Anti-corruption and accountability

The Government has adopted an anti-corruption strategy 2010-2017, the implementation of which covers all sectors. A roadmap based on the "PRECIS" approach (Prevention, Education, Conditions, Incitement and Sanctions) has been developed to accelerate the implementation of anti-corruption strategies, with accountability, transparency, consolidation of the rule of law and decentralization as conditions for success. Civil society organizations have been involved through several initiatives such as CHOC (Changing Attitudes, Opposition to Corruption).

There is a Ministerial Committee to Combat Corruption, coordinated by the Inspector General of Pharmaceutical Services and Laboratories. In addition, internal anti-corruption committees have been set up in public hospitals and transparency and denunciation materials (complaint and suggestion boxes, etc.) have been installed. The Anti-Corruption Quick Results Initiatives were implemented with the support of CONAC in hospitals. The milestones of these Anti-Corruption Quick Results Initiatives have been translated into measures to strengthen governance and secure hospital revenues and assets.

At the national level, accountability remains an important issue in the health system and represents an obstacle to the ownership of the implementation of HSS by all actors. To date, several institutional mechanisms (monthly activity report, annual activity reports, annual performance report, etc.) have been put in place so that health authorities, at all levels of the health pyramid, can report on the implementation of their activities. The establishment of exchange platforms (annual conference of officials, coordination meetings, steering and monitoring committees, CCIA, etc.) highlights the concern and willingness of the public authorities to involve all stakeholders in the implementation of HSS and decision-making. However, insufficient financial resources for the organization of coordination meetings, especially at decentralized level, limit their functionality.

Social control

Social control of health interventions, one of the modalities of which is community participation in the activities of the health system, is "quite weak". Dialogue structures exist at all levels of the health pyramid and should participate in co-financing and co-management interventions of health structures. But, they are not very functional for the most part. [149] However, it is worth noting the strong impact of civil society and patient associations in the control of health interventions.

3.7.2. STRATEGIC MANAGEMENT

Strategic steering/management consists of leading an organization towards achieving the objectives previously defined by making effective and efficient use of available resources. In

this document, the description and analysis of the strategic management of the health sector is structured around four main axes:

(i) strategic planning and coordination,

(ii) strategic monitoring ,

(iii) monitoring and evaluation of interventions,

(iv) partnership for health.

Health monitoring

In the health sector, the health monitoring system is organized around the National Observatory of Public Health (NPHO) created in 2010. One of its main missions is to ensure the surveillance of the health status of populations, cohorts of epidemiological interest in order to prevent the spread of epidemics and / or pandemics. However, the NPHO is faced with some difficulties to effectively implement this mission due to insufficient human, financial and technological resources.

Strategic planning, coordination and monitoring in the health sector

Strategic Planning

Strategic planning in the health sector has as reference framework, the Cameroon Vision 2035, declined in the GESP for the period 2010-2020 and the NDS 30 for the period 2020-2030. It has become operational in the health sector through the HSS 2001-2015, the 2016-2027 and the updated HSS 2020-2030. However, there is little implementation of these reference frameworks because of their insufficient publication, appropriation and use for planning at all levels of the health pyramid. Instead, the emphasis is on programming and budgeting to the detriment of operational planning and linkage to the health sector strategy set out in the NHDP.

In addition, at the regional and operational levels, there has been a low availability of health sector reference documents (HSS 2016-2027; NHDP 2016-2020, IMEP etc.) Hence, the lack of ownership of strategic orientations at these levels of the health pyramid. Indeed, the majority of the health districts surveyed claimed to have developed their District Health Development Plans, but these were insufficiently implemented and had low ownership. This problem was most acute in the Littoral region and part of the Central region where the development of DHDP did not take place during the 2016-2020 programme cycle.

Strategic Coordination

As far as coordination is concerned, the health sector continues to be characterized by a multiplicity of coordination bodies. Indeed, most health programs and projects have an intersectoral or interministerial steering and guidance body at the central level (Country Coordinating Mechanism for financing the Global Fund to fight TB, HIV, Malaria, the Inter-

Agency Coordination Committee, etc.). These vertical programme coordination bodies do not have a monitoring body. These problems of coordination and strategic steering have repercussions at the regional level. The majority of actors interviewed at the regional level stated that multisectoral coordination mechanisms were not adequate although they existed. The Administrative Coordination Committees (ACCs) led by the administrative authorities serve as a multisectoral consultation framework to discuss development issues at the regional and operational levels. But these do not sufficiently address health issues for their resolution.

For MINSANTE, an internal management committee for the Planning, Programming, Budgeting and Monitoring and Evaluation chain was set up in 2009. To ensure its annual functioning, an act signed by the Minister of Public Health updated the composition of the committee. However, related meetings are not frequently held. It should be noted that planning activities at the central level are not aggregations of needs expressed by the lower levels of the health pyramid. Consequently, budgetary allocations are made in an egalitarian manner without taking into account the specificities of the different regions and structures. With the budget reform in 2007 and revised in 2018, followed by the introduction of the programme budget in 2013, the role of the Planning, Programming, Budgeting and Monitoring and Evaluation Channel has been better defined and strengthened. A decree of the Head of State of 2018, sets the budgetary calendar and specifies for each stage (planning, programming, budgeting and monitoring and evaluation), the approach, activities, timetable, actors, expected results and deliverables.

Intelligence

Strategic intelligence in the health sector consists of foresight in order to collect the strategic information necessary to anticipate developments and innovations in the field of health. This is a continuous action aimed at actively monitoring the external environment in order to anticipate developments and ensure the flexibility of the health system. It is therefore a decision-making aid useful for strategic management and operational decision-making in the implementation of health interventions. This role should be carried out by the Technical Secretariat of the sectoral sub-committee of the health sector.

Monitoring and evaluation

The Integrated Monitoring and Evaluation Plan (IMEP) of the HSS 2016-2020 has been validated but its implementation has not yet been evaluated. In the majority of cases, annual reports are produced by health facilities and then transmitted to higher levels but are rarely shared with the general public. However, each structure should be able to disseminate the validated reports to the community.

It can also be noted that the structures of the higher levels do not systematically give feedback when they receive reports. In addition, the lower levels initiate very few reports spontaneously.

In addition, as a result of budgetary reform within Cameroon's administration, management control was instituted as a monitoring and evaluation mechanism and a tool to assist in performance management. Its deployment is gradual.

A major breakthrough has been achieved with the introduction of DHIS2 for the reporting of health data from the monthly activity report of HFs and other specific programmes. With a completeness of about 90%, DHIS2 allows the monthly collection of data from 6,202 enlisted HFs. It also allows the weekly reporting of epidemiological surveillance data. It is the main source of data for monitoring and evaluation of health activities and interventions.

Partnership for Health

The health sector has developed a real partnership dynamics, thanks to the expansion of its networks both nationally and internationally.

At the international level, Cameroon is a member of global partnerships for health, such as the International Health Partnership (IHP+); GAVI alliance, Global Health agenda etc. It also cooperates with bilateral and multilateral partners who support health internationally.

At the national level, the partnership portfolio includes several hundred actors: ministerial departments, institutions and organizations under supervision, public and private companies, decentralized local authorities, NGOs and associations.

The current institutional and technical framework for coordination requires reinforcement and multifaceted support to animate capitalize and make profitable this important partnership heritage. In addition, partnership research would benefit from being more offensive to anticipate the announced withdrawal of certain partners.

CHAPTER 4: PRIORITY PROBLEMS IN THE HEALTH SECTOR

The situational analysis that took into account the orientations of the NDS30, the HSS 2020-2030 and the recommendations of the evaluation of the implementation of the 2016-2020 NHDP expired made it possible to identify the priority problems of the health sector for the 2021-2025 cycle. These are articulated around the 5 strategic axes of the HSS 2020-2030.

4.1. HEALTH PROMOTION AND NUTRITION

- Low consideration of social determinants of health in the provision of health services and care and public policies (nutrition, sanitation, environmental health, etc.);
- Insufficient synergy of intersectoral intervention;
- Low involvement of decentralized local authorities in health promotion interventions;
- Low functionality of UHC adherence mechanisms.

4.2. DISEASE PREVENTION

- Underestimation by health sector actors of the comparative advantages of disease prevention compared to case management;
- Campaigns for the prevention and detection of diseases that are poorly executed, particularly in health areas;
- Low availability of data for better decision-making related to disease prevention;
- Low use of prevention services offered;
- Poor consideration of the prevention component when developing epidemic response strategies;
- Insufficient decentralization of the response to epidemics;
- Implementation of interventions has high impact on the health of the mother, child, newborn and adolescent insufficient.

