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

Report No.: PIDISDSA16709

Date Prepared/Updated: 25-Feb-2016

I. BASIC INFORMATION

A. Basic Project Data

Country:	Cameroon	**Project ID:**	P156679
		Parent Project ID (if any):	
Project Name:	Health System Performance Project (P156679)		
Region:	AFRICA		
Estimated Appraisal Date:	16-Feb-2016	**Estimated Board Date:**	03-May-2016
Practice Area (Lead):	Health, Nutrition & Population	**Lending Instrument:**	Investment Project Financing
Sector(s):	Health (80%), Public administration- Health (20%)		
Theme(s):	Health system performance (40%), Child health (20%), Population and reproductive health (20%), Nutrition and food security (10%), Ot her communicable diseases (10%)		
Borrower(s):	MINEPAT		
Implementing Agency:	Ministry of Public Health		

Financing (in USD Million)

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

Environmental Category:	B - Partial Assessment
Appraisal Review Decision (from Decision Note):	The review did authorize the team to appraise and negotiate
Other Decision:	
Is this a Repeater project?	No

B. Introduction and Context

Country Context

Cameroon has an estimated population of 22.8 million (2014) and the annual population growth rate is 2.7, with 41 percent of the population under 15 years old. Cameroon's average Growth Domestic Product (GDP) growth in real terms has stood between 3.3 (2010) and 5.9 percent (2014) over the last five years, with GDP per capita per year (PPP) estimated at US$2,400 in 2013. Cameroon is a lower middle income country, but poverty levels are high and social indicators remain low. It was ranked 153nd out of the 188 countries tracked in the 2014 Human Development Index (HDI) and is one of a group of countries whose HDI scores have deteriorated in the past two decades.

Despite great development potential (significant natural resources, a relatively educated work force and capable bureaucracy), Cameroon's economic growth is lagging behind its potential and has not had a lasting impact on poverty. Cameroon is endowed with significant natural resources, including oil, high value timber species and agricultural products (coffee, cotton, cocoa). Poor infrastructure, an unfavorable business environment, and weak governance hamper economic activity and make it difficult to reach the growth rates needed to reduce poverty in a sustainable manner. After a significant decrease in poverty rates in the 1990s, the poverty rate has barely shifted between 2000 and 2007. Since 2001, it is estimated that around 40 percent of the population lives below the poverty line and chronic poverty stands at about 26 percent. In 2014, poverty incidence was 38 percent (using the national poverty line). These averages are high compared to other countries in the region with similar economic characteristics.

Sectoral and institutional Context

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

There are also major disparities in health outcomes and access to health services. Significant progress has been made to reduce infant and under-five child mortality in many regions of the country, but major geographic discrepancies remain, particularly between the three northern regions (Far North, North and Adamaoua) and the rest of the country. Child mortality remains extremely high in the poorest parts of the country, such as the North and the Far North, where close to 20 percent of the children born die before their fifth birthday (173 deaths and 154 deaths per 1,000 live births in the North and the Far North, respectively, in comparison with the national average of 103 deaths per 1,000 live births).

Childhood malnutrition remains widespread, indicators have remained stagnant for over 20 years and are characterized by enormous disparities. The northern regions are hardest hit, and malnutrition rates in these regions are on the rise. The overall percentage of wasting among the

population of children under five years of age doubled between 2004 and 2011and more than quadrupled in the fourth quintile. Stunting, which is an indicator of chronic malnutrition, was 36% in 1991 and 32% in 2014. The difference between urban (22%) and rural (41%) areas is significant and four regions are especially affected by high rates of stunting: the Far North (44%), the North (40%), Adamawa (40%), and the East (38%). As a result, Cameroon is one of the countries that have made the least progress in reducing stunting.

Regional inequalities in education outcomes are also significant. The net enrollment rate for primary education in 2014 was 63, 74 and 74 percent in the Far North, the North and Adamawa regions respectively, versus 85-95 percent in the other regions. At the secondary level, in 2011 gross enrollment was 22 and 29 percent and net enrollment only 14 and 18 percent in the Far North and North regions respectively. Girls remain discriminated, particularly those from the most socioeconomically disadvantaged groups and from northern Cameroon. Evidence on Cameroon shows that women's educational attainment is a strong determinant of fertility, access to reproductive health services, and child survival and child nutrition, highlighting the critical constraint that low girls' education levels represent for the North and Far North.

While Cameroon has an overall high level of health spending of US$138 per capita per year (PPP) (2013), its epidemiological profile corresponds to countries with much lower per capita spending, as described above. Households are bearing a large share of health expenditures (52.2% of total health expenditures, NHA 2011), almost exclusively through out-of-pocket expenditures as coverage with risk-pooling mechanisms is very low (1.2%, NHA 2011), leading to a greater risk of impoverishment and vulnerability for poor households. Additionally, financial governance is a main issue in the health sector: informal payments, corruption, and rigidity of public spending procedures. This health financing situation is leading to significant geographic and socio-economic inequities in access to essential health services. Consequently, there is a need to increase efficiency and prioritization in public spending to improve health outcomes.

