Report Number : ICRR0021328

1. Project Data

Project ID	Project Name	
P104525	CM-Health Sector Supp. SWAP SIL (FY08)	
Country	**Practice Area(Lead)**	**Additional Financing**
Cameroon	Health, Nutrition & Population	P146795,P146795
L/C/TF Number(s)	**Closing Date (Original)**	**Total Project Cost (USD)**
IDA-44780,IDA-54860,TF-17128,TF-58012	31-Mar-2014	60,690,049.88
Bank Approval Date	**Closing Date (Actual)**	
24-Jun-2008	31-Dec-2017	

	IBRD/IDA (USD)	Grants (USD)
Original Commitment	25,000,000.00	20,000,000.00
Revised Commitment	44,962,097.27	20,000,000.00
Actual	41,813,906.62	18,876,143.26

Prepared by	Reviewed by	ICR Review Coordinator	Group
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2. Project Objectives and Components

a. Objectives

According to the Financing Agreement (p. 5), the project's objectives were "to increase utilization and improve the quality of health services within the country of the Recipient with a particular focus on child and maternal health and communicable diseases."

A May 2011 restructuring revised outcome targets for some indicators and reduced the planned scope of the project from country-wide to four regions. At this point, according to the ICR (p. 12) and the project team, 6% of Bank funds had been disbursed, though the disbursement profile provided in the ICR (p. 3) appeared to indicate that less than 6% had been disbursed at that point. A February 2014 restructuring revised the unit of measurement for all outcome targets from percentages to absolute numbers, as "it was difficult to compute reliable estimates of the population covered" (ICR, p. 12); it is therefore not known whether this revision of targets represented a change in the project's ambition. An Additional Financing (AF) in June 2014 doubled each of those numerical outcome targets, as an increase in the project's geographic scope almost doubled the overall size of the population covered from 2.5 million (in four regions) to 4.6 million (adding three additional regions). As the revised targets at the 2011 restructuring were set in percentage terms and therefore are not comparable to the numerical outcome data provided, and the 2014 AF accompanied an increase in the project's scope, this Review will not perform a split rating.

b. Were the project objectives/key associated outcome targets revised during implementation?
Yes

Did the Board approve the revised objectives/key associated outcome targets?
Yes

Date of Board Approval
11-May-2011

c. Will a split evaluation be undertaken?
No

d. Components

The project's components were intended to support "possible quick wins in the medium term" while supporting the design and implementation of broader and more comprehensive longer-term reforms (Project Appraisal Document (PAD), p. 9).

1. District Service Delivery (appraisal: US$ 20 million; AF, additional US$ 20 million from IDA and US$ 15 million from the Health Results Innovation Multi-Donor Trust Fund (HRITF); actual, US$ 47.6 million). This component was to focus on three critical impediments to the delivery of services at the district level: (i) scarcity of funds to meet operating expenses, to be addressed through channeling financial resources to districts for operating resources to meet the day-to-day requirements of a district health system (supervision, community outreach, recruitment of contractual staff, bonus payments, consumables); (ii) lack of focus on achievement of results and of accountability mechanisms, to be addressed by pilot testing several approaches to performance-based contracting, including contracting of districts, non-governmental organizations (NGOs), and health facilities; and (iii) modest managerial capacity at the district level, also to be addressed by pilot testing alternative approaches, including competitive recruitment of individuals from the private sector. Contracting was to be initiated in four regions and subsequently scaled up. The

component was to support performance-based financing (PBF, covering operating costs, goods, and technical assistance) between district-level Special Funds for Health Promotion and District Health Committees, NGOs, and/or health facilities; contribute to the operating costs of the Special Funds for Health Promotion; and finance the national-level procurement of required drugs, reagents, and commodities.