4.3. CASE MANAGEMENT

- Insufficient development of the national network of SONUB and SONUC;
- Insufficient quality of care and health services (quality of diagnosis and curative management of cases, provision of MPA and CPA);
- Lateness in preparation, detection and response in the management of EPD cases;

- Poor organization of community case management;
- Insufficient compliance with national care guidelines;
- Inadequacy in the supply chain for commodities and stocks;
- Insufficiency in case management of emerging and re-emerging diseases including Neglected Tropical Diseases (NTDs),
- Inadequate consideration of non-communicable diseases in health policy;
- Delay in the management of correctable disabilities.

4.4. HEALTH SYSTEM STRENGTHENING

- Insufficient development of new funding mechanisms at the operational level, particularly those enabling dialogue structures to function effectively;
- Weak existence of mechanisms for pooling disease risk;
- Limited physical and financial accessibility to health facilities;
- Poor mechanisms for monitoring the resources allocated to health in the various partner administrations and decentralized local authorities. ;
- Low mobilization of resources allocated to the implementation of the NHDP for all strategic axes;
- Limited quality affordability to health care and services for vulnerable populations;
- Human resources quantitatively and qualitatively insufficient and unequitably distributed in the regions;
- Poor implementation of HRH motivation and retention mechanisms;
- Insufficient technical platform and health infrastructure at all levels of the health pyramid;
- Insufficient provision of four wheel drive vehicles to the District Health Services and the IHC/MHC of off-road motorcycles to regularly carry out supervision, including cold chain equipment;
- Weak evolution of Health Districts towards servicing;
- Low utilization of health facilities and services;
- Low use of quality medicines and pharmaceuticals
- Persistence of fake medicines and illicit trafficking in pharmaceutical products;
- Low valuation of local pharmaceutical potential;
    - Low development of health research and decision-making not always based on evidence.

4.5. GOVERNANCE AND STRATEGIC STEERING

- Shortcomings in the effective implementation of planning, coordination and monitoring and evaluation mechanisms for health sector interventions at all levels of the health pyramid;
- Weak enforcement of HFs's accountability, and audit mechanisms;
- Low dissemination and appropriation of reference documents at all levels of the health pyramid;
- Low involvement of key health sector stakeholders in planning, coordination and monitoring and evaluation activities.

CHAPTER 5: OBJECTIVES, TARGETS AND INTERVENTION FRAMEWORK OF THE NHDP

5.1. OBJECTIVES AND TARGETS OF THE NHDP 2021-2025

5.1.1. OVERALL OBJECTIVE OF THE NHDP

Overall objective of the PNDS: Improve population access to quality essential and specialized priority health services and care

In other words, Cameroon aims to offer universal access to quality essential health services, without any form of exclusion or discrimination. It is in this perspective that the PNDS 2021–2025 is resolutely committed, which favors strengthening the health system and governance for the optimal implementation of high-impact interventions, capable of significantly reducing mortality and morbidity among all targets. , with a particular emphasis on the most vulnerable (mother-child target).

The implementation of the PNDS will be structured around 3 vertical axes, namely (i) health promotion and nutrition, (ii) disease prevention, (iii) case management; and 2 transversal axes which are (iv) strengthening the health system and (v) governance and strategic management.

5.1.2. SPECIFIC OBJECTIVES AND TARGETS OF THE NHDP

The interventions developed in the intervention framework bellow are designed to ensure the realization of the priority targets for the 2021-2025 cycle. These are summarized in the table below

SPECIFIC OBJECTIVES	TARGETS
STRATEGIC AREA 1 : HEALTH PROMOTION AND NUTRITION	
Sub-strategic axis 1.1 Institutional and community capacity and coordination for health promotion	
Specific Objective1.1 : Strengthen institutional capacities, coordination and community participation in health promotioncommunauté dans	Increase the proportion of HD with functional DHC from 94.2% to 95%
	Increase the ratio of CHW per inhabitants to 1 per 1000 inhabitants
	Achieve a Community MAR completeness rate of 100%

le domaine de la promotion de la santé	Improve the proportion of the CTD budget allocated to FOSA within the framework of decentralization
	Improve by 30% 35% the rate of access of indigenous populations to basic social services (notably health) and to public life
	Improve the proportion of the FRPS budget allocated to support COSADI
Sub-strategic axis 1.2 : Living environment of the populations	
Specific Objective: **1.2** Improving the living environment of populations	Increase the percentage of households using improved toilets from 57.9% to 75%
	Reduce the proportion of households that use solid fuel as their primary source of domestic energy for cooking from 78% to 50%
	Improve the proportion of households with access to drinking water by increasing it from 79% to 90%
	Reduce the mortality rate attributable to unsafe water, sanitation system deficiencies and lack of hygiene (access to inadequate WASH services) (SDG 3.9.2.) by 45.2 per 100,000 inhabitants at 25 per 100,000 inhabitants
	Increase the proportion of health districts implementing Community-Led Total (CLTS) from 55% to 75%
	Improve the proportion of subject companies with a Health and Safety Committee (HSC) installed and functional from 25% to 40%
	Reduce the number of work accidents (fatal and non-fatal) from 684 to 382
	Improve the proportion of households living in decent housing from 35% to 35.5%
	Improve the proportion of households with access to a sanitation system from 2.5% to 3%
	Improve daily water production capacity by increasing it from 1,100,000m3/day to 1,600,000m3/day
	Increase the drinking water supply rate from 47% to 55%
	Increase the service rate of improved on-site sanitation infrastructure from 45% to 61%

	Increase the quantity of municipal solid waste disposed of adequately from 7,000 to 11,000 tonnes
	Reduce the percentage of people vulnerable to climate change from 1.3% to 1%
Sub-strategic axis 1.3: Strengthening health-promoting skills	
Sub-strategic axis 1.3 : Develop health promotion actions in in order to strengthen health promoting skills for individuals and communities	Reduce the prevalence of teenage pregnancies from 24% to 17%
	Reduce the prevalence of smoking among subjects aged 15 and over from 4.3% to 2%
	Reduce the chronic malnutrition rate of pregnant or lactating women from 39.4% to 20%
	Reduce the prevalence of food insecurity from 10 to 7%
	Increase from 50 to 70% the proportion of targets reached during awareness activities on the fight against drug consumption in school and out-of-school settings
	Reduce the number of deaths due to road accidents from 473 to 385
	Ensure the availability of a source of drinking water in 100% of educational establishments
	Reduce the chronic malnutrition rate among children under 5 years old from 29% to 26%
Sub-strategic axis 1.4 : Essential Family Practices and Family Planning, Promotion of adolescent health and Post-Abortion Care	
Specific Objective 1.4 : Lead out families to adopt essential family practices including family planning and birth registration	Improve modern contraceptive prevalence among women of childbearing age by increasing it from 15% to 30%
	Reduce the proportion of unmet FP needs from 23% to 13%
	Reduce the fertility rate among adolescent girls aged 15 to 19 from 24% to 15% per 1,000 adolescent girls
	Reduce the proportion of women aged 20 to 24 married or in a relationship before the age of 15 from 10.7% to 8%
	Reduce the proportion of women aged 20 to 24 married or in a relationship before the age of 18 from 29.8% to 20%
	Reduce from 31.5% to 25% the proportion of women and girls aged 15 or over who have lived as a couple who are victims of physical, sexual or psychological violence inflicted during the previous 12 months by their current partner or a former partner

	Reduce from 15 to 10% the proportion of children who have suffered at least one form of violence or abuse
	Ensure the establishment of a birth certificate for at least 95% of registered live births
AXE STRATEGIQUE 2 : DISEASE PREVENTION DE LA MALADIE	
Sub-strategic axis 2.1 : Prevention of communicable diseases	
Specific Objective 2.1 : reduce the incidence/prevalence of the main communicable diseases (HIV, malaria and tuberculosis) and eliminate some NTDs (lymphatic filariasis and HAT	Reduce HIV incidence from 40,000 to 1.7‰
	Reduce HIV prevalence from 2.70% to 3.7%
	Reduce the prevalence of viral hepatitis B from 8.30% to 6%
	Increase coverage of preventive chemotherapy for onchocerciasis from 81% to 86%
	Reduce the prevalence rate of malaria in children under 5 years old from 24% to 16%
	Increase the % of pregnant women infected with HIV and on ART from 63.91% to 95%
	Reduce the prevalence rate of communicable diseases in prisons from 20% to 14%
	Reduce the incidence of TPM+ tuberculosis from 194 new cases per 100,000 inhabitants to 1.7%
	Ensure the deworming of 100% of school-age children
Sub-strategic axis 2.2: EPDs and public health events, surveillance and response to epidemic-prone diseases, zoonosis and public health events	
Specific Objective2.2 : Reduce the risks of occurrence of major public health events and epidemic-prone diseases including zoonosis	Improve the proportion of measles epidemics notified and investigated from 61% to 90%
	Increase the proportion of the target population having received all the vaccines provided for by the national program from 52% to 90%
	Increase vaccination coverage with the reference antigen (Penta3) from 88% to 95%
	Improve vaccination coverage in RR1 from 73.9% to 85%
	Improve the Index of main capacities required according to the International Health Regulations (IHR) from 40% to 100%

