



# Combined Project Information Documents / Integrated Safeguards Datasheet (PID/ISDS)

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Appraisal Stage | Date Prepared/Updated: 12-Mar-2018 | Report No: PIDISDSA24048



**BASIC INFORMATION**

**A. Basic Project Data**

Country Cameroon	Project ID P164954	Project Name Health System Performance Reinforcement Project - Additional Financing	Parent Project ID (if any) P156679
Parent Project Name Health System Performance Reinforcement Project	Region AFRICA	Estimated Appraisal Date 19-Feb-2018	Estimated Board Date 03-Apr-2018
Practice Area (Lead) Health, Nutrition & Population	Financing Instrument Investment Project Financing	Borrower(s) MINEPAT, MINSANTE	Implementing Agency Ministry of Public Health

Proposed Development Objective(s) Parent

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 Development Objective(s) Additional Financing

The new Project Development Objective (PDO) is (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 the said Eligible Emergency

Components

- Strengthening of Health Service Delivery
- Institutional Strengthening for Improved Health System Performance
- Strengthening emergency, sexual and reproductive health services, and WASH and nutrition service delivery for refugee and host populations in the northern and East regions
- Contingent Emergency Response

Financing (in US\$, millions)

**SUMMARY**

<b>Total Project Cost</b>	163.00
<b>Total Financing</b>	163.00



Financing Gap	0.00
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**DETAILS**

<b>Total World Bank Group Financing</b>	136.00
World Bank Lending	136.00

Environmental Assessment Category  
Partial Assessment (B)

Decision  
The review did authorize the preparation to continue

**B. Introduction and Context**

**Country Context**

1. **Cameroon is a lower middle-income, central African country that shares borders with six countries<sup>1</sup> Nigeria and Chad in the North, and Central African Republic (CAR) in the East.** Cameroon’s population is large (22.8 million), young (41 percent under 15 years) and diverse, with 250 ethnic groups spread across its ten regions<sup>2</sup>. 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 four regions collectively host an estimated 341,000 refugees - the 11<sup>th</sup> largest number of refugees in the world, and 6<sup>th</sup> largest in Africa - who fled the conflict in CAR and Boko Haram insurgents on Cameroons’ borders with Nigeria and Chad. Refugees constitute over 2 percent of Cameroons population, and 60 percent of refugees are below the age of 18 years.

2. **Cameroon’s dependency on commodity prices has rendered macroeconomic performance volatile and uneven.** Cameroon is well endowed in 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

<sup>1</sup> Nigeria, Gabon, Equatorial Guinea, Republic of Congo, and Chad and Central African Republic (CAR).

<sup>2</sup> Cameroon is administratively divided into 10 regions: Far North, North, Adamawa, West, North-West, Littoral, South-West, South, Central and East.



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.

3. **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<sup>3</sup>.** Poverty is increasingly concentrated in rural areas and the northern regions. 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.

### **Refugee and humanitarian crisis in the Northern and East regions**

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

5. **Approximately 235,000 CAR refugees live along the eastern border (the majority of them in the East region and the rest in the Adamawa and North regions).** These refugees generally fled violence in the CAR in two waves. Approximately 100,000 refugees fled the Central African Republic between 2003 and 2006, primarily from border regions. While some of these refugees have achieved a degree of socio-economic inclusion, living out of camps and integrated in their host communities, the majority remains extremely vulnerable in terms of food security and has very limited access to livelihoods. An additional 160,000 CAR refugees arrived after 2013. Some of these refugees originated from more distant parts of the CAR, including Bangui. Overall, 30% of CAR refugees live in of the seven dedicated refugee sites while 70% live in villages. CAR refugees represent around 5 percent of the total population in Adamawa and 18 percent in the East region; it should be noted that in some of the most affected municipalities such as Garoua-Boulai (Adamawa) or Kenzou (East), refugees largely outnumber the local population. Areas hosting refugee populations are poor and isolated, with limited access to services. In some areas, post-2013 refugee arrivals strained previous host-refugee relationships that were largely positive, and have in some localities led to tensions related to access to scarce resources and land. Humanitarian assistance being primarily directed to refugees, in particular in the dedicated sites, has also caused resentment among host communities.

