République du Cameroun
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Ministère de la Santé Publique

Republic of Cameroon
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Ministry of Public Health

NATIONAL HEALTH DEVELOPMENT PLAN

N.H.D.P.
2016-2020

MOH

AUGUST 2016

MOH
Ministry of Public Health

National Health Development Plan

NHDP 2016-2020

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ARV	Antiretroviral
AWP	Annual Work Plan
CBO	Community-Based Organization
CENAME	National Centre for the Procurement of Essential Drugs and Medical Supplies
CHP	Complementary Health Package
CHRACERH	Hospital Centre for Research, Human Reproduction and Endoscopy Surgery
CICRB	Chantal Biya International Research Centre
CLTS	Community-led Total Sanitation
CMO	Chief Medical Officer
COCSEC	Operational Committee for the multi-sector coordination of the NHDP Implementation, Monitoring/ Evaluation
CORECSES	Regional Committee for the coordination and Monitoring/Evaluation of NHDP implementation
CSM	Community-based Self-Monitoring
CSO	Civil Society Organization
DALY	Disability-Adjusted Life Years
DGSN	General Delegation for National Security
DHC	District Health Committee
DLMEP	Department of Disease, Epidemics and Pandemics Control
DMC	District Management Committee
DMO	District Medical Officer
ECAM	Cameroon Household Survey
EmONC	Emergency Obstetric and Neonatal Care
EPD	Epidemic-Prone Disease
EPI	Expanded Programme on Immunization
FCFA	Franc of the Financial Community of Africa
FP	Family Planning
GAVI	Global Alliance for Vaccines and Immunization
GESP	Growth and Employment Strategy Paper
HDDP	Health District Development Plan
HRDP	Human Resource Development Plan
HSSIP	Health Sector Support Investment Project (PAISS)
IHC	Integrated Health Centre
IMCI	Integrated Management of Childhood Illnesses
LANACOME	National Laboratory for the Quality Control of Drugs and Valuation
LLIN	Long Lasting Insecticide-treated Net
MCHNAW	Maternal and Child Health Nutrition Action Week
MDG	Millenium Development Goal
MHC	Medicalised Health Centre
MICS	Multiple Indicators Cluster Survey
MINAC	Ministry of Arts and Culture
MINADER	Ministry of Agriculture and Rural Development
MINAS	Ministry of Social Affairs
MINATD	Ministry of Territorial Administration and Decentralisation

MINCOM	Ministry of Communication
MINDEF	Ministry of Defence
MINDEPDED	Ministry of Environment, Nature Protection And Sustainable Development
MINEDUB	Ministry of Basic Education
MINEFOP	Ministry of Employment and Vocational Training
MINEPAT	Ministry of Economy, Planning and Regional Development
MINEPIA	Ministry of Husbandry, Fisheries and Animal Industries
MINESUP	Ministry of Higher Education
MINFORPRA	Ministry of Public Service and Administrative Reform
MINJEC	Ministry of Youth Affairs and Civic Education
MINJUSTICE	Ministry of Justice
MINPROFF	Ministry of Women's Empowerment and the Family
MINRESI	Ministry of Scientific Research and Innovation
MINTP	Ministry of Public Works
MINTSS	Ministry of Labour and Social Security
MOH	Ministry of Public Health
NACC	National AIDS Control Committee
NCCP	National Cancer Control Programme
NCD	Non-Communicable Disease
NDRA	National Drug Regulation Authority
NGO	Non-Governmental Organization
NGP	National Governance Programme
NHA	National Health Accounts
NIMSP-NCD	National Integrated and Multi-sector Strategic Plan for the control of Non-Communicable Diseases
NIS	National Institute of Statistics
NMCP	National Malaria Control Programme
NPHO	National Public Health Observatory
NTBCP	National Tuberculosis Control Programme
NTD	Neglected Tropical Disease
PAI	Public Administration Institution
PETS	Public Expenditure Tracking Survey
PMTCT/PC	Prevention of Mother-to-Child Transmission of HIV/ Pediatric care
RANC	Refocused Antenatal Consultation
RDPH	Regional Delegation of Public Health
RLA	Regional and Local Authorities
RPSC	Regional Pharmaceutical Supply Centre
SC	Steering Committee
SDG	Sustainable Development Goal
STI	Sexually Transmitted Infection
TFP	Technical and Financial Partner
UNFPA	United Nations Fund for Population Advancement
WHO	World Health Organisation

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PREFACE

The implementation of the 2016-2027 Health Sector Strategy (HSS) during the next five years will take place in an epidemiological context characterized by the predominance of communicable diseases, the most important being: HIV/AIDS, malaria and tuberculosis. An upward trend in non-communicable diseases was noted, namely: cardiovascular conditions, cancers and road accidents.
To bring down the current statistics noted in the epidemiological profile, the Government will work towards " ensuring universal access to quality health care and services for all social strata by 2035 with the full participation of the communities".

The 2016-2020 National Health Development Plan (NHDP), implementation instrument of the 2016-2027 HSS, is the first step in achieving this ambition. It defines the guidelines for the next five years while emphasizing key interventions in the priority areas below: (i) maternal, newborn, child and adolescent health; (ii) control of the main communicable diseases and the most frequent non-communicable diseases through greater community partnership; (iii) development of priority secondary and tertiary health care and (iv) strengthening of the health system pillars.
It is the reference document and an invaluable working tool for all actors in the health sector who will find in it a foothold in developing their operational plans. To this end, the 2016-2027 HSS requires all stakeholders to include in the various plans that will be drafted during this five-year period only activities that align with those in the NHDP.

Therefore, we call on all heads of health facilities at different levels of the health pyramid, Technical and Financial Partners, partner administrations, and civil society actors concerned with achieving the objectives projected in the 2016-2027 HSS, to master it for its effective implementation.

Minister of Public Health

ACKNOWLEDGEMENTS

On behalf of the Government of Cameroon, I would like to extend my gratitude to all the people who offered their technical and/or financial support in the development of this document.

Minister of Public Health

EXECUTIVE SUMMARY

The 2016-2020 National Health Development Plan, first operational plan of the 2016-2027 Health Sector Strategy was validated in January 2016 by the steering committee of the health sector. The development process of this 2016-2020 NHDP was participatory, involving all stakeholders in the sector (health care and service providers of the MOH and partner administrations, TFPs in the health sector, civil society, etc.).

This reference document will enable all actors, each according to their realities and in conformity with the 2016-2027 HSS, to draw up their annual and multi-year operational plans. Multi-year plans elaborated at the operational level shall be consolidated at the regional level and will serve as working paper for developing the Regional Consolidated Health Development Plans (RCHDP).

The priority domains of the 2016-2020 NHDP are : (i) maternal, newborn, child and adolescent health (ii) control of priority communicable diseases and of the most frequent non-communicable diseases (diabetes, HBP) through the revitalization of primary health care (PHC); (iii) development of priority specialized health care and (iv) strengthening the health system pillars.

PART ONE : SITUATION ANALYSIS

3.3.2.1 BACKGROUND

Since 2014, Cameroon ranks among middle income countries with a GDP of US$ 32.05 billion, corresponding to an annual income of US$ 1 445 per inhabitant. Yet, 40% of its population is still living below the poverty threshold, defined as an annual income of FCFA 269 443, or US$ 539 per adult[i].

As at 1 January 2015, the population of Cameroon was estimated at 22 179 707 inhabitants. Life expectancy was estimated at 51.7 years in 2010 and according to projections, it will be 56.3 years in 2021. Average age is 17.7 years. The majority of this population lives in urban areas.

Cameroon's Human Development Index (HDI) is low; the country ranked 153 worldwide out of the 188 evaluated in 2014. The Inequality-adjusted Human Development Index (IHDI) recorded an increasing trend, from 0.330 in 2013 to 0.344 in 2015, reflecting a rise in inequalities in the living standards in the country[1].

3.3.2.1 HEALTH SITUATION

The current health situation is characterized by the predominance of communicable diseases (HIV/AIDS, malaria, tuberculosis, etc.) and a significant increase of non-communicable

[i]Conversion rate: FCFA 500 = USD 1

diseases, including cardiovascular conditions, cancers, mental diseases and trauma due to road accidents.

In 2001, as part of the health system performance assessment, WHO classified Cameroon 164 out of the 191 countries assessed[2]. This rank reflects the weakness of the Cameroon health system pillars having as consequence its inability to efficiently address the needs of the populations.

PART TWO : INTERVENTION FRAMEWORK

3.3.2.1 OBJECTIVES AND GENERAL STRATEGIC FRAMEWORK OF THE 2016-2020 NHDP

The health sector vision developed in the 2016-2027 HSS stems from the 2035 vision of the President of the Republic for Cameroon to be **"a country where universal access to quality health care and services is ensured for all social strata by 2035, with the full participation of communities"**. The general objective of the NHDP aligns with this perspective which is to **"make accessible quality priority essential and specialized services and care in at least 50% of regional and district hospitals by 2020"**.

3.3.2.1 LOGICAL FRAMEWORK FOR INTERVENTIONS

The analysis of the health situation in the health sector enabled to develop a logical framework for interventions which is centered around 5 main strategic focus areas :

(i) health promotion that will seek the adoption of healthy behaviours by the population ;

(ii) disease prevention, which on the one hand shall focus on the intensification of the control of priority diseases under surveillance, and on the other hand, raising awareness of the populations on the main risk factors of diseases ;

(iii) case management that will prioritize the implementation of integrated high-impact intervention packages;

(iv) health system strengthening which will emphasize on implementing a financing strategy geared towards universal health coverage, rehabilitating and refurbishing dilapidated health facilities; building and equipping PUTAC hospitals; retaining HRH at their duty posts in difficult-to-access areas and encouraging CHWs. Moreover, the permanent supply of health facilities with essential drugs, vaccines, consumables and reagents shall be done through reinforcing stocks management logistics;

(v) strengthening governance, strategic steering and leadership at all levels of the health system will be based on a more efficient management of financial resources, the reinforcement of the monitoring/evaluation system, signing contracts with the private sub-sector and community actors, reinforcing supervision and community participation.

To reach the NHDP projected objectives, two essential prerequisites must be met: (i) the pursuit of reforms proposed in the HSS, and (ii) the reinforcement of the sector-wide approach.

For each strategic objective, targets and performance indicators were developed. As such, a total of 116 direct achievement indicators, 59 effects indicators and 13 impact indicators were developed to measure the impact of selected activities on projected results.

PART THREE : IMPLEMENTATION AND MONITORING/EVALUATION FRAMEWORK

3.3.2.1 IMPLEMENTATION FRAMEWORK

The priority of MOH at the central level shall be to ensure on the one hand, the execution of reforms proposed in the 2016-2027 HSS, which are indispensable for achieving the objectives of the 2016-2020 NHDP, and on the other hand, the alignment of its budget with defined priorities. Partner ministries shall operate through actions earmarked as part of their specific missions in the health sector. Regional Delegations for Public Health on their part shall provide the technical and logistical supervision of health districts in charge of implementing planned interventions.

NHDP implementation and monitoring/evaluation shall be carried out at all levels of the health pyramid (central, regional and operational). Integrated operational and monitoring/evaluation work plans shall be drafted at all levels of the health system and their objectives will match with those of the 2016-2027 HSS and subsequent NHDPs.

3.3.2.1 MONITORING/EVALUATION FRAMEWORK

The development the monitoring/evaluation plan shall be guided by the objectives of the 2016-2027 HSS and the 2016-2020 NHDP. The monitoring/evaluation process shall be conducted through supervision, collection of routine data, studies, audits, assessments and coordination meetings. An inspection and control system shall be set up to ensure: (i) the actual execution of tasks planned in the NHDP based on established standards; (ii) compliance with the rules and procedures; (iii) reliability of technical and financial reports at all levels of the health pyramid.

PART FOUR: BUDGETARY FRAMEWORK

Costs estimates for the implementation of actions identified in the 2016-2020 NHDP was carried out through objective-based budgeting (One Health). The total cost of the 2016-2020 NHDP is estimated at FCFA 2,135.7 billion distributed as follows : FCFA 119.9 billion for health promotion; FCFA 2,00.2 billion for disease prevention; FCFA 438. 1 billion for curative case management; FCFA 1. 256. 1 billion for strengthening the health system and FCFA 120. 7 billion for governance and strategic steering. Funds available for the same period are estimated at FCFA 1, 717. 8 billion, giving an average annual gap of FCFA 58 billion.

INTRODUCTION AND METHODOLOGY

The elaboration of the 2016-2020 National Health Development Plan follows the validation of the 2016-2027 Health Sector Strategy which was considered a contribution of the health sector to poverty eradication.

The 2016-2020 NHDP is the initial phase of the operationalization of this strategy. It comprises high-impact interventions whose implementation shall help meet the challenges of the current health situation which is marked by (i) high preventable morbidity and mortality in all regions especially the mother and child targets in the Northern and East Regions; (ii) the beginning of an epidemiological transition translated by a significant increase in the number of CNCDs (cancers, HBP, Diabetes, strokes, etc.) and finally; (iii) a weak health system undermined by insufficient resources and unable to provide sustainable solutions to health issues.

Based on the prioritization in the 2016-2027 HSS, major components of the health system to receive particular attention in the 2016-2020 NHDP are : (i) maternal, newborn, child and adolescent health; (ii) communicable and non-communicable disease control through the revitalization of primary health care (PHC) and strengthening community partnership; (iii) primary health care strengthening and the development of priority specialized care; (iv) strengthening the health system and governance.
The weakness of the health system pillars is indeed one of the main bottlenecks that prevent the populations from receiving the healthcare and services packages intended for them.

The 2016-2020 NHDP is divided into four parts:

- Part 1 : made up of 2 chapters : (i) background, and (ii) health situation (analytical description of the epidemiological profile of the health system pillars) ;
- Part 2 : interventions framework. This part recalls the HSS Vision, the NHDP strategic objectives and the logical framework of interventions;
- Part 3 : implementation, monitoring/evaluation framework. It presents the institutional mechanism and the monitoring/evaluation modalities for the NHDP implementation. This part is made up of two chapters: (i) implementation framework and (ii) M/E framework;
- Part 4 : the budgetary framework (programming and budgeting).

METHODOLOGY IN DEVELOPPING THE FIVE-YEAR PLAN (2016-2020 NHDP)

The development process of the 2016-2027 HSSP and the 2016-2020 NHDP was largely supported by the use of the following documents : (i) the "2001-2015 HSS Assessment Report " ; (ii) the document entitled "Situational Diagnosis of the health sector" ; (iii) the document entitled "Strategic choices of the health sector" ; (iv) the report on participatory consultations organized in the 10 Regions of Cameroon with implementation stakeholders of the 2001-2015 HSS and beneficiaries of health interventions; (v) the 2011-2015 NHDP; (vi) various strategic plans for disease control : (Cm-YP, RMNCH plan, plan for the control of chronic non communicable diseases etc.) ; (vii) different progress reports ; (viii) survey reports (MICS, ECAM, HDS) ; and (ix) the 2012 HSS report.

3.3.2.1 ORGANISATIONAL AND INSTITUTIONAL FRAMEWORK

A technical task force was established by Decision No.1412/D/MINSANTE/SG of 28 November 2014 of the Ministry of Public Health[3]. Chaired by the Secretary General of the MOH, this task force had as main mission to produce the various documents of the development process of the 2016-2027 HSS and of its first 2016- 2020 NHDP. Members of this multi-sector technical group and ad hoc experts mobilized for that purpose were the main architects in elaborating the 2016-2020 NHDP. They were tasked with collecting and compiling data, as well as drafting the document which was submitted for technical validation of the multi-sector task force.

The methodology used in drafting the NHDP is rooted in two reference documents namely: (i) the Methodological Guide for strategic planning in Cameroon, 2011 edition (MINEPAT)[4] and (ii) WHO guide for developing a national health policy and a national strategic health plan[5].

The logical framework of this NHDP is based on the main strategic guidelines of the 2016-2027 HSS and the activities of its intervention framework were jointly validated by experts from the 10 Regions and the central level.

The methodological supervision was provided by the Ministry of Economy, Planning and Regional Development (MINEPAT) and WHO experts. In line with its prerogatives, the Steering and Monitoring Committee of the HSS implementation approved the project, the methodology and the final document.

3.3.2.1 METHODOLOGY

Conceptually, the drafting process included six successive and complementary stages:

(i) Analysis of the achievement level of the 2011-2015 NHDP objectives and lessons from the implementation of this strategic document. Indeed, the analysis of performances helped to define the scope of the new 2016-2020 NHDP taking into account lessons learned from the assessment of the 2001-2015 HSS, the prioritization done in the 2016-2027 HSS and the institutional capacities of health structures;

(ii) Analysis of results from participatory consultations (reports of interviews and "focus group discussions" with stakeholders in the health system at all levels of the health pyramid) and numerous working sessions were necessary to identify, analyze and prioritize the needs and expectations of the populations in the 10 Regions of the country;

(iii) The identification of interventions to include in the NHDP, in line with the prioritization in the 2016-2027 HSS, and that of the targets to reach in each of the five components took into account the needs expressed by the populations, available resources and the capacities of health structures;

(iv) The development of the first draft of the NHDP;

(v) The technical validation of the NHDP by all stakeholders;

(vi) The validation of the NHDP by the steering committee.

The expertise of different stakeholders was sought at each phase of the process with a view to give priority to participatory approach and ensure the quality of the document to be produced.

PART ONE : SITUATION ANALYSIS

CHAPTER 1: BACKGROUND

1.1. GEOGRAPHICAL SITUATION

Cameroon, a Central African country, has a surface area of 475 650 Sq. km. It is bordered to the west by Nigeria, to the south by Congo, Gabon and Equatorial Guinea, to the East by Central African Republic, to the north by Chad. Independent since 1960, Cameroon has two official languages : English and French.

1.1.1 NATURAL ENVIRONMENT, DIVERSITY OF LANDSCAPES AND ECOSYSTEMS

Cameroon is characterized by:

i. The high plateaus in the west;
ii. Low lands in the Centre and the East;
iii. Coastal plains, river basins and the Lake Chad basin.

The country has six main ecosystems (marine and coastal, dense and humid rainforest, highlands, wooded tropical savannah, fresh water and semi-arid) which include diverse topography, vegetation and climate conditions[6].

1.1.2 CLIMATE

Cameroon may be divided into three main climatic zones :

- The humid equatorial zone, with an average annual temperature of 25°C, an annual gap that ranged between 3°C and annual rainfall varying between 1500 mm in Yaounde and 3000 mm in Douala;
- The Sudanese zone characterized by average annual rainfall of 1000 mm distributed in two seasons ;
- The sudano-sahelian zone characterized by low precipitations with an annual average of 700mm distributed in two seasons[6].

1.1.3 HYDROGRAPHY

Cameroon is home to many rivers and lakes found in the 4 main basins : The Atlantic basins (Sanaga, Nyong, Wouri), the Congo basin (Kadéï, Ngoko), the Niger basin (Benoue) and the Lake Chad basin (Logone). The density of the hydrographic network is a major asset to facilitate access to potable water.

1.2. SOCIO-DEMOGRAPHIC AND ETHNOLOGICAL SITUATION

1.2.1 DEMOGRAPHY

According to the 3rd General Census of Population and Housing, the population of Cameroon was estimated at approximately 22 179 707 inhabitants as at 1 January 2015. It would

probably reach 25 094 303 inhabitants in 2020, with a population growth rate of 2.6% between 2005 and 2010.

This population is extremely youthful with a median age of 17.7 years. The average age of the population is 22.1 years. The under 15 age group accounts for 43.6% of the total population while those aged below 25 years represent 64.2%[7].

The majority of the population dwells in urban areas (52%). There is high population density in big cities: Douala (2 717 695 inhabitants in 2015) and Yaounde (2 785 637 inhabitants in 2015)[8].

1.2.2 ETHNOGRAPHY

Given its geographical position, Cameroon is at the crossroads of secular migratory routes of the Sudanese, Fulani and Bantu people. The country has about 250 ethnic groups distributed into five main cultural groups:

- the Sudanese, Hamite and Semite from the semi-arid northern region, generally Muslims, Christians or animists;
- populations from the Western plateaus (West and North-west Regions) of the semi-Bantu group, generally Christians or animists;
- people from the coastal tropical forests (Littoral, South-west Regions and the coastal area of the South Region), of the Bantu group, mostly Christians and animists;
- people from the equatorial tropical forest of the South (Centre, South and East Regions), partly Bantu, generally Christians or animists, partly semi-bantus, Sudanese or Pygmies, mostly animists or Christians.

1.2.3 SOCIO-ECONOMIC SITUATION

Socially, with a Human Development Index (HDI) of 0.512, Cameroon was ranked 152nd out of the 187 countries assessed in 2014. The Inequality-Adjusted Human Development Index (IHDI) witnessed an upward trend from 0.330 in 2013 to 0.344 in 2015[9].

The wealthiest layers of the population, such as those living in urban areas, have greater access to public health facilities. For instance, 46.7% of deliveries were assisted by a qualified staff in rural area against 86.7% in urban area[7].

Despite the drop in the incidence of monetary poverty nationally by 2.4 points between 2007 and 2014 (37.5% in 2014 against 39.9% in 2007), rural poverty has not decreased. The incidence of poverty stood at 56.8% in 2014; representing an increase by 1.8 points compared to 2007. On the contrary, the urban area presents a poverty rate of 8.9%, representing a drop by 3.3 points compared to 2007[10].

Adult literacy rate (15 years and above) stood at 70.7%, including 63.0 % for women against 78.9 % for men. In 2010, the gross enrolment rate in primary school was estimated at 119.8%, with 110.9 % girls and 128.6 % boys[11].

As concerns living conditions:

- As for housing, 60% of the population does not have documents (even informal) in order (lease, rental agreement or land certificate) for the house they are living in ;
- As concerns water, in 2010, 71% of the population had access to potable water[7].

Cameroon's economy is highly diversified, but predominantly agriculture-based and derives most of its resources from the export of commodities; and manufactured goods are mostly imported. The country enjoyed relative prosperity in the post-independence years, followed by significant recession in the mid-80s induced by a serious world economic crisis. In 2014, Cameroon's GDP reached US$ 32.05 billion, or US$ 1 445 per capita ranking the country amongst lower- middle-income countries[12].

In terms of employment, the economic crisis narrowed the windows of prospects. The supply of salaried jobs is disproportionate to the constantly increasing demand for jobs, this contributes to the remarkable growth of the informal sector in big cities. Moreover, a high concentration of women in the informal sector, namely petty business and food production, is noted. Despite their prominent role in the socio-economic development, women are still faced with issues such as illiteracy and low access to the main training fields amongst others.

1.3. POLITICAL AND ADMINISTRATIVE SITUATION

Cameroon is made up of 10 Regions, divided into 58 Divisions and 360 Sub-divisions. There are 360 councils[13]. Law No. 2004/017 of 22 July 2004 on the orientation of Decentralization provides for the devolution of powers, competences and resources to councils. In the health sector, Decree No. 2010/0246/PM defines competences devolved to councils, this concerns the construction, equipment and management of Integrated Health Centres (IHC). Moreover, Mayors are chairs of the management committees of District Hospitals (DH) and Medicalized Health Centres (MHC), while Government Delegates to urban councils chair the management committees of Regional Hospitals (RH) and Central Hospitals (CH).

The political landscape comprises more than 200 political parties.

1.4. COMMUNICATION MEANS

Cameroon has dense transport infrastructures with road networks and railways. The road network was considerably increased to reach about 77 589 km in 2012 with only 5 133 km tarred[14]. Roads are poorly maintained therefore, considerable efforts should be made to prevent risks of accidents.

In addition, the country has air and sea network. Air transport network comprises 6 operational aerodromes including 3 international airports (Douala, Yaounde-Nsimalen and Garoua) and 3 secondary airports (Maroua, Ngaoundéré, Bafoussam). As concern sea transport, the country has 4 autonomous seaports : Douala, Garoua, Kribi and Limbe[15].

1.5. ACCESS AND USE OF INFORMATION AND COMMUNICATION TECHNOLOGIES

In 2014, 78.9% of Cameroonians used a mobile telephone, 21.2 % used a computer and only 16.2% used the internet[16]. The number of mobile telephone subscribers moved from 4.5 million to 14.8 million between 2007 and 2013, giving a geographical coverage of 83.3%[17].

As concerns weekly exposure to the mass media, heads of households frequently use the television (42%) than the radio (24%) or read newspapers (11 %). Yet, a little more than half of heads of households (51%) are not exposed to any media on a weekly basis (radio, television, newspapers).

Exposure to Information and Communication Technologies (ICT) and to the medias increases with the level of education and income. Therefore, health information is not always accessible to the most underprivileged.

Moreover, social networks are increasingly used to mobilize and educate the populations.

1.6. EQUITY AND SOCIAL JUSTICE IN HEALTH

Cameroon ratified many international conventions including those related to the elimination of all forms of discrimination, namely those concerning children and women's rights. Moreover, certain groups of the population remain marginalized such as : (i) Pygmies (forests), (ii) Bororos (Northern region), or (iii) populations living on islands either because of their attachment to their socio-cultural and economic environment, or actions conducted that are inadequate and/or not adapted for their integration.