Sub-strategic axis 2.3 : Maternal, Newborn, Child and Adolescent Health and PMTCT	
Specific Objective 2.3 : Increase the coverage of high-impact prevention interventions for the mother, newborn and child targets	Increase the ANC 4 coverage rate from 65% to 95%
	Reduce the rate of HIV transmission from mother to child from 3% to 1% (proportion of children exposed to HIV)
	Reduce the proportion of newborns weighing less than 2500 g from 7% to 5%
	Improve by 50% the proportion of pregnant women having received at least 3 doses of IPT during their pregnancy (% IPT3)
	Bring 100% of HD and assimilated DS to offer CESOM according to standards (9 functions)
Sub-strategic axis 2.4 : Prevention of non communicable diseases	
Specific Objective2.4 : Reduce the incidence/prevalence of the main non communicable diseases	Reduce the prevalence of type 2 diabetes in adults aged 18 and over from 2.85% to 1%
	Reduce the mortality rate attributable to cardiovascular diseases, cancer, diabetes or chronic respiratory diseases from 22% to 18%
	Reduce hospital prevalence of hypertension by 25%
	Reduce the incidence of cervical cancer from 21% to 12%
	Ensure 100% support and psychological assistance for soldiers returning from a SPO
	Reduce from 21 to 12% the percentage of targets reached during awareness campaigns on the prevention of disability and disabling illnesses in children
CASE MANAGEMENT	
Sub-strategic axis 3.1 : Curative management of communicable and non communicable diseases	
Specific Objective 3.1 : Ensure a curative management according to standards of the main communicable and non-communicable diseases as well as their complications	Increase the therapeutic success rate of smear-positive tuberculosis patients from 86% to 89%
	Reduce the specific mortality rate of malaria in children under 5 years old from 35.7 to 24%
	Improve the proportion of Buruli ulcer cases cured without complications from 82% to 98%
	Reduce the perioperative mortality rate from 20% to 10% in 4th category hospitals

	Reduce the direct intra-hospital obstetric fatality rate from 107 deaths per 100,000 to 96 deaths per 100,000
	Increase the percentage of elderly people who benefit from health and psychosocial assistance from 8,000 to 25,000
Sub-strategic axis 3.2 : Maternal, newborn, child and adolescent conditions	
Specific Objective3.2 : Ensure an overall management according to standards of the maternal, newborn, child and adolescent health issues at the community level	Improve from 60.4% to 90% the proportion of newborns who received postnatal care within 48 hours of birth
	Improve the proportion of repaired obstetric fistula cases from 9% to 25%
	Improve the cesarean delivery rate from 3.5% to 8%
	Reduce the maternal mortality rate from 406 to 300/100,000 NV
	Reduce the neonatal mortality rate from 28/1000NV to 17/1000 NV
	Reduce the infant mortality rate from 48/1000NV to 36/1000NV
	Reduce the infant and child mortality rate from 80/1000NV to 62/1000NV
	Increase from 35% to 100% the percentage of pregnant women diagnosed with syphilis in CPN and who receive treatment according to the standards
	Improve the proportion of deliveries attended by qualified personnel from 61.3% to 75%
	Increase the proportion of live births resulting in a birth declaration to 100%
Sub-strategic axis 3.3 : Emergencies and public health events	
Specific Objective3.3 : Ensure the management of medical and surgical emergencies, and public health events, according to standard operating procedures (SOPs)	Increase from 77% to 100% the proportion of public health emergencies for which the Incident Management System has been activated at the national level
	Increase the proportion of District Hospitals offering blood transfusion according to standards from 10% to 60%
	Achieve a proportion of 100% of DS with a medical ambulance and whose referral versus referral system is functional
	Achieve a 100% proportion of Regional Emergency Operations Centers that have the required HRS
Sub-strategic axis 3.4 : Management of Disability	

Specific Objective 3.4 : Reduce the proportion of the population with at least one correctable disability	Proportion of patients suffering from cataract and having regained visual acuity greater than 3/10 one week after surgical intervention
	Number of disabled people cared for in functional rehabilitation centers
AXE STRATEGIQUE 4: RENFORCEMENT DU SYSTEME DE SANTE	
Lead out 75% of HD to reach the consolidation phase	
Sub-strategic axis 4.1 : Health Financing	
reduce out-of-pocket payments from households through equitable and sustainable financing policy	Reduce the proportion of health expenses borne by households from 52% to 30%
	Improve the rate of people covered by a social health protection mechanism from 20% to 60%
	Increase the proportion of the health budget in the national budget to 15% (SND30)
	Increase from 45% to 65% the proportion of mutual social security companies covering at least three (03) risks
	Increase from 22.7% to 23% the proportion of the employed active population covered for at least three (03) risks
Sub-strategic axis 4.2 : Healthcare and service provision	
Ensure the harmonious development of infrastructure, equipment and the availability of healthcare and service packages according to standards in category 3, 4, 5 and 6 health facilities	Achieve a proportion of 100% of DHs built according to standards
	Achieve a percentage of 100% Health District Services built according to standards
	Increase to 100% the percentage of DH who deliver the full CAP
	Improve the number of patients cured in military medical structures from 253,478 patients to 260,000
	Increase from 20% to 33% the proportion of front-line health establishments (IHC and MHC) which deliver the complete MAP
Sub-strategic axis 4.3 : Drugs and other pharmaceutical products	
Increase the availability and use of quality drugs and pharmaceutical products in all HDs	Improve to 100% the proportion of health facilities that have a basic set of essential medicines available and affordable in a sustainable manner
	Reduce the share of street drugs in the total drug supply to 0%

	Increase the share of traditional medicines in the total supply of medicines to 25%
Sub-strategic axis 4.4 : Human Resources for Health	
Augmenter, selon les besoins priorisés, la disponibilité des RHS	Improve from 52% to 60% the percentage of health structures equipped with at least 50% of human resources according to standards
Increase the availability of HRH according to prioritized needs	Change the Number of medical doctors per inhabitant to 1 per 10,000 inhabitants
	Improve the number of students trained per year in human and animal health from 4,400 to 5,000
Sub-strategic axis 4.5 : **Health Information and Research in Health**	
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	Increase the MAR promptness rate in DHIS2 from 56.6% to 80%
	Increase the MAR completeness rate in DHIS2 to 80%
	Improve the proportion of search results that have been returned from 70% to 80%
	Improve the percentage of authorized research projects whose results have been published from 90% to 100%
	Increase to at least 70% the proportion of deaths occurring in health care settings that have been declared to the competent Civil Status Center
	Increase to at least 70% the proportion of deaths whose cause has been identified and documented
AXE STRATEGIQUE 5 : GOVERNANCE AND STRATEGIC STEERING	
Improve the rate of achievement of the 2020-2030 HSS objectives by increasing it from 32% to 80%	
Sub-strategic axis 5.1 : Gouvernance	
Specific Objective5.1: Improve governance in the sector through the strengthening of standardization, regulation and accountability	Improve the rate of achievement of the 2020-2030 HSS objectives from 32% to 80%
	Increase the proportion of the budget allocated to programmatic priorities from 0% to 100%
	Reduce by 50% the rate of loss of resources allocated to operational level structures
	Audit and control at least 60% of health structures per year
Sub-strategic axis 5.2 : Strategic steering	

Specific Objective5.2: Reinforce planning, supervision, coordination as well as strategic and health surveillance at all levels of the health pyramid	Improve the rate of completion of inspection missions (central level) and integrated supervision (RDPH and HD) to 100%
	Get 100% of DRSP to fill in the projected performance monitoring dashboard in the NHDP
	Produce 01 annual health sector review report
	Ensure the linkage 100% of the AWP of health sector structures to the NHDP

