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Report No: PAD2735

INTERNATIONAL DEVELOPMENT ASSOCIATION

PROJECT PAPER

ON A

PROPOSED ADDITIONAL CREDIT

IN THE AMOUNT OF €5 MILLION
(US$6 MILLION EQUIVALENT)

AND A

PROPOSED ADDITIONAL GRANT FROM THE IDA18 REFUGEE SUB-WINDOW
IN THE AMOUNT OF SDR 20.8 MILLION
(US$30 MILLION EQUIVALENT)

TO THE

REPUBLIC OF CAMEROON

FOR THE

HEALTH SYSTEM PERFORMANCE REINFORCEMENT PROJECT

MARCH 30, 2018

Health, Nutrition, and Population Global Practice
Africa Region

CURRENCY EQUIVALENTS
(Exchange Rate Effective February 28, 2018)

Currency Unit =	CFA Franc (FCFA)
FCFA 537.8768 =	US$ 1
US$ 0.6916 =	SDR 1
US$ 0.8184 =	EUR 1

FISCAL YEAR
January 1 - December 31

ABBREVIATIONS AND ACRONYMS

AIDS	Acquired Immunodeficiency Syndrome
AF	Additional Financing
ANC	Antenatal Care
BUNEC	National Office of Civil Registration (*Bureau National de l'Etat Civil*)
CAR	Central African Republic
CBO	Community-based Organization
CDP	Communal Development Plans
CDPSP	Community Development Program Support Project
CDVA	Contract Development and Verification Agency
CERC	Contingent Emergency Response Component
CHW	Community Health Worker
CIS	Heath Information Unit *(Cellule d'information Sanitaire)*
CRVS	Civil Registration and Vital Statistics
DA	Designated Account
DALY	Disability Adjusted Life Year
DHIS2	District Health Information Software 2
DPF	Development Policy Financing
ERSP	Education Reform Support Project
FGM	Female Genital Mutilation
FGM/C	Female Genital Mutilation or Cutting
FM	Financial Management
FCV	Fragility, Conflict, and Violence
GBV	Gender-based Violence
GDP	Gross Domestic Product
GFF	Global Financing Facility
GoC	Government of Cameroon
GRM	Grievance Redress Mechanism
GRS	Grievance Redress Service
HD	Human Development
HIV	Human Immunodeficiency Virus
HSPRP	Health System Performance Reinforcement Project
HSS	Health Sector Strategy (*Stratégie Sectorielle de la Santé*)

HSSIP	Health Sector Support Investment Project
HWMP	Hygiene and Waste Management Plan
HWTS	Household Water Treatment and Safe Storage
IC	Investment Case
IDP	Internally Displaced Person
IE	Impact Evaluation
IFR	Interim Financial Report
IPP	Indigenous Peoples Plan
IPF	Investment Project Financing
IPPF	Indigenous Peoples Planning Framework
ISR	Implementation Status and Results Report
LDP	Letter of Development Policy
M&E	Monitoring and Evaluation
MHM	Menstrual Hygiene Management
MINMAP	Ministry of Public Procurement (*Ministère de Marchés Publics*)
MoPH	Ministry of Public Health
MWMP	Medical Waste Management Plan
NGO	Nongovernmental Organization
NPF	New Procurement Framework
NTD	Neglected Topical Disease
OP	Operational Policy
PBF	Performance-Based Financing
PDO	Project Development Objective
PHEOC	Public Health Emergency Operation Center
PIU	Project Implementation Unit
PPP	Purchasing Power Parity
PPSD	Procurement Strategy for Development
PTSD	Post-Traumatic Stress Disorder
RMNCAH	Reproductive, Maternal, Newborn, Child, and Adolescent Health
RPBA	Recovery and Peacebuilding Assessment
RSW	Refugee Sub-Window
SDI	Service Delivery Indicator
SSNP	Social Safety Nets Project
ToR	Terms of Reference
UHC	Universal Health Coverage
UN	United Nations
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
WASH	Water, Sanitation, and Hygiene
WFP	World Food Programme

BASIC INFORMATION – PARENT (Health System Performance Reinforcement Project - P156679)

Country	Product Line	Team Leader(s)		
Cameroon	IBRD/IDA	Ibrahim Magazi		
Project ID	**Financing Instrument**	**Resp CC**	**Req CC**	**Practice Area (Lead)**
P156679	Investment Project Financing	GHN13 (9542)	AFCC1 (6544)	Health, Nutrition & Population

Implementing Agency: Ministry of Public Health

Is this a regionally tagged project?	
No	
[ ] Situations of Urgent Need or Capacity Constraints [ ] Financial Intermediaries [ ] Series of Projects	Bank/IFC Collaboration No

Approval Date	Closing Date	Original Environmental Assessment Category	Current EA Category
03-May-2016	31-May-2021	Partial Assessment (B)	Partial Assessment (B)

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.

Ratings (from Parent ISR)

	Implementation	Latest ISR

	29-Jun-2016	29-Nov-2016	14-Apr-2017	23-Oct-2017
Progress towards achievement of PDO	S	S	MS	MS
Overall Implementation Progress (IP)	S	MS	MS	MS
Overall Safeguards Rating	S	S	S	S
Overall Risk	S	S	S	S

BASIC INFORMATION – ADDITIONAL FINANCING (Health System Performance Reinforcement Project - Additional Financing - P164954)

Project ID	Project Name	Additional Financing Type	Urgent Need or Capacity Constraints
P164954	Health System Performance Reinforcement Project - Additional Financing	Restructuring, Scale Up	Yes
Financing instrument	**Product line**	**Approval Date**	
Investment Project Financing	IBRD/IDA	12-Apr-2018	
Projected Date of Full Disbursement	**Bank/IFC Collaboration**		
31-Dec-2022	No		
Is this a regionally tagged project?			
No			

[✓] Situations of Urgent Need or Capacity Constraints

[ ] Financial Intermediaries

[ ] Series of Projects

PROJECT FINANCING DATA – PARENT (Health System Performance Reinforcement Project - P156679)

Disbursement Summary (from Parent ISR)

Source of Funds	Net Commitments	Total Disbursed	Remaining Balance	Disbursed
IBRD				%
IDA	100.00	9.28	95.72	8.8 %
Grants	27.00	4.06	22.94	15 %

PROJECT FINANCING DATA – ADDITIONAL FINANCING (Health System Performance Reinforcement Project - Additional Financing - P164954)

FINANCING DATA (US$, Millions)

SUMMARY

Total Project Cost	163.00
Total Financing	163.00
Financing Gap	0.00

DETAILS

International Development Association (IDA)	136.00
IDA Credit	106.00
IDA Grant	30.00
Trust Funds	27.00
Global Financing Facility	27.00

COMPLIANCE

Policy

Does the project depart from the CPF in content or in other significant respects?

[ ] Yes [✓] No

Does the project require any other Policy waiver(s)?

[ ] Yes [✓] No

INSTITUTIONAL DATA

Practice Area (Lead)

Health, Nutrition & Population

Contributing Practice Areas

Climate Change and Disaster Screening

This operation has been screened for short and long-term climate change and disaster risks

Gender Tag

Does the project plan to undertake any of the following?

a. Analysis to identify Project-relevant gaps between males and females, especially in light of country gaps identified through SCD and CPF

Yes

b. Specific action(s) to address the gender gaps identified in (a) and/or to improve women or men's empowerment

Yes

c. Include Indicators in results framework to monitor outcomes from actions identified in (b)

Yes

PROJECT TEAM

Bank Staff

Name	Role	Specialization	Unit
Jean Claude Taptue Fotso	Team Leader (ADM Responsible)	Public Health	GHN13
Ibrahim Magazi	Team Leader	Public Health	GHN13
Ibrah Rahamane Sanoussi	Procurement Specialist (ADM Responsible)	Procurement	GGOPF
Celestin Adjalou Niamien	Financial Management Specialist	Financial Management	GGOAC
Aissatou Chipkaou	Team Member	Operations & Quality control	GHN13

Benjamin Burckhart	Team Member	Social Protection	GSU01
Bertille Gerardine Ngameni Wepanjue	Team Member	Financial management	GGOAC
Carole Ndjitcheu	Team Member	Administrative support	AFCC1
Charlotte Noudjieu Cheumani	Social Safeguards Specialist	Social safeguards	GSU01
Chrystelle Isabelle Mfout Tapouh	Team Member	Operations support	AFCC1
Cyrille Valence Ngouana Kengne	Environmental Safeguards Specialist	Environmental safguards	GEN07
Edith Ruguru Mwenda	Team Member	Legal counsel	LEGAM
FNU Owono Owono	Team Member	Social Safeguards	GSU01
Faly Diallo	Team Member	Financial management	WFACS
Hamadou Saidou	Team Member	Impact Evaluation	GHNDR
Helene Simonne Ndjebet Yaka	Team Member	Operations	AFCC1
Karamath Djivede Sybille Adamon	Team Member	Public Health	GHNGE
Kazumi Inden	Team Member	Community based health	GHNGE
Kristyna Bishop	Social Safeguards Specialist	social safeguards	GSU01
Maud Juquois	Team Member	Health Economics	GHN13
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Opope Oyaka Tshivuila Matala	Team Member	Reproductive health	GHN13
Paul Jacob Robyn	Team Member	Public Health	GHN07
Robert Anthony Soeters	Team Member	Performance-Based Financing	GHN07
Sariette Jene M. C. Jippe	Team Member	Operations support	GHN13

Extended Team

Name	Title	Organization	Location

CAMEROON

HEALTH SYSTEM PERFORMANCE REINFORCEMENT PROJECT - ADDITIONAL FINANCING

TABLE OF CONTENTS

I. BACKGROUND AND RATIONALE FOR ADDITIONAL FINANCING

A. Introduction

1. **This Project Paper seeks the approval of the Executive Directors to provide an additional financing (AF) to the Republic of Cameroon's Health System Performance Reinforcement Project (HSPRP) (P156679) in an amount of US$36 million (comprised of a US$6 million Credit from IDA national allocation and US$30 million grant from the IDA18 Refugee Sub-Window [RSW]).** The proposed AF aims to mitigate the health and economic impact of the conflict in the Far North region and the refugee crisis in the northern (Far North, North, Adamawa) and East regions of Cameroon by providing essential health, nutrition, and water, sanitation, and hygiene (WASH) services to refugees and refugee-host communities. The proposed AF would (a) revise the Project Development Objective (PDO) to reflect the addition of refugees as program beneficiaries and a Contingent Emergency Response Component (CERC), (b) reinforce select activities under the original program Components 1 and 2 and include new activities targeting refugees, (c) restructure the parent project to include two new components (3 and 4), (d) revise the Results Framework to include one new PDO level indicator and two intermediate level indicators to reflect the AF activities, and (e) extend the project closure date. The targets of the original indicators will be revised to reflect the increase in beneficiaries.

2. **The Government of Cameroon (GoC) requested the AF on August 11, 2017** by sending a Letter of Development Policy (LDP). The GoC meets all three criteria to access financing through the regional sub-window on refugees and host communities[1]: (a) Cameroon hosts 375,415 refugees as of end-2016,[2] (b) the World Bank Group in consultation with the United Nations High Commissioner for Refugees (UNHCR) has determined that Cameroon adheres to a framework for the protection of refugees that is adequate for the purpose of the IDA18 RSW,[3] and (c) the GoC has articulated a strategic approach to move toward long-term solutions that benefit refugees and host communities. The access to the RSW for Cameroon was approved by the Board on September 29, 2017. The AF will support the implementation of Cameroon's policy commitments related to the refugee issues outlined in the LDP. The proposed AF package is scheduled to be presented to the Board in April 2018, to be effective in June 2018, and the current closing date of May 21, 2021, will be extended to December 31, 2022.

3. **The proposed AF will be implemented as part of an integrated multisectoral approach** in partnership with the Education, Social Protection and Labor, and Social, Urban, Rural, and Resilience Global Practices.

4. **Since 2012, performance-based financing (PBF) has successfully been implemented in Cameroon as a mechanism to improve the quality and accessibility of health services in regions already**

[1] A country is eligible if (a) the number of UNHCR-registered refugees, including persons in refugee-like situations, it hosts is at least 25,000 or 0.1 percent of the country population; (b) the country adheres to an adequate framework for the protection of refugees; (c) the country has an action plan, strategy, or similar document that describes concrete steps, including possible policy reforms that the country will undertake toward long-term solutions that benefit refugees and host communities, consistent with the overall purpose of the window.
[2] UNHCR. 2016. "Global Trends: Forced Displacement in 2016."
[3] Adequacy is determined based on adherence of national policies and/or practices consistent with international refugee protection standards.

affected by the refugee crisis. The Cameroon Health Sector Support Investment Project (P104525) implemented PBF in the East regions (100 percent coverage) in 2012. The impact evaluation of this project, (IE) conducted in 2015, showed significant improvements in the quality of health services, reduction of user fees, reduction of corruption, and improved utilization of health services (for example, family planning and vaccinations)[4]. This success led to the GoC's decision to scale-up PBF nationally with the support of the Health System Performance Reinforcement Project (P156679), which was approved by the Board in 2016. The national scale up of PBF commenced in the Far North, North, and Adamawa regions in 2016. Routine data have already shown some improvements in the quality, accessibility, and utilization of health services. Similar to observations in other fragile states such as the Central African Republic (CAR), Burundi, and the Democratic Republic of Congo, PBF has been shown to improve the resilience of health facilities during a humanitarian crisis and improve their capacity to provide health services for the affected population.

5. **Building on the success of the parent project, and the PBF program in Cameroon, the AF will finance PBF payments** to (a) establish health facilities in refugee-hosting regions to reinforce the equitable coverage of the current primary health care, maternal and child health and nutrition package; (b) scale up civil registration and vital statistics (CRVS) activities; (c) reinforce monitoring and evaluation (M&E) systems; and (d) strengthen communicable disease surveillance systems and epidemic preparedness and response in refugee-host communities and refugee camps.

6. **In addition, the AF will support new activities specific to the health needs of refugees not covered by the parent project**, including (a) provision of emergency, sexual, and reproductive health services, including those related to the management of gender-based violence (GBV) including physical, sexual, and psychological violence and female genital mutilation (FGM); (b) nutrition, deworming, and soft WASH service delivery and activities related to the Early Years Package; (c) implementation of a comprehensive mental health and psychosocial support program; and (d) support for institutional capacity building, including, but not limited to, (i) sensitivity training of frontline health professionals, community health workers (CHWs), community-based organizations (CBOs), and civil registration officers; (ii) skills training of health professionals on basic and comprehensive emergency obstetric and newborn care; (iii) training of health professionals and CHWs on the management of GBV, FGM, mental health, psychosocial conditions, nutrition, neglected topical diseases (NTDs), and WASH.

7. **Considering the inherent security and health risks associated with a humanitarian crisis, as well as the ongoing political risks, a CERC has been included in accordance with Bank Policy, IPF, Section III paragraphs 12 and 13 for projects in Situations of Urgent Need of Assistance or Capacity Constraints.** This will allow for rapid reallocation of project proceeds in the event of a natural or artificial disaster or crisis that has caused, or is likely to imminently cause, a major adverse economic and/or social impact.

B. Country, Economic, and Social Context

8. **Cameroon is a lower-middle-income, central African country that shares borders with six countries[5] including Nigeria and Chad in the north and CAR in the east.** Cameroon's population is large

[4] De Walque, D; Robyn, RJ; Saidou, H; Sorgho, G, Steenland, M. 2017. "Looking into the Performance-Based Financing Black Box. Evidence from an Impact Evaluation in the Health Sector in Cameroon."
[5] Nigeria, Gabon, Equatorial Guinea, Democratic Republic of Congo, Chad, and CAR.

(22.8 million), young (41 percent under 15 years), and diverse, with 250 ethnic groups spread across its 10 regions.[6]

9. **Despite Cameroon's resilient and diversified economy, the global oil shock and security challenges have had an impact on economic growth**. Cameroon is well endowed with natural resources, (oil, timber, fertile land, agricultural production including coffee, cotton, and cocoa) and in 2016, the gross domestic product (GDP) per capita per year (purchasing power parity [PPP]) was estimated at US$3,285. Following a recession during the mid-90s, growth accelerated to almost 6 percent (2014–2015), reflecting strong public infrastructure investments, coupled with favorable commodity prices and financial deepening. Growth declined to an estimated 3.7 percent in 2017, driven by the continued decline in rubber, coffee, and oil production, precipitated by the sharp decline in oil prices (from US$110 per barrel in 2014 to US$55 per barrel in 2017), and aging plantations. Cameroon's growth slowdown, in the presence of a relatively diversified and resilient economy, reflects a narrowing of its fiscal and external margins of maneuver and an increase in its public debt. Cameroon remains unable to realize its full development potential mostly because of its poor infrastructure, unfavorable business environment, and weak governance of the private and public sectors.

10. **Despite more than a decade of consistent economic growth, 37.5 percent of Cameroonians live below the poverty line, chronic poverty stands at an estimated 26 percent and the number of absolute poor increased by 12 percent between 2007 and 2014 to 8.1 million people.[7]** Poverty is increasingly concentrated in rural areas and the northern[8] regions. A total of 56.8 percent of people in rural areas and the majority of people in the Far North (74.3 percent), the North (67.9 percent), the North-West (55.3 percent) and, to a lesser extent, Adamawa (47.1 percent) live on less than US$1.95 a day. Inequality has increased, per capita income has stagnated, and the Gini coefficient is high at 44.0 (2014), implying that the bottom 20 percent consume less than 5 percent of all consumption, whereas the richest 20 percent consume almost half of all consumption. Poverty is gender biased. In comparison to men, women have fewer completed years of education (8.2 years versus 6.7 years) and lower literacy rates (87 percent versus 74 percent), with negative impact on economic welfare, fertility, child survival, and access to reproductive and health services. Entrenched patriarchal norms dictate that girls and women in these communities are married early,[9] have limited access to land, and are prohibited from inheriting on the death of their husband.

Refugee Crisis in the Northern and East regions

11. **Four of Cameroon's poorest regions (Far North, North, Adamawa, and East) experience persisting fragility due to security threats in its borders with CAR (East, Adamawa, and North regions) and Nigeria (Far North).** These regions collectively host an estimated 338,505 refugees and asylum-seekers[10] fleeing the conflict in CAR and Boko Haram insurgents on Cameroon's borders with Nigeria and

[6] Cameroon is administratively divided into 10 regions: Far North, North, Adamawa, West, North-West, Littoral, South-West, South, Central, and East.
[7] Cameroon's fourth household survey.
[8] Northern regions refer to the Far North region, North region and Adamawa region.
[9] The legal age of marriage for girls in Cameroon is 15 years, versus 18 years for boys, and in Adamawa, Far North, and North-West regions, girls are married between 8 and 9 years. UNHCR. "Cameroon: Information on Forced or Arranged Marriage." Accessed November 28, 2017, http://www.refworld.org/docid/3f51ec864.html.
[10] As of end November 2017. Data source from UNHCR.

Chad. Cameroon currently hosts the 11th largest number of refugees in the world and 6th largest in Africa, and refugees constitute over 2 percent of Cameroon's population.

12. **Even before the massive influx of displaced populations, refugee-hosting regions (northern[11] and East regions) experienced the highest and deepest levels of poverty, highest inequality rates, and lowest human development (HD) indicators in Cameroon.** Hosting regions are subject to multiple poverty traps, including low agriculture productivity, poor infrastructure, high fertility, and limited access to basic social services (health, education, water, and sanitation), and livelihood. They account for 66 percent of poor households in the country, even though they are home to only 38 percent of Cameroon's population. Forced displacements have greatly increased humanitarian needs, exacerbated poverty levels, and put significant pressure on already overstretched social, economic, and governance structures and natural resources. The increased fragility, insecurity, and violence in the border countries and northern regions have resulted in the loss of livestock, interruption of agricultural activities, trade decreases, and closed markets, roads, and borders.