6. **Approximately 90,000 Nigerian refugees live in the Far North region.** The destabilizing impact of refugee populations in this region is compounded by the presence of 241,000 internally displaced persons (IDPs). These refugees fled the Boko Haram attacks, and most have been in exile for three to four years. Approximately one-fourth of these refugees have experienced multiple displacements. The traumatic events they have experienced, coupled with suspicion and stigmatization from security forces, authorities, and in some instances host populations following incidents of indiscriminate violent attacks against civilians by armed elements, have hindered opportunities for social inclusion. The inadequate recognition of UNHCR-issued refugee documents for refugees registered in Minawao camp and a lack of identification papers out-of-camp refugees place significant restrictions on freedom of movement and, in the case of out-of-camp

<sup>3</sup> Cameroons fourth household survey (ECAM-4)



refugees also makes it difficult to distinguish between them, IDPs, and hosts. Approximately 62,000 refugees live in the Minawao refugee camp that opened in July 2013, where living conditions are poor and the populations remains fully dependent on humanitarian assistance. Refugees who live outside the camp and IDPs face an even more precarious situation with some living in areas that are extremely difficult to access or are unregistered and lack any documentation. 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, and cross-border traffic restrictions have destabilized the economy of a region that was already very poor, under-serviced, and largely dependent on trade with Nigeria. Looking ahead, there is the risk of further increases in the number of people displaced by the Boko Haram conflict.

7. **The refugee crisis primarily affects remote and poor border regions** Even prior to the massive influx of displaced populations, refugee-hosting regions (particularly Adamawa and the Far North) presented the highest and deepest levels of poverty, highest inequality rates and lowest human development indicators in Cameroon. Hosting regions are subject to multiple poverty traps, including low agriculture productivity, increasing vulnerability to external shocks<sup>4</sup>, poor infrastructure, high fertility and limited access to basic social services (health, education, water, sanitation), and livelihood. The increased fragility, insecurity and violence has led to a loss of livestock, interrupted agricultural activities and trade, and closed markets, roads and frontiers, further exacerbating poverty levels, particularly in cross-border areas<sup>5</sup>. Altogether, these four regions (North, Far North, East and Adamawa) account for 66 percent of poor households in the country (even though they are home to only 38 percent of the total population). 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.

8. According to preliminary results of CAR refugee poverty analysis (American University of Beirut, forthcoming), using expenditure data from a Household Economy Analysis (UNHCR/IFORD 2017), CAR refugees in the East, Adamawa and North regions show alarming levels of poverty. Data suggests that 98% of CAR refugees fall below the national poverty line (FCFA 22,500 per person per month) and 96% of refugees fall below the extreme poverty line (less than FCFA 17,962 per person per month). If the Minimum Food Basket (MFB) calculated by the World Food Program is used as a reference, 71% of the CAR refugee population fall below this line, meaning that their expenditure is less than FCFA 8,800 per person per month – the amount necessary to purchase minimum food energy requirements (emergency standards: 2,100 kcal / person / day).

## Sectoral Context

9. **Refugees, particularly women and children, have a disproportionately higher burden of disease compared to the host population.** These include: (i) malnutrition and anemia, (ii) infectious diseases like worm and parasitic infestation, cholera, shigella, measles, malaria and tuberculosis and (iii) treatable non-communicable diseases, which are further exacerbated by a lack of access to regular medication<sup>6</sup>. The increased predisposition to disease coupled with restricted access to high quality healthcare due to poor health seeking behavior, limited access to health facilities, and poor quality of health services, leads to high rates of mortality.