The May 2011 level 2 restructuring addressed institutional challenges the project had encountered. The Special Funds for Health Promotion, which were to have purchased health services from health facilities, had not received the prerequisite legal status to play this role, and their technical capacity was not sufficient to develop and implement performance-based financing. The restructuring assigned the purchasing role instead to international institutions/NGOs with relevant experience. The project's scope was also reduced to sixteen districts in four regions, and some indicators and targets were revised.

The June 2014 AF extended PBF to additional areas, adding three poorer Northern Regions of the country and also covering impact evaluation control group facilities in the project's original four regions. In the three Northern Regions, a "Community PBF" element was added in order to improve health-seeking behavior and geographical access to preventive and curative health services, involving performance contracts for community health workers (CHWs) who were to be trained in the management of childhood diseases, performance of basic curative services, referral for complicated cases, and sensitization and outreach campaigns.

2. Institutional strengthening (appraisal: US$ 5 million; AF, additional US$ 5 million from the HRITF; actual, US$ 8.9 million). This component was to finance technical and financial support to strengthen key normative functions of the Ministry of Health at the national, regional, and district levels: (i) contract design and management, including setting up institutional framework/systems and building capacity to prepare, negotiate, and manage contracts; and (ii) establishment of a unified information system to generate up-to-date and reliable financial and programmatic data. The AF further supported these activities.

e. Comments on Project Cost, Financing, Borrower Contribution, and Dates

Project cost: Original total project cost was US$ 25 million. The ICR provided two figures for actual total costs: US$ 56.5 million (p. 48) and US$ 60.7 million (p. 2). The ICR did not explain the difference between planned and actual costs, and the project team explained that final cost figures will only be available after the final audit, which was delayed and not complete as of October 2018.

Financing: The project was initially financed by a US$ 25 million International Development Association (IDA) Sector Investment Loan (SIL). It was originally to embody a Sector Wide Approach (SWAp), intended to provide flexible financing in support of the Ministry of Health's program. IDA financing was to be coordinated with financial support from France and Germany, and was to complement additional support from the African Development Bank, UNICEF, and the World Health Organization. However, the failure of the Special Funds for Health Promotion to obtain prerequisite legal status for participation in the

project caused France and Germany to withdraw from the SWAp in 2008, and the project proceeded as a Bank-financed SIL. The AF added another IDA Credit of US$ 20 million, and a US$ 20 million Grant from the HRITF, bringing total planned project financing to US$ 65 million.

Borrower contribution: No Borrower contribution was planned or made.

Dates: The project was approved on June 24, 2008 and became effective on March 3, 2009. A restructuring in 2010-2011 (with discussions beginning in July 2010 and approval in May 2011) amended the project's institutional arrangements and revised some results indicators and targets. The mid-term review was conducted in May 2013. A February 5, 2014 restructuring again revised the results framework, reallocated funds between expenditure categories, and extended the project's closing date by 22 months (from March 31, 2014 to January 31, 2016). On June 24, 2014, AF was approved, and the closing date was further extended to December 31, 2017. A final restructuring on January 2, 2017 revised the Financing Agreement to allow flexibility of funds use between the IDA Credit and Trust Fund grant and to revise staffing arrangements. An end-line qualitative and quantitative impact evaluation was conducted in March 2017. The project closed on December 31, 2017.

