Sum of People who have	Annually	Report from PBF Statistics	MoPH

	received essential HNP services+ Number of consultations provided to the poor and vulnerable free of charge in targeted areas + adolescent girls benefiting from multisectoral services)			
Female beneficiaries	Based on the assessment and definition of direct project beneficiaries, specify what percentage of the beneficiaries are female	Annually	Report from PBF Statistics	MoPH
Intermediate Results Indicators				
Indicator Name	Description (indicator definition etc.)	Frequency	Data Source / Methodology	Responsibility for Data Collection
Pregnant women receiving at least 4 antenatal care visits in the Northern regions (percentage)	Number of pregnant women who had at least 4 antenatal care visits before delivery in Adamawa, Far-North, North and East regions (percentage)	Quarterly	Report from PBF Statistics	MoPH
Adolescent girls aged 10-19 years benefiting of multisectoral services supported by the GFF IC (number)	Adolescent girls aged 10-19 years benefiting of multisectoral services supported by the GFF Investment Case (number), for example: conditional cash transfer program for adolescent girls linked to education outcomes, life skills coaching, an education sector PBF pilot and additional cash transfer support for health, sanitation and nutrition outcomes (to be finalized with the IC)	Annually	Report from Project and National Multisectoral Program for Combating Maternal, Newborn and Child Mortality	MoPH
Women 15-49 using modern contraceptive methods in the 3 Northern regions (Percentage)	Women 15-49 using modern methods such as injections, pills, implants, IUDs and condoms would be taken into account (same definition as in the MICS 2014 survey will be used) in Adamawa, Far-North, North and East regions	Annually	Households survey	MoPH

Children aged 6-59 months who received a vitamin A supplement in the last six months	Number of children aged 6-59 months who received a vitamin A supplement in the last six months	Quarterly	Report from PBF Statistics	MoPH
Percentage of facilities with 100% tracer drugs available in targeted health facilities on the day of the visit	Based on current levels in HSSIP project and 6% in new areas (baseline for HSSIP)	Quarterly	Report from PBF Statistics	MoPH
Number of consultations provided to the poor and vulnerable free of charge in targeted areas	Using the validated definition and selection criteria for identification of the poor and vulnerable	Quarterly	Report from PBF Statistics	MoPH
Patients/people referred to health facilities by community health workers	Patients/people referred to the health facilities by community health workers contracted in the PBF program	Quarterly	Report from PBF Statistics	MoPH
Percentage of reported maternal deaths audited in PBF districts	Percentage of reported maternal deaths audited in PBF districts	Quarterly	Report from PBF Statistics	MoPH
Percentage of health facilities conducting community interface meetings	Percentage of facilities in the PBF program who conduct quarterly community-facility interface meetings to ensure beneficiary feedback and decision-making is accounted for in health service delivery	Quarterly	Report from PBF Statistics	MoPH
Percentage of the national population covered by the PBF program	Percentage of the total national population covered by the PBF program (measured by district populations included in the program)	Annually	Report from PBF Statistics	MoPH
Percentage of the total budget for family planning needs funded by the Ministry of Public Health budget	Percentage of the total budget for family planning needs funded by the Ministry of Public Health budget	Annually	MoPH budget UNFPA FP needs budget estimates	MoPH

Annex 2: Detailed Project Description

CAMEROON: Health System Performance Reinforcement Project

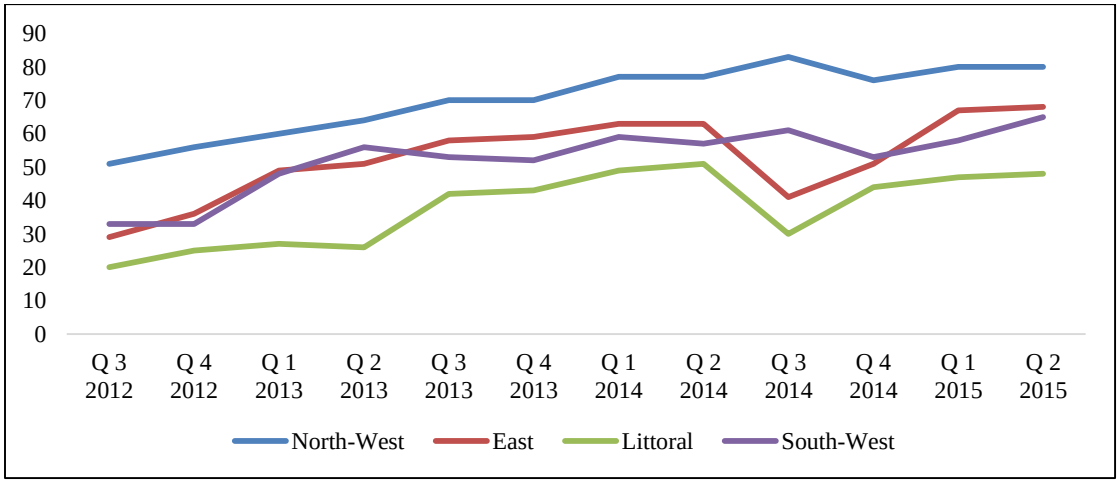
Current implementation of Performance-Based Financing in Cameroon

1. **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 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.

2. **The project 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 children fully 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.

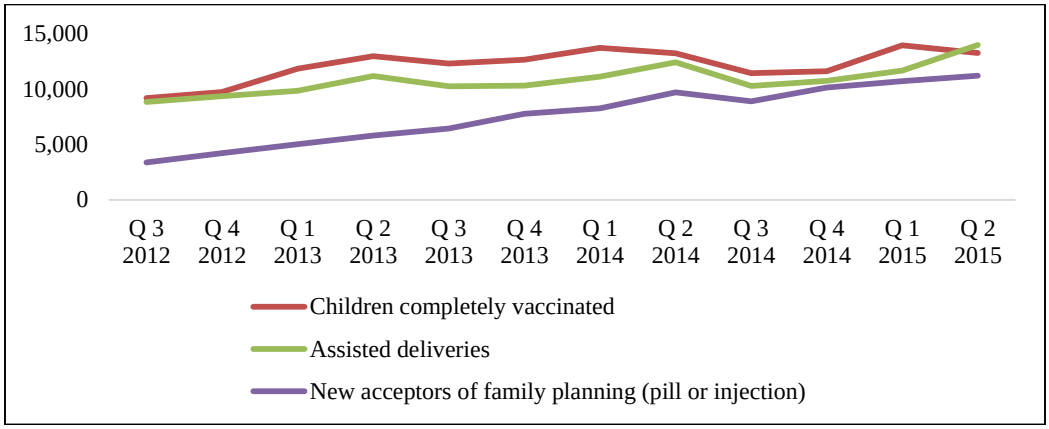
3. **The number of health facilities achieving an average score of 75 percent of the quality index of services has increased by almost seven times since the third quarter of 2012, from 9.3 percent to 71.6 percent in the first quarter of 2015.** For primary health care centers, average quality of care scores, measured by the quarterly quality checklist conducted by the regional and district health teams, in collaboration with the purchasing agencies, have increase from an average score of 33 (out of 100) in the third quarter of 2012 to an average of 65.

Figure 3: Average quality of care scores for PBF primary health care centers, 2012-2015



Source: Cameroon PBF Portal (www.fbrcameroun.org)

Figure 4: Provision of key maternal and child health services in PBF facilities, 2012-2015

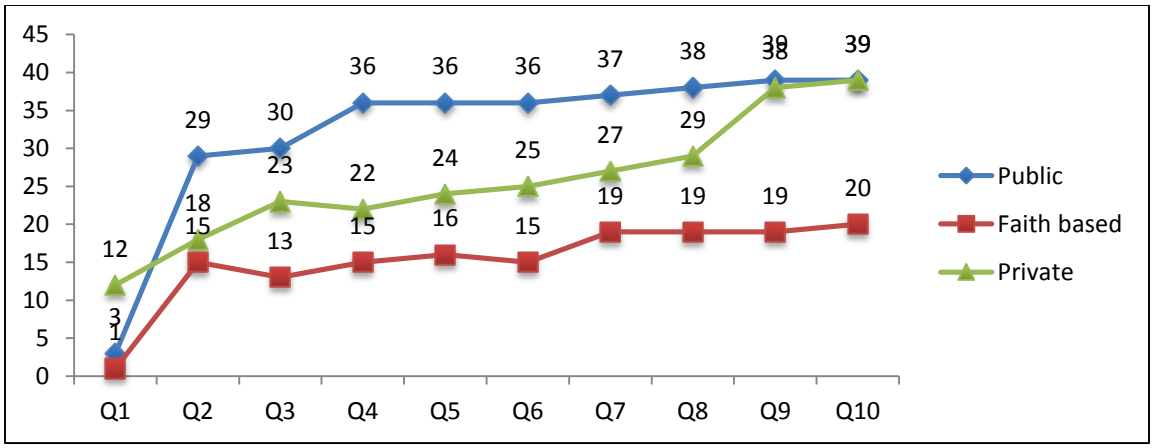


Source: Cameroon PBF Portal (www.fbrcameroun.org)

4. **Since the PBF program began in 2011, the project has used an innovative approach for public-private partnerships in the health sector.** In PBF zones, all public and faith-based facilities are eligible for the project whereas only private health facilities which fulfilled norms and standard required by the national policy (administrative documents that allow its creation and functioning according to the law; adequate infrastructure, staff and equipment) can be included in the project. Based on these criteria, a district medical officer evaluates each private health facility before granting authorization to the PPA to sign their first performance contract. All facilities with PBF contracts are treated equally by the PPA.

5. **In the first two years of the pilot in Littoral region, the number of contracted providers that were private-for-profit increased substantially, reaching 40 percent of all providers by 2013**. Results have shown that through strategic contracting, private facilities are not only offering higher quality of care, but also a larger package of services than before, including more preventive, promotional and community-based care, as well as free services for the poor and vulnerable.

Figure 5: Health facilities with PBF contracts in Littoral region, by sector, 2011-2013



Source: Cameroon PBF Portal (www.fbrcameroun.org)

6. **In Cameroon PBF has been found to be an effective mechanism in reinforcing public-private partnerships in the health sector and motivating private providers to improve the quality of health care, to collaborate with public and faith-based facilities for effective referral and counter referral of patients and to provide preventive and promotional health care that are essential to public health goals and UHC.** As such, PBF provides a unique opportunity for government to regulate the private sector and to use them to increase health resources available to the population in urban areas.

7. **An Additional Financing (AF) of the HSSIP of US$40 million was approved in June 2014.** 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 Adamawa, 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 February 2016, upon completion of the baseline survey and recruitment of firms, including NGOs, who will provide technical assistance for contract development and verification activities.

8. **Since late-2014, the project has engaged in a reform process to better integrate PBF into the national health 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.

9. **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 in all regions where they are deemed sufficiently functional to play this role.

10. **The Government of Cameroon has begun providing counterpart financing for PBF.** Since 2014, the Ministry of Public Health 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 million) 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 or poorly spent towards the PBF budget line. They have also committed to revisiting their overall health budget to align it to the PBF approach.

11. **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 (UNFPA) and nutrition (UNICEF) indicators directly through the PIU. The joint-financing is being piloted in the East region for the second half of 2015. This is planned as an initial pilot that will be expanded 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.

12. **The AF is already disbursing well (US$22 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 package 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 in mid-2016.

13. **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 of the Community PBF intervention, combined with various formats of "community monitoring", on key health service delivery outcomes.

14. **At the global level**, **the WBG and the key DPs launched a Global Financing Facility 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 services.** Cameroon is one of the second-wave countries selected in July 2015. The GFF consultations and preparation of the GFF Investment Case were launched during the October 2015 project preparation mission.

15. **PDO:** The proposed Project Development Objective is to increase utilization and improve the quality of health services with a particular focus on reproductive, maternal, child and adolescent health and nutrition services.

16. **Project Beneficiaries: The project will support the ongoing implementation of PBF in the 26 health districts covered by the original operation, the 18 health districts recently added through the Additional Financing, and an incremental roll out of PBF to national coverage.** With coverage at 25 percent of the population in 2016, the operation would support a gradual scale-up of approximately an additional 20 percent of the population 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 36 districts in the three northern regions of Cameroon (Far North, North, and Adamawa) to address the urgent and growing needs in those regions. In total, the three northern regions include 54 health districts with a population of 7,614,882 (2016). The direct beneficiaries of the supported interventions include women, adolescents and children under 5. Results from PBF will be captured for the new operation by disaggregating the results of the newly targeted districts from the original 44 districts covered by the Health Sector Support Investment Project (HSSIP). Once HSSIP funds have been fully disbursed, the original 44 districts will be financed by the new operation and the results will then be integrated into the Results Framework of the new operation.

17. **The project will have two components.** Component 1: Strengthening of Health Service Delivery, and Component 2: Institutional Strengthening for Improved Health System Performance. Both components address key strategies identified in the new national HSS (2016-2027), as well as other strategic plans such as the National Strategic Plan for Adolescent and Youth Health in Cameroon (2015-2019), the Strategic Plan for the National Multisectoral Program for Combating Maternal, Newborn & Child Mortality in Cameroon (2014-2020) and for the Strategic Plan for Reproductive, Maternal, Neonatal and Infant Health (2014-2020).

18. **The IDA allocation for this project is US$100 million. A grant of US$27 million from the Global Financing Facility (GFF) Trust Fund is included to support investments in RMNCAH and nutrition (US$25 million) and civil registration and vital statistics (CRVS) systems (US$2 million).** The proposed project would support the progressive national scale-up of the PBF program as well as implementation of other high-impact interventions supported by the GFF and nutrition trust funds. The GFF-supported interventions will have a multi-sectoral approach and conjointly improve health outcomes through investing in social protection and education as well as health.

Component 1: Strengthening of Health Service Delivery (US$109 million (US$89 million IDA, US$20 million GFF)

19. **Component 1 includes continuing support to the ongoing PBF intervention that currently 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.** While the project will support the national scale-up of PBF, which has been identified as a key objective of the Government of Cameroon, the extent to which national coverage can be achieved by 2020 will depend on financial commitments realized by the government and

development partners engaged in the health sector. The progress toward national coverage will be assessed at the Mid-Term Review of the project. Component 2 includes strengthening institutional capacity at the national level to foster the development of equitable, efficient, and sustainable national health financing strategies to achieve the national health goals. It also focuses on increasing the capacity at the county level to plan, budget, implement, and monitor the effective delivery of an essential package of health services.

20. **Sub-Component 1.1: Payment of performance ($US70 million IDA):** In the 44 districts in the North-West, South-West, East and Littoral regions currently covered by the HSSIP and the additional health districts where PBF will be scaled-up, this component will provide PBF payments: (i) to health facilities 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 health services as well as ensuring community organization to support positive health behavior.

21. **After the establishment of Contract Development and Verification Agencies (CDVAs) 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)**.

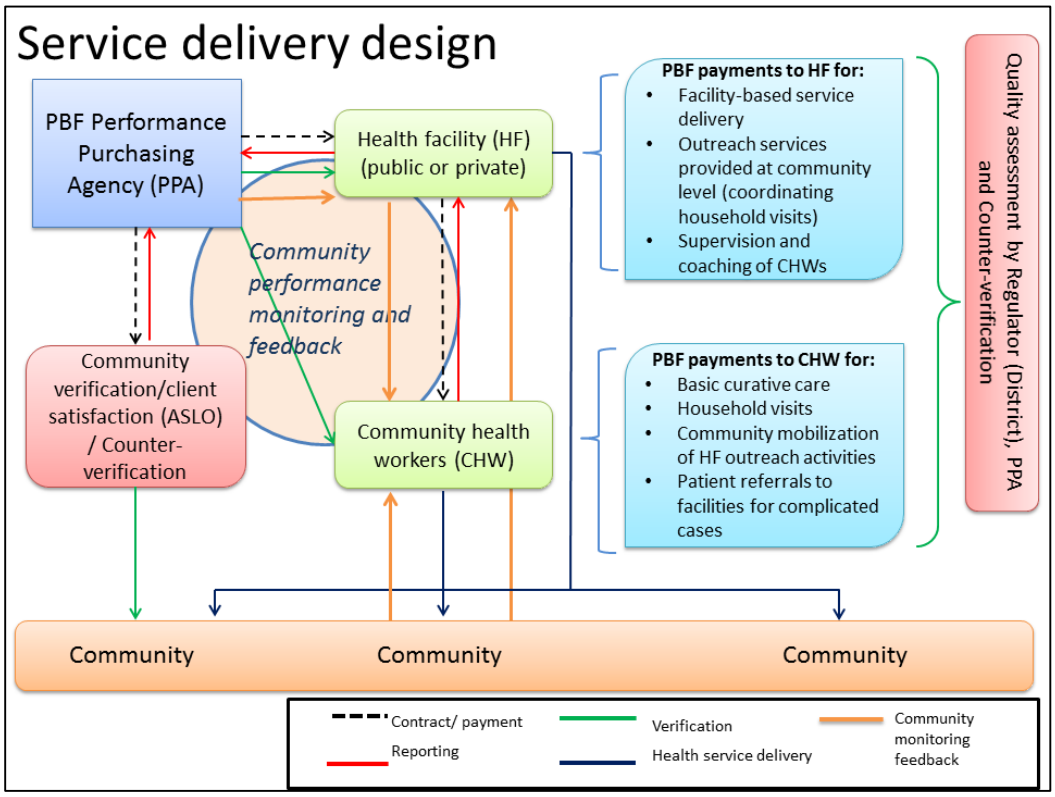
22. **As per the current project design, Component 1 will provide PBF payments**: (i) to health facilities in the targeted regions conditional on the quantity and quality of services delivered via in-clinic activities and/or via health-outreach activities, and (ii) to community health workers for providing 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.

23. **The project will also introduce financial mechanisms to improve access among poor and vulnerable households to essential health services at the community and health facility levels.** The mechanism used to identify the poor that will be applied will build on both the experiences from the Health Sector Support Investment Project (P104525) and the Cameroon Social Safety Nets Project (P128534). In the zones covered by both the health and safety nets projects, the methodology for identification will use a combination of community-based targeting and proxy-means testing, while in zones that are not covered by the Social Safety Nets Project, identification will rely on a combination of community-based targeting and identification at the point of service delivery by service providers.