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

The Investment Case is being developed through a collaborative multi-stakeholder process anchored at the National Multisectoral Program for Combating Maternal, Newborn & Child Mortality, which is composed of representatives from the ministries of health, education, youth and gender, finance and planning, as well as civil society and development partners engaged in the heath sector. The preparation of the Investment Case began in December 2015 and is expected to be completed by April 2016. It will identify an evidence-based set of priorities for improving RM NCAH outcomes in Cameroon, linked to priority interventions identified in the national Health Sector Strategy. The initial discussions around priorities for the Investment Case

have informed the development of this document, and the project is expected to make a significant contribution to supporting the Investment Case. On the health financing strategy, discussions have begun in 2015 and its development is one of the objectives of the 2016-2027 Health Sector Strategy. A technical committee, including the UHC technical group, will lead the process. Additional analytical work to inform the assessment of health financing in Cameroon will be conducted during the first semester of 2016, and it is expected to have the health financing strategy in 2017. Different partners are supporting the process (WHO, CHAI, World Bank, etc.).

The original Cameroon Health Sector Support Investment Project (HSSIP, P104525) is a US$25 million project (approved in 2008), which aims to provide key maternal and child health services to target populations in their vicinity through PBF. The Project Development Objective is to increase utilization and improve the quality of health services with a particular focus on maternal and child health and communicable diseases. The project began implementing Performance-Based Financing (PBF) in the Littoral region in 2011, followed by a scale-up to the North-West, South-West and East regions in 2012. The project is currently implementing PBF in public, private and faith-based organization (FBO) facilities across 26 districts in the four regions, covering a total population of approximately three million people. Since the launching of PBF, the quality and utilization of maternal and child health services has increased substantially.

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

C. Proposed Development Objective(s)

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, adolescent and child health and nutrition services.

Key Results

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

1. People who have received essential HNP services (number)
2. Children 12-23 months fully immunized (number)
3. Births attended by skilled professional (number)
4. Average score of the quality of care checklist

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

D. Project Description

Project Description

The project is to be comprised of two components that aim to improve performance of the health sector: (i) improving the quantity and quality of preventive, curative and promotional health services through Performance-Based Financing and complementary high-impact interventions; and (ii) Strengthening institutional capacity for improved health system performance. Both components address key strategies identified in the new national Health Sector Strategy (2016-2027), as well as other strategic plans such as the National Strategic Plan for Adolescent and Youth Health in Cameroon (2015-2019), the Strategic Plan for the National Multisectoral Program for Combating Maternal, Newborn & Child Mortality in Cameroon (2014-2020) and for the Strategic Plan for Reproductive, Maternal, Neonatal and Infant Health (2014-2020).

Component 1: Strengthening health service delivery through Performance-Based Financing and other high-impact interventions for RMNACH outcomes (initial estimation: US$108 million (US $89 million IDA, US$19 million GFF), includes continuing support to the ongoing PBF intervention that currently covers approximately 25 percent of the country, as well as incrementally increasing coverage, first focusing on scaling-up to full coverage in the three northern regions. While the project will support the national scale-up of PBF, which has been identified as a key objective of the Government of Cameroon, the extent to which national coverage can be achieved by 2020 will depend on financial commitments realized by the government and development partners engaged in the health sector. The progress for which the scale-up is being achieved will be assessed at the Mid-Term Review of the project. Component 2 includes strengthening institutional capacity at the national level to foster development of equitable, efficient, and sustainable national health financing strategies to achieve the national health goals, and increase the capacity at the county level to plan, budget, implement, and monitor the effective delivery of an essential package of health services.

Component 1 will support the ongoing implementation of PBF in the 26 health districts covered by the original operation, the 17 health districts newly added through the Additional Financing, and an incremental roll out of PBF to national coverage. With coverage at 25 percent of the population in 2015, the operation would support a gradual scale-up of an additional 20 percent per year between 2017 and 2020. During the first phase of the extension (2016-2018), the operation will focus on scaling-up to the remaining districts in the three northern regions of Cameroon to address the urgent and growing needs in those regions. Component 1 will also provide support to key interventions that are aligned with the pillars of the GFF Investment Case, in particular improving reproductive health, adolescent health and nutrition outcomes in the country.