3. Relevance of Objectives

Rationale

At appraisal, most key indicators of child health and nutrition (with the exception of immunization) had stagnated or worsened since 1990. Cameroon's epidemiological profile corresponded to that in countries that spent dramatically less per capita on health, reflecting inefficiencies in the allocation of resources and production of health services, as well as inequities in the distribution of human resources and facilities. The pattern of health expenditures was not aligned with the burden of disease; HIVAIDS, malaria, tuberculosis (TB), and maternal and childhood illnesses represented 45% of the total Disability Adjusted Life Years lost but only 25% of the Medium-Tern Expenditure Framework for 2002-2007. The country's 2001-2020 Health Sector Strategy aimed to reduce morbidity and mortality, especially among vulnerable groups; improve geographic access to a basic package of health services; and strengthen management and efficiency at all levels of the health system. The mid-term evaluation of that strategy, while noting improvement, highlighted remaining challenges: excessive centralization of the health system; pervasive human resource issues; the high cost of care; public sector financing below recommended standards and skewed in favor of urban areas and disease-specific programs; slow and cumbersome flow of public-sector funds; poor governance; relative neglect of preventive and promotional care; and fragmented, unreliable monitoring and evaluation systems. Based on these findings, the Ministry of Health prepared an enhanced and revamped strategy to govern the preparation of district-level planning for 2009-2012, focused on reduction of child mortality, improved maternal health, strengthened fights against communicable and non-communicable disease, and reduction of hunger and malnutrition. The strategy contained three cross-cutting dimensions: strengthened delivery of health services, decentralized care and enhanced autonomy and management of districts, and

strengthened normative functions (policy, regulation, supervision, coordination, financing, monitoring, and evaluation).

The project's objectives were highly aligned with these country conditions and government strategy at appraisal, and also with the 2006 Interim Strategy Note with key dimensions of managing for results, addressing governance issues, and strengthening harmonization with other development partners. The objectives remained highly relevant to Bank strategy at closing. The current Country Partnership Framework (FY 2017 - FY 2021) emphasizes three strategic focus areas: addressing poverty traps in rural areas (with a focus on the Northern Regions), fostering infrastructure and public sector development, and improving governance. Within the first focus area, there are objectives to improve maternal and child health, to expand social safety nets, and to improve access to local infrastructure. The objectives remain similarly highly consistent with the Government's current National Health Development Strategy (2016-2020), whose overall objective is to make affordable priority essential and specialized health services available in at least half of district and regional hospitals by 2020 through health promotion, disease prevention, case management, health systems strengthening, and improved governance and strategic management.

Rating
High

4. Achievement of Objectives (Efficacy)

Objective 1
Objective

Increase utilization of health services within the country of the Recipient with a particular focus on child and maternal health and communicable diseases

Rationale

The project's theory of change anticipated that demand-side interventions (fee waivers for poor families, implemented through reimbursement of facilities for lost revenues) and quality improvements through PBF would increase utilization of services. The addition of CHWs at the AF was to provide further demand-side elements through sensitization and promotion campaigns.

Outputs

584 performance contracts were signed with health facilities. The community PBF initiative supported antenatal and prenatal care, family planning services, immunization campaigns, basic curative care, household visits, and referrals to facilities for complicated cases. The project team explained that the M&E system focused on tracking results indicators rather than outputs, and therefore the number of CHWs recruited, trained, and contracted as part of the PBF scheme is not known. Fee waivers were introduced for

essential services to vulnerable households; to mitigate against revenue shortfalls, health facilities were reimbursed for services provided free of charge. The project team explained that varying methods were used to identify vulnerable patients and to determine eligibility for the fee waivers.

The project supported 4.86 million one-day hospital admissions, 694,000 normal surgeries, 333,000 normal deliveries, 20,000 complicated deliveries, 25,000 Cesarean sections, 54,400 major surgeries, and 8.1 million outpatient consultations.

Outcomes

The project provided access to a basic package of health, nutrition, or reproductive health services to a cumulative total of 7.17 million people, exceeding the mid-project target of 750,000 and the revised target of 1.5 million. The number of people with access to this basic package reported on an annual basis increased from 416,000 in 2012 to 1.56 million in 2017; the 7.17 million figure is the sum of the annual figures from 2012 through 2017 and almost certainly counts the same person served multiple times. 866,402 consultations were provided to people free of charge over the entire project period, exceeding the revised target of 75,000.

393,000 children were immunized with DPT3, exceeding the mid-project target of 100,000 and the revised target of 200,000. This result is cumulative; the annual number of children immunized increased steadily from 42,200 in 2012 to 82,900 in 2017. The original baseline for this indicator was expressed in percentage terms -- 80.6% -- with an original target of 85%; the indicator was changed from percentage to absolute numerical terms in 2012. 424,000 children received one dose of Vitamin A before their first birthday in the last six months, exceeding the revised target of 200,000.