5.2. INTERVENTION FRAMEWORK OF THE NHDP 2021-2025

Overall objective of the HSS: Contribute to the development of healthy, productive human capital capable of supporting strong, inclusive and sustainable growth

Overall objective NHDP: Improve people's access to quality priority essential and specialized health services and care

Table 20: Framework for intervention

STRATEGIC AXIS 1: PROMOTION OF HEALTH AND NUTRITION							
Central problem of the component: Insufficient capacity of populations to adopt favourable behaviours to solve their health problems							
Strategic Outcome: Bring the populations to adopt healthy behaviours by 2025							
Strategic sub-axis 1.1: Institutional, community and coordination capacities in the field of health promotion							
Specific objective S.O 1.1: Strengthen institutional capacity, coordination and community participation in the field of health promotion in 80% of HDs							
TARGETS: • Increase the proportion of DS with functional Health District Committee (HDC) from 94.2% to 95% • Improve the ratio of CHW per inhabitants • Achieve a Community MAR completeness rate of 100% • Improve the proportion of the DTC budget allocated to Health Facilities within the framework of decentralization • Improve by 30% 35% the rate of access of indigenous populations to basic social services (notably health) and to public life • Improve the proportion of the RFHP budget allocated to support HDCs							
Implementation Strategy	**Interventions**	**Administration Responsible**	**Timeline**				
			2021	**2022**	**2023**	**2024**	**2025**
1.1.1 Providing technical expertise and transfer of competences to administrations of the health sector for an effective implementation of health promotion actions	1.1.1.1. Strengthen the availability of health promotion inputs (human resources, finance, medicines, awareness-raising materials, etc.) at all levels of the health pyramid.	MOH	X	X	X	X	X

	1.1.1.2 Strengthening the provision of initial training in community health	MOH	X	X	X	X	X
	1.1.1.3 Strengthen the capacity of RDPH/HD technical services in the area of health promotion	MOH	X	X	X	X	X
1.1.2 Transfer of competence to the community for an appropriation of health interventions	1.1.2.1. Provide technical support to community leaders and actors (CBO, CSO, CHW, and Dialogue Structures) in solving environmental health problems	MOH	X	X	X	X	X
1.1.3. Strengthening the legal framework for greater community participation							
1.1.4 Providing technical expertise and transfer of competences to RLAs and community-based organizations (dialogue structures, civil society organizations, non governmental organizations) in the field of health promotion	1.1.4.1 Support DTCs in the development and implementation of health and nutrition promotion interventions	MOH	X	X	X	X	X
1.1.5 Improving the multi-sector coordination in the implementation of health promotion interventions	1.1.5.1. Develop and implement at all levels of the health pyramid, a multi-year and multisectoral Health Promotion and Nutrition Plan	MOH	X	X	X	X	X
1.1.6: Revising the training curricula to better take into account the socio- environmental approach in educational programs	1.1.6.1. Develop training curricula that take into account the socio-environmental approach in teaching programmes	MOH	X	X	X	X	X
1.1.7: Improving the provision of health promotion services that meet the needs of the individual as a whole	1.1.7.1. Develop a level of care and coordination of community service provision in the health district	MOH	X	X	X	X	X

Strategic sub-axis 1.2: Living environment of populations

Specific objective S.O 1.2: Improve the living environment of populations in at least 70% of health districts

Targets:
- Increase the percentage of households using improved toilets from 57.9% to 75%
- Reduce the proportion of households that use solid fuel as their primary source of domestic energy for cooking from 78% to 50%
- Improve the proportion of households with access to drinking water by increasing it from 79% to 90%
- Reduce the mortality rate attributable to unsafe water, sanitation system deficiencies and lack of hygiene (access to inadequate WASH services) (SDG 3.9.2.)from 45.2 per 100 000 inhabitants to 25 per 100,000 inhabitants
- Increase from 55% to 75% the proportion of health districts implementing Community-Led Total (CLTS)
- Improve the proportion of subject companies with a Health and Safety Committee (CHS) installed and functional from 25% to 40%
- Reduce the number of work accidents (fatal and non-fatal) from 684 to 382
- Improve the proportion of households living in decent housing from 35% to 35.5%
- Improve the proportion of households with access to a sanitation system from 2.5% to 3%
- Improve daily water production capacity by increasing it from 1,100,000m^3/day to 1,600,000m^3/day
- Increase the drinking water supply rate from 47% to 55%
- Increase the service rate of improved on-site sanitation infrastructure from 45% to 61%
- Increase the quantity of municipal solid waste disposed of adequately from 7,000 to 11,000 tonnes
- Reduce the percentage of people vulnerable to climate change from 1.3% to 1%

Implementation Strategy	Interventions	Administration Responsible	Timeline				
			2021	2022	2023	2024	2025
1.2.1: Improving environmental health (water, hygiene, and sanitation)	1.2.1.1.Continue scaling up community-led total sanitation (CLTS) in councils /HDs	MOH	X	X	X	X	X
	1.2.1.2.Ensure training and equitable deployment of sanitary engineering personnel in HDs	MOH	X	X	X	X	X
	1.2.1.3. Strengthening health and safety in the workplace	MINTSS	X	X	X	X	X
	1.2.1.4. Improving daily drinking water production capacity	MINEE	X	X	X	X	X

	1.2.1.5. Develop drinking water production, storage and distribution facilities with a daily production capacity of less than 100m^3	MINEE	X	X	X	X	X
	1.2.1.6. Strengthening hygiene and sanitation in prisons	MINJUSTICE	X	X	X	X	X
1.2.2: Promoting structured urban development and planning of slums	1.2.2.1 Improve people's access to decent housing	MINHDU	X	X	X	X	X
1.2.3: Strengthening preventive actions against soil, water and air pollution	1.2.3.1 Developing urban sanitation systems	MINHDU	X	X	X	X	X
	1.2.3.2 Improve access to sewage management	MINEE	X	X	X	X	X
1.2.4 Developing best practices for resilience and management of risks and disasters related to climate change	1.2.4.1 Strengthening the resilience of populations and production systems for adaptation to climate change	MINEPDED	X	X	X	X	X

Strategic sub-axis 1.3: Strengthening health-promoting skills

Specific objective S.O 1.3: Develop promotional actions in at least 80% of HDs, in order to strengthen the health-promoting skills of individuals and communities

Targets

- Reduce the prevalence of teenage pregnancies from 24% to 17%
- Reduce the prevalence of smoking among subjects aged 15 and over from 4.3% to 2%
- Reduce the chronic malnutrition rate of pregnant or lactating women from 39.4% to 20%
- Reduce the prevalence of food insecurity from 10 to 7%
- Increase from 50 to 70% the proportion of targets reached during awareness-raising activities on the fight against drug consumption in school and outside of school.
- Reduce the number of deaths due to road accidents from 473 to 385
- Ensure the availability of a source of drinking water in 100% of primary schools
- Reduce from 29% to 26% the rate of chronic malnutrition among under 5 years old children

Implementation Strategy	**Interventions**	**Administration Responsible**	**Timeline**				
			2021	2022	2023	2024	2025

1.3.1 Promoting healthy eating and nutrition habits	1.3.1.1. Developing C4D for the adoption of healthy behaviours in food/nutrition	MOH	X	X	X	X	X
	1.3.1.2.Developing a nutritional surveillance system	MOH	X	X	X	X	X
	1.3.1.3.Strengthening food and nutrition security for vulnerable populations	MINADER	X	X	X	X	X
	1.3.1.4. Establishment of a national plan to combat malnutrition (breastfeeding mothers and children under 5)	MOH	X	X	X	X	X
	1.3.1.5. Establishment of a price support system for access to nutrients and infant foods	MINCOMMERCE	X	X	X	X	X
	1.3.1.6. Strengthening food safety	MINCOMMERCE					
1.3.2: Control of smoking, alcohol abuse and consumption of illicit substances (modifiable risk factors for non-communicable diseases)	1.3.2.1. Strengthening mechanisms to control the use of tobacco, drugs and other illicit substances	MOH	X	X	X	X	X
	1.3.2.2. Strengthening the law against drug use in schools and out-of-school environment	MINAS	X	X	X	X	X
	1.3.2.3. Stepping up the fight against drugs and violence in schools	MINESEC	X	X	X	X	X
1.3.3 Reinforcing road safety	1.3.3.1. Developing mechanisms for reducing risks due to road users' behaviour	MINT	X	X	X	X	X
	1.3.3.2. Stepping up the fight against road safety and various types of traffic	MINDEF	X	X	X	X	X
1.3.4 Strengthening the practice of physical and sport activities	1.3.4.1. Promote and publicize physical and sports activities (PSA)	MINSEP	X	X	X	X	X