Public health facilities are mostly accessible to the wealthier : 14.5% for the poorest quintile against 25% for the richest quintile in 2007. Moreover, there are disparities in the geographical access to healthcare according to the area of residence (between the rural and urban areas).

CHAPTER 2 : HEALTH SITUATION

2.1. ORGANIZATION OF THE HEALTH SECTOR IN CAMEROON

Cameroon's health sector is divided into three levels (central, intermediate and peripheral) and comprises three sub-levels: (i) public sub-sector ; (ii) private sub-sector (non-profit making and for-profit); and (iii) traditional sub-sector. Each level of the pyramid has administrative, health and dialogue structures (see table 1).

Table 1 : The different levels of the health pyramid and their functions

Level	Administrative structures	Competence	Healthcare structures	Dialogue structures
Central	-Minister's Office, Secretariat General, - Secretary of State to MOH - Technical departments and others ranking as such	- Development of policies - Coordination - Regulation - Supervision	- General Hospital, University Teaching Hospital, Central hospital and others ranking as such, CENAME, CPC, - CHRACERH, LANACOME, CIRCB, ONSP)	- National Council of Health, Hygiene and Social Affairs
Intermediate	- 10 Regional Delegations	- Technical support to Health Districts - Regional coordination - Regulation - Supervision	- Regional hospital and others ranking as such; Regional Fund for Health Promotion.	- Regional Fund for Health Promotion.
Peripheral	- 189 Health Districts	- Care provision - District Coordination - Regulation	- District hospital - Clinic - MHC - IHC, Health cabinets	- DHC; DMC - Health Committee; Management Committee

Source : MOH. Human Resources Development Plan: Situation and diagnosis (2012). Completed using the 2013 organizational chart

The health sector was also divided into five components with three vertical ones namely: (i) health promotion; (ii) disease prevention; (iii) case management, and two horizontal or cross-cutting components: (iv) health system strengthening and (v) governance (standardization, regulation and accountability) and strategic steering (planning, supervision, coordination and strategic and health surveillance).

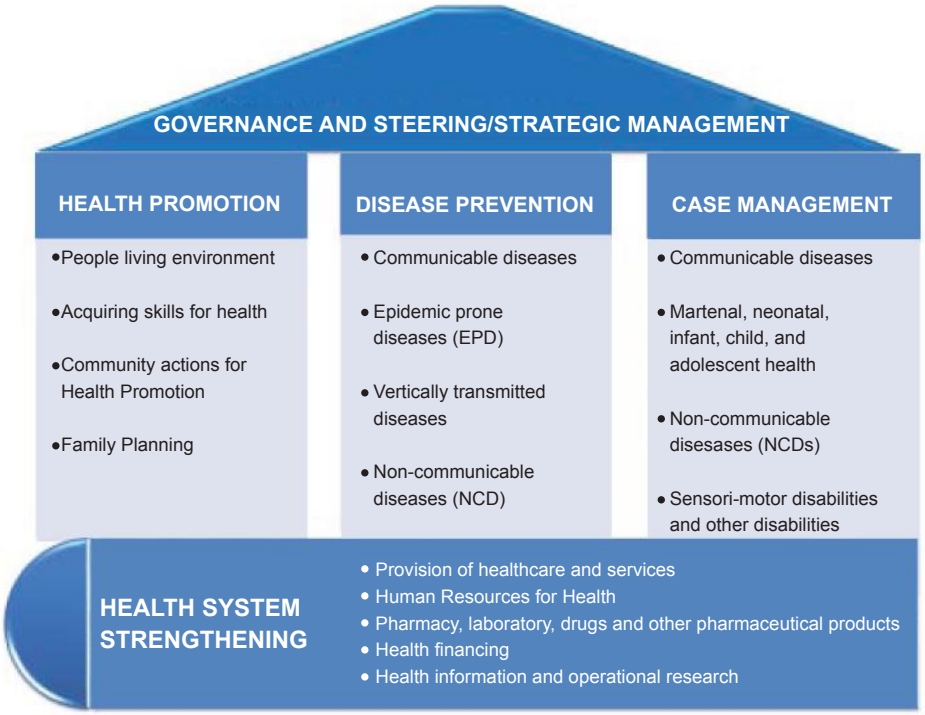

Figure 1: Distribution of the health sector into components and sub-components

Source : MOH, 2016-2027 HSS

2.2. EPIDEMIOLOGICAL PROFILE

The epidemiological profile of the country (see table 2) is characterized by a predominance of communicable diseases. The most important ones include: HIV/AIDS, malaria and tuberculosis. These three diseases represent 23.66% of the global burden of morbidity. There is also an increase in mortality due to Non-Communicable Diseases (NCD) notably cardiovascular conditions, cancers, mental diseases and traumas due to road accidents. To this non-exhaustive list, we can add occupational accidents (for 12.2% workers) and occupational diseases (7.5% workers)[18].

In children below 5 years of age, lower respiratory tract infections, malaria, diarrheal diseases and nutritional deficiencies are the main causes of morbidity and mortality, . Maternal mortality on her part, remains high at 782 deaths per 100,000 live births[19].

Table 2 : Contribution of diseases to mortality and morbidity in Cameroon in 2013

No.	Diseases or disease groups	Contribution to disease burden (DALY)	Contribution to deaths (%)
1	HIV/AIDS	11.48%	14.24%
2	Neonatal diseases	11.27%	8.47%
3	Malaria	10.77%	8.78%
4	Lower respiratory tract infections	10.12%	10.52%
5	Diarrheal diseases	5.57%	5.01%
6	Nutritional deficiencies	5.03%	3.74%
7	Cardiovascular diseases	4.67%	11.56%
8	Road accidents	3.95%	4.38%
9	Mental diseases and drug abuses	3.53%	0.86%
10	Other accidents	2.88%	2.87%
11	Cancers	2.02%	4.45%
12	Complications related to pregnancy, delivery and the infanto-juvenile period	1.95%	2.17%
13	Muscle and bone diseases	1.82%	0.14%
14	Neglected Tropical Diseases	1.82%	0.22%
15	Tuberculosis	1.41%	2.08%
16	Chronic respiratory diseases	1.38%	1.47%
17	STIs	1.31%	1.01%
18	Cirrhosis	1.30%	2.42%
19	Neurological diseases	1,15%	0.87%
20	Renal diseases	0.76%	0.83%
21	Other causes	15.81%	13.91%
	Total	100.00%	100.00%

Very high
High
Moderate
Low

Source: Results obtained from data of the 2013 Global Burden of Diseases[20]

2.2.1 Health Promotion

Key health determinants identified in Cameroon are : (i) low access to potable water, (ii) poor hygiene practices and waste management, (iii) inadequate housing, (iv) sedentary lifestyle, (v) nutritional and micronutrient deficiencies, (vi) excessive weight, (vii) illicit or noxious drug abuse and (viii) unmet needs in family planning.

The coverage level of the population through the provision of basic services of health promotion is still weak which is a sign that populations expectations are unmet. This is explained by : (i) a low community participation in the implementation of health actions and the low support of persons and households in adopting healthy behaviours; (ii) low salaries of CHWs compared to how they are solicited by the health system.

For example, the table below presents the situation of hygiene and sanitation per Region in 2011.

Table 3: Situation of hygiene and sanitation in Regions

Region	Proportion (in %) of the population having access to potable water **	Proportion (in %) of the population living in houses with improved latrines[(a)]**	Percentage of households living in makeshift houses*
Adamawa	60.7	60.6	4.8
Centre (Yaounde excluded)	58.8	37.9	19.9
East	25.3	35.8	20.2
Far North	37.8	16.9	8.5
Littoral (Douala excluded)	78.6	66.8	12.6
North	35.4	32.6	17.0
North west	51.5	56.2	7.8
West	59.7	56.4	4.7
South	44.3	55.6	14.5
South west	75.4	61.4	12.5
Yaounde	89.1	85.8	7.8
Douala	96.4	85.4	1.8
Urban	88.5	81.3	6.4
Rural	42.0	34.3	13.6
Cameroon	59.8	52.4	10.2

*Source: *DHS-MICS, 2011 ; **NIS, National progress report on MDG for the year 2012 ; [(a)] WCs, improved latrines*

2.2.2 Disease Prevention and case management

Since 2010, the country experienced an epidemiological transition characterized by a slight decrease in the prevalence of communicable diseases and an increase in non-communicable diseases (HBP, diabetes, etc.)[20].

2.2.2.1 Communicable diseases

In 2013, HIV/AIDS, STIs, malaria, tuberculosis, lower respiratory tract infections and diarrheal infections represented about 41% of the global burden of disease and accounted for 42% of all deaths (see Table 2). The high prevalence of these cited diseases was the origin of the putting in place of the following priority health programmes: The National Malaria Control Programme (NMCP), National Programme for the Fight against Tuberculosis (NPFT), The

National AIDS Control Committee (NACC) and the Enlarge Programme on Immunization (EPI) (These were institutional responses to curbing their magnitude)

HIV/AIDS

HIV/AIDS prevalence witnessed a drop in recent years from 5.5% in 2004 to 4.3% in 2011. Prevalence in men stands at 2.9% while women account for 5.6%[21], hence reflecting a feminization of the epidemic. Moreover, there is high prevalence (8.1%) in the 35 - 39 year age group. Similarly, the prevalence among adolescents and the youths between 15-19 years of age is 1.2% [22]. In 2014, the number of new HIV infections was estimated at 58 775 against 44 477 cases in 2015.[23] The most exposed populations to HIV are: sex workers (36.8 %)[24], homosexuals (37.2 %)[25] and truck drivers (16%)[26].

Since 1st May 2007, antiretroviral are free of charge for patients consulting in HIV management sites (ATC/Management Units)[27]. This free-of-charge policy helped to shift from 17 156 PLWHIV on ART in 2005 to 145 038 in 2014,[28] which is only 27% of unmet needs[29].

Key problems noted in the management of HIV/AIDS are:

- Late screening of cases and low recourse to care by HIV-positive patients;
- The provision of counselling/screening to clients/patients is not systematic in HFs;
- Low availability of Management units (44%[30] HDs do not have a management site);
- The absence of a sustainability plan for the acquisition of ARVs, after Global Fund financing which would end in 2020;
- Insufficient qualified HR for the comprehensive management of PLWHIV and the lack of decentralization in the "controlled distribution" of ARVs in the community by CHWs;
- The weak functionality of the facility to assist in the treatment observance of patients on ART.

Many studies on HIV/AIDS were conducted, especially in areas such as : treatment observance of patients on ART and HIV resistance to ARVs, but few of these results were used for decision-making.

Viral hepatitis

The average seroprevalence of viral hepatitis B, C and D were 12%, 1.03% and 10% in 2014[31]respectively. Immunization against viral hepatitis B is available and free for children aged 0 to 11 months. In the absence of a vaccine against viral hepatitis C, the State subsidizes the cost of the therapeutic management of this condition. Yet, it is still not affordable to the poorest (an average of FCFA 2 262 000 for 48 months treatment)[32]. ARVs for the management of viral hepatitis B, on their part are available in district hospitals and subsidized at FCFA 5000 /month.

Tuberculosis

The incidence of Tuberculosis in Cameroon is very high. In 2015, according to the NTBCP, 26 570 cases of all forms of TB were detected of which 15 082 were new microscopic cases which corresponds to notification rates of 132.85 and 75.41 respectively, per 100 000 inhabitants[33,34]. HIV prevalence among TB patients ranges from 16% in the Far North to 63% in the North west. TB cure rate ranges from 65% (Yaounde) to 86% (North). TB is rife in prisons where the reporting rate is ten times above the national average which is 125 per 100 000 inhabitants[35]. In 2013, there were 238 operational Diagnostic and Treatment Centers (DTC) representing a ratio of one DTC for 87 886 inhabitants (WHO standard is between 50 000 and 150 000 inhabitants)[36].

Problems encountered in the comprehensive management of TB are :

- low reporting rate of cases (48% only in 2013)[37] ;
- diagnosis times are quite long;
- delayed treatment of cases due to low financial access to health care and services;
- inadequate preventive measures in hospitals.

Malaria

Malaria remains the leading cause for consultation and hospitalization in Cameroon. Indeed, in 2013, 28.7%[38] of the population consulted for malaria in health facilities and this scourge was responsible for 22% deaths[39].

Malaria-related morbidity in hospitals dropped from 41.6% to 27.5%[40] between 2008 and 2012. During the same period, this morbidity equally reduced in pregnant women from 49% to 11%[41]. Since then, the institutional response consisted in the free treatment of malaria in children below five years of age, the free distribution of LLINs to the general population (37.4% of households had an LLIN for 2 persons in 2014[42]), intermittent preventive treatment for pregnant women (26% pregnant women who came for ANC received at least 3 doses of IPT in 2014[43]) and the chemo-prophylaxis of seasonal malaria in the Far-north and North Regions.

The main problems encountered in malaria control are :

- low use of LLINs distributed to the population ;
- non-compliance by some providers with the NMCP guidelines regarding the management of malaria cases (diagnosis and treatment) ;
- non-compliance in some health facilities with the free-of-charge policy for the treatment of malaria in children below five years of age.

Epidemic-prone diseases (EPDs) and emergencies

In the course of the last five years, the national epidemiological profile (see table 4) was especially marked by various epidemics : cholera, bacterial meningitis, influenza, measles, yellow fever and poliomyelitis. Moreover, new NTDs such as rabies, poisoning by snake bites and dengue fever were identified but a majority are still to be documented[44].

Some EPDs are targeted in the routine Expanded Programmes on Immunization, namely tuberculosis, poliomyelitis, diphtheria, maternal and neonatal tetanus, pertussis, viral

hepatitis B, *Heamophilus influenzae type B* infection diseases, pneumococcal infection diseases, rotavirus diarrhea, yellow fever, measles and rubella. The quality of routine data, lack of running materials and cold chain, weak achievements of advanced strategies and heavy reliance on external funding for the acquisition of inputs remain concerns and challenges to overcome for routine EPI.

Surveillance system of EPDs and public health events

The integrated surveillance strategy of EPDs and response was adopted in Cameroon in 2005. In 2011, the IDSR guidelines was updated to factor in aspects of the IHR (2005), including principles regarding the "One health" approach. To date, there is no national multi-sector strategic plan of response to epidemics and other health emergencies to guarantee an efficient response to epidemics. Difficulties encountered in surveillance and response among others are : low capacities of the staff in charge of proper screening and prompt management of declared cases, late transfer of samples to reference laboratories and low availability of logistics for preparedness and response in the event of epidemics, etc. The situation of EPDs over the past four years is summarized in the table below.

Table 4: History of EPDs in Cameroon from 2011 to 2015

EPD	2011			2012			2013			2014			2015		
	Suspected cases	Deaths	Lethality (%)	Suspected cases	Deaths	Lethality (%)	Suspected cases	Deaths	Lethality (%)	Suspected cases	Deaths	Lethality (%)	Suspected cases	Deaths	Lethality (%)
Cholera	23 152	843	3.6	125	4	3.2	29	0	0,0	3 355	184	5.5	228	10	4.4
Meningitis	2 733	191	7.0	1 128	103	9.1	1 013	68	6.7	1 156	60	5.2	1 230	62	5.0
Malaria	1 389 072	2 255	0.2	-	-	-	614 433	711	0.1	1 291 938	1 769	0.1	-	-	-
Measles	4 574	27	0.6	14 806	73	0.5	1 681	10	0.6	4 152	16	0.4	9 895	39	0.4
Severe acute gastroenteritis	1366	2	0.1	21877	60	0.3	46017	63	0.1	53477	80	0.1	56706	70	0.1
Bloody diarrhea	2 114	4	0.2	7 376	13	0.2	10 966	7	0.1	13 066	11	0.1	12 892	9	0.1
Typhoid fever	-	-	-	55100	21	0.0	138758	31	0.0	176899	28	0.0	229849	28	0.0
Human influenza	34 087	14	0.0	35 868	37	0.1	70 234	6	0.0	83 640	5	0.0	99 645	12	0.0
Poliomyelitis	187	0	0.0	216	1	0.5	444	2	0.5	700	2	0.3	498	2	0.4

Source : History of EPDs, 2011-2015. (DLMEP, unpublished)

This table presents EPDs that caused the greatest number of deaths between 2011 and 2014. These are : malaria (4 735 deaths excluding 2012 and 2015 statistics), cholera (1 041 deaths), bacterial meningitis (484 deaths), gastroenteritis (205 deaths) and measles (126 deaths). Unfortunately, experiences drawn from these epidemics were not used for establishing a sustainable response structure and sustainable strategies, as recommended in the National IDSR Technical Guide.

Neglected Tropical Diseases

The major Neglected Tropical Diseases (NTDs) constitute the main priority health programmes. These are :

Onchocerciasis

In 2013, over 1.5 million people had serious skin lesions[45]caused by this condition. In 2014, the therapeutic coverage rate with Community-directed Treatment with Ivermectin (CDTI) stood at 79.84% and the geographical coverage rate was 98.98%[46].

Lymphatic filariasis

Its prevalence varies from 6% in the North-west to 1.1% in the West[47]. The mapping done in 2012 showed the following results : (i) 154 of the 181 HDs surveyed were endemic for lymphatic filariasis, (ii) 100 HDs were co-endemic for Onchocerciasis and (iii) 24 HDs for loiasis [48]. To date, the control strategy for *Lymphatic filariasis* consists in the mass treatment with Ivermectin and Albendazole in endemic areas[49].

Schistosomiasis

Two million Cameroonian are currently infected by this disease[50]. School-age children (5-14 years) which is the most vulnerable group account for 50% of infected persons. One third of the general population is exposed to risk factors of the disease[51].

Leprosy

In 2014, 719 cases of leprosy were recorded in Cameroon. To date, about fifteen health districts remain highly endemic for this disease[52]. Four Regions namely Adamawa, East, North and South-west have the greatest number of cases, with statistics that are two or four times higher than the national average [53].

Buruli ulcer

This disease is rife in the Nyong valley (Centre), in the Bankim basin (Adamawa) and in Mbonge (South-west). The number of endemic health districts increased from 5 in 2005 to approximately 30 in 2015 despite the free treatment. Yet, the number of Diagnostic and Treatment centres for Buruli ulcer (DTC-BU) remains unchanged. Studies revealed that indirect costs inherent to the management of this disease are a significant burden for patients and their families[54,55].

Human African Trypanosomiasis (HAT)[56]

Currently, there are five active pockets of HAT in Cameroon, namely : Campo, Bipindi, Fontem, Mamfe and Doume. Occasional activities for sensitization, mobilization, screening and free treatment are organized every year in these areas. Information of morbidity related to HAT are not updated. However, the population at risk was estimated at about 70 000 persons in 2006.

Trachoma

Trachoma is endemic in the Far-north (14 health districts) and North (3 health districts) regions. In 2014, 1 156 483 patients were treated and 3 889 cases of trichiasis underwent surgery[57].

NTD case management is included in the health package of HFs at the operational level. Some of these affections receive mass chemoprophylaxis on an annual basis (schistosomiasis, onchocerciasis, helminthiasis, lymphatic filariasis and trachoma), and this considerably reduces the morbidity rate. Other NTDs are treated on a case-base.

2.2.2.2 NON-COMMUNICABLE DISEASES (NCDS)

Generally, the epidemiological situation of Non-Communicable diseases is not really clear similarly to the prevalence of their risk factors. In 2013, chronic non-communicable diseases represented about 40% of the global burden of disease (see table 2). In the course of the same year, they were responsible for 882 and 862 deaths per 100 000 inhabitants in men and women, respectively[58]. Among the most frequent NCDs are: cardiovascular diseases, cancers, road accidents.

Group 1 : HBP and other cardiovascular diseases, diabetes and chronic kidney diseases : accounting for about 11.56% deaths, cardiovascular diseases represented the second cause of mortality in Cameroon in 2013 (see table 2). The national prevalence of hypertension was 29.7% and of diabetes was 6.6% in 2015[59]. Normative documents for good management of the above-mentioned conditions at the operational level are not available and management is neither harmonized nor properly supervised. Data on the national prevalence of kidney diseases are not yet available. Yet, it is noted that the management of chronic kidney diseases and their complications, though subsidized, remains expensive and unaffordable for a majority of patients.

Group 2 : cancers, asthma and chronic respiratory diseases : In 2012, 14 000 new cancer cases were screened and about 25 000 people were living with cancer. More than 80% of people with cancer are diagnosed when the disease is very advanced and most of them die within a period of 12 months following diagnosis. The most common cancers are : breast (18.5%), cervix (13.8%), lymph nodes such as non-Hodgkin lymphomas (11.9%), prostate (7.3%), connective tissue such as Kaposi sarcoma (6.9%), and the liver (3%)[60]. Cancer

prevention and screening remain inadequate. On its part, the national prevalence of asthma is still undocumented, yet it stood at 2.3% in Yaoundé in 2014[61]. Regarding tobacco control, it is a key challenge for the health system as it requires combined efforts by many other sectors.

Group 3: oral diseases, chronic vision and hearing impairments : The national prevalence of oral diseases is yet to be known and there is no national policy, nor control plan for oral health. However, some studies in this regard revealed prevalence rates of 73% in the 9-12 years age group, and 92.3% in the 13-17 years age group in 1999 especially in rural areas in the North-west Region[62]. Moreover, sensory impairments (35%) are the most frequent especially visual (22%) and hearing (1 %)[63] deficiencies.
Eye diseases are a real public health concern that required the setting up of a National Blindness and Onchocerciasis Control Programme. However, qualified human resources and services intended for the management of these diseases in HFs at the operational level are lacking. As concerns cataract, mobile campaigns are organized regularly to carry out mass operations in HDs. ENT care on their part are most often provided in 1st , 2nd , 3rd and 4th category hospitals. To date, the country has only 72 ENT specialists[64].

Group 4: Epilepsy and other neurological, mental and psychosocial diseases, sickle cell disease, genetic and degenerative diseases : In 2008, epilepsy prevalence in Cameroon stood at 5.8% in hospitals[65]. The most affected localities were the Mbam area (Mbam and Inoubou, Mbam and Kim) 6%, the Lekie Division (5.9%), Nkam, the health districts of Mbengwi, Batibo, Kumbo and Ndu (in the North-west) and the town of Garoua. The 10 -29 years age group is the most affected (89.2%)[66].
According to WHO, the prevalence of sickle cell trait in Cameroon varies between 20 and 30%, representing a population of about 3.5 million people, with about 2% homozygotes[67]. Neonatal diagnosis of the sickle cell trait is not yet systematic for newborns at risk and awareness and prevention actions for sickle cell and mental diseases are still poorly implemented. Neuropsychiatric diseases also contribute to the global burden of diseases by 6.1%[68].

Group 5 : Traumas, violence, poisoning, medical and surgical emergencies and public health events: Cameroon witnesses many natural disasters, such as floods, outbreaks and other emergencies (terrorist acts, influx of refugees and displaced populations, road accidents, occupational accidents, plane crash, shipwreck, multiple fire recurrent in marketplaces). Between 2011 and 2013, the number of road accident victims slightly decreased, from 3 552 to 3 071 for the injured and 1 588 to 1 170 for deaths. However, the lethality rate of road accidents remains high (40%)[69].
Multi-sector preparedness and coordination in the management of emergencies and public health events are inadequate. The same goes for human resources allocated to this end. The

above-mentioned causes are the main bottlenecks in the response to emergency situations. A national emergency plan was developed in 2011 for the management of medical and surgical emergencies and public health events. But its optimal implementation is being delayed.

As concerns NCDs in general, policy documents and strategic plans for the control of these diseases were developed to better organize the institutional response considering their magnitude. But most of these health facilities at the operational level do not have appropriate technical platforms to provide quality health care and services corresponding to populations expectations. Finally, though a strategic NCD control plan was drafted, the surveillance of risk factors of these diseases is not ensured.

Disabilities :

About 5% of the population suffers at least from one disability. Sensory impairments (3.5%) are the most common, followed by motor deficiencies (1.5%)[70]. Some health facilities have physiotherapy and functional rehabilitation services, but generally, aspects of disability prevention and management are not considered enough in the health system.

2.2.2.3 MATERNAL AND CHILD HEALTH

Maternal health

At the national level, maternal mortality rose from 669 to 782 deaths per 100 000 live births between 2004 and 2011[71]. Factors justifying these are : (i) low rate of deliveries assisted by a qualified health personnel (64.7% in 2014)[72], (ii) low financial and geographical access to healthcare services, (iii) low availability of blood products; (iv) poor implementation of high impact interventions on maternal health.

Antenatal consultation: Between 2011 and 2014, ANC coverage decreased from 84.7% to 82.8% for ANC1. During the same period, the number of women who went for ANC4 reduced by 3.4 points (from 62.2% to 58.8%)[73].

Assisted deliveries : rate of deliveries assisted by a trained staff reduced from 63.6% to 61.3% between 2011 and 2014, representing a drop by 2.3%[74].

Postnatal consultation: slightly above one third of parturients (35%) did not receive postnatal care in 2014 and there are important regional disparities[75].

Family planning : In 2014, contraceptive prevalence was 34.4%[76]. Modern contraceptive prevalence was 16.1% (MICS 2014) while unmet needs were evaluated at 18%[77]. Abortion rate in women between 15 to 35 years varied between 30% and 40 %[78].