311,000 births were attended by skilled professionals, exceeding the mid-project target of 30,000 and the revised target of 60,000. This result is cumulative; the annual number of attended births increased steadily from 25,000 in 2012 to 71,600 in 2017. The original baseline for this indicator was expressed in percentage terms -- 63% -- with an original target of 66% and a revised target of 70% in 2011; the indicator was changed from percentage to absolute numerical terms in 2012. 1.1 million pregnant women received antenatal care during a visit to a health provider, exceeding the revised target of 200,000. There were 165,000 acceptors of modern contraceptive methods, exceeding the revised target of 40,000.

14,900 new cases of TB were detected and treated, exceeding the mid-project target of 5,000 and the revised target of 10,000. This result is cumulative; the annual number of new TB cases detected and treated increased from 1,560 in 2012 to 2.900 in 2015, and then decreased slightly to 2,600 in 2016 and 2,700 in 2017. The TB treatment success rate increased from 74% in 2008 to 80.36% in 2017, exceeding the target of 80%.

There were 7.8 million direct project beneficiaries, exceeding the mid-project target of 885,000 and the revised target of 1.77 million. According to the ICR (p. 17, fn 9), this indicator is an aggregation of the number of people with access to a basic package of health services, number of children fully vaccinated, and

number of births attended by qualified personnel. The number of direct beneficiaries reported on an annual basis increased from 480,000 in 2012 to 1.71 million in 2017; the 7.8 million figure is the sum of the annual figures from 2012 through 2017 and almost certainly counts the same person multiple times. Of those, 3.77 million were female, again a cumulative number that likely counts the same person multiple times, exceeding the mid-project target of 443,000 and the revised target of 885,000.

The end-of-project impact evaluation, which employed a difference-in-differences regression model methodology covering 2012 through 2015 that compared four groups (facilities using PBF; facilities with the same per capita financial resources and supervision/managerial autonomy but no PBF; facilities with no additional resources or PBF but supervision/managerial autonomy; and status quo facilities), and based on baseline and end-line household and facility surveys, found no difference between the status quo (control) group and the PBF group in skilled delivery; and a 17-percentage-point increase in full vaccination for the PBF group. The Borrower's ICR (p. 92) stated that assisted childbirth by medical staff in health facilities increased by 1.3% under PBF but fell by 0.7% in other health facilities.

Rating
Substantial

Objective 2
Objective

Improve the quality of health services within the country of the Recipient with a particular focus on child and maternal health and communicable diseases

Rationale

The project's theory of change anticipated that activities intended to address service delivery issues, including enhanced supervision, community outreach, recruitment of contractors, payment of performance bonuses to heath facilities, capacity building and technical assistance, reliable supply of consumables, and rehabilitation and equipment of facilities (financed by health administrators' use of a portion of their PBF payments) would improve the quality of health services.

The outputs relevant to this objective are the same as those listed under the first objective.

Outcomes

20.97% of health facilities had tracer drugs available on the day of the last visit, not achieving the target of 75%. The project team stated that information was not available for the exact time frame for this result, baseline data, or the list of tracer drugs. The Borrower's ICR (p. 92) reported that the level of availability of

essential drugs increased by more than 10% at health facilities under PBF but stagnated (1% increase) in other health facilities.

63.5% of health facilities achieved an average score of 75% or above on a quality index of services provided through RBF, exceeding the revised target of 60%.