24. **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.

25. **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.** As with other health services provided by contracted facilities, services declared by health facilities as provided free of charge to the poor and vulnerable will be counter-verified through community verification services, in order to ensure patients identified as poor and vulnerable are in fact poor and vulnerable. The cost per capita and budgeting of the PBF program includes the payments made for the above-mentioned pro-poor services.

Figure 6: PBF and Community PBF service delivery model



26. **A quantified quality checklist will be designed for each level of the service package and will provide the foundation for measuring results (with increased weights given to process measures).** The quality checklist will introduce measures related to rational prescribing of generic drugs, essential drug management and availability tracer drugs. Facility payments will be made quarterly: (i) on the basis of a set of incentivized indicators (defined by the Ministry of Health) emphasizing reproductive, maternal and child health; and (ii) after quantity and quality of services have been declared and verified (ex-ante and ex post).

Table 3: Indicators for the Community Health Worker

	Indicator	Unit price (in USD)
1	Malnutrition cases confirmed by the facility	1.0
2	Pregnant women received in the facility for delivery referred by the CHW	1.0
3	New acceptors of family planning	1.0
4	Postnatal care consultation	0.4
5	Prenatal Consultations 1st Trimester	0.4
6	Family Planning drop-outs	0.5
7	ANC drop-outs	0.6
8	Immunization drop-out under 18-months	2.0
9	VAT drop-outs (Pregnant women)	0.4
10	Drop-out cases of acute malnutrition	0.5
11	Household visit (with health worker)	0.6
12	Public sensitization event	0.6
13	Provision of micronutrient powders through community distribution	0.4
14	Indigents referred to health center	1.0

27. **Sub-Component 1.2: Support to the implementation and supervision of Performance-Based Financing ($US11 million IDA, US$8 million GFF):** To support PBF implementation and supervision (capacity building, verification and counter verification, IT system, etc.), the project will support Contract Development and Verification Agencies covering each region, using either the Regional Fund for Health Promotion or NGOs. Given the large sizes of certain regions (both in terms of geography and population), agency annexes will be established in each district (or batches of districts, depending on the size of each district and logistical considerations). The contract management and verification for PBF implementation is estimated to be at 18 percent of the total PBF budget, which is in-line with international experience.

28. 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. In order to avoid incentivizing overproduction of services as a mean to increase hospital revenue, the main function of the PBF program in the tertiary hospital is to redistribute revenue based on performance outcomes linked to quality improvements. 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 CDVAs in each region. No resources from the proposed project will finance the actual payment of PBF subsidies, for tertiary services.

Table 4: Proposed extension plan for national scale-up of PBF in Cameroon, 2016-2020

			2017		2018		2019		2020	
Region	**% Pop covered 2015**	**Total pop. 2015**	**%**	**Pop.**	**%**	**Pop.**	**%**	**Pop.**	**%**	**Pop.**
Adamawa	35%	1,183,362	35%	414,177	100%	1,203,479	100%	1,223,938	100%	1,244,744
Center	0%	4,085,946	13%	531,173	13%	540,203	50%	2,113,025	100%	4,297,892
East	98%	893,103	100%	893,103	100%	908,286	100%	923,727	100%	939,430
Far North	42%	4,018,963	42%	1,687,964	100%	4,087,285	100%	4,156,769	100%	4,227,435
Littoral	19%	3,326,811	19%	632,094	50%	1,691,683	50%	1,720,442	100%	3,499,376
North	29%	2,433,705	29%	705,774	100%	2,475,078	100%	2,517,154	100%	2,559,946
North-West	28%	2,031,810	30%	609,543	50%	1,033,175	75%	1,576,109	100%	2,137,203
West	0%	2,009,482	0%	0	50%	1,021,822	50%	1,039,193	100%	2,113,718
South	0%	781,465	0%	0	50%	397,375	50%	404,130	100%	822,001
South-West	41%	1,562,932	41%	640,802	50%	794,751	75%	1,212,393	100%	1,644,004
Cameroon	**25%**	**22,327,579**	**35%**	**6,114,631**	**53%**	**14,153,137**	**69%**	**16,886,879**	**100%**	**23,485,749**

29. The resources needed to scale-up PBF nationally are approximately US$215 million. The budget will be financed by the new operation supported by the Bank (US$100 million IDA), development partners engaged in the PBF program, and the Government of Cameroonian (via the budget of the Ministry of Public Health through a conversion of certain existing budgetary lines with poor or inefficient execution rates, and additional resources mobilized for health). A detailed costing is currently being prepared by the government and task team and will be validated by mid-2016.

Table 5: Estimated resource requirements for a phased national scale-up of PBF in Cameroon, 2017-2020

		Government	**IDA/GFF**	**Partners/other**	**Total**
2017	Contribution (%)	**15%**	**85%**	**0%**	**100%**
	US$	2,751,584*	15,592,306*	0	18,343,892
2018	Contribution (%)	**20%**	**70%**	**10%**	**100%**
	US$	9,907,196	34,675,187	4,953,598	49,535,981
2019	Contribution (%)	**40%**	**50%**	**10%**	**100%**
	US$	27,019,007	33,773,759	6,754,751	67,547,518
2020	Contribution (%)	**50%**	**40%**	**10%**	**100%**
	US$	49,320,072	39,456,058	9,864,015	98,640,146
Total	**US$ (2017-2019)**	**86,246,276**	**107,905,004**	**21,572,365**	**215,723,645**
	Contribution (%)	**40%**	**50%**	**10%**	**100%**

*Note: Budgeted for the Ministry of Public Health and current Health Sector Support Investment Project

30. **<u>Sub-Component 1.3: Additional support for improving access to a key package of RMNCAH and nutrition services (US$8 million IDA, US$12 million GFF)</u>:** Sub-

Component 2.3 will support non-PBF activities identified as priority RMNCAH interventions without current funding commitments within the GFF Investment Case, as well as critical inputs to reinforce the availability and quality of nutrition services. Interventions supported by the Investment Case will be linked to priority interventions identified in the national Health Sector Strategy. The development of the Investment Case will be led by a Multisectoral committee anchored at the National Multisectoral Program for Combating Maternal, Newborn & Child Mortality that is composed of representatives from the ministries of health, education, youth and gender, finance and planning, as well as civil society and development partners engaged in the heath sector. The preparation of the Investment Case (IC) began in-country in December 2015 and is expected to be completed in mid-2016. The investment case will only be partly financed by the GFF Trust Fund and help bring to the fore commitments from other partners in this regard.

31. While the final list of interventions to be supported by the GFF trust fund will be validated when the GFF Investment Case is approved at the country level, the initial stages of the prioritization process have identified several key areas for which support will be provided. These include:

    a. Support to a multisectoral approach to address adolescent health, education and demographic challenges in the northern regions of Cameroon;
    b. Providing support to reinforcing nutrition services to ensure that services supported through PBF payments are of high quality and high impact;
    c. Support to the development and implementation of a communication and behavior change strategy including formative research, identification of priority behaviors, key message development, development of communication tools and training manuals for health and nutrition;
    d. Support to the piloting of Kangaroo Mother Care (KMC) to reduce risks related to low birth weight; and
    e. Providing critical support for maternal health, neonatal health and family planning services, family planning and adolescent health services, responding to gaps in financing of the Strategic Plan for the National Multisectoral Program for Combating Maternal, Newborn & Child Mortality in Cameroon (2014-2020).

32. **The final set of activities and allocations to each of them will be determined based on the consultative process for the development of the Investment Case. So far, several complementarities with programs being implemented by other development partners have been identified.** Community-based approaches for preventive, promotional and referral services have been identified as a central service delivery modality for improving access to RMNCAH services in the three northern regions. While several partners (UNICEF, UNFPA) are piloting community initiatives, the substantial scale-up of the Community PBF approach will be an opportunity to rollout an effective community-based service delivery platform at scale, which can integrate key services currently being supported by other partners at much smaller scales. In addition, the combination of the maternal health voucher program (Cheque Santé) and PBF in the northern regions provides a unique opportunity to improve both supply and demand for maternal health services by reducing financial barriers for enrollees while

improving the quality of services. Additional complementarities between ongoing initiatives have been identified and will be central to the Investment Case.

33. **Support to improve health outcomes by addressing the multisectoral determinants of health, with a particular focus on the economic, education, and demographic challenges in the northern regions of Cameroon, especially for adolescent girls (US$7 million GFF Trust Fund).** Potential activities include a comprehensive Human Development (HD) program that builds on preexisting programs for a comprehensive approach to addressing the highly interrelated health, education, and fertility challenges prevalent in the northern regions in Cameroon. Investments will focus on underutilized and highly cost effective interventions. This includes, in addition to the health sector PBF program, (i) additional awareness/ sensitization modules on adolescent girls, and a conditional cash transfer program for adolescent girls linked to education outcomes and providing life skills coaching (building on the existing Social Safety Nets Project's implementation arrangements); (ii) adolescent girls health module in school curriculum, and an education sector PBF pilot (building on the outcomes of a feasibility study and pre- pilot launched in 2016 by the World Bank and the Ministry of Education and on the experience of the health sector PBF program) and (iii) additional cash transfer support for health, sanitation and nutrition outcomes for the safety net program's target population (also building on the Social Safety Nets Project).

34. **During its first phase, the project will support the design of the Multisectoral program,** including further policy dialogue related to the education PBF pilot (in particular related to sharing the health experience and multi-sectorial dimensions) and awareness and cash transfer program for adolescent girls. Implementation of the joint program, in coordination with the Safety Net Project and Ministry of Education's program, is expected to begin prior to the mid-term of the project, and will include a prospective impact evaluation, as well as an overall learning agenda. The specifics of the GFF learning agenda will also be defined during the GFF Investment Case preparation process and be defined in the final investment case.

35. **Providing additional support to reinforcing nutrition services to ensure that services supported through PBF payments are of high quality and high impact (US$5 million GFF Trust Fund).** In addition to the financial resources mobilized for paying performance subsidies for nutrition services under Component 1.1, resources will also be earmarked for the provision of essential inputs for nutrition services. The mobilized resources for provision of inputs would include micronutrients for community-based distribution (through the Community PBF program), development of protocols and guidelines, and training of facility-based health workers and community health workers (CHW). Priority areas include guidelines on the promotion of infant and young child feeding practices, the management of acute malnutrition, promotion of exclusive breastfeeding during prenatal, delivery and postnatal care, and promotion of women's nutrition, notably adolescents and pregnant women. The management of moderate acute malnutrition will use locally available foods and will be initially done at the health facility level. Mothers will be encouraged to make in-kind contributions, but the center may need additional resources to complement the ingredients.

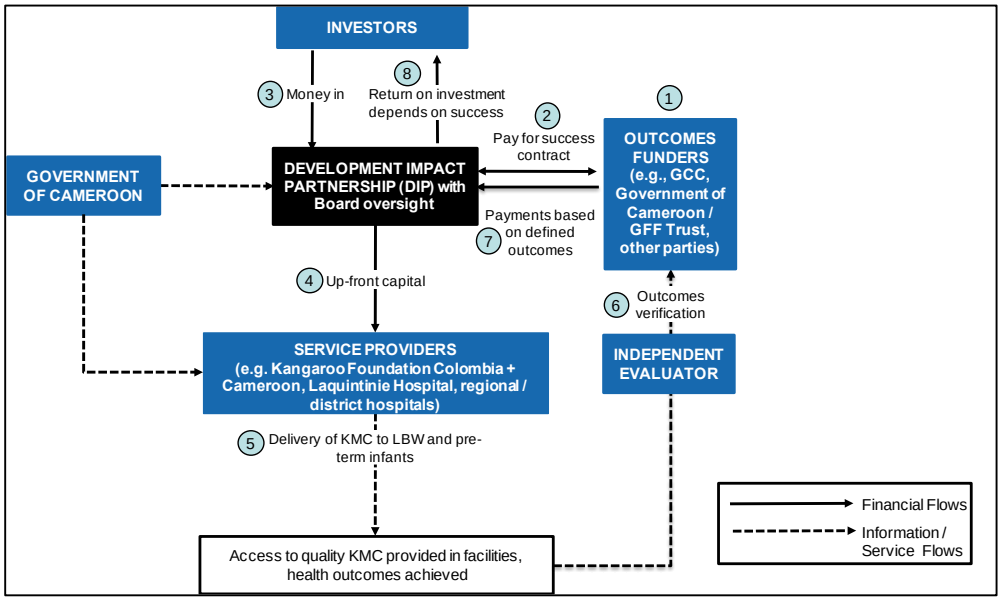
36. **Support to the piloting of Kangaroo Mother Care (KMC) to reduce risks related to low birth weight (US$2 million GFF Trust Fund).** KMC involves continuous skin-to-skin

contact between caregivers and low birth weight infants and exclusive or near-exclusive breastfeeding. KMC allows infants to spend less time – if any – in incubators, leading to more efficient use of limited resources. A Cochrane Review of 16 randomized control trials concluded that KMC significantly reduces LBW neonatal mortality, infection and hypothermia, as well as the number of days in hospital. KMC has also been shown to improve parent-infant attachment, and infant growth and development. Preliminary results from a GCC-funded study indicate that KMC has a positive impact on cognitive development that lasts into adulthood (measured at 18-20 years), associated with improved school and wage earning outcomes. GCC is funding the development of a KMC train-the-trainer program in Cameroon. This program is being developed by the Kangaroo Foundation, a leading Colombia-based KMC trainer, in partnership with Laquintinie Hospital in Douala and the new Kangaroo Foundation Cameroon. This initial program development phase is running from April 2015 to November 2016. Results will include: a detailed KMC training program appropriate for the Cameroonian context; five hospitals trained in KMC, with the necessary staff and infrastructure (for example, for clean water); and a new e-learning platform to support training, certification, and monitoring.

37. **GCC plans to launch a CAD$6-9 million DIB, in cooperation with partners,** in 2017, which would fund KMC scale-up in Cameroon until about 2020 (to be confirmed based on 2016 DIB development activities). GCC is working with the MaRS Centre for Impact Investing and Social Finance to explore a KMC DIB. The proposed KMC DIB would align with existing interventions designed to strengthen the healthcare system in Cameroon. For example, it would aim to leverage the existing hospital data tracking and performance management system used by the Performance-Based Financing program, run by the World Bank in cooperation with the Ministry of Public Health. It would also complement the Chèque Santé program, which aims to improve access to healthcare and increase the number of hospital births. These synergies would allow for greater efficiency in resource allocation, as some of the institutional arrangements important for a KMC DIB are already in place, and hospitals are familiar with incentive and results-based financing programs. The KMC DIB would also complement other maternal and newborn health initiatives – including those designed to improve maternal nutrition and access to prenatal care, which could lower the incidence of LBW.

38. **The GFF trust fund will support the KMC DIB by contributing US$2 million to leverage an additional CAD$4-7 million in outcomes funding commitments from donors, as well as an equivalent amount from private investors.** A DIB could fund KMC rollout to as many as ~25 national/regional hospitals and ~30 district hospitals in Cameroon, depending on the scale-up plan, delivering improved health outcomes for roughly 4,000 LBW infants per year. Funders – for example, GCC, the MoPH, and other donors – would only pay for the delivery of agreed target outcomes. Target outcomes could include: increase in access to quality KMC for LBW infants; weight gain as an indicator of quality KMC; and reduction in mortality for LBW infants. Private investors would provide upfront working capital for the program, and would take on the financial risk, in an innovative example of how the GFF approach can be used to draw new actors into the financing of development activities.

Figure 7: Illustrative Structure of a KMC DIB for Cameroon



39. **Providing critical support for maternal health, neonatal health and family planning services, family planning and adolescent health services, responding to gaps in financing of the Strategic Plan for the National Multisectoral Program for Combating Maternal, Newborn & Child Mortality in Cameroon (2014-2020) (US$6 million).** The selection of activities to be supported under this component of the Investment Case will be confirmed upon completion of the resource gap for priority interventions included in the Investment Case.

Component 2: Institutional Strengthening for Improved Health System Performance (US$18 million (US$11 million IDA, US$7 million GFF (US$5 million RMNCAH and US$2 million CRVS))

40. **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.

41. **Sub-Component 2.1: Strengthening institutional capacities for improved health system stewardship, including monitoring and evaluation (US$4 million IDA, US$3 million GFF):** Sub-Component 2.1 will provide support at the central level of the Ministry of Public Health through analytical work, policy dialogue and institutional strengthening 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; and (v) harnessing the private and faith-based health sectors through strategic contracting. 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.

42. **This sub-component will also support the development and implementation of the country's national health financing strategy, community health strategy, and public-private partnership strategy (US$1 million IDA)**, which are to be developed within the GFF implementation framework. Given the dearth of information on health financing in Cameroon, the project will support the various analytical work necessary for the development of the national health strategy. These include a public expenditure review for the health sector, two rounds of national health accounts, and a study on public financial management (conducted jointly with the Governance Global Practice at the World Bank and Health Financing unit at the World Health Organization), with the final list being identified during the national health financing strategy workshop that was conducted during the February 2016 appraisal mission. The sub-component will also provide support to trainings and workshops related to the design of the strategy.

43. **Complementarily to the implementation of community PBF intervention and strengthening of primary health care service delivery**, the Project will support the development of a national community health strategy. Indeed, to improve maternal and child health outcomes, community-based interventions play a key role. Thus, the development of a community health strategy will help to provide directions to strengthen community organization and involvement for effective contribution to the promotion, prevention and the treatment for maternal and child health.

44. **Private sector in Cameroon is an important health provider**. It makes up 34 percent of the total staff in the health sector, with 19 percent in the faith-based private sector, 4 percent in the nonprofit private sector, and 12 percent in the for-profit private sector. The Project will support development of national tools to strengthen the partnership between the Ministry of Public Health and private health providers and performance of the private sector.

45. **Addressing judicial reforms related to decentralized decision-making and financial and managerial autonomy of health service providers and regulatory bodies will also be necessary.** Experience has shown that the effect of providing additional resources to health facilities through PBF subsidies can be constrained if managerial autonomy for decision-making at the point of service delivery is insufficient. Health care providers need appropriate levels autonomy to be able to address challenges they face with local solutions. Since 2011, health facilities in PBF zones have been granted this autonomy as part of the "pilot phase" of

PBF, but the deeper systemic reforms necessary to ensure this is maintained as the program scales-up need to be identified and addressed in the early stages of the project.