More than half of maternal deaths (69%) due to direct obstetrical causes could be avoided if the provision of healthcare and services for maternal health is strengthened especially at the

operational level. These direct causes are : hemorrhages (41.9%), severe pre-eclampsia and eclampsia (16.7%), severe postpartum infection (4.4%) severe abortion complications (4.1%)[79].

Child health

Between 2011 and 2014, neonatal mortality slightly decreased from 29 to 28‰. During the same period, infant and child mortality decreased from 144‰ to 103‰, while infant mortality rate dropped from 62% to 60‰[80]. For children aged between 2 months and 5 years, malaria (21%), diarrhea (17%), pneumonia (17%) and HIV/AIDS (7%) are the main causes of mortality in this age group[81]. Moreover, chronic malnutrition is the cause of 14.7% deaths in children below 5 years of age[82]. Essential family practices and high impact interventions on child health (immunization and exclusive breastfeeding, etc.) are not really implemented to reverse the trend of the above-mentioned data.

PMTCT

According to the 2014 NACC annual activity report on PMTCT, out of 825 150 expected pregnancies, 573 793 (69.5%) were consulted during ANC and 493 510 (86% ANCs and 60% expected pregnancies) were screened for HIV, including 31 112 (6.3%) HIV positive results. HIV prevalence varies from 12.2% in the Centre Region to 2.2% in the North Region[83]. Overall, 10 599 (34%) out of 31 112 HIV positive pregnant women were put on ART, representing 25% of expected HIV positive pregnant women[84].

The goal of eliminating mother-to-child transmission of HIV by 2015 has not yet been reached. Though the number of health facilities offering PMTCT services increased between 2010 and 2014 from 2 067 to 3 466 out of the operational 3990 HFs of the country, this rate is still low[85].

Option B+ which consists in **"Putting all HIV positive pregnant women on treatment without waiting for CD4 results"** was adopted in the country in 2012. In 2014, out of 41 684 HIV positive pregnant women attended for HIV, 31 112 (74%) were tested and 11 698 (71%) were placed on ARV prophylaxes. The integration of PMTCT component in ANC activities is effective in all regions, even if ANC coverage is not always satisfactory.

Limiting factors that influence the poor response of the system in PMTCT are :

- low PMTCT service provision in rural areas (insufficient trained staff and inputs not available in some HFs) ;
- recurrent stock-outs of tests and ARVs[86].

2.2.3 PERFORMANCE OF THE HEALTH SYSTEM

The Cameroon health system, which ranks 164th out of 191 countries following an evaluation carried out by WHO in 2011, is fragile, hence does not effectively respond to the needs of the populations[87]. To better describe this health system and assess the impact of each pillar

of the health system on the general performance, analysis will focus on the 6 points below : (i) health financing; (ii) provision of healthcare and services; (iii) pharmacy, laboratory, drugs and other pharmaceutical products; (iv) human resources; (v) health information system and health research; (vi) governance and strategic steering.

2.2.3.1 HEALTH FINANCING

Cameroon does not yet have a national strategy for health financing. Therefore, the different functions of financing described below (resources collections, risk sharing mechanisms and purchase of health services) do not apply to a national logical framework.

COLLECTION OF FINANCIAL RESOURCES

In 2012, the total amount of health financing stood at FCFA 728 billion, representing 5.4% of the GDP. The main sources of financing were: households (70.6%), Government (14.6%), the private sector (7.7%) and donors (6.9%)[88].

Funding by the State: Over the 2010-2015 period, the national budget allocated to the health sector witnessed a substantial increase in absolute terms from FCFA 166.6 to 207.1 billion. In spite of this increase, the share allocated to the health sector, expressed in percentage of the national budget decreased from 7.2% in 2011 to 5.5% in 2015[89]. It is important to note that since the reform of the programme budget in 2013, MOH is considered as the sole ministry of the health sector. Despite the lack of a strategic advocacy document to increase the financial resources of the State for health, it is important to note that many actions to *advocate* for an increase of the MOH budget *were carried out* in the past years but did not result in a strong political commitment for health.

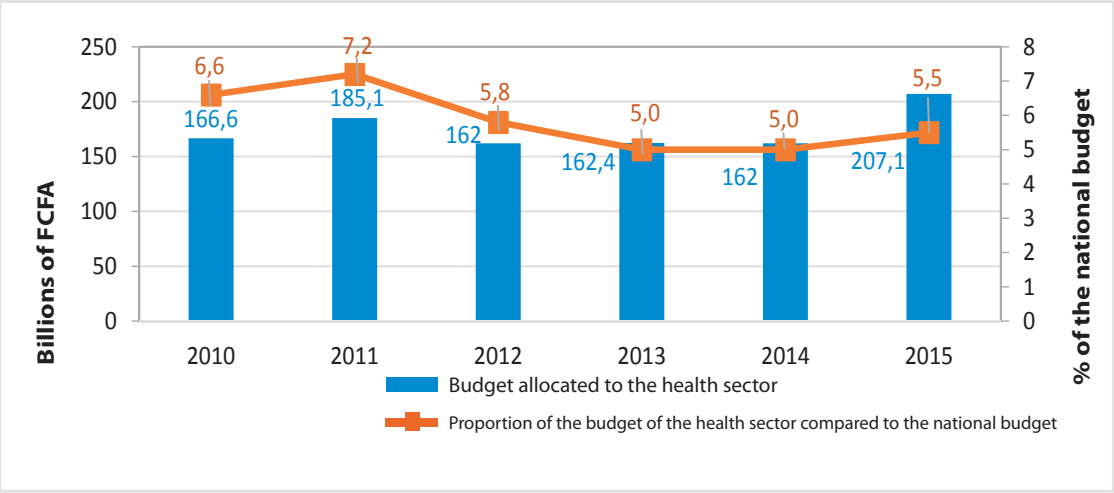

Figure 2 : Evolution of the national budget allocated to the health sector and percentage of the national budget from 2010 to 2015

Source : 2010-2014 Settlement bills and 2015 Finance Law

Funding from households: households contribution to health expenditures represented 70.6% of total health expenditure in 2012[90]. The bulk of this funding is done through out-of-pocket payment at the time of care and there is not yet a strategy aimed at capitalizing these funds to strengthen global efficiency and equity in the sector.

External funding: over the 2011-2015 period, external funding contributed to the tune of FCFA 519.7 billion in health expenditure, representing an annual average of 104 billion (see Table 5)[91]. In 2015, the Global Financing Facility (GFF) initiative was launched to finance high impact interventions for maternal and child health.

Table 5: Contribution of partners in health financing (billion of FCFA).

Partners	Total funding 2011-2015 (in billion FCFA)
Multilateral	423.9
Global Fund	292.2
GAVI	66.1
World Bank	12.5
WHO	4.5
Others	48.6
Bilateral	91.5
China	35.0
KFW	14.0
Others	42.5
International NGO	4.3
TOTAL 2011-2015	1035.1

Source : MOH 2015. DCOOP. Unpublished document

Innovative funding: Recourse to innovative funding is still poorly developed in Cameroon. However, some initiatives are being experimented, for example, participation in the world initiative UNITAID through taxes on air tickets for international flights (deduction of 10% on airport stamp). However, these initiatives do not represent a very substantial source of funding in view of setting up the universal health coverage (UHC).

MECHANISMS FOR POOLING RESOURCES AND HEALTH RISK SHARING

Mechanisms for pooling resources remain insufficient in the health sector. Indeed, health expenditure of households consist at about 99% in direct payments at the point of contact with care provision. Only 1% of this expenditure goes through risk pooling mechanisms or third parties[92] such as: mutual health associations (43 were active in 2014) that provide health coverage for 63 000 persons, private insurance companies (16 were active in 2014), providing insurance for 190 408 persons for health risk, civil servants mutual health associations, and the National Social Insurance Fund (occupational accident and disease section) which provide social protection for 1 163 534 persons[93,94].

There is also a solidarity fund, financed to the tune of 10% for payments made to health facilities, which was created in order to solve urgent health issues and guarantee fairness in the health system. However, there is no legislation about its use.

In 2011, it was estimated that less than 3% of the population was covered by a health risk mechanism.[95] Recommendations by the Interministerial committee for the Review of Programmes during the 2015 session advocate for the development of a strategy to set up the UHC in Cameroon. It is essential to note that UHC will only be implemented through the equitable mobilization of internal resources.

PURCHASE OF HEALTHCARE AND SERVICES

Several payment mechanisms for health services exist in the health sector, including:
(i) out-of-pocket payments by households; (ii) reimbursement of expenses by mutual associations/health insurance by people covered by the user charges; (iii) subvention of free care for some priority interventions; (iv) performance based financing and (v) budgetary allocation of the State for the operation of health facilities.

Budget allocation: As part of the current decentralization policy, FCFA 6 billion of the MOH budget were allocated to RLAs for investment in health in 2015. These funds are inadequate compared to the needs of health facilities. There is not yet any pre-established objective criteria for the distribution of the budget allocated to health facilities. Financial resources management remains closely centralized.

Moreover, operating budgets allocated to health facilities are insufficient and difficult to mobilize due to complex procedures and budget heads that are not always adapted to the missions and operational needs of health districts.

Budget execution : Commitment rate was oscillated between 88 and 96% over the 2010-2015 period. However, it is indispensable to know the amounts that were really executed compared to commitments made. Moreover, efficiency is still low as concerns health expenditure. For instance, in 2012, Cameroon spent $61 per capita but obtained comparable results with countries spending $10 and $15 per inhabitant[96]. Generally, health financing encounters many difficulties, including: low efficiency in the use of resources, inadequate

financial resources allocated to health compared with identified needs, differed availability of financial information, low visibility and predictability of the chain of expenditure, etc.

2.2.3.2 HEALTHCARE AND SERVICE PROVISION

Central level

1st and 2nd category hospitals are two types of HFs at the central level. To date, they do not fully play their role as referral structures mainly due to lack of adequate technical platforms, referrals and late use of care services by patients and the costs of services which remain high for most patients. Subsidies for some types of services are now done by these hospitals to reduce the costs of the management of some chronic diseases such as terminal kidney diseases that require hemodialysis, some cancers, etc. but the lack of sustainable health risk pooling mechanisms, health care and services offered in these hospitals still remain unaffordable for the underprivileged social strata.

Besides, these hospitals, which are supposed to bring technical support to HFs of the devolved level equally deliver MHP and CHP like district hospitals, MHCs and IHCs. An assessment to identify obstacles and difficulties preventing these structures from efficiently fulfilling their missions is envisaged.

Finally, at the central level, regularly held coordination meetings most often serve as a platform for information sharing, proposals of solutions and guidelines. Consequently, their content should be improved and include the analysis of organizational and structural bottlenecks that prevent the achievement of targeted goals. Meetings of the steering committees and those organized by multi-sector committees of priority health programmes are also opportunities for consulting with key stakeholders to solve crosscutting health issues and ensure a good coherence and efficiency of multi-sector interventions implemented in the sector. However, meetings are not regular and do not involve regional delegations for public health although they are in charge of ensuring the planning of the implementation of the health policy at the devolved level (multi-sector technical meetings).

Intermediate level

Regional Delegations for Public Health (RDPH) : The intermediate or regional level is made up of ten Regional Delegations for Public Health (RDPH). They have as permanent mission to provide technical support to health districts, coordination and administrative management of all HRH in the region. At the level of regional delegations there are control brigades for health care and activities. Yet, to date no study has helped evaluate the real level of execution of their missions. Most RDPH do not have health development plans. Moreover, for lack of adequate funding, Consolidated Regional Health Development Plans (CRHDP) developed between 2006 and 2009 were not fully implemented. The report of missions done in 2013 in the 10 regions by the TS/SC-HSS[97] revealed a global lack in human, material and financial resources as well as inadequate capacity of regional delegations and district medical officers in implementing the management process. This qualitative and quantitative

deficit in human resources hinders its planning, coordination and technical support capacity at the regional level. Therefore, in these delegations there are : (i) a plethora of thematic plans containing many duplicates and monitoring/evaluation tools instead of a unique consolidated plan and only one monitoring/evaluation plan of the delegation.

Health facilities of the intermediate level: today, the intermediate level has 14 regional hospitals and others ranking as such (3rd category) which are supposed to receive referred cases from health facilities of the operational level. However, for lack of relevant evaluation of their functionality, it is difficult to objectively appreciate performances. As concerns human resources in these hospitals, capacity building does not always fall within a previously developed training plan. The absence of a personnel management plan at this level and the lack of financial resources compared to expressed or identified training needs partly explain this situation.

Moreover, coordination meetings are opportunities for sharing knowledge among care providers and capitalizing on best practices. But they are less frequently organized because of the lack of funding allocated to coordination and poor leadership of hospital heads.[98]

Health district

Decree No. 95/013 of 7 February 1995 to organize the national territory into health districts and their autonomy is the peak of their development (viability process).

The 2001-2015 HSS set among other objectives to **"reduce by one third the global burden of death by setting up a health facility that provides the Minimum Health Package (MHP), within an hours walk and for 90% of the population**"[99]. To effectively play their role and offer primary health care to the population, health districts should be developed[100,101]. However, to date, it is difficult to assess the development level of the 189 health districts of the country given that no study had recently been conducted. However, only 7.4% of health districts in 2007 were considered to be developed.[102] In these conditions, most structures of this level of the health pyramid do not have the development level that would enable them fully provide quality MHP and CHP to populations.

Besides, results of the PETS II survey showed that 24.5% of the health facilities of the operational level did not have delivery kits; 39.5% did not have a heat sterilization system; 67.5% did not have caesarian kits and 11.6% did not have functional microscopes.[103]

Situation of the implementation of primary health care (PHC) : the coverage level of the PHC component is low. (see table 6).

Table 6: Coverage rate of the main primary health care interventions

Components	Indicator	Value	Year	Reference
Promotion of good feeding habits	Food insecurity rate (%)	8.1	2011	106
	Breastfeeding prevalence (%)	28.2	2011	107
	Anemia in women (%)	40	2011	108
	Anemia in children (%)	60	2011	

Components	Indicator	Value	Year	Reference
	Obesity in women (%)	32	2011	
Adequate supply in potable water and basic sanitation measure: WASH	Access to potable water (%)	72.9	2014	109
	Access to improved toilets (%)	34.9	2014	
	Maternal mortality (per 100 000 births)	782	2011	110
	Infant and child mortality (per 1 000 births)	103	2014	
	Modern contraceptive prevalence (%)	21	2014	
Immunization against the main infectious diseases	Children vaccinated with the reference DTC3 antigen (%)	79.6	2014	111
Prevention and control of local endemics and epidemics	Malaria-related hospital morbidity (%)	20.7	2014	112
Treatment of common diseases and lesions	Subjective morbidity rate (%)	25	2007	113
	Use of health care services (%)	52.6	2007	
Supply in essential drugs	Availability of essential drugs (%)	86	2015	114 115
	Average stock-out per year (day)	18.1	2015	
	Consumption of poor quality essential drugs (%)	61.4	2012	
Health education	Health literacy rate	n.d.	n.d.	

Source: MOH 2015. "Situation and Diagnosis of the health sector"

Situation related to the implementation of Complementary Health Package (CHP) : DHs and those ranking as such aim mainly at providing CHP to populations. But, to date, there is only a marginal number of district hospitals providing comprehensive CHP.

Infrastructure and equipment: In 2014, there were 4 034 public (72%) and private (28%) health facilities (table 7)[104]. These figures are probably below reality as there is no updated health map. In addition, significant differences exist between the distributions of HFs among health regions on the one hand, and between rural and urban areas on the other hand. There is also an uncontrolled proliferation of private health facilities, many of which are not approved by the MOH.

The low availability of disaggregated data on: (i) the functionality of the existing technical platforms, (ii) the implementation level of MHP/CHP, (iii) the state of infrastructure (constructions which are abandoned, under rehabilitation or old), does not help give a precise description of imbalances between rural and urban areas or among regions as related to the availability of quality infrastructure and equipment.

In absolute terms, the number of first category health facilities is high.[105] But, there is no available assessment report that could inform on the number of HFs (buildings, equipment and health workforce) according to standards. There is a disparity between the rate of construction of health facilities, their equipment, the deployment of human resources and health logistics, this hinders the provision of comprehensive MHPs in HFs at the operational level. In this context, it is difficult to provide information on the percentage of the population receiving quality primary health care packages[106] and CHP.

Regarding equipment, there is little information on the number of HFs which have assessed the obsolete state of their equipment.[107] The biomedical equipment is not properly maintained because of lack of an operating maintenance system, and a skilled multidisciplinary staff dedicated to the task. In health areas, most of the HF infrastructure, running materials and equipment are also obsolete or do not operate because of lack of an appropriate maintenance and depreciation system.

Table 7: Distribution of health facilities per region in Cameroon in 2016

REGION	Faith based non-profit	Private non-profit	Private for profit	Public	TOTAL
Adamaoua	38	39		124	201
Centre	187	750	191	474	1602
East	58	74		177	309
Far-North	19	65		356	440
Littoral	184	581	148	244	1157
North	18	49	6	254	327
North-west	90		45	234	369
West	83	318		415	816
South	35	72	1	206	314
South-West	35		92	191	318
TOTAL	**747**	**1948**	**483**	**2675**	**5853**

Source: Health Map 2016/HIU MOH

Community-based management: Presently there is no available national policy for community health. There is a health committee (HC) in every area, made up of representatives of each village in the area. The main actors of the community health system include CHWs, though their work is not acknowledged. Many work as volunteers. Yet, the amount of work assigned to them is beyond volunteerism. Discussion to provide all HDs with CHWs, and set up compensation or motivation schemes for the latter is underway.

Other types of care and service provision

- *Traditional medicine*

The traditional sub-sector is an important link of the health system as 80% of the African population uses this form of medicine[108] . This statistic is not available in Cameroon.

In promoting traditional medicine, the Government established a service in charge of traditional medicine in the decree organizing the Ministry of Public Health[109] . However, the implementation of this action is slow, notably the establishment of a legal framework organizing the functioning, coordination and follow-up of activities related to this sub-sector.

- *Home care*

The low quality of care in public health facilities and the very high costs related to services in private health facilities incite users to use informal or home care. Other factors justifying the development of informal home care, include: (i) the fraudulent use of health staff

professional identity; (ii) the need for social integration among qualified professionals and (iii) the very high cost of home care for some patients.

Modalities for the provision of services

Fixed and outreach strategies

Activities related to the MHP and CHP are carried out in fixed, outreach or mobile strategy. A study on the geographical access to health services, according to the quintile and the area or region of residence, has shown that the poorest needed twice the time used by the richest quintile to reach the nearest Integrated Health Centre, that is, 19.4 minutes for people from the richest quintile against 43.2 minutes for the poorest quintile. Generally, the furthest village is about 80 km from a health centre, which limits access to care[110.]

The referral and counter-referral system

There are no comprehensive studies published on the functionality of the referral and counter-referral system in Cameroon. However, it has often been described as less performant.[111,112,113]

Other modalities for services provision

New modalities have been recently defined in the health system. These are contract signing; social marketing; decentralisation involving Regional and Local Authorities; telemedicine; and task shifting[114]. All the benefits of these innovative modalities concerning the provision of services are not leveraged and capitalised enough to improve the geographical and financial access to health services and care.

2.2.3.3 PHARMACY, LABORATORY, DRUGS AND OTHER PHARMACEUTICAL PRODUCTS

Supply and distribution: The national system for the supply of essential drugs include CENAME, RFHP and pharmacies of health facilities. The pharmacist per capita ratio varies from 1 per 6,920 to 1 per 177,051 inhabitants depending on regions[115].

Geographical and financial access: In 2008, the availability level of tracer drugs was estimated at 86% and the stock-out average time in the first semester of 2015 was 18 days[116,117]. For some years, some drugs such as: (i) TB drugs, 1st and 2nd line antiretroviral, and antimalarial drug combinations (ACT, Artesunate and Artemether injection for children aged 0 to 5 years); (ii) leprosy drugs; (iii) anti-cancer drugs, etc. are provided free of charge or subsidized.

Drug regulation: There is no consultation framework between the various structures of NDRA on information sharing and a better application of guidelines regulating the pharmaceutical sector. Quality control made by LANACOME is unfortunately not systematic for all imported batches. In addition, there is no regular inspection of pharmaceutical structures.

Pharmacovigilance: The national system for pharmacovigilance is being developed. A draft text organizing pharmacovigilance, and a guide for best practices in pharmacovigilance, have

been developed, but not yet validated. There is a specialized commission for pharmacovigilance within the National Commission on Drugs. In accordance with the missions of the DPML defined in the decree organizing the MOH, it is the National Centre for Pharmacovigilance.

Laboratory: Decree No.1465 of 9 November 1990 regulates the practice of medical analysis and lays down the modalities for the establishment and functioning of private medical analysis laboratories. With regard to laboratories in public health facilities, their organization and functioning depend on the internal organization of the health facilities.
Decree No. 450/PM of 22 October 1998 to lay down the modalities for the approval of pharmaceutical products include provisions allowing the registration of laboratory reagents by one of the specialized sub-commissions of the National Drug Commission. This sub-commission does not always have adequate logistics and human resources for the effective and diligent evaluation of the reagent quality.
The National Public Health Laboratory established in 2013, was renovated to improve its technical platform. The evaluation of the quality of medical analyses at the national level is not effective. Apart from a pilot experience supported by a development partner, there is no accreditation system for laboratories and the related regulation is still not available to date. In addition, the lack of laboratory networking in the country does not help enhance their capacities.

Street drugs and auto-medication: For many years in Cameroon, the sale of drugs was reserved to pharmacies and pro-pharmacies. But, since 1980, the phenomenon of informal supply of drugs has developed significantly. This situation exposes populations to the consumption of under-dosed, counterfeit and sometimes expired products.[118] To fight against this phenomenon, Cameroon has adhered to some initiatives among which "WHO Impact" and "*l'Appel de Cotonou de la fondation CHIRAC sur la lutte contre la contrefaçon des produits de santé*" (the Cotonou call of the Chirac Foundation on the fight against counterfeit drugs) and has adopted a national plan for the fight against the illicit sale of drugs.
In addition, according to the joint decision No. 0050/MINDIC/MSP of 19 August 1996 laying out the practical modalities for the fight against the illicit sale of drugs and pharmaceutical products, ten (10) control committees presided over by governors of regions were established. The General Inspectorate for Pharmaceutical Services and Laboratory coordinates activities to fight against the illicit sale of drugs.

2.2.3.4 HUMAN RESOURCES FOR HEALTH

Situation and needs of the sector: The global needs in HRH were evaluated after the 2011 General Census of Health Personnel. These needs are detailed in the Human Resource Development Plan (HRDP)[119]. In 2012, the health sector had 38 207 health personnel, all categories included[120.] The Strategic Plan for the Development of Human Resources for Health (2013-2020 SPDHRH) revealed a lack of personnel in the following categories: medical doctors, pharmacists, qualified nurses and midwives. In addition, they were highly concentrated in big cities, especially Yaounde and Douala. The health personnel/population

ratio (medical doctor, nurse and midwife) was 1.07 per 1000 inhabitants in 2011 while WHO recommends 2.3 personnel per 1000 inhabitants[121].

Table 8: Distribution of human resources for health per region

Qualifications	REGIONS										Diaspora	TOTAL
	Adamawa	Centre	East	Far North	LT	NO	NW	WE	SO	SW		
CRW	3	26	27	131	6	11	47	97	11	8	0	367
Social Assistant	1	54	1	9	9	3	0	12	5	11	0	105
Other health professionals	7	305	55	176	508	26	499	555	44	237	1	2 413
Administrative staff	47	770	58	69	191	58	184	131	64	152	0	1 724
Dental Surgeon	4	22	0	4	17	1	2	3	3	2	0	58
Pharmacy clerk	5	133	42	166	137	92	211	234	24	134	0	1 178
Nurse	817	4 512	874	1 733	3 276	965	1 590	2 599	781	1 804	3	18 954
General Practitioner	38	500	53	71	307	42	82	116	45	94	72	1 420
Specialist doctor	16	192	5	10	127	3	9	26	11	16	7	422
Paramedical	176	1 343	204	342	786	160	377	593	175	368	2	4 526
Support staff	77	1 401	120	816	1 534	227	844	726	100	828	0	6 673
Pharmacist	7	38	4	12	40	8	2	26	4	21	0	162
Traditional doctor / Traditional birth attendant	0	0	0	189	0	10	0	1	1	4	0	205
Total	**1 198**	**9 296**	**1 443**	**3 728**	**6 938**	**1 606**	**3 847**	**5 119**	**1 268**	**3 679**	**85**	**38 207**

Source: MOH & GCHP, 2011.

Generally, MOH human resources are insufficient in terms of quality and quantity and are unequally distributed throughout the national territory. To date, efforts are made to retain the health workforce working in difficult-to-access areas, namely the Northern regions, South-West (Bakassi and Akwaya) and Centre (Yoko, Deuk, etc.).

Production of Human Resources for Health (HRH): The numerous medical and paramedical training schools are expected to lead to an overproduction of health professionals in the next five years. This situation would be a real issue regarding the recruitment of these trained personnel, with a potential risk for malpractices.
The continuous training of health professionals, though indispensable, is not systematic. This training is also inadequate and poorly structured compared to the needs of the country. There is no training curriculum and marginal needs are not taken into consideration.