The impact evaluation surveys asked women twelve questions related to their satisfaction with individual elements of their visits to health facilities. There was no increase in satisfaction over time for the control group, but the PBF group showed an 8.6-percentage-point increase. PBF was associated with a 24.1-point difference from the control group in satisfaction with health facility cleanliness, and a 15.4-point difference in satisfaction with facility operating hours. Women receiving the full PBF intervention reported satisfaction with health work communication at a rate 10.6 points higher than women attending control clinics, but there was no evidence that PBF had an impact on the reported courteousness of heath staff, time spent with health workers, or the ease of obtaining prescribed medicines. Relative to the control, PBF produced a 9.9-point increase in satisfaction with child health consultations; the Borrower's ICR (p. 92) reported that the level of beneficiary satisfaction with child health services increased by 15% for PBF facilities but decreased by 7% in other health facilities.

Health workers were also surveyed as part of the quantitative impact evaluation. Health workers in the PBF group were 31 percentage points more likely than those in the control group to be satisfied with the physical condition of their health facility building. Staffing, however, was less affected, with small and non-significant increases over the study period in the number of nurses present in all study groups. Both the PBF and additional financing groups reported large improvements in reported satisfaction with the quantity and quality of equipment, including delivery equipment, and the availability of supplies and of family planning methods. A parallel qualitative impact evaluation produced similar results: PBF improved staff satisfaction/motivation, work environments, equipment, and supervision.

Rating
Substantial

Rationale

Although there were frequent issues with reporting, including internal inconsistencies within the main ICR and between the ICR and the Borrower's ICR, the project team was able to clarify achievement on most indicators. Achievement exceeded targets on most indicators related to both objectives, and the impact evaluations provided evidence of attribution through comparison of treatment and control facilities. Efficacy is therefore rated fully Substantial.

Overall Efficacy Rating
Substantial

5. Efficiency

The PAD (pp. 69-75) did not contain a formal economic analysis but instead postulated a four-fold economic rationale for the project: many of the services (especially those to control infectious disease) had strong positive externalities and high public good content; the project aimed to support underserved areas in an effort to reduce the rich/poor gap, as the public facilities supported tended to serve primarily poor people (with the better-off using the private sector); the project would improve the efficiency of public spending by further aligning expenditures to the burden of disease and introducing accountability mechanisms through performance contracting; and the project was to support the government to provide services in areas where there was market failure, primarily health prevention and promotional activities.

The ICR (pp. 49-55), using available service delivery costs and output data at the health facility level, as well as the World Health Organization standard for interpreting cost effectiveness analysis results, found a US$ 402 incremental cost effectiveness ratio that was cost effective (significantly less than Cameroon's per capita gross domestic product, US$ 1,375).

The ICR (p. 21) reported several sources of administrative efficiency: improved management of health facility revenues, reduction of parallel sales of drugs, and public display of service costs, all bringing more competition into purchasing. However, these are markers of sectoral efficiency rather than project efficiency. In terms of use of project resources, there were moderate operational inefficiencies. The project became effective more than eight months after approval due to delays in the adoption of an operations manual, establishment of an operational unit, recruitment of a program manager and other specialists, and preparation of terms of reference for recruitment of an external audit firm. Implementation was further delayed for almost three years after effectiveness due to shortcomings in the institutional arrangements for PBF, especially lack of detailed technical requirements and implementation mechanisms for PBF in the project documents, and inadequate autonomy for the Special Fund for Health Promotion to operate independently from heath facilities. The 2011 restructuring largely resolved these issues, but lengthy procurement processes stretched the time required to process this restructuring. "Cumbersome" payment procedures for PBF and understaffing of the project's fiduciary team, resulting in irregular and delayed payments throughout the project's lifetime, were noted in the ICR (p. 28) and the Borrower's ICR (pp. 90, 94), and health facilities did not always validate their bills, such that they did not always receive the full payments they were due. These payment issues both caused and were exacerbated by high turnover of health workers at the facility level. National policy initially limited facilities' ability to make independent decisions, operationalize their business plans, and manage their resources and staff, though many of these issues were resolved with the passage of legislation on the autonomy of public institutions in 2010. Finally, the security situation impacted implementation, as Boko Haram operations in the northern regions hampered the project team's ability to conduct regular field supervision.