	1.3.4.2. Strengthening sports activities in schools	MINESEC	X	X	X	X	X
1.3.5. Strengthening Integrated Communication for Development (C4D) and social marketing	1.3.5.1. Develop and implement an integrated strategic communication plan for the adoption of healthy behaviours	MOH	X	X	X	X	X
	1.3.5.2. Improving health and psychological support in schools	MINESEC	X	X	X	X	X
	1.3.5.3. Health promotion in School	MINEDUB MINESEC	X	X	X	X	X
	1.3.5.4. Public assistance for the elderly	MINAS		X	X	X	
Strategic Sub-axis 4: Essential Family Practices, Family Planning, Adolescent Health Promotion and Post-abortion Care							
Specific objective S.O: 1.4: Bring 75% of families to adopt essential family practices, including family planning.							
Targets Improve modern contraceptive prevalence among women of childbearing age by increasing it from 15% to 30% Reduce the proportion of unmet FP needs from 23% to 13% Reduce the fertility rate among adolescent girls aged 15 to 19 from 24% to 15% per 1,000 adolescent girls Reduce the proportion of women aged 20 to 24 married or in a relationship before the age of 15 from 10.7% to 8% Reduce the proportion of women aged 20 to 24 married or in a relationship before the age of 18 from 29.8% to 20% Reduce from 31.5% to 25% the proportion of women and girls aged 15 or over who have lived as a couple who are victims of physical, sexual or psychological violence inflicted during the previous 12 months by their current partner or a former partner Reduce from 15 to 10% the proportion of children who have suffered at least one form of violence or abuse Improve the proportion of deliveries attended by qualified personnel from 61.3% to 75% Ensure the establishment of a birth certificate for at least 95% of registered live births							
Implementation Strategy	**Interventions**	**Administration Responsible**	**Timeline**				
			2021	**2022**	**2023**	**2024**	**2025**
1.4.1: Improving public policies in favour of Family planning (FP)	1.4.1.1 Develop FP repositioning mechanisms	MOH	X	X	X	X	X

1.4.2. Improving demand for FP services	1.4.2.1. Develop and implement an integrated strategic communication plan for the adoption of healthy and healthy behaviours (PM see 1.3.5.1.)	MOH	X	X	X	X	X
1.4.3 Improving FP service delivery and use	1.4.3.1. Expand and ensure availability of FP service provision in HFS and at community level (modern contraceptives, FP equipment, etc.)	MOH	X	X	X	X	X
	1.4.3.2. Developing FP services adapted to youth and adolescents	MOH	X	X	X	X	X
1.4.4. Strengthening the monitoring and coordination of RH/FP interventions	See the Governance and Strategic Management Axis		X	X	X	X	X
1.4.5. Strengthening the promotion, monitoring and coordination of birth registration	1.4.5.1. Develop integrated communication, awareness and training modules on birth registration	BUNEC		X	X	X	X
	1.4.5.2. Scale up the installation of civil status offices in health facilities	BUNEC MINSANTE		X	X	X	X
	1.4.5.3. Organize integrated BUNEC-MINSANTE campaigns	BUNEC MINSANTE		X	X	X	X
	1.4.5.4. Strengthen the interoperability of DHIS2 and SIGEC systems	BUNEC MINSANTE		X	X	X	X
1.4.6: Strengthening other essential household practices conducive to health	1.4.6.1.Develop information sharing mechanisms in communities (in family, prison, school, and specific groups) for the CTI	MOH	X	X	X	X	X
	1.4.6.2.Mobilizing communities for ITI uptake and demand for health services	MINPROFF	X	X	X	X	X
	1.4.6.3. Strengthening the fight against gender-based violence	MINPROFF	X	X	X	X	X
	1.4.6.4.Promoting mechanisms for the protection of children's rights	MINPROFF	X	X	X	X	X

STRATEGIC AXIS 2: DISEASE PREVENTION
Central component issue: Morbidity and mortality of communicable and non-communicable diseases remain high in Cameroon
Strategic goal: By 2025, reduce premature mortality from preventable diseases
Strategic Sub-axis 2.1: Prevention of Communicable Diseases
PREV Specific Objective 2.1: Reduce by at least 30% the incidence/prevalence of major communicable diseases (HIV, malaria and TB) and eradicate some NTDs (lymphatic filarioisis and HAT)
Targets 1. Reduce HIV incidence to 1.7‰ 2. Reduce HIV prevalence from 2.70% to 3.7% 3. Reduce the prevalence of viral hepatitis B from 8.30% to 6% 4. Increase coverage of preventive chemotherapy for onchocerciasis from 81% to 86% 5. Reduce the prevalence rate of malaria in children under 5 years old from 24% to 16% 6. Improve the percentage of Long-Lasting Insecticide-Impregnated Mosquito Nets (LLINs) distributed among those planned by increasing it from 77.3% to 100% 7. Increase the % of pregnant women infected with HIV and on ART from 63.91% to 95% 8. Reduce the prevalence rate of communicable diseases in prisons from 20% to 14% 9. Reduce the incidence of TPM+ tuberculosis from 194 new cases per 100,000 inhabitants to 1.7% 10. Ensure deworming of 100% of school-age children

Implementation Strategy	Interventions	Administration Responsible	Timeline				
			2021	2022	2023	2024	2025
2.1.1: Strengthening the coordination and integration of the preventive interventions of communicable diseases	2.1.1.1. Strengthening the technical skills of institutional and community actors	MOH	X	X	X	X	X
	2.1.1.2. Develop and implement an integrated communication strategy taking into account health promotion and disease prevention aspects (PM see 1.3.5.1.)	MOH	X	X	X	X	X
	2.1.1.3. Develop and implement integrated strategies for the effective use of health care and services at all levels	MOH		X	X	X	X
	2.1.2.1. Regularly supply HFS with prevention inputs for communicable diseases	MOH	X	X	X	X	X

2.1.2: Strengthening the prevention of HIV/AIDS, Tuberculosis, STIs and Viral Hepatitis especially for the most vulnerable groups	2.1.2.2. Organizing screening activities for the prevention of major communicable diseases	MOH	X	X	X	X	X
	2.1.2.3. Strengthening STI/AIDS prevention in young people	MINJEC	X	X	X	X	X
2.1.3 Strengthening Malaria Prevention	2.1.3.1 Regularly supply communities with malaria prevention inputs	MOH	X	X	X	X	X
	2.1.3.2 Develop multisectoral mechanisms for malaria prevention	MOH	X	X	X	X	X
	2.1.3.3. Organize chemo prevention campaigns for seasonal malaria	MOH	x	x	x	x	x
	2.1.3.4. Strengthening intermittent preventive treatment in pregnant women	MOH	x	x	x	x	x
2.1.4: Strengthening the prevention of NTDs and other communicable diseases	2.1.4.1 Strengthening Epidemiological Surveillance of Neglected Tropical Diseases	MOH	X	X	X	X	X
	2.1.4.2. Prevention of endemic diseases in prisons	MINJUSTICE	X	X	X	X	X
Strategic sub-axis 2.2: Surveillance and response to diseases with epidemic potential, zoonoses and public health events							
Specific objective PREV 2.2: Reduce the risk of the occurrence of major public health events, epidemic-prone diseases as well as Zoonoses in at least 90% of districts							
Targets: 1. Improve the proportion of measles epidemics notified and investigated from 61% to 90% 2. Increase the proportion of the target population having received all the vaccines provided for by the national program from 52% to 90% 3. Increase vaccination coverage with the reference antigen (Penta3) from 88% to 95% 4. Improve vaccination coverage in RR1 from 73.9% to 85% 5. Improve the Index of main capacities required according to the International Health Regulations (IHR) from 40% to 100%							
Implementation Strategy	Interventions	Administration Responsible	2021	2022	2023	2024	2025