13. **There are two distinct refugee situations in Cameroon**—with marked differences in the challenges faced by refugees and host communities.

14. **Approximately 248,000 refugees from CAR live along the eastern border (the majority of them in the East region and the rest in the Adamawa and North regions).** These refugees fled the violence in CAR in two waves. The first occurred between 2003 to 2006 and saw an estimated 100,000 CAR refugees settling in Cameroon, while the second wave (after 2013) led to an influx of an additional 160,000 CAR refugees. Overall, 69 percent of CAR refugees have achieved a degree of socioeconomic inclusion, are integrated in villages among the host communities, and sometimes live in households headed by Cameroonians; however, 31 percent of CAR refugees live in one of seven dedicated refugee sites. CAR refugees represent about 5 percent of the total population in Adamawa and 18 percent in the East region. In some municipalities, CAR refugees represent more than half of the overall population (that is, in Kenzou—East region—CAR refugees account for 70 percent of total population). In some areas, post-2013 refugee arrivals have put a strain on host-refugee relationships, which were largely positive, and have led to conflict over resources and land use. Humanitarian assistance, often primarily directed to refugees, has also caused resentment among host communities who do not benefit from humanitarian aid. Despite humanitarian efforts directed toward refugees, the majority remain fully dependent on aid and live in extreme poverty.[12] The situation may further deteriorate as a result of the gradual reduction of humanitarian assistance, for example, between 2017 and 2018, the World Food Programme (WFP) reduced the number of refugees receiving monthly food rations by 50 percent.

[11] Northern regions refer to the Far North region, North region and Adamawa region.

[12] According to a Food Security and Poverty Vulnerability Analysis of CAR refugees in Cameroon, conducted by the American University of Beirut in collaboration with UNHCR and WFP, poverty is alarmingly widespread among the CAR refugee population, with the vast majority living far below the extreme poverty line. Based on the Republic of Cameroon's national poverty lines, 98.5percent of CAR refugees fall below the poverty line (CFAF22,500 per person per month) and 97.7percent fall below the extreme poverty line (CFAF 17,962 per person per month). This is equally true for the old (arrival between 2004 and 2006) and new caseload (arrival between 2013 and 2017). Even when applying the Minimum Food Basket, as determined by WFP, which established that a person needs a minimum of CFAF 8,800 per month to reach minimum food requirements of 2,100 kcal per day, 70.1 percent of the total CAR refugee population do not have sufficient means to consume sufficient levels of food even with current levels of assistance provided.

15. **Approximately 91,000 refugees from Nigeria live in the Far North region.** The destabilizing impact of the refugee population in this region is compounded by the presence of 242,000 internally displaced persons (IDPs). These refugees fled the Boko Haram attacks and most have been in exile for three to four years. The majority of Nigerian refugees (± 62,500 refugees as of January 31, 2018) live in the Minawao refugee camp, where living conditions are poor and the population remains fully dependent on humanitarian assistance. The remaining 25,000 to 30,000 Nigerian refugees live outside the camp, side-by-side with IDPs, and host populations in villages. UNHCR has registered all Nigerian refugees residing in the Minawao camp using a biometric registration system and have distributed refugee-ID-cards; however, refugees who reside outside of the camp are yet to receive refugee-ID cards to facilitate their identification and protection. The limited social and economic inclusion of Nigerian refugees into host communities has been attributed to the fact that (a) Nigerian refugees are mobile and about 25 percent have experienced multiple displacements; (b) the Far North region has been a breeding ground for members of Boko Haram, who have led indiscriminate violent attacks and suicide bombings against civilian and armed forces and raid villages on Cameroonian territory; and (c) the lack of identification documents of out-of-camp refugees makes it difficult to distinguish between refugees, IDPs, and hosts. Overall, the situation remains very fluid, with ongoing movements of people that follow the ebb and flow of the conflict. Inflows of refugees and IDPs, continued insecurity, violent attacks, and cross-border traffic restrictions have destabilized the economy of a region that was already very poor, underserved, and largely dependent on trade with Nigeria. The continued volatility in CAR and increasing frequency of attacks by Boko Haram, reduces the likelihood of refugees returning home; if anything, increasing numbers are expected in the northern and East regions

16. **The majority of refugee children do not have birth certificates.** According to a Food Security and Poverty Vulnerability Analysis of CAR refugees in Cameroon, an estimated 70 percent of refugee children under five years, in the North, do not have a birth certificate. Moreover, 87 percent of refugees in the East region have not registered all their children, compared to less than 30 percent of host community families. These estimates are expected to be worse among Nigerian refugee children in the Far North regions.

17. **GBV, including sexual violence,[13] against women is widespread in Cameroon, and more specifically in refugee-hosting communities, and prostitution has become a survival mechanism consequent to the limited access to livelihoods for refugees.** The Demographic and Health Survey (2011) showed that 55 percent of women over 15 years of age experienced physical violence, mostly by their current or recent partner and also by biological and stepparents or siblings. About 20 percent of sexually active women report their first sexual experience (that is, first time) as being forced, especially for those under the age of 15 (30 percent). Among ever-married women, 60 percent have suffered physical, sexual, or emotional violence at the hands of their current or former husband. Women are particularly vulnerable to sexual violence when collecting firewood, drawing water, using latrines at night, and moving outside their camp. Harmful traditional practices, including breast ironing and female genital mutilation or cutting (FGM/C), are prevalent in Cameroon (1 percent of girls and women ages 15–49 years have undergone

[13] GBV refers to physical, sexual, emotional, and psychological abuse, and financial control by a person (or a group of people) that cause harm to another person.

FGM/C, 2004–2015)[14] and in female refugees from Chad (44 percent)[15], Nigeria (25 percent),[16] and CAR (24.2 percent).[17] While FGM/C was criminalized in Cameroon in 2016, concrete measures have not been implemented to enforce this law, which reduces the likelihood that these practices will stop, particularly in refugee communities.

18. **The GoC is committed to addressing the crises and has adopted an emergency plan to respond to the impact of the crises in the four regions**. An interministerial ad hoc committee to manage the refugee crisis was created by the GoC by Presidential Order 269 on March 13, 2014. The Government relies heavily on humanitarian partners, including UNHCR, and development partners to provide assistance to refugees (Box 1). This largely reflects the lack of fiscal resources and limited administrative and technical capacity available in remote border regions. Part of the commitment by humanitarian and development partners is through budget support and multiannual cooperation programs. In addition, the Government is strongly committed to the ongoing Recovery and Peacebuilding Assessment (RPBA) process, which was launched in 2017 and has a dedicated pillar: that is, 'security, forced displacement and protection'. Finally, the LDP clearly outlines the engagement of the GoC to improve the living conditions of displaced persons and refugees.[18] Box 1 illustrates the key stakeholder agreements that the GoC has taken to address the refugee crisis.

[14] OHCHR. "Committee on the Rights of the Child Examines the Report of Cameroon." Accessed November 28, 2017, http://www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=21675&LangID=E

[15] Percentage represents the prevalence of girls and women ages 15–49 years who have undergone FGM/C between 2004 and 2015.

[16] Percentage represents the prevalence of girls and women ages 15–49 years who have undergone FGM/C between 2004 and 2015.

[17] Percentage represents the prevalence of girls and women ages 15–49 years who have undergone FGM/C between 2004 and 2015.

[18] Cameroon is a party to most major international agreements relevant to refugees. These include the 1951 Convention and the 1967 Protocol relating to the Status of Refugees and the 1969 Organisation of African Unity Convention Governing the Specific Aspects of Refugee Problems in Africa. The status and treatment of refugees in Cameroon is governed by Law No. 2005/006 of July 2005 and implementing Decree No. 2011/389 of November 2011. Under these statutes, registered refugees and IDPs can access health and education services without paying significant fees. Documentation, however, remains a critical issue.

Box 1. Stakeholder Agreements for Long-Term Solutions That Benefit Refugees and Host Communities

Agreement 1: The Ministry of Economy, Planning and Regional Development (Ministère de l'Economie, de la Planification et de l'Aménagement du Territoire [MINEPAT]), European Union, United Nations (UN), and World Bank; July 2016

The RPBA (2018–2022), targeting the four regions, was launched in 2017. It (a) assessed economic, social, and physical impact of the conflict in the Far North region; (b) identified immediate and medium-term recovery and peacebuilding requirements; (c) laid the foundations for elaboration of a longer-term recovery and peacebuilding strategy; and (d) aimed at strengthening the link between humanitarian, development, and peacebuilding.

Agreement 2: MINESANTE and UNHCR; August 2016

UNHCR committed to financing 70 percent of fees for health services in public health facilities for CAR and Nigerian refugees in the Far North, North, Adamawa, and East regions for 2018–2020.[19] The convention is valid for two years (renewable), with an estimated allocation of US$19 million for 2018–2020.[20]

Agreement 3: UNHCR, Government of Cameroon, and Government of Nigeria; March 2017

Tripartite agreement for the voluntary repatriation of Nigerian refugees living in Cameroon. A Tripartite Commission was established to oversee the implementation phase of the agreement and ensure that practical modalities are developed to carry out the terms of the agreement.[21]

Agreement 4: MINEPAT, UNHCR (October 2016), and World Bank (from June 2018)

The objective of this agreement is to improve the living conditions of the populations in the East, North, and Adamawa regions that host the refugees from CAR. Under this agreement, the following activities are included: (a) elaborate a support plan for the local councils that host refugees and mobilize funds for its implementation, (b) facilitate inclusion of the needs of refugees and hosting populations in plans and budgets of the Government and development partners, and (c) coordinate socioeconomic interventions related to improving the living conditions of refugees and host populations. A Steering Committee and a Technical Secretariat were established. Functioning of the Technical Secretariat is financed by UNHCR until June 2018; thereafter, the functioning of the Technical Secretariat will be financed by the four projects benefiting from the IDA18 RSW. These include the three AFs (HSPRP - P164954; the Social Safety Nets for Crisis Response Project - P164830 [SSNP], and the Community Development Program Support Project Response to Forced Displacement - P164803 [CDPSP]), and the Education Reform Support Project - P160926 [ERSP]).

Agreement 5: Letter of Development Policy (August 11, 2017)

The LDP on the support program for refugees and their host communities is the Cameroonian Government's statement of commitment to displaced persons and refugees, outlining the measures that have been implemented to improve their living conditions.

C. Sector and Institutional Context

19. **Poor maternal, reproductive, and child health and nutrition outcomes in Cameroon continue to be profound and a pervasive problem**. Cameroon ranks 145 out of 179 countries on the mother's index,

[19] Convention Cadre entre Le Ministère de la Santé Publique et Le Haut-commissariat des Nations Unies pour les Réfugiés au Cameroun (2016). Accessed January 20,2018. https://www.humanitarianresponse.info/system/files/documents/files/convention_hcr_minsante.pdf

[20] Republic of Cameroon, Development Policy Letter, August 14, 2017.

[21] Relief web (2017). Tripartite Agreement for the Voluntary Repatriation of Nigerian Refugees Living between the Government of the Republic of Cameroon, the Government of the Federal Republic of Nigeria, and the UN High Commissioner for Refugees. Accessed January 20, 2018. https://reliefweb.int/report/cameroon/tripartite-agreement-voluntary-repatriation-nigerian-refugees-living-cameroon

lagging behind poorer countries, such as Mozambique, Uganda, and Zimbabwe.[22] Maternal mortality increased between 1990 to 2014 (from 430 to 782 maternal deaths per 100,000 live births).[23] Child mortality remains extremely high (national average: 103 deaths per 1,000 live births), particularly in the poorest parts of the country such as the North (173 deaths per 1,000 live births) and Far North (154 death per 1,000 live births), where close to 20 percent of children die before their fifth birthday. Almost one-third of children under five years test positive for malaria (30 percent) and suffer from diarrhea (20 percent) and 35 percent of children under two years are not fully immunized.[24].

20. **Malnutrition affects a large proportion of children in Cameroon, and the overall percentage of wasting among children under five years doubled between 2004 and 2011.** In 2014, one-third (32 percent) of children in Cameroon were stunted, which is four times that of the upper-middle-income country average.[25] In comparison to urban areas (22 percent), stunting in the rural areas (41 percent) was significantly higher, particularly in the poorest regions; Far North (44 percent), North (40 percent), Adamawa (40 percent), and East (38 percent).[26] Malnutrition is the contributing cause of almost half (48 percent) of under-five deaths.[27] Undernutrition is a major cause of lost human capital in the Cameroonian population, through direct losses in productivity linked to poor physical status, indirect losses due to poor cognitive function, learning deficits, and losses resulting from increased medical costs.

21. **Infectious diseases, including malaria and human immunodeficiency virus (HIV) infection, remain the leading causes of death in Cameroon.** In 2016, an estimated 560,000 people were living with HIV in Cameroon and 29,000 people died from acquired immunodeficiency syndrome (AIDS)-related complications, accounting for 13.4 percent of all deaths in Cameroon.[28] Malaria contributes to the largest disease burden in Cameroon (absolute Disability Adjusted Life Years (DALYs): 2,035,765.50[29]). It accounts for 40–50 percent of medical consultations, 40 percent of deaths among children less than five years, and 23 percent of hospitalizations. Malaria is the leading cause of death among children under five years and pregnant women.

22. **Refugees, particularly women and children, have a disproportionately higher burden of disease compared to the host population**. The most prevalent diseases in refugees in Cameroon are upper respiratory tract infections (20.8 percent), malaria (7.6 percent), intestinal worms (7.4 percent), and watery diarrhea (6.8 percent). Furthermore, refugees in Cameroon have a high burden of non-communicable diseases such as musculoskeletal disorders (31.8 percent) and cardiovascular diseases (26.3 percent). WASH services are a critical need in refugee-affected areas.[30] Only 28 percent of the

[22] "State of the World's Mothers. 2015. Save the Children." Indicators of the 2013 mother's index include (a) lifetime risk of maternal death, (b) under-5 mortality rate, (c) expected years of formal education, (d) gross national income per capita, and (e) participation of women in national government.
[23] *Source:* MICS 2014.
[24] *Source:* MICS 2014.
[25] Stunting, defined as low height-for-age, is an indicator of chronic malnutrition. *Source:* MICS 2014.
[26] *Source:* MICS 2014.
[27] *Source:* MICS 2014.
[28] WHO. "Cameroon: WHO Statistical Profile." http://www.who.int/gho/countries/cmr.pdf?ua=1. Accessed November 21, 2017.
[29] DALY is a measure of overall disease burden expressed as the number of years lost due to ill-health, disability, or early death. It represents two categories, Years of life lost and years lived with disability.
[30] UNICEF. 2017. "Cameroon Humanitarian Situation Report." https://reliefweb.int/report/unicef-cameroon-humanitarian-situation-report-september-2017. Accessed November 26, 2017.

population in the North, East, and Adamawa regions have access to potable water[31] and less to adequate sanitation. This increases the risk of diseases directly attributed to the lack of water and sanitation facilities and hygiene, including diarrheal diseases, intestinal worms, and parasitic infestations, as well as preventable outbreaks such as cholera and hepatitis E.

23. **Mental health problems have been identified as a critical challenge for refugees in Cameroon, and in 2016, epilepsy (63 percent) and psychotic disorders (22.1 percent) were the most common mental health illness in refugees.** Refugees often have acute mental health conditions and trauma symptoms including depression and post-traumatic stress disorder (PTSD) consequent to atrocities faced before or during displacement, separation, GBV including sexual violence, resettlement, and the traumatic migration experience. This trauma is compounded by a generalized sense of hopelessness, absence of employment opportunities, and social dysfunction. Children and adolescents often have higher prevalence of mental illness with various investigations revealing rates of PTSD (50 to 90 percent) and major depression (6 to 40 percent).[32] Those with mental disorders are more likely to engage in unhealthy lifestyle behaviors such as smoking, alcohol use, poor nutrition, and lack of physical activity and have a significantly increased risk of developing another chronic disorder.

24. **At least 22 percent of refugees in Cameroon are women of reproductive age (2016) and 20 percent are children under five years.** Displacement complicates the delivery of maternal and obstetric care, increases the risk of illegal abortion and unsafe childbirth. In crisis settings, at least 15 percent of pregnant women need emergency obstetric care, 9–15 percent of newborns need lifesaving emergency care, young girls have less control over when they fall pregnant, and married adolescents have the lowest contraception use. Consequently, the majority (over 60 percent, 2015) of preventable maternal and child (53 percent, 2015) deaths occur in countries affected by humanitarian crisis or fragile settings. This translates to an estimated 500 women dying during childbirth every day from giving birth in humanitarian and fragile settings.

Institutional Context

25. **The GoC has identified PBF as a central strategy to address weaknesses in its health systems** and aims to (a) improve the efficiency of the allocation and use of resources, (b) improve health worker performance through increased motivation, satisfaction, and autonomy for decision making at the point of service delivery; and (c) increase the population's use of essential health services through improved quality of health services and cost reduction of these services. Cameroon has a rich experience in PBF, which has been implemented in the country for six years. The Health Sector Support Investment Project (HSSIP, P104525) supported the implementation of PBF in 44 of the 189 health districts in Cameroon. Indeed, the scale-up of PBF to a national program by the HSPRP (P156679), the parent project, builds on the results and lessons learned from HSSIP and the experiences of other countries implementing similar projects. Since the launch of PBF, the quality and utilization of maternal and child health services has been increased substantially.

[31] *Source:* Republic of Cameroon, Development Policy Letter, August 14, 2017.
[32] The World Bank 2016. "Mental Health among Displaced People and Refugees: Making the Case for Action at the World Bank Group."

26. **UNHCR in partnership with other local and international humanitarian (for example, International Medical Corps) and development partners provide free health care for the majority of refugees in Cameroon; however, financing is diminishing.** In the Far North, where the limited number of largely dilapidated health facilities are under resourced, UNHCR has established health facilities within the Minawao refugee camp, with dedicated health personnel and resources, to cater to the health needs of refugees. Refugees who reside outside of the camps in the northern regions and those residing in the East regions—where the rollout of PBF has significantly improved the quality of health services and capacity of health centers—receive health care services at health facilities and the costs are covered by UNHCR. A limited number of 'new arrivals', yet to be registered with UNHCR, who required medical attention at health facilities (outside of the camp) were considered 'vulnerable' using the PBF mechanism and received health care at no charge. These health facilities received an average PBF subsidy for the management of a limited number of vulnerable refugees and host populations.

D. Original Project Status and Performance

27. **The parent HSPRP (P156679) is a five-year project with two sources of financing:** (a) US$100 million of IDA to scale up PBF from a pilot project to a national program and (b) US$27.00 million grant from the Multi-Donor Trust Fund for the Global Financing Facility (GFF), to improve reproductive, maternal, newborn, child, and adolescent health (RMNCAH). It received Board approval on May 3, 2016 and became effective on December 13, 2016, with a closing date of May 31, 2021. According to the Implementation Status and Results Reports (ISRs) between October 2016 and 2017, progress toward achievement of the PDO and overall implementation were both rated Moderately Satisfactory. The overall safeguards rating is rated Satisfactory. To date, approximately 9.43 percent of IDA credit (US$9.66 million) and 15.04 percent of the GFF grant (US$4.06 million) have been disbursed. The disbursement level is below projections because of a 12-month overlap between the pilot PBF program (HSSIP) (approved in 2008) and the parent HSPRP. With the closure of HSSIP on December 31, 2017, disbursement levels are expected to increase rapidly over the next few months. This is the first AF of the HSPRP.