Efficiency Rating
Modest

a. If available, enter the Economic Rate of Return (ERR) and/or Financial Rate of Return (FRR) at appraisal and the re-estimated value at evaluation:

	Rate Available?	Point value (%)	*Coverage/Scope (%)
Appraisal		0	0 ☐Not Applicable
ICR Estimate		0	0 ☐Not Applicable

* Refers to percent of total project cost for which ERR/FRR was calculated.

6. Outcome

The project's objectives were highly relevant to country conditions, Bank strategy, and government strategy. Efficacy was substantial, as targets for key indicators were achieved or exceeded for both objectives, and both qualitative and qualitative impact evaluations provided convincing evidence of project impact. Efficiency, however, was modest, given delays, staffing shortages, and security concerns that diminished cost effectiveness. Taken together, these ratings indicate moderate shortcomings, leading to an Outcome rating of Moderately Satisfactory.

a. Outcome Rating
Moderately Satisfactory

7. Risk to Development Outcome

The ICR (pp. 22-23) cited significant and sustainable institutional strengthening under the project, including the Ministry of Health's ability to develop norms/guidelines and to monitor performance; the Project Implementation Unit's transformation into a permanent National PBF Technical Unit; the capacity of heads of district health administrations to coordinate, evaluate, and validate the performance of health facilities; and the overall financial governance of the health system, especially with regard to parallel sales of drugs. The country's health sector strategy for 2016-2027 includes PBF as a transversal dimension, and the government plans to allocate at least 15-20% of the health ministry's budget to PBF moving forward (ICR, p. 34, and Borrower's ICR, p. 91). Due to the perceived success of the project, the government is also applying PBF to other sectors, including education, early childhood development, and public procurement (ICR, p. 93). An ongoing follow-up operation (Health

System Performance Reinforcement Project, 2016-2021, US$ 127 million) is scaling up PBF to the health sector of the entire country.

The major risk moving forward is financial. Transfers of subsidies to health facilities were delayed throughout the project's lifetime, leading to accumulation of arrears; according to the ICR (p. 34), this situation "will stifle the health facilities from having the financial wherewithal to deliver quality health services to the population they serve."

8. Assessment of Bank Performance

a. Quality-at-Entry

Project preparation involved key stakeholders from both government and development partners. The Bank team supported analytic studies on governance, fiscal space analysis, and M&E capacity that informed project design. Key lessons were taken from a previous health project in the country, from Bank-wide experience with similar health programs, and from the experience of the IDA-funded HIV/AIDS Multi-Sectoral Program (PAD, p. 12): (i) a realistic, simplified design, feasible in the local context, improves the likelihood of success; (ii) involving local stakeholders in determining priorities and designing interventions enhances ownership; (iii) objectives and targets must be realistic, with well established systems for measuring results; (iv) implementation and institutional arrangements should be in place prior to Board approval; (v) close supervision, involving Bank management, should be present from the start-up phase; (vi) disease-specific interventions should be integrated into broader health planning, budgeting, and programming; (vii) harmonized, multi-donor support to a sector program can help ensure reliability of financing, strengthen results, enhance accountability, and reduce transaction costs; (viii) performance-based financing empowers providers while holding them accountable; and (ix) use of country systems and structures, where feasible, builds capacity and promotes sustainability. Risk assessment at appraisal highlighted challenges with systemic corruption and lack of capacity in financial management and procurement (PAD, pp. 16-17).

However, there were moderate shortcomings. The results framework, while logically formulated, contained outcome indicators that disproportionately favored the utilization objective. Institutional arrangements for PBF were not sufficiently detailed at the outset, leading to extended implementation delays.