<sup>4</sup> Vulnerability to food insecurity, malnutrition and epidemics are exacerbated by the deterioration of the economic landscape, recurring floods and droughts and by the lack of access to adequate basic social services

<sup>5</sup> The bordering regions of Nigeria in the Far North (Mayo Sava, Mayo Tsanaga, Logone-Chari districts) and the CAR in the East (Lom-Jerem, Kadei and Bouma-Ngoko districts) and Adamawa (Mbéré and Vina districts) are more directly and more severely affected by the crises. In these areas, physical destruction (Far North), lack of pre-crisis administrative services, high flows of displaced populations, and growing insecurity, including serious security incidents, and an increase in crime makes the lives of local and displaced people particularly difficult.

<sup>6</sup> Langlois, EV, et al. (2016) Refugees: towards better access to health-care services. *The Lancet*; 387;10016 p319-321



10. **The most common causes of death in refugees globally are acute upper respiratory tract infections (URTI) (21 percent), malaria (14 percent), lower respiratory tract infections (LRTI) (11 percent), intestinal worms (6 percent), and watery diarrhea (6 percent)**<sup>7</sup>. Acute URIs are the leading cause of morbidity and death in refugee children under-five years. The disease profile in refugees in Cameroon mirrors that observed globally. The most prevalent diseases in refugees in Cameroon are URIs (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 like musculoskeletal disorders (31.8 percent) and cardiovascular diseases (26.3 percent). 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<sup>8</sup>.

11. **Risks associated with hosting refugees include disease outbreaks, food scarcity, unsafe drinking water, overburdened schools and health facilities, and environmental degradation**<sup>9</sup>. In the northern and East regions of Cameroon, 2.4 million people are food-insecure, including 253,000 children who suffer from moderate or severe acute malnutrition. WASH services are a critical need in refugee affected areas<sup>10</sup>. Only 28 percent of the population in the North, East and Adamawa regions has access to potable water<sup>11</sup> 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 like cholera and hepatitis E.

12. **The situation of displaced women and girls, who account for 53 percent of refugees in Cameroon, is particularly difficult**. 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<sup>12</sup>, have limited access to land and are prohibited from inheriting on the death of their husband. Sexual and gender-based violence (SGBV) against women is pervasive, including rape, sexual exploitation, physical assault, and domestic violence, and the levels of prostitution is high. Women are particularly vulnerable to sexual violence when collecting firewood, drawing water, using latrines at night, and moving outside their camp. An estimated 55 percent of women over 15 years, and 60 percent of married women have experienced either physical, sexual or emotional violence. Harmful traditional practices, including breast ironing and female genital mutilation or cutting (FGM/C) is prevalent in Cameroon (1percent of girls and women age 15-49 years who have undergone FGM/C, 2004-2015)<sup>13</sup>, and in female refugees from Chad (44 percent)<sup>14</sup>, Nigeria (25 percent)<sup>13</sup> and CAR (24.2 percent)<sup>13</sup>. 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.

13. **At least 22 percent of refugees in the northern and East regions of Cameroon are women of**

<sup>7</sup> UNHCR. Global strategy for public health 2014-2018. Source : <http://www.unhcr-strategy-2014-2018.html>

<sup>8</sup> UNHCR. UNHCR public health 2016 Annual global overview. Source : <http://twine.unhcr.org/ar2016/> Accessed : 11/29/2017

<sup>9</sup> Tataha, L, et al. (2016) Impact of Refugees on Local Health Systems: a difference-in-difference-analysis in Cameroon. PloS One, 11 (12): e0168820

<sup>10</sup> UNICEF. Cameroon Humanitarian Situation Report, September 2017. Source: <https://reliefweb.int/report/unicef-cameroon-humanitarian-situation-report-september-2017>. Accessed: 11/26/2017

<sup>11</sup> Source: Republic of Cameroon, Development Policy Letter; 14 August 2017.

<sup>12</sup> 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. Source: <http://www.refworld.org/docid/3f51ec864.html> . Accessed: 11/28/2017

<sup>13</sup> OHCHR. Committee on the rights of the child examines the report of Cameroon. Source:

<http://www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=21675&LangID=E> Accessed: 11/28/2017

<sup>14</sup> Percentage represents the prevalence of girls and women age 15-49 years who have undergone FGM/C, between 2004-2015



**reproductive age (2016), and 20 percent are children under 5 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 live-saving emergency care, young girls have less control over where 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.