28. **The PDO of the parent project is to 'increase utilization and improve the quality of health services with a particular focus on reproductive, maternal, child and adolescent health and nutritional services'.** It is supply oriented and involves contracting health facilities to provide maternal and child health services to target populations through PBF. The project was designed not only to strengthen the health system at all levels but also to ensure the availability of a minimum package of RMNCAH services for the population in the context of achieving Universal Health Coverage (UHC) for every women and every child in selected provinces. Health services targeted by the intervention include, but are not limited to, outpatient consultations, immunization of children, antenatal care (ANC) services, assisted deliveries, family planning services, prevention and treatment services for HIV/AIDS, malaria, and tuberculosis. In addition to improving access to and utilization of quality health services for the general population, the project maintains a specific focus on improving access to and utilization of essential health services for vulnerable populations.

29. The parent project has two components:

(a) **Component 1: Strengthening health service delivery** (Total: US$109 million: US$89 million IDA, US$20 million GFF). It supports the scaling-up of PBF from a pilot project to a national

program, initially focusing on the three northern regions (Far North, North, and Adamawa). This component has three subcomponents:

- **Subcomponent 1.1: Payment of performance** (US$70 million IDA). It supports the incremental scale-up of PBF to all 189 districts in Cameroon, and provides PBF payments to (a) health facilities conditional on the quantity and quality of services delivered through in-clinic activities and/or through health-outreach activities (b) CHWs for providing select basic preventative and referral health services, as well as ensuring community organization to support positive health behavior.

- **Subcomponent 1.2: Support the implementation and supervision of PBF** (US$11 million IDA, US$8 million GFF). It supports PBF implementation and supervision (capacity building, verification and counter verification, IT system, and so on).

- **Subcomponent 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 supports the implementation of the GFF investment case (IC) for Cameroon, which includes RMNCAH activities, health systems strengthening approaches, and high quality nutritional services in the northern[33] and East regions.

(b) **Component 2: Institutional strengthening for improved health system performance** (Total: US$18 million: US$11 million IDA, US$7 million GFF [US$5 million for RMNCAH and US$2 million for CRVS]). It supports the strengthening of national, regional, and district institutions to improve health system performance. It provides institutional support for moving PBF from a pilot project to a national program, supports analytical work and policy dialogue to facilitate the development and implementation of health reforms that reduce bottlenecks in the health systems, and improves efficiency and health outcomes. Furthermore, this component supports analytical work and institutional reforms needed to develop a national health strategy and also supports Cameroon toward achieving UHC. This component has three subcomponents:

- **Subcomponent 2.1: Supports 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). It contributes to the building of a reliable health information system for tracking key performance indicators. It provides resources to support the ongoing rollout of the District Health Information Software 2 (DHIS2) platform, the national PBF portal, and the links between the two.

- **Subcomponent 2.2: Reinforcement of civil registration and vital statistics systems** (US$2 million IDA, US$2 million GFF). It supports the building of the national CRVS systems. The National Office of Civil Registration (*Bureau National de l'Etat Civil,* BUNEC) has recently been established, and its role is to coordinate interventions from different ministries related to civil registration. In partnership with the Ministry of

[33] Northern regions refer to the Far North region, North region and Adamawa region.

Public Health (MoPH), it supports investments to improve data collection and quality for mothers and children.

- **Subcomponent 2.3: Program coordination** (US$5 million IDA, US$2 million GFF). It supports operating costs for the PBF Technical Unit (*Cellule Technique Nationale PBF*) and Project Implementation Unit (PIU) (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 MoPH (Direction of Family Health, Direction of Health Promotion, Direction of Human Resources, Direction of Financial Resources and Planning, and so on) and the National Program for the Reduction of Maternal and Child Mortality, which is playing a coordination role in GFF. These performance contracts are tools to enhance governance and stewardship in the Central MoPH departments and are an essential part of the project.

30. **Progress under Component 1 is satisfactory.** The scaling-up of PBF is ongoing and the first phase (2016–2018) targets 55 new districts. To date, 78 of the 189 districts and 47 percent of the Cameroonian population are covered by PBF, including 100 percent coverage in the East, Adamawa, and North regions. Far North (41 percent), Littoral (56 percent), North-West (65 percent), and South-West (62 percent) are partially covered, and PBF activities will commence in the Center, South, and West regions in 2018. Additional ongoing activities include the training of personnel, mapping of health facilities in targeted districts, hiring of additional verification agents, and signing of performance contracts with new health facilities. Scaling-up of PBF in the Far North region was delayed due to the ongoing insecurity and long process to establish a regional Contract Development and Verification Agency (CDVA). The security challenges in the Far North have also delayed GFF activities that support nutrition, adolescent health, and CRVS.

31. **Progress under Component 2 is satisfactory.** In 2018, the following surveys will be conducted in Cameroon to fill information gaps of other data collection activities: (a) the first round of the Service Delivery Indicator (SDI) survey for health and (b) the Health and Social Safety Net projects' household survey, covering the four regions prioritized by the GFF-supported RMNCAH IC (Adamawa, East, Far North, and North). Elaboration on the national health financing strategy is ongoing, with significant analytical work being carried out to support this. The GFF-supported IC was validated at the national level on October 18, 2016 and is now at the implementation stage. The Government is currently organizing regional workshops in the four priority regions to develop regional implementation plans. To date, the East and Adamawa regions have been completed and the remaining two regions will be completed in the coming months. BUNEC is currently designing the PBF civil registration program, which will be piloted in three regions (Adamawa, Littoral, and South-West) in 2018. A workshop to design and develop indicators and tools for this pilot project took place in Douala in October 2017.

E. Rationale for AF

32. **Given the growing numbers of refugees and IDPs, the escalating humanitarian crisis, and rapidly increasing health needs of refugees and refugee-host communities**, the GoC seeks an AF to the HSPRP to urgently reinforce select activities currently being implemented as part of the parent project and

introduce a set of priority interventions that address the specific health, nutrition, and WASH needs of refugees and host populations.

33. **The proposed changes will strengthen the parent project's overall development impact of improving the health of women, children, and adolescents**, and the Health, Nutrition, and Population Global Practice goal of ending preventable deaths and disability through health systems strengthening for UHC. It builds on the achievements of the parent project while seeking to strengthen the existing program package to better serve the needs of refugees. Furthermore, the proposed AF will contribute to the attainment of Sustainable Development Goals: 1 (No Poverty), 2 (Zero Hunger), 3 (Good Health and Well-Being), and 5 (Gender Equality).

34. **The proposed investment is aligned with the new Country Partnership Framework of Cameroon** (Report No. 107896-CM, February 28, 2017), as well as the Government's strategy to improve the living conditions of refugees, IDPs, and host populations. Lastly, the AF will facilitate the GoC's commitment to move toward long-term solutions that benefit refugees and host communities (Box 1).

35. **The proposed AF is fully consistent with the original PDO**. There are no outstanding or unresolved safeguards in the project. The additional investments would neither require any changes to the environmental category B of the project nor would they trigger any new safeguard policies. The proposed package of interventions will also complement and reinforce those being introduced as part of the Governments National Action Plan for the Early Years, thus strengthening the development impact of both projects. The Early Years Plan for Cameroon, which also focuses on the northern[34] regions, will address the multisectoral constraints to early childhood development by introducing activities related to (a) social protection (communication for behavior change through home visits and parental education), (b) nutrition (multisectoral approach at the decentralized/local council level), (c) education (comprehensive early childhood development education system), and (d) health.

F. Rational for an Integrated Multisectoral Approach

36. **The World Bank is adopting an integrated approach, with four projects targeting refugees and host communities, to enhance the impact on the refugee population and host communities.** These include three AFs (HSPRP - P164954; the Social Safety Nets for Crisis Response Project - P164830 [SSNP], and the Community Development Program Support Project Response to Forced Displacement - P164803 [CDPSP]), and the Education Reform Support Project - P160926 [ERSP]), all of which will benefit from the RSW financing and aim to support refugees and host communities (Box 2; annex 3). Integrated approaches, implemented in a coordinated and multisectoral fashion, are more effective and have greater impact than interventions that work in isolation. The proposed activities largely complement each other and will be implemented in parallel. It will address the multisectoral determinants of health resulting in a greater impact on health outcomes, and the sharing of resources, where possible, will make the overall project more cost-effective.

37. **The implementation of a harmonized approach between these four projects will provide an integrated package of services to host communities.** This would include (a) aligning HD interventions with local planning processes, (b) promoting synergies between the construction of basic infrastructure under

[34] Northern regions refer to the Far North region, North region and Adamawa region.

the CDPSP and cash-for-work under the SSNP; (c) using community workers across all projects to provide HD, psychosocial, and social cohesion services. For example, as part of the integrated approach, under the HSPRP, ERSP, SSNP and CDPSP, teachers (education), CHW (health), and community workers (SSNP and CDPSP) will be trained and sensitized on GBV including sexual violence, mental health, psychosocial problems, as well as early warning signs (for example, signs of psychological distress), for implementation at the community level. A confidential, coordinated referral mechanism will be established for referral to community-level support mechanisms or health specialist at the health facility, as appropriate.[35]

38. **Integrated coordination of projects' stakeholders at the local and national levels will ensure synergies of the responses.** The three projects (SSNP, HSPRP and CDPSP III) will harmonize their methodology for the implementation of activities targeting communities and at local council level to ensure synergies, information sharing, coordination and collaboration, and avoid duplication and fragmentation. All existing sectoral communal committees (CDPSP, ERSP and SSNP) will be integrated into one overall committee at the communal level. CHW representatives and members of the district health committee will participate in coordination meetings organized at the local council level. This will be achieved through CDPSP III-supported Municipal Councils Extended to Sectors, which monitor elaboration and implementation of Communal Development Plans (CDPs). At the village level, the CHW will participate in the village development committees (*Comités de Concertation*) established by the CDPSP over the last decade. Refugees will be represented in the villages' committees. At the regional level, regional delegation of public health and CDVA representatives will participate in quarterly coordination meetings held between different PIUs, local authorities, and humanitarian actors including UNHCR. At the national level, the national PBF unit in partnership with other respective PIUs will de facto collaborate and coordinate, as they will consolidate M&E reporting on RSW-financed activities and regularly report to an ad hoc interministerial committee comprising MINEPAT, the Ministry of Territorial Administration (Ministre de l'Administration territorial [MINAT]), Ministry of Decentralization and Local Development, Ministry of Public Health (Ministère de la Santé Publique [MINSANTE]), Ministry of Basic Education (Ministère de l'Education de Base [MINEDUB]),[36] the World Bank, and UNHCR on refugee-related activities, in addition to their respective project's Steering Committees.

Box 2. Overview of Integrated Approach

The World Bank is supporting an integrated approach to address key challenges facing refugees and host communities, building on the work of ongoing projects (CDPSP, SSNP, and HSPRP) and complementing projects in the pipeline (ERSP).

Key features of the integrated approach include the following:

- Adopting common targeting mechanisms (same local council/health districts and harmonized vulnerability criteria);
- Integrating interventions across four projects (as related to refugees and host communities);
- Using consolidated reporting for the four projects on refugee-related activities;
- Aligning HD interventions with local planning processes;

[35] Mental Health and Psychosocial Support in Humanitarian Emergencies. 2017. https://interagencystandingcommittee.org/mental-health-and-psychosocial-support-emergency-settings/content/inter-agency-referral-guidance.

[36] The four projects included in the integrated approach will be represented by their respective line ministries.

- Promoting synergies between the construction of basic infrastructure under the CDPSP and interventions under the ERSP, SSNP, and HSPRP;
- Using community workers across all projects to provide HD, psychosocial, and social cohesion services;
- Using common grievance mechanisms; and
- Developing a single beneficiary database using existing national-, UNHCR-, and project-level data.

Concrete examples of the integrated approach

The integrated approach proposed in the Project Paper will promote synergies between the CDPSP and HD projects (ERSP and HSPRP. Therefore, if the CDPSP is supporting infrastructure investments in the health sector for example, this will be done in collaboration with the health project (that also benefit from AF under IDA18 RSW) that will focus more on the provision of qualified service providers, thus improving the quality of service delivery. The same approach will be used with regard to education.

The four projects will assess how to harmonize and integrate activities at different levels:

- Central level. The existing coordination mechanism established under the Partnership Agreement between the GoC and UNHCR will be used and reinforced.
- Project management level. The PIUs will coordinate at the national and regional levels, through an overlapping M&E framework, local coordination mechanisms and reporting to a refugee-specific Steering Committee.
- Community level. All existing sectoral communal committees (CDPSP, ERSP and SSNP) will be integrated into one overall committee at the communal level. CHW representatives and members of the district health committee will participate in coordination meetings organized at the local council level.

Building on the RPBA process, efforts will be made to engage with additional actors, including the UN Resident Humanitarian Coordinator, UN agencies, international humanitarian organizations, key bilateral partners, the private sector, and nongovernmental organizations (NGOs).

39. **The coordinated projects will provide two entry points for policy dialogue**:

(a) Establishing an integrated approach to the medium-term socioeconomic aspects of forced displacement to bridge fragmentation across Government entities and enhance Government coordination with humanitarian and development actors. Over time, the objective for the Government is to build capacity to lead the development response to forced displacement crises by factoring forcibly displaced populations systematically into national planning and resource allocation processes and to prepare for possible future shocks.

(b) The integrated approach will focus on lagging regions. To this end, the World Bank Group will support a review of allocation of Government resources according to vulnerability criteria, across all affected populations. This effort is part of the broader World Bank Group policy dialogue on decentralization and public financial management. For CAR refugees in the East, Adamawa, and North regions, the objective is to manage a gradual transition from humanitarian assistance to a government-led development approach, inclusive of both displaced persons and host communities. For Nigerian refugees in the Far North, where the security situation remains fluid, the focus is on restoring conditions for a medium-term intervention. Flexibility will be key to allow for needed adjustments as refugee situations evolve.

40. **The described approach will allow for quick implementation to address pressing needs and will also empower and strengthen the relevant sector agencies in addressing forced displacement under a common framework**. The proposed integrated approach leverages AF of existing operations to help significantly reduce the time lag between preparation and implementation, which tends to be long in Cameroon (12–18 months). Moreover, a dedicated senior staff, already based in Yaoundé—in addition to the respective Task Team Leaders and technical teams—will ensure the effective implementation and coordination of the proposed program, as well as synergies between the four projects that will benefit from RSW financing.

II. DESCRIPTION OF ADDITIONAL FINANCING

A. Project Development Objectives

41. **The proposed AF would entail a revision of the PDO to reflect the addition of refugees as program beneficiaries and inclusion of a CERC**. The revised PDO is to "(i) increase utilization and improve the quality of health services with a particular focus on reproductive, maternal, child and adolescent health, and nutritional services for the population of Cameroon, including refugees and refugee host communities, and (ii) in the event of an Eligible Emergency, to provide immediate and effective response to said Eligible Emergency." One PDO level indicator and two intermediate indicators will be added to the Results Framework to reflect the refugee beneficiaries and new project activities. Furthermore, the targets of the original indicators will be revised to reflect the increase in beneficiaries. The closing date will be extended to December 31, 2022.

B. PDO and Intermediate Level Indicators

42. **The proposed AF has eight PDO level indicators and 13 intermediate level indicators** that will be used to monitor progress in reaching the PDOs.

PDO level indicators

- Number of people who have received essential HNP services (Target 6,020,987)
- Percentage of children 12–23 months fully immunized in the 3 northern regions (Far north, North and Adamawa) and the East (Target 80 percent)
- Percentage of births attended by a skilled professional in the 3 northern regions (Far north, North and Adamawa) and the East (Target 55 percent)
- Average score of the quality of care checklist (Target 50 percent)
- Number of children under 24 months weighed for growth monitoring in the 3 northern regions (Far north, North and Adamawa) and the East (Target 1,646,480)
- Number of direct project beneficiaries (Target 8,267,467)
- Number of female beneficiaries (Target 4,216,408)

- Number of refugees who have received health care (curative and preventative) at health facilities in the northern (Far north, North and Adamawa) and East regions (Target 600,000)

Intermediate level indicators

- Percentage of pregnant women receiving at least 4 antenatal care visits in the 3 northern regions (Far north, North and Adamawa) and the East (Target 60 percent)
- Number of adolescent girls 10–19 years benefiting from multisectoral services supported by the GFF Investment Case (Target: 150,000)
- Percentage of women 15–49 using modern contraceptive methods in the 3 northern regions (Far north, North and Adamawa) and the East (Target: 22 percent)
- Number of children aged 6–59 months who received a vitamin A supplement in the last six months (Target 504,286)
- Percentage of facilities with 100 percent tracer drugs available in targeted health facilities on the day of the visit (Target: 40 percent)
- Percentage of the national population covered by the PBF program (Target: 95 percent)
- Percentage of the total budget for family planning needs funded by the Ministry of Public Health budget (Target: 50 percent)
- Number of consultations provided to the poor and vulnerable free of charge (Target 1,502,057).
- Number of patients/people referred to the health facilities by community health workers (Target 343,890).
- Percentage of reported maternal deaths audited in PBF districts (Target: 25 percent).
- Percentage of health facilities conducting community interface meetings (Target: 60 percent).
- Number of children and pregnant women dewormed (Target 3,542,000).
- Number of refugee children and pregnant women dewormed (Target 637,000).

C. Project Beneficiaries

43. **Project beneficiaries include refugees and refugee-host communities** in the Far North, North, Adamawa, and East regions.

D. Project Components and Financing

44. **The requested AF of US$36 million** will support the following: (a) reinforcement of select activities under Components 1 and 2 in refugee-affected areas (Far North, North, Adamawa, and East regions), (b) restructuring of the parent project to include (i) a third component that introduces interventions tailored to the health needs of refugees and refugee-host communities and (ii) a fourth component with a zero-dollar allocation, as a CERC.

45. **The proposed components are described in the following paragraphs.**

46. **Component 1: Strengthening of health service delivery** (Total costs under parent project: US$109 million: US$89 million IDA, US$20 million GFF. Total new costs under AF: US$130 million: US$89 million IDA, US$20 million GFF, US$6 million IDA AF credit, and US$15 million IDA18 RSW AF Grant). The parent project supports the national scale-up of PBF, starting in the three northern[37] regions. The AF will finance the reinforcement of equity mechanisms to ensure provision of primary health care, maternal and child health care, and nutrition services for refugees and vulnerable host populations. The AF will also finance new PBF indicators related to interventions targeted to specific needs of refugees, which will be added to the package of health care delivered at the community level, primary health centers, district and regional hospitals. These specific interventions include lifesaving sexual and reproductive health services, including those related to the management of rape, FGM, and GBV; deworming; soft WASH interventions; mental health; and psychosocial support programs.

47. Under Component 1, the AF will support the following activities:

(a) PBF payments to health facilities to

- Waive fees for all refugees and vulnerable host populations for health care. Refugee and vulnerable host populations who pay out of pocket would be at increased risk of catastrophic health expenditure and be driven deeper into poverty. Fee waivers at health facilities for all refugees and vulnerable host populations will ensure equitable access to comprehensive and quality health services for all refugees, while still prioritizing members of the host community who are most in need.[38] Household beneficiaries of the SSNP are also poor and vulnerable and will receive health care free of charge. Health facilities that waive fees will be reimbursed with high PBF subsidies, which is equivalent to between four to six times the PBF subsidy payment for a 'normal' patient.

- Subcontract CHWs and CBOs from the host community and refugee camps to provide select basic preventative and referral services and support positive behavior.

(b) PBF quality improvement bonuses will be given to health facilities in crisis areas to rapidly increase the quality of health care, including the reconstruction of health facilities destroyed due to conflict.