46. **Addressing critical bottlenecks and constraints in the pharmaceutical sector for improved regulation and availability of essential medicines and RMNCAH products (US$4 million GFF Trust Fund).** The pharmaceutical public supply system in Cameroon is currently organized according to a couple of different models across the country. At the central level, all 10 regions are mainly supplied by a unique public central medical store (CENAME). The regional distribution of essential drugs is organized around a regional monopolistic store. In most of the regions, public health facilities are independent and buy medicines from the regional warehouse but in three pilot regions (North-West, the South-West and Littoral), the Regional Funds for Health Promotion are in charge of medicines management and consign stocks at the facility level.

47. **Access to quality pharmaceuticals is a significant constraint to improving RMNCAH outcomes in Cameroon**, and so the GFF Investment Case will cover interventions that would improve the quality of RMNCAH products circulating in Cameroon. The four areas for intervening include:

    i. Strengthening the medicines regulatory authority and the medicines registration process, to make sure that only high quality generic medicines are approved by the country (US$1 million);
    ii. Fostering pharmaceutical inspection capabilities to better regulate the wholesale/distribution sector and to scale up the fight against counterfeit and illicit medicines which is a prominent issue in the country (US$1 million);
    iii. Strengthening the quality assurance system of the Central Medical Store to improve the performance of the national procurement system (US$1 million); and
    iv. Continuing the reform of the governance of the pharmaceutical sector based on the WHO assessment conducted two years ago (US$1 million).

48. **The existing PBF project has started introducing more autonomy in pharmaceutical management at the facility level and more flexibility in the procurement of medicines.** While the government considers scaling up the PBF approach, this is an excellent opportunity to take stock of the different initiatives and evaluate the performance of the different systems, and propose a new pharmaceutical public supply system that will be compatible with the PBF approach and ensure availability, affordability and quality of essential RMNCAH medicines. This may include changing and strengthening the governance of the pharmaceutical sector at the national and regional level, improving warehousing distribution of medicines by professionalizing the existing entities or leveraging the private sector, establishing a robust performance management system of the supply chain that may be connected to the PBF data management platform and health/logistics management information systems. The approach to reform the system will be based on evidence (data from the different systems will be analyzed and compared), 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.

49. **Sub-component 2.1 will also support institutional strengthening of information systems monitoring and evaluation, and performance measurement mechanisms for the health system (US$1 million IDA, US$1 million GFF Trust Fund).** Given the fragmentation, unreliability, and inaccuracy of the existing routine reporting system for the health sector, challenges exist in using results from this system as the basis for measuring health facility performance. As such, the project will contribute to building a reliable health information system for tracking key performance indicators by providing resources to support the ongoing rollout of the DHIS2 platform and the national PBF portal and the linkages between the two. Use of mobile technology for activities such as community verification, beneficiary feedback and community reporting, will be integrated into an upgrade and extension of the PBF portal.

50. **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.** For instance, two rounds of Service Delivery Indicators (SDI) surveys will be implemented to fill an information gap left by other data collection activities in Cameroon. The SDI methodology provides robust and precise indicators about a number of the within-facility aspects that transform resources into results. As PBF will be rolled-out nationally in the health sector and piloted for the education sector, SDI data (collected both at health and education facilities) will provide the user perspective on service provision by looking at the facility's resources and its clinicians'/teachers' effort and competence. This information fills a gap in the results chain between inputs and outcomes, thus broadening and refining policy options. Moreover, and to the extent possible, the analysis will be done with local partners.

51. **Part of the SDI approach is to develop local capacity to analyze service-delivery related information.** The SDI team works with the implementation partner to analyze and report the results from the survey. This has generally worked well and provides a basis for future research and analysis by the local partners on service delivery. For Cameroon, two rounds of SDI for health and education will be conducted, with the first in early 2017 soon after the project becomes effective. Results will be released to various stakeholders in content formats that are adapted to their ability to use the information.

52. **The project will also work with the Primary Health Care Performance Initiative (PHCPI), a global initiative led by the World Bank, the Bill and Melinda Gates Foundation and the World Health Organization to track key performance indicators for Cameroon's primary health care system.** The policy dialogue surrounding this, including benchmarking Cameroon's performance with the performance of other countries, will help identify which parts of the system are working well and which ones aren't, and enhance accountability and provide decision-makers with essential information to drive improvements. PHCPI began contributing to this dialogue by holding a workshop during the project identification mission in October 2015 that reviewed the trends of Cameroon's primary health care key performance indicators. Further analytical work by PHCPI on primary health care bottlenecks was presented in February 2016 during the GFF Investment Case prioritization workshop.

53. **Finally, since PBF payments are to be made based on service volumes and quality, external reviewers will assess the declared results, ex post verification activities will be conducted by an independent third party and an External Evaluation Agency (EEA) will be contracted by the MoPH to check the veracity of the information provided by health services.** 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 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. A performance assessment of these agencies is ongoing to assess if these universities can continue to play the role of EEAs, or if a new national structure should be identified/developed.

54. **Health workforce investments.** By linking the robust information systems developed through the PBF mechanism to the national health workforce observatory and human resources information systems, Sub-component 2.1 will support building institutional capacities to address health worker shortages and poor distribution through evidence-based decision- and policy-making. This may include: identifying priority posts for future recruitment and deployment; informing public financing plans for tertiary education for health professionals to increase the production capacity and pipeline of new graduates; developing career development and training plans for the existing health workforce that responds to quality improvements identified through the facility scorecard; and reviewing and/or clarifying health worker scopes of practice to shift or share tasks when appropriate—particularly for lower-trained cadres concentrated at primary health care facilities, such as nursing assistants, laboratory and pharmacist assistants, and community health workers. Engaging community health workers through the innovative PBF mechanism has shown to be effective to increase service utilization, and is important for PBF scale up to the Northern regions where health workforce shortages are most acute.

55. **Sub-Component 2.2: Reinforcement of civil registration and vital statistics systems (US$2 million IDA, US$2 million GFF):** This sub-component will support the building of the national civil registration and vital statistics systems. The National Office of Civil Registration (*BUNEC-Bureau National de l'Etat Civil*) has been recently created and its role is to coordinate interventions from different Ministries related to civil registration. Its partnership with the Ministry of Public Health will support investments to improve data collection and quality for mothers and children. The prioritization, costing and planning of interventions will be outlined in a specific chapter in the GFF Investment Case.

56. **In addition to the direct support IDA financing will provide to CRVS under this sub-component, approximately US$7-10 million of IDA financing in the proposed operation across various sub-components supports strengthening of CRVS systems in Cameroon through various channels:** (i) increasing birth registration rates through PBF indicators at the community, health facility and district levels through ensuring registrations are made for each delivery and maternal death audits are conducted; (ii) reinforcing the HMIS system through piloting and scaling-up DHIS-2 and linking data with the CRVS system and PBF portal; (iii) training and capacity-building activities for the PBF program at all levels of the health system that will include components on both birth registration, death registration and maternal death

autopsies; and (iv) piloting mobile technology (smart phones and tablets) for enhanced and more efficient community verification, linking verification results to the online platforms and identifying geographical areas where birth registration remains low.

57. **For the activities to be financed by the additional US$2 million GFF trust fund dedicated to CRVS, the key interventions will be agreed upon in the final GFF Investment Case through a participatory identification process.** The Ministry of Public Health, Ministry of the Interior and project team are coordinating with the UNICEF regional office (Dakar), who is conducting a CRVS systems assessment for Cameroon in early 2016. Based on the results of the systems assessment, additional expertise will be hired via international and local consultants in mid-2016 to assist the government prioritize the activities to be supported by the GFF trust fund and develop the investment case chapter on CRVS.

58. **Sub-Component 2.3: Program coordination (US$5 million IDA, US$2 million GFF):** The project will support operating costs for the PBF Technical Unit and Project Implementation Unit (now housed within the PBF Technical Unit) for activities directly related to the project and the PBF program, including internal performance contracts for the PBF Technical Unit and other central departments at the Ministry of Public Health (Direction of Family Health, Direction of Health Promotion, Direction of Human Resources, Direction of Financial Resources and Planning, etc.) and programs playing a coordination role in the GFF (National Program for the reduction of Maternal and Child Mortality). These performance contracts are a tool to enhance governance and stewardship in the central Ministry of Public Health departments and are an essential part of the project.

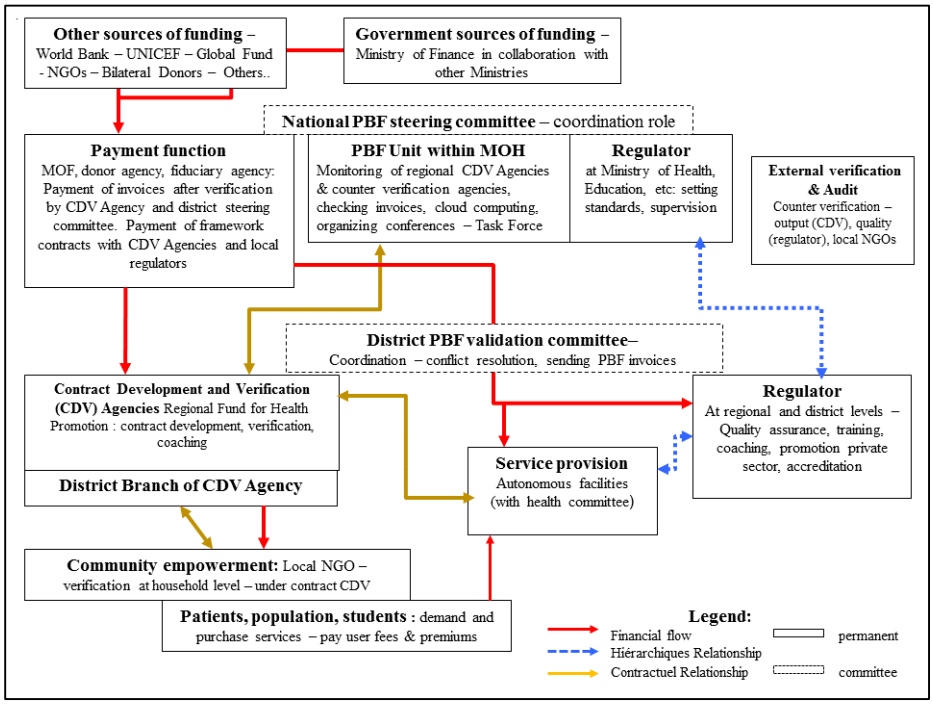
Annex 3: Implementation Arrangements

CAMEROON: Health System Performance Reinforcement Project

Project Institutional and Implementation Arrangements

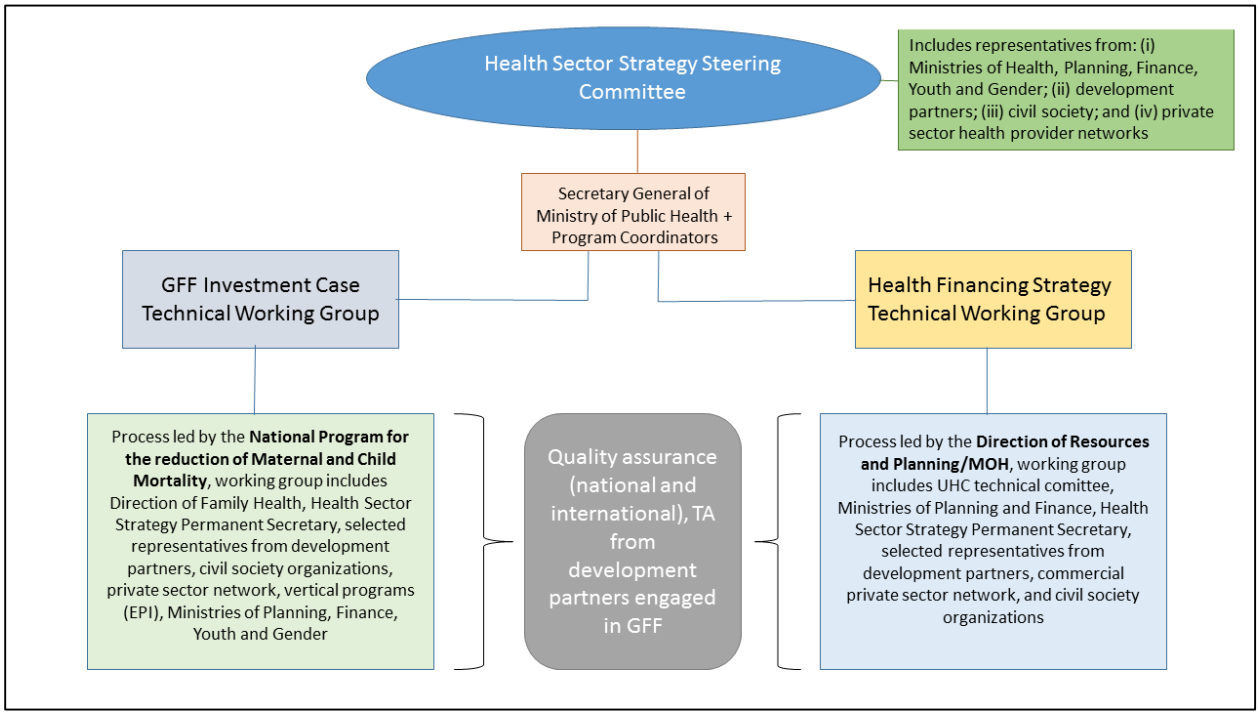
1. **At the central level of the Ministry of Public Health, the Health Sector Strategy Steering Committee (created in 2005), chaired by the Minister of Public Health, will oversee the achievement of the project's objectives.** Under the authority of the Health Sector Strategy Steering Committee, a specific project technical committee will be created to provide direct oversight and support to the project. To ensure institutional memory, the current steering committee of the HSSIP project will be converted into the technical committee for the new project. Chaired by the Director of the Division of Cooperation and Partnerships, the technical committee will include: (i) the most pertinent directorates of the MoPH; and (ii) key ministries whose support is needed for successful implementation and sustainability of PBF in Cameroon (Ministry of Economy and Planning and Ministry of Finance). The technical committee will be tasked to: (i) validate the overall strategic direction of the PBF program; (ii) validate the overall strategic direction of other interventions supported by the Project; (iii) ensure that the procedures set forth in the project implementation manual are followed; (iv) examine the different contracts and intervene where necessary to resolve issues; (v) monitor PBF and other activities' implementation and intervene where problem resolution may require the support of committee members; and (vi) disseminate the results of the evaluations with a view toward mobilizing additional resources and expanding the PBF approach in the country.

Figure 8: Implementation arrangements of the Cameroon PBF program



2. **Also, as part of the GFF process, the national GFF coordination platform will oversee achievement of interventions related to the GFF Investment Case and Health Financing Strategy.** The role and composition of the GFF platform (integrated into existing in-country coordination mechanisms) was validated during appraisal of the Project.

Figure 9: Cameroon GFF coordination platform



3. **Under the HSSIP, a dedicated PIU was established for day-to-day management of the project.** To institutionalize leadership and coordination of the PBF program within the government and across partners, in 2014 the MoPH established a National PBF Technical Unit responsible for day to day implementation of the program and for informing the HSS Steering Committee of the progress achieved in implementing the PBF approach. The PBF Technical Unit is currently staffed with four full-time staff recruited from various directorates of the MoPH and is tasked with: (i) developing norms and procedures for the PBF program; (ii) coordination and leadership of development partners, vertical programs and departments within the MoPH involved in the PBF program; (iii) conducting performance evaluation and coaching activities for decentralized actors such as the Regional Health Delegations, Contracting and Verification Agencies, and Regional Funds for Health Promotion; (iv) preparing and implementing PBF training programs; and (v) developing the scale-up plan for national coverage. The Coordinator of the PBF Technical Unit, co-Coordinator of the Unit, M&E expert and Judicial Services expert have all been appointed by the Minister of Public Health through a merit-based internal competitive process.

Project administration mechanisms

4. **Under the proposed operation no dedicated PIU external to the ministry will be created, as was the case for the HSSIP.** The National PBF Technical Unit will be tasked with overseeing both coordination of the overall PBF program as well as specific project implementation. The fiduciary requirements of the PBF Technical Unit will increase substantially as the entirety of responsibilities from the HSSIP PIU will be transferred to the PBF unit. The four staff will remain under the proposed operation and will be reinforced through the recruitment of additional staff and experts. As the experience with the HSSIP staff was highly satisfactory and they hold invaluable experience and knowledge in implementation of the PBF program, the majority of staff from the HSSIP PIU will be transferred to PBF Technical Unit. These include the Financial Management Specialist, the Procurement Specialist, the Accountant and Assistant Accountant, and Internal Auditor. Other experts, such as a PBF Expert, a Public Health expert, a Health System Reform Expert, a Health Economist, an Indigenous Peoples and Health Specialist a Pharmaceutical Specialist, a Communications Expert, and a Monitoring and Evaluation Specialist (with international experience in PBF as well as experience in computer programming) will be recruited in accordance with IDA guidelines for the selection of consultants. Other experts may be recruited on a need basis.

5. **The project will also support the recruitment of additional technical staff to support the programs and departments involved in GFF-related processe**s. These include a Reproductive Health Specialist and Monitoring and Evaluation Specialist (with international experience) for the National Program for the reduction of Maternal and Child Mortality and a Health Economist and Health Financing Expert for the Department of Financial Resources and Planning within the Ministry of Public Health.

6. **The project policies and procedures will be incorporated in a project implementation manual.** It will be completed by a national PBF manual prepared by the PBF Technical Unit. The PBF Technical Unit and the Bank will ensure that implementation manuals prepared by the CDVAs are consistent with each other and with the project's overall implementation manual, safeguard instruments and national PBF manual.