Use of human resources: There is instability of the health personnel at the duty posts. In the public sub-sector, salaries allocated to health personnel to date do not motivate their retention in the system, which partly explains the brain drain. For devolved services, the posting schemes do not always include the information provided by the Regional Delegate for Public Health. Sometimes, there is inadequacy between the personnel profile and the duty post, which partly explains low performances.

Management of careers: there is no career management plan for HRH. The promotion of workers is not always based on merit. Promotions are not automatic. In rural zones, especially, the personnel often occupies the same duty post for a very long time, which generally demotivates them and leads to frustration. Some personnel in devolved health facilities do not have any training opportunity or promotion all through their career [551].

Remuneration: The remuneration of HRH is low regardless of the category and corps. In addition, in public HFs, mechanisms established to reduce the costs of care for the mother-child couple, lead to a significant drop in revenues with a negative impact on the salaries of the personnel paid on the income from costs recovery.

2.2.3.5 National Health Information System and Research in Health

- *National health information system*

The National Health Information System (NHIS) is facing a lot of challenges due to: (i) numerous collection tools, (ii) the great number of indicators to collect and analyze ; (iii) the existence of many non-interrelated parallel information sub-systems. In addition, the institutional and organizational framework of the NHIS remains fragmented. There is no management procedures manual, and very few structures have a monitoring dashboard to follow up activities.
The low availability of disaggregated data per region and per district on the analyzed themes does not always provide specific information on the health situation of populations and

consequently, does not guide the choice of priority action areas and allocate resources based on needs.
The lack of information on disaggregated health indicators and the real capacities of HDs and RDPH to meet the projected goals and the past performances are a major obstacle for the orientation of technical support from the central level.

- *Research in Health*

Research in health is a support tool for the orientation of health policy. The weaknesses of this area are: (i) the non-compliance with the existing legal regulatory framework which governs the practice of research in Health in Cameroon; (ii) the inadequate financial resources allocated to the functioning of regulatory bodies; (iii) the under-financing of research activities by public and private structures; (iv) the inadequate ethical supervision, (v) and the absence of culture of research in health.
International recommendations prescribe that at least 2% of national budgets for ministries in charge of health, and at least 5% of development assistance funds should be allocated to research in health, but this proportion is still low (less than 1%). In addition, the dissemination and exploitation of these research results are low when available, and low capacity to use them for decision-making at the national level.

2.2.3.6 GOVERNANCE AND STRATEGIC STEERING

- *Governance*

Legal and regulatory framework: The legal and regulatory framework of Health in Cameroon has improved since independence. To date, many legal instruments regulate the main functions and the implementation of interventions in the health system. However, many other regulatory instruments should still be drafted to complement this mechanism and facilitate the governance of the system, notably: the public health code and hospital reform (legal and/or regulatory instruments on (i) management of emergencies; (ii) free care for the poor; (iii) pricing of medical procedures which is outdated, because the current pricing does not reflect the social and economic situation of the country, etc.).
Moreover, regulation still faces many challenges: (i) poor implementation of existing instruments; (ii) insufficient human resources trained in legal and political sciences, especially in the devolved level; (iii) noncompliance with the formulation process of legal instruments by stakeholders of the health system, thus leading to many legislative and regulatory acts with often competitive and even contradictory provisions; (iv) the ignorance of existing legal instruments.
As concerns governance, the legislation in force provides for administrative or legal sanctions based on the offences committed. However, the organizational and structural mechanism established to handle legal affairs in the health system is still limited to the central level through the Division of Legal Affairs and Litigation which most of the time is flooded with work.

Audits and internal controls: External audits and controls are limited because of the lack of human resources, logistic, material and financial means. Moreover, there is low implementation of recommendations following inspection missions.[122] To partially address this challenge, control brigades were established in Regional Delegations for Public Health equipped with personnel[123] to ensure the follow-up and internal control of health structures in the region at a lower cost, and to promptly address low performance issues. But, to date, they are not fully operational.

Relating to the negative perception of the quality of services and care provided (36% of negative responses according to ECAM III), for many years, the Government has made significant efforts through the National Programme on Governance (NPG) which aims at improving the quality of care provided to users. PROMAGAR (project for the modernization of Cameroon administration through the implementation of results-based management) on its part, intends to improve the functioning of public services.

Accountability: The notion of accountability refers to the duty to systematically report to stakeholders. In the health sector, there are platforms for consultation and exchange of best practices. At the central level, this includes: (i) the steering and monitoring committee for the implementation of the health sector strategy. This committee is a multi-sector coordination framework which gathers all the major stakeholders in the sector;[124] (ii) conferences of central and external services organized every year by the MOH, which serve as a platform of exchanges among major stakeholders of the health sector; (iii) coordination meetings organized at all levels of the health pyramid are also consultation frameworks established to involve all the stakeholders of the health system in the implementation of the NHDP and thus ensure accountability. However, the functionality of this institutional mechanism is still to be improved as accountability is not yet systematic at all levels of the health pyramid.

Social control: Regarding social control, out of 226 claims and denunciations made in 2013, 174 (77%) were processed[125]. However, it should be noted that social control in the health system is still limited because users and healthcare and service providers lack information on their rights and duties. Yet, if social control is properly done, it will be an important lever to improve governance. In the health system, social control bodies include: (i) the National Council for Health, Hygiene and Social Affairs (central level); (ii) the Regional Funds for Health Promotion (RFHPs) (regional level), the district health committees, Hospital Management Committees, Health Committees (peripheral level)[126]. Generally, these dialogue structures are less functional.

- *Strategic steering*

Strategic surveillance: In the health sector, the strategic surveillance mechanism is organized by the National Public Health Observatory (NPHO) established in 2010. However, its missions are not effectively implemented due to the lack of human, financial and

technological resources. In addition, coordination between HIU and NPHO is not sufficiently ensured and data transmission is not systematic between both structures.

Planning, coordination and monitoring of interventions

Coordination and monitoring bodies for the implementation of the HSS were established at all levels of the health pyramid but are less operational at the devolved level.

Moreover, health structures do not always have action plans and when these plans are developed, they do not always align with the NHDP priorities. Finally, monitoring of data in the system is hindered by: (i) quality health information intended for decision-making is not always available and data collection tools in health facilities are still many; (ii) there are no integrated and harmonized tools per level of the health pyramid to ensure data compilation and summary, and quality control of data collected and forwarded is not systematic; and (iii) the monitoring and supervision of health structures in lower level by those in the higher level is hindered by logistical, financial and planning difficulties.

In 2006, many multiyear plans were developed, notably: (i) Consolidated Regional Health Development Plans (CRHDP); (ii) Health Districts Health Development Plans (HDHDP); (iii) plans of various health priority programmes. However, most of these plans were not implemented due to:

- the weak institutional capacities of the structures which developed them;
- the constraints and obstacles related to slow administrative procedures during mobilization of financial resources in the public sub-sector (long procurement procedures);
- the weak participation of the stakeholders from the private sub-sector and of RLAs in the financing of health activities;
- the weak visibility of long term financing allocated by TFPs;
- absence of a clear diagnosis and prioritization of problems to address in the various plans developed (in effect, heads of health facilities planned too many interventions which were difficult to finance and monitor).

To date, the main issue in the health system is **"its weak capacity to meet the social and health needs of populations because of the weakness of its pillars"**

The consequences of this key issue are:

- low adoption of healthy behaviours by populations;
- growing prevalence and incidence of risk factors of preventable diseases;
- low quality of case management in health facilities and in the community;
- high morbidity and mortality that could be prevented.

PART TWO : INTERVENTIONS FRAMEWORK

CHAPTER 3 : GENERAL STRATEGIC FRAMEWORK, ALIGNMENT, VISION AND OBJECTIVES OF THE 2016-2020 NHDP

3.1. INSTITUTIONAL ALIGNMENT OF THE 2016-2020 NHDP

In 2009, Cameroon adopted a vision for 2035: *"Cameroon: An emerging and democratic country united in its diversity".* In this Vision, the country adopted four general objectives including that of "reducing poverty to a socially acceptable level".

The 2010-2020 Growth and Employment Strategy Paper (GESP) designed for the implementation of the initial stage of the vision, identified[127] the improvement of the health of populations both as a social development and economic growth objective. The GESP also reaffirmed the will of the Government to carry on the achievement of the overall Millennium Development Goals (MDGs).

To achieve national and international goals in health (SDGs, GESP) and move towards universal health coverage, Cameroon has just adopted a new HSS which provides for:

a) Extending primary essential healthcare and services: major interventions in this option will focus on primary healthcare (health promotion, disease prevention, curative management of common diseases in the community). This includes providing minimum and complementary health packages (MHP and CHP) to control the main communicable and non-communicable diseases and address public health events.

b) Improving the provision of priority specialized health services and care: this will include increasing service provision for the management of priority chronic diseases and public health events requiring care or special measures.

2016-2020 NHDP focuses primarily on the strengthening of the health system and governance; maternal, newborn, and child health; management of medical and surgical emergencies and public health events; and disease prevention.

3.2. REMINDER ON THE STRATEGIC AXES OF THE 2016-2017 HSS

Table 9: Description of strategic axes

OVERALL OBJECTVE OF THE STRATEGY: To contribute to the development of a healthy, productive manpower capable of ensuring a strong, inclusive and sustainable growth. TRACER INDICATORS: Life expectancy at birth 57.35[207] years in 2014 Gross mortality rate: 10.4 per 1000 inhabitants in 2014 VERIFICATION SOURCE: DHS-MICS, WHO annual reports					
Strategic axes	**Strategic objectives**	**Performance indicators**	**Baseline (2015)**	**Targets (2020)**	**Verification Source:**
Health Promotion	Enabling the population to adopt healthy behaviours by 2027	% of households using improved toilets	34.9% in 2014 MICS 5	45%	DHS, MICS, ECAM, studies
		Prevalence of obesity in urban areas	23.5% in 2015 Kingue et al.	22%	STEPS
		Tobacco consumption rate (tobacco smokers)	6 % in 2014 (GATS)	5 %	GATS survey
		Percentage of targeted companies which apply principles related to occupational health and safety	ND *	20%	DHS, MICS, ECAM, studies
		Malnutrition rate in children below 5 years of age	14.8% in 2014 (MICS 5)	13.8%	DHS, MICS, ECAM, studies
Disease prevention	Reducing premature mortality due to preventable diseases	Prevalence of Hypertension in urban areas	29.7% in 2015 Kingue et al.	28%	STEPS
		% of children aged 0-5 years sleeping under a LLIN.	54.8% in 2014 MICS5	85%	DHS-MICS
		% of HIV-positive pregnant women on ART	59.3%	75%	NACC Report 2015
Case Management	Reducing overall mortality and lethality in health facilities and in the	Peri-operative mortality in 3rd and 4th category hospitals	ND*	- 50% annually	Studies/ Surveys
		Maternal mortality rate	782 /100,000 live births in 2011 (DHS-MICS)	638/100,000	DHS-MICS

OVERALL OBJECTVE OF THE STRATEGY: To contribute to the development of a healthy, productive manpower capable of ensuring a strong, inclusive and sustainable growth. TRACER INDICATORS: Life expectancy at birth 57.35[207] years in 2014 Gross mortality rate: 10.4 per 1000 inhabitants in 2014 VERIFICATION SOURCE: DHS-MICS, WHO annual reports					
Strategic axes	**Strategic objectives**	**Performance indicators**	**Baseline (2015)**	**Targets (2020)**	**Verification Source:**
	community	Child mortality rate	60 /1,000 live births in 2014 (MICS 5)	52/1,000	DHS-MICS
		Newborn mortality rate	28 /1,000 live births in 2014 (MICS5)	24/1,000	DHS-MICS
		Newborn and child mortality rate	103 /1,000 live births in 2014 (MICS 5)	90/1,000	DHS-MICS
		Hospital direct obstetrical lethality rate	ND*	-20 % over the period	Studies/Surveys
Strengthening of the health system	Building the institutional capacities of health structures for a sustainable and equitable access of populations to quality health care and services	Overall Index for the availability of health care and services (IGDS)	ND*	25%	SARA survey
Governance and strategic steering	Improving the performance of the health system at all levels.	Achievement rate of the 2016-2017 HSS objectives	ND*	30%	Reports of the steering committee

*For indicators with no reference values, studies will be conducted to determine these as early as possible and the projected targets will therefore be improved.

3.3. OBJECTIVES OF THE 2016-2020 NATIONAL HEALTH DEVELOPMENT PLAN

3.3.1 GENERAL OBJECTIVE

Overall objective of the NHDP: "***make accessible priority quality essential and specialized care services in at least 50% of regional and district hospitals by 2020".***

The implementation of the NHDP will focus on 3 vertical aspects, namely (i) health promotion, (ii) disease prevention, (iii) case management; and two cross-cutting aspects which are (iv) strengthening of the health system and (v) governance and strategic steering.

3.3.2. SPECIFIC OBJECTIVES

3.3.2.1 Health promotion

By 2020:

(i) build institutional and community capacities, and strengthen community participation in the implementation of health interventions in 40% HDs;
(ii) improve the living conditions of populations in at least 30% of health districts;
(iii) develop promotion actions in at least 40% of HDs in order to strengthen health promoting skills for individuals and communities;
(iv) bring 25% families to adopt essential family practices including family planning.

3.3.2.2 Disease prevention

By 2020:

(i) reduce by 10% the incidence/prevalence of the main communicable diseases (HIV, malaria and tuberculosis) and eliminate some NTDs (lymphatic filariasis and HAT);
(ii) reduce in at least 50% of districts the risks of occurrence of major public health events and epidemic-prone diseases including zoonoses;
(iii) By 2020, increase by at least 70% the coverage of high-impact prevention interventions for the mother, newborn and child targets in at least 60% of HDs;
(iv) reduce by at least 5% the incidence/prevalence of the main non communicable diseases.

3.3.2.3 Case management

By 2020:

(i) ensure a curative management according to standards of the main communicable and non-communicable diseases as well as their complications in at least 30% of health facilities;
(ii) ensure an overall management according to standards of the maternal, newborn, child and adolescent health issues at the community level and in at least 60% of health facilities;
(iii) ensure the management of medical and surgical emergencies, and public health events, according to standard operating procedures (SOPs) in at least 60% of HDs;
(iv) reduce by at least 10% the proportion of the population with at least one correctable disability.

3.3.2.4 Strengthening of the health system

By 2020:

(i) reduce by at least 10% out-of-pocket payments from households through equitable and sustainable financing policy;
(ii) ensure the harmonious development of infrastructure, equipment and the availability of healthcare and service packages according to standards in at least 40% of category 3, 4, 5 and 6 health facilities;

(iii) increase by 25% the availability and use of quality drugs and pharmaceutical products in all HDs;
(iv) Increase the availability of HRH in at least 40% of HDs, RDPH and central Departments according to prioritized needs;
(v) ensure the development of research in health and the availability of quality health information for decision-making based on evidence at all levels of the health pyramid.

3.3.2.5 Governance and strategic steering

In this strategic axis, these objectives were adopted:

(i) to improve governance in the sector through the strengthening of standardization, regulation and accountability;
(ii) to reinforce planning, supervision, coordination as well as strategic and health surveillance in 80% of HDs and RDPH .

CHAPTER 4: LOGICAL FRAMEWORK OF INTERVENTIONS

Overall objective of the strategy: To contribute to the development of a healthy and productive manpower capable of ensuring a strong, integral and sustainable growth.
IMPACT INDICATORS OF THE HSS: Maternal mortality ratio (Baseline 782 deaths/100,000 live births in 2011)
Newborn and child mortality rate (Baseline 103 deaths/1000 live births in 2011)
VERIFICATION SOURCE: DHS-MICS, WHO annual reports

Overall objective the NHDP: ***To provide and make accessible quality priority essential and specialized healthcare and services to the population***

Table 10: Logical framework of 2016-2020 NHDPS

STRATEGIC AXIS 1 : HEALTH PROMOTION									
Core issue of the component:	Inadequate capacities of populations to adopt healthy behaviours to address their health issues								
Strategic objective:	Bring the population to adopt healthy behaviours by 2020								
Tracer Indicators:	- % of household members using improved private toilets								
	- Prevalence of obesity in urban areas								
	- Percentage of targeted companies which apply the principles of occupational health and safety								
	- Chronic malnutrition rate in children below 5 years of age								
Strategic sub-axis 1.1: Institutional, community and coordination capacities in the area of health promotion									
Specific objective HP 1 1: By 2020, strengthen institutional, coordination capacities and the participation of the community in 40% HDs in the area of health promotion	Tracer Indicators	Baseline	Source	Period					Success requirements
				2016	2017	2018	2019	2020	
	Percentage of HDs with functional DHCs [(a)]	65 % in 2015	DOSTS Report 2015	70%	75%	80%	85%	90%	

Implementation strategy	Interventions	Tracer Indicators	Service in charge	Implementing partners	2016	2017	2018	2019	2020	Success requirements
1.1.1 Availability of technical expertise and transfer of competence to administrations of the health sector for an effective implementation of health promotion actions	1.1.1.1.Strengthen at all levels the availability of promotion inputs in health facilities (human and financial resources, drugs, outreach material, etc.)	Percentage of the MOH budget allocated to health promotion interventions	DRFP	DPS, RDPH, MINFI, DPML, MINFOPRA	X	X	X	X	X	Availability of financial and human resources, recruitment by MINFOPRA depending on the expressed HRH needs
1.1.2 Transfer of competence to community stakeholders for the appropriation of health interventions	1.1.2.1. Technical support to leaders and community stakeholders (CBOs, CSOs, CHWs, RLAs and Dialogue Structures) in addressing health issues in their environment	Percentage of HD CSOs affiliated to the CSO regional platform having contributed to the implementation of the HD AWP	DOSTS	DPS, DLMEP, RDPH, HD, DHC, TFP, CSO/NGO, MINATD RLA	X	X	X	X	X	
	1.1.2.2.Train and recruit polyvalent CHWs for the provision of MHP activities at the community level (see appendix 2)	Percentage of HDs having at least 3 polyvalent CHWs trained for the provision of community MHP	DOSTS	DRH, DPS, RDPH, FRSP, SD	X	X	X	X	X	
1.1.3 Strengthening of the legal framework for a better community participation	1.1.3.1. Update the legal framework for community participation	Availability of updated regulatory instrument governing community participation in heath interventions	DOSTS	MOH (General Inspectorates, DAJC, DPS, DPML, NBTP, Tech., TS-SC/HSS, Ethical Committee, RDPH, HD)	X	X				

1.1.4: Provision of technical expertise and transfer of competence to RLAs and Community-Based Organizations (Dialogue Structures, Civil Society Organizations, Non Governmental Organizations) in the area of health promotion[(b)]										
1.1.5 Improvement of multi-sector coordination for health promotion interventions	1.1.5.1.Develop and implement a multiannual and multi-sector health promotion plan	Goal achievement rate of the multiannual health promotion plan	DPS/HPD		X	X	X	X	X	The main stakeholders take part in all the phases of the plan design process (participatory approach), adequate financial resources are available to implement and ensure M/E of planned interventions; beneficiaries understand, adhere and participate in promotion activities

	1.1.5.2.Design and carry out AWP activities for health promotion in schools, universities and professional environments	Percentage of targeted secondary schools having an implementation report for health promotion activities	MINEDUB MINESEC, MINSESUP MINTSS	MOH (DPS), RLA, CSO	X	X	X	X	X	
1.1.6: Update of training curricula for a better integration of social and environmental approach in syllabuses[(b)]										
1.1.7: Improvement of health promotion service provision that meet all the needs of the individual	1.1.7.1. Ensure the availability and implementation of community healthcare and service packages	Percentage of HDs providing at least 50% of the community intervention packages in their AWP	DPS	RDPH, HD, DHC, HC, CSO, Civil Society, RLA	X	X	X	X	X	The legal framework and the interventions guide regulating community participation is updated, disseminated, and takes into account the motivation aspects for the community stakeholders

Strategic sub-axis1.2: Living conditions of the populations										
Specific objective HP 1 2: y 2020 improve the living conditions of populations in at least 30% of health districts		**Tracer indicators**	Baseline	Source	Period					Success requirements
					2016	2017	2018	2019	2020	
		Percentage of households using solid fuel as first source of domestic energy used for cooking	80.4%	MICS 5	78%	76.5 %	75%	72.5 %	70%	
		Percentage of households with access to potable water	72.9 %	MICS 5	73.5%	74%	75%	76.5 %	78%	
Implementation strategy	Interventions	Tracer Indicators	Service in charge	Implementing partners	2016	2017	2018	2019	2020	Success requirements
1.2.1: Improvement of the hygiene environment (Water, Sanitation and Hygiene, etc.)	1.2.1.1. Continuous scaling up of Community-Led Total Sanitation (CLTS) in councils/HDs	Percentage of HDs implementing CLTS[(a)]	DPS	RDPH, HD, MINEE, RLA, MINATD,	X	X	X	X	X	Collaboration and coordination are effective between MOH and MINEE on the establishment of CLTS; RLAs actively participate in sanitation activities and consider CLTS as priority actions; no social and cultural barriers in the use of toilets.

	1.2.1.2.Ensure the equitable training and deployment of health engineering staff in HDs	Proportion of HDs with health engineering HRs	DPS	RDPH, HD, HD, CSO, RLA		X			X	
	1.2.1.3. Among professionals develop health promotion and disease prevention interventions	Achievement rate of activities provided for in the health plan of targeted companies over the last 12 months	MINTSS	DCOOP, Employer Groups, Companies, MINTSS ,DPS	X	X	X	X	X	Company managers (public and private) understand the challenges and participate in health promotion activities of their employees
1.2.2: Promotion of structured urbanization for towns, and development of slums[(b)]										
1.2.3: Strengthening prevention actions against soil, water and air pollution[(b)]										
1.2.4 Development of best practices on resilience and management of climate-related risks and disasters[(b)]										

Strategic sub-axis 1.3: Strengthening of health promoting skills for individuals and communities										
Specific objective HP3 1 3: By 2020, develop promotion actions in at least 40% of HDs in order to strengthen aptitudes that are favourable to the health of individuals and communities		Tracer indicators	Baseline	Source	Period					Success requirements
					2016	2017	2018	2019	2020	
		Prevalence of pregnancies among adolescent girls	25.2%	MICS 5	24%	22%	19%	17%	14%	
		Prevalence of smoking in persons aged 15 and above	6%	GATS 2013	6%	5.5%	5.5%	5.5%	5%	
Implementation strategy	Interventions	Tracer Indicators	Service in charge	Implementing partners	2016	2017	2018	2019	2020	Success requirements
1.3.1 Promotion of good feeding habits	1.3.1.1.Develop C4D for the adoption of healthy behaviours in the field of food and nutrition	Percentage of HDs having an integrated Communication plan for health promotion and disease prevention	DPS/HPD	MINCOMMERCE, MINADER, ANOR, MINEDUB, MINESEC, MINESUP, MINMIDT	X	X	X	X	X	
1.3.2: Fight against smoking, alcohol abuse and consumption of illicit substances[(b)]										

1.3.3 Strengthening road safety	1.3.3.1.Build capacities for drivers and populations living in accident-prone areas in first aid (pre-hospital management)	Percentage of HDs having community teams trained in first aid	DOSTS	DLMEP, NPHO, MINATD, MINTRANSPORT, MINTP, DGSN, RDPH, Red Cross, Fire-fighters, AMUCAM, etc.			X		X	
	1.3.3.2.Strengthening C4D for road safety	Number of victims (injured or dead) of inter urban road accidents	MINTRANSPORT	DPS, DOSTS, Secretariat of State for Defence, DGSN, CONAROUTE	X	X	X	X	X	NHDP objectives integrated in partner ministries work plans, close collaboration between MOH and MINTRANSPORT
1.3.4 Strengthening sport and physical activities	1.3.4.1.Ensure construction/rehabilitation of proximity sport infrastructure for the practice of physical exercise	Proportion of RLAs with developed and conventional spaces for sport and physical activities	CU	DPS, RDPH, HD, MINATD, RLA, MINHDU, MINSEP		X	X	X		Strong collaboration between MOH and MINSEP
	1.3.4.2. Increase the number of sports instructors in divisions/sub-divisions	Percentage of approved centres for sports and physical activities having a trained sports instructor	MINSEP	All ministries	X	X	X	X	X	

1.3.5. Strengthening of integrated communication for development (C4D) and social marketing	1.3.5.1.Develop C4D for the adoption of healthy behaviours in the following areas: food/nutrition, prevention and screening of communicable and non-communicable diseases, abuse of psycho active substances, especially narcotic drugs and alcohol	% of children aged 6 to 23 months having received food from at least four food groups in the previous day Prevalence of dental decay in primary school pupils	DPS/HPD	MINCOM, RDPH, HD, HF, CHW, Councils, CSO/CBO, MINADER, MINEPIA, MINPROFF, MINEDUB, MINESEC, Mobile telephone operators	X	X	X	X	X	Close collaboration between MOH and partner ministries