[37] Northern regions refer to the Far North region, North region and Adamawa region.
[38] UNHCR. "Global Strategy for Public Health 2014–2018." http://www.unhcr-strategy-2014-2018.html.

48. The remaining activities supported by the parent project under Component 1 will remain unchanged.

49. **Component 2: Institutional strengthening for improved health system performance** (Total cost under parent project: US$18 million: US$11 million IDA, US$7 million GFF [US$5 million RMNCAH and US$2 million for CRVS]. Total new cost under AF: US$23 million: US$11 million IDA, US$7 million GFF [US$5 million RMNCAH, US$2 million for CRVS] and US$5 million IDA18 RSW AF Grant). The parent project supports (a) activities that strengthen national-, regional-, and district-level institutions to improve health system performance; (b) analytical work and policy dialogue to facilitate the development of health reforms; (c) implementation support for health reforms that address bottlenecks in the health system and improve efficiency and health outcomes; and (d) analytical work and institutional reforms needed to develop a national health strategy and support Cameroon toward achieving UHC.

50. Under Component 2, the AF will support the following activities:

- Scale-up activities carried out by BUNEC under the parent project to strengthen CRVS activities for refugees and host communities. Birth registrations will be conducted for all deliveries and birth certificates will be provided to mothers irrespective of nationality. The identification of children in preschool and schools who do not have a birth certificate will be conducted in partnership with the education sector. Children who do not attend school and those who are orphaned or separated from parents and communities by conflict will be identified by CHWs and CBOs, and will be provided with a birth certificate using the most accurate information available. Refugees and IDPs, as well as host population living in households benefiting from the SSNP without documentation will be assisted to acquire official identification documents and birth certificates. Trained register officers will go into the communities and villages during activities organized to register refugees and host populations without birth certificates and documentations, and they will be assisted to acquire official identification documents. Civil registration centers under performance contracts will receive subsidies for registration documents delivered to refugees and vulnerable host population.

- Reinforce activities related to M&E. The crisis in the northern[39] regions, particularly the Far North, have crippled the already weak routine monitoring systems. The AF will support the reinforcement of the M&E system, as well as information systems, by integrating related activities into the performance contract of health facilities, districts, regional delegations, CDVAs, and *Cellule d'information Sanitaire* (CIS) of the MoPH. Furthermore, this component will contribute to the financing of Steering Committees and Technical Secretariats at the central level and a Grievance Redress Mechanism (GRM).

- Strengthen communicable disease surveillance systems and epidemic preparedness and response in refugee-host communities and refugee camps. In recent years, Cameroon has had numerous disease outbreaks, particularly in refugee-affected areas in the North and Far

[39] Northern regions refer to the Far North region, North region and Adamawa region.

North regions. These include leishmaniosis (2017),[40] polio (2014),[41] yellow fever (2013),[42] measles (2015),[43] and cholera (2011–2014). Between 2011 and 2014, Cameroon reported 26,621 cases of cholera leading to 1,031 deaths.[44] These periodic outbreaks affect thousands of households each year and kill as many as 10 percent of those who contract the disease.[45] Despite Cameroon's vulnerability to outbreaks, particularly in the Far North, there has been minimal investment in strengthening communicable disease surveillance and response systems, and the first Public Health Emergency Operation Center (PHEOC) is still under construction in Yaoundé. Once fully operational, the PHEOC can coordinate an emergency response within 120 minutes of identification of a public health emergency.[46] The AF will support the (a) enhancement of community-level and regional-level surveillance and reporting systems in the northern[47] and East regions, by integrating surveillance indicators in the performance contract of health facilities, health districts, and regional delegation and CIS; (b) analytical work on existing surveillance systems in refugee-affected regions; (c) review and update of disease priorities in the northern and East regions and review and develop guidelines, protocols, and tools to enhance surveillance and reporting processes; and (d) enhancement of the communicable diseases outbreak preparedness and response capacity.

51. The remaining activities supported by the parent project under Component 2 will remain unchanged.

52. **Component 3: Strengthening emergency, sexual and reproductive health services, and water sanitation hygiene and nutrition service delivery for refugee and host populations in the northern and East regions** (Total new cost: US$10 million IDA18 RSW Grant). The AF will finance the following activities using the PBF approach:

(a) Development of norms, guidelines, and training modules on (i) emergency health services and lifesaving sexual and reproductive health services, including those related to the management of rape, FGM, and GBV; (ii) nutrition, deworming, and soft WASH interventions in preschools, schools, health facilities, at the community level, including refugee camps and the host population and including other activities in the Early Years Package; (iii)

[40] Outbreak news today. 2017. "Leishmaniosis Outbreak Reported in Cameroon." Accessed November 30, 2017.http://outbreaknewstoday.com/leishmaniasis-outbreak-reported-cameroon-58045/.
[41] WHO. 2014. "Poliovirus in Cameroon - Update." Accessed November 30, 2017. http://www.who.int/csr/don/2014_03_17_polio/en/
[42] WHO. 2013. "Yellow fever in Cameroon." Accessed November 30, 2017. http://www.who.int/csr/don/2013_10_08/en/
[43] Reliefweb. 2015. "Cameroon: Measles and Cholera Outbreaks – Nov 2015." Accessed November 30, 2017. https://reliefweb.int/disaster/ep-2015-000156-cmr
[44] CDC. 2017. "CDC Fights Cholera in Cameroon." Accessed November 30, 2017. https://www.cdc.gov/ncezid/dfwed/stories/fighting-cholera-cameroon.html
[45] CDC. 2017. "CDC Fights Cholera in Cameroon." Accessed November 30, 2017. https://www.cdc.gov/ncezid/dfwed/stories/fighting-cholera-cameroon.html
[46] CDC. 2017. "Global Health Security Agenda: GHSA Emergency Operations Center Action Package." Accessed November 30, 2017. https://www.cdc.gov/globalhealth/security/actionpackages/emergency_operations_centers.htm.
[47] Northern regions refer to the Far North region, North region and Adamawa region.

comprehensive mental health and psychosocial support programs for refugees, IDPs, and host populations; and (iv) biomedical waste management.

(b) Support institutional capacity building, including (i) sensitivity training of frontline health professionals, CHWs, and CBOs from refugee and host communities and civil registration officers; (ii) training of health professionals on basic and comprehensive emergency obstetric and newborn care; and (iii) training of health professionals and CHWs on the management of GBV (Box 3), FGM, mental health, psychosocial conditions, nutrition, NTDs, biomedical waste management, and WASH.

53. The proposed soft WASH activities will be combined with action research on water and sanitation practices in health facilities, sanitation marketing, handwashing, household water treatment and safe storage (HWTS), and menstrual hygiene management (MHM). The project also supports strengthening health communication toward good sanitation and hygiene behaviors among refugees and host community populations at health and nutrition facilities, schools (including preschools), and communities in an enabling environment.

Box 3. Gender and GBV, including Sexual Violence

This project is acutely focused on gender and complementary activities that have been introduced in each project to ensure maximum impact.

- **HSPRP** will (a) provide emergency health services, sexual and reproductive health services, including those related to the management of rape, FGM, and GBV; (b) deliver a comprehensive mental health and psychosocial support program for victims of GBV, including sexual violence, at the health facility and community level; (c) provide sensitivity training on GBV and sexual violence for frontline health professionals and CHWs and through school-based sexual health programs; (d) deliver focused training of health professionals and CHWs on the management of rape, FGM, and GBV, including physical, sexual, and psychological violence; and (e) conduct formative research on MHM.
- **SSNP** will introduce complementary interventions to address GBV by including men, boys, couples, and their communities. The feasibility of establishing an Early Warning System on GBV issues, shared by the four projects, will be studied. In local councils overlapping with the HSPRP, the SSNP will explore identifying and referring beneficiaries in need of this care to health structures.
- **ERSP** will carry out training activities to teachers and pedagogic supervisors, complemented by sensitization on gender and GBV, including sexual violence.
- **CDPSP**. Community development plans must explore the specific concerns of women and girls linked to any subprojects, community investments, and social mobilization efforts to ensure they are considered in any plan. If women and female youth are not part of community consultations, their issues may not surface and even when they do participate, sociocultural norms may limit the extent to which GBV issues are discussed. Therefore, facilitating discussions on sensitive topics such as GBV issues with community members is key.[48] Also, there is always a woman to be selected in the village development committee (*Comité de Concertation*), whose function is to follow up implementation of both CDPs and the village plan. Moreover, the CDPSP will also carry out activities aimed at supporting documentation, especially birth certificates. Women without IDs (95 percent of the population) cannot have access to the justice system. For example, according to Cameroon's penal code, a female youth under the age of 18 cannot be forced into marriage. However, without IDs, it is very difficult for women to defend their rights. Therefore, supporting documentation, along with awareness-raising campaigns, would be a good opportunity to fight GBV, including sexual violence.

In addition, adjustments will be made in the project's environmental and social management framework to tackle GBV issues, including sexual violence, given the vulnerability of the targeted beneficiaries (see section IV.E). Refugees' camps are also not exempt from violence against women. Apart from cultural and religious factors, which may hinder the equal development of women and girls (access to school, household occupations and exclusion from the decision-making system), phenomena such as rape, sexual exploitation, physical assault, domestic violence, and prostitution are also a reality for refugees.

54. **Component 4: Contingent Emergency Response Component** (Total new cost US$0). A CERC will be included under the project in accordance with Bank Policy paragraphs 12 and 13, for projects in Situations of Urgent Need of Assistance or Capacity Constraints. This will allow for rapid reallocation of project proceeds in the event of a natural or artificial disaster or crisis that has caused, or is likely to imminently cause, a major adverse economic and/or social impact.

55. Following the procedures governed by Bank Policy Section III. Para 12 and 13 (a CERC Operations Manual (CERC OM) will be prepared by each country as a condition of disbursement. Triggers will be clearly outlined in the CERC operations manual (OM) acceptable to the World Bank. Disbursements will

[48] World Bank. 2017. "Kenya Development Response to Displacement Impact Projects. Understanding and Addressing Gender-Based Violence."

be made against an approved list of goods, works, and services required to support crisis mitigation, response and recovery. All expenditures under this activity will be in accordance with paragraphs 12 and 13 of Bank Policy IPF and will be appraised, reviewed, and found to be acceptable to the World Bank before any disbursement is made (Rapid Response to Crisis and Emergencies).

56. The closing date of the project will be extended from May 31, 2012, to December 31, 2022. Table 1 provides a summary of the parent and AF components.

Table 1. Summary of Parent Project and AF Components

Component under Parent Project	Proposed Component under AF	Current Cost (US$, millions) (a)	Proposed Cost (US$, millions) (a+b+c)	AF Allocation: IDA18 Credit (US$, millions) (b)	AF IDA18 RSW Allocation (US$, millions) (c)	Action
Component 1: Strengthening of health service delivery	***Component 1: Strengthening of health service delivery***	***109***	***130***	***6***	***15***	***Revised: Reinforcement of Subcomponent 1.1***
• *Subcomponent 1.1: Payment of performance*	• *Subcomponent 1.1: Payment of performance*	*70*	*91*	*6*	*15*	*Revised: Reinforcement*
• Subcomponent 1.2: Support the implementation and supervision of PBF	• Subcomponent 1.2: Support the implementation and supervision of PBF	19	19	0	0	No change
• Subcomponent 1.3: Additional support for improving access to a key package of RMNCAH and nutrition services	• Subcomponent 1.3: Additional support for improving access to a key package of RMNCAH and nutrition services	20	20	0	0	No change
Component 2: Institutional Strengthening for Improved Health	***Component 2: Institutional Strengthening for Improved Health***	*18*	*23*	*0*	*5*	***Revised: Inclusion of new activities and reinforcement***

Component under Parent Project	Proposed Component under AF	Current Cost (US$, millions) (a)	Proposed Cost (US$, millions) (a+b+c)	AF Allocation: IDA18 Credit (US$, millions) (b)	AF IDA18 RSW Allocation (US$, millions) (c)	Action
System Performance	***System Performance***					***of Subcomponents 2.1 and 2.2***
• *Subcomponent 2.1: Supports institutional strengthening of information systems monitoring and evaluation, and performance measurement mechanisms for the health system*	*Subcomponent 2.1: Supports institutional strengthening of information systems monitoring and evaluation, and performance measurement mechanisms for the health system*	*7*	*10*	*0*	*3*	*Revised: reinforcement and inclusion of new activities*
• *Subcomponent 2.2: Reinforcement of civil registration and vital statistics systems*	*Subcomponent 2.2: Reinforcement of civil registration and vital statistics systems*	*4*	*6*	*0*	*2*	*Revised: reinforcement*
• Subcomponent 2.3: Program coordination	Subcomponent 2.3: Program coordination	7	7	0	0	No change
-	***Component 3: Strengthening emergency, sexual and reproductive health services, and water and sanitation and hygiene and nutrition service delivery for refugee and host populations in the***	*0*	*10*	*0*	*10*	*Revised: New component*

Component under Parent Project	Proposed Component under AF	Current Cost (US$, millions) (a)	Proposed Cost (US$, millions) (a+b+c)	AF Allocation: IDA18 Credit (US$, millions) (b)	AF IDA18 RSW Allocation (US$, millions) (c)	Action
	northern[49] and East regions.					
-	***Component 4: Contingent Emergency Response Component***	*0*	*0*	*0*	*0*	*Revised: New component*

Note: Changes with the AF are italicized.

E. Lessons Learnt and Reflected in the Design of This Multisectoral Project

57. **PBF approach in humanitarian crisis**

(a) PBF IEs have found substantial improvements in utilization and quality of essential health services across a range of countries experiencing varying levels of fragility or conflict.

- **Cameroon** (IE conducted in the North-West, South-West, and East region)
  - Humanitarian crisis in the Far North, North, East, and Adamawa regions
  - The PBF approach significantly increased the utilization of maternal and child health services (vaccinations of mothers and children, use of modern family planning, HIV testing), improved the structural quality of health services (availability of essential inputs, equipment, health professionals), reduced formal and informal out-of-pocket health expenditure, and increased the level of patient satisfaction[50]
- **Democratic Republic of Congo** (IE conducted in Katanga province)
  - Classified as a fragility, conflict, and violence (FCV) country

[49] Northern regions refer to the Far North region, North region and Adamawa region.
[50] De Walque,D; Robyn, PJ; Saidou, H; Sorgho, G; Steenland. 2017. "Looking into the Performance-Based Financing Black Box. Evidence from an Impact Evaluation in the Health Sector in Cameroon."

- The PBF approach was associated with a reduction in health worker absenteeism, reduction in user fees, and increased preventative sessions and outreach services.[51]

- **Burundi**

  - Classified as an FCV country

  - An IE of the Burundi PBF program showed that the approach increased the probability of institutional delivery (21 percentage points), use of ANC services (7 percentage points), and modern family planning services (5 percentage points). The program also increased the quality of care and improved equity[52]

- **Nigeria**

  - In Adamawa state in Nigeria, the PBF program increased coverage of institutional delivery, immunization, and family planning from 1–11 percent at baseline to 27–36 percent in less than a year, despite the 'state of emergency' security situation and sluggish health performance in the northern states

(b) The PBF approach has also been shown to[53]

- Motivate and empower providers to focus on results and introduce a results-oriented culture at health facilities;

- Improve accountability as facilities, providers, and supervisors are held accountable for delivering results and are provided the required resources to carry out activities;

- Promote quality improvements, with systematic reviews of the quality of care using standardized checklists;

- Contribute to enhanced supervision and availability of data which is critical for reporting results;

- Focus attention on underserved areas, when used as a mechanism for redressing inequities in service delivery; and

- Demonstrate the importance of (a) putting in place mechanisms for validating results and ascertaining client satisfaction, (b) introducing penalties for nonperformance and sliding scales for remunerating results contingent on quality improvements, and (c) conducting rigorous IEs.

[51] World Bank. 2013. "Impact Evaluation of PBF in Haut-Katanga district, Democratic Republic of Congo."
[52] Bonfrer, I; Soeters, R, van de Poel, E; Basenya, O; Longin, G; van de Looij, F; van Doorslaer, E. 2013. "The Effects of Performance-Based Financing on the Use and Quality of Health Care in Burundi: An Impact Evaluation."
[53] World Bank. 2014. "The Great Lakes Emergency Sexual and Gender Based Violence and Women's Health Project."

58. **GBV, including sexual violence**[54]

(a) Multisectoral interventions are critical for supporting survivors of GBV and sexual violence, who require multifaceted assistance, including medical treatment, mental health counselling, psychosocial support, and legal services.

(b) Health services are an important entry point both for responding to the needs of survivors and for preventing further violence. There are important synergies from investments in GBV and maternal, reproductive, and obstetric care which require specialized expertise and health system capacity. Given that GBV is an important risk factor for other negative health outcomes (that is, unwanted pregnancy, HIV/AIDS, and other sexually transmitted infections), violence prevention will also contribute to preventing these outcomes.

(c) There is growing evidence that screening protocols are highly effective in increased detection and referral of survivors of GBV and sexual violence and provision of follow-up treatment with the World Health Organization including these protocols among its 10 violence prevention strategies. Routine screening for intimate partner violence can potentially improve identification, care, and treatment of violence.

59. **Mental health and psychological support**[55]

(a) Strengthened capacity and increased resources for mental health support will not only benefit survivors but also the broader population, many of whom suffer from trauma related to prolonged conflict.

(b) A multidisciplinary approach is required to tackle mental health as a development challenge. This needs to integrate health services at the community level, in schools, and in the workplace to explicitly address the mental health and psychosocial needs of displaced people and host communities, including alcohol and other drug-use problems.

(c) An effective mental health and psychosocial response should also include innovative social protection and employment schemes that facilitate the reintegration of affected persons into social and economic activities.

(d) Effective scaled-up responses to improve the mental health and psychosocial well-being of conflict-affected populations require careful adaptation to specific contexts of multilayered systems of services and supports (for example, provision of basic needs and essential services such as food, shelter, water, sanitation, and basic health care; action to strengthen community and family supports; emotional and practical support through individual, family, or group interventions; and community-based primary health care systems).

[54] World Bank. 2014. “The Great Lakes Emergency Sexual and Gender Based Violence and Women’s Health Project.”
[55] The World Bank. 2016.” Mental Health among Displaced People and Refugees: Making the Case for Action at the World Bank Group.”