2.2.1 Strengthening the epidemiological surveillance system	2.2.1.1. Strengthen the operational capacities of HDs in the prevention of epidemics and public health events	MOH	X	X	X	X	X
	2.2.1.2. Update annually the mapping of health risks in the RDPHHDs (HDs at risk of epidemics and health emergencies) and develop annual operational plans for appropriate responses to the health risks identified.	MOH	X	X	X	X	X
2.2.2: Improving the prevention of vaccine preventable diseases	2.2.2.1. Organize campaigns and additional intensified vaccination activities (Polio vaccination, deworming of children from 12 to 59 months during SASNIM) at the national level	MOH	X	X	X	X	X
	2.2.2.2. Strengthen routine immunization service provision (vaccine procurement, community linkages, micro-planning, advanced strategies) For the record	MOH	X	X	X	X	X
2.2.3: Improving the prevention of other EPDs not included in the EPI							
2.2.4 Strengthening preparedness and response to epidemics and major public health events	2.2.4.1. Ensure the continued supply of inputs to HDs needed to respond to epidemics and potential emerging diseases.	MOH	X	X	X	X	X
	2.2.4.2. Strengthening the Integrated Disease Surveillance and Response (IDSR)	MOH	X	X	X	X	X
	2.2.4.3. Strengthen implementation of the International Health Regulations (IHR) and preparedness for health emergencies (SDG 3.d.1)	MOH	X	X	X	X	X
Strategic Sub-Axis 2.3: RMNCAH and PMTCT							

Specific objective PREV 2.3: Increase by at least 80% the coverage of high-impact preventive interventions for the mother, newborn and child target in at least 80% of health districts							
Targets: 1. Increase the ANC 4 coverage rate from 65% to 95% 2. Reduce the rate of HIV transmission from mother to child from 3% to 1% (proportion of children exposed to HIV) 3. Reduce the proportion of newborns weighing less than 2500g from 7% to 5% 4. Improve by 50% the proportion of pregnant women who received at least 3 doses of IPT during their pregnancy (% IPT3) 5. Bring 100% of HD and similar DS to offer CESOM according to standards (9 functions)							
Implementation Strategy	Interventions	Responsible	2021	2022	2023	2024	2025
2.3.1 Institutional Capacity Building (HFS) and Community Capacity Building in RMNCAH	2.3.1.1. Ensure in HFSs, the permanent availability of inputs for effective M&E interventions on maternal, newborn, child and adolescent targets (early HIV tests, PCR, maternity equipment, drugs for IPT, PMTCT, HIV, vaccines etc.)	MOH	X	X	X	X	X
	2.3.1.2. Strengthen the capacities of institutional and community providers of targeted HDs for a quality service offer in PMTCT, ANC, postnatal care, post-abortion care	MOH	X	X	X	X	X
	Extending SONU Monitoring to all health districts	MOH	X	X	X	X	X
2.3.2: Improved RMNCAH services and care	2.3.2.1. Gradually expand the offer of RMNCAH services and care nationwide (advanced strategy, telemedicine, subsidy or free for certain groups, etc.) While improving the quality of care offered (good reception, use of normative documents)	MOH	X	X	X	X	X

	2.3.2.2. Prevention of disability and disabling diseases in children	MINAS	X	X	X	X	X
2.3.3: Strengthening integrated communication at all levels for citizen mobilization around RMNCAH targets	2.3.3.1. Strengthen the use of C4D (advocacy, social mobilization, and community animation) in HFs care services	MOH	X	X	X	X	X
Strategic Sub-axis 2.4: Prevention of Non-communicable Diseases							
PREV Specific Objective 2.4: Reduce by at least 10% the incidence/prevalence of major non-communicable diseases							
Target 1. Reduce the prevalence of type 2 diabetes in adults at least 18 years old from 2.85% to 1% 2. Reduce the mortality rate attributable to cardiovascular diseases, cancer, diabetes or chronic respiratory diseases from 22% to 18% 3. Reduce hospital prevalence of hypertension by 25% 4. Reduce the incidence of cervical cancer from 21% to 12% 5. Ensure 100% support and psychological assistance for soldiers returning from an OPS 6. Reduce from 21 to 12% the percentage of targets reached during awareness campaigns on the prevention of disability and disabling illnesses in children							
Implementation Strategy	**Interventions**	**Administration Responsible**	**2021**	**2022**	**2023**	**2024**	**2025**
2.4.1: Strengthening coordination and integration of NCD prevention interventions	2.4.1.1. Develop and implement an integrated and multisectoral NCD strategy	MOH		X	X		
	2.4.1.2. Develop and implement a multisectoral coordination and monitoring and evaluation mechanism for Non Communicable Diseases prevention interventions	MOH			X	X	
2.4.2. Promotion of health research to reduce the incidence of NTDs	2.4.2.1. Strengthening the system for the suppression and marketing of fraudulent food products or smuggling	MINCOMMERCE	X	X	X	X	X
	2.4.2.2. Strengthening early intervention actions for the misuse of dependent substances	MOH		X	X	X	X
	2.4.2.3. Strengthen the support, monitoring and care of MINDEF staff in the field of health	MINDEF		X	X	X	X
2.4.2 Promoting Research to Reduce the Impact of NCDs							

2.4.3 Raising population awareness on non-communicable diseases and encouraging prevention	2.4.4.1. Develop an integrated communication strategy for the prevention of non-communicable diseases (For the record)	MOH	X	X	X	X	X
	2.4.4.2. Organize at least one annual prevention and screening campaign at regional level for NCDs (hypertension, diabetes, cancers, etc.)	MOH	X	X	X	X	X
2.4.4: Improved prevention of oral diseases, visual and hearing disorders							
2.4.5 Strengthening the prevention of sickle cell disease from other genetic and degenerative diseases	2.4.6.1. Increasing the availability of genetic disease prevention (sickle cell disease) services at the operational level	MOH	X	X	X	X	X
2.4.6: Strengthening the prevention of mental illness, epilepsy and other neurological conditions							
2.4.7: Strengthening the prevention of diabetes, hypertension, other cardiovascular diseases and kidney diseases							
2.4.8: Strengthening the prevention of cancer, asthma and other chronic respiratory diseases							
2.4.9:Strengthening the prevention of rare diseases							

STRATEGIC AXIS 3: CASE MANAGEMENT							
Central component issue: The quality of diagnosis and curative case management is insufficient							
Strategic goal: By 2025, reduce overall mortality and lethality in health facilities and in the community							
Strategic sub-axis 3.1: Curative management of communicable and non-communicable diseases							
Specific objective SO 3.1: Provide curative care for all communicable and non-communicable diseases as well as their complications according to standards in at least 80% of health facilities							
Targets: 1. Increase the therapeutic success rate of smear-positive tuberculosis patients from 86% to 89% 2. Reduce the specific mortality rate of malaria in children under 5 years old from 35.7 to 24% 3. Improve the proportion of Buruli ulcer cases cured without complications by increasing it from 82% to 98% 4. Reduce the perioperative mortality rate from 20% to 10% in 1st, 2nd, 3rd and 4th category hospitals 5. Reduce the direct intra-hospital obstetric fatality rate from 107 deaths per 100,000 to 96 deaths per 100,000 6. Increase the percentage of elderly people who benefit from health and psychosocial assistance from 8,000 to 25,000							
Implementation Strategy	**Interventions**	**Administration Responsible**	**Timeline**				
			2021	**2022**	**2023**	**2024**	**2025**
3.1.1. Improving the quality of care and services in HFs through focusing on patients reception.	3.1.1.1. Develop mechanisms for continuous improvement of the quality of health care and services at all levels of the health pyramid	MOH	X	X	X	X	X
3.1.2 Improving diagnosis and curative management of HIV/AIDS, TB, STDs and Viral Hepatitis	3.1.2.1. Ensure the availability of inputs for the diagnosis and management of cases of communicable diseases (HIV, TB, STI and Viral Hepatitis)	MOH	X	X	X	X	X
3.1.3. Improving diagnosis and management of malaria cases and the main causes of fever (dengue, typhoid, influenza, etc.)	3.1.3.1. Systematize the use of validated operational procedures and protocols for the diagnosis and management of malaria cases	MOH	X	X	X	X	X