Strategic sub-axis 1.4: Essential family practices, family planning, promotion of adolescent health, and post-abortion care										
Specific objective HP4 1 34: By 2020, bring 25% families to adopt essential family practices including family planning.		Tracer indicators	Baseline	Source	Period					Success requirements
					2016	2017	2018	2019	2020	
		Modern contraceptive prevalence rate in women of childbearing age	16%	Calculated from MICS 5 data	22%	24%	25%	27%	30%	
		Propotion of unmet needs in FP	18%	MICS 5	17%	16%	16%	15%	14%	
Implementation strategy	Interventions	Tracer indicators	Managers	Implementing partners	2016	2017	2018	2019	2020	Success requirements
1.4.1: Improvement of public policies on FP[(b)]										
1.4.2: Improvement of FP services requirements[(b)]										
1.4.3: Improvement of FP service provision and use	1.4.3.1.Extend and ensure the availability of FP service provision in HFs and at the	Average number of stock-outs for essential tracer drugs in HFs (FOR THE RECORD)	DSF	DPS, RDPH, SSD, DSF, CENAME, DPML,	X	X	X	X	X	Information and rational supply procedures are mastered in the

	community level (modern contraceptive, FP equipment, etc.)			MINJEC, MINESEC, MINESUP, CSO						chain
1.4.4: Strengthening the monitoring and coordination of RH/FP interventions[(b)]										
1.4.5: Strengthening of other health promoting essential family practices	1.4.5.1.Develop information sharing mechanisms on EFP in the community (discussion groups, home visits, etc.)	Proportion of DHs having a technical personnel trained in EFP[(a)]	MOH (DSF)	MOH (DPS, DRH,RDPH, SSD, HF)		X			X	
	1.4.5.2.Strengthen health education and C4D in families, prisons and schools, so as to help individuals address their health issues together (population mobilization)	Percentage of households implementing at least 7 out of 15 essential family practices[(a)]	DPS	MINCOM, DSF, RDPH, HD, SD, Community stakeholders	X	X	X	X	X	Availability of financial resources

STRATEGIC AXIS 2: DISEASE PREVENTION									
	Core problem of the component: Morbidity and mortality from communicable and non-communicable diseases remain high in Cameroon								
	Strategic objective: By 2020, reduce premature mortality due to preventable diseases								
	Tracer indicators:								
	Prevalence of hypertension in adults aged 15 years and above in urban areas								
Strategic sub-axis 2.1: Prevention of communicable diseases									
Specific objective PREV1 2 1: reduce by 10% the incidence/prevalence of the main communicable diseases (HIV, malaria and tuberculosis) and eliminate some NTDs (lymphatic filariasis and HAT).	Tracer indicators	Baseline	Source	Period					Success requirements
				2016	2017	2018	2019	2020	
	Incidence of HIV	2.4‰	Country profile of HIV estimates in Cameroon 2010-2020	2.3‰	2.2 ‰	2.1 ‰	2.0 ‰	1.9 ‰	
	Prevalence of HIV	4.3%	EDS-MICS 2011.	4.2%	4.1 %	4.1%	4.0%	3.9%	
	Prevalence of Viral Hepatitis B	11.9%	CPC 2015	11.5%	11.0 %	10.5 %	10.3 %	10.0 %	
	Coverage of preventive chemotherapy for onchocerciasis (CDTI) coverage)	80%	2015 activity report for NTDs	81%	82%	83%	84%	85%	
	Incidence of TPM+tuberculosis	117 new cases per 100,000 inhabitants in 2015	Cameroon National Coordination Body Single Concept note TB/HIV 2016-2017	102.5	88	73.5	58.5	44.5	

Implementation strategy	Interventions	Tracer indicators	Services in charge	Implementing partners	2016	2017	2018	2019	2020	Success requirements
2.1.1: Strengthening of coordination and integration of interventions on the prevention of communicable diseases	2.1.1.1.Strengthening technical skills of institutional and community stakeholders (CBO, CHW, RLA leaders) for the integrated prevention of the most frequent communicable diseases (HIV, STI, viral hepatitis, malaria, cholera and Ebola)	Proportion of HDs with at least 3 polyvalent CHWs trained for the provision of quality community MHP (health promotion, disease prevention and case management) (FOR THE RECORD)	MOH (DRH)	MOH (DPS, DLMEP, RDPH, HD), MINATD, CSO/NGO, Partners, RLA		X		X		
	2.1.1.2.Develop and implement an integrated strategy for communication which takes into account the aspects of health promotion and disease prevention.	Percentage of HDs having carried out and documented at least 75% of IEC/C4D activities included in their Integrated Communication Plan	MOH (DPS)	MINCOM, MINSANTE (DLMEP, RDPH, HD, CNLS and other priority programmes), community stakeholders	X	X	X	X	X	
2.1.2: Improve the prevention of HIV/AIDS, tuberculosis, STIs and viral hepatitis mainly for the most vulnerable groups	2.1.2.1. Regular supply of HFs with prevention inputs for communicable diseases	Average number of essential tracer drugs stock-outs in HFs (FOR THE RECORD)	MOH (DPML)	MOH (CENAME, RDPH, RFHP, HD, HF), CSO/CBO	X	X	X	X	X	

	2.1.2.2.Organizing communication/counseling/screening activities for the prevention of the main communicable diseases within the general population and in special populations (prisons, secondary schools, universities, companies, etc.).	Percentage of inmates aged 15-49 years having screened for HIV in the last 12 months and who collected their results								
		Percentage of people aged 15-49 years having screened for HIV in the last 12 months and collected their results	MOH (DPS)	MOH (DLMEP, RDPH, HD), MINATD, MINESEC, MINESUP, MINJUSTICE, CSO/NGO, NACC	X	X	X	X	X	Availability of material and financial resources
2.1.3 Strengthening of Malaria prevention	2.1.3.1.Purchase and distribute LLINs	Percentage of households having a LLIN for two people	MOH (DLMEP)	MOH (DPS, RDPH, DOSTS, DCOOP, PNLP), MINFI, CSO/NGO, TFP	X				X	Availability of material and financial resources
	2.1.3.2.Organise preventive treatment campaigns for seasonal malaria and NTDs	Proportion of children below 5 years in the North and Far-North having received a preventive treatment for seasonal malaria	MOH (DLMEP)	MOH (DPS, RDPH, DOSTS, DCOOP, PNLP), MINFI, CSO/NGO, TFP	X	X	X	X	X	Availability of material and financial resources
2.1.4: Strengthening the prevention of NTDs and other communicable diseases[(b)]										

Strategic sub-axis 2.2: EPDs and public health events, surveillance and response to epidemic-prone diseases, zoonoses and public health events										
Specific objective PREV2 2.2: By 2020, reduce in at least 50% of districts the risks of occurrence of major public health events and epidemic-prone diseases including zoonoses.		**Tracer indicators**	Baseline	Source	Period					Success requirements
					2016	2017	2018	2019	2020	
		Percentage of HDs with measles outbreak and having organized response according to national guidelines	34%	DLMEP Report 2014	70%	80%	90%	95%	95%	
		Percentage of measles outbreak notified and investigated	50%	DLMEP Report 2014	70%	80%	90%	95%	95%	
Implementation strategy	Interventions	Tracer indicators	Services in charge	Implementing partners	2016	2017	2018	2019	2020	Success requirements
2.2.1 Strengthening of the epidemiological surveillance system	2.2.1.1.Build institutional capacities for CERPLE (Regional Epidemics Prevention and Control Centres) for the coordination of emergencies at the regional level	Percentage of CERPLE with minimal operational capacities needed for surveillance and response to EPDs/public health events[(a)]	MOH (DLMEP)	MOH (RDPH, DRH, DSF), dialogue structure, partners		X			X	
	2.2.1.2.Develop and coordinate a national functional laboratory network for the surveillance of EPDs and other diseases	Percentage of RDPH having reference laboratories operating as a	MOH (DPML)	MOH (RDPH, HD, LNSP), TFP	X	X	X	X	X	

		network for the surveillance of EPDs								
	2.2.1.3.Update health risk map in RDPH/HDs (HDs at risk of epidemics and health emergency) every year and develop annual operational plans for appropriate responses to identified health risks.	Proportion of RDPH that updated annual map of epidemics risks and subsequent operational response plans	MOH (DLMEP)	MINATD, MINCOM, MOH (RDPH, NPHO, CIS)	X	X	X	X	X	
2.2.2: Improving the prevention of vaccine preventable diseases	2.2.2.1.Organise intensified additional immunization activities and campaigns (Immunization against Polio, deworming of children from 12 to 59 months during MCHNAW) nationally.	Percentage of HDs that organized immunization campaigns and intensified additional activities	MOH (DSF)	MOH (EPI, DPS, SDV, RDPH, HD, HF, CHW), TFP, CSO/CBO	X	X	X	X	X	
	2.2.2.2. Strengthen the provision of service for routine immunization (purchase of vaccines, strengthening of relationship with communities, micro-planning, outreach strategies) FOR THE RECORD	Percentage of targeted HDs that organized immunization campaigns and intensified additional activities (FOR THE RECORD)	MOH (DSF)	MOH (EPI, SDV, RDPH, HD, HF, CHW), community structure	X	X	X	X	X	

2.2.3 : Improving the prevention of other EPDs not included in the EPI[(b)]										
2.2.4 Strengthening preparedness and response to epidemics and major public health events	2.2.4.1.Ensure ongoing supply of HDs with inputs needed for response against epidemics and potential emerging diseases.	Percentage of HDs with inputs for response against other EPDs not included in the EPI over the last three months	MOH (DPML)	MOH (DLMEP, RDPH, DHS, HF, CHW, CENAME), partners, CSO/CBO	X	X	X	X	X	Availability of financial resources, and control of the influx of refugee in border regions
	2.2.4.2.Strengthen the mechanism of Integrated Disease Surveillance and Response (IDSR) to EPDs	Percentage of HDs affected by measles epidemics and that organized response according to national guidelines (FOR THE RECORD)	MOH (DLMEP)	MOH (DPS, DPML, RDPH, SSD, HF, CHW, CENAME), TFP, CSO/CBO	X	X	X	X	X	Resources are mobilized for case detection and response

Strategic sub-axis 2.3: Maternal, Newborn, Child and Adolescent Health and PMTCT									
Specific objective PREV3 2.3: By 2020, increase by at least 70% the coverage of high-impact prevention interventions for the mother, newborn and child targets in at least 60% of HDs	Tracer indicators	Baseline	Source	Period					Success requirements
				2016	2017	2018	2019	2020	
	Immunization coverage with the reference antigen (Penta3)	84.50%	MOH EPI Report 2015	85%	86%	88%	90%	92%	
	Coverage in ANC 1	82.8%	MICS5	83%	83%	84%	84.5 %	85%	
	Immunization coverage in measles /rubella vaccine	80%	MICS5	81%	82%	83%	85%	86%	
	Percentage of HIV positive pregnant women on ART	84.4%	NACC Report 2015	85%	86%	86.5 %	87%	88%	
	% of children aged 0-5 years sleeping under a LLIN	54.80%	MICS 5	85%	86%	88%	89%	90%	
	Mother-to-child transmission rate of HIV (percentage of HIV-exposed children)	6.5%	NACC Report 2014	6%	5.5%	5%	4.5%	4%	
	Percentage of newborn with low birth weight (below 2.500 grammes)	9%	MICS5	7%	7%	6%	6%	6%	
	Percentage of pregnant women having received at least 3 doses of IPT during pregnancy (% IPT3)	26%	MICS 5	35%	40%	45%	50%	55%	

Implementation strategy	Interventions	Tracer Indicators	Services in charge	Implementing partners	2016	2017	2018	2019	2020	Success requirements
2.3.1 Building institutional (HF) and community capacities in the area of RMNCAH	2.3.1.1.Ensure the permanent availability in HFs of inputs for effective implementation of high-impact interventions on the Mother, Newborn, Child and Adolescent targets (early HIV screening, PCR, equipment for maternity wards, drugs for IPT, PMTCT, HIV, vaccines, etc.	Average number of essential tracer drugs stock-outs in HFs (FOR THE RECORD)	MOH (DPML)	MOH (DLMEP, CENAME, RHPF, DSF, RDPH,SSD, HF), TFP, NGO		X	X	X	X	
	2.3.1.2.Building capacities for institution and community providers in the targeted HDs for a quality service provision in the following areas: PTMCT, ANC, PNC, PAC	Percentage of HDs providing EmONC according to standards (9 functions) [(a)]	MOH (DSF)	MOH (DLMEP, DEP, RDPH, HD, HF, RHPF, CENAME), NGO	X	X	X	X	X	Ambulatory care centres are developed and operational enough

2.3.2: Improving the provision of RMNCAH healthcare and services	2.3.2.1.Gradually extend the provision of RMNCAH healthcare and services (outreach strategy, telemedicine, subsidy or free care for some groups, etc.) at the national level while improving the quality of care provided (good reception, use of normative documents)	Delivery rates in a health facility	MOH (DSF)	MOH (DLMEP, DEP, RDPH, HD, HF, RHPF, CENAME), NGO	X	X	X	X	X	Availability of financial resources
		Percentage of HFs implementing Option B+	MOH (NACC)	MOH (DLMEP), TFP						
2.3.3: Strengthening of integrated communication at all levels for population mobilization around the RMNCAH targets	2.3.3.1.Carry on C4D (advocacy, social mobilization, CBC and community supervision) to increase the use of healthcare and services provided in HFs and by CHWs	Percentage of children that came for PNC within 48 hours following birth.	MOH (DSF)	MOH (DLMEP), TFP						
						X	X	X	X	
Strategic sub-axis 2.4: Prevention of non communicable diseases										
Specific objective PREV 42.4: By 2020, reduce by at least 5% the prevalence of the main non communicable diseases (diabetes and Hypertension)		Tracer indicators	Baseline	Source	Period					Success requirements
					2016	2017	2018	2019	2020	
		Prevalence of hypertension in people aged 15 and above in urban areas (FOR THE RECORD)	29.7%	Kingue et al. 2015	29%	28.5 %	28%	27.5 %	27%	
		Prevalence of Type 2 Diabetes in people aged at least 18 years in urban areas	6.60%	Kingue et al. 2015	6.60%	6.60 %	6.5%	6%	5.8%	

Implementation strategy	Interventions	Tracer indicators	Service in charge	Implementing partners	2016	2017	2018	2019	2020	Success requirements
2.4.1: Strengthening the coordination and integration of interventions on the prevention of NTDs [(b)]										
2.4.2 Promoting interventions that enable to reduce modifiable risk factors of non-communicable diseases: smoking, poor feeding, sedentary lifestyle and alcohol abuse	2.4.2.1. Strengthen the mechanism prohibiting the sales of illicit or smuggled food products	Annual number of seizures made for smuggled food products	MINCOMMERCE	MINCOMMERCE, MINADER, ANOR	X	X	X	X	X	
2.4.3 Promoting research to reduce the incidence of NTDs[(b)]										
2.4.4 Sensitization of the population non communicable diseases and encouraging prevention	2.4.4.1.Develop a strategy for integrated communication for the prevention of non communicable diseases (FOR THE RECORD)	Percentage of HDs with an integrated communication plan for health promotion and disease prevention (FOR THE RECORD)	MOH (DPS)	MOH (DLMEP, DROS, RDPH, HD, HF), NIS, TFP, MINCOM	X	X	X	X	X	
	2.4.4.2.Organize at least one annual campaign at the regional level for the prevention and screening of NTDs (Hypertension, diabetes, cancers, etc.)	2.4.4.2.Organize at least one annual campaign at the regional level for the prevention and screening of NTDs (Hypertension, diabetes, cancers, etc.)	MOH (DLMEP)	MOH (DOSTS, DPS, RDPH, SSD, HF, Priority programmes), TFP	X	X	X	X	X	

2.4.5 : Improving the prevention of oral diseases, visual and hearing impairments[b]										
2.4.6 Strengthening the prevention of sickle-cell anemia, other genetic and degenerative diseases	2.4.6.1.Strengthen the availability of service provision for the prevention of genetic diseases (sickle cell anemia) at the operational level	Percentage of RDPH that organized at least one screening and sensitization campaign of sickle cell anemia	MOH (DLMEP)	MOH (RDPH, HD, HF, dialogue structure), community stakeholders	X	X	X	X	X	
2.4.7 : Strengthening the prevention of mental disorders, epilepsy and other neurological disorders[b]										
2.4.8: Strengthening the prevention of diabetes, hypertension, cardiovascular and kidney diseases[b]										
2.4.9: Strengthening the prevention of cancer, asthma and other chronic respiratory diseases[b]										
2.4.10:Strengthening the prevention of rare diseases[b]										

STRATEGIC AXIS 3: CASE MANAGEMENT										
Core problem of the component:	The quality of diagnosis and curative case management is inadequate.									
Strategic objective:	By 2020, reduce the overall mortality and lethality in health facilities and the community									
Tracer indicators:	- Peri-operative mortality rate in 3rd and 4th category hospitals									
	- Specific mortality rate for malaria in children below 5 years of age									
	- Intra-hospital direct obstetrical lethality rate									
	- Maternal mortality rate									
	- Newborn mortality rate									
	- Child mortality rate									
	- Neonatal and child mortality rate									
Strategic sub-axis 3.1: Curative management of communicable and non communicable diseases										
Specific objective CM 1 3.1: By 2020, ensure a curative management according to standards of the main communicable and non-communicable diseases as well as their complications in at least 30% of health facilities.		Tracer indicators	Baseline	Source	Period					Success requirements
					2016	2017	2018	2019	2020	
		Treatment success rate of smear-positive TB patients	82%	2013 Cohort, NTBCP Report	83%	84%	85%	86%	87%	Treatment success rate of TPB+
		Percentage of cases of Buruli ulcer cured without any complications	80%	activity report on NTD	82%	84%	86%	88%	90%	
Implementation strategy	Interventions	Tracer indicators	Service in charge	Implementing partners	2016	2017	2018	2019	2020	Success requirements
3.1.1.Improving the quality of healthcare and services in HFs in their 8 aspects, focusing on the reception of patients	3.1.1.1. Sensitize healthcare and service providers on the importance of good reception	Satisfaction index from beneficiaries of health services and care	MOH and NIS	MOH (DOSTS, RDPH, HF, Comm. Unit., CONAC, CONSUPE, DGRE	X	X	X	X	X	

3.1.2 Improving the diagnosis and curative case management of HIV/AIDS, TB, STIs and viral Hepatitis	3.1.2.1.Ensure the availability of inputs for the diagnosis and case management of communicable diseases (HIV, TB, STIs and viral Hepatitis)	Average number of essential tracer drugs stock-outs in HFs (FOR THE RECORD)	DPML	DLMEP, RDPH, NTBCP, NACC, CAPR, DHS, HF, CHW	X	X	X	X	X	Anticipation actions taken for the potential withdrawal of some TFPs committed in the purchase of drugs especially ARV, vaccines, RH products, blood products and their derivatives.
3.1.3. Improving the diagnosis and case management of malaria and main causes of fever (Dengue, Typhoid, Flu...)	3.1.3.1. Systematic use of operational procedures and protocols approved for the diagnosis and case management of malaria	Percentage of 4th, 5th and 6th category targeted hospitals where 75% of technical staff apply protocols for case management of communicable diseases (Malaria, AIDS, TB)	MOH (DLMEP)	MOH (DOSTS, IGSMP, DPS, RDPH, DHS, Priority programmes, HF)		X	X	X	X	
3.1.4: Improving the diagnosis and case management of Neglected Tropical Diseases	3.1.4.1. Systematic use of operational procedures and protocols approved for the diagnosis and treatment of NTDs	Percentage of targeted DHs where 75% of technical staff apply protocols for the management of main NTDs (Buruli Ulcer, Leprosy)	MOH (DLMEP)	MOH (DOSTS, IGSMP, DPS, RDPH, DHS, Priority programmes, HF)		X	X	X	X	
3.1.5: Improving the diagnosis and case management of Non Communicable Diseases	3.1.5.1.Decentralize the management of chronic diseases (Hypertension, stroke, diabetes, etc.) through the creation of ambulatory medical	% of targeted MHCs where 75% of technical staff apply guidelines for task shifting during the management of hypertension and	MOH (DLMEP)	MOH (DSF, DPML, IHC, MHC, DH, HD), Priority programmes, community	X	X	X	X	X	

	centres and task shifting at the devolved level	diabetes		stakeholders						
	3.1.5.2.Organize care activities/campaigns out of HFs for populations living in difficult-to-access areas	Hypertension/diabetes screening rate recorded during World Days for the fight against these pathologies	MOH (DOSTS)	MOH (DLMEP, RDPH, DHS, Priority programmes, HF, CHW), CSO	X	X	X	X	X	The process of task shifting at the operational level is effective in the health system
3.1.6: Improving the comprehensive (holistic) case management at all levels of the health pyramid	3.1.6.1 Develop and ensure the use of simplified guides and protocols for the comprehensive management of diseases	Percentage of 4th, 5th and 6th category targeted hospitals where 75% of technical staff apply protocols for case management of communicable diseases (Malaria, AIDS, TB) (FOR THE RECORD)	MOH (DOSTS)	MOH (DLMEP, RDPH, DHS, HF, CHW), CSO	X	X	X	X	X	
		% of targeted MHCs and DHs where 75% of technical staff use management standards/protocols of main non communicable diseases (diabetes, mental health, Hypertension)								

	3.1.6.2. Sensitize care providers on the patient-centered approach (holistic case management)	Satisfaction index for the beneficiaries of health services and care (FOR THE RECORD)	MOH (General Inspectorates) and NIS	MOH (DOSTS, RDPH, HF, Communication. Unit., CONAC, CONSUPE, DGRE	X	X	X	X	X	
	3.1.6.3.Ensure hospital management of children below 5 years of age according to standards	% of targeted IHCs and MHCs that managed at least 80% of children below 5 years of age suffering from diarrhoea/ARIs with IMCI approach	MOH (DLMEP)	MOH (DOSTS, DSF, HF, RDPH, HD)	X	X	X	X	X	
	3.1.6.4.Develop and implement palliative care protocols	% of DHs and RHs using approved palliative care protocols	MOH (DOSTS)	MOH (DLMEP, NCaCP, HF, RDPH, HD)	X	X	X	X	X	
Strategic sub-axis 3.2: Maternal, newborn, child and adolescent conditions										
Specific objective CM2.3.2: By 2020, ensure an overall management according to standards, of the maternal, newborn, child and adolescent health issues at the community level and in at least 60% of health facilities.		Tracer indicators	Baseline	Source	Period					Success requirements
					2016	2017	2018	2019	2020	
		Percentage of newborn who came for postnatal care within 48 hours following birth	68.5%	MICS5	69%	69.5 %	70%	72.5 %	75%	Improving technical platforms, reception and accessibility to care
		Delivery rates in a health facility	61.3%	MICS5	62%	64%	66%	68%	70%	
		Percentage of obstetric fistula cases repaired	ND		Increase by 30% over the period					Improving financial accessiblity to care
		Rates of caesarian sections	2.4%	CEmONC Survey 2015	3.5%	5%	6%	7%	8%	

Implementation strategy		Tracer Indicators	Service in charge	Implementing partners	2016	2017	2018	2019	2020	Success requirements
3.2.1 Improving financial and cultural accessibility to RMNCAH care and services by targeting as priority the most vulnerable populations and the most underprivileged districts	3.2.1.1.Strengthening the implementation of ongoing strategies aimed at improving geographical, cultural and financial accessibility of RMNCAH targets to quality services and care	Percentage of IHCs that achieved at least half of the planned outreach/simplified strategies	MOH (DSF)	MOH (DLMEP, RDPH, HD HF)	X	X	X	X	X	
3.2.2. Improving geographical availability and accessibility to services related to the prevention of vertical transmission of HIV and Hepatitis B from mother to child (scaling up PMTCT in the overall functional HFs) [(b)]										
3.2.3 Improving the integrated management of child illnesses (Clinical and community IMCI)	3.2.3.1.Provide children below 5 years of age with healthcare and services while using IMCI approach	Percentage of DHs with at least 1 personnel trained in clinical IMCI	MOH (DSF)	MOH (DLMEP, RDPH, HF, CHW), CSO/CBO, MINJUSTICE, DGSN, MINDEF	X	X	X	X	X	Availability of financial resources for the training of HRH in IMCI
3.2.4 : Improving the availability of quality RMNCAH service and care provision packages	3.2.4.1.Ensure the proper use at all levels of normative documents and operational procedures for the management of mother and child health.	Percentage of targeted MHCs and DHs where 75% of technical personnel apply approved protocols for the management of mother and child health	MOH (DOSTS)	MOH (DSF, IGSMP)	X	X	X	X	X	

	3.2.4.2 Strengthening service provision for the proper management of adolescent health in district hospitals.	Percentage of DHs that have user-friendly services for the management of adolescent health.	MOH (DSF)	MOH (DOSTS, HF), MINPROFF, MINJEC, MINAS		X	X	X	X	
	3.2.4.3.Ensure in HDs the availability of high-impact intervention packages on the maternal, newborn and child health (BEmONC, EmONC, CEmOC, PAC...)	Percentage of children born of HIV positive mothers on ART	MOH (DSF)	MOH (DRH, DLMEP, DPML, NACC)	X	X	X	X	X	
		Percentage of HDs providing at least 75% of CHP interventions (FOR THE RECORD)								
3.2.5 Building of institutional capacities in RMNCAH in HFs and the community[(b)]										
3.2.6: Strengthening integrated communication at all levels for population mobilization around maternal, newborn and child health[(b)].										