F. Implementation Arrangements

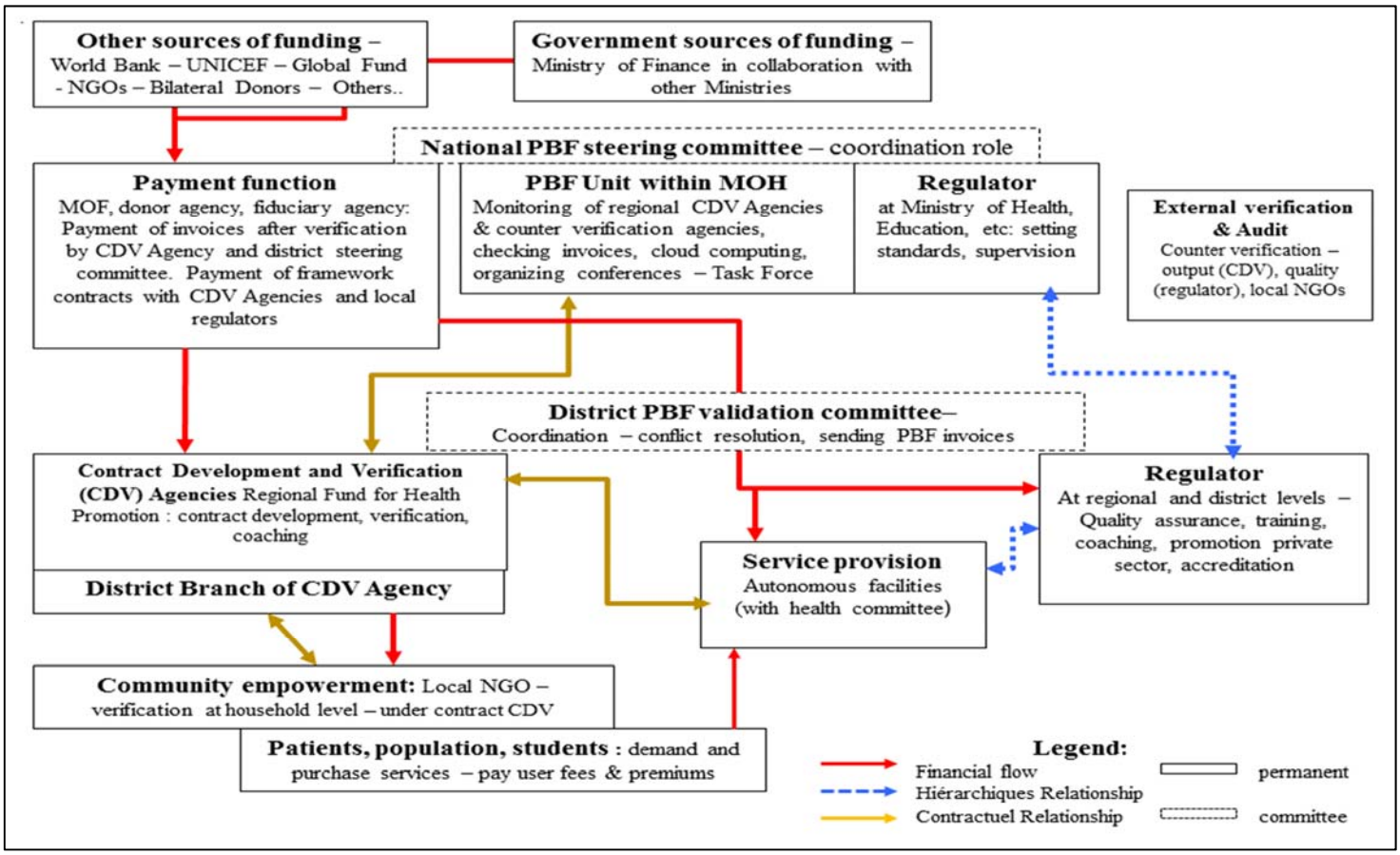
Institutional and Implementation Arrangements

60. **The implementation arrangements will remain largely the same** as for the parent project in the Far North, North, Adamawa, and East regions (figure 1).

61. At the central level of the MoPH, the Health Sector Strategy (*Stratégie Sectorielle de la Santé*, HSS) Steering Committee (created in 2005), chaired by the Minister of Public Health, will continue to provide oversight and strategic guidance to the project and will oversee the achievement of the project objectives. Under the authority of the HSS Steering Committee, a specific project technical committee has been created to provide direct oversight and support to the project. The technical committee, chaired by the general secretary of MoPH, includes (a) select directories of the MoPH and (b) 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's tasks include to (a) validate the overall strategic direction of the PBF program, (b) validate the overall strategic direction of other interventions supported by the project, (c) ensure that the procedures set forth in the project implementation manual are followed, (d) examine the different contracts and intervene where necessary to resolve issues, (e) monitor PBF and other activities' implementation and intervene where problem resolution may require the support of committee members, and (f) disseminate the results of the evaluations with a view toward mobilizing additional resources and expanding the PBF approach in the country.

62. Project implementation will continue to be coordinated by the PBF Technical Unit of the Ministry of Health and supported if needed by appropriate consultants. The PBF Technical Unit is responsible for the day-to-day management of the project, informs the HSS Steering Committee of progress achieved in implementing the PBF approach, oversees both the coordination of the overall PBF program and specific project implementation for activities supported by the GFF Trust Fund. Also, it will manage and oversee the achievements of the interventions related to the AF for the IDA18 RSW. The PBF Technical Unit is tasked with (a) developing norms and procedures for the PBF program; (b) coordinating among and leading development partners, vertical programs, and departments within the MoPH involved in the PBF program; (c) conducting performance contracting, evaluation, and coaching activities for decentralized actors such as the Regional Health Delegations, Contracting and Verification Agencies, and Regional Funds for Health Promotion; (d) preparing and implementing PBF training programs; and (e) developing the scale-up plan for national coverage. The procedure for activities supported by the AF will be incorporated in the project implementation manual and the national PBF manual. The national PBF manual will be the key strategic document providing operational guidelines for implementation of PBF and refugee-related activities.

Figure 1. Institutional Arrangements for Implementation



63. The project will continue to use CDVAs established in each region for the following tasks: (a) contracting and coaching health service providers, (b) contracting CBOs for community verification and verification of declared results by contracted agents. In the regions where refugees are established, CDVAs will be responsible for the coaching of health facilities to provide essential health, nutrition, and WASH services to refugees and vulnerable host populations, according to the PBF manual. Upon verification, CDVAs will send payment requests through the PBF portal,[56] 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 CBOs directly for community verification activities.

64. To stimulate the demand side, community PBF is integrated in the project as a complement to PBF at the health facility level. CHWs and CBOs are trained and contracted by health facilities to provide prevention and promotional activities at the community level. These include, but are not limited to, (a) the referral of poor and vulnerable patients, pregnant women, infants, and women of childbearing age to health facilities; (b) identification of patients lost to follow-up; and (c) home visits. CHWs and CBOs are

[56] www.fbrcameroun.org.

supervised by health personnel from health facilities. Their activities are evaluated and verified by health facilities and counter verified by CDVA verifiers. Their performance payment is made monthly through the health facilities. For the AF, the package of activities carried out by CHWs and CBOs will be expanded to include refugees and host populations as beneficiaries. CHWs and CBOs (for example, schools and NGOs) from refugee and host communities will be contracted to provide community activities in refugee and host communities and refugee camps, under the supervision of the health facilities.

65. **GRM.** Project beneficiaries will have access to the GRM. The four projects will establish a harmonized GRM mechanism, by setting up a single free hotline for the four projects.

Box 4. Integrated RSW Coordination and Project's Management

- **GRM.** Indigenous Peoples Plan (IPP) and Resettlement Action Plans (RAPs) will include a unique and harmonized GRM, which will address complaints received from the population (refugees included). The GRM to be implemented will build on the CDPSP's experience based on three essential components: (a) systematic collection and management of the project's activities related to claims by the PIU; (b) a formal, popular complaint mechanism through a free hotline number; and (c) requests for direction and management to/by local councils and local authorities (traditional rulers included). Based on these three pillars, the borrower should refine its actual GRM. This will serve as a 'one-stop shop' GRM that will be streamlined in other World Bank Group-financed projects.
- **RSW-shared M&E system.** The respective M&E system will be coordinated to ensure synergies and savings in data collection on refugees and host communities.

III. KEY RISKS

A. Overall Risk Rating and Explanation of Key Risks

66. **The overall risk is rated Substantial.** Risk identified include (a) political and governance (b) technical design of the project or program, (c) institutional capacity for implementation and sustainability, (d) insecurity and challenging context of the northern[57] regions, (e) fiduciary aspects, and (f) the protection of refugees.

Table 2. Systematic Operations Risk Rating Tool (SORT)

Risk Category	Rating
1. Political and Governance	High
2. Macroeconomic	Substantial
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	Moderate

[57] Northern regions refer to the Far North region, North region and Adamawa region.

Risk Category	Rating
8. Stakeholders	Moderate
9. Other: Refugee Protection	Substantial
Overall	**Substantial**

67. **Political and governance risks are High**. Governance indicators for Cameroon (e.g. World Governance Indicators, Mo Ibrahim Index, Corruption Perception index) suggest considerable challenges that affect social accountability and the proper management of resources. This is compounded by uncertainty related to the upcoming local, legislative and presidential elections, planned for October 2018, which could shift the GoC's priorities for the health sector, particularly if there is a change in leadership. This could disrupt the ongoing Government-led structural health sector reforms aimed at improving efficiency and performance of the health sector, implementation of both the parent project and additional financing activities, particularly in regions of fragility, and weakening of the GOC's commitment to the refugee protection framework. The project has incorporated mitigation measures including: (i) intensive community mobilization, and sensitization; (ii) adoption of a holistic and sustainable approach to address the health needs of both refugees and host community members simultaneously (iii) a robust capacity building and training component at all levels of the health system, which will strengthen institutional capacity and stewardship of the PBF program, and (iv) implementation of a core package of activities on citizen engagement at a the community level to foster social accountability. With regards to the risk related to fragility and access to some areas, the World Bank has been engaged with the GoC, the UN and the EU on the Recovery and Peace-Building Assessment (RPBA) process since 2016 and will continue to do so.

68. **The macroeconomic risks are substantial**. The macroeconomic risks are related to deterioration in fiscal and external balances between 2014 and 2016, exposing macroeconomic stability, and the country's vulnerability to oil prices despite its relatively diversified economic base. A further unanticipated widening of the fiscal deficit would put pressure on the Government to reduce spending on key programs such as in health and education.

69. **Risks related to the technical design of the project or program remain Substantial.** 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 risks are considered substantial. To mitigate the risk of the technical complexity of the scale-up, the rollout is being done in a phased manner, targeting approximately an additional 20 percent of the population per year. Significant implementation support is being provided throughout the process and at each stage assessments are being made to identify and address any bottlenecks for successful scale-up. The project is anchored within the MoPH under the National PBF Technical Unit to strengthen institutional capacity and ownership, minimize implementation delays, and mitigate risks. In addition, the project has recruited a PBF expert to strengthen the technical capacity of the PBF Technical Unit.

70. **Risks related to the institutional capacity for implementation and sustainability remain Substantial.** Piloting PBF has been successful and there is broad support for a national expansion, but financial and institutional sustainability remains a risk. To mitigate these risks, the World Bank project includes a robust capacity building and training component into the project. This will not only allow

strengthened stewardship of the program at the national level but also allow 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. The progressive increase in the Government contribution to PBF is part of the ongoing Development Policy Financing (DPF) Program between Cameroon and the World Bank. It aims to support the GoC's efforts to implement structural reforms that facilitate fiscal adjustments, boost competitiveness, and mitigate economic vulnerability created by the economic crisis following the steep fall in the price of oil, which accounts for 76 percent of the Economic and Monetary Community of Central Africa's (CEMAC) exports revenue in 2014. One trigger of this DPF Program is to increase the level of funding and management capacity of health facilities and improve the availability of essential medicines in health regions and districts covered by PBF: (a) the 2018 public health budget increases the minimum allocation to primary and secondary care facilities and regulators to at least 15 percent of the public budget and uses performance-based flexible payments in health regions and districts covered by PBF and (b) the MoPH has signed an official document that allows health facilities to buy pharmaceuticals and other medical supplies directly from licensed suppliers (public or private). Activities under the AF will be fully integrated in the PBF program, thus benefiting from all sustainability mitigating measures implemented.

71. **Fiduciary risks for the project remain Substantial.** The country environment risk in procurement especially in public contracts, the delays in procurement processes, and the lack of transparency in the allocation and use of resources in the health sector in Cameroon remain a challenge and the parent project and AF are allocating 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 parent project includes a very strong training/capacity-building program, which ensures 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 the risk, the experienced fiduciary personnel who ran the first PBF project in Cameroon and has extensive institutional memory was transferred from the PIU of the first PBF project (HSSIP) to the national PBF unit of the parent project. Additional fiduciary staff are being recruited to support the increased workload of the parent project. If the AF requires additional human resources, more staff will be recruited.

72. **Environmental and social risks are Moderate.** The AF will not change the safeguard category of the project, which remains category B, as it is not anticipated that the project activity will have a large-scale negative impact on the environment and population. However, there are predictable potential negative environmental and social risks and 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 addition, soft WASH interventions in schools and in refugee camps might lead to conflicts. The AF triggers the same two safeguard policies triggered by the parent project: OP/BP 4.01 - Environmental Assessment and OP/BP 4.10 - Indigenous People. A social assessment was undertaken during the preparation of the parent project and an Indigenous Peoples Planning Framework (IPPF)/IPP was prepared for the parent project and disclosed on February 25, 2016. The Action Plan also included indicators and a budget that are being used during project implementation to evaluate progress and results. In accordance with OP/PB 4.01, the Medical Waste Management Plan (MWMP) was prepared for

the parent project, disclosed in 2014, and is being implemented as planned. To better mitigate and manage the abovementioned risks, the MWMP will become a Hygiene and Waste Management Plan (HWMP) and will be updated during project implementation (within three months from project launching) to include measures related to GRM, occupational safety, GBV risks, MHM, HWTS, and so on and the project will recruit a safeguard specialist. In addition, the project will develop and use a rapid environmental and social screening checklist/criterion to ensure that selection of beneficiary refugee camps, schools, and preschools (if any) is based on a thorough investigation. Findings of the rapid environmental screening will be reflected in the HWMP.

73. **Stakeholders risk is Moderate** given the multiple actors whose experience and cooperation will greatly enhance project activities. These include partners such as UNHCR, the main strategic partner in the field and partners from the three projects (Education, Social Protection and Labor, and Social, Urban, Rural, and Resilience). Coordination of stakeholders would be the primary risk to consider, which will be mitigated by extensive communication and inclusion of stakeholders during the design and implementation of the project.

74. **Insecurity, challenging context of the northern[58] 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 increased need of health services for these displaced populations affected by the instability. Challenges will persist in efforts to provide support to health service delivery through the PBF program, ensure appropriate monitoring and verification of service delivery is conducted, and provide sufficient implementation support to the project.

75. To mitigate these risks and address these challenges, the project has partnered with other development partners working in the area and has contracted well-functioning NGOs already based in the regions for contracting, verification, and coaching activities. 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 provides 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 also takes advantage of the community PBF platform of contracting CHWs and CBOs to use them to help identify, sensitize, and refer displaced people and refugees in communities served by contracted health facilities.

76. **Refugee protection risks are Substantial.** The World Bank, in consultation with UNHCR, has confirmed that Cameroon's protection framework is adequate for the purposes of the sub-window. UNHCR has provided the World Bank with an overall positive assessment of Cameroon's protection framework. However, five key risks have been identified: (a) potential deportation remains of particular concern in the volatile security environment in the Far North region; (b) insecurity and high levels of

[58] Northern regions refer to the Far North region, North region and Adamawa region.

violence in the Far North pose significant protection challenges; (c) the Government does not issue identity documents to refugees; (d) GBV, including sexual violence, remains one of the most serious threats to the safety and security of refugees and IDP women and children; and (e) refugees have the right to legal residency, primary education, public health, and employment, but their living conditions are generally precarious because of the lack of employment and regular income. To mitigate these risks, the GoC has committed to a number of new progressive reforms, outlined in its LDP: (a) preparing a medium-term refugee management strategy; (b) facilitating greater access to basic social services for refugees, host communities, and IDPs; (c) improving legal security for refugees to facilitate their resilience; and (d) better understanding the causes of vulnerability of refugees and host communities. The GoC has also taken explicit protection-related commitments in the LDP: "(i) Issuance and recognition of biometric identity documents for refugees (along with travel documents): in accordance with Decree 2007/255 of September 4, 2007 and Decree 2016/373 of August 4, 2016 on the procedures for Law 97/012 of January 10, 1997 on the requirements for the entry and exit of foreigners (DGSN – MINATD); (ii) Systematic issuance of birth certificates for refugee children born in Cameroon with new registry offices (or reinforcement of existing registry offices) in areas with large populations of refugees and displaced persons; and (iii) Strengthening of the institutional capacities of refugee status management bodies to facilitate the registration of asylum seekers and decisions on refugee status (MINREX Technical Secretariat) and ensure that the population census planned in Cameroon in 2018 is comprehensive and counts all of the people living in border areas." The Steering Committee will also provide a platform to discuss the issue of refugees and returns. At the project level, to mitigate refugee protection risks, the CDPSP will contribute to civil registration (issuance of birth certificates or duplicates), social cohesion, and peace through participatory approach.

IV. APPRAISAL SUMMARY

A. Economic and Financial Analysis

Economic Analysis

77. **The AF will strengthen the development impact of the parent project** by ensuring that refugees (current and incoming) and vulnerable host populations have sustainable and equitable access to high-impact emergency health services, primary health care, and maternal and child health services; mental, psychosocial, and GBV (including sexual violence) services, and WASH and nutrition interventions. Activities under Component 2 will scale up provision of identification documents for refugees. This will support the GoC's request to scale up the documentation of refugees and host populations, and where possible, assist them to acquire identification documents and birth certificates, all of which facilitate their access to other social and educational benefits. The health surveillance and security components will reinforce protection and prevention against infectious diseases in refugee-hosting regions in Cameroon

78. **The economic analysis conducted for the parent project remains valid**, except that it does not cover the new activities in Subcomponent 2.1 (strengthen communicable disease surveillance systems and epidemic preparedness and response in refugee-host communities and refugee camps) and Component 3 (strengthen emergency, sexual, and reproductive health services and WASH and nutrition service delivery for refugee and host populations in the northern[59] and East regions). These additional

[59] Northern regions refer to the Far North region, North region and Adamawa region.

activities, supported by the AF, will contribute to Cameroon's long-term development agenda by (a) improving the survival of refugee and host populations and reducing mortality and morbidity related to communicable and non-communicable diseases; (b) increasing household earnings and saving unnecessary health care and social care costs; (c) increasing productivity, labor supply, and human capital; (d) increasing consumption or production of goods and services that would otherwise not be consumed or produced; (e) improving health system efficiency; and (f) promoting equity and shared prosperity.

79. **Increased access to the new proposed package of services (under Subcomponent 2.1 and Component 3) is expected to have a direct impact on the leading causes of DALYs in the country.**[60] Component 2 will strengthen M&E, diseases surveillance, and epidemic preparedness to track progress in the provision of essential services to refugee and refugee-host communities during the crisis and recovery stage and ensure that outbreaks of communicable diseases are identified and managed promptly and effectively. Infectious diseases are the leading cause of death in Cameroon, both for host populations and refugees, more particularly, those with epidemic potential remain a huge threat to the destabilization of the entire health system (as recently demonstrated with the Ebola outbreak in Guinea, Liberia, and Sierra Leone). Subcomponent 2.1 will thus help Cameroon's health system to be more resilient and will strengthen it in terms of early detection of epidemic-prone diseases, thus preserving health and well-being of refugees and host communities.

80. A detailed economic and financial analysis for the proposed activities related to GBV including sexual violence was not carried out due to the scarcity of data on economic impact of service provision for survivors of GBV including sexual violence, as well as the emergency nature of the project preparation process. It is well known that the development impacts of violence against women, men, and children are high. A review of the literature found that the cost of intimate partner violence is significant in low- and middle-income countries relative to other development expenditures.[61] The same review highlighted the economic costs of inaction and emphasized the urgent need for governments to address violence against women.

81. **Violence has a direct and indirect negative effect on individuals, households, and communities as reflected in additional medical expenses, decreased labor market participation, and intergenerational impacts** (for example, disruption in schooling for children in the households). Beyond the physical and psychological damage for the individuals involved, GBV (including sexual violence) also carries important social and economic costs. Economically, survivors not only have reduced short-term income potential but they may also suffer from longer-term effects including injuries and trauma, reducing long-term income and productivity.[62] Overall the proposed activities to address GBV (including

[60] Institute of Health Metrics and Evaluation. 2017. "Global Burden of Disease in Cameroon." Accessed January 25, 2018, http://www.healthdata.org/cameroon.