7. **As mentioned above, the project will continue to use Contracting and Verification Agencies in the seven regions currently covered by the HSSIP,** and will establish agencies in the remaining three regions. CDVAs will be tasked with contracting and coaching health service providers and regulatory agents (Regional Health Delegations and District Medical Teams), contracting community-based organizations for community verification, and verification of declared results by contracted agents. Upon verification, CDVAs will send payment requests through the PBF portal (www.fbrcameroun.org), which will be received, validated and processed by the National PBF Technical Unit. Payments will be made directly to health facilities and regulatory bodies, each of which will have their own independent bank account. CDVAs will pay Community-Based Organizations directly for community verification activities.

8. **Counter-verification of the program's results will be conducted by an independent third party.** The independent External Evaluation Agency will be contracted by the Ministry of

Public Health within nine months of effectiveness. The EEA's roles will include ex-post fact verification of service volumes and quality delivered by health facilities contracted with the PPA and for which PBF payments have been made.

9. **Performance contracts will be established with technical departments and vertical programs at the central level of the MoPH.** A multi-stakeholder committee composed of the PBF Technical Unit, representatives from the Ministry of Economy and Planning, and the Ministry of Finance, and development partners will be created to evaluate these departments and verify results achieved prior to payment. The national PBF manual will be the strategic document providing operational guidelines for implementation of the PBF-related activities.

10. **The financing will comply with the existing manual of procedures and funds received and expenses will be included in Quarterly financial reports according to the same format.**

11. **All project funds will be subject to a financial audit following existing audit arrangements.** The terms of reference of existing independent external auditor will be amended to take into account this financing.

Financial Management, Disbursements and Procurement Arrangements

Financial Management Arrangements

12. **The proposed FM arrangements under the project satisfies the Bank's minimum requirements under OP/BP10.00,** and therefore is adequate to provide, with reasonable assurance, accurate and timely information on the status of the project as required by IDA. With regards to the complexity of the project that will include performance-based rewards and will involve many implementing agencies and stakeholders, the preliminary FM risk is assessed as substantial

13. **The new operation will transfer fiduciary and coordination responsibilities of the project from the PIU under the HSSIP to the National PBF Technical Unit.** That being said, the new operation will build upon the experience and skills of the PIU developed under the HSSIP by transferring the existing financial management team from the original HSSIP project to the PBF unit. The Project Implementation Unit comprises one Finance and Administrative Officer, one Accountant, one Assistant Accountant and one Internal Auditor. They are well qualified and experienced in World Bank financed projects and have been adequately managing the ongoing operation as substantiated by the last FM supervision rating which was assessed as Satisfactory. In addition a dedicated accountant will be recruited to reinforce the accounting team.

14. The detailed FM arrangements are as follows:

Staffing:

15. The project FM team that comprises an FM officer and an accountant under the current project will be strengthened to take into account the new scope of the project that will include all ten

(10) regions of the country. This will be done through a progressive competitive recruitment approach at central level aimed at recruiting four (4) accountants earlier in 2017 and two additional (2) in 2018. Such team reinforcement will be assessed with accuracy during implementation

Budgeting:

16. **The project budget process (elaboration, implementation and monitoring) will be clearly stipulated in the Project procedures Manual that would include detailed accounting financial and administrative procedures.** The annual work program and budgets will be prepared by the PBF Technical Unit in coordination with all the implementing entities and submitted to the Steering Committee for approval before the beginning of the year. The Steering Committee would also approve changes in the budget and revised action plans. The annual budget would be managed through the accounting software.

Accounting:

17. **Project accounting, policies and procedures will be documented in the FM section of the manual.** The Accounting software used by the ongoing HSSIP project and set under its multi-project and multi-site version will be customized to record all the project's transactions following Bank guidelines, and to prepare the financial statements for the project. The accounting team is familiar with handling accounting and reporting activities through the software consistent with Bank procedures. That team will be reinforced with a new accountant to be recruited.

Internal control and internal auditing

18. ***Internal Control Systems:*** The MoPH will prepare the project implementation manual including internal controls, budget process, assets safeguards, and roles and responsibilities of all the stakeholders based on the provisions of the existing implementation manual of the HSSIP. PBF implementation procedures will also be summarily included in the implementation manual and detailed in a specific PBF manual that would specify among other (i) credible unit costs that will be taken into account in budget elaboration, (ii) the criteria to be eligible to PBF, (iii) the results control process.

19. ***Internal Auditing****:* The intervention scope of the internal audit unit of the HSSIP will be extended to the new project's activities. Internal audit field missions (including PBF activities) will be conducted on a risk-based approach that will include ensuring that CDVA and NGO activities are compliant with their contracts, payments are effective and made to the correct beneficiaries and that transactions are processed in a timely manner.

20. **With regards to the PBF activities, the Internal Audit unit would team up with the independent verification agent to ensure the verification of the PBF outputs are compliant with the specified and agreed technical and quality standards**.

Financial Reporting

21. **The PBF Technical Unit will produce quarterly unaudited Interim Financial Reports (IFRs) during project implementation encompassing activities for all components.** The IFRs are to be produced on a quarterly basis and submitted to the Bank within 45 days after the end of the calendar quarterly period. The IFR will present the financial statements (sources and used of funds and use of funds per component/categories/activities). The reporting procedures and content will be described in the project procedures manual. The reporting format would comprise (i) a statement of funds received and used which included cash payment and cash balances; (ii) detailed used of funds including amount and beneficiaries; and (iii) a statement of commitment.

22. With regards to the PBF component, reports (records) evidencing the performance-based outputs will be produced by the CVAs and validated by the PBF technical Unit to support subsequent payments.

23. **The PBF Technical Unit will also produce the project's Annual Financial Statements and these statements will comply with SYSCOHADA and World Bank requirements.** These Financial Statements will be comprised of:

    - Statement of Sources and Uses of Funds which includes all cash receipts, cash payments and cash balances
    - Statement of Commitments
    - Accounting Policies Adopted and Explanatory Notes
    - A Management Assertion that project funds have been expended for the intended purposes as specified in the relevant financing agreements.

24. **The contracted NGOs and Verification Agencies will receive advances** to cover their operational costs and will be subjected to reporting arrangements that will be described in their contracts.

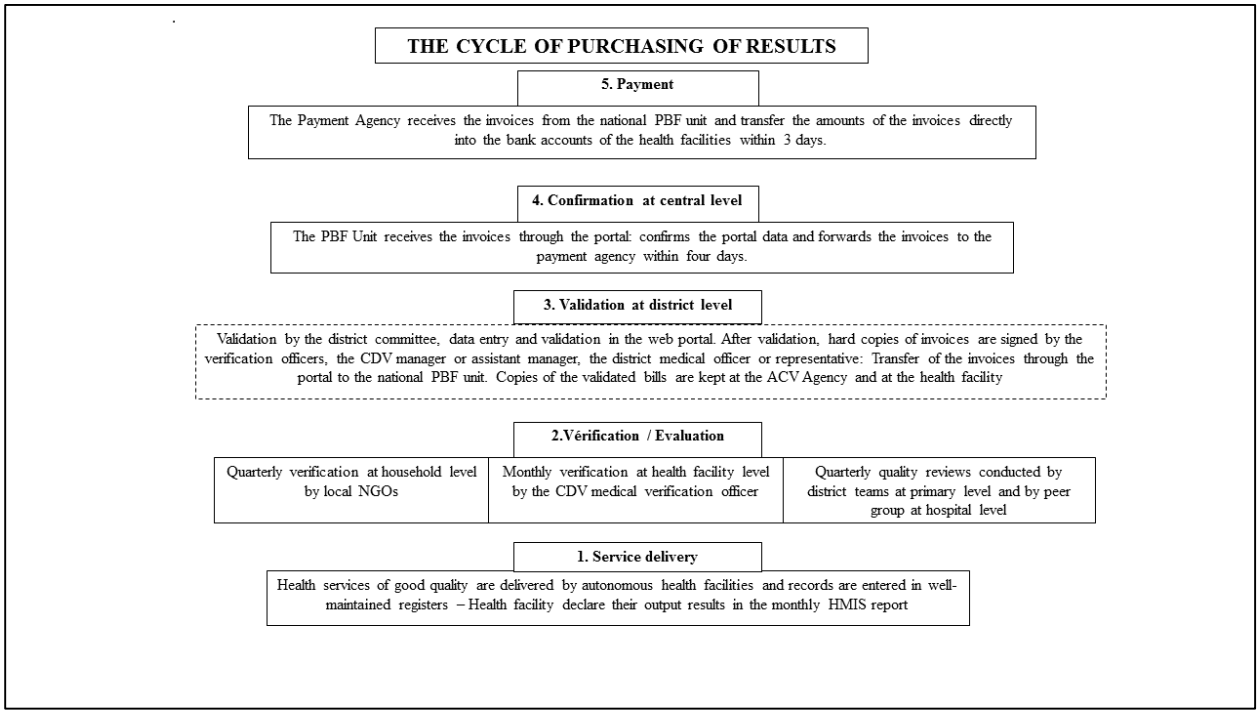
Auditing

25. **The Financing Agreement requires the submission of Audited Financial Statements for Projects to IDA within six months after the end of each fiscal year.** The audit reports should reflect all the activities of the project. Due to the large scope of the project, five (5) external auditors with qualification and experience satisfactory to the World Bank will be recruited to conduct annual audits of the project financial statement (PFS). Each of them will be dedicated to two regions and one of them will conduct audit activities at the PBF technical unit in addition to his affected regions. Appropriate terms of reference for the external auditors will therefore be provided to the project team. The external auditors will prepare a Management Letter giving observations and comments, providing recommendations for improvements in accounting records, systems, controls and compliance with financial covenants in the Financial Agreement. The external audit arrangements (number of audit firms to be recruited) will be reviewed within the first month of implementation.

Funds Flow and Disbursements arrangements

26. **The financial roles of the purchasing agencies contracted will change under the new operation.** Under the original operation and AF, PPAs main activities were contracting, verification and subsidy payments to contracted providers upon validation by the PIU. Under the new project design, the payment component of the agency will be removed, allowing them to focus efforts on their other responsibilities (contract management, verification and coaching). Upon validation of payment requests by the National PBF Technical Unit, the fiduciary arm of the unit will make direct payments to health centers, bypassing the transitory PPA bank account that existed under the current operation. As each provider is obligated to have an independent bank account, direct payment transfers between the PIU and providers is possible. As such, PBF implementation agencies will no longer be called Performance Purchasing Agencies but Contracting and Verification Agencies. An example of this model is the Burkina Faso PBF program. It is expected that the new model will: (i) reduce transaction time between validation of results and reception of PBF subsidies, (ii) reduce operational costs of agencies as their fiduciary role will be substantially reduced, and (iii) allow the PIU to focus on its main task in the new national model, which is to be primarily one payer of PBF subsidies among various payment sources (other partners and the government). However, the accounting role of the PPAs/CDVAs will be maintained for verification and record of financial transactions in the PBF portal. It is expected that their accounting team will comprise an accountant, an assistant accountant and a pool of two (2) to five (5) accountants (depending on the workload) dedicated to record purposes in the PBF portal.

Figure 10: Verification and payment procedures for PBF subsidies



27. **For Component 1, after verification of reported results, CDVAs will address a request to the National PBF Technical Unit through the online portal, followed by sending of relevant documents and the technical unit will transfer funds to the contracted health facilities for services rendered in the health sector.** Each CDVA and NGOs will open an operational account in commercial banks, acceptable to IDA.

28. **Designated account**. Funds will be transferred from the Bank to the Designated Accounts in Euros. Four (4) Designated Accounts (DA-A to D) will be opened in XAF at the Standard Chartered Bank of Cameroon and managed by the CAA: DA- A to D will be segregated. Activities to be financed under each DA is detailed in the respective Disbursement Letter (DL). For each Designated Account a correspondent operational account will be opened in the Standard Chartered Bank of Cameroon and managed by the PBF technical unit. Disbursements will be made to the DAs from which transfers will be made to the operational account. Health facilities, NGOs and CDVAs bank accounts will be replenished from the PBF unit operational account. The same will apply to others services providers and suppliers.

29. **Disbursement methods*:*** The following disbursement methods may be used under the project: reimbursement, advance, direct payment and special commitment as specified in the Disbursement Letter (DL) and in accordance with the World Bank Disbursement Guidelines for Projects, dated May 1, 2006. The disbursement will be report based for all DAs with a specificity for DA-A that will disburse based on a report that includes records evidencing the performance-based payments. The ceiling for DA-A (PBF component) will be fixed at XAF 4 Billion and for DAs-B to D will be flexible (based on the expenditure forecast for the first 6 months after project effectiveness). Following effectiveness, the PBF unit will submit an initial advance request that will be made into the Designated Accounts and subsequent disbursements will be made on a quarterly basis (or as needed) against submission of IFRs or performance based reports (PBF component) as specified in the Disbursement Letters.

30. As DA-B and DA-C will finance using a pari pasu mechanism with a shared percentage of 60%-40% from IDA and GFF, respectively.

31. **All replenishments or reimbursement applications will be fully documented.** Documentation will be retained at the PBF Technical unit for review by Bank staff members and external auditors.

32. The funds flows arrangements are described below.

Figure 11: Fund flows for IDA & GFF

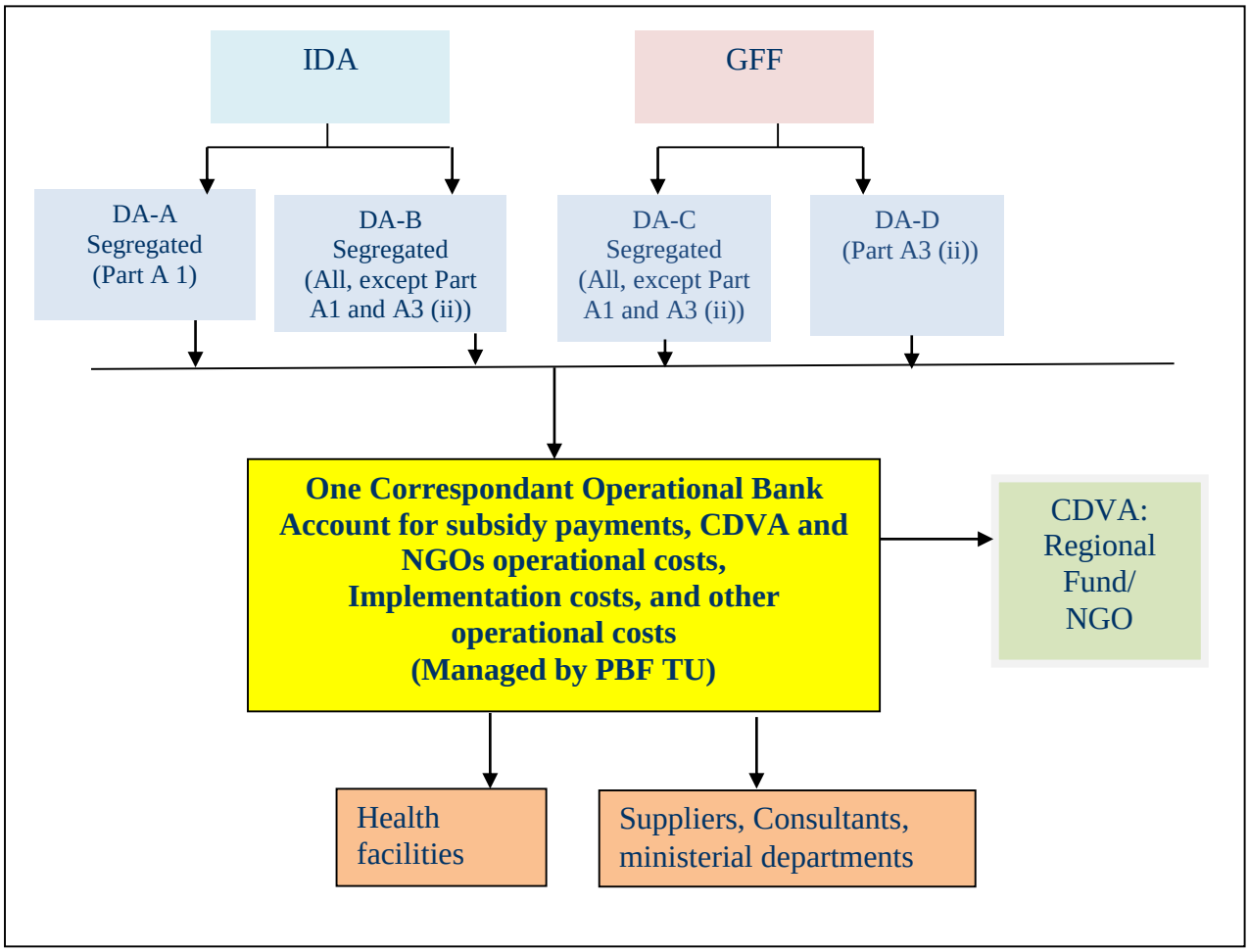


Table 6: Financial Management action plan

Area of Weaknesses	**Action**	**Responsible party**	**Deadline**
Key staff	Recruit Financial Management Specialist	*PBF unit*	*Before effectiveness*
Staffing	Recruit Accountant, Assistant Accountant, Internal Auditor Recruit four (4) accountants earlier in 2017 and two additional (2) in 2018	*PBF Unit* *PBF unit*	*2 months after effectiveness* *2017/2018 (depending on actual needs)*
Internal Controls	Draft a new manual of procedures taking into account the specificities of the new project	*PBF unit*	*Before effectiveness*

Area of Weaknesses	Action	Responsible party	Deadline
Accounting & Reporting	Customize the accounting software to fit the new project needs.	*PBF unit*	*Two months after effectiveness*
External audit	Recruit five (5) external auditors, each of them dedicated to two regions	*PBF unit*	*Within 5 months of effectiveness*

Implementation FM Support Plan

33. **Based on the outcome of the FM risk assessment, the following implementation support plan is proposed based on the project FM residual rating of substantial**. The objective of the implementation support plan is to ensure a satisfactory financial management system is maintained throughout the project's life.

Table 7: Financial Management implementation support plan

FM Activity	Frequency
Desk reviews	
Interim financial reports review	Quarterly
Internal Audit report review of the program	Quarterly/ Risk based approach basis
External Audit report review of the program	Annually
Review of other relevant information such as interim internal control systems reports.	Continuous as they become available
Review of overall operation of the FM system	Bi-annual
Monitoring of actions taken on issues highlighted in audit reports, auditors' management letters, internal audit and other reports	As needed
Transaction reviews (if needed)	As needed
FM training sessions	During implementation and as and when needed.