Strategic sub-axis 3.3: Emergencies and public health events										
Specific objective Case management 3.3.3: By 2020, ensure the management of medical and surgical emergencies and public health events according to standard operating procedures (SOPs) in at least 60% of HDs.		Tracer indicators	Baseline	Source	Period					Success requirements
					2016	2017	2018	2019	2020	
		Peri-operative mortality in 2nd, 3rd and 4th category hospitals (FOR THE RECORD)	ND		Reduction by 20% by the end of the period					Basic study, stakeholder commitment (TFP, MOH, community stakeholders, private sector) to the financing of NHDP interventions
		Percentage of targeted DHs that managed at least 80% of medical and surgical emergency cases according to SOPs in the 6 last months	ND		13%	40%	53%	100%	100%	
Implementation strategy	Interventions	Tracer indicators	Service in charge	Implementing partners	2016	2017	2018	2019	2020	Success requirements
3.3.1: Strengthening multi-sector coordination in the management of emergencies and public health events	3.3.1.1.Establish at all levels a support funds for the coordination of the management of emergencies and public health events (FOR THE RECORD see CERPLE)	Percentage of CERPLE having minimal operational capacities needed for the surveillance of EPDs/public health events and response	MOH (DLMEP)	MOH (DCOOP, DLMEP, RDPH, HD), other ministries, TFP	X	X	X	X	X	
	3.3.1.2.Ensure the functioning of the National Emergency Operation Centre for effective	Availability of a budgeted national plan for the management of public health events and annual reports of	MOH (DOSTS/DLMEP)	MOH (RDPH, HD), MINATD, other ministries, TFP	X	X	X	X	X	

	management and coordination of field activities	activities related to the implementation of the plan								
			MOH (DLMEP)	DLMEP, MINATD, other ministries, TFP						
3.3.2: Strengthening the provisional management process of resources for effective management of medical and surgical emergency cases and public health events	3.3.2.1 Regularly supply health structures with inputs for the management of medical and surgical emergencies after assessment of their institutional, consumption and management capacities	Percentage of DHs and RHs which have drugs/consumables for effective management of common medical and surgical emergencies and EPDs	DPML	DOSTS, DLMEP, RFHP, MINATD, other ministries, TFP	X	X	X	X	X	
	3.3.2.2.Strengthening the functioning of the response mechanism to emergencies (regular simulation of emergency situations, staffing of investigation and response teams)	Proportion of RDPH having made simulation of emergency situation yearly	MINATD (DPC)	MOH (DOSTS, NPHO, DEP, HIU, DROS, DLMEP, RDPH), partner ministries	X	X	X	X	X	Resources are mobilised for simulation exercises
	3.3.2.3.Establish multi-sector Rapid Intervention and Response Teams (RIRTs) in the 10 regions	Percentage of RDPH with Rapid Intervention and Response Teams (RIRTs)	MOH (DLMEP/DOSTS)	MOH (NPHO, DEP, HIU, DROS, RDPH), partner ministries	X	X	X	X	X	

3.3.3 Improving the diagnosis and curative case management of emergencies and public health events	3.3.3.1.Ensure pre-hospital management (first aid) of emergency cases with the full participation of the community	Percentage of HDs with community teams trained in first aid (FOR THE RECORD)	MOH (DLMEP)	MOH (DOSTS, RDPH, HD, HF), partner ministries, Red-Cross		X	X	X	X	
	3.3.3.2.Build financial, infrastructural, and technological capacities of CERPLE, the National Emergency Operation Centre, and border health posts on rapid and effective response in case of epidemics and other public health emergencies (FOR THE RECORD)	Proportion of CERPLE with minimal operational capacities needed for the surveillance of EPDs/public health events and response[(a)] (FOR THE RECORD)	MOH (DLMEP)	MOH (DRFP, DOSTS, HF), partner ministries, Red-Cross	X		X		X	Availability of financial resources
	3.3.3.3.Build HHR technical capacities of DHs/ RHs/ border health posts and community actors for an effective response to epidemics or other public health emergencies	Proportion of targeted DHs that managed at least 80% of medical and surgical emergencies cases according to SOPs during the last 6 months (FOR THE RECORD)	MINATD/MOH	MOH, MINDEF , UNHCR , MINCOM, MINJUSTICE, MINAS, MINPROFF, DGSN, TFPs		X	X	X	X	An institutional and community health human resources needs assessment is carried out and a substantial allocation of resources is effective.

Strategic sub axis 3.4 : Management of Disability										
Specific objective CM 43.4: Reduce by at least 10% the proportion of the population with at least one correctable disability by 2020.		Tracer indicators	Baseline	Source	Period					Success requirements
					2016	2017	2018	2019	2020	
		Proportion of cataract patients and who recovered their sight after surgery	ND		increase by 50% by the end of the period					
Implementation strategy	Interventions	Tracer indicators	Service in charge	Implementing partners	2016	2017	2018	2019	2020	Success requirements
3.4.1 : Drafting an integrated and coordinated policy for the management of disability, including mental disorder	3.4.1.1.Ensure disability management in accordance with updated guidelines and standards	Proportion of RHs and CHs that ensured medical management according to the SOPs of at least 70% of correctable physical disability cases	MOH (DLMEP)	MOH (RDPHs, HDs, HFs), MINAS, MINFI, learned societies, TFPs	X	X	X	X	X	
		Proportion of DHs with an operational physiotherapy unit								
3.4.2 : Decentralizing the interventions of disability management	3.4.2.1.Strengthen institutional capacities and those of stakeholders in the prevention and management of correctable disability	Proportion of RDPH that organized at least one annual cataract surgery campaign	MOH (DLMEP)	M (DPS, HRD, RDPH), MINAS, MINPROFF	X		X		X	The management of disability is valued in promoting and motivating the staff

STRATEGIC AXIS 4 : STRENGTHENING THE HEALTH SYSTEM										
	Core problem of the component: Low development of health system pillars									
	Strategic objective: Increase institutional capacities of health facilities for equitable access of populations to quality health care and services									
	Tracer Indicators:									
	Global index on the availability of healthcare and services									
Strategic sub axis 4.1 : Health Financing										
Specific objective SHS14.1: Reduce by at least 10% out-of-pocket payments of households through an equitable and sustainable policy by 2020		Tracer indicators	Baseline	Source	Period					Success requirements
					2016	2017	2018	2019	2020	
		% of health expenditure borne by households	70.6 %	NIS - National Health Accounts 2012	69%	67%	65%	63%	60%	Implementation of viable prepayment mechanisms
		Proportion of population covered by a health risk sharing mechanism	3%	DHS-MICS 2011	6%	7%	8%	9%	10%	
Implementation strategy	Interventions	Tracer Indicators	Service in charge	Implementing partners	2016	2017	2018	2019	2020	Success requirements
4.1.1 Developing health risk sharing mechanisms	4.1.1.1.Develop and implement a national financing strategy – oriented towards UHC	Proportion of the national budget allocated to the health sector	MOH(DRFP)	MOH (DPS,RDPH), MINTSS, MINAS, MINPROF, CDT, TFPs, MINEPAT, MINFI	X	X	X	X	X	The Government is engaged in reform

	4.1.1.2.Reinforce financial risk protection mechanisms to improve access to health care (health insurance, social security, healthcare vouchers, mutual health organizations, etc)	Proportion of the population covered by a disease risk sharing mechanism (FOR THE RECORD)	MOH(DPS)	MOH (DRFP,RDPH), MINTSS, MINAS, MINPROF, CDT, TFPs, MINEPAT, MINFI	X	X	X	X	X	
4.1.2 : Rationalizing and strengthening institutional mechanisms of health financing	4.1.2.1. Produce annually and ensure the availability of health financing analysis tools	Availability of an approved financial information analysis report	MOH(DRFP)	MOH (HIU,RDPH), TFPs, MINEPAT, MINFI	X	X	X	X	X	
4.1.3 Strengthening financial resource mobilisation	4.1.3.1.Strengthen advocacy for increased budgetary allocation of the sector	Proportion of the national budget allocated to the health sector (FOR THE RECORD)	MOH (DRFP)	MOH (DCOOP, HFs, RDPH), MINEPAT, MINFI	X	X	X	X	X	
4.1.4: Reinforcing autonomy in the management of financial resources at the operational level	4.1.4.1.Draft framework laws that give more autonomy in the management of revenues allocated to HFs at the decentralized level in order to match funding received and problems identified in HFs	Availability of a framework instrument that grants autonomy in the management of revenues allocated to HFs at the decentralized level	MOH (DRFP)	MOH (DAJC, RDPH) TFPs, MINEPAT, MINFI		X				
	4.1.4.2. Annually adopt a distribution key for the MOH budget taking into account NHDP priorities	Availability of a report validating the distribution key of the MOH budget in the various programmes	MOH (DRFP)	MOH (RDPH, DEP, STCP-HSS), RLAs	X	X	X	X	X	

4.1.5: Strengthening the performance and efficiency of the health system	4.1.5.1. Gradually extend the performance purchasing system taking into account the results of the PBF impact assessment on the health system and services	Proportion of Health Districts that integrated the Performance-based funding approach (PBF)	MOH (DRFP)	MOH (SG, DCOOP, RDPH, HDs, HFs), MINTSS, MINAS, MINPROFF, RLAs, TFPs, MINEPAT,MINFI	X	X	X	X	X	Availability of up-to-date texts on how to use revenue allocated and other legal texts necessary for scaling up PBF
	4.1.5.2.Preparing the National Health Accounts at regular intervals	Availability of a report on the National Health Accounts	MOH (HIU)	MOH (DRFP,RDPH), NIS, TFPs, MINEPAT,MINFI		X		X		
Strategic sub axis 4.2 : Healthcare and service provision										
Specific Objective SHS 2 4.2: By 2027, ensure the harmonious development of infrastructure, equipment and the availability of healthcare and service packages according to standards in at least 40% of category 3, 4, 5 and 6 health facilities		Tracer Indicators	Baseline	Source	Period					Success requirements
					2016	2017	2018	2019	2020	
		Proportion of developed HDs[(a)]	7%	MOH speech at the NA 2015 budget			40%		80%	Resources are mobilized and available to finance planned interventions in the NHDP

Implementation strategy	Interventions	Tracer indicators	Service in charge	Implementing partners	2016	2017	2018	2019	2020	Success requirements
4.2.1: Building institutional capacities of HDs focused on the development of HFs for a better case management at all levels of the health system	4.2.1.1. Update and implement hospital reforms	Availability of updated instruments governing the organization and functioning of public HFs and case management (FOR THE RECORD)			X	X	X	X	X	
4.2.2 : Improving provision of infrastructure (construction/rehabilitation/extension of health facilities based on standards and equipment)	4.2.2.1.Develop and implement a validated development plan for health infrastructure in the health sector to ensure availability of quality PHC at the operational level and priority specialized care	Availability of a national infrastructure development plan (construction/rehabilitation/ extension, equipment and maintenance)	MOH (DEP)/RLAs	MOH (DRFP,DOSTS, RDPH, HFs), TFPs, MINTP, MINATD	X	X	X	X	X	
		Proportion of the population living within a radius of less than 5 km from a health facility (IHC, MHC and HD)								
		Proportion of IHCs, MHCs and HDs constructed or rehabilitated according to standards and in accordance with the infrastructure development plan								
	4.2.2.1.Ensure maintenance of infrastructures and equipment	Proportion of HDs that have a multi-purpose biomedical maintenance agent	MOH (HRD)	MOH (DRFP, RDPH), MINESEC, MINESUP	X	X	X	X	X	

		Proportion of RDPH that signed biomedical, electricity/refrigeration, plumbing contracts with maintenance companies	MOH (DEP)	MOH (RDPH, HDs), CSOs						
4.2.3 Increasing the number of equipment in health facilities based on standards	4.2.3.1. Develop and implement a coherent plan for equipping Health facilities at all levels according to priority needs	Proportion of HDs equipped based on standards and according to the National health infrastructures development plan	MOH (DEP/DOSTS)	MOH (DEP, DRFP, RDPH, HFs), TFPs, MINTP, RLAs		X	X	X	X	
	4.2.3.2.Construct, equip and make functional the National Blood Transfusion Centres and approved Specialized Centres at the devolved level and ensure the permanent availability of blood products	Proportion of RDPH with an approved regional blood transfusion structure	MOH (DEP/DOSTS/ DPML)	MOH (DRFP,HRD, RDPH, NBTP, HFs), TFPs, MINTP		X	X	X	X	
4.2.4 : Strengthening community action and providing the community with inputs based on standards and priorities[(b)]										
4.2.5 : Setting up a quality assurance system for healthcare and services [(b)]										
4.2.6 Improving the availability of quality health care and service packages in health facilities at all levels:	4.2.6.1.Gradually increase the availability/accessibility of MHP/CHP in HFs at the operational level	Proportion of DHs providing at least 75% of the interventions of the CHP (FOR THE RECORD)	MOH (DOSTS)	MOH (DRFP, RDPH, HFs), TFPs, MINTP	X	X	X	X	X	

development of health districts and centres of excellence		Proportion of public IHCs and MHCs delivering at least 80% of MHP interventions	MOH (DOSTS)	MOH (DRFP, RDPH, HFs)		X		X		
	4.2.6.2.Provide schools and universities with first aid kits	Proportion of schools and universities health centres with a first aid kit	MINEDUB/MINESEC/MINESUP	MOH (DLMEP, DOSTS)		X	X	X	X	
	4.2.6.3.Evaluate and classify HDs according to their level of viability[(a)]	Proportion of HDs whose level of development was assessed	MOH (DOSTS)	MOH (DRFP, RDPH, HFs), TFPs		X		X		
4.2.7. Strengthening the referral/counter referral system[(b)]										

Strategic sub axis 4.3 : Drugs and other pharmaceutical products										
Specific objective SHS 3 4.3: By 2020, increase by 25% the availability and use of quality drugs and pharmaceutical products in all HDs		Tracer Indicators	Baseline	Source	Period					Success requirements
					2016	2017	2018	2019	2020	
		Proportion of blood transfusion needs met	18%	2015 NBTP Activity report	20%	30%	40%	50%	60%	
		Average number of stock-out days of essential tracer drug in health facilities	6 Days	DPML, MOH 2015 Report	6 Days	5 Days	4 Days	3 Days	2 Days	
Implementation strategy	Interventions	Tracer indicators	Service in charge	Implementing partners	2016	2017	2018	2019	2020	Success requirements
4.3.1 Strengthening regulatory mechanisms in the pharmaceutical, medical analysis and blood transfusion sectors	4.3.1.1. Update and implement the National Pharmaceutical Master Plan at all levels (supply, quality assurance, access and rational use of drugs , pharmacovigilance, etc.)	Availability of updated National Pharmaceutical Master Plan and activity report of the year preceding the evaluation of the implementation of this plan	MOH (DPML)	MOH(NDRA, CENAME, RFHP, RDPH, HDs, HFs), TPFs	X	X	X	X	X	
	4.3.1.2.Organize and make operational the National Laboratory Network (RENALAB)	Availability of a regulatory instrument establishing and organizing the National Laboratory Network and annual reports of data transmission activities	MOH (DPML)	MOH (IGSPL, LANACOME, RFHP, CPC, NPHL, RDPH, HDs, HFs), TFPs	X	X	X	X	X	

4.3.2: Strengthening quality assurance mechanisms and the availability of drugs and other pharmaceutical products	4.3.2.1.Create and make operational an Integrated Pharmacovigilance Centre in each region	Proportion of regions that produced an annual activity report on Pharmacovigilance	MOH (DPML)	MOH (NDRA, CENAME, RFHP, RDPH, HDs, HFs)		X	X	X	X	
	4.3.2.2.Reinforcing the quality assurance system of drugs	Proportion of pharmaceutical products controlled before and after marketing in pharmacies and public hospital pharmacies	MOH (DPML)	MOH (NDRA, CENAME, RFHP, RDPH, HDs, HFs)	X	X	X	X	X	
	4.3.2.3.Strengthen the supply chain of essential drugs and acquire a central warehouse, reagents, vaccines and other medical devices and cold chain logistics	Average number of stock-out days of essential tracer drugs in RFHP	MOH (DPML)	MOH (CENAME, RFHP, RDPH, HDs, HFs)	X	X	X	X	X	
4.3.3: Promoting the rational use of quality drugs	4.3.3.1Strengthen the management of drugs in health facilities (training in the rational and computerized management of stocks, …)	Average number of stock-out days of essential tracer drugs in HFs (FOR THE RECORD)	MOH (DPML)	MOH (CENAME, RFHP, RDPH, HDs, HFs)	X	X	X	X	X	
	4.3.3.2.Intensify the fight against the use of illicit drugs (street drugs, counterfeit drugs, illegal laboratories, etc.)	Proportion of RDPH that organized seizures and destruction of illicit drugs annually	MOH(DPML)	MOH (NDRA, CENAME, RFHP, RDPH, HDs, HFs), ONPC	X	X	X	X	X	
4.3.4: Establishing sustainable financing mechanisms for drugs[(b)]										

Strategic sub axis 4.4: Human Resources for Health										
Specific objective SHS 4 4.4: Increase the availability of HRH in at least 40% of HDs, RDPH and central Departments according to prioritized needs by 2020		Tracer Indicators	Baseline	Source	Period					Success requirements
					2016	2017	2018	2019	2020	
		Proportion of MHCs, IHCs and DHs with at least 50% of the required technical staff	40%	Annual Reports on HRDP Implementation, 2013 HRH Census	42%	43%	45%	48%	50%	Retention and motivation of personnel posted in difficult-to-access areas
Implementation strategy	Interventions	Tracer indicators	Service in charge	Implementing partners	2016	2017	2018	2019	2020	Success requirements
4.4.1 Gradual staffing of health facilities according to standards (quality and quantity)	4.4.1.1.Build the managerial capacities of heads of technical structures at the central level, RDPH, GHs /CHs/RHs and HDs with high development potential	Percentage of Regional delegates and targeted DHSs who received training/ capacity building in management	MOH (HRD)	All the technical departments, MINFOPRA, MINFI, TFPs			X		X	
	4.4.1.2.Recruit HRH in the following priority areas (midwifery, psychiatry, emergency doctors, mortuary attendants, etc.)	Percentage of MHCs and DHs in northern regions, East and South regions with at least a midwife	MOH (HRD)	All the technical departments, MINFOPRA, MINFI, TFPs	X	X	X	X	X	Advocacy with MINIFI is strengthened and the human resources requested are recruited
	4.4.1.3. Ensure the continuous updating of public and private health workforce and their equal geographical distribution in the public sub-sector	Proportion of RDPH that sent consolidated and complete data of the HRH, including that of the private and traditional sub-sector to the DHR annually	MOH (DHR)	All the technical departments, MINFOPRA, MINFI, TFPs	X	X	X	X	X	

	4.4.1.4.Rationally deploy recruited or existing staff in health facilities, taking into account private sector resources	Proportion of MHCs, IHCs and DHs with at least 50% of the required technical staff (FOR THE RECORD)	MOH (HRD)	All the technical departments, MINFOPRA, MINFI, TFPs	X	X	X	X	X	
	4.4.1.5. Capacity building of HRH pending recruitment in identified priority areas: mental health, maternal and child health, emergency medicine and surgery)	% of doctors in MHCs and DHs with at most four years experience who benefited from at least continuous training in the targeted areas	MOH (HRD)	All the technical departments, MINFOPRA, MINFI, TFPs	X	X	X	X	X	
4.4.2 : Improving the rational management of human resources	4.4.2.1. Upscale the computerized definition and monitoring of the career profile of health work force (central and regional SIGIPES)	Proportion of RDPH equipped with IT tools for the management and follow-up of career profiles (Regional SIGIPES)	MOH (HRD)	All the technical departments, MINFOPRA, MINFI, TFPs	X	X	X	X	X	Personnel career monitoring indicators and procedures are integrated into integrated supervision tools
	4.4.2.2.Ensure continuous evaluation of professional practices	Proportion of MHCs and DHs with 75% of targeted staff applying validated protocols for the management of health issues	MOH (HRD)	All the technical departments, MINFOPRA, MINFI, TFPs	X	X	X	X	X	
	4.4.2.3.Reinforce the implementation of the HRH motivation plan (rewards and retention in difficult-to-access and insecure areas)	HRH Satisfaction Index	MOH (HRD)	All the technical departments, MINFOPRA, MINFI, TFPs	X	X	X	X	X	

		Percentage of IHCs, MHCs and DHs that are difficult to access and insecure and have at least 50% HRH who have been working for 3 years	MOH (HRD)	All the technical departments, MINFOPRA, MINFI, TFPs, Councils	X	X	X	X	X	

Strategic sub axis 4.5 : Health Information and Research in Health										
Specific Objective SHS 5 4.5: Ensure the development of research in health and the availability of quality health information for evidence-based decision-making at all levels of the health pyramid by 2020		Tracer Indicators	Baseline	Source	Period					Success requirements
					2016	2017	2018	2019	2020	
		Promptness rate of MARs in HDs	0	NHIS	40%	45%	50%	55%	90%	
		completeness rate of MARs in HDs	0	NHIS	40%	45%	50%	55%	100%	
		Proportion of research results reported	ND		40%	45%	50%	55%	60%	
		Proportion of research results that were used for decision-making	ND		40%	45%	50%	55%	60%	
Implementation strategy	Interventions	Tracer indicators	Service in charge	Implementing partners	2016	2017	2018	2019	2020	Success requirements
4.5.1: Strengthening the national health information system	4.5.1.2.Conduct baseline surveys for the monitoring/evaluation of the NHDP and HSS	Percentage of baseline surveys carried out to monitor the implementation of the 2016-2020 NHDP	MOH (TS/SC-HSS)	MOH (All technical departments, learned societies), MINRESI	X	X				Financial resources are available
4.5.2 : Strengthening health research	4.5.2.1.Build the capacities of managers at the devolved levels in the field of health research	Proportion of Regional Delegates who benefited from capacity building in research projects	MOH (DROS)	MOH (HRD, RDPH, HD, HFs)		X			X	

4.5.3 : Improving the use of health data for decision-making at all levels	4.5.3.1.Disseminate at all levels the results of research carried out in the health system and promote the use of evidence for Decision-making	Percentage of research findings that have been the subject of decision-making (FOR THE RECORD)	MOH (DROS)	MOH (TS/SC-HSS, DEP, NPHO, CIS , Technical departments), MINRESI	X	X	X	X	X	
STRATEGIC AXIS 5 : STRATEGIC GOVERNANCE AND STEERING										
	Core Problem of the component : Low performances of the health system									
	Strategic objective: increase the performance of the health system at all levels by 2020									
	Tracer Indicators :									
	- Achievement rate of the 2016-2020 NHDP objectives									

Strategic sub axis 5.1 : Governance									
Specific Objective SG1 5.1: Improve governance in the sector through the strengthening of standardization, regulation and accountability by 2020	Tracer Indicators	Baseline	Source	Period					Success requirements
				2016	2017	2018	2019	2020	
	Proportion of targeted MHCs and DHs with 75% of staff applying validated protocols for the management of maternal and child health issues (FOR THE RECORD)	ND	Audit or activity report	50%	55%	60%	65%	70%	
	Corruption perception Index in the sector	7.56/10	National anti-corruption strategy in Cameroon CONAC	7.5/ 10	7.2/ 10	5/10	4.5/ 10	4/10	

Implementation strategy	Interventions	Tracer Indicators	Service in charge	Implementing partners	2016	2017	2018	2019	2020	Success requirements
5.1.1 : Strengthening the legislative and regulatory framework of the sector	5.1.1.1.Prepare/update reforms adapted to the new environment of the sector, especially instruments on hospital reform, the functioning of the coordination and M/E bodies for the implementation of the NHDP, community participation, etc.	Availability of an updated legal instrument governing community participation in health interventions (FOR THE RECORD)	MOH (DOSTS)	MOH (General Inspectorates , DAJC, DPS, DPML, BTNP, Tech. Dir. , TS-SC/HSS, ethics committee, RDPH, HDs)		X			X	
		Availability of an updated regulatory text governing the organization and functioning of NHDP steering, coordination and M/E bodies at all levels								
		Availability of updated legal/regulatory texts governing the organization and functioning of public hospitals and case management								
	5.1.1.2.Reinforce quality approach through accreditation of public and private HFs	Proportion of accredited DHs and others ranking as such (with a quality assurance system for healthcare and services)	MOH (DOSTS)	MOH (General Inspectorate, DEP, DPS, learned societies), ethics committee						