[61] The literature review (Intimate Partner Violence: Economic Costs and Implications for Growth and Development) conducted for the World Bank in Vietnam, the total cost of intimate partner violence, including out-of-pocket expenditure, missed income and productivity loss, was over 3.0 percent of GDP or nearly double of what was spent on primary education. In Bangladesh, the cost of intimate partner violence, with only out-of-pocket expenditure and reduced income for missing work, was twice what the Government spent on primary education. In Uganda, the productivity loss due to intimate partner violence-related absenteeism was estimated at 1.3 percent of GDP (2012).

[62] Wilman, C. 2013: Women experiencing IPV earned 29 percent less than women who did not, and this increased to 43 percent less if the violence was severe.

sexual violence), will contribute directly to improvements in health outcomes, poverty reduction, and social inclusion.

82. **Rationale for public sector financing.** This AF will support activities that are in the public sector and are of a public good nature. The private sector has no incentives to finance any of these activities. In the absence of financing by the World Bank, the GoC may not be able to finance these activities and the country will continue to experience political and economic pressures from migrations. In the context of the 1951 Refugee Convention, the GoC is responsible to ensure refugees do not return to a territory where his or her life or freedom is threatened (the principle of "non-refoulement"[63]). In accordance with the requirements of the convention and protocol, states often provide services to migrants, namely those who are in the process of applying for asylum or have already secured refugee status. In theory, refugees often have access to the same services as the citizen of a country. These services include some kind of legal status, health care, education, and employment opportunities. The Government plays a key role in the handling of a range of issues that can only (or predominantly) be accomplished or implemented through Government action. The main rationales warranting public action include the incorporation of externalities or spillovers, redistribution, and social and political concerns related to host communities and refugees.

83. **Value added of World Bank's support.** The World Bank's support will allow the Government to reach its strategic objectives in the management of refugees and refugee-hosting communities. The strategy involves the transition from the provision of humanitarian support to refugees' inclusion in a longer-term agenda of development and social protection. Underlying the transition is a potential reduction of humanitarian support by UN agencies, particularly UNHCR. It is in this context that the World Bank is well placed to support such a transition, not only leveraging but also adding value to the foundational support provided to refugees by key humanitarian partners, including UNHCR, WFP, United Nations Children's Fund (UNICEF), as well as national and international NGOs. The World Bank project will also leverage its substantial experience and practice in several sectors related to forced displacement, governance, service delivery, and HD, and will pair and complement other projects in the World Bank's portfolio in Cameroon, including the SSNP, which aims to (a) alleviate poverty and vulnerability in host communities and (b) explore avenues of integrating refugees into national systems, notably the accompanying measures focused on human capital; public works and ID registration and active citizenship for those who desire it; the CDPSP, which aims to alleviate the vulnerability of both refugees and host communities and mitigate inter-communities' conflicts by (i) improving access to basic social services, (ii) stimulating the local economy through small public infrastructures, (iii) fostering sustainable management of natural resources, and (iv) fostering the inclusion of refugees in local governance and development. The projects have made the necessary links for a comprehensive multisectoral approach that covers the basic HD needs of refugees and hosting communities.

Financial Analysis

84. **Cameroon's economy is severely affected by the refugee crisis in the northern[64] and East regions**. The Far North, North, Adamawa, and East that host refugees represent about 41.3 percent of Cameroon's population (about 9.1 million people). An estimated 341,000 refugees have progressively

[63] Non-refoulement" refers to expel, deportation or return
[64] Northern regions refer to the Far North region, North region and Adamawa region.

taken refuge in Cameroon since 2004, which has strained Cameroon's public finances, service delivery, and environment. The crisis is expected to worsen the poverty incidence and widen income inequality among Cameroonians. Financing requirements to support the influx of CAR and Nigerian refugees have been estimated at US$176.3 million in 2016 and at US$198 million in 2017. Overall, humanitarian priority needs, including those of IDPs and vulnerable host populations, amount to US$310 million in 2017 and US$305 million in 2018.[65] The financing gap reaches 81 percent. The International Monetary Fund has calculated the budgetary impact of the conflict due to Boko Haram (including security expenditure) at around 1–2 percent of GDP in 2015, which translates to between US$325–US$650 million.[66] The GoC has estimated the financial impact of the destruction of goods, houses (40,000 homes destroyed), schools, markets, roads, and health centers to about US$80 million. However, the share of investment budget allocated to these regions never reached 10 percent of the total budget between 2013 and 2016. In this challenging environment, GDP growth in Cameroon has decelerated from almost 6 percent (2014–2015) to an estimated 3.7 percent (2017), despite a relatively diversified and resilient economy, which reflects a narrowing of Cameroon's fiscal and external margins of maneuver and an increase in its public debt.

B. Technical

85. As all new interventions under Subcomponent 2.1 and Component 3 will be delivered using the PBF approach of the parent project, the technical design would remain the same as under the original project. PBF has mechanisms to ensure equity of access for the poor and vulnerable. First, higher levels of equity bonuses are given to health facilities situated in hard-to-reach areas and serving poor populations. This helps reduce the cost of care and covers transportation costs to the city to purchase inputs or to the community for outreach activities and home visits. Second, higher levels of subsidies are paid to health facilities for health care provided free of charge to poor or vulnerable patients. Each health facility has the right to provide health care free of charge for up to 20 percent of the population who are the poorest, for which they will be compensated with high levels of PBF subsidies. In instances of crisis or emergency when more of the population are unable to pay for health care, the ceiling for the provision of subsidized free care can be raised or even completely removed. If the emergency affects the whole population of the catchment area of the given health facility, up to 100 percent of the population can receive health care free of charge. This emergency includes the forced displacement of a population in the catchment area of a health facility.

86. The new interventions follow best practices for provision of quality services for refugees and refugee-hosting communities. It was informed by reviewing lessons on best practice at an international level, including experiences in fragile and conflict-affected states, as well as extensive discussions with Government counterparts during preparation and appraisal missions, and consultations with multilateral and bilateral donors (including UNHCR), with extensive experience implementing these types of programs.

[65] See Humanitarian Response Plans for Cameroon (2016 and 2017). https://www.humanitarianresponse.info/operations/cameroon

[66] Extrême_Nord du Cameroun : le casse-tête de la reconstruction en période de conflit. Accessed January 1, 2017. https://www.crisisgroup.org/fr/africa/central-africa/cameroon/b133-extreme-nord-du-cameroun-le-casse-tete-de-la-reconstruction-en-periode-de-conflit.

C. Financial Management

87. The financial management (FM) arrangements will be managed within the existing setup for the original health project. The project continues to submit the quarterly Interim Financial Reports (IFRs) and the last evaluation of FM was Moderately Satisfactory. The FM core team consists of one financial specialist, two accountants, and an internal auditor. The team is well qualified and experienced and has been working on the PBF project in Cameroon for more than five years. They are in the process of recruiting new staff to manage the increased workload created by the scaling-up of PBF, management of GFF activities, and the transfer of payment responsibilities from the CDVAs to the National Technical PBF unit. The same financial arrangement will continue for the AF and additional staff will be recruited if needed.

88. Overall, the FM performance of the project and associated risk were rated Moderately Satisfactory and Substantial, respectively, following the last supervision mission conducted by the World Bank FM team. This is due to shortcomings that are related mainly to inconsistencies in the financial statements and poor management of the advances made under the project. This risk level will remain the same for the AF. The project is taking actions to address these weaknesses especially with regard to the implementation of the new health project. On that basis, it has been agreed that FM arrangements would remain the same as for the original project. However, because the current arrangement is not taking into account the AF specificities that include health care operations toward refugees and host communities, it is considered that the following measures should be taken within three months of effectiveness to mitigate the associated risk: (a) the project procedures manual should be updated to take into account the accounting and reporting needs under the AF; (b) the accounting software should be customized accordingly, (c) two new dedicated Designated Accounts (DA) should be opened and managed by the Autonomous Amortization Unit (Caisse Autonome d'Amortissement [CAA]), and (d) to ensure the annual financial statements that will be produced under the AF are audited and the Terms of Reference (ToR) of the initial project external auditor will be updated to reflect the AF activities.

89. There are no overdue unaudited IFRs or audit reports in the project and the sector at the time of preparation of this AF. The IFRs are prepared every quarter and submitted to the World Bank regularly (for example, 45 days after the end of each quarter) with a delay that is being taken care of to ensure future IFRs are submitted on time. For the sake of reporting on the activities performed under the AF, the National PBF unit will submit quarterly IFRs in a form and content acceptable to the World Bank within 45 days after the end of the quarter. The format will be the same as that of the ongoing project and will be prepared jointly. The 2016 audit report was submitted on time and the external auditor expressed a qualified opinion pertaining mainly to the inconsistencies in the financial statements and the lack of justification of the advances pertaining to previous fiscal years. The accounts of this AF will be audited together with the initial project on an annual basis and the external audit report along with the Management Letter will be submitted to IDA within six months after the end of each calendar year. The ToR of the external auditing firm will include the scope of this AF and the project will comply with the World Bank disclosure policy of audit reports.

90. **Disbursement.** Upon AF effectiveness, the current disbursement arrangements (IFR based for PBF activities) under the initial project will apply to the AF as well. The proposed additional funding of an amount of US$36 million to be disbursed over three years will finance 100 percent of eligible expenditures inclusive of taxes. For that purpose, one new designated accounts (DA) will be opened in a commercial

bank acceptable to IDA and managed by CAA. The ceiling of the DA will be established by the Government in agreement with the Bank (WFACS) depending on the disbursement methods. In addition to the advances to the DA, the other methods of disbursing the funds (reimbursement, direct payment and special commitment) will also be available to the project. The minimum value of applications for these methods is 20 percent of the DAs ceiling. The project will have to sign and submit Withdrawal Applications (WA) electronically using the eSignatures module accessible from the Bank's Client Connection website. Additional instructions for disbursements will be provided in the Disbursement Letters that will be issued for this AF.

91. The CERC OM and the Disbursement and Financial Information Letter will include the detailed disbursement arrangements applicable under the CERC component of the proposed AF. As part of such arrangements, a positive list could be used, which would be featured in the CERC OM, and would include the items against which disbursements will be made. Where a positive list of expenditures is used, the documentation required to support disbursement requests should be agreed (for example, invoices and bills of lading for food imports) and recorded in the CERC OM and the Disbursement Letter.

92. For the Contingent Emergency Response Component, the existing flexibility in the Bank Guidance for Contingent Emergency Response Components (CERC), would be used to provide significant advances in order to provide the necessary liquidity for fast response. The level of the advance needed for the CERC would be established independently of any existing advances for the project components and recorded in the revised Disbursement and Financial Information Letter. The advances for the CERC would be deposited in separate Designated Accounts established for the purpose.

93. If ineligible expenditures are found to have been made from the Designated and/or Project Accounts, the borrower will be obligated to refund the same. If the Designated Account remains inactive for more than six months, the WB may reduce the amount advanced. The WB will have the right, as reflected in the terms of the Financing Agreement, to suspend disbursement of the funds if significant conditions, including reporting requirements, are not complied with. Additional details regarding disbursement are provided in the Disbursement and Financial Information Letter (DFILs).

94. The table below sets out the expenditure categories to be financed out of the AF. This table takes into account the prevailing Country Financing Parameter in setting out the financing levels.

Table 3. Allocation of the Proceeds of the AF by Disbursement Category, in U.S. dollar

Category of Expenditure	Allocation	Disbursement Percent
	Proposed	Proposed
Cat 1: Performance-Based Payments under Parts A.1, A.2(a) A.4 and Part C.1 of the Project	31,000,000	100.00
Cat 2: Goods, consultants' services, Training and Operating Costs for the Project except Parts A1, A.2(a), A.4 and Part C.1 of the Project	5,000,000	100.00
Cat 3: Emergency Expenditures under Part D of the Project	0	100.00

Table 4. Action Plan

Risk	Mitigation Measures	Timeline

The AF funds might be comingled with the initial financing funds	Open one segregated DA	Immediately after effectiveness
The AF activities may not be adequately captured in the current internal control system	Update the procedures manual to take into account the AF specificities (operations toward refugees and host communities) including the associated accounting and reporting needs	Within two months of effectiveness
Delays may occur for the submission of agreed consolidated IFRs and annual project financial statements	Customize the accounting software to take into account the AF activities	Within two months of effectiveness
The AF annual financial statements might not be audited	Update the ToR of the external auditor	Within three months of effectiveness

95. Based on the current overall residual FM risk, which is Substantial, the project will be supervised twice a year to ensure that the FM arrangements still operate well and funds are used for the intended purposes and in an efficient way.

D. Procurement

Applicable policies and procedures

96. The project will be governed by the New Procurement Framework (NPF). All goods, works, non-consulting services, and consulting services required for the project and to be financed out of the proceeds of the loan shall be procured in accordance with the requirements set forth or referred to in the Procurement Regulations (World Bank Procurement Regulations for IPF Borrowers, dated July 1, 2016, revised in November 2017) and the provisions of the Procurement Plan. In line with Clause 12 of the World Bank Policy - Investment Policy Financing for 'Situations of Urgent Need of Assistance or Capacity constraints", a Project Procurement Strategy for Development (PPSD) and the derived Procurement Plan may be deferred up to the project implementation phase. Considering that the activities under this project are similar to the parent project, the client with the support of the World Bank will avail these documents (PPSD and the Procurement plan) no later than the beginning of this project.

Procurement Arrangement

97. Procurement arrangements under the parent project are the responsibility of the PBF Technical Unit (PIU), with technical support provided by the special tender board placed under authority of the original HSSIP (P104525). The special tender board was set up by the Ministry of Public Procurement (*Ministère de Marchés Publics*, MINMAP) Decree 006/A/MINMAP on May 8, 2013 and modified by Decree 00000181/A/MINMAP on August 17, 2015. The overall procurement risk for the project was rated High at the start of the parent project due to, among other factors, (a) the country environment risk of corruption in procurement, especially in public contracts, (b) the relatively limited experience in the implementation of World Bank-financed projects for PBF Technical Unit and MINMAP, and (c) the potential conflict of interest for MINMAP in relation to the management of complaints linked to contracts directly handled by MINMAP. Mitigation Action Plans that were agreed on were implemented. These include (a) recruitment of a qualified procurement specialist, (b) establishment of an administrative and financial manual to include procurement arrangements related to this project, and (c) installation of a comprehensive record

keeping system. This has brought the procurement residual risk to Substantial and the most recent procurement performance evaluation was rated Satisfactory.

98. The key risks identified for procurement under this project are as follows: (a) staff involved in the project may not have sufficient knowledge of the NPF and/or there is a risk of confusion with previous sets of guidelines, (b) inadequate communication and interaction between the beneficiaries and the project unit may lead to delays in procurement processes and poor cost estimations, (c) administrative routines may increase delays in the procurement processes and affect project implementation, and (d) poor filing may lead to the loss of documents. The residual risk will remain Substantial after adopting the agreed mitigation Action Plan summarized in table 5.

Table 5. Key risks identified for procurement and mitigating action plan

Risk	Action	Responsibility	Date
1. Staff involved in the project who may not have sufficient knowledge on the NPF and/or risk of confusion with the former guidelines	Organize workshop sessions to train on the NPF all staff involved in the procurement of the project; Continuous hands-on trainings on the NPF to identified key staff	PIU/World Bank World Bank Procurement Specialist	2 months after effectiveness During the life of the project
2. Inadequate communication and interaction between the beneficiaries and the PIU, which may lead to delays in procurement processes and poor estimation of the costs	Update the manual of administrative, financial, accounting procedures to consider this AF, the NPF and clarify the role of each team member involved in the procurement process of the project and the maximum delay for each procurement stage, specifically about the review, approval system, and signature of contracts	PIU	2 months after effectiveness
3. Administrative routines may increase delays in the procurement processes and affect project implementation	Exercise quality control on all aspects of the procurement process, including developing ToRs, technical specifications, bidding documents, proposals, request for quotations, evaluation, and award	PIU	During the life of the project
	Monitor on a regular basis the Procurement Plan implementation and set up a close follow-up in relation to beneficiaries and official bodies involved (MINMAP, CAA) to ensure that appropriate actions are taken on time	PIU	During the life of the project
4. Poor filing, which can lead to loss of documents	Set up an appropriate filing system at the level of PIU to ensure compliance with the World Bank procurement filing manual	PIU/Procurement specialist	During the life of the project

99. **Frequency of procurement reviews and supervision.** The World Bank's prior and post reviews will be carried out based on thresholds indicated in table 6. IDA will conduct six-monthly supervision missions and annual post-procurement reviews. The standard post-procurement reviews by World Bank staff should cover at least 15 percent of contracts subject to post review. Post reviews consist of reviewing technical, financial, and procurement reports by World Bank staff or consultants selected and hired by the World Bank. Project supervision missions shall include a World Bank procurement specialist or a specialized consultant. IDA may also conduct an Independent Procurement Review at any time until two years after the closing date of the project.

100. **Procurement prior review.** The procurement risk is rated Substantial. Table 6 summarizes the procurement prior review for 'Substantial' risk. These prior review thresholds can evolve per the variation of procurement risk during the life of the project.

Table 6. Procurement Prior Review Thresholds (US$, millions)

Type of Procurement	Thresholds
Goods, information technology, and non-consulting services	2
Consulting firms	1
Individual consultants	0.3

E. Social (including Safeguards)

101. The AF will not change the safeguard category of the project, which remains category B, as it is not anticipated that the project activity will have a large-scale negative impact on the environment and population. The AF triggers the same two safeguard policies triggered by the parent project: OP/BP 4.01 - Environmental Assessment and OP/BP 4.10 - Indigenous People. A social assessment was undertaken during the preparation of the parent project and an IPPF/IPP was prepared for the parent project and disclosed on February 25, 2016. The Action Plan also included indicators and a budget that are being used during project implementation to evaluate progress and results.

102. **OP 4.10 Indigenous Peoples.** Even though indigenous peoples are not part of the refugee population in Cameroon, presence of CAR's Bororos—a historically marginalized population—should be well monitored to ensure that actions to be developed in the framework of this AF meet their specific needs. The borrower would then update or elaborate the/an IPP that specifically sets actions to be performed for Bororos.

103. **GBV.** As GBV is widespread in Cameroon and in neighboring countries, refugee camps are also not exempted from violence against women. Apart from cultural and religious factors which hinder the development of women and girls (access to school, household occupations, and exclusion from the decision-making system), phenomena such as rape, sexual exploitation, physical assault, domestic violence, and prostitution are a reality among refugees. These are risks that could jeopardize the implementation of the AF. The borrower would consider preparing or amending the project's social assessment to handle those GBV issues and set up a mitigation plan that will be implemented in all refugees' settlements.

104. **GRM.** The IPP will include a unique and harmonized GRM that will address complaints received from the populations (refugees included). The GRM to be implemented will build on CDPSP's experience based on three essential components: (a) systematic collection and management of project activities-related claims by the PIU, (b) formal popular complaint mechanism through a 'green phone number', (c) requests direction and management to/by local councils and local authorities (traditional rulers included). Based on these three pillars, the borrower should refine its actual GRM. This will serve as a 'one-stop shop' GRM that will be streamlined in other World Bank Group-financed projects.

F. Environment (including Safeguards)

105. The OP/BP 4.01 Environmental Assessment safeguard was triggered during preparation of the parent 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/BP 4.01, the MWMP was prepared and is being implemented as planned. Given the envisioned soft WASH interventions at the community level including refugee camps, the MWMP will become the HWMP and will be updated (within three months from project launching) to include measures related to GRM, occupational safety, GBV risks, MHM, HWTS, and so on. The project will recruit a safeguard specialist. The project will not support refugee sites that are in or near national forest reserves, national parks, wildlife reserves, and national historic monuments. In addition, when selecting and supporting beneficiary camps established by UNHCR, due attention will be paid to the risk of artificial or natural hazards and the potential risk of conflict with the local population, protection of water resources, drainage and soil conditions, rainfall patterns, analysis of seasonal variations in water yield and quality throughout the year, solid waste disposal, number of animals in camps, availability of an Environmental Action Plan for refugee camps or settlements, and so on.