Quality-at-Entry Rating
Moderately Satisfactory

b. Quality of supervision

Supervision was intensive, with missions undertaken on average every two months. All missions were adequately reported. The Bank team maintained policy dialogue with the highest levels of government, working with the International Monetary Fund and Country Management Unit to trigger PBF mechanisms in the country's development policy operation. Although there were three task team leaders during the project's lifetime, the second and third had each been previously a part of the project team, and so continuity was maintained. Implementation challenges were largely resolved through restructuring, and the AF boosted implementation and extended the project's reach to the country's poorest and most vulnerable geographic regions.

Moderate shortcomings included lack of attention to safeguard issues (see Section 10a) and inadequate mechanisms to address financial management challenges. No indicators were added at the restructurings to measure directly the quality objective; achievement of this objective was measured solely through the end-of-project impact evaluation.

Quality of Supervision Rating
Moderately Satisfactory

Overall Bank Performance Rating
Moderately Satisfactory

9. M&E Design, Implementation, & Utilization

a. M&E Design

Project M&E was to rely to a maximum extent on mechanisms being established nationally. Most of the project's results indicators were aligned with national indicators at both the final and intermediate outcome level. In order to track performance of specific activities funded under the project, a complementary simple system for tracking project inputs and outputs was to be established and managed by the Ministry of Health unit coordinating the joint donor program. At the national level, proposed data collection methods were to include a combination of household surveys, public expenditure tracking surveys, and special facility surveys (to measure coverage, quality, provider knowledge, and user satisfaction). The National Statistics Institute and other local research groups were to be subcontracted to carry out the surveys and support impact evaluations, especially of the performance contracting approach (PAD, p. 14). Outcome indicators were well defined in the PAD (pp. 36-39), with baselines, targets, and data collection instruments adequately specified. However, the project's original results framework did not contain adequate outcome indicators for measuring improvements in quality of health services, and the outcome indicators expressed in percentage terms were later found to be inadequate due to concerns about accurate measurement of the denominator.

b. M&E Implementation

The ICR (p. 30) described project-level data management as "not the best." Although routine data collection and systematic monitoring of indicators were achieved at the local and regional levels, data were not adequately and systematically aggregated and documented in the established project portal at the national level. The 2013 mid-term review noted the absence of a centralized routine data collection and management system. Over two dozen indicators were monitored and reported at the health facility level on a monthly basis, and these indicators were used to populate the results framework.

Project restructuring revised many of the outcome indicators. Due to delays in project implementation, the planned 2011 baseline impact evaluation was not conducted. The mid-term impact evaluation was conducted in May 2013, and endline qualitative and quantitative impact evaluations were conducted in March 2017. The quantitative impact evaluation used rigorous and randomized sampling techniques to measure project impact at the household and health facility level. Ultimately, the project relied on the end-of-project impact evaluation for assessment of the quality objective.

c. M&E Utilization

According to the ICR (p. 31), regular supervision reports were used to inform decision making at all levels. A large mid-term review workshop provided program managers at the regional and national levels the opportunity to share results and experiences with stakeholders. Findings from the PBF impact evaluations were disseminated at a workshop attended by the Minister of Health and development partners.

M&E Quality Rating

Modest

10. Other Issues

a. Safeguards

The project was classified as Environmental Assessment category B and triggered the Environmental Assessment (OP/BP/GP 4.01) and Indigenous Peoples (OP 4.10) safeguard policies. The major environmental issue was waste management. A medical waste management plan was prepared and reviewed by the Bank, its quality and content judged to be satisfactory, and its contents disclosed prior to appraisal. An Emergency Action Plan (2008-2012) was proposed, covering capacity building, support for

implementation of proposed actions, research and studies on medical waste management, and strengthened supervision, control, monitoring, and evaluation. An Indigenous Peoples Plan was also prepared. Although indigenous groups did not reside in the project's initial four provinces, the Plan was to be immediately applied once the project scaled up. According to the ICR (p. 32), these plans were updated in 2016, but issues around implementation were not documented. The ICR did not state whether there was compliance with safeguard policies. The project team later confirmed that implementation of the medical waste management plan and Indigenous Peoples Plan was not documented.