34. **Financial Covenants**

a) A financial management system including records, accounts and preparation of related financial statements shall be maintained in accordance with accounting standards acceptable to the Bank.

b) The Financial Statements will be audited in accordance with international auditing standards. The Audited Financial Statements for each period shall be furnished to the Association not later than six (6) months after the end of the project fiscal year. The Borrower shall therefore recruit an external auditor not later than six (6) months of effectiveness

c) The Borrower shall prepare and furnish to the Association not later than 45 days after the end of each calendar quarter, interim un-audited financial reports for the Project, in form and substance satisfactory to the Association

d) The Borrower will be compliant with all the rules and procedures required for withdrawals from the Designated Accounts of the project.

Conclusion of the assessment

35. **Based on the Bank's assessment, the FM residual risk for the Project is deemed Substantial.** The proposed FM arrangements are considered satisfactory in fulfillment of the requirements under Bank OP 10.00. The implementing entity will ensure that the Bank's Guidelines*: Preventing and Combating Fraud and Corruption in Projects financed by IBRD Loans and IDA Credits and Grants* (dated October 15, 2006 and revised January 2011) are followed under the project.

Procurement

Guidelines

36. Procurement for Cameroon Health System Performance Reinforcement Project will be carried out in accordance with the World Bank "Guidelines: Procurement of Goods, Works, and Non-Consulting Services under International Bank for Reconstruction and Development (IBRD) Loans and IDA Credits & Grants by World Bank Borrowers" dated January, 2011, revised July 2014; and "Guidelines: Selection and Employment of Consultants under IBRD Loans and IDA Credit & Grants by World Bank Borrowers", dated January, 2011, revised July 2014, and the provisions stipulated in the Legal Agreement. Procurement (works, goods and non-consulting services) or Consultant Selection methods, prequalification, estimated costs, prior review requirements, and time-frame are agreed in the Procurement Plan. The Procurement Plan will be updated at least annually or as required to reflect the actual project implementation. The Bank's Standard Bidding Documents (SBD) or Cameroon National Standard Bidding Documents satisfactory to the Association will be used. To the extent practicable the Bank's Standard Bidding Documents for works, goods and Non- Consulting Services and Standard Request for Proposals, as well as all standard evaluation forms, will be used throughout project implementation.

Advertising

37. The Borrower is required to prepare and submit to the Bank a General Procurement Notice (GPN). The Bank will arrange for its publication in UN Development Business online (UNDB online) and on the Bank's external website. The General Procurement Notice shall contain information concerning the Borrower, amount and purpose of the credit, scope of procurement reflecting the Procurement Plan, and the name, telephone (or fax) number, and address (es) of the Borrower's agency (ies) responsible for procurement, and the address of a widely used electronic portal with free national and international access or website where the subsequent Specific Procurement Notices will be posted. If known, the scheduled date for availability of prequalification or bidding documents should be indicated. The related prequalification or bidding documents, as the case may be, shall not be released to the public earlier than the date of publication of the General Procurement Notice.

38. In the case of ICB or LIB, invitations to prequalify or to bid, as the case may be, shall be advertised as Specific Procurement Notices in at least one newspaper of national circulation in the Borrower's country, or in the official gazette, or on a widely used website or electronic portal with free national and international access, in English, French, or Spanish, or at the option of the Borrower, in a national language. Such invitations shall also be published in UNDB online. Notification shall be given in sufficient time to enable prospective bidders to obtain prequalification or bidding documents and prepare and submit their responses. The Bank will arrange the simultaneous publication of all Specific Procurement Notices prepared and submitted by the Borrowers on the Bank's external website.

39. In the case of National Competitive Bidding (NCB), the complete text of advertisement shall be published in a national newspaper of wide circulation in the National Language, or in the official gazette, provided that it is of wide circulation, or on a widely used website or electronic portal with free national and international access. The Borrower may publish a shorter version of the advertisement text, including the minimum relevant information, in the national press provided that the full text is simultaneously published in the official gazette or on a widely used website or electronic portal with free national and international access. Notification shall be given to prospective bidders in sufficient time to enable them to obtain relevant documents.

40. To obtain expressions of interest (EOIs), the Borrower shall include a list of expected consulting assignments in the General Procurement Notice, and shall advertise a request for expressions of interest (REOI) for each contract for consulting firms in the national gazette, provided that it is of wide circulation, or in at least one newspaper, or technical or financial magazine, of national circulation in the Borrower's country, or in a widely used electronic portal with free national and international access in English, French, or Spanish.

41. **Requirements for National Competitive Bidding:** Goods and non-consulting services contracts will use NCB procurement methods in accordance with national procedures using SBDs acceptable to IDA and subject to the additional requirements:

42. In accordance with paragraph 1.16 (e) of the Procurement Guidelines, each bidding document and contract financed out of the proceeds of the financing shall provide that: (i) the bidders, suppliers, contractors and their subcontractors, agents, personnel, consultants, service providers, or suppliers shall permit the World Bank as Supervising Entity, at its request, to inspect all accounts, records, and other documents relating to the submission of bids and contract performance, and to have said accounts and records audited by auditors appointed by the World Bank/Supervising Entity; and (ii) the deliberate and material violation of such provision may amount to an obstructive practice as defined in paragraph 1.16 (a) (v).
    - The invitations to bid shall be advertised in national newspapers with wide circulation.
    - The bid evaluation, qualification of bidders, and contract award criteria shall be clearly indicated in the bidding documents.
    - The bidders shall be given adequate response time (at least four weeks) to submit bids from the date of the invitation to bid or the date of availability of bidding documents, whichever is later.
    - Eligible bidders, including foreign bidders, shall be allowed to participate.

- No domestic preference shall be given to domestic contractors or to domestically process manufacturing goods; and association with a national firm shall not be a condition for participation in a bidding process.
- Bids are awarded to the most substantially responsive and the lowest evaluated bidder proven this bidder is qualified. No scoring system shall be allowed for the evaluation of bids and no "blanket" limitation to the number of lots that can be awarded to a bidder shall apply.
- Qualification criteria shall only concern the bidder's capability and resources to perform the contract, taking into account objective and measurable factors.
- Fees charged for the bidding documents shall be reasonable and reflect only the cost of their printing and delivery to prospective bidders, and shall not be so high as to discourage qualified bidders.

43. **Procurement Environment**: Recent changes in the Cameroon legislation have modified the institutional architecture of the bodies responsible for public procurement in the country. The new organizational structure was introduced through three decrees issued on 8 March, 2012, and recently on August 5, 2013. No special exceptions, permits or licenses need to be specified in the Financing Agreement since the procurement code, approved by the President of the Republic in September, 2004 allows International Development Association (IDA) procedures to take precedence over any contrary provisions in local regulations.

44. Procurement arrangements for Bank-financed projects in Cameroon have been under discussion for some time as the national system has been revised to shift responsibility for the bulk of procurement and contract management from decentralized agencies to a newly created MINMAP. IDA fielded a procurement mission between October 31 and November 10, 2012 to assess the potential effects of these changes and notably the possible consequences on Bank financed projects in Cameroon. The mission concluded that the new centralized system could lead to a number of positive outcomes. However, concerns were raised with respect to technical and legal responsibilities as well as regulatory issues. This mission was followed by another one conducted jointly with other Development Partners based in Cameroon during the period of January 28 to February 3, 2013, in order to: (a) discuss the recommendations of the initial mission; (b) facilitate the transition from the old to the new procurement system; and (c) ensure the smooth implementation of the Bank financed projects. MINMAP has confirmed in writing to the Bank that it accepts the proposed short term measures of the donors concerning existing projects as identified in the documents of negotiations and the legal agreements, which consist of the creation of special tender boards with full procurement responsibility and the Program Coordination Unit (''*Maître d'Ouvrage''*) in charge of the publication of tenders, contracts award and signature of all contracts.

45. Specific procurement arrangements for this Project: Procurement for activities to be carried out for the project, will be the responsibility of the PBF Technical Unit with the technical support of the special tenders board set up by MINMAP Decree 006/A/MINMAP on May 8th 2013 modified by Decree 00000181/A/MINMAP on August 17th 2015. The mandate of this body should be broadened to cover the procurement of this project.

46. **Procurement of Works**: Each contract estimated to cost more than US$200,000 and less than US$10,000,000 will be conducted through national competitive bidding, in accordance with national procedures using standard bidding document acceptable to IDA. Small works estimated to cost less than US$200,000 equivalent per contract may be procured through shopping, based on price quotation obtained from at least three contractors in response to a written invitation to qualified contractors.

47. **Procurement of Goods and Non Consulting Services**: Goods procured under this Project would include vehicles, furniture and office equipment. Taking into account (level of value added) manufacturing/producers capacity in the country, procurement of goods will be bulked where feasible (similar nature and need at same time period) into bid packages of at least US$1 million equivalent, so that they can be procured through suitable methods to secure competitive prices. Goods estimated to cost US$1 million equivalent and above per contract will be procured through ICB, which will use the Bank's Standard Bidding Documents. For other goods contracts costing less than US$1.0 million equivalent, NCB procurement methods will be used in accordance with national procedures using Standard Bidding Document acceptable to Word Bank and subject to the additional requirements set forth or referred to above in paragraph on Requirements for National Competitive Bidding.

48. Procurement of goods and non-consulting services, including those of readily available off the-shelf maintenance of the office electronic equipment and other services such as printing, and editing, which cannot be grouped into bid packages of US$100,000 or more, may be procured through prudent shopping in conformity with Clause 3.5 of the procurement guidelines.

49. Based on country-specific needs and circumstances, shopping thresholds for the purchase of vehicles and fuel may be increased up to US$500,000, considering the major car dealers and oil providers are consulted. At the beginning of the project, vehicles procurement packages estimated to cost US$200,000 or less can be procured through UNOPS or other United Nations agencies.

50. **Selection of Consultants:** Consulting services will be needed for the following activities: (a) technical assistance; (b) feasibility studies and any other critical studies; (c) technical and financial audit. These consulting services will be procured with the most appropriate method among the following which are allowed by Bank guidelines and included in the approved procurement plan: Quality-and Cost-Based Selection (QCBS), Quality-Based Selection (QBS), Selection under a Fixed Budget (SFB), Least-Cost Selection (LCS). Selection based on Consultants' Qualifications (CQS) will be used for assignments that shall not exceed US$300,000. Single Source selection shall also be used in accordance with the provisions of paragraphs 3.9 to 3.13 of the Consultant Guidelines, with World Bank's prior agreement. All terms of reference will be subject to World Bank Prior Review.

51. Assignments of Engineering Designs & Contract Supervision in excess of US$300,000, and all other technical Assistance assignments above US$100,000, must be procured on the basis of international short-lists and in accordance with the provisions of the paragraph 2.6 of the consultants' guidelines.

52. Consultants for services meeting the requirements of Section V of the consultant guidelines will be selected under the provisions for the Selection of Individual Consultants, through comparison of qualifications among candidates expressing interest in the assignment or approached directly.

53. **Operating Costs** financed by the project include, inter alia, utilities and offices supplies, vehicle operation, maintenance and insurance, building and equipment maintenance costs. They will be procured using the project's financial and administrative procedures included in the operation manual and based on the annual work plan and budget. For services (car maintenance, computers maintenance, etc.) to be financed through operating costs, the project will proceed by service contracting for a defined period.

54. **Trainings, Workshops, Seminars, Conferences and Study Tours** will be carried out on the basis of approved annual work plan and budget that will identify the general framework of training and similar activities for the year, including the nature of training, study tours, workshops, the number of participants, and cost estimates.

55. **Capacity assessment of the Implementation Arrangements for procurement.** The Appraisal mission and government counterparts reviewed all institutional arrangements for the Project. It was confirmed that different to the ongoing health project, the new operation will not have a dedicated Project Implementation Unit but will be implemented by the PBF Technical Unit within the Ministry of Public Health. As such, the fiduciary requirements of the PBF Technical Unit will increase substantially as the fiduciary responsibilities of the HSSIP PIU will be transferred to the PBF unit.

56. The new operation will transfer fiduciary and coordination responsibilities of the project from the PIU under the HSSIP (P104525) to the National PBF Technical Unit, including compliance with procurement procedures. That being said, the new operation will build upon the experience and skills of the PIU developed under the HSSIP. An assessment of these procurement arrangements of the project has been carried out and the procurement assessment recommended the following mitigation measures for PFB Technical Unit: (i) recruitment of qualified procurement specialist, (ii) establishment of an administrative and financial manual to include procurement arrangements related to this project, and (iii) installation of a comprehensive record keeping system. Details are provided in a mitigation action plan below.

57. The two manuals (Project Implementation Manual PIM-and the Administrative, Financial and Accounting Manual) used under the HSSIP (P104525) will be revised to take into account existence of the National PBF Technical Unit, MINMAP and the new procurement environment. To ensure that the above mentioned procurement corrective measures will be met in due time, an action plan is proposed hereafter with tasks to be performed, responsible body as well as time-frame:

Table 8: Procurement action plan

Action to be undertaken	Timeframe	Responsible body
1. Recruitment of Procurement Specialist	By effectiveness	PBF Technical Unit
2. Elaboration and submission of a procurement plan to the World Bank	Final version was discussed during negotiations	PBF Technical Unit
3. Updating and submitting to IDA the project Implementation Manual and the Administrative Financial and Accountant Manual, comprising a section on procurement for use by the project	Final documents by effectiveness	PBF Technical Unit
4. Select and Maintain during the project's life a procurement specialist with experience and knowledge acceptable to the World Bank	By effectiveness	PBF Technical Unit
5. Creation of a special tender board "*Commission spéciale de Passation des Marchés* " (CSPM), which is acceptable to the Bank, through the revision of the HSSIP (P104525) CSPM decree to extend its use to the current Cameroon Health System Performance Reinforcement Project.	By effectiveness	PBF Technical Unit/MINMAP

58. Overall **project procurement risks**: The overall procurement risk for the project is rated as High**.** This is due to, among other factors, the country environment risk of corruption in procurement, especially in public contracts, the relatively limited experience in the implementation of Bank-financed projects for PBF Technical Unit and MINMAP, the potential conflict of interest for MINMAP in relation to the management of complaints linked to contracts directly handled by MINMAP. Mitigation action plans have been agreed upon, which, if properly implemented and monitored, will bring this risk down to Substantial**.**

59. **Procurement plan**: A procurement plan satisfactory to the Bank for project implementation, providing the basis for the procurement methods was prepared during appraisal. This plan which covers the first 18 months of project implementation was discussed and agreed upon by the Borrower and the project team at negotiations. It will be available in the Project's database and a summary will be disclosed on the Bank's external website once the project is approved by IDA Board of Executive Directors. The Procurement Plan will be updated in agreement with the Project Team at least annually or as required to reflect the actual project implementation needs and improvement in institutional capacity.

60. **Publication of Results and Debriefing**: The Borrower shall publish information on UNDB online for all contracts under ICB and LIB, and all direct contracts, and in the National press

for all contracts under NCB. Such publication shall be within two weeks of receiving the Bank's no objection to the award recommendation for contracts subject to the Bank's prior review, and within two weeks of the Borrower's award decision for contracts subject to the Bank's post review. The disclosure of results is also required for selection of consultants. The Borrower shall publish information on UNDB online for all contracts when the short list included any foreign firm and all single-source selection contracts awarded to foreign firms, and in the National press all contracts where the short list comprises only National firms and all single-source selection contracts awarded to National firms. Such publication shall be within two weeks after receiving the Bank's no objection for award of the contract subject to the Bank's prior review, and within two weeks of successful negotiations with the selected firm for contracts subject to the Bank's post review.

61. **Fraud and Corruption**: The procuring entity as well as Bidders/Suppliers/Contractors/ Services Providers shall observe the highest standard of ethics during the procurement and execution of contracts financed under the program in accordance with paragraphs 1.16 and 1.17 of the Procurement Guidelines and paragraphs 1.23 and 1.24 of the Consultants Guidelines. The Guidelines on Preventing and Combating Fraud and Corruption in Projects Financed by IBRD Loans and IDA Credits and Grants", dated October 15, 2006, and revised in January, 2011, will apply to this project.

62. **Frequency of Procurement Supervision**: The capacity assessment of the implementing agency has recommended support missions at least twice a year and a post review of procurement actions will be conducted on an annual basis and no less than one in five contracts should be reviewed.

63. **Summarized Procurement Plan:** The main works, goods and non-consulting services to be procured in the project are listed in table below:

Table 9: Procurement plan for works, goods and non-consulting services

1	2	3	4	5	6	7	8	9
Ref. No.	**Contract (Description)**	**Estimated Cost in USD**	**Procurement Method**	**Pre-qualification (yes/no)**	**Domestic Preference (yes/no)**	**Review by Bank (Prior / Post)**	**Expected Bid-Opening Date**	**Comments**
1	Supply and installation of office equipment and furniture and fixtures	250,000	National offers	No	No	Post	September 30, 2016	
2	Purchase of 06 double cabin pick-up vehicles	385,000	UNOPS	No	No	Prior	September 1, 2016	
3	Recruitment of rapid money transfer agency	65,000	Provider consultations	No	No	Post	September 30, 2016	
4	Staff and vehicle insurance	80,000	Provider consultations	No	No	Post	September 30, 2016	

64. Prior **review thresholds for Works, Goods and Non-consultant services:** Contracts estimated to cost above US$5 million for works and US$0.5 million for goods per contract, all Direct Contracting with cost above US$100,000 and eventually others as identified in the procurement plan will be subject to prior review by the World Bank.