	5.1.1.3.Prepare and disseminate management protocols and normative documents in some targeted areas (mental health, EmONC and PAC)	% of MHCs and DHs, with 75% of the technical staff using management standards/protocols of the main non communicable diseases: diabetes, mental disorders, Hypertension (FOR THE RECORD)	MOH (DOSTS)	MOH (DEP, DPS, learned societies), ethics committee	X	X	X	X	X	
5.1.2 : Improving transparency and accountability	5.1.2.1.Strengthen governance in health facilities	Satisfaction index of beneficiaries of healthcare and services	MOH (General Inspectorates) and NIS	MOH (DOSTS, DRFP, HFs , comm. Unit), CONAC, CONSUPE, General directory for external research (GDER)	X	X	X	X	X	
	5.1.2.2.Establish mechanisms to ensure social control at all levels of the health pyramid	Proportion of DHs and RHs whose annual technical and financial reports validated by members of the hospital management committee were transmitted	MOH (DOSTS/DPS	MOH (DRFP, HFs , CELCOM, dialogue structures, CSOs, NGOs)	X	X	X	X	X	
	5.1.2.3.Organize internal and external controls/audits to ensure the management of resources and activities according to	Proportion of whole distributors and pharmacies inspected	General Inspectorates	All managers, CONAC, CONSUPE, GDER	X	X	X	X	X	

	standards and procedures in force at all levels of the health pyramid	Proportion of GHs, CHs and RHs that had an external audit	General Inspectorates	All managers, CONAC, CONSUPE, GDER, control brigades, audit firm						
	5.1.2.4.Develop the culture of accountability at all levels of the health pyramid to ensure transparency in resource management	Proportion of Category 1 and 2 hospitals that submitted their technical activities reports to MOH and/or published them online	General Inspectorates , DRFP	MOH (SG, All managers, CONAC, CONSUPE, GDER, dialogue structures , CSOs/NGOs)	X	X	X	X	X	
		Proportion of Central Departments, public administrative institutions (health) and RDPH that produced an annual performance report	General Inspectorates , DRFP	MOH (SG, All the managers, CONAC, CONSUPE, GDER, dialogue structures , CSOs/NGOs)						
	5.1.2.5 Establish and perpetuate Rapid Result Initiatives (RRIs) in category 1, 2, 3 and 4 hospitals	Proportion of category 1 to 4 health facilities that implement RRIs	General Inspectorates	CELCOM, All the managers, CONAC, CONSUPE, GDER	X	X	X	X	X	
5.1.3 : Increasing the participation of beneficiaries and implementing stakeholders in the management process[(b)]										

5.1.4 : Building the managerial capacities of heads and managers of health facilities[(b)]										
5.1.5 : Strengthening the logical link between strategic planning, preparation, allocation and monitoring the execution of the budget	5.1.5.1 Revive the PPBS chain of the MOH	Availability of a report on the implementation of PPBS chain activities (taking into account NHDP interventions in MTEF, respecting the budget distribution as mentioned in the MTEF etc.)	Coordinator of PPBS chain	TS/SC-HSS, DEP, DRFP, Follow-up unit	X	X	X	X	X	
5.1.6 : Improving working conditions and computerizing the managerial process[(b)]										
Strategic sub axis 5.2 : Strategic steering										
Specific Objective SG2 5.2: By 2020 reinforce the planning, supervision, coordination, and strategic and health surveillance at all levels of the health pyramid		Tracer Indicators	Baseline	Source	Period					Success requirements
					2016	2017	2018	2019	2020	
		Achievement rate of integrated supervision missions of RDPH and HDs	ND	2015 TS/SC-HSS Report	20%	25%	30%	40%	50%	
		Proportion of recommendations of coordination meetings/SC that were implemented	80%	2015 TS/SC-HSS Report	100 %	100 %	100 %	100 %	100%	

Implementation strategy	Interventions	Tracer indicators	Service in charge	Implementing partners	2016	2017	2018	2019	2020	Conditions for success
5.2.1 : Reinforcing the institutional framework of strategic steering	5.2.1.1.Develop/update HDs action plans in line with NHDP	Proportion of HDs with HDDP in line with NHDP	MOH (TS/SC-HSS)	MOH (DEP/CPP , heads of priority programmes, RDPH, HDs)	X	X	X	X	X	
	5.2.1.2. Support RDPH in the development of consolidated regional health plans and regional AWPs in line with NHDP	Proportion of RDPH that developed consolidated regional health plans and regional AWPs in line with 2016-2020 NHDP	MOH (TS/SC-HSS)	MOH (DEP/CPP, Heads of priority programmes, RDPH, HDs)	X	X	X	X	X	
	5.2.1.3.Develop and implement the approved prison health policy document	Availability of the approved prison health policy document and the annual reports of health activities in prisons	MINJUSTICE	MOH (TS/SC-HSS, DEP, DLMEP, RDPH), other ministries	X	X	X	X	X	
	5.2.1.4.Make operational the steering, coordination and follow-up mechanism of the NHDP implementation	Proportion of HDs and RDPH that organized at least 3 coordination and follow-up meetings for the implementation of their AWP and that produced a substantial annual report	TS/SC-HSS	All programmes heads , TFPs, Partner Ministries, DEP	X	X	X	X	X	

		Proportion of recommendations of the coordination/SC meetings that were carried out (FOR THE RECORD)	TS/SC-HSS	All programmes heads, TFPs, Partner Ministries, DEP						
		Proportion of HDs with the final evaluation report of HDDP	TS/SC-HSS	All HD heads						
		Proportion of RDPH with final evaluation report of RCHDP	TS/SC-HSS	All RDPH						
	5.2.1.5.Organize on a quarterly basis coordination and monitoring and evaluation meetings of the 2016-2020 NHDP at all levels	Proportion of HDs and RDPH that complete the monitoring dashboard of performance projected in the NHDP	TS/SC-HSS	MOH (SG, Tech. Dir., DEP) MINEPAT	X	X	X	X	X	The institutional framework for implementing the NHDP is functional, human and financial resources are available to ensure coordination of interventions in the health system
		Achievement rate of Integrated Supervision Missions of Regional and District levels (FOR THE RECORD)	TS/SC-HSS	MOH (SG, Tech. Dir., DEP) MINEPAT						

	5.2.1.6.Organize on annual basis a sector or thematic health review with all stakeholders	Availability of an annual report on the sector or thematic health review	TS/SC-HSS	MOH (SG, Tech. Dir., DEP) MINEPAT	X	X	X	X	X	
	5.2.1.7.Organize the mid-term and final evaluation of the NHDP implementation	Proportion of HDs and RDPH with NHPD mid-term evaluation reports	TS/SC-HSS	MOH (SG, Tech. Dir., DEP) MINEPAT			X			
	5.2.1.8. Edit, popularize and disseminate the results of reviews and evaluations to all stakeholders (CSOs, TFPs, private sector, learned societies, professional associations, MOH structures and partner ministries)	Proportion of HDs and RDPH that have the final NHDP Evaluation Report	TS/SC-HSS	MOH (SG, DEP, CS, CIS, Tech. Dir.), CSOs, TFPs, private sector, learned societies, professional associations, MOH structures and partner ministries	X	X	X	X	X	
5.2.2 Strengthening the strategic surveillance mechanism	5.2.2.1. Reinforce the strategic monitoring system	Availability of the annual strategic monitoring report	NPHO	MOH (CIS, DLMEP, DOSTS,TS/SC-HSS	X	X	X	X	X	
5.2.3 : Strengthening devolution and decentralisation										

5.2.4 Strengthening national partnership	5.2.4.1. Strengthen partnership with private actors, civil society and community actors (capacity building of contractors-OCASC, FALC, CEPCA, RENAFSOM, CSO, etc. -Document actions of regional CSO platforms and experiences with the private sector, etc.)	Percentage of agreements signed and respected between the MOH and CSOs working in the health sector	MOH (DCOOP)	MOH (DAJC, DRFP, other Tech. dept, RDPH, HDs, HFs) , TFPs , RLAs, CSOs, NGOs	X	X	X	X	X	
5.2.5 Improving the alignment and harmonization of TFPs interventions	5.2.5.1.Develop and implement a National Compact around the health sector strategy (validation of a document of national platform for political dialogue)	Achievement rate of the National Compact objectives	MOH (TS/SC-HSS)	MOH (DCOOP, RDPH, DRFP, other Tech. Dept.), TFPs, CSOs, NGOs	X	X	X	X	X	

(a) See page 97 of IMEP for the definition

(b) The cells in gray color in the above logical framework of interventions refer to the strategies whose interventions shall formally be developed during the 2nd cycle of the planning (See page 185 of the HSS 2016-2027)

PART THREE : IMPLEMENTATION AND MONITORING/ EVALUATION FRAMEWORK

CHAPTER 5 : IMPLEMENTATION FRAMEWORK

5.1. INSTITUTIONAL FRAMEWORK FOR IMPLEMENTATION AND COORDINATION MECHANISMS

In accordance with Government's guidelines, the 2016-2020 NHDP will be implemented in a legal environment characterized by the implementation of Law No. 2007/006 of 26 December 2007 on the financial regime of the State. This law, which came into force in 2013, institutionalizes programme-based budgeting with clear objectives to be achieved within a set period of time.

It prioritizes performance and the efficient and proper use of public resources. Thus, in an economic context with limited resources, the move from a logic of resources to a performance logic based on effectiveness and efficiency will enable to achieve more quickly the results planned in the NHDP.

The 2016-2020 NHDP will be implemented through operational plans developed at all levels of the health pyramid (central, intermediate and peripheral).

5.1.1. NATIONAL LEVEL

At the national level, MINEPAT is the reference institution responsible for supporting the different sectors in the development of their respective strategies. As such, it shall be responsible for ensuring inter-sector collaboration, as well as monitoring the implementation of the GESP while ensuring the coherence of sector and thematic strategies. MINEPAT shall also mobilize resources for the implementation of the HSS and NHDP. A Memorandum of Understanding will be signed by each stakeholder to confirm their commitments in funding the NHDP and HSS.

5.1.2. CENTRAL LEVEL

As part of the monitoring of the effective implementation of the NHDP, the central level will, inter alia, be responsible for: (i) developing planning tools to enable the NHDP to present its intervention in concrete activities and tasks; (ii) technical support to decentralized health structures in the planning, coordination and monitoring of the NHDP; (iii) development of normative documents and their effective use for quality services; (iv) mobilization of the necessary resources and their optimal allocation for the implementation of the planned interventions; (v) implementation of reforms needed to achieve the objectives set out in the HSS and NHDP; (vi) strengthening partnership with the civil society and the private sub-sector as well as their effective participation in the implementation of NHDP's actions; (vii) development/update of legal texts.

At this level of the health pyramid, three structures bodies will assume the steering, coordination and monitoring of the implementation of NHDP interventions. These include:

(i) the Steering and Monitoring Committee of the implementation of the HSS (SC); (ii) the Technical Monitoring Committee (TMC); and (iii) the Technical Secretariat of the Steering Committee (TS/SC-HSS).

The Steering and Monitoring Committee of the HSS (SC): The steering committee is an interministerial committee chaired by the Minister of Public Health. This committee shall be responsible for the strategic coordination of the implementation of the 2016-2020 NHDP, coherence and synergy between the actions of the different stakeholders involved in this implementation (MOH, partner ministries and TFPs). It will also ensure that resources of the sector, especially those of the MOH, are aligned with the priorities adopted in the HSS.

To ensure a successful multi-sector approach and achievement of objectives set out in the NHDP, the steering committee will ensure the harmonious functioning of the other technical coordination and consultation bodies set up at all levels of the health pyramid.

In accordance with the recommendations of the strategic planning guide, there exists at the central level two technical bodies that assist the steering committee in its steering and coordination role. These are the Technical Committee for Monitoring the Implementation of the NHDP and the Technical Secretariat of the Steering Committee.

The Technical Monitoring Committee: Chaired by the Secretary General of the Ministry of Public Health, shall be responsible for:

- the review and approval of the various documents and reports prepared and produced by the Technical Secretariat before their submission to the Steering Committee. These include: (i) M/E reports on HSS implementation, (ii) all policy documents developed (NHDP, Health Funding Strategy, PRCDS, planning tools and M/E, etc.);
- the technical management of the cross-cutting issues to the various ministerial departments involved in the M/E of the implementation of the HSS;
- the proposal of corrective measures to remove potential bottlenecks that could impede the achievement of the objectives set out in the NHDP.

The Technical Secretariat of the Steering Committee for the monitoring of the implementation of the Health Sector Strategy (TS/SC-HSS) : under the responsibility of a coordinator, this secretariat is the executing body for the decisions taken by the Steering committee. It shall ensure the operational coordination of the monitoring /evaluation of the implementation of the 2016-2020 NHDP and provide technical support to health facilities at all levels of the health pyramid in the preparation and monitoring of the implementation of their multi-year health development plans and subsequently their AWPs.

The TS/SC-HSS will also ensure strategic alignment with the NHDP of the various planning documents produced (MOH roadmap, AWP, MTEF, etc.) and propose possible adjustments to ensure coherence between the above-mentioned documents and the synergy of interventions in the sector. The secretariat will therefore be responsible for providing technical support to the development and monitoring of the implementation of the annual

work plans and health development plans of HDs, RDPH and health facilities at the central level. In order to effectively carry out its missions, the TS/SC-HSS will define a roadmap including partnership meetings with all stakeholders in the health sector.

The other missions of the TS/SC-HSS are: (i) strengthening the sector approach and the effective implementation of a compact; (ii) developing simplified planning tools and then provide technical support to health facilities at all levels in the development of their annual or multi-annual multi-sector work plans; (iii) designing and developing tools for the collection, analysis in close collaboration with the Health Information Unit (HIU) and the Planning and Programming Unit (PPU); (iv) providing feedback to stakeholders on performance; (v) monitoring the 2016-2020 NHDP performance framework; (vi) assessing the results achievement level per strategic axis through the organization of semi-annual and annual reviews of programmes/actions; (vii) conducting mid-term and final evaluations of the HSS implementation; (viii) developing a new HSS; and (ix) providing strategic and logistical support for the operation of thematic groups and multi-sector subcommittees existing in the sector.

5.1.3. Devolved level

At the devolved level, two bodies will coordinate, monitor and evaluate the implementation of the HSS and the NHDP. These are: the Regional Committee for the Coordination and Monitoring/Evaluation of NHDP implementation (CORECSES) and the Operational Committee for Coordination and Monitoring/Evaluation of NHDP implementation (COCSES).

5.1.3.1. At the intermediate level: The Regional Committee for the Coordination and Monitoring/Evaluation of HSS implementation (CORECSES)

At the intermediate level, the coordination of the 2016-2020 NHDP implementation monitoring will be ensured by CORECSES, which is a branch of the SC at the regional level. CORECSES will be chaired by the Regional Governor (representative of the MOH at the regional level) and the Regional Delegate of Public Health shall provide the secretarial services. RDPH will draw up their Regional Consolidated Health Development Plans (RCHDP) and ensure that each Health District has an HDDP and an annual work plan.

The main tasks of this committee will be to: (i) develop the PRCDS with all stakeholders under the coordination and supervision of the Technical Secretariat of the HSS Steering Committee; (ii) the sector coordination and monitoring of the implementation of the 2016-2020 NHDP at the regional level; (iii) the development of the Integrated Monitoring/Evaluation Plan of the PRCDS and the multi-sector dashboard of the RDPH.

In order to be productive, CORECSES will also ensure that the activities proposed in the various HDDPs and AWPs of HDs are coherent and focus on the achievement of the NHDP objectives. It will therefore have to provide technical support to Health Districts in the preparation of their Health Development Plans (HDPs), their AWPs and the monitoring dashboards of these AWPs. The Chief of the control brigade of the RDPH will work in synergy with the regional coordinators of priority programmes . A decision of the Prime Minister will specify the provisions inherent to its organization, functioning, and missions.

The Technical Secretariat of CORECSES (TS/CORECSES) will also have to: (i) ensure data compilation of the devolved level for each strategic axis; (ii) provide feedback from the regional level to health districts; (iii) validate and consolidate the progress reports of HDs; (iv) participate in thematic or sector reviews organized by the SC.

All other multi-sector thematic sub-committees existing in the region will be integrated into the regional coordination and monitoring committee of the HDDP implementation. The RDPH will provide the technical secretarial services of the committee.

5.1.3.2. At the peripheral level: Operational Committee for Coordination and Monitoring/Evaluation of HSS implementation (COCSES)

At the operational level, the NHDP will be distributed into the HDDP of the 189 health districts. Each HD will develop its own HDDP that will be presented as an AWP. The monitoring of the HDDP implementation in each health district will be ensured by a COCSES which will be chaired by the Senior Divisional Officer/Divisional Officer. The District Medical Officer (DMO) will provide the technical secretarial services of this committee.

COCSES will be responsible for developing the HDDP and the AWP of the HD while ensuring that these two documents are aligned with the NHDP. It is the same for the HDDP monitoring plan, which should align with the 2016-2020 IMEP. It will also ensure the operational monitoring of indicators included in the HD multi-sector dashboard. In addition, it will provide periodic information on the tracer indicators of the monitoring/evaluation of its AWP/HDDP to CORECSE. The various COCSES will mainly ensure the AWP consolidation of health areas as well as the organization of supervision missions, multi-sector coordination meetings and decentralized monitoring.

Table 10 presents an overview of the various coordination and monitoring-evaluation structures of the NHDP/HSS at all levels of the health pyramid and their composition, role and the frequency of meetings.

Table 11 : Coordination bodies of the NHDP implementation

BODIES	COMPOSITION	ROLE/FREQUENCY OF MEETINGS
Steering and monitoring Committee of the HSS implementation	**PRESIDENT** : Minister of Public Health, **MEMBERS** : A representative of the PM office; A senior official from the partner ministries (MINTSS, MINAS, MINPROFF, MINEDUB, MINESEC, MINESUP, MINADER, MINEPIA, MINEE, MINEPDED, MINJEC, MINCOM); Health official of MINDEF, MINJUSTICE, DGSN, MINFI The President of the Cameroon Medical Association, The President of the Association of Paramedical Staff, President of the Pharmaceutical Society of Cameroon, the representative of GICAM, CVUC and CSOs; the leader of bilateral and multilateral TFPs in the health sector.	**STEERING AND MONITORING/EVALUATION OF THE HSS IMPLEMENTATION:** **Formulation of guidelines** for an effective implementation, monitoring and evaluation of the HSS; **Final validation of the strategic documents** developed (health financing strategy, HSS, NHDP, 2001- 2015 HSS evaluation reports, etc.) ; **Continuous advocacy** to increase financial resources for the health sector (Seeking sustainable solutions to health financing) Semi-annual meetings and as need arises.
Technical Committee of the Monitoring Evaluation of the HSS Implementation	**PRESIDENT** : SG of the MOH **MEMBRES** : the person in charge of planning the PBSS chain of the MOH and partner ministries; Health focal points in partner ministries (MINDEF, DGSN, MINJUSTICE etc.) ; the Coordinator of the Technical Secretariat of the Steering Committee; the head of the monitoring/evaluation unit; heads of the priority health programmes of the MOH, representatives of the TFPs; the (10) Regional Delegates of Public Health (RDPH).	**STRATEGIC COORDINATION of the HSS Implementation:** Review and approval of (i) performance reports and M/E on HSS implementation, (ii) strategic documents presented by the Technical Secretariat before submission to the Steering Committee; Technical management of cross-cutting issues in the various ministries involved in the HSS M/E (Financing, M&E arrangements, planning, etc.) ; Proposals of corrective measures to remove the bottlenecks that impede the achievement of the NHDP objectives.; Alignment of the health actions included in the various plans of partner ministries; Meetings every 4 months or as need arises.
Technical Secretariat of the Steering and Monitoring Committee of the HSS implementation	**Coordinator**: Preferably public health doctor Technical Staff (i) a statistician; (ii) an accountant; (iii) an expert in planning, monitoring/evaluation (iv) Computer Engineer, (v) experts in health economics; (vi) public finance expert; (vii) two public health doctors (epidemiology/health system).	**OPERATIONAL COORDINATION OF HSS/NHDP MONITORING AND IMPLEMENTATION**: Follow-up interventions (actions and programmes) executed by the health sector administrations quarterly and proposal of corrective measures for low performances noted; Quarterly/annual evaluation of the level of achievement of results by strategic axis of programmes/actions; Mid-term and final evaluation of the HSS; Development of a new HSS; Logistical support for the operation of thematic groups and multi-sector subcommittees. ; Prepare minutes of meetings and performance reports;

BODIES	COMPOSITION	ROLE/FREQUENCY OF MEETINGS
		Update M/E tools of HSS implementation and technical support to RDPH/HDs for M/E of the implementation of their plans; Support all levels of the health pyramid for the production of sector statistics; Organize thematic or sector reviews Keep physical or electronic archives; Draft minutes of meetings.
Regional Committee of the Coordination and Monitoring/Evaluation of the HSS Implementation	**PRESIDENT** : Governor (Representative of the MOH) **Technical Secretariat**: RDPH, **MEMBERS** : Regional Delegates of partner ministries, (MINAS, MINPROFF, MINEDUB, MINESEC, MINESUP, MINADER, MINEPIA, MINEE, MINEPDED, MINJEC, MINCOM) the head of the prison infirmary at the regional level; manager of the RFHP ; Representative of the CSO regional platform	Coordination and monitoring/evaluation of the HSS implementation and the NHDP at the regional level and other tasks that will be assigned by the TS/SC-HSS Quarterly meetings and as need arises
Operational Committee of the Coordination and Monitoring/Evaluation of the HSS Implementation	**PRESIDENT** : SDO/DO **TECHNICAL SECRETARIAT**: District Medical Officer; **MEMBERS** : (i) President of DHC ; (ii) Members of DCT ; (iii) Divisional delegates of partner ministries; (iv) members of the District core team; (v) heads of RLAs and civil society organizations affiliated to the regional CSO platform	Coordination and monitoring /evaluation of the HSS implementation and the NHDP at the operational level and other tasks that will be assigned by the TS/SC-HSS Quarterly meetings and as need arises.

CHAPTER 6 : MONITORING/EVALUATION FRAMEWORK

The evaluation of the 2001-2015 HSS highlighted some shortcomings in the monitoring and evaluation of this document. These include: (i) lack of integrated operational tools for monitoring this HSS and the expired NHDP (multi-sector monitoring dashboards); (ii) lack of operational procedures to facilitate the organization of follow-up activities at all levels of the health pyramid; (iii) irregular coordination meetings which are institutional frameworks for monitoring/evaluation of performances achieved in RDPH and HDs.

A monitoring and evaluation plan of the NHDP will therefore be developed separately at the beginning of the NHDP implementation to make up for this deficiency. This will mainly include results, effects and impact indicators that will enable a gradual assessment of implementation levels of planned activities and the achievement of NHDP objectives.

Note: As for indicators whose basic values are not available, initial surveys will be carried out to determine the beginning of the NHDP implementation.

Monitoring/evaluation will be done through supervision, analysis of data collected during reviews, audits, surveys, coordination meetings, etc.

PART FOUR : BUDGETARY FRAMEWORK

CHAPTER 7. FUNDING OF THE 2016-2020 NHDP

This chapter presents the financing projections for the 2016-2020 NHDP implementation : (i) the budget framework for the next five years, (ii) the projected costs of the 2016-2020 NHDP, (iii) analysis of financing gaps and (iv) financial sustainability strategies.

7.1. BUDGETARY FRAMEWORK

Financing projections were made based on the existing national strategic commitment documents. On the one hand, the GESP projects a continuous and increasing funding flow for the MOH and partner ministries between 2016 and 2020. On the other hand, a decrease in external resources is foreseen. This reflects the possible disengagement of some multilateral partners and the support of bilateral partners maintained till 2020. There is a projected decline in resources in the health sector as from 2019. This is partly justified by the completion of the implementation of the three-year emergency plan (Table 12).

Table 12: 2016 - 2020 financing projections (in Billions FCFA)

	PERIOD: 2016 -2020					TOTAL 2016-2020
SOURCE OF FINANCING	2016	2017	2018	2019	2020	
MOH (CBMT)	143.6	179.4	200.9	227.0	256.5	1 007.6
RELATED MINISTRIES	15.4	14.3	14.1	15.1	15.5	74.5
MULTILATERAL PARTNERS (GLOBAL FUND, GAVI, BM, WHO, UNICEF, UNFPA, UNAIDS, HKI, SABIN VACCINE)	93.4	98.6	108.4	62.9	62.9	426.1
BILATERAL PARTNERS (United States, Germany, France)	12.4	12.4	11.6	11.6	11.6	59.6
EMERGENCY PLAN (PLANUT)	41.0	50.0	59.0			150.0
PROJECTED FUNDS	**305.8**	**354.7**	**394.0**	**316.6**	**346.5**	**1 717.8**

Source : Budgetary framework of the 2016-2027 HSS

7.2. PROJECTED COSTS OF THE 2016-2020 NHDP

7.2.1 HYPOTHESIS

The real health financing needs were estimated using the One Health tool with the same methodology as for the 2016-2027 Sector Strategy. This tool enables to estimate the costs of health interventions based on targets set and integrates the analysis of bottlenecks and the budgeting of corrective actions, thus helping to have a holistic estimation of needs for health

financing. This cost estimate is based on programme data and target that existed in 2015 and has a dynamic database that will allow for adjustments if necessary during implementation.

7.2.2. ANALYSIS OF ESTIMATED COST

The overall cost of the 2016-2020 NHDP implementation was estimated at FCFA 2,135.7 billion over a period of five years, that is, an average annual cost of FCFA 417 billion. Generally, there is a growing need for health financing for the period 2016-2020.

7.2.2.1. Estimated cost per component and sub-component

According to the orientations of the strategy and the NHDP priorities, strengthening the health system will take a significant share of resources. Because of this prioritization, the share of resources allocated to this component is 50% (Figure 3). This is because this component brings together all the major pillars of the health system: health infrastructure, medicines, human resources, health financing and the health information system. This component is important in addressing increased demand for healthcare and services and improved geographical and financial access to quality healthcare (Table 12).