Component 2: Strengthening g institutional capacity for improved health system performance (initial estimation: US$19 million (US$11 million IDA, US$8 million GFF (US$6 million RMNACH and US$2 million for CRVS)), will support institutional strengthening at national, regional, and district levels for improved health system performance. In addition to providing institutional support for moving PBF from a pilot project to a national program, Component 2 will also support analytical work, and policy dialogue to facilitate the development of these reforms, as well as implementation support for a few key reforms that address system bottlenecks for achieving more efficient use of health sector resources and improved health outcomes.

As such, Component 2 will provide additional support at the central level of the Ministry of Public Health through analytical work and policy dialogue related to several of the main

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

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

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

Component Name

Strengthening health service delivery through Performance-Based Financing and other high-impact interventions for RMNACH outcomes

Comments (optional)

Component Name

Strengthening institutional capacity for improved health system performance

Comments (optional)

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

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

F. Environmental and Social Safeguards Specialists

Emeran Serge M. Menang Evouna (GEN07)

Kristyna Bishop (GSU01)

II. Implementation

Institutional and Implementation Arrangements

Under the proposed operation no dedicated PIU external to the ministry will be created, as was the

case for the HSSIP. As such, the National PBF Technical Unit will be tasked with overseeing both coordination of the overall PBF program as well as specific project implementation. As such, the fiduciary requirements of the PBF Technical Unit will increase substantially as the entirety of responsibilities from the HSSIP PIU will be transferred to the PBF unit. The four staff will remain under the proposed operation and will be reinforced through the recruitment of additional staff and experts. As the experience with the HSSIP staff was highly satisfactory and they hold invaluable experience and knowledge in implementation of the PBF program, the majority of staff from the HSSIP PIU will be transferred to PBF Technical Unit. Other experts may be recruited on as needed basis.

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

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

III. Safeguard Policies that might apply

Safeguard Policies	Triggered?	Explanation (Optional)
Environmental Assessment OP/BP 4.01	Yes	This policy was triggered due to the potential increase in production of medical waste, resulting from an increase in use of health services as an impact of the proposed project. A new Medical Waste Management Framework has been prepared and disclosed, as an instrument to identify mitigation measures for these potential impacts, and guide preparation of health facility specific plans.
Natural Habitats OP/BP 4.04	No	The project is not expected to impact on natural habitats.
Forests OP/BP 4.36	No	The project is not expected to impact on forests.
Pest Management OP 4.09	No	The project is not expected to impact on pests.
Physical Cultural Resources OP/BP 4.11	No	The project is not expected to impact on physical cultural resources.
Indigenous Peoples OP/BP 4.10	Yes	This policy has been triggered as indigenous peoples are present in the East region. A social audit and assessment, reviewing the implementation of the IPPF for the previous Health Sector Support project and evaluating the current health status and concerns of these communities, has informed the IPP that was prepared for the project, consulted on and disclosed in country and Infoshop.

Involuntary Resettlement OP/ BP 4.12	No	The project will not include any involuntary resettlement.
Safety of Dams OP/BP 4.37	No	The project will not include construction or rehabilitation of dams, nor rely on dams.
Projects on International Waterways OP/BP 7.50	No	The project is not expected to impact on any international waterway.
Projects in Disputed Areas OP/ BP 7.60	No	The project will not be located in a disputed area.

IV. Key Safeguard Policy Issues and Their Management

A. Summary of Key Safeguard Issues

1. Describe any safeguard issues and impacts associated with the proposed project. Identify and describe any potential large scale, significant and/or irreversible impacts:

The MWMP prepared for the previous project was implemented as planned. The borrower has updated MWMP for the new operation (new technical and geographical scope) and the report has been disclosed in country and in the Infoshop. During the update process, all relevant stakeholders were consulted.

A social assessment and audit was undertaken in order to evaluate the impact of activities financed during the previous project on increasing access to primary health care for the Baka communities, identify lessons learned from those activities and identify some adaptations that might be necessary in order to improve access under this project. Based on these findings, and consultations with the communities, an Indigenous Peoples Action Plan was prepared seeking to ensure that Baka communities derive benefits from the project. Both the social assessment/audit and the Action Plan have been disclosed in country and Infoshop.

2. Describe any potential indirect and/or long term impacts due to anticipated future activities in the project area:

There are no long term impacts due to the anticipated future activities in the project area.

3. Describe any project alternatives (if relevant) considered to help avoid or minimize adverse impacts.

Not relevant.

4. Describe measures taken by the borrower to address safeguard policy issues. Provide an assessment of borrower capacity to plan and implement the measures described.

The Ministry of Public Health has a unit that is responsible for environmental issues which works in close collaboration with the Ministry of Environment, Nature Protection and Sustainable Development (MINEPDED). The Unit has well trained staff and when necessary seeks support from MINEPDED or external consultants. It was agreed that the same arrangement will be maintained during the implementation of the Additional Financing period of the original HSSIP project (P104525).