65. The main consulting assignments of the project are listed in the table below.

Table 10: Procurement plan for consulting services

1	2	3	4	5	6	7
Ref. No.	**Description of Assignment**	**Estimated Cost in USD**	**Selection Method**	**Review by Bank (Prior / Post)**	**Expected Proposals Submission Date**	**Comments**
1	Consultant for elaboration of PBF manual	40,000	Individual Consultant	Post	March 30, 2016	Completed
2	Consultant for elaboration of project implementation manual	30,000	Least Cost Selection	Post	March 30, 2016	Completed
3	Financial auditing firm	90,000	Individual Consultant	Post	March 1, 2017	
4	Communication Expert	41,000	Individual Consultant	Post	September 30, 2016	
5	Pharmaceutical Expert	41,000	Individual Consultant	Post	September 30, 2016	
6	Monitoring and Evaluation Expert	41,000	Individual Consultant	Post	September 30, 2016	
7	Health Financing Expert	41,000	Individual Consultant	Post	September 30, 2016	
8	Procurement Expert	41,000	Individual Consultant	Prior	September 30, 2016	
9	PBF Expert	41,000	Individual Consultant	Post	September 30, 2016	
10	Public Health Expert	41,000	Individual Consultant	Post	September 30, 2016	
11	Firm for PBF Counter Verification	100,000	Consultant Qualifications	Post	October 30, 2016	
12	Consultant for updating FM information system	60,000	Individual Consultant	Post	October 30, 2016	

66. **Prior review thresholds for consultant services:** Consultant services estimated to cost above US$200,000 for firms, US$100,000 for individuals, US$100,000 for Single Source selection of consultants (firms and individuals) per contract and eventually others as identified in the procurement plan will be subject to prior review by the World Bank. Short Lists of Consultants for Assignments of Engineering Designs & Contract Supervisions estimated to cost less than US$300,000 and all other Consultancy Assignments whose estimated cost don't exceed US$100,000 per contract may be composed entirely of national consultants in accordance with the provisions of paragraph 2.7 of the Consultant Guidelines.

Environmental and Social (including safeguards)

Social (including safeguards)

67. **The project is expected to have a positive social impact by improving access to health care services for the poorest households, particularly in zones where the Social Safety Nets Project is also being implemented.** Component 1 (through the payment for performance) will provide incentives for health facilities to reduce staff absenteeism and to

improve staff responsiveness with patients, as well as provide free care to the poor and vulnerable.

68. **Indigenous Peoples live in the East and South region and therefore OP/BP 4.10 has been triggered in order to ensure that these populations will benefit from the project in culturally appropriate and effective ways.** A social assessment was undertaken during preparation in order to evaluate access and quality of health care provided to indigenous peoples under the original project as well as identify ways in which the project design could be improved in order to increase the coverage and effectiveness of the services being supported under this project. The social assessment found that the Performance Purchasing Agency in the East introduced specific measures to ensure indigenous peoples in the region are benefitting from the improved availability and quality of health services in their areas. At the same time, it identified several key areas in which adaptations should be made and these have been included as specific measures in the Indigenous Peoples Action Plan that has been prepared and disclosed per the requirements of the policy. The IPPF/IPP was disclosed in country and in the Infoshop on February 25, 2016. The Action Plan also includes indicators and budget that will be used during project implementation to evaluate progress and results.

69. **The project is expected to have a positive impact for women in Cameroon.** Given that the project's main objectives are to improve reproductive, maternal and child and nutrition services, improving women's health is an essential component of this intervention. Particular attention will be given to ensuring active participation of women in project implementation especially as it relates to health choices and care at the community level.

70. **The government and Bank have been actively engaged in dialogue over the current HSSIP project in Cameroon.** This project has enabled the Bank team to conduct an ongoing dialogue with the government and beneficiaries at both the national and local levels. The components of this project build on lessons learned from the previous project and use the existing consultation and participation platforms.

Environment (including Safeguards)

71. **The project is rated as Environmental Assessment (EA) category B**. Activities related to the proposed project may lead to an increase in Medical Waste, this waste may be considered as adverse environmental impacts of the project.

72. **Two safeguard policies are triggered by the project, the first is OP/BP 4.01 Environmental Assessment because of the potential negative environmental impacts related to the handling and the disposal of medical waste (such as placentas, syringes, and material used for delivery of pregnant women) in health facilities covered by the project**. In accordance with OP/PB4.01, the Medical Waste Management Plan (MWMP) was prepared for the original project and was implemented as planned (purchase/installation of generators). The PIU has recruited a consultant to update the MWMP for the new operation (new technical and geographical scope) which was finalized and disclosed in country and in the Infoshop on February 25, 2016 prior to the appraisal mission.

73. **The World Bank's supervision missions will include environmental and social safeguards specialists in order to assist the project implementation unit by** (i) providing regular implementation support, (ii) carrying out field reviews of safeguards implementation, and (iii) monitoring safeguards implementation based on periodic progress reports.

74. **OP/BP 4.01 Environmental Assessment: This policy is triggered; the project has minimal environmental impacts that shall be governed by national and local laws and procedures.** An existing medical waste management plan prepared for the ongoing Bank financed project has been updated during implementation to continue to facilitate the mitigation of potential adverse impacts. In addition, the plan will be reviewed twice a year and a sample of facilities will be visited to supervise implementation of the MWMP.

Monitoring & Evaluation

75. **The Results Framework focuses on accountability for results in the delivery of RMNCAH and nutrition services.** The project approach to results monitoring aims at extending beyond tracking of inputs and outputs by placing a strong emphasis on intermediate outcomes. When possible, the proposed results framework will use existing indicators and data to measure the progress of both the project and its contribution to the overall national program; this will benefit the program by strengthening and increasing the efficiency of existing data collection mechanisms. For example, routine monthly and quarterly data collected via the web-based PBF system will be aggregated for the project's quarterly and annual indicators and be linked to the national HMIS system (currently being reinforced by the introduction and scale-up of DHIS-2).

76. **The project monitoring system** will include (i) identification and consolidation of M&E indicators; (ii) training and capacity building initiatives at the national, regional, and local levels; (iii) standardized methods and tools to facilitate systematic collection and sharing of information; (iv) an independent review by external technical consultants (External Evaluation Agency); and (v) annual program evaluations and strategic planning exercises for each component.

Role of Partners

77. **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 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.

78. **Development partners will also play a key role in the overall coordination of the GFF**. The country coordination platform for GFF has development partner, civil society and private

sector representation at the various levels (national steering committee of Health Sector Strategy, the Technical and Financing Partner coordination group, and the National Program for the reduction of Maternal and Child Mortality). Partners will also provide key inputs to the process of developing the GFF Investment Case and national health financing strategy, and contribute to the Investment Case by providing resources for implementation of the prioritized interventions.

Annex 4: Implementation Support Plan

CAMEROON: Health System Performance Reinforcement Project

Strategy and Approach for Implementation Support

1. **The proposed implementation plan is consistent with the current PBF operation.** While the previous HSSIP project used a Project Implementation Unit, the proposed HSSP project will be using government structures for implementation that will be embedded inside government departments and managed by the Government. The fiduciary and technical capacity will be strengthened as well with the majority of skills and experience (and staff) from the HSSIP PIU being transferred to the National PBF Technical Unit. Program implementation rests under the responsibility of MOH with targeted and continuous implementation support and technical advice from the World Bank and development partners. The Bank's implementation support will broadly consist of:

    - Capacity building activities to strengthen the national and local levels' ability to implement the program, covering the technical, fiduciary, and social and environmental dimensions.
    - Provision of technical advice and implementation support geared to the attainment of the program's Development Objectives.
    - On-going monitoring of implementation progress, including regularly reviewing key outcome and intermediate indicators, and identification of bottlenecks.
    - Monitoring risks and identification of corresponding mitigation measures.
    - Close coordination with other donors and development partners to leverage resources, ensure coordination of efforts, and avoid duplication.

2. **Further, implementation support will include the provision of capacity strengthening in procurement, financial management and governance and anti-corruption.** An annual fiduciary review will be conducted for the program; adequate budget will need to be allocated for this review. This review will be supplemented by on-site visits done by the Bank's fiduciary staff at least twice a year. Reliance will also be placed on the annual audit reports produced by the Controller and Auditor General. In addition, desk reviews will be done for audit, financial, procurement and any other reports received during the financial year. In-depth reviews may also be commissioned by the Bank whenever deemed necessary.

Table 11: Implementation Support Plan

Time	Focus	Skills Needed	Resource Estimate	Partner Role
First twelve months	Capacity building for the PBF	PBF expert	200,000 (IDA)	
	Capacity building on FM, procurement, internal audit and safeguard	FM and procurement staff, and consultants		

	implementation and compliance			
12-48 months	Implementation support	Same as above	150,000 each subsequent year	

Table 12: Skills mix required

Skills Needed	Number of Staff Weeks	Number of Trips	Comments
Task team leader	15 SWs annually	Field trips as required	Washington based
Procurement	5 SWs annually	Field trips as required	Country office based
FM Specialist	5 SWs annually	Field trips as required.	Country office based
Nutrition Specialist	3 SW annually	Field trip as required	Washington based
Environment specialist	1 SW annually	Field trip as required	Country Office based
Indigenous people and Health Specialist	2 SW annually	Field trip as required	Country Office based
M&E Specialist	4 SW annually	Field trips as required	Country office based
PBF Specialist	8 SW annually	Field trips as required	International
Health financing specialist	5 SW annually	Field trips as required	DC based
Economist	4 SW annually	Field trip as required	DC based
Governance Specialist	1 SW annually	Field trips as required	Country office based
Administrative Support	6 SW annually	Field trips as required	5 weeks Country office based 1 week DC based

Annex 5: Economic and Financial Analysis

CAMEROON: Health System Performance Reinforcement Project

I. Rationale and objective of the Project

1. **The overall development impact of the proposed Project will be the improvement of the health of women, children and adolescents.** Specifically, the development objective of the Project is to increase utilization and improve the quality of health services with a particular focus on reproductive, maternal, child and adolescent health and nutrition services.

2. **To achieve this objective, the Project investments will contribute to strengthening the performance of the health system through continued scaling-up Performance-Based Financing that has been successfully piloted in Cameroon (with support of an ongoing World Bank health operation).** Through the PBF mechanism, coverage and quality of RMNCAH services for the population will be increased, especially in the poorest and most disadvantaged provinces of Cameroon. Component 1 of the Project aims at strengthening health service delivery through PBF and component 2 at institutional strengthening for improved health system performance.

II. Rationale for public sector engagement

3. **The rationale for public sector engagement for this Project is based on the role of the government to promote economic and social goals and their spillover effects**. Investments funded through the Project are to strengthen health services delivery through PBF and institutional capacity for improving health system performance (thus increasing utilization and quality of health services, and for the most vulnerable), then contributing to universal health coverage. Public sector investment is also key to provide and promote preventive health services and support equity improvements to access good quality RMNCAH services. Moreover, these interventions have positive externalities and important spillovers (societal returns of investing in women's and children's health for economic growth) which justify the role of the government.

III. Value added of World Bank support

4. **The value added of the World Bank support to Cameroon on health system performance** is: (i) its technical input based on international experience on health systems strengthening and specifically on performance-based financing and capacity to mobilize a wide-range of technical expertise to support key strategies and reforms (e.g., RMNCAH investment case, health financing strategy) but also (ii) its convening role to support mobilization and channel additional resources to scale-up delivery of effective and efficient RMNCAH services, as Cameroon is now part of the Global Financing Facility in support of Every Woman Every Child (initiative launched by the World Bank and key development partners in September 2014). Additionally, the ongoing Cameroon Health Sector Support Investment Project has been successfully supporting the Government to implement key reforms such as the introduction of Performance-Based Financing. The World Bank is playing a key role to promote innovative

approaches in the health sector (for example, Community PBF) and overall human development sector promoting a multisector approach (component 1.3 will support innovative interventions through a comprehensive program to address education, health and fertility challenges).

IV. Methodology of the economic analysis

5. **The economic analysis of the Project draws on empirical evidence, including results from the current PBF project and PBF impact evaluation in Cameroon, to demonstrate that the expected benefits outweigh the costs of the proposed interventions in terms of health, poverty and social impacts.** Detailed economic and financial analysis conducted during project preparation includes: (i) a cost-effectiveness analysis of the project (what is the incremental cost effectiveness ratio?); (ii) a cost-benefit analysis of the project (how much does the project cost per saved life year?) and (iii) a financial analysis (how financially sustainable is the project?). In addition, the development of the Cameroon RMNCAH investment case and prioritization of interventions as part of the GFF process is built on an evidence-based approach.

V. Cost effectiveness analysis of the project investments

6. **The cost-effectiveness analysis focuses only on interventions funded through Component 1 of the Project (Strengthening health service delivery through Performance-Based Financing),** representing 86 percent of Project's investments as activities under Component 2 (Institutional Strengthening for Improved Health System Performance) deal mostly with capacity building and it is more complex to assess their impact and benefits.

7. **A rigorous impact evaluation has been conducted in Cameroon** (design and research question detailed in the box below) and its results will be used to conduct the cost-effectiveness analysis (final results to be available by mid-2016).

Box 1: The PBF Impact Evaluation in Cameroon (design and research questions)

The objective of the impact evaluation was to explore the impact of PBF on service coverage, quality and health outcomes in Cameroon. Moreover, the study has examined the factors that influence the impact of PBF− an area of considerable operational significance since PBF often involves a package of constituent interventions: linking payment and results, independent verification of results, managerial autonomy to facilities and enhanced systematic supervision of facilities. The larger policy objectives are to (a) Identify the impact of PBF on maternal and child health (MCH) service coverage and quality, (b) Identify key factors responsible for this impact, and (c) Assess cost-effectiveness of PBF as a strategy to improve coverage and quality. In doing so, we expect that the results from the impact evaluation will be useful to designing national PBF policy in Cameroon and will also contribute to the larger body of knowledge on PBF.

The impact evaluation focused on the following research questions:

a. Does the PBF program increase the coverage of MCH services?
b. Does the PBF program increase the quality of MCH services delivered?
c. Is it the enhanced monitoring & evaluation and supervision or the link between payments and results that leads to improvements observed in quality or coverage?
d. What is the contribution of enhanced supervision and monitoring to improving MCH service coverage and quality in the absence of increased autonomy or additional financial resources?

In addition, the impact evaluation also examined the following research questions that relate to intermediate outcomes in the hypothesized causal pathway:

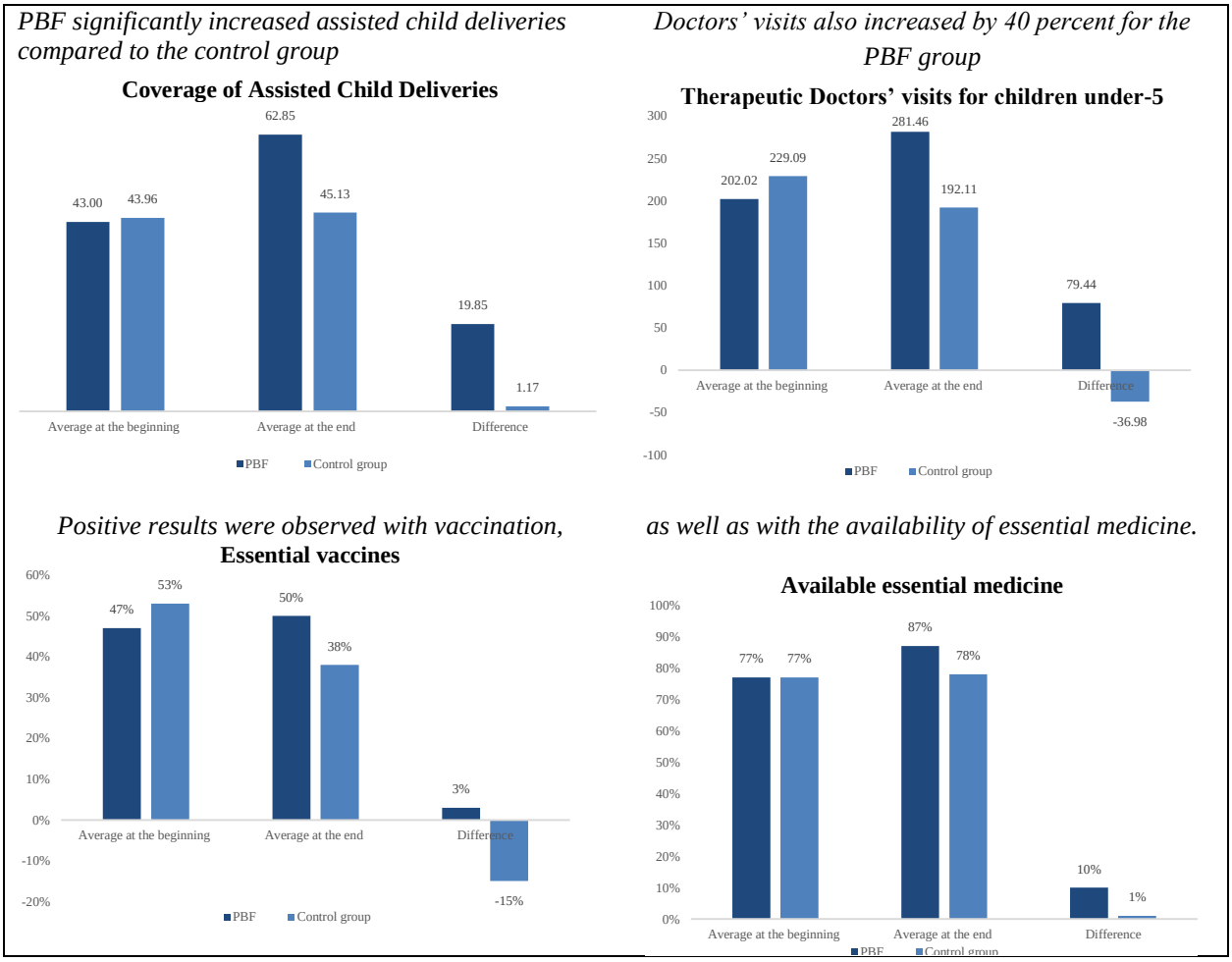
1. Does the PBF program lower informal charges for health services?
2. Does the PBF program lower formal user charges?
3. Does the PBF program increase funds available at the operational (i.e., facility) level?
4. Does the PBF program improve physical and social accessibility of health services? Accessibility of health services will be examined in terms of the convenience of facility opening hours, availability of services through outreach, client perceptions of convenience of accessing health services and client perceptions of health providers' attitudes towards clients
5. Does the PBF program lower staff absenteeism?
6. Does the PBF program increase demand generation activities by health facilities?