14. **The majority of refugee children do not have birth certificates.** Only 35 percent of refugee children in the North, under 5 years, have (30 percent) or are in the process of receiving (5 percent), a birth certificate. Furthermore, 13 percent of refugees in the East region have registered all their children, with 11 percent in the process of registration. Only 18 percent and 35% respectively of medium and wealthy refugee households have registered all their children, and none of the poor households. In contrast, nearly 70% of host community families have registered all their children.

### **Institutional Context**

15. The Government of Cameroon has identified PBF as a central strategy to address weaknesses in its health systems and aims to: (i) improve the efficiency of the allocation and use of resources; (ii) improve health worker performance through increased motivation, satisfaction and autonomy for decision-making at the point of service delivery; and (iii) increase the population's use of essential health services through 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 HSSIP project supported the implementation of PBF in 44 of the 189 health districts in Cameroon. Indeed, the scaled up of PBF to a national program by the HSPRP (P164954) parent project builds on the results and lessons learned from the HSSIP (P104525) project 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.

## **C. Proposed Development Objective(s)**

### **Original PDO**

16. 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.

### **Current PDO**

17. The revised PDO 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 for the population of Cameroon, including refugees and refugee host communities".

### **Key Results**

18. The proposed AF has eight PDO level indicators, and five intermediate level indicators that will be used to monitor progress in reaching the project development objectives:

19. 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 and the East



- (Target 80.00 percent)
  - Percentage of births attended by a skilled professional in the 3 Northern regions and the East (Target 55.00 percent)
  - Percentage average score of the quality of care checklist (Target 50.00 percent)
  - Number of children 24 months being weighed for growth monitoring in the 3 Northern regions 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 healthcare (curative and preventative) at health facilities in the northern and East regions (Target 600,000).
20. Intermediate level indicators:
- Number of children aged 6-59 months who received a vitamin A supplement in the last six months (Target 504,286).
  - 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).
  - Number of children and pregnant women dewormed (Target 3,542,000).
  - Number of refugee children and pregnant women dewormed (Target 637,000).

#### **D. Project Description**

21. The proposed AF aims to mitigate the health and economic impact of the conflict in the Far North region, and refugee crisis in the northern (Far-North, North, Adamawa) and East regions of Cameroon by providing essential health, nutrition, and soft water, sanitation and hygiene (WASH) services to refugees and refugee-host communities.

#### **Summary of activities under each components:**

##### **Component 1: Strengthening health service delivery at facility and community level**

22. Original project activities:
- National scale up of PBF to all 189 districts in Cameroon
  - Implementation and supervision of PBF
  - Implementation of GFF investment case, including reproductive, maternal, newborn, child and adolescent health (RMNCAH) activities
  - Health system strengthening
  - High quality nutrition services
23. Proposed AF activities:
- PBF payments to health facilities to waive fees for refugees and vulnerable host populations for primary healthcare, maternal and child healthcare, and nutrition services.
  - PBF payments to sub-contract community health workers (CHW) and community-based organisation (CBO) from host community and refugee camps to provide.
  - PBF quality improvement bonuses for destroyed health facilities in crisis areas, to make them operational.



**Component 2: Institutional strengthening for improved health system performance**

24. Original project activities:
- Institutional strengthening of information systems, monitoring and evaluation and performance mechanisms for health systems
  - Building of a reliable health information system
  - Supports ongoing rollout of District Health Information Software 2 (DHIS2) platform
  - Supports national PBF portal
  - Supports linkage between DHIS2 platform and national PBF portal
  - Reinforcement of civil registration and vital statistics (CRVS) system
  - Support operating costs for the PBF Technical Unit and Project Implementation Unit
25. Proposed AF activities:
- Scale up CRVS
  - Provision of birth certificate
  - Support the reinforcement of the monitoring and evaluation system and information systems
  - Strengthen communicable disease surveillance systems and epidemic preparedness and response

**Component 3 (new): Strengthening emergency, sexual and reproductive health services, and WASH and nutrition service delivery for refugee and host populations in the northern and East regions.**

26. Proposed AF activities:
- Emergency health services
  - Life-saving sexual and reproductive health services, including rape, FGM and GBV
  - Nutrition intervention including deworming
  - Soft WASH interventions
  - Comprehensive mental health and psychosocial support program
  - Institutional capacity building: sensitivity training; training on basic and comprehensive emergency Obstetric and Newborn Care; training on the management of rape, FGM and GBV, including physical, sexual and psychological violence.