The MWMP prepared for the previous project was implemented as planned (purchase/installation of generators). The borrower has updated the MWMP for the new operation (new technical and geographical scope) and the report was finalized and disclosed in country and in the Infoshop prior to appraisal. During the update process, all relevant stakeholders have being consulted.

5. Identify the key stakeholders and describe the mechanisms for consultation and disclosure

on safeguard policies, with an emphasis on potentially affected people.
The key stakeholders include indigenous peoples (Baka) of the East region, health service providers and health system managers (district, regional and central level administrative units), and patients and communities that are served in the project's implementation zone. These groups have participated in the process to prepare the safeguard instruments and their inputs have been incorporated into the final documents. Specific consultations with indigenous communities and the staff working at the health centers that provide care for these communities were undertaken in the preparation of the updated Indigenous Peoples Action Plan.

B. Disclosure Requirements

Environmental Assessment/Audit/Management Plan/Other	
Date of receipt by the Bank	09-Feb-2016
Date of submission to InfoShop	25-Feb-2016
For category A projects, date of distributing the Executive Summary of the EA to the Executive Directors	
"In country" Disclosure	
Cameroon	25-Feb-2016
Comments:	
Indigenous Peoples Development Plan/Framework	
Date of receipt by the Bank	09-Feb-2016
Date of submission to InfoShop	25-Feb-2016
"In country" Disclosure	
Cameroon	25-Feb-2016
Comments:	
If the project triggers the Pest Management and/or Physical Cultural Resources policies, the respective issues are to be addressed and disclosed as part of the Environmental Assessment/ Audit/or EMP.	
If in-country disclosure of any of the above documents is not expected, please explain why:	

C. Compliance Monitoring Indicators at the Corporate Level

OP/BP/GP 4.01 - Environment Assessment	
Does the project require a stand-alone EA (including EMP) report?	Yes [×] No [ ] NA [ ]
If yes, then did the Regional Environment Unit or Practice Manager (PM) review and approve the EA report?	Yes [×] No [ ] NA [ ]
Are the cost and the accountabilities for the EMP incorporated in the credit/loan?	Yes [×] No [ ] NA [ ]
OP/BP 4.10 - Indigenous Peoples	
Has a separate Indigenous Peoples Plan/Planning Framework	Yes [×] No [ ] NA [ ]

(as appropriate) been prepared in consultation with affected Indigenous Peoples?	
If yes, then did the Regional unit responsible for safeguards or Practice Manager review the plan?	Yes [×] No [ ] NA [ ]
If the whole project is designed to benefit IP, has the design been reviewed and approved by the Regional Social Development Unit or Practice Manager?	Yes [×] No [ ] NA [ ]
The World Bank Policy on Disclosure of Information	
Have relevant safeguard policies documents been sent to the World Bank's Infoshop?	Yes [×] No [ ] NA [ ]
Have relevant documents been disclosed in-country in a public place in a form and language that are understandable and accessible to project-affected groups and local NGOs?	Yes [×] No [ ] NA [ ]
All Safeguard Policies	
Have satisfactory calendar, budget and clear institutional responsibilities been prepared for the implementation of measures related to safeguard policies?	Yes [×] No [ ] NA [ ]
Have costs related to safeguard policy measures been included in the project cost?	Yes [×] No [ ] NA [ ]
Does the Monitoring and Evaluation system of the project include the monitoring of safeguard impacts and measures related to safeguard policies?	Yes [×] No [ ] NA [ ]
Have satisfactory implementation arrangements been agreed with the borrower and the same been adequately reflected in the project legal documents?	Yes [×] No [ ] NA [ ]

V. Contact point

World Bank

Contact: Paul Jacob Robyn
Title: Health Specialist

Borrower/Client/Recipient

Name: MINEPAT
Contact: Mr. Louis Paul Motaze
Title: Minister of Economy , Planning and Regional Development
Email:

Implementing Agencies

Name: Ministry of Public Health
Contact: Andre Mamma Fouda
Title: Minister of Public Health
Email: andrmama@yahoo.fr

VI. For more information contact:

The InfoShop
The World Bank
1818 H Street, NW
Washington, D.C. 20433
Telephone: (202) 458-4500
Fax: (202) 522-1500
Web: http://www.worldbank.org/infoshop

VII. Approval

Task Team Leader(s):	Name: Paul Jacob Robyn	
Approved By		
Safeguards Advisor:	Name: Johanna van Tilburg (SA)	Date: 25-Feb-2016
Practice Manager/ Manager:	Name: Trina S. Haque (PMGR)	Date: 25-Feb-2016
Country Director:	Name: Elisabeth Huybens (CD)	Date: 25-Feb-2016

Public Disclosure Copy