The study has a pre-post with comparison design. We relied primarily on experimental control to answer the main research questions for this study. Individual health facilities in each region were randomized to one of the 4 study groups. Individual public and private primary care health facilities in 14 districts from the 3 pilot regions were randomly assigned to each study group to create a factorial study design. This process of random allocation seeks to ensure that the four study groups are comparable in terms of observed and unobserved characteristics that could affect treatment outcomes so that average differences in outcome can be causally attributed.

Treatment 1: PBF with health worker performance bonuses	**Control 1:** Same per capita financial resources as PBF but not linked to performance; Same supervision and monitoring and managerial autonomy as T1
Control 2: No additional resources but same supervision and monitoring as PBF arms and T 1 and C1	**Control 3:** Status quo

8. **Preliminary results from the PBF impact evaluation demonstrate significant improvements in utilization and quality of care** in facilities receiving the PBF intervention, in comparison with facilities in a control group, as shown in the figure below.

Figure 12: Performance Based Financing (PBF) in the Cameroon's health sector 2012-15



Source: World Bank 2015

9. **Indicators selected to assess the impact of the Project interventions** are the following (based on PDO and PBF indicators):

- Children 12-23 months fully immunized;
- Births attended by skilled professional
- Pregnant women receiving antenatal care during a visit to a health provider;
- Pregnant/lactating women, adolescent girls and/or children under age five reached by basic nutrition services;
- Acceptors of modern contraceptive methods;
- Number of HIV+ pregnant women benefiting from HIV/AIDS services: Prevention of mother to child transmission (PMTCT); VCT; neonatal treatment. from prevention of Mother to Child transmission (PMTCT);
- Curative services provided to poor and vulnerable people free of charge.

10. **The costs of the intervention selected for the cost-effectiveness analysis are the costs for component 1 (US$114 million),** broken down between indicators using information from the ongoing PBF Project. Costs for the selected PBF indicators were calculated using PBF

operational and payment data for 2015 in all treatment facilities of the four regions: North-West; South-West; East and Littoral. Also, costs of sub-component 1.2 (support for the implementation and supervision of Performance-Based Financing, US$19 million) were equally split between all indicators. Costs for the interventions funded under sub-component 1.3 (Additional support for improving access to a key package of RMNCAH and nutrition services) were divided as follows:

a. Costs for support to the multisector approach to address health, education and demographic challenges were divided between indicators related to maternal health;
b. Costs for additional support to reinforce nutrition services were added to the basic nutrition services indicator;
c. Costs for providing critical inputs for family planning and adolescent health services were added to the family planning indicator.

Table 13: Repartition of Project cost

Indicators	**Rule of calculation for financing**	**Total cost (in US$ million)**
Children 12-23 months fully immunized;	=6.2% of comp 1.1 (PBF) +1/7 of comp 1.2 +US$ 1.75 million of comp 1.3	8.8
Births attended by skilled professional	=4.7% of comp 1.1 (PBF) +1/7 of comp 1.2 +US$ 1.75 million of comp 1.3	7.8
Pregnant women receiving antenatal care during a visit to a health provider	=3.6% of comp 1.1 (PBF) +1/7 of comp 1.2 +US$ 1.75 million of comp 1.3	7.0
Pregnant/lactating women, adolescent girls and/or children under age five reached by basic nutrition services	=13% of comp 1.1 (PBF, proxy households visit) +1/7 of comp 1.2 +US$ 12 million of comp 1.3	23.8
Acceptors (new and old) of modern contraceptive methods.	=3.7% of comp 1.1 (PBF) +1/7 of comp 1.2 +US$ 7.75 million of comp 1.3	13.1
HIV/AIDS services for pregnant women: Prevention of mother to child transmission (PMTCT); VCT; neonatal treatment.	=19.5% of comp 1.1 (PBF) +1/7 of comp 1.2	16.4
Curative services provided to poor and vulnerable people free of charge	=4.2% of comp 1.1 (PBF) +1/7 of comp 1.2	5.6
TOTAL (in US$ million)		82.4

11. **Projections of indicators are based on:** (i) current baseline of the indicators in the targeted regions of PBF; (ii) evolution of indicators observed during the current PBF pilot and (iii) duration of the intervention (4 years). These projections are reflected in the targets of the results framework for the Project.

Table 14: Summary of the cost-effectiveness analysis

	Project intervention			Cost		
Indicators	**Baseline**	**Target 2021**	**Evolution**	**Per intervention (in million US$)**	**Per capita (in US$)**	**Interpretation**
Children 12-23 months fully immunized	117,192	684,891	567,699	8.8	15.5	US$15.5 by additional fully immunized children
Births attended by skilled professional	117,429	677,327	559,898	7.8	11.4	US$11.4 by additional assisted birth
Pregnant women receiving antenatal care during a visit to a health provider	427,015	2,840,367	2,413,352	7.0	2.9	US$2.9 by additional pregnant woman receiving ANC
Pregnant/lactating women, adolescent girls and/or children under age five reached by basic nutrition services[9]	175,835	2,082,766	1,906,931	23.8	12.5	US$12.5 by additional person reached by basic nutrition services
Acceptors (new and old) of modern contraceptive methods	139,681	1,188,035	1,048,354	13.1	12.5	US$12.5 by additional acceptor of modern contraceptive method
HIV/AIDS services for pregnant women: Prevention of mother to child transmission (PMTCT); VCT; neonatal treatment.	218,563	874,252	655,689	16.4	25.0	US$25 by additional pregnant woman benefiting from HIV/AIDS services
Curative services provided to poor and vulnerable people free of charge	-	1,302,057	1,302,057	5.6	4.3	US$4.3 by additional poor people benefiting from curative services
Beneficiaries[10]	990,605.50	6,621,364.00	5,630,758.50	56.06	10.0	**Incremental Cost-Effectiveness Ratio**
Women beneficiaries[11]	117,192	684,891	567,699	8.8	15.5	**Incremental Cost-Effectiveness Ratio**

[9] Proxy: growth monitoring for children under 24 months and nutrition services through PBF for pregnant women
[10] Number of beneficiaries is higher as in the results framework as the definition here is broader: it includes also people receiving HIV and family planning services.
[11] Calculated with beneficiaries from assisted deliveries, antenatal care, half of people reached by basic nutrition services and family planning indicators.

12. The table below presents the additional beneficiaries for the selected interventions of the project compared to the baseline situation (2015). **The estimated incremental cost-effectiveness ratio is US$10 and specifically for women beneficiaries this incremental cost-effectiveness is estimated at US$15.5.** From this preliminary estimation, the project appears to be cost-effective and comparable to similar interventions in developing countries. Indeed, analysis of maternal and neonatal health interventions in developing countries[12] presents cost-effectiveness of different interventions ranging from US$1-223.

13. **The set of interventions on RMNCAH included in the PBF package** have proven to be cost effective in a variety of studies and across many countries and evidence suggests that providing this package to mothers and children is highly cost-effective (US$82-142 per DALY averted). The table below presents average costs of health and interventions funded by the Project per benefit (cost per disability-adjusted life year, DALY[13], saved). Health interventions that cost less than US$100 per DALY are considered highly cost-effective by international standards. Thus, interventions funded by the Project can be considered highly cost-effective.

Table 15: Average costs of health intervention per benefit

Intervention	Cost effectiveness ratio (US$ per DALY)	Source
Reproductive health		
Average Costs per Benefit of Family Planning	**30**	Disease Control Priorities in Developing Countries Contraception, chapter 57
Prenatal care consultations	**82-142**	Jamison et al (2006). Disease Control Priorities in Developing Countries, p. 46.
Delivery care	**82-142**	Jamison et al (2006). Disease Control Priorities in Developing Countries, p. 46.
Child health and nutrition		
Vitamin A capsules <age 2	**10**	DCPP (2008) Stimulating Economic Growth Through Improved Nutrition
Growth monitoring and counseling	**8-10**	Jamison et al (2006). Disease Control Priorities in Developing Countries, p. 560
Traditional expanded program on immunization (EPI)	**7**	Jamison et al (2006). Disease Control Priorities in Developing Countries, p. 560
Child survival program with nutrition component	**41-43**	Jamison et al (2006). Disease Control Priorities in Developing Countries, p. 560
Management of childhood illnesses	218	DCPP (2008) Using Evidence About "Best Buys" to Advance Global Health
Malaria		
Rapid diagnostic tests for malaria	**75-112**	WHO (2008) Cost-effectiveness of malaria diagnostic methods in sub-Saharan Africa in an era of combination therapy
Malaria prevention	24	DCPP (2008) Using Evidence About "Best Buys" to

[12] Adam and al (2005), Achieving the millennium development goals- Cost effectiveness analysis of strategies for maternal and neonatal health in developing countries, BMJ journals.

[13] DALYs are a measure of overall burden of disease, expressed as the number of years lost due to ill-health, disability or early death.

		Advance Global Health
Diarrhea treatment (oral rehydration therapy)	132	DCP (2006) Disease control priorities in developing countries p.45
HIV/AIDS		
VCT in Generalized low-level epidemic in Sub-Saharan Africa	**14-261**	DCP (2006) Disease control priorities in developing countries p.339
HIV treatment with CTX prophylaxis	**43**	Abimbola TO, Marston BJ. (2012). The cost-effectiveness of co-trimoxazole in people with advanced HIV infection initiating antiretroviral therapy in sub-Saharan Africa. J Acquired Immune Deficiency Syndrome.
Prevention of Mother to Child Transmission (PMTCT)	**5-37**	Jamison et al (2006). Disease Control Priorities in Developing Countries, p. 1084.

14. **The Project will thus contribute to improved allocative efficiency in the health sector which is a major issue in Cameroon.** Total health expenditures have increased since 2000, from US$81 per capita to US$138 per capita in 2013 (PPP, constant 2011), but health outcomes are still poor considering investments and GDP of Cameroon (in comparison with similar countries): maternal mortality and malnutrition status among children has actually increased over the past ten years (from 690 in 2004 to 782 deaths per 100,000 live births in 2011). According to the latest National Health Accounts, only three percent of total health expenditures is spent for preventive services and six percent of current health expenditures for reproductive health services**.**

15. **Financial sustainability.** A preliminary fiscal sustainability analysis of the investments of the Project demonstrates that activities funded by the Project are sustainable. Indeed, investments of the Project consist mostly in strengthening the performance of the health system (strengthening service delivery and efficiency) by scaling-up the PBF mechanism which has proven its impact to improve utilization and quality of health services. Moreover, funding for interventions under the Project represents a limited share of the national budget dedicated by the country for health (and even if the public expenditures for health are low in the general budget).

Table 16: Impact of the Project's investments on fiscal sustainability

	Cameroon	Comments
GDP (current US$, million)	**33,550**	**WDI, 2014**
Health expenditure, public (% of government budget)	**8.5%**	**WDI, 2013**
Health expenditure, public (% of GDP)	**1.8%**	**WDI, 2013**
Public health expenditures (current US$, million)	**604**	**WDI, 2014**
Total project Investment, million US$ (per year)	**35.5**	**US$142 for 4 years, approximation**
Estimation nationwide PBF cost (million US$)	**86.8**	**US$4/year/hab Population: 21.7 million**
Share of project investments in health public spending	**5.9%**	

Annex 6: District mapping of PBF scale-up in northern regions of Cameroon

CAMEROON: Health System Performance Reinforcement Project

1. The table below presents for the three northern regions of Cameroon (North, Far North and Adamawa), the districts currently covered by the Health Sector Support Investment Project and the remaining districts in these regions in which the proposed Health System Performance Reinforcement Project will support the scale-up of Performance Based Financing.

Table 17: District mapping of PBF scale-up in northern regions of Cameroon

Region	District	Population (2016)	Number of primary care facilities	Number of hospitals	Covered by PAISS AF	Included in new operation scale-up
ADAMAWA	BANKIM	89507	14	1		Yes
	BANYO	149239	17	1		Yes
	DJOHONG	66849	9	1		Yes
	MEIGANGA	142057	14	1		Yes
	NGAOUNDAL	73747	8	0		Yes
	NGAOUNDERE RURAL	188107	23	1	Yes	
	NGAOUNDERE URBAIN	224215	13	1	Yes	
	TIBATI	95911	28	1		Yes
	TIGNERE	105569	15	1		Yes
Sub-total	**9**	**1135201**	**141**	**8**	**2**	**7**
FAR NORTH	BOGO	118347	11	1		Yes
	BOURHA	78525	15	1	Yes	
	GAZAWA	65552	7	0		Yes
	GOULFEY	33077	9	1		Yes
	GUERE	122162	10	1		Yes
	GUIDIGUIS	153457	18	2	Yes	
	HINA	131026	10	2		Yes
	KAELE	129410	21	1	Yes	
	KAR HAY	130642	12	1	Yes	
	KOLOFATA	134921	6	1		Yes
	KOUSSERI	198681	13	1		Yes
	KOZA	185815	18	1	Yes	
	MADA	122172	10	1		Yes
	MAGA	156190	9	1		Yes
	MAKARY	140985	9	1		Yes
	MAROUA 3	105744	15	0		Yes
	MAROUA RURAL(I)	145692	14	3		Yes

	MAROUA URBAIN(II)	168864	7	3		Yes
	MERI	198452	11	1		Yes
	MINDIF	71542	12	1		Yes
	MOGODE	112984	11	1	Yes	
	MOKOLO	211906	14	1	Yes	
	MORA	186948	19	1	Yes	
	MOUTOURWA	47220	10	1		Yes
	MOUVOULDAYE	242716	8	1	Yes	
	PETTE	53203	7	1		Yes
	ROUA	95360	6	1		Yes
	TOKOMBERE	150136	10	1	Yes	
	VELE	121726	11	1		Yes
	YAGOUA	255290	11	2	Yes	
Sub-total	**30**	**4068745**	**344**	**35**	**11**	**19**
NORTH	BIBEMI	138493	14	1		Yes
	FIGUIL	102028	11	3		Yes
	GAROUA I	255116	17	9		Yes
	GAROUA II	265240	13	1		Yes
	GASCHIGA	104682	17	1		Yes
	GOLOMBE	75459	6	1	Yes	
	GUIDER	249911	21	1	Yes	
	LAGDO	158887	18	1	Yes	
	MAYO OULO	142964	10	1	Yes	
	NGONG	222844	19	1		Yes
	PITOA	169640	18	1		Yes
	POLI	85657	23	1		Yes
	REY BOUBA	108950	13	1	Yes	
	TCHOLLIRE	146770	17	1		Yes
	TOUBORO	184295	14	1		Yes
Sub-total	**15**	**2410936**	**231**	**25**	**5**	**10**
Total	**54**	**7614882**	**716**	**68**	**18**	**36**

Annex 7: Health Services Incentivized through the PBF program

CAMEROON: Health System Performance Reinforcement Project

1. The tables below present the list of health services at the primary and secondary care level included in the national Cameroon PBF program as of January 2016. They do not include specific indicators currently being piloted by UNICEF and UNFPA in the East region. As the list of indicators is assess and revised (where necessary) on an annual basis, the services covered by the program supported by the proposed operation will be based on the 2016 list, and revisited each calendar year.

Table 18: Services included in the PBF program, primary care level

Code	Primary care indicators	Base subsidy FCFA	Base subsidy US$
1.1	Outpatient Consult – nurse	F 150	US$0.36
1.2	Outpatient Consult – doctor	F 300	US$0.71
1.3	Outpatient Consult – indigent	F 600	US$1.43
1.3	Outpatients Consult - indigent- epidemic / hum crisis	F 600	US$1.43
2.1	In patient days	F 225	US$0.53
2.1	In patient days – indigent	F 900	US$2.14
2.1	In patient days - indigent - indigent- epidemic / hum crisis	F 900	US$2.14
3.1	Minor surgery	F 450	US$1.08
3.2	Minor surgery – indigent	F 1,800	US$4.28
4.1	Referred patient arrived hospital	F 450	US$1.08
5.1	STI cases treated according to protocol	F 300	US$0.71
	Child Fully Immunized	F450	US$1.08
6.1	Penta1 or Penta 2 or Penta 3 with Yellow Fever and Measles	F 1,050	US$2.49
7.1	IPT1 or IPT2 or IPT3	F 300	US$0.71
8.1	2 - 5 Tetanus Vaccination of Pregnant Woman	F 450	US$1.08
9.1	VIT A Distribution	F 30	US$0.07
10.1	ANC1 or ANC2 or ANC3 or ANC4	F 300	US$0.71
11.1	Normal delivery	F 2,400	US$5.71
11.2	Normal delivery- indigent	F 7,200	US$17.14
12.1	Obstructed delivery	F 2,250	US$5.36
12.2	Obstructed delivery – indigent	F 9,000	US$21.42
13.1	Curretage after spontaneous abortion or therapeutic abortion	F 2,700	US$6.43
14.1	Postnatal consultation	F 300	US$0.71
15.1	FP: New visit or existing visit for pills or injectable	F 1,500	US$3.57
16.1	FP: implants or IUDs	F 2,250	US$5.36
17.1	Voluntary counselling and testing for HIV / AIDS including pregnant women	F 300	US$0.71
18.1	HIV+ Pregnant woman put on ARV prophylaxis protocol	F 6,000	US$14.28
19.1	Treatment of new born baby from HIV+ mother	F 6,000	US$14.28
20.1	New AAFB + PTB patient	F 3,000	US$7.14
21.1	PTB case treated and cured	F 12,000	US$28.56
22.1	Household visit following the protocol	F 900	US$2.14
23.1	Cases referred by community and arrived (max 5% OPD)	F 300	US$0.71

24.1	Dropout recovered (max 2% OPD)	F 300	US$0.71
25.1	Child 6-59 months treated MAM moderate acute malnutrition	F 450	US$1.08
26.1	Child 6-59 months managed for severe acute malnutrition (SAM)	F 1,500	US$3.57
29.1	Quality Improvement Bonus QIB	F 600,000	US$1428

Table 19: Services included in the PBF program, secondary care level

Code	Secondary care indicators	Base subsidy FCFA	Base subsidy US$
51.1	New consultation by doctor	F 250	US$0.50
51.2	New consult doctor – indigent	F 1,000	US$2.00
52.1	New consult doctor – outbreak - humanitarian crisis	F 375	US$0.75
52.2	Inpatient days	F 1,500	US$3.00
53.1	Inpatients day - indigents + Outbreak cases	F 750	US$1.50
54.1	Counter referral arrived at HC	F 500	US$1.00
55.1	STI cases treated to protocol	F 2,500	US$5.00
56.1	New AAFB+ PTB patient	F 25,000	US$50.00
57.1	PTB case treated and cured	F 5,000	US$10.00
57.2	Major surgery (not C Section)	F 20,000	US$40.00
58.1	Major surgery (not C Section) – indigents	F 1,000	US$2.00
58.2	Minor surgery	F 4,000	US$8.00
59.1	Minor surgery – indigent	F 1,500	US$3.00
60.1	Blood transfusion	F 1,500	US$3.00
60.2	Normal delivery	F 6,000	US$12.00
61.1	Normal delivery – indigent	F 5,000	US$10.00
61.2	Caesarean sections	F 20,000	US$40.00
62.1	Caesarean sections – indigent	F 2,000	US$4.00
62.2	Obstructed childbirth (vacuum, forceps)	F 8,000	US$16.00
63.1	Obstructed childbirth (vacuum, forceps) – indigents	F 1,250	US$2.50
64.1	PF: New or old acceptance pills or injectable	F 2,500	US$5.00
65.1	FP: implants or IUDs	F 12,500	US$25.00
66.1	FP: permanent methods: vasectomy or tubal ligation	F 3,750	US$7.50
67.1	Post abortion curretage or therapeutic abortion	F 500	US$1.00
68.1	Antenatal Cons (new & old) ANC 1 or ANC2 or ANC3 or ANC4	F 500	US$1.00
69.1	IPT1 or IPT2 or IPT3	F 750	US$1.50
70.1	Voluntary testing for HIV / AIDS including pregnant women	F 7,000	US$14.00
71.1	Pregnant woman HIV+ put on ARV prophylaxis protocol	F 7,000	US$14.00
72.1	Treatment of new born from HIV+ mother	F 2,000	US$4.00
73.1	New HIV cases put on ARVs	F 12,500	US$25.00
74.1	Follow up of patients on ARV- twice a year	F 2,500	US$5.00
81.1	Hemo dialyse	F1,000,000	US$2,000.00

Annex 8: What is Performance Based Financing

CAMEROON: Health System Performance Reinforcement Project

1. **Performance-Based Financing (PBF) is a supply-side Results-Based Financing (RBF) approach**.[14] PBF pays for outputs or results and this is different from classical programs which focus on procuring inputs. In the health sector, outputs or results are predominantly produced by health facilities whereas some results are produced by the health administration. Such outputs or results include quality services produced by health facilities and certain actions by the health administration. Income from PBF is used by health facilities and the health administration to procure necessary inputs and to pay performance bonuses.