**Component 4 (new): Contingent Emergency Response**

27. Proposed AF activities:
- This will allow for rapid reallocation of project proceeds in the event of a natural or man-made disaster or crisis that has caused, or is likely to imminently cause, a major adverse economic and/or social impact

**Detailed description of activities under each components:**

**28. Component 1: Strengthening health service delivery at facility and community level** (Total new costs under AF: US\$119 million: US\$89 million IDA, US\$20 million GFF, US\$6 million IDA credit and US\$4 million IDA18 RSW Grant). This component currently supports the national scale up of PBF, starting in the three Northern regions. It consists of 3 subcomponents: sub-component 1.1: Payment of performance, which supports the incremental scale up of PBF to all 189 districts in Cameroon, and provides PBF payments: (i) to health facilities conditional on the quantity and quality of services delivered via in-clinic activities and/or via health-outreach activities, and (ii) to CHWs for providing select basic preventative and referral health services, as well as ensuring community organization to support positive



health behavior. Subcomponent 1.2: supports the implementation and supervision of PBF. Sub-component 1.3: provides support for the implementation of the GFF investment case for Cameroon, which includes RMNCAH activities, health systems strengthening approaches and high quality nutritional services in the northern and East regions.

29. The AF will support the reinforcement of equity mechanisms to ensure provision of primary healthcare, maternal and child health care and, nutrition services for refugees and vulnerable host populations. It includes (i) PBF payments to Health facilities to waive fees for all refugees and vulnerable host populations for primary healthcare, maternal and child healthcare, and nutrition services and sub-contract CHWs and CBOs from the host community and refugee camps to provide select basic preventative and referral services, and support positive behavior; and (ii) PBF quality improvement bonuses for health facilities in crisis areas that have been destroyed due to conflict, which will be used to make the health facility operational.

30. **Component 2: Institutional Strengthening for Improved Health System Performance** (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 grant). The current project supports three sub-components. Sub-component 2.1 supports institutional strengthening of information systems, monitoring and evaluation, and performance measurement mechanisms for the health system. This sub-component 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 linkages between the two. Sub-Component 2.2 reinforces civil registration and vital statistics systems and supports the building of the national CRVS systems. Sub-Component 2.3 component supports operating costs for the PBF Technical Unit and Project Implementation Unit (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.

31. The AF will support (i) the scale up of activities carried out by BUNEC to strengthen civil registration and vital statistics activities for refugees and host communities. Birth registrations will be conducted for all deliveries, and birth certificates provided to mothers irrespective of nationality. Civil registration centers under performance contracts will receive high level subsidies for registration documents delivered to refugees and vulnerable host population (ii) support the reinforcement of the monitoring and evaluation system, as well as information systems, by integrating related activities into the performance contract of health facilities, Districts, regional delegations, CDVAs and CIS (Cellule d'information Sanitaire) of the Ministry of Health (iii) 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 North regions. These include Leishmaniosis (2017)<sup>15</sup> Polio (2014)<sup>16</sup>, yellow fever (2013)<sup>17</sup>, measles (2015)<sup>18</sup> and cholera (2011-2014). Between 2011-2014, Cameroon reported 26, 621 cases of cholera leading to 1031 death<sup>19</sup>. These periodic outbreaks affect thousands of households each year, and kill as many as 10 percent of those who contract the disease.<sup>20</sup> Despite Cameroons vulnerability to outbreaks, particularly in the Far North, there has been minimal investments in strengthen 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

<sup>15</sup> Outbreak news today (2017). Leishmaniosis outbreak reported in Cameroon. Source: <http://outbreaknewstoday.com/leishmaniosis-outbreak-reported-cameroon-58045/> Accessed: 11/30/2017

<sup>16</sup> WHO (2014). Poliovirus in Cameroon – update. Source: [http://www.who.int/csr/don/2014\\_03\\_17\\_polio/en/](http://www.who.int/csr/don/2014_03_17_polio/en/) Accessed: 11/30/2017.