3.1.4: Improving the diagnosis and management of cases of Neglected Tropical Diseases	3.1.4.1. Systematize the use of validated operational procedures and protocols for the diagnosis and treatment of NTDs	MOH	X	X	X	X	X
3.1.5: Improving the diagnosis and management of cases of Non-communicable diseases	3.1.5.1. Decentralizing the case management for diabetes and hypertension through the creation of care units at the decentralized levels of the health pyramid	MOH	X	X	X	X	X
	3.1.5.2. Organize community-based Non communicable Diseases diagnostic activities	MOH	X	X	X	X	X
	3.1.5.3. Improve the diagnosis and management of mental illness and substance dependence	MOH	X	X	X	X	X
3.1.6: Improving the comprehensive (holistic) management of cases at all levels of the health pyramid	3.1.6.1 Build the capacity of health workers to use simplified guides and protocols for comprehensive disease management	MOH	X	X	X	X	X
	3.1.6.2. Ensure hospital case management for children under 5 years of age according to standards	MOH	X	X	X	X	X
	3.1.6.3. Improving health care for prisoners	MINJUSTICE	X	X	X	X	X
	3.1.6.4. Develop and implement palliative care protocols	MOH	X	X	X	X	X
	3.1.6.5. Providing appropriate health and psychosocial assistance to older people	MINAS	X	X	X	X	X

	3.1.6.6. Facilitating access to health for vulnerable indigenous populations	MINAS	X	X	X	X	X
Strategic sub-axis 3.2: Maternal, neonatal, infant and adolescent conditions and health							
Specific objective SO 3.2: Ensure the overall management and according the standards maternal, new-born, child and adolescent health problems at the level of the community and in at least 80% health facilities							
Targets 1. Improve from 60.4% to 90% the proportion of newborns who received postnatal care within 48 hours of birth 2. Improve the proportion of repaired obstetric fistula cases from 9% to 25% 3. Improve the cesarean delivery rate from 3.5% to 8% 4. Reduce the maternal mortality rate from 406 to 300/100,000 NV 5. Reduce the neonatal mortality rate from 28/1000NV to 17/1000NV 6. Reduce the infant mortality rate from 48/1000NV to 36/1000NV 7. Reduce the infant and child mortality rate from 80/1000NV to 62/1000NV 8. Increase the percentage of pregnant women diagnosed with syphilis in ANC from 35% to 100% and who receive treatment according to the standards 9. Increase the proportion of live births resulting in a birth declaration to 100%							
Implementation Strategy	Interventions	**Administration Responsible**	Timeline				
			2021	2022	2023	2024	2025

3.2.1 Improving financial and cultural accessibility to RMNCAH care	3.2.1.1. Strengthen the implementation of ongoing strategies to improve the geographical, cultural and financial accessibility of RMNCAH targets to quality health services and care	MOH	X	X	X	X	X
3.2.2. Improving the availability and geographical access of services for the prevention of vertical transmission of HIV and Hepatitis B from the mother to the child (scaling-up PMTCT in functional HFs)	3.2.2.1. Increasing the availability of PMTCT inputs	MOH	X	X	X	X	X
	3.2.2.2. Strengthen strategies aimed at reaching targets to PMTCT services and care, including in advanced strategies.	MOH	X	X	X	X	X
3.2.3 Improving the quality of the Integrated Management of Childhood Illness (clinical and community IMCI)	3.2.3.1. Providing health services and care to children under 5 years of age with IMCI in the 4th and 5th category HFs	MOH	X	X	X	X	X
3.2.4: Improving the availability of the provision of quality RMNCAH service and care package	3.2.4.1. Strengthen the provision of services for the adequate management of adolescent health problems in district hospitals.	MOH	X	X	X	X	X
	3.2.4.2. Ensure in the HDs, the availability of packages of interventions with high impact on the health of the mother, the newborn and the child	MOH	X	X	X	X	X
	3.2.4.3. Strengthen the capacities of Health Units to provide pregnant women with a package of care and services integrating aspects related to civil status	BUNEC	X	X	X	X	X
3.2.5 Strengthening the capacities of HFs and the community in RMNCAH	3.2.5.1. Implement innovative mechanisms to build the capacity of RMNCAH staff	MOH	X	X	X	X	X

3.2.6: Strengthening integrated communication at all levels for citizen mobilization for maternal, newborn and child health issues	SEE STRATEGIC AXIS: PROMOTING HEALTH AND NUTRITION		X	X	X	X	X
Strategic Sub-Axis 3.3: Public Health Emergencies and Events							
Specific objective OS 3.3: Ensure the management of medical and surgical emergencies, disasters and public health events in at least 80% of health facilities according to standard operating procedures							
Targets: Increase from 77% to 100% the proportion of public health emergencies for which the Incident Management System has been activated at the national level Increase the proportion of District Hospitals offering blood transfusion according to standards from 10% to 60% Achieve a proportion of 100% of DS with a medical ambulance and whose referral versus referral system is functional Achieve a 100% proportion of Regional Emergency Operations Centers that have the required HRS							
Implementation Strategy	Interventions	Responsible	Timeline				
			2021	2022	2023	2024	2025
3.3.1: Strengthening multi-sector coordination in the management of medical and surgical emergencies and public health events	3.3.1.1. Establish a support fund at all levels for the coordination of emergency management and public health events (For the record)	MOH	X	X	X	X	X
	3.3.1.2. Ensure the functioning of the National Emergency Operations Centre for effective management and coordination of field activities	MOH	X X	X X	X X	X X	X X

	3.3.1.3. Provide support for victims of security crises, disasters, natural disasters with a view to their rapid return to "normal" living conditions	MINAS					
3.3.2: Strengthening the resource management forecasting procecss	3.3.2.1 Regularly supply health facilities with inputs for the management of medical-surgical emergencies after assessment of their institutional, consumption and management capacities	MOH	X	X	X	X	X
	3.3.2.2. Enhance the functionality of the emergency response system (emergency situations; staffing of investigation and response teams)	MOH	X	X	X	X	X
	3.3.2.3. Establish multi-sectoral Investigation and Rapid Response Teams (RRTs) in the 10 regions	MOH	X	X	X	X	X
	3.3.2.4. Develop mechanisms for operationalizing the referral and counter referral mechanism in all regions						

3.3.3 Strengthening diagnosis and curative management of emergencies and public health events	3.3.3.1. Ensure pre-hospital management (first aid) of emergency cases with full community participation	MOH	X	X	X	X	X
	3.3.3.2. Strengthen the financial, infrastructural and technological capacities of CERPLE, the National Emergency Operations Centre and border health posts for a rapid and effective response in the event of epidemics or other public health emergencies	MOH	X	X	X	X	X
	3.3.3.3. Strengthen the technical capacities of HD/HR/Border Health Posts and community actors for an effective response in the event of epidemics or other public health emergencies	MOH	X	X	X	X	X
Strategic sub-axis 3.4: Disability care							
Specific objective OS 3.4 : Reduce by at least 20% the proportion of the population with at least one correctable disability							
Targets: Proportion of patients suffering from cataract and having regained visual acuity greater than 3/10 one week after surgical intervention Number of disabled people cared for in functional rehabilitation centers							
Implementation Strategy	Interventions	Responsible	Timeline				
			2021	2022	2023	2024	2025

3.4.1: Establishing an integrated and coordinated policy for disability management including mental disability	3.4.1.1 Ensure disability cares according to updated guidelines and standards	MOH	X	X	X	X	X
	3.4.1.2 Social protection of persons with disabilities	MINAS					
	3.4.1.3 Prevention of disability and disabling diseases in children	MINAS					
3.4.2: Decentralizing the management of disability interventions	3.4.2.1. Strengthen institutional capacities and those of actors responsible for the prevention and management of correctable disability	MOH	X	X	X	X	X
	3.4.2.2. Improving the offer of specialized rehabilitation services functional of Persons with Disabilities	MINAS	X	X	X	X	X
	3.4.2.2. Building and equipment of the Rehabiliation centre for the disabled persons (Centre de Réhabilitation des Personnes Handicapées : CRPH) in Maroua	MINAS	X	X	X	X	X
	3.4.2.3. Renovation of the Cardinal Paul Emile LEGER (CNRPH-CPEL) National Centre for the Rehabilitation of Persons with Disabilities in Yaoundé	MINAS	X	X	X	X	X