b. Fiduciary Compliance

The ICR (p. 32) stated that the project complied with the Bank's financial management operational policies and procedures. Interim Financial Reports were submitted consistently but sometimes with delays. At the time of the ICR, the 2016 audit report had been submitted with qualified opinion, but its recommendations had not yet been implemented. The fiscal year 2017 audit was scheduled to be completed by May 31, 2018; the project team stated that it was not yet complete in October 2018 due to delays in the recruitment process for an external auditor. The fund flow mechanism did not work smoothly throughout implementation, as the project experienced an inactive Designated Account situation for more than six months. Furthermore, at closure, the project had accumulated a total debt of US$ 7 million due to lack of routine contract management at the project level. At the last financial management supervision mission, the Bank team requested that this debt be paid with funds from a follow-on project, but no action had been taken at the time of the ICR, and the project team stated in October 2018 that negotiations were ongoing. Other financial management issues included a fraudulent payment made by the National Payment Agency, and ineligible expenses identified following an in-depth review conducted by the financial management team. The ICR (p. 32) noted that financial management performance was rated Moderately Unsatisfactory following this review, but it does not describe whether and how these issues were resolved.

The ICR (p. 32) reported that the project complied with the Bank's procurement policies and procedures. The project team prepared an 18-month procurement plan at inception, and this plan was consistently updated to accommodate new activities that emerged during implementation. According to the ICR (p. 32), procurement was rated Moderately Satisfactory during most of the project's lifetime, primarily due to weak procurement capacity, issues around coordination among Project Implementation Unit staff, delays in preparing Terms of Reference, and inadequate technical specification at the beneficiary level. The situation improved as the Bank monitored activities and organized procurement trainings and clinics.

c. Unintended impacts (Positive or Negative)

Although the tertiary sector was not included in project design, the project provided technical assistance to support PBF in one major hospital, leading to reported improvements in efficiency and resource management (ICR, pp. 24-25).

d. Other

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11. Ratings

Ratings	ICR	IEG	Reason for Disagreements/Comment
Outcome	Moderately Satisfactory	Moderately Satisfactory	---
Bank Performance	Satisfactory	Moderately Satisfactory	There were moderate shortcomings in both quality at entry and supervision, including issues related to the results framework, institutional arrangements for performance-based financing, attention to safeguards, and challenges with financial management.
Quality of M&E	Modest	Modest	---
Quality of ICR		Modest	---

12. Lessons

The ICR (pp. 35-36) and Borrower's ICR (pp. 93-97) offered numerous useful lessons and recommendations, including:

Uninterrupted payment of performance-based financing subsidies is key to motivating health personnel and improving health facilities' operating environments. In this case, although PBF "revolutionized the way business is done in Cameroon's health sector," arrears in payment of subsidies led to lengthy delays in payments, negatively impacting efficiency.

Strong monitoring and evaluation systems, supported by competent and adequate staff, are essential for effective tracking of implementation and results. In this case, although reporting was accurate and complete at the facility level, there were shortcomings with data collection and consolidation at the national level, complicating assessment of achievement.

Involving higher levels of government at the outset of discussions of performance-based financing implementation holds the potential for significant policy development impact. Through a development policy operation, PBF has now been institutionalized in the national budget with a budget line item.

13. Assessment Recommended?

No

14. Comments on Quality of ICR

The ICR's narrative was clear and concise, documenting well the project's implementation experience and challenges. Its lessons were well grounded in project experience and should prove useful to future operations in the regions. However, the ICR contained numerous instances of incomplete, inaccurate, and/or internally inconsistent data concerning project costs and dates, achievement, and outcome (restructuring dates, original costs by component, outcome indicators, and outcome rating); these were significant shortcomings that required extensive clarifications from the project team. In addition, the ICR did not contain adequate information on compliance with safeguard policies.

a. Quality of ICR Rating
Modest