<sup>17</sup> WHO. (2013). Yellow fever Cameroon. Source: [http://www.who.int/csr/don/2013\\_10\\_08/en/](http://www.who.int/csr/don/2013_10_08/en/) Accessed: 11/30/2017

<sup>18</sup> Reliefweb (2015). Cameroon: Measles and cholera outbreaks – Nov 2015. Source: <https://reliefweb.int/disaster/ep-2015-000156-cmr> . Accessed 11/30/2017

<sup>19</sup> CDC. (2017) CDC Fights Cholera in Cameroon. Source : <https://www.cdc.gov/ncezid/dfwed/stories/fighting-cholera-cameroon.html>. Accessed: 11/30/2017

<sup>20</sup> Idem.



response within 120 minutes of identification of a public health emergency<sup>21</sup>. The AF will support the enhancement of community-level and regional level surveillance and reporting systems in the northern and East regions, by integrating surveillance indicators in the performance contract of health facilities, health districts and regional delegation and CIS (ii) analytical work on existing surveillance systems in refugee affected regions, (iii) 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 (iv) enhancement of the communicable diseases outbreak preparedness and response capacity.

32. **Component 3 (new) : Strengthening emergency, sexual and reproductive health services, and WASH and nutrition service delivery for refugee and host populations in the northern and East regions.** (Total new cost US\$21 million IDA18 RSW Grant). The AF will finance the following activities using the PBF strategy: (i) provision of emergency health services and life-saving sexual and reproductive health services, including those related to the management of rape, FGM and GBV; (ii) support the provision of select nutrition, deworming and soft WASH interventions in preschools, schools, health facilities, at community-level, including refugee camps; (iii) deliver a comprehensive mental health and psychosocial support program for refugees, IDPs and host populations, (iv) support institutional capacity building, including: (a) sensitivity training of frontline health professionals, CHW and CBOs from refugee and host communities, and civil registration officers (b) training of skilled birth attendants on basic and comprehensive emergency Obstetric and Newborn Care (c) training of health professionals, CHW and CBOs from refugee and host communities on the management of rape, FGM and GBV, including physical, sexual and psychological violence.

33. The proposed soft WASH activities include, but are not limited to, ASA on water and sanitation practices in health facilities, and formative research on sanitation marketing, handwashing, household water treatment and safe storage (HWTS), and menstrual hygiene management (MHM). Evidence-based programming based on these analytical work is expected to ensure socio-cultural and gender sensitivity with special attention to vulnerable populations, to synchronize impact from an integrated multisectoral approach, as well as to inform more inclusive and comprehensive policies. The project also supports strengthening health communication towards good sanitation and hygiene behaviors among refugees and host community populations at health and nutrition facilities, schools (including pre-schools if any), and communities in an enabling environment. CHWs and school children will most likely be agents of change for good sanitation and hygiene behaviors in their entire communities.

34. **Component 4: Contingent Emergency Response** (Total new cost US\$0). A CERC will be included under the project in accordance with Operational Policy (OP) 10.00 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 man-made disaster or crisis that has caused, or is likely to imminently cause, a major adverse economic and/or social impact.