STRATEGIC AXIS 4: STRENGTHENING THE HEALTH SYSTEM							
Central problem of the component: Insufficient development of health system pillars							
Strategic objective: Increase the institutional capacities of health structures for equitable access of populations to quality health care and services							
Strategic sub-axis 4.1: Health financing							
Specific objective 4.1: reduce by at least 30% out-of-pocket payments from households through a fair and sustainable financing policy							
Targets: Reduce the proportion of health expenses borne by households from 52% to 30% Improve the rate of people covered by a social health protection mechanism from 20% to 60% Increase the proportion of the health budget in the national budget to 15% (SND30) Increase from 45% to 65% the proportion of mutual social security companies covering at least three (03) risks Increase from 22.7% to 23% the proportion of the employed active population covered for at least three (03) risks							
Implementation Strategy	**Interventions**	**Responsible Administration**	**2021**	**2022**	**2023**	**2024**	**2025**
4.1.1 Developing disease risk sharing mechanisms	4.1.1.1. Develop and implement a national UHC-oriented financing strategy	MOH DTC	X	X	X	X	X
	4.1.1.2. Reduce the share of household out-of-pocket payments in total health expenditure from 70% to 50%	MOH	X	X	X	X	X
	4.1.1.3. Strengthen financial risk protection mechanisms to improve access to care (health insurance, social security, health vouchers, mutual health insurance, etc.)	MINTSS	X	X	X	X	X
	4.1.1.4. Strengthening the social security system	MINTSS	X	X	X	X	X
	4.1.1.5. Extension of social security to the marginal layers	MINTSS	X	X	X	X	X
	4.1.1.6. Extension of social security to the material field (branches) of social security	MINTSS	X	X	X	X	X
	4.1.1.7. Operationalization of Universal Health Coverage						

4.1.2: Streamlining and strengthening institutional health financing mechanisms	4.1.2.1. Improving budget management and health financing	MOH	X	X	X	X	X
4.1.3 Strengthening financial resource mobilization	4.1.3.1. Update and disseminate a health financing strategy document	MOH			X	X	X
	4.2.3.2. Operationalizing the NATIONAL COMPACT	MOH			X	X	X
4.1.4: Strengthening autonomous financial management at the operational level	4.1.4.1.Develop framework texts granting more autonomy in the management of revenues allocated to HFS at the decentralized level in order to promote the match between the funding received and the problems identified in the HFS	MOH			X	X	X
4.1.5: Strengthening the performance and efficiency of the health system	4.1.5.1. Evaluate quarterly the performance of health structures at all levels of the health pyramid by integrating incentive mechanisms for positive competition between HFSs	MOH	X	X	X	X	X
	4.1.5.2.Develop the National Health Accounts on a triennial basis	MOH	X	X	X	X	X
	4.1.5.3. Introduce hospital performance contracts to promote quality of care and empowerment of HFS	MOH	X	X			
Strategic sub-axis 4.2: Provision of care and services							
Specific objective 4.2: Ensure the harmonious development of infrastructure, equipment and the availability of health care and service packages according to standards in at least 80% of category 3, 4, 5 and 6 health facilities							
Targets: Achieve a proportion of 100% of DHs built according to standards Achieve a percentage of 100% Health District Services built according to standards Increase to 100% the percentage of DH who deliver the full CAP Improve the number of patients cured in military medical structures from 253,478 patients to 260,000 Increase from 20% to 33% the proportion of front-line health establishments (IHC and MHC) which deliver the complete MAP							
Implementation Strategy	**Interventions**	**Responsible**	**2021**	**2022**	**2023**	**2024**	**2025**

4.2.1: Institutional capacity building of HFs for a better case management at all levels of the health pyramid	4.2.1.1. Update and implement the hospital reform taking into account the health card	MOH	X	X	X	X	X
	4.2.1.3 Develop mechanisms and tools for the evolution of SDs towards their servicing	MOH	X	X	X	X	X
	4.2.1.4 Institutionalizing traditional medicine	MOH	X	X	X	X	X
	4.2.1.5 Strengthening the technical platforms of reference hospital structures	MOH					
4.2.2 Improving infrastructure supply (construction / rehabilitation / expansion of health facilities according to standards)	4.2.2.1. Develop and implement health development plans at all levels that incorporate a coherent and realistic vision for infrastructure and equipment development	MOH	X	X	X	X	X
	4.2.2.2. Ensure the construction and equipment of prison health infrastructures	MINJUSTICE	X	X	X	X	X
4.2.3 Enhancing equipment in health services based on standards	4.2.3.1. Develop and implement a coherent plan for equipping health facilities at all levels according to prioritized needs	MOH	X	X	X	X	X
	4.2.3.2. Build, equip and make functional the National Centre and the approved Specialized Structures for blood transfusion at the deconcentrated level and ensure the permanent availability of blood products	MOH	X	X	X	X	X
	4.2.3.3. Strengthening the operational capabilities of hospital emergency departments	MOH					
4.2.4: Strenghtening community action and providing the community level with inputs according to standards and priorities (community healthcare and service provision)	4.2.4.1. Disseminate the National Strategic Plan for Community Health (PSNSC) and its investment case	MOH	X	X	X	X	X
	4.2.4.2 Establish mechanisms for capacity building of community actors	MOH					

4.2.5. Setting up a quality assurance system for health care and services	4.2.5.1 Strengthening mechanisms to ensure quality of health care and services	MOH	X	X	X	X	
4.2.6 Improving the availability of quality health care and service packages in health facilities at all levels: development of health districts and centres of excellence	4.2.6.1. Progressively strengthen the availability/accessibility of LDCs/BCPs in working-level HFS	MOH	X	X	X	X	
	4.2.6.2. Equipping schools and universities with first aid kits	MINEDUBMINESEC	X	X	X	X	X
	4.2.6.3. Increase the supervision and assistance of Veterans and War Victims	MINDEF	X	X	X		
	4.2.6.4. Improve the capacity of military health structures and formations to support national public health policy	MINDEF	X	X	X	X	X
4.2.7: Strengthening the referral/counter referral system	4.2.7.1 Update the Activities package for each services	MOH	X	X	X	X	X
Strategic Sub-Axis 4.3: Drugs and Other Pharmaceutical Products							
Specific Objective 4.3: Increase increase by 50% the availability and use of quality drugs and other pharmaceutical products in all HDs							
Targets: Improve to 100% the proportion of health facilities that have a basic set of essential medicines available and affordable in a sustainable manner Reduce the share of street drugs in the total drug supply to 0% Increase the share of traditional medicines in the total supply of medicines to 25%							

Implementation Strategy	Interventions	Responsible	2021	2022	2023	2024	2025
4.3.1: Reinforcing 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 medicines, pharmacovigilance, etc.)	MOH	X	X	X	X	X
	4.3.1.2. Organize and operate the National Network of Laboratories (RENALAB)	MOH					
4.3.2: Strengthening quality assurance mechanisms and the availability of drugs and other pharmaceutical products	4.3.2.1. Establish and operate an integrated pharmacovigilance center in each region	MOH	X	X	X	X	
	4.3.2.2. Strengthening the quality assurance system for medicinal products and pharmaceuticals	MOH	X	X	X	X	X
	4.3.2.3. Strengthen the supply chain of essential medicines and acquire a central warehouse, reagents, vaccines and other medical devices and cold chain logistics	MOH	X	X	X	X	X
4.3.3 Promoting the rational use of quality drugs	4.3.3.1. Strengthen medication management in health facilities (training in rational stock management, computerized stock monitoring, etc.)	MOH	X	X	X	X	X

	4.3.3.2. Step up the fight against the use of illicit medicines (street medicines, counterfeits, illegal laboratories, etc.)	MOH	X	X	X	X	X
4.3.4: Establishing sustainable financing mechanisms for drugs	4.3.4.1 Promotion of traditional pharmacopoeia	MOH	X	X	X	X	X
	4.3.4.2. Implement a plan to structure the traditional medicine sub-sector with a view to defining standards and Publishing the products derived from them.	MOH	X	X	X	X	X

HSS Strategic Sub-Axis 4.4: Health Human Resources							
Specific objective 4.4: increase the availability of HRH in at least 80% of HDs, RDPH and central services according to priority needs							
Targets: Improve from 52% to 60% the percentage of health structures equipped with at least 50% of human resources according to standards Change the Number of medical doctors per inhabitant to 1 per 10,000 inhabitants Improve the number of students trained per year in human and animal health from 4,400 to 5,000							
Implementation Strategy	**Interventions**	**Administration Responsible**	**Chronograms**				
			2021	**2022**	**2023**	**2024**	**2025**
4.4.1 Progressive staffing of structures according to the standards (quality and quantity)	4.4.1.1. Develop mechanisms to improve the managerial and technical capacities of health sector managers at all levels	MOH	X	X	X	X	X

	4.4.1.2. Recruit HRH in the following priority areas (midwives, psychiatry, emergency physicians, mortuary attendantss, etc.)	MOH	X	X	X	X	X
	4.4.1.3. Ensure the continuous updating of information on the HRH of MISANTE and health sector administrations and their geo-distribution*.	MOH	X	X	X	X	X
	4.4.1.4. Develop mechanisms