V. WORLD BANK GRIEVANCE REDRESS

106. 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/en/projects-operations/products-and-services/grievance-redress-service*. For information on how to submit complaints to the World Bank Inspection Panel, please visit *www.inspectionpanel.org*

VI. SUMMARY OF CHANGES

I. SUMMARY TABLE OF CHANGES

	Changed	Not Changed
Change in Project's Development Objectives	✓	
Change in Results Framework	✓	
Change in Components and Cost	✓	
Change in Loan Closing Date(s)	✓	
Change in Procurement	✓	
Change in Implementing Agency		✓
Cancellations Proposed		✓
Reallocation between Disbursement Categories		✓
Change in Disbursements Arrangements		✓
Change in Safeguard Policies Triggered		✓
Change of EA category		✓
Change in Legal Covenants		✓
Change in Institutional Arrangements		✓
Change in Financial Management		✓
Change in APA Reliance		✓
Other Change(s)		✓

II. DETAILED CHANGE(S)

PROJECT DEVELOPMENT OBJECTIVE

Current PDO

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.

Proposed New PDO

The new Project Development Objective (PDO) is to: (i) increase utilization and improve the quality of health services with a particular focus on reproductive, maternal, child and adolescent health, and nutritional services for the population of Cameroon, including refugees and refugee host communities, and (ii) in the event of an Eligible Emergency, to provide immediate and effective response to said Eligible Emergency

RESULTS FRAMEWORK

Project Development Objective Indicators

People who have received essential HNP services
Unit of Measure: Number
Indicator Type: Custom

	Baseline	Actual (Current)	End Target	Action
Value	0.00	1,194,615.00	6,020,987.00	Revised
Date	30-Jun-2016	30-Jun-2017	31-Dec-2022	

Children 12-23 months fully immunized in the 3 Northern regions and the East
Unit of Measure: Percentage
Indicator Type: Custom

	Baseline	Actual (Current)	End Target	Action
Value	68.00	68.00	80.00	Revised
Date	30-Jun-2016	29-Mar-2017	31-Dec-2022	

Births attended by a skilled professional in the 3 Northern regions and the East
Unit of Measure: Percentage
Indicator Type: Custom

	Baseline	Actual (Current)	End Target	Action
Value	37.60	37.60	55.00	Revised
Date	30-Jun-2016	29-Mar-2017	31-Dec-2022	

Average score of the quality of care checklist
Unit of Measure: Percentage
Indicator Type: Custom

	Baseline	Actual (Current)	End Target	Action
Value	30.00	36.00	50.00	Revised
Date	30-Jun-2016	30-Jun-2017	31-Dec-2022	

Children under 24 months being weighed for growth monitoring in the 3 northern regions (Adamaoua, North, Far north) and the East
Unit of Measure: Number
Indicator Type: Custom

	Baseline	Actual (Current)	End Target	Action
Value	0.00	16,501.00	1,646,480.00	Revised
Date	30-Jun-2016	30-Jun-2017	31-Dec-2022	

Direct project beneficiaries
Unit of Measure: Number
Indicator Type: Custom

	Baseline	Actual (Current)	End Target	Action
Value	0.00	1,211,116.00	8,267,467.00	Revised
Date	30-Jun-2016	30-Jun-2017	31-Dec-2022	

Female beneficiaries
Unit of Measure: Number
Indicator Type: Custom Supplement

	Baseline	Actual (Current)	End Target	Action
Value	0.00	617,669.00	4,216,408.00	Revised

Refugees who have received healthcare (curative and preventative) at health facilities in northern and East regions
Unit of Measure: Number
Indicator Type: Custom

	Baseline	Actual (Current)	End Target	Action
Value	0.00	0.00	600,000.00	New
Date	02-Jul-2018		31-Dec-2022	

Intermediate Indicators

Pregnant women receiving at least 4 antenatal care visits in the 3 Northern regions and the East
Unit of Measure: Percentage
Indicator Type: Custom

	Baseline	Actual (Current)	End Target	Action
Value	42.80	42.80	60.00	Revised
Date	30-Jun-2016	29-Mar-2017	31-Dec-2022	

Adolescent girls 10-19 years benefiting from multisectoral services supported by the GFF Investment Case
Unit of Measure: Number
Indicator Type: Custom

	Baseline	Actual (Current)	End Target	Action
Value	0.00	0.00	150,000.00	Revised
Date	30-Jun-2016	29-Mar-2017	31-Dec-2022	

Women 15-49 using modern contraceptive methods in the 3 Northern regions and the East
Unit of Measure: Percentage
Indicator Type: Custom

	Baseline	Actual (Current)	End Target	Action
Value	12.80	12.80	22.00	Revised
Date	30-Jun-2016	29-Mar-2017	31-Dec-2022	

Children aged 6-59 months who received a vitamin A supplement in the last six months
Unit of Measure: Number
Indicator Type: Custom

	Baseline	Actual (Current)	End Target	Action
Value	0.00	166,205.00	504,286.00	Revised
Date	30-Jun-2016	30-Jun-2017	31-Dec-2022	

Percentage of facilities with 100% tracer drugs available in targeted health facilities on the day of the visit
Unit of Measure: Percentage
Indicator Type: Custom

	Baseline	Actual (Current)	End Target	Action
Value	20.00	21.00	40.00	Revised

Date	30-Jun-2016	30-Jun-2017	31-Dec-2022	

Number of consultations provided to the poor and vulnerable free of charge
Unit of Measure: Number
Indicator Type: Custom

	Baseline	Actual (Current)	End Target	Action
Value	0.00	199,428.00	1,502,057.00	Revised
Date	30-Jun-2016	30-Jun-2017	31-Dec-2022	

Patients/people referred to the health facilities by community health workers
Unit of Measure: Number
Indicator Type: Custom

	Baseline	Actual (Current)	End Target	Action
Value	0.00	58,821.00	343,890.00	Revised
Date	30-Jun-2016	30-Jun-2017	31-Dec-2022	

Percentage of reported maternal deaths audited in PBF districts
Unit of Measure: Percentage
Indicator Type: Custom

	Baseline	Actual (Current)	End Target	Action
Value	0.00	0.00	25.00	Revised
Date	30-Jun-2016	29-Mar-2017	31-Dec-2022	

Percentage of health facilities conducting community interface meetings
Unit of Measure: Percentage
Indicator Type: Custom

	Baseline	Actual (Current)	End Target	Action
Value	4.00	15.00	60.00	Marked for Deletion
Date	30-Jun-2016	30-Jun-2017	31-May-2021	

Percentage of the national population covered by the PBF program
Unit of Measure: Percentage
Indicator Type: Custom

	Baseline	Actual (Current)	End Target	Action
Value	25.00	38.00	95.00	Revised

Date	30-Jun-2016	29-Sep-2017	31-Dec-2022	

Percentage of the total budget for family planning needs funded by the Ministry of Public Health budget
Unit of Measure: Percentage
Indicator Type: Custom

	Baseline	Actual (Current)	End Target	Action
Value	0.00	0.00	50.00	Marked for Deletion
Date	30-Jun-2016	29-Mar-2017	31-Dec-2022	

Number of children and pregnant women dewormed
Unit of Measure: Number
Indicator Type: Custom

	Baseline	Actual (Current)	End Target	Action
Value	0.00	0.00	3,542,000.00	New
Date	02-Jul-2018		31-Dec-2022	

Number of refugee children and pregnant women dewormed
Unit of Measure: Number
Indicator Type: Custom

	Baseline	Actual (Current)	End Target	Action
Value	0.00	0.00	637,000.00	New
Date	02-Jul-2018		31-Dec-2022	

COMPONENTS

Current Component Name	Current Cost (US$, millions)	Action	Proposed Component Name	Proposed Cost (US$, millions)
Strengthening of Health Service Delivery	109.00	Revised	Strengthening of Health Service Delivery	130.00
Institutional Strengthening for Improved Health System Performance	18.00	Revised	Institutional Strengthening for Improved Health System Performance	23.00
	0.00	New	Strengthening emergency, sexual and reproductive health services, and water, sanitation and hygiene	10.00

			and nutrition service delivery for refugee and host populations in the northern and East regions	
	0.00	New	Contingent Emergency Response Component	0.00
TOTAL	**127.00**			**163.00**

LOAN CLOSING DATE(S)

Ln/Cr/Tf	Status	Original Closing	Current Closing(s)	Proposed Closing	Proposed Deadline for Withdrawal Applications
IDA-57900	Effective	31-May-2021	31-May-2021	31-Dec-2022	30-Apr-2023
TF-A2177	Effective	31-May-2021	31-May-2021	31-Dec-2022	30-Apr-2023

Expected Disbursements (in US$, millions)

Fiscal Year	2016	2017	2018	2019	2020	2021	2022	2023	2024
Annual	0.00	9.04	20.71	29.61	31.83	31.18	28.33	12.31	0.00
Cumulative	0.00	9.04	29.74	59.35	91.18	122.36	150.69	163.00	163.00

SYSTEMATIC OPERATIONS RISK-RATING TOOL (SORT)

Risk Category	Latest ISR Rating	Current Rating
Political and Governance	Moderate	High
Macroeconomic	Moderate	Substantial
Sector Strategies and Policies	Moderate	Moderate
Technical Design of Project or Program	Substantial	Substantial
Institutional Capacity for Implementation and Sustainability	Substantial	Substantial
Fiduciary	Substantial	Substantial
Environment and Social	Moderate	Moderate
Stakeholders	Moderate	Moderate
Other	Substantial	Substantial

Overall	Substantial	Substantial

LEGAL COVENANTS – Health System Performance Reinforcement Project - Additional Financing (P164954)

Sections and Description
Without limitation upon the provisions of Paragraph (a) of Section I.A.2 of the Financing Agreement, the PBF Technical Unit shall at all times: (i) be comprised of qualified and experienced personnel in adequate numbers and to this end, inter alia, recruit: (A) a procurement specialist and a financial management specialist; and (B) 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 the Financial Agreement, with qualifications and terms of reference acceptable to the Association; and (ii) be responsible for coordinating the day-to-day implementation of the Project, including, preparing the proposed overall Annual Work Plan and Budget for the Project, updating the Procurement Plan and consolidating the Project reports for the Technical Working Group.
The Recipient shall not later than thirty (30) days after the Effective Date update the Project operational manual, containing detailed arrangements and procedures for: (a) institutional coordination and day-to-day execution of the Project; (b) Project budgeting, disbursement and financial management; (c) procurement; (d) monitoring, evaluation, reporting and communication; (e) environmental and safeguard management; and (f) such other administrative, financial, technical and organizational arrangements and procedures as shall be required for the Project.
The Recipient shall maintain or, as needed, in accordance with Section III of the Financing Agreement, 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; and The Recipient shall cause said external verification agents to carry out, once every semester, throughout Project implementation, verification exercises of Basic Health Services Package, including community and focus group surveys, beneficiary spot checks, verification of data provided and records kept by the relevant Participating Health Authority in relation to the Basic Health Services Package, and assessments of the quality of health services provided under such Basic Health Services Package, in accordance with the provisions of the PBF Manual.

Conditions

Type	Description
Effectiveness	Article V. 5.01. The Additional Condition of Effectiveness consists of the following, namely, that the Association is satisfied that the Recipient has an adequate refugee protection framework.
Type	Description
Disbursement	Schedule 2. Section III. B. (b). Under Category (1) unless such a withdrawal is made on the basis of a Performance-Based Contract executed between an Implementing Agent, on behalf of the Recipient and a Participating Health

	Authority in accordance with the provisions of Section I.G.2 of Schedule 2 to this Agreement.
Type Disbursement	Description Schedule 2. Section. III. (c) under Category (3), for Emergency Expenditures, under Part D of the Project, unless and until the Association is satisfied, and notified the Recipient of its satisfaction, that all of the following conditions have been met in respect of said activities: (i) the Recipient has determined that an Eligible Crisis or Emergency has occurred, has furnished to the Association a request to include said activities in the CER Part in order to respond to said Eligible Crisis or Emergency, and the Association has agreed with such determination, accepted said request and notified the Recipient thereof; (ii) the Recipient has prepared and disclosed all safeguards instruments required for said activities, and the Recipient has implemented any actions which are required to be taken under said instruments, all in accordance with the provisions of Section I.D of Schedule 2 to this Agreement; (iii) the Recipient's Coordinating Authority has adequate staff and resources, in accordance with the provisions of Section I.D of this Schedule 2 to this Agreement, for the purposes of said activities; and (iv) the Recipient has adopted an CER Operations Manual in form, substance and manner acceptable to the Association and the provisions of the CER Operations Manual remain, or have been updated in accordance with the provisions of Section I.D of this Schedule 2 so as to be - appropriate for the inclusion and implementation of said activities under the CER Part.

VII. RESULTS FRAMEWORK

Results Framework

COUNTRY : Cameroon

Health System Performance Reinforcement Project - Additional Financing

Project Development Objectives

The new Project Development Objective (PDO) is to: (i) increase utilization and improve the quality of health services with a particular focus on reproductive, maternal, child and adolescent health, and nutritional services for the population of Cameroon, including refugees and refugee host communities, and (ii) in the event of an Eligible Emergency, to provide immediate and effective response to said Eligible Emergency

Project Development Objective Indicators

Action	Indicator Name	Core	Unit of Measure	Baseline	End Target	Frequency	Data Source / Methodology	Responsibility for Data Collection
Revised	Name: People who have received essential HNP services		Number	0.00	6,020,987.00	Quarterly	Report from PBF Statistics	MOPH
Description:								
Revised	Name: Children 12-23 months fully immunized in		Percentage	68.00	80.00	Annually	Household	MOPH

	the 3 Northern regions and the East						Survey	
Description:								
Revised	**Name:** Births attended by a skilled professional in the 3 Northern regions and the East		Percentage	37.60	55.00	Annually	Household survey	MOPH
Description: Deliveries attended by a qualified health professional in Adamaoua, Far-North, North and East regions								
Revised	**Name:** Average score of the quality of care checklist		Percentage	30.00	50.00	Quarterly	Report from PBF Statistics	MOPH
Description:								
Revised	**Name:** Children under 24 months being weighed for growth monitoring in the 3 northern regions (Adamaoua, North, Far north) and the East		Number	0.00	1,646,480.00	Quarterly	Report from PBF Statistics	MOPH

Description: Children under 24 months being weighed for growth monitoring in the 3 Northern regions

Revised	**Name:** Direct project beneficiaries		Number	0.00	8,267,467.00	Quarterly	Report from PBF Statistics	MOPH
Revised	Female beneficiaries		Number	0.00	4,216,408.00	Quarterly	Report from PBF Statistics	MOPH

Description: Direct beneficiaries are people or groups who directly derive benefits from an intervention (i.e., children who benefit from an immunization program; families that have a new piped water connection). Please note that this indicator requires supplemental information. Supplemental Value: Female beneficiaries (percentage). Based on the assessment and definition of direct project beneficiaries, specify what proportion of the direct project beneficiaries are female. This indicator is calculated as a percentage.

New	**Name:** Refugees who have received healthcare (curative and preventative) at health facilities in northern and East regions		Number	0.00	600,000.00	Quarterly	Report from PBF Statistics	MOPH

Description:

Intermediate Results Indicators

Action	Indicator Name	Core	Unit of Measure	Baseline	End Target	Frequency	Data Source / Methodology	Responsibility for Data Collection
Revised	**Name:** Pregnant women receiving at least 4 antenatal care visits in the 3 Northern regions and the East		Percentage	42.80	60.00	Annually	Household Survey	MOPH
Description: Number of pregnant women who had at least 4 antenatal care visits before delivery in Adamaoua, Far-North, North and East regions (percentage)								
Revised	**Name:** Adolescent girls 10-19 years benefiting from multisectoral services supported by the GFF Investment Case		Number	0.00	150,000.00	Annualy	Report from Project and National Multisectoral Program for Combating Maternal, Newborn and Child Mortality	MOPH
Description: Adolescent girls aged 10-19 years benefiting from 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 from health, sanitation and nutrition outcomes (to be finalized with the Investment Case)								
Revised	**Name:** Women 15-49 using modern contraceptive methods in the 3		Percentage	12.80	22.00	Annually	Household surveys	MOPH

	Northern regions and the East							
Description: Women 15-49 using modern methods such as injections, pills, implants, IUDs and condoms would be taken into account (same definition as the MICS 2014 survey will be used) in Adamaoua, Far North, North and East regions.								
Revised	**Name:** Children aged 6-59 months who received a vitamin A supplement in the last six months		Number	0.00	504,286.00	Quarterly	Report from PBF Statistics	MOPH
Description:								
Revised	**Name:** Percentage of facilities with 100% tracer drugs available in targeted health facilities on the day of the visit		Percentage	20.00	40.00	Quarterly	Report from PBF Statistics	MOPH
Description: Based on current levels in HSSIP project and 6% in new areas (baseline for HSSIP)								
Revised	**Name:** Number of consultations provided to the poor and vulnerable free of charge		Number	0.00	1,502,057.00	Quarterly	Report from PBF Statistics	MOPH
Description: Using the validated definition and selection criteria for identification of the poor and vulnerable.								
Revised	**Name:** Patients/people referred to the		Number	0.00	343,890.00	Quarterly	Report from PBF statistics	MOPH

	health facilities by community health workers							
Description:								
Revised	**Name:** Percentage of reported maternal deaths audited in PBF districts		Percentage	0.00	25.00	Quarterly	Report from PBF Statistics	MOPH
Description:								
Revised	**Name:** Percentage of the national population covered by the PBF program		Percentage	25.00	95.00	Quarterly	Report from PBF Statistics	MOPH
Description: Percentage of the total national population covered by the PBF program (measured by district populations included in the program)								
New	**Name:** Number of children and pregnant women dewormed		Number	0.00	3,542,000.00	Quarterly	Report from PBF Statistics	MOPH
Description:								
New	**Name:** Number of refugee children and pregnant women dewormed		Number	0.00	637,000.00	Quarterly	Report from PBF Statistics	MOPH
Description:								

Target Values

Project Development Objective Indicators

Action	Indicator Name	Baseline	End Target
Revised	People who have received essential HNP services	0.00	6,020,987.00
Revised	Children 12-23 months fully immunized in the 3 Northern regions and the East	68.00	80.00
Revised	Births attended by a skilled professional in the 3 Northern regions and the East	37.60	55.00
Revised	Average score of the quality of care checklist	30.00	50.00
Revised	Children under 24 months being weighed for growth monitoring in the 3 northern regions (Adamaoua, North, Far north) and the East	0.00	1,646,480.00
Revised	Direct project beneficiaries	0.00	8,267,467.00
Revised	Female beneficiaries	0.00	4,216,408.00
New	Refugees who have received healthcare (curative and preventative) at health facilities in northern and East regions	0.00	600,000.00

Intermediate Results Indicators

Action	Indicator Name	Baseline	End Target
Revised	Pregnant women receiving at least 4 antenatal care visits in the 3 Northern regions and the East	42.80	60.00

Revised	Adolescent girls 10-19 years benefiting from multisectoral services supported by the GFF Investment Case	0.00	150,000.00
Revised	Women 15-49 using modern contraceptive methods in the 3 Northern regions and the East	12.80	22.00
Revised	Children aged 6-59 months who received a vitamin A supplement in the last six months	0.00	504,286.00
Revised	Percentage of facilities with 100% tracer drugs available in targeted health facilities on the day of the visit	20.00	40.00
Revised	Number of consultations provided to the poor and vulnerable free of charge	0.00	1,502,057.00
Revised	Patients/people referred to the health facilities by community health workers	0.00	343,890.00
Revised	Percentage of reported maternal deaths audited in PBF districts	0.00	25.00
Revised	Percentage of the national population covered by the PBF program	25.00	95.00
New	Number of children and pregnant women dewormed	0.00	3,542,000.00
New	Number of refugee children and pregnant women dewormed	0.00	637,000.00

Annex 1. The Government's Approach to the Refugee Crisis

1. There is a commitment from the Government to welcome refugees. Among national and local authorities there is both a commitment to acceptance and harmony and concerns around tensions with hosting communities and potential security risks stemming from the presence of refugees and increased cross-border activities. While the approach toward CAR refugees in the East has been relatively welcoming (with a degree of socioeconomic inclusion in host communities), the attitude toward Nigerian refugees in the Far North has been influenced by the fear of Boko Haram, with repeated reports of Nigerian refugees being rejected at the border or forcibly returned and the imposition of a stricter encampment policy.