2. **PBF is based on operational and tacit knowledge developed over the past 15 years in South-East Asia and Africa, and is in continuous development incorporating lessons learned**. The effectiveness of PBF was proven through a rigorous Impact Evaluation in Rwanda.[15] A PBF toolkit has been developed by the World Bank and an English version has been available since April 2014, while a French language version is available and a Spanish language version is being published.[16]

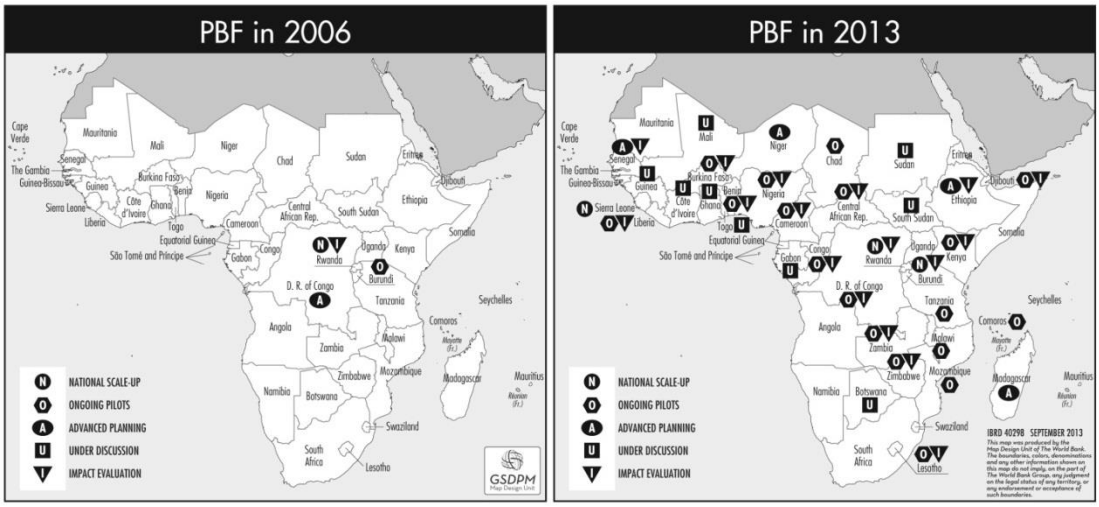
3. **PBF is applicable in a wide variety of lower and middle income country contexts**. The diversity and the applicability of PBF are evident when looking at the contexts where such programs are carried out: Burundi, DRC and Nigeria versus Indonesia, Kyrgyzstan and Vietnam. Currently, over 30 countries in Africa, and Central and South-East Asia are planning, designing, and implementing such programs. PBF has expanded rapidly in Sub-Saharan Africa; see image below.

[14] Musgrove, P. (2011). Financial and Other Rewards For Good Performance or Results: A Guided Tour of Concepts and Terms and a Short Glossary. Washington DC.

15 (i) Basinga, P., P. Gertler, et al. (2011). Effect on maternal and child health services in Rwanda of payment to primary health-care providers for performance: an impact evaluation. The Lancet 377: 1421-1428; (ii) Gertler, P. and C. Vermeersch (2012). Using Performance Incentives to Improve Health Outcomes. *Policy Research Working Paper WPS6100*. Washington DC, The World Bank. Walque, D. d., P. J. Gertler, et al. (2013); (iii) Using Provider Performance Incentives to Increase HIV Testing and Counseling Services in Rwanda. *Policy Research Working Paper WPS6364*. Washington DC, The World Bank.

16 Fritsche, G., R. Soeters, et al. (2014). Performance-Based Financing Toolkit. Washington DC, © World Bank. https://openknowledge.worldbank.org/handle/10986/17194 License: CC BY 3.0 IGO.

Figure 13: Rapid expansion of PBF projects in Sub-Saharan Africa between 2006 and 2013



4. **Certain aspects of PBF and how they relate to the Cameroon will be discussed in the following sections**. These aspects are: (a) purchasing quality services; (b) separation of functions; (c) health facility autonomy; (d) verification and counter-verification; and (e) data management and invoicing.

Purchasing Quality Services

5. **PBF purchases quality health services**. Important notions are leveraging existing resources; changing incentive structures; purchasing balanced packages; purchasing conditional on quality; and PBF pricing versus the real cost of services.

6. **PBF purchases quality health services through leveraging existing means of production**. The purchase is through a fee-for-service provider payment mechanism, conditional on the quality of services. Key to understanding PBF is the notion of leveraging. Existing building, equipment, medical consumables, cash income from other sources and staffing are leveraged through PBF.

7. **PBF changes incentive structures at various levels in the health system**. The incentives need to be strong enough to influence health worker coping strategies while they provide additional income to enable health facilities to procure missing equipment, to maintain and repair equipment and premises and to stock essential life -saving medicines.

8. **PBF purchases a balanced package of services at the community & health center level and at the first referral hospital level**. A lack of coverage for essential health services guides purchasing at the community & health center level. At the hospital level additional services complementing the primary levels are purchased; for instance complicated deliveries or more sophisticated reproductive health services. In general, there are 15-25 services in each package. Ideally, incentives are targeted at preventive services used by everybody whilst facilitating access to curative services for the poorest. PBF budget allocation is about 2/3 at the community and health center level, and 1/3 for the first referral hospital level.

9. **Quality is measured and rewarded through the use of a quantified quality checklist**. This checklist is custom-made to reflect the particularities of each context. It is measured once per quarter, typically by an incentivized district health administration (for the health centers) or by a peer-evaluation mechanism (for the hospitals). The impact of the quality measure depends on the type of PBF system. It can be a quality bonus with a maximum of 25 percent of earnings (in the 'carrot' system) or a deduction of 100 percent of earnings if the quality is 0 (in the 'stick' system). In the case of Cameroon a quality bonus is applied.

10. **PBF fees have little to do with the actual cost of services**. First, the actual cost of a service (which includes apportioned annuity of building and equipment; staff cost; medicines and medical consumables) is much higher than a PBF fee for that service. Second, PBF is a pricing system; the fee is proportional to the relative public health importance and the level of coverage of that service. Third, a PBF fee includes a rural hardship element, and therefore the fee is higher in harder to reach areas. Finally, certain services can be targeted to the poorest of the poor and attract a higher fee than the same service for the better off. Also, PBF fees can be changed depending on budget availability; upward if more money becomes available, and downward if the disbursement is higher than expected. PBF is a strategic purchasing mechanism.

11. **A simplified example of PBF is provided in Table 1**. The bulleted list with bracketed numbers that follows this paragraph shows how the performance of the health facility is financed and how the health facility chooses to use the financing. In this example, individual health facilities are provided funds based on the quantity and quality of services they produce as independently verified. Each bracketed number refers to a field in table 1. For example, [1] refers to the number of children the health facility has fully immunized in the past quarter.

    [1] If a health facility fully immunizes 60 children in a quarter;

    [2] The health facility could earn US$120 (60 × US$2 per child fully immunized);

    [3] The health facility could earn US$1,080 for 60 deliveries because each delivery earns US$18. A typical minimum package of PBF services at a health center would contain 15–25 services;

    [4] This health facility would earn US$2,196 as unadjusted subtotal for the services it produced over the past quarter;

    [5] The total amount would be adjusted for the remoteness or difficulty of the facility (equity bonus), because urban or peri-urban facilities could earn a disproportionate amount. In the example in table 1, this particular facility would earn 20 percent more because of the difficulties it faces;

    [6] The total would also be adjusted by a quality score based on a checklist administered at the facility every quarter. This facility would earn 60 percent of what it would be entitled to because of the quality correction. The quality correction is a maximum of 25 percent of earnings from the past quarter [6]. This facility thus earns 60 percent of the 25 percent for its quality;

[7] The funds earned (US$3,030 in this example) are transferred to the bank account of the facility;

[8] In this example, the health facility also has some other sources of cash revenue (US$970), and these are added to the PBF earnings; and

[9] The health facility had US$4,000 in income over the past quarter, and the expenses section illustrates how this could have been used. The income can be used for

(a) Health facility operational costs, such as medicines and consumables, outreach expenses, and health facility maintenance and repair;

(b) Performance bonuses for health workers (up to 50 percent) according to defined criteria; this facility decided to spend 26 percent of its total income on performance bonuses (34 percent of its PBF earnings; however, because of other sources of cash income, such funds are managed integrally); and

(c) Savings; this health facility is saving not only to buy a motorcycle to facilitate community outreach but also to have a cash buffer.

Table 20: Simplified example of how PBF works in a health facility

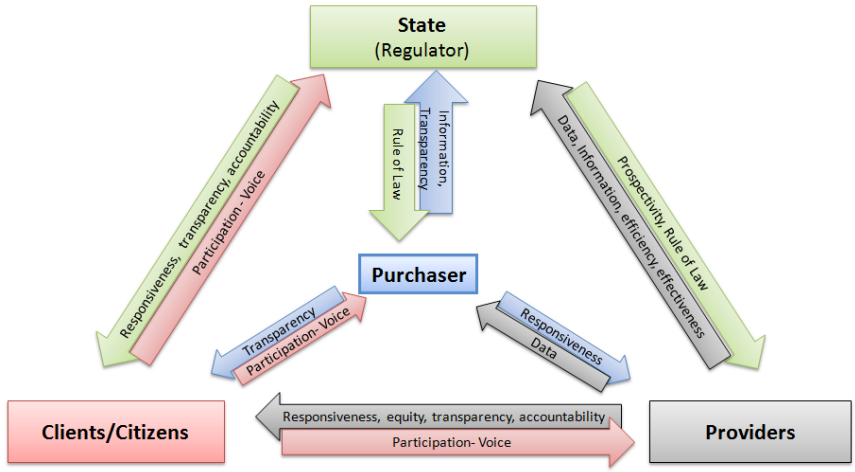
Health facility revenues over the previous period	**Number provided**	**Unit price (US$)**	**Total earned (US$)**
Child fully vaccinated	60 [1]	2	120 [2]
Skilled birth attendance	60	18	1,080 [3]
Curative care	1,480	0.5	740
Curative care for the vulnerable patient (up to a maximum of 20% of curative consultations)	320	0.80	256
[A typical minimum package for a health center would contain 15 to 25 services.]	-	-	-
Subtotal			2,196 [4]
Remoteness (equity) bonus	+20%		439 [5]
Quality bonus	60% of 25%		395 [6]
Total PBF subsidies			3,030 [7]
Other revenues (direct—insurance, and so on)			970 [8]
Total revenues			4,000
Health facility expenses			
Fixed salaries staff			800
Operational costs			350
medicines and consumables			1,000
Outreach expenditures			250
Repairs to the health facility			300
Savings into health facility bank account			250
Subtotal			2,950
Bonuses to staff in the facility = total expenses minus subtotal			1,050
Total expenses			4,000 [9]

Separation of Functions

12. **A precondition for obtaining credible performance results is a separation of functions**. It is best practice to strive for a full separation of functions between the chief players in the health care arena: the fund-holder, the purchaser, the provider, the community, community health committees, local PBF steering committees and the national PBF coordination mechanisms.

13. **In a separation of functions different functions are allocated to different health system stakeholders**. In PBF, the following functions are distinguished: Provision; Regulation; Purchasing; Fund holding and Community voice. In Figure 2 below, the separation of functions is illustrated:

Figure 14: The Separation of Functions and its Governance Issues[17]



Health Facility Autonomy

14. **Health facility autonomy is an important pre-requisite for PBF**. Health facility autonomy is important in (i) holistic management of cash resources; (ii) managing a bank account; (iii) procurement of goods; (iv) repairs to facility and equipment; and (v) managing human resources.

15. **Community oversight is important when decentralizing public funding**. To enhance governance, community oversight mechanisms are strengthened when available, or introduced when absent.

Verification and Counter-Verification

16. **Credible verification is at the heart of PBF systems and two types can be discerned.**

[17] Remme, M., P.-B. Peerenboom, et al. (2012). *Le Financement base sur la Performance et al Bonne Gouvernance*: *Leçons apprises in Republique Centrafricaine.* PBF Community Of Practice Working Paper Series WP8 ed.

a. The first type is the so-called 'ex-ante verification'; the verification before payment for performance is made. The *ex-ante quantity verification* is typically carried out by a third party contracted to do the purchasing on behalf of the fund holder(s) and regulator. The *ex-ante quality verification* is frequently carried out by the district health administration through a performance contract.
b. The second type is the 'ex-post verification'; the verification which is done after payment for performance has been carried out. Whereas the ex-ante verification is routinely (monthly and quarterly) carried out for all contracted health facilities, the ex-post verification is done on a random sample of health facilities and health administrations. Different systems exist, but the *ex-post quantity verification* is typically carried out by the purchasing agent, through grassroots organizations. Such mechanisms are also called 'community client satisfaction surveys'. On the one hand, such systems discourage the 'phantom patient phenomenon' (a service claimed that did not take place), and on the other they collect valuable feedback from the community on their perception of the quality of these services. Ex-post verification is also done on performance frameworks that are predominantly assessed through internal mechanisms, and on the quality checklists.

Data management and invoicing

17. **PBF needs good data-management and invoicing systems to pay regularly for performance**. Such PBF data-management and invoicing systems are characterized by (i) limited data-sets; (ii) good data accuracy; (iii) a high degree of data completeness; (iv) good data accessibility, and (v) transparency. In an increasing number of PBF projects, a web-enabled application is used. A public frontend makes accessible information on performance and payments to the general public. Accessibility to these web-enabled applications down to the district level is reasonable in lower and middle-income countries, and this accessibility is improving with growing connectivity. See for instance the Cameroon PBF portal http://www.fbrcameroun.org/ or the Nigeria PBF portal https://nphcda.thenewtechs.com/.

18. **PBF data management and invoicing systems are purposefully linked to decentralized governance mechanisms**. In well-designed PBF systems, a district level steering committee acts as a district-level governing board for PBF. Such decentralized decision making is important as knowledge on how health facilities function is best at the district level. Purposefully linking civil society and Government systems in this steering committee enhances governance significantly. Timely access to good quality data and invoices through the web-enabled application effectively enable such governance**.**

19. **PBF approaches are dynamic, and in constant adaptation based on lessons learned and experiential knowledge gained**. PBF approaches have evolved considerably since they were first applied in Cambodia in the late nineteen-nineties.[18,19] These experiences have moved for instance from contracting individuals to contracting institutions, from purchasing a restricted

[18] Bhushan, I., S. Keller, et al. (2002). Achieving the Twin Objectives of Efficiency and Equity: Contracting Health Services in Cambodia. ERD Policy Brief No. 6. Philippines.
[19] Soeters, R. and F. Griffiths (2003). "Improving Government health services through contract management: a case from Cambodia." Health Policy and Planning 18(1): 74-83.

package to purchasing more comprehensive packages, from purchasing only quantity, to purchasing both quantity and quality, from not engaging the district health administration, to fully engaging the health administration not only at the district level, but also at higher levels such as the provincial and national levels. The PBF approaches have expanded to experimenting with the pharmaceutical supply chain, with the education sector, with road maintenance and even engaging the security forces.[20] Verification mechanisms and purchasing arrangements are also in a flux, while the increasing use of modern ICT solutions such as the use of mobile devices and the internet leads to better data availability, contribute to governance and learning.

[20] Soeters, R., P.-B. Peerenboom, et al. (2011). "Performance Based Health Financing Experiment Improves Care in a Failed State." Health Affairs 30(8): 1518-1527.

Annex 9: Map of Cameroon

CAMEROON: Health System Performance Reinforcement Project