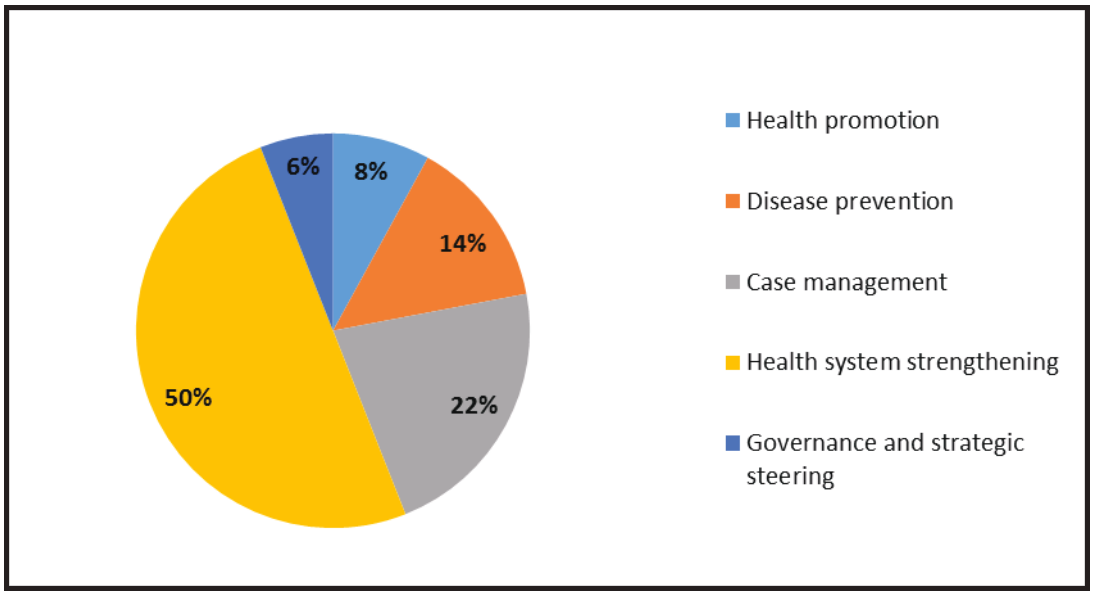

Figure 3 : Overall distribution of 2016-2020 NHDP costs per component

Source : One Health Tool analysis

The case management component accounts for 22% of the NHDP budget. This is because the component includes, among others, the management of various pathologies (diagnosis and treatment): communicable and non-communicable diseases, high-impact interventions for maternal, neonatal, child and adolescent health, etc. The health promotion component represents 8% of the projected resources. Such a level of funding will help to fill the funding gap for health promotion identified as a bottleneck for improving the health of populations in the Chapter entitled “Situation Analysis”. Finally, disease prevention component represents 14% of the projected resources and strategic steering and governance component 6% of these resources.

Table 13: Breakdown of NHDP costs per axis and strategic sub axis for the period 2016-2020

STRATEGIC AXIS	STRATEGIC SUB AXIS	TOTAL COSTS IN BILLIONS FCFA
Health Promotion	Institutional and community capacity and coordination for health promotion	19.5
	Living conditions of populations	42.7
	Strengthening health-promoting skills	35.1
	Essential Family Practices and Family Planning, Promotion of adolescent health and Post-Abortion Care	22.5
	Total 1	119.9
Disease Prevention	2.1.Prevention of Communicable Diseases	127.9
	2.2. EPDs and public health events, surveillance and response to epidemic-prone diseases, zoonotic diseases and public health events	38.8
	2.3.RMNCAH/PMTCT	22.0
	2.4.Prevention of non-communicable diseases	12.0
	Total 2	200.2
Case Management	3.1. Curative care of communicable and non-communicable diseases	337.5
	3.2.Maternal, neonatal, child and adolescent illnesses	99.2
	3.3.Emergencies, disasters and humanitarian crises	1.0
	3.4.Management of disability	1.2
	Total 3	438.1
Health system strengthening	4.1.Health financing	84.0
	4.2.Healthcare provision and services	361.2
	4.3.Drugs and other pharmaceutical products	204.6
	4.4.Human Resource for health	603.9
	4.5. Health information and research in health	2.4
	Total 4	1 256.1
Governance and strategic steering	5.1. Governance	60.0
	5.2. Governance and strategic steering	60.7
	Total 5	120.7
TOTAL COST OF 2016-2020 NHDP		2 135.7

7.2.2.2. Estimated cost per year

Table 13 and Figure 4 below show the distribution and evolution of the allocations of each component in the global budget.

Table 14: Annual distribution of costs of the 2016-2020 NHDP per strategic axis

	PERIOD				
STRATEGIC AXIS	2016	2017	2018	2019	2020
Health Promotion	7%	8%	7%	8%	9%
Disease Prevention	15%	13%	15%	14%	14%
Case Management	18%	21%	22%	23%	25%
Health system strengthening	54%	52%	50%	49%	47%
Governance and strategic steering	6%	6%	6%	6%	6%

Source : One Health Tool analysis

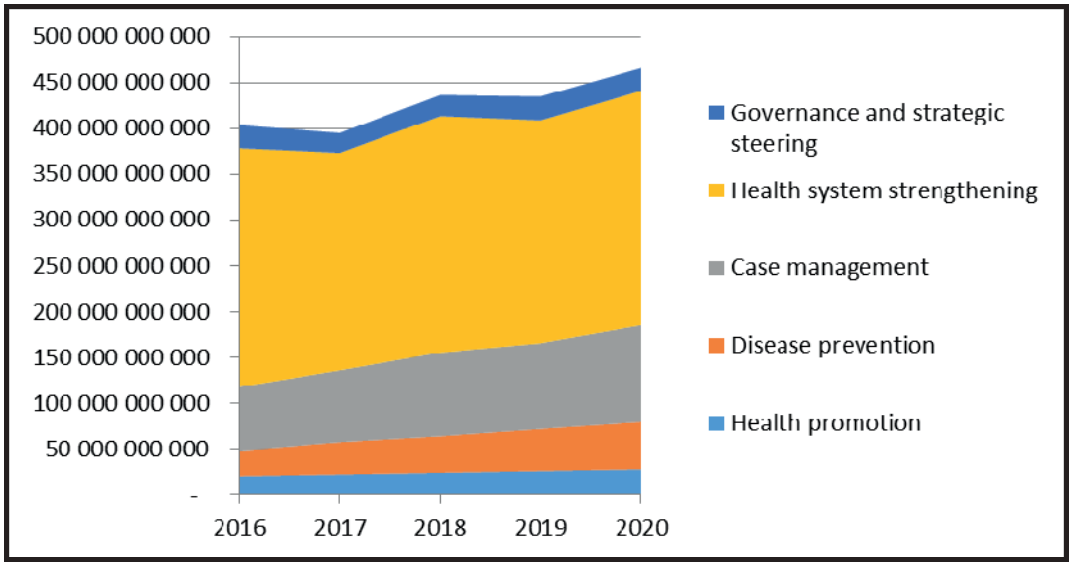

Figure 4: Evolution of costs for the 2016-2020 NHDP per strategic axis

Source : One Health Tool analysis

7.2.2.3. Projected cost and impact

Budget adjudication for HSS interventions will have a direct impact on the level of achievement of key health indicators. The figure below shows the evolution of maternal mortality if high impact interventions on maternal health defined in the 2016-2020 NHDP are fully financed (Figure5). This direct correlation means that if the volume of funding is not sufficient, the evolution will reduce.

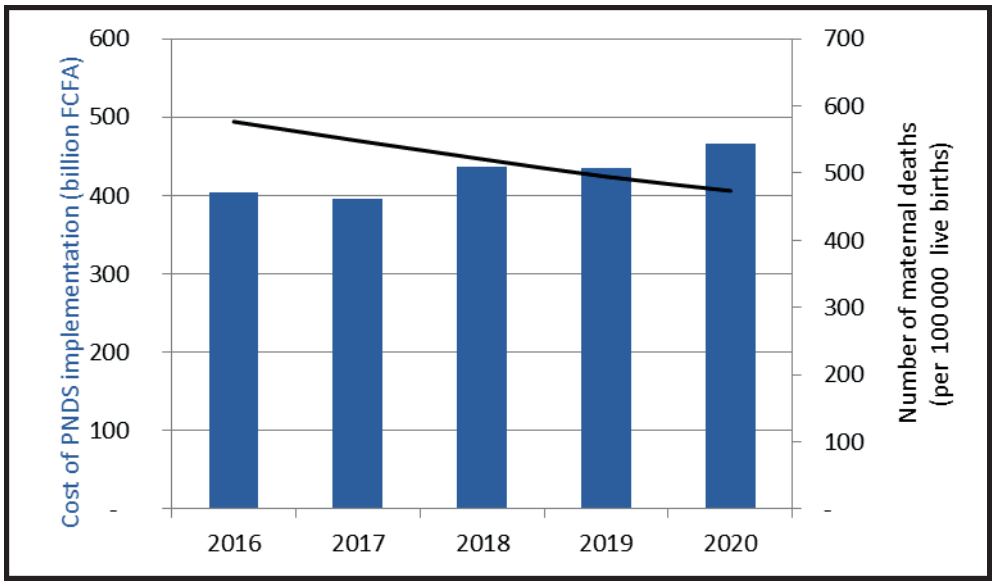

Figure 5: Cost of the 2016-2020 NHDP and impact on maternal mortality

Source : Analysis of One Health Tool estimates

7.3. ANALYSIS OF FINANCING GAPS

Available resources for the health sector over the period 2016-2020 are FCFA 1 717 billion. By comparing the current health needs projected in the NHDP over the same period (that is, 2,136 billion), there is a gap in health financing of FCFA 418 billion over the period 2016-2020, with an annual average of about FCFA 84 billion (Table 15).

Table 15: Comparison between real needs and projected financing (FCFA billion)

	PERIOD					Total
	2016	2017	2018	2019	2020	
TOTAL OF ESTIMATED FINANCING	305.8	354.7	394.0	316.6	346.5	1 717.8
NHDP COST	403.6	395.1	436.3	434.8	465.9	2 135.7
FINANCING GAP	97.8	40.4	42.3	118.2	119.4	418.1

The financing gap reflects the limited resources allocated to health. In order to fill this gap, advocacy will be conducted with MINEPAT and MINFI for a significant increase in the allocation of the State budget for health, as well as the possible introduction of innovative funding mechanisms for health.

It is important to note here that the contribution of households (which is a significant source of financing) is not taken into account in this gap analysis. In fact, it has been shown that out-of-pocket payments have a negative impact on access to healthcare for populations and cannot be used to fill the above gap in the current effort towards Universal Health Coverage.

7.4. FINANCIAL VIABILITY STRATEGY

The financing of the various interventions selected in the NHDP will be mobilized in a concerted manner at the level of the State, its development partners, NGOs and the private sector. The updating of the medium-term expenditure framework for the sector with the selected interventions will allow for a greater mobilization of financial resources from national and external partners.

The health financing strategy is being developed at the Ministry of Public Health and will detail aspects related to revenue collection, pooling of resources and purchase of interventions. This process is part of the ongoing multi-sector reflection on a Universal Health Coverage system. At the end, this strategy will ensure the financial sustainability of the health sector while reducing the direct participation of households according to the principles of efficiency and equity.

APPENDIX 1 : RAPID EVALUATION CRITERIA OF THE VIABILITY LEVEL OF A HEALTH DISTRICT

Component	Criteria	Min Score	Max Score	
Technical viability				
Availability of technical human resources	DHS staff	0	2	0 : No Medical Doctor at the HD 1 : 1 Medical Doctor at the HD + 1Head of the health bureau + 1 Head of financial affaires bureau 2 : Full team in accordance with the organizational chart of the MOH
	Technical staff in IHCs	0	2	0 : Number of staff required < 50 % 1 : Number of staff required ≥ 50 % and < 75% 2 : Number of staff required ≥ 75 %
	Technical staff at the District Hospital	1	2	Rural DH : 1. At least : Major sub criteria: 1 Medical Doctor +1 Anesth + 2 Lab Tech + 1 X-Ray Tech + 5 nurses[2] Minor sub criteria : 1 nutritionist +1Physiotherapist 2. Requirements: Major sub criteria : 2 Medical Doctors +1 Anesth + 2 Lab Tech + 1 X-Ray Tech + 5 nurses Minor sub criteria : 1 nutritionist +1Physiotherapist
	Technical staff at the District Hospital	1	2	Urban HD : 1. At least : Major sub criteria : At least 5 Medical doctors +1 Anesth + 5 Lab Techs + 2 X-Ray Techs + 10 nurses Minor sub criteria : 1 nutritionist +1Physiotherapist 2. Requirements:

[2] The score should be given to the HD assessed even in the absence of 2 minor sub criteria

Component	Criteria	Min Score	Max Score	
				Major sub criteria; At least 10 Medical doctors +1 Anesth + 10 Lab Techs + 4 X-ray Techs + 15 nurses minor sub-criteria: 1 nutritionist +1Physiotherapist
Packages for healthcare and services	Availability of the MHP in IHC/MHC	1	4	1. IHC/MHC provides less than 50% of the MHP interventions 2. IHC/MHC provides between 50% and 75% of the MHP interventions 3. IHC/MHC provides between 75% and 85% of the MHP interventions 4. IHC/MHC provides more than 85% of MHP interventions
	Availability of CHP	1	4	1. DH provides less than 50% of CHP interventions 2. DH provides between 50% and 75% of CHP interventions 3. DH provides between 75% and 85% of CHP interventions 4. DH provides more than 85% of CHP interventions
Infrastructure	Availability of quality infrastructure in IHC/MHC	1	3	1. IHC/MHC fenced and with a leak proof roof 2. IHC/MHC fenced and with a leak proof roof, clean walls, clean toilets and potable water 3. IHC/MHC with upgraded infrastructure
	Availability of a quality infrastructure at the DH	1	3	1. DH fenced and with a leak proof roof 2. DH fenced and with a leak proof roof, clean walls, clean toilets and potable water 3. DH with upgraded infrastructure
	Health Coverage	1	3	1. Less than 25% of HAs have an IHC 2. Between 25% and 50% of HAs have at least one IHC 3. More than 50% of HAs have at least one IHC
Equipment	Minimum equipment for IHCs	0	3	Minimum : 1 Functional microscope + 1 functional tensiometer + sterilizer + delivery kit + delivery table + isothermal box + complete minor surgery box + 4 observation beds + 1 solar energy source (Electric) + scale + 1 functional refrigerator
				0: Less than 25% of IHCs have the aforementioned equipment; 1 : 25 - <50% of IHCs ; 2 : 50 - <80% of IHCs ; 3 : 80% and more IHCs/MHCs have the aforementioned equipment
	Minimum equipment for DHs	0	3	At least 10 services are available (paediatrics, surgery, internal medicine, gynaecology, maternity, IEC and demonstration rooms, outpatient department and functional operating

Component	Criteria	Min Score	Max Score	
				theater, laboratory with 4 functional departments (Parasitology, biochemistry, bacteriology, Immunology, etc.), functional radiology service, morgue, pharmacy 5 services with at least 75% of the range of services
				0 : Less than 25% of available services and equipment; 2 : 25 - <75% of available services and equipment 3 : More than 80% of available services and equipment
Maintenance of infrastructure and equipment	Availability at the DH of two versatile workers and trained in biomedical, electricity/refrigeration, plumbing, computers, furniture maintenance	0	3	1: Lack of versatile technicians to maintain equipment and infrastructure at the DH (irregular maintenance of infrastructure) 1 : One of the two versatile technicians required to maintain the DH equipment and infrastructure is present 2 : Presence of the two versatile technicians required to ensure the maintenance of equipment and infrastructure at the DH. 3 : Availability of a depreciation plan for infrastructure and equipment and availability of the two versatile technicians needed to maintain equipment and infrastructure at the DH
Logistics	Availability at the HDS of a 4 x 4 vehicle in good condition	0	2	0 : HD does not have a 4x4 vehicle in good condition for supervision: 2: HD with a 4x4 vehicle in good condition for supervision
	Availability of at least one motorcycle in good condition for the implementation of strategies in each HA to carry out outreach and mobile strategies	1	3	1: Less than 50% of HAs have a motorcycle in good condition 2: At least 75% of HAs have a motorcycle in good condition 3: More than 75% of HAs have a motorcycle in good condition
Drugs, reagents and essential medical devices	availability of essential drugs in IHC/MHC/DH	0	2	0 : IHC/MHC/DH with stock-outs of essential drugs of more than 7 days in the past 3 months 1 : IHC/MHC/DH with stock-outs of essential drugs for less than 7 days in the past 3

Component	Criteria	Min Score	Max Score	
				months 2 IHC/MHC/DH with no stock-outs of essential drugs for the last 3 months
	Promoting the use of generic drugs in DH	1	2	1. Less than 50% of DH doctors prescribe generic drugs 2. More than 50% of DH doctors prescribe generic drugs
Standard operational procedures	Availability of standard operational procedures for quality healthcare and service in HFs of the operational level	1	3	1. At least 50% of operational level HFs have standard operational procedures and updated protocols for case management 2. At least 75% of FHs at the operational level have standard operational procedures and updated protocols for case management 3. All the HFs at the operational level have standard operational procedures and updated protocols for case management
Governance				
Regulation	Respect of regulation in health facilities at the operational level	1	2	1: Existence of internal regulations in health facilities at the operational level 2: Availability at the operational level of the latest semi-annual report on compliance with provisions of these internal rules by health facilities staff
	Fight against corruption at the operational level	1	3	1 : Existence of a suggestion box in all HFs of the operational level 2 : Existence of a suggestion box in all HFs and of a report on the collection of concerns of HF users signed by all the stakeholders. 3 : Availability of a survey report made on the satisfaction of HF users of the HD
Training and Research	Continuous training	1	4	1 Availability of a statement of needs for continuous education in the IHC/MHC/D H 2: Availability of two copies of a statement of continuous training needs in IHC/MHC/DH and a request for capacity building for hospital healthcare and service providers and the district health service 3 at least 30% of the staff identified in the IHCs/MHCs have benefitted from capacity building 4 : at least 50% of the staff identified in the IHCs/MHCs have benefitted from capacity building in the areas targeted by the HF.
	Operational research	0	2	0 : No research carried out

Component	Criteria	Min Score	Max Score	
				1 : Availability of a research protocol 2 : Availability of a research protocol with at least one research report submitted to the RDPH
Financing	Institutional and Community Financing	1	3	1. HFs with 25 to 49% of the funding needed for the implementation of the agreed AWP 2. HFs with 50 to 74% of the funding for the implementation of the agreed AWP 3. HFs with 75 to 100% of the funding available for the implementation of the agreed AWP
	Functional DHC	0	2	0: non functional DHC 2 : functional DHC
	Functional Hospital Management Committee	0	2	0 : non functional HMC 2 : functional HMC ;
	Functional Health Committee	0	2	0 : all HAs do not have any functional Health Committee 1 : 50% of HAs have a functional health committee 2 : At least 75% of HAs have a functional health committee.
Management process	Health development plan and/or AWP	0	4	0: No plan is available during the period evaluated 1 : Existing plan but not aligned with NHDP 2 : Existing plan aligned with the NHDP 4 : Existing plan aligned with the NHDP and prepared with all the key actors of the HD
	M/E	0	4	0 : No available dashboard to follow up AWP of HD 1: Existing M/E plan but not aligned with the IMEP of the NHDP 2: available integrated performance dashboard; 3: HD M/E plan aligned with the IMEP and multi-sector dashboard for the monitoring of the available performances; 4 : HD M/E plan in line with the IMEP and multi-sector dashboard for the monitoring of the available performances and used for M/E of performance.

Component	Criteria	Min Score	Max Score	
	Supervision of HICs/MHCs	1	3	1 : Less than 50% of IHCs/MHCs were supervised at least once in the previous year 2 : 75 % of IHCs/MHCs were supervised at least twice in the previous year 3 : 100% of IHCs/MHCs were supervised at least twice in the previous year. Same for District Hospital providers.
Performance achieved	Use of curative care (NC/inhabitant /year)	1	3	1: if Utilization rate <. 1; 2: if Utilization rate > 1 but < 2; 3: If utilization rate >2
	ANC coverage (%)	0	3	0 : < 25% ; 1 : 25 - <50% ; 2 : 50- < 80% ; 3 : ≥80%
	TB cure rate (%)	0	3	0 : < 25% ; 1 : 25 - <50% ; 2 : 50- < 80% ; 3 : ≥80%
	ANC coverage (%)	0	3	0 : < 25% ; 1 : 25 - <50% ; 2 : 50- < 80% ; 3 : ≥80%
	Assisted Deliveries (%)	0	3	0 : < 25% ; 1 : 25 - <50% ; 2 : 50- < 80% ; 3 : ≥80%
	DTC3 coverage (%)	0	3	0 : < 25% ; 1 : 25 - <50% ; 2 : 50- < 80% ; 3 : ≥80%
	Patients referred among inpatients	0	3	0 : If reference rate is < 25% ; 1 : If reference rate is between 25 - <50% ; 2 If reference rate is between : 50- < 80% ; 3 : If reference rate is between ≥80%
	Hospitalization rate in DH (%)	0	3	0 :<1% ; 1 :1-<3%, 2 : 3-<5% ; 3 : 5- 10%.
	Caesarean sections (%)	0	3	0 : Rate < 1% ; 1 : rate between 4 and 5% : 2 rate between 6 and 9% ; 3 : rate between 10-15%
Overall total		18	85	

HD classification grid

- Health district in the start-up/operationalization phase: performance between 18 and 40 points.
- Health District in consolidation/functional phase: performance between 41 and 75.
- Health District in empowerment/viability phase : performance between 76 and 117.

APPENDIX 2 : OPERATIONAL DEFINITIONS OF CONCEPTS USED IN THE NHDP

1. Standard on the number of multi-purpose CHWs: the required standard is 1 CHW/1 000 inhabitants (rural area) and 1 CHW/2 500 (urban). To date, this number is not known accurately. However, within the timeframe covered by this NHDP, it should be ensured that each district has at least 3 versatile CHWs, and gradually, ensure that the standard for the number of CHWs per district is respected.

2. Functional DHC: DHC that has a specific activity framework drawn from the AWP of the HD and has documented at least 50% of the activities carried out during the period evaluated.

3. HD implementing CLTS: HD in which at least 50% of households/neighbourhood/village have improved toilets, a source of potable water and a hand-washing device.

4. Minimum intervention capacities of a CERPLE: 1) Meeting room for the coordination of public health interventions; 2) office automation and computer equipment and communication equipment (computer, telephone etc.); 3) adapted vehicle for case investigation and organization of response; 4) prepositioning of drugs for response; 5) appropriate profile for the person in charge of CERPLE: CAFETP graduate (Cameroon Field Epidemiology) or Public Health; 6) availability of a budget line or emergency management support fund.

5. Essential Family Practices: 1) exclusive breastfeeding; 2) preventive child care (ex: vaccination, IMAI, etc.); 3) use of a mosquito net; 4) hand washing with soap; 5) nutritional supplement after 6 months; 6) rehydration of the child with ORS in case of diarrhoea; 7) consultation at the health centre in case of illness; 8) promotion of modern contraceptive methods in women of childbearing age (WCBA).

6. IHCs/ MHCs/ DHs implementing task shifting in the management of Hypertension and Diabetes: development of the task shifting management approach as well as the creation of ambulatory medical centres are strategies to improve the availability of quality health care and services to beneficiaries. It has as prerequisite: 1) the availability of operational procedures for management and their dissemination at all the levels of the health pyramid, 2) strengthening the control, monitoring and supervision of actors at the devolved level, 3) capacity building for institutional and community service providers at the devolved level.

7. Minimum Technical Platform for the management of Medical and Surgical Emergency of a District Hospital: Emergency services with at least 1) a functional ambulance, 2) a complete tensiometer , 3) Small surgery box , (4) steam and heat sterilization equipment, (5) oxygen, (6) emergency drugs, (7) personnel capable of managing the complications of hypertension and diabetes, 8) staff trained in EmONC/CEmOC.

8. Accredited district hospital: health facility with quality assurance system and health services: FP, EmONC/CEmONC, PAC, emergency obstetric surgery, management of HIV/AIDS, Malaria, Tuberculosis, Hypertension, Diabetes, RANC.

9. Nine CEmONC functions: 1) administration of AB/general route, 2) parenteral administration of uterotonics, 3) parenteral administration of anticonvulsants, 4) evacuation of conception product (MVA), 5) artificial delivery, 6) instrument-assisted breech delivery (vacuum forceps) 7) newborn resuscitation, 8) blood transfusion and caesarean section, 9) caesarean section practice. HF must offer these 9 functions to qualify as complete EmONC HF.

10. Functional CSOs: These are CSOs from HDs affiliated to the CSO regional platform and that have contributed to the implementation of the AWP of the HD (implementation of at least 2 activities included in the AWP of the HD during the period evaluated).

ACKNOWLEDGEMENTS

The Minister of Public Health thanks his collaborators, FTPs and experts who contributed to the preparation of this document, especially:

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	Dr. NDI Norbert Francis	**MINJUSTICE**
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