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<sup>21</sup> CDC. (2017) Global Health Security Agenda: GHSA Emergency Operations Center Action Package. Source : [https://www.cdc.gov/globalhealth/security/actionpackages/emergency\\_operations\\_centers.htm](https://www.cdc.gov/globalhealth/security/actionpackages/emergency_operations_centers.htm) . Accessed 11/30/2017



## E. Implementation

1. The implementation arrangements will remain largely the same as for the parent project in the Far north, North, Adamawa and East regions.
2. At the central level of the Ministry of Public Health (MOPH), the Health Sector Strategy (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: (i) select directorates of the MOPH; and (ii) key ministries whose support is needed for successful implementation and sustainability of PBF in Cameroon (Ministry of Economy and Planning and Ministry of Finance). The technical committee's tasks include to: (i) validate the overall strategic direction of the PBF program; (ii) validate the overall strategic direction of other interventions supported by the project; (iii) ensure that the procedures set forth in the project implementation manual are followed; (iv) examine the different contracts and intervene where necessary to resolve issues; (v) monitor PBF and other activities' implementation and intervene where problem resolution may require the support of committee members; and (vi) disseminate the results of the evaluations with a view toward mobilizing additional resources and expanding the PBF approach in the country.
3. Project implementation will continue to be coordinated by the PBF technical unit (*Cellule Technique Nationale PBF*) 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 achievements of the interventions related to the AF for the IDA 18 refugee sub-window. The PBF technical unit is tasked with: (i) developing norms and procedures for the PBF program; (ii) coordination and leadership of development partners, vertical programs and departments within the MOPH involved in the PBF program; (iii) conducting performance contracting, evaluation and coaching activities for decentralized actors such as the Regional Health Delegations, Contracting and Verification Agencies, and Regional Funds for Health Promotion; (iv) preparing and implementing PBF training programs; and (v) developing the scale-up plan for national coverage. The 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.
4. The project will continue to use CDVAs established in each region for the following tasks: (i) contracting and coaching health service providers, (ii) 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<sup>22</sup>, 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.
5. 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, (i) the referral of poor and vulnerable patients, pregnant women, infants and women of child bearing age to health facilities, (ii) identification of patients lost to



follow-up, and (iii) home visits. CHWs and CBOs are 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 (e.g. 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.

**F. 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. These regions are divided into five (5) agro-ecological zones of Cameroon: bimodal and mono-modal agro-ecological zone (On the coastal area, it has a multitude of anthropogenic pressure and it is also a highly urbanized zone with acute air pollution and urban waste management issues); the Sudano-sahelian and Guinean savannah zones (These are dry zones that are mostly affected by pressures such as fuel wood harvesting, which lead to indoor air pollution, nutritional emergency, exposure to floods, which always bring a threat of cholera, malaria and dengue) and the Western Highlands. 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.

**G. Environmental and Social Safeguards Specialists on the Team**

Kristyna Bishop, Social Safeguards Specialist  
Charlotte Noudjieu Cheumani, Social Safeguards Specialist  
Cyrille Valence Ngouana Kengne, Environmental Safeguards Specialist

**SAFEGUARD POLICIES THAT MIGHT APPLY**

Safeguard Policies	Triggered?	Explanation (Optional)
Environmental Assessment OP/BP 4.01	Yes	The additional financing 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. OP/BP 4.01 is triggered because they are predictable

<sup>22</sup> www.fbrcameroun.org



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 addition, soft WASH interventions in schools and in refugee camps might lead to conflicts. To comply with OP/BP 4.01-Environmental Assessment, a Medical Waste Management Plan (MWMP) was prepared in 2008, updated and disclosed on Infoshop in 2014. A social assessment was undertaken in 2016. Based on these instruments, the project developed an action plan and a Performance Based Financing and Quality of care checklist that includes waste management, hygiene and safety issues. Their implementation has been satisfactory. The checklist and the action will be updated to include GRM requirements, GBV measures, occupational safety measures, etc. To better mitigate and manage the environmental and social risks and impacts, the project will recruit a safeguards specialist. In addition, the MWMP was transformed into a Hygiene and Waste Management Plan (HWMP) and disclosed on the Bank website on March, 9 2018. HWMP includes new technical and geographical scope, measures related to GRM, occupational safety, GBV risks, menstrual hygiene management, household water treatment and safe storage (HWTS), etc. The project will report on the implementation of environmental and social development aspects on a quarterly basis.

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 the Bank website on March, 9 2018.