2. Overall, the legal framework governing the situation of refugees is adequate, but implementation is difficult. Cameroon is a party to most major international agreements relevant to refugees (1951 Convention, 1967 Protocol, and 1969 Organisation of African Unity Convention) and promulgated a refugee law in 2005. In terms of IDP protection, Cameroon acceded to the Kampala Convention in April 2015, but it remains to domesticate the convention into national law. Within the framework convention on the gradual integration of refugees into the national health system that was signed between the Ministry for Public Health and UNHCR in October 2016, UNHCR subsidizes the free provision of basic health care services for refugees (70 percent of the costs); however, the convention currently covers less than 50 percent of the health districts which host refugees. As for access to education, while refugees benefit in principle from free access to primary public education, as with poor Cameroonians, they often struggle to cover the substantive secondary costs (APEE contribution, uniforms, school material, and so on). Documentation, however, remains a critical issue for refugees. For the time being refugee cards are issued to refugees by UNHCR; however, these cards are not always recognized by authorities and security forces at local level which can have a negative impact on free movement and access to the labor market and services. As for out-of-camp refugees in the Far North region, registration of refugees and access to refugee cards remains a challenge and puts refugees in an even more precarious situation in terms of protection. While refugees have the right to own land, this is in practice not consistently implemented due to traditional rules governing land distribution and competing local claims.

3. There is neither a clear policy nor institutional arrangements to manage the medium-term, socioeconomic dimension of the refugee crisis. Several ministries and various levels of Government share overlapping responsibilities. The Ministry of Territorial Administration (Ministre de l'Administration territorial [MINAT]) and Ministry of Decentralization and Local Development are central to the Government's approach to refugees, particularly in rural areas where they are represented through a strong network of *gouverneurs*, *prefets,* and *sous-prefets*, who play a key role related to issues such as intelligence and crisis management, land issues, and local conflicts. The Ministry of Regional Administration and Decentralization is furthermore the focal point within the Government for humanitarian issues. MINEPAT is the key coordinating counterpart for development actors and is also coleading the RPBA process. Sectoral ministries (for example, education, water, health, agriculture, or social affairs) tend to pay relatively less attention to remote hosting regions. Devolved and decentralized authorities as well as traditional leaders often lack resources, although some have developed creative responses to improve the situation of their communities. The network of associations and civil society organizations is comparably weak (for example, youth and women) and operates in a fragmented manner, that is, with varying objectives and coordination mechanisms.

4. Despite the fact that the emergency phase is over, the Government continues to rely on external partners, including on UNHCR, to manage and provide assistance to refugees. This largely reflects a lack of fiscal resources (with only a small share of budget resources allocated to hosting regions) and the limited administrative and technical capacity available in remote border regions.

5. The influx of refugees increases pressure on basic community infrastructure and generates urgent needs with regard to access to education, food, water, sanitation, and health care. Education is, in this context, one of the many sectors that requires support from Cameroonian authorities and development partners. No specific measures have been taken by MINEDUB to support schools with increased refugee-related enrollment. Many affected schools lack sufficient numbers of teachers, and quality teaching and learning materials. While some data are available from specialized agencies, MINEDUB faces a shortage of data relevant to the education challenges of refugees and affected host communities at the school level to inform pragmatic support to schools. There is a need for the education sector to identify and update needs on a regular basis and to establish a response mechanism to address immediate needs in schools.

Annex 2. Commitments of the Government in Support of Refugees, Internally Displaced Populations, and Host Communities

Commitments/Actions of Government	Responsibility (Government Side)	Implementation Deadline	Monitoring Strategy UNHCR/Focal Point UNHCR	Implementation under RSW
Sector/thematic area 1: Defining a medium-term and long-term strategy for refugees, IDPs, and host communities				
1. Develop a national strategy on forced displacement ('operational implementation of Pillar 1 of the Recovery and Peacebuilding Strategy') and strengthen its leadership with a medium-term and long-term strategy to address forced displacement ('to ensure the proper coherence of the actions taken by the Government, local and regional authorities and their humanitarian and development partners')	MINATD/MINREX/MINEPAT	June 2018	RCP Pillar 1/Support Plan/MYMP	Steering Committee
2. Develop an operational plan covering the period 2018–2022 to strengthen solidarity mechanism for refugees and IDPs	MINEPAT/MINATD/MINREX	June 2018	RCP Pillar 1/MYMP	Steering Committee
Sector/thematic area 2: Ensure better coordination of State actions under the existing MINEPAT-UNHCR Partnership Agreement				
1. The Steering Committee of the MINEPAT-UNHCR Partnership Agreement a. "Serves as a platform for all of the development actions so that the programs can be prioritized in the regions/areas/villages affected by inflows of refugees" b. The Government "plans to extend it to the other regions affected by the refugee and internally displaced persons crisis" (beyond the East, Adamawa and North) c. "The Government intends to use the Partnership Agreement between the Government of Cameroon	MINEPAT	2017–2020	MINEPAT-UNHCR Partnership Agreement and Support Plan/RCP Pillar 1/Objectives 2 et 3 MYMP	Safety Nets Health Education CDPSP Steering Committee

Commitments/Actions of Government	Responsibility (Government Side)	Implementation Deadline	Monitoring Strategy UNHCR/Focal Point UNHCR	Implementation under RSW
and the United Nations High Commissioner for Refugees (…) to coordinate action under Pillar 1 of the Recovery and Peace Consolidation Strategy, in close collaboration with the Forced Displacement Program" d. The RCP Strategic Steering Committee's "decisions will guide the deliberations of the Steering Committee for the Partnership Agreement with UNHCR", which will coordinate the monitoring of "projects available to it" implementation and "Pillar 1 of the Recovery and Peace Consolidation Strategy" e. "IDA18 resources will be used to finance the Secretariat of the Steering Committee for the Partnership Agreement and for implementing support plans for towns hosting refugees"				
Sector/thematic area 3: Ensure refugees' protection				
1. Issuance and recognition of biometric identity documents for refugees	MINATD/DGSN	End of 2019	Objective 1 MYMP /Protection	Safety Nets
2. Systematic issuance of birth certificates for refugee children born in Cameroon with new registry offices (or reinforcement of existing registry offices) in border areas	MINATD/CTD	2018–2019	Objective 1 MYMP/Protection Community Services	Safety Nets CDPSP
3. Strengthening of the institutional capacities of refugee status management bodies (Technical Secretariat)	MINREX	2018–2019	Objective 1 MYMP/Protection	Steering Committee
4. "In terms of protection, IDA18 resources will be used to finance strengthening of the Technical Secretariat for	MINREX, MINATD/CTD, MINATD, DGSN	2018–2019	Objective 1 MYMP/Protection	Safety Nets

Commitments/Actions of Government	Responsibility (Government Side)	Implementation Deadline	Monitoring Strategy UNHCR/Focal Point UNHCR	Implementation under RSW
attributing refugee status, strengthening deconcentrated registry offices and issuance of biometric identity documents"			Community Services	
5. Support mechanisms for a permanent return of IDPs that maintains their dignity and their security	MINATD/MINDEF/MINEPAT	2018	Objective 4 MYMP /Protection	CDPSP Safety Nets
6. "For Nigerian refugees applying for repatriation, the Government undertakes to facilitate their return under the terms set out in the Tripartite Agreement. For refugees wishing to remain in Cameroon, the Government will provide assistance and protection in accordance with international standards"	MINATD/MINREX/MINDEF	2018	Objective 4 MYMP /Protection	Steering Committee
Sector/thematic area 4: Facilitate greater access to basic social services and socio-economic inclusion of refugees, host populations and IDPs				
1. Draft support plans complementing local council-level development plans implemented by the CDPSP	MINEPAT	December 2018	Support Plan	CDPSP
2. Prioritize programs that promote social and economic integration in the local council/health districts affected by flows of refugees and provide basic services equitably at the local level	MINEPAT	2018	Support Plan Objectives 2 and 3 MYMP Livelihoods Strategy	Safety Nets Health Education CDPSP
3. Facilitate refugees' resilience, autonomy, and access to basic social services and to IGAs	MINEPAT	2018	Support Plan Objectives 2 and 3 MYMP Livelihoods Strategy	Safety Nets Health Education CDPSP

Commitments/Actions of Government	Responsibility (Government Side)	Implementation Deadline	Monitoring Strategy UNHCR/Focal Point UNHCR	Implementation under RSW
4. Define a policy and local arrangements for refugees' access to crop and grazing land	MINADER/MINEPIA/MINCAF	2018	Support Plan Livelihoods Strategy Objectives 2 and 3 MYMP	Steering Committee
5. Develop/extend to areas affected by flows of refugees and IDPs the Safety Nets, Health and Basic education projects	MINEPAT/WB Projects	December 2018	Support Plan Strategy CBI Livelihoods Strategy Objectives 1 and 2 MYMP	Safety Nets Health Education
Sector/thematic area 5: To acquire knowledge tools to better address the refugees crisis				
1. Assess poverty and vulnerability factors affecting refugees and host communities (multisectoral study led by INS)	MINEPAT/MINAS	June 2018	Strategy CBI Livelihoods Strategy MYMP	Safety Net
2. Develop a strategic note on documentation of refugees to define documentation process for refugees and issuance of identity documents	MINEPAT/MINATD	June 2018	Objective 1 MYMP Protection	Steering Committee Safety Net
3. Develop recommendations on agro-pastoral conflicts in the Far North, complementing the study carried out in the East, North, and Adamawa	MINADER/MINEPIA/MINCAF	June 2018	Livelihoods Strategy	Steering Committee
IDA18 Financing				

Commitments/Actions of Government	Responsibility (Government Side)	Implementation Deadline	Monitoring Strategy UNHCR/Focal Point UNHCR	Implementation under RSW
1. IDA18 resources will be used to finance strengthening of the Technical Secretariat for attributing refugee status, strengthening deconcentrated registry offices, and issuance of biometric identity documents	MINREX	2018–2019		Safety Nets
2. IDA18 resources will be used to finance the Secretariat of the Steering Committee for the Partnership Agreement and for implementing support plans for towns hosting refugees.	MINEPAT	2017–2019		Safety Nets Health Education CDPSP
3. The 'Social Safety Net' project, the Health System Performance Reinforcement project, the Basic Education Project, and CDPSP are to receive IDA funds.	MINEPAT/MINSANTE/MINEDUB	2018–2019		Safety Nets Health Education CDPSP

Annex 3. World Bank integrated approach through IDA18 Refugee Sub-Window in Cameroon

1. The World Bank is supporting an integrated approach to address key challenges facing refugees and host communities, building on the work of the ongoing projects (CDPSP, SSNP, and HSRSP) and complementing projects in the pipeline (ERSP). Table 3.1 summarizes the key interventions financed under IDA18 RSW.

Table 3. 1. Interventions under Preparation in Cameroon Supported by IDA18 RSW

Project Name	Additional Activities under RSW	Additional Amount under RSW (Grant)	Synergies under RSW
ERSP (P160926)	• Improved distribution of teachers recruited by the state in public primary schools (including focus on refugee-affected local councils) • Increased capacities of teachers in the effective and efficient use of the new curriculum in preprimary and primary schools (including focus on refugee-affected local councils) • Increased availability of essential textbooks in public primary schools • Increased access to preschool in rural areas through community preschools, in line with national standards • Establishment of a standardized student learning assessment system for primary and secondary education • Integrated education management information system functional and operational • Improved learning environment and quality of education for children in host community schools affected refugees • Support a transition from input-based financing to PBF at the school level. (including focus on refugee-affected local councils)	US$36 million	Integration of health, nutrition, and early childhood development contents in community preschool centers Inclusion of contents related to GBV prevention, child rights, and refugee protection in teacher training School-based sensitization on birth registration Modules on parental education
SSNP AF	• Human capital development (parental awareness campaigns) for children ages 3 to 5 • Development of training modules in partnership with UNICEF • Facilitator training (recruitment, contract, duration, and training) • Registering for national ID and birth certificate	US$60 million	Common targeting at the local council level Training sessions (parental education) in schools Organization of public hearings and sensitization
HSPRP AF	The proposed AF will support the reinforcement of equity mechanisms of PBF to ensure the provision of health care services to refugees and vulnerable host	US$36 million	School-based activities (psychosocial support,

Project Name	Additional Activities under RSW	Additional Amount under RSW (Grant)	Synergies under RSW
	populations and will finance training of health personnel and provision, through the PBF approach, of new specific health care to refugees and host population (management of rape, FGM, and GBV, including physical, sexual, and psychological violence)		deworming, nutrition, WASH, and other health promotion activities)
CDPSP AF	The proposed AF will assist in continuing activities initiated under the original project CDPSP III (Components 1, 2 and 3) to ensure sustainability and alleviate pressures in host local councils induced by the influx of refugees. The AF will target 41 local councils in the Far North, North, Adamawa, and East regions currently affected by the influx of refugees. Under this AF and based on its experience with working in local councils hosting refugees, CDPSP III will be the main vehicle for (a) enhancing through community-driven development activities both service delivery and social cohesion in refugee-hosting areas, (b) reinforcing the capacity of local governments in accountable frontline services delivery for both displaced and host communities; and (c) strengthening the capacity and role of local government in facilitating land planning and management through an inclusive approach.	US$48 million	Enhance service delivery and social services for the local councils hosting refugees Develop social infrastructure in the education sector

Annex 4. Results monitoring and evaluation

1. **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.

2. **Routine monthly and quarterly data collected through the web-based PBF system will be aggregated for the project's quarterly and annual indicators and will be linked to the national health management information system system (currently being reinforced by the introduction and scale-up of DHIS2).** The project monitoring system will include (a) identification and consolidation of M&E indicators; (b) training and capacity-building initiatives at the national, regional, and local levels; (c) standardized methods and tools to facilitate systematic collection and sharing of information; (d) an independent review by external technical consultants (External Evaluation Agency); and (e) annual program evaluations and strategic planning exercises for each component.

3. **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 IEs, qualitative research, specific surveys, process evaluations, was defined in early 2016 during the process of developing the Investment Case.

4. **In addition to the ongoing community PBF IE, the project will also include a prospective evaluation for the multisectoral program in the northern[67] regions, plus several rounds of SDI surveys and national health accounts**.

Sustainability

5. **Technical sustainability will be ensured by capacity-building and knowledge transfer activities throughout the project.** While capacity already exists for implementing Component 1 through 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.

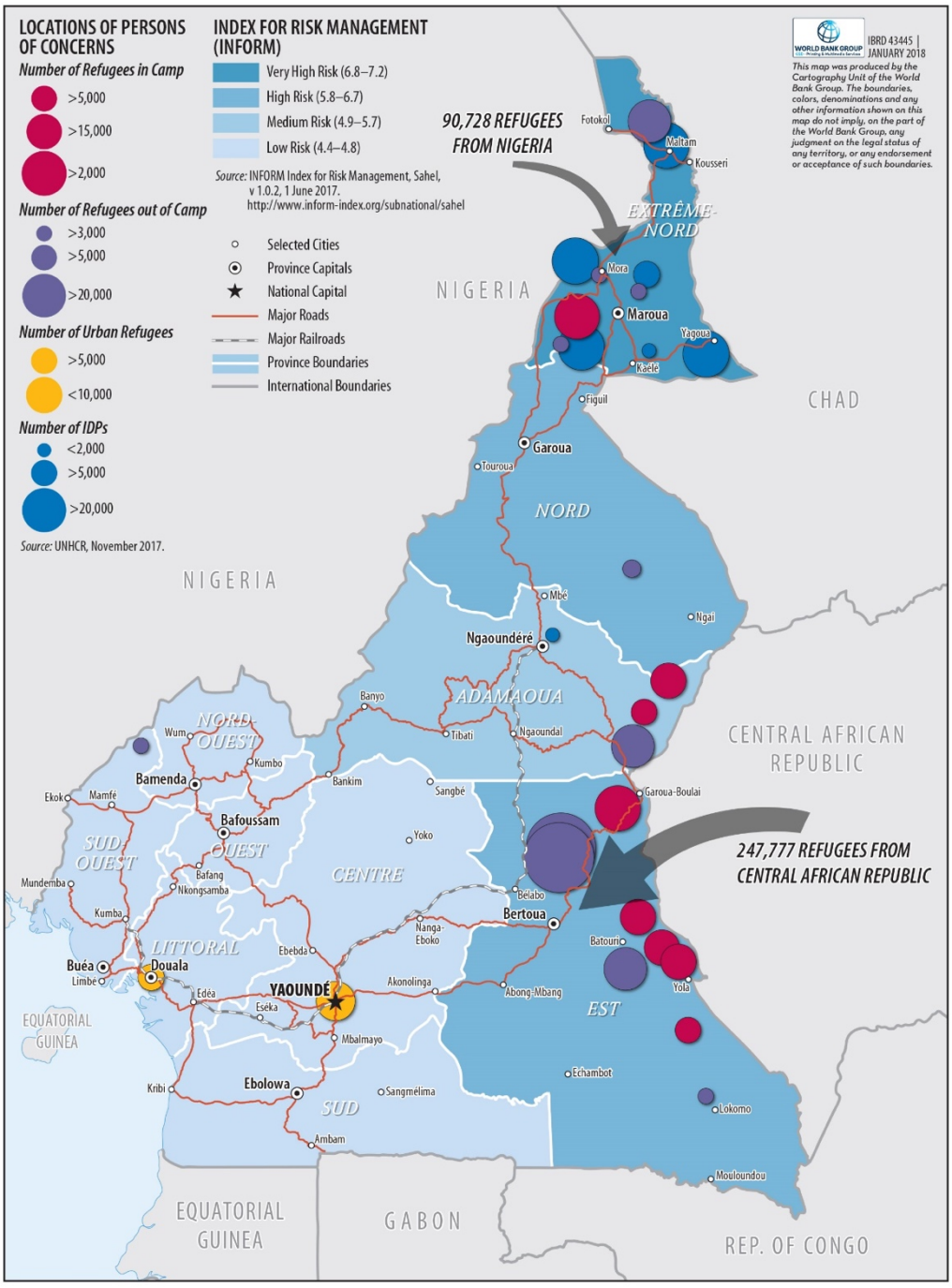
6. **Financial sustainability of PBF can be reasonably achieved given the limited cost of this mechanism and the current low level of financing the Government is investing in the health sector.** The project will help improve the efficiency of health spending by improving the outcomes obtained from the current total health expenditure of US$138 per capita per year (PPP). By spending US$4– US$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,

[67] Northern regions refer to the Far North region, North region and Adamawa region.

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.

7. **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 World 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 UHC.

Annex 5. Cameroon MAP of Refugees and Host Communities



Source: World Bank, January 2018.