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.

**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:

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 successfully implemented as planned. This project does entail significant impacts. However, they 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 addition, soft WASH and Nutrition interventions including deworming in schools, community and in refugee camps might lead to conflicts and gender based violence.

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. The project will limit its support to health facilities, refugees camps and communities with limited environmental and social adverse risks and impacts. 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 man-made 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.

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 Gov. of Cameroon has already taken significant steps to protect its environment through a National Policy on Environmental Protection and a series of legislative and regulatory texts for environmental protection and nature conservation (i.e. comprehensive environmental and social legal framework, including the 1996 Environmental Law and its implementation decrees). The Decree 2012/2809 of 26 September 2012 stipulating conditions of waste management in Cameroon, including health care waste (medical and pharmaceutical), regulates waste management in Cameroon. Per this Decree, it is the responsibility of the waste generator to ensure that the waste is packaged, transported, treated and disposed of in terms of the legal requirements and that there is an auditable record of the steps involved in storing, collecting and transporting the waste. To comply with national legislative and regulatory requirements and with the WB policies triggered (OP/BP 4.01-Environmental Assessment), a Medical Waste



Management Plan (MWMP) was prepared in 2014. Based on this instrument the project developed a Performance Based Financing and Quality of care checklist that includes waste management, hygiene and safety issues. The level of compliance of these activities with environment and safeguards has been satisfactory. To better mitigate and manage the above-mentioned risks, the project will recruit a safeguard specialist; in addition, the MWMP was transformed into a Hygiene and Waste Management Plan (HWMP), and was updated and disclosed in country march 8 and on the Bank website on March, 9 2018. HWMP includes new technical and geographical scope, measures related to GRM, occupational safety, GBV risks, menstrual hygiene management, household water treatment and safe storage (HWTS).

5. Identify the key stakeholders and describe the mechanisms for consultation and disclosure on safeguard policies, with an emphasis on potentially affected people.

During the project preparation process, the stakeholders (health officials, affected people, CSOs and public administration partners) and there is an ongoing social dialogue with key stakeholders. They was consulted during the update of the preparation of the Hygiene and Waste Management Plan (HWMP). 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 (N.B. The sections below appear only if corresponding safeguard policy is triggered)**

**Environmental Assessment/Audit/Management Plan/Other**

Date of receipt by the Bank	Date of submission for disclosure	For category A projects, date of distributing the Executive Summary of the EA to the Executive Directors
09-Feb-2016	25-Feb-2016	

**"In country" Disclosure**

Cameroon  
25-Feb-2016

Comments

**Indigenous Peoples Development Plan/Framework**

Date of receipt by the Bank	Date of submission for disclosure
09-Feb-2016	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 (to be filled in when the ISDS is finalized by the project decision meeting) (N.B. The sections below appear only if corresponding safeguard policy is triggered)**

**OP/BP/GP 4.01 - Environment Assessment**

Does the project require a stand-alone EA (including EMP) report?

If yes, then did the Regional Environment Unit or Practice Manager (PM) review and approve the EA report?

Are the cost and the accountabilities for the EMP incorporated in the credit/loan?

**OP/BP 4.10 - Indigenous Peoples**

Has a separate Indigenous Peoples Plan/Planning Framework (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?

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?

**The World Bank Policy on Disclosure of Information**

Have relevant safeguard policies documents been sent to the World Bank for disclosure?

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?



### All Safeguard Policies

Have satisfactory calendar, budget and clear institutional responsibilities been prepared for the implementation of measures related to safeguard policies?

Have costs related to safeguard policy measures been included in the project cost?

Does the Monitoring and Evaluation system of the project include the monitoring of safeguard impacts and measures related to safeguard policies?

Have satisfactory implementation arrangements been agreed with the borrower and the same been adequately reflected in the project legal documents?

### CONTACT POINT

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#### Implementing Agencies

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**APPROVAL**

Task Team Leader(s):	Ibrahim Magazi
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**Approved By**

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Country Director:	Elisabeth Huybens	13-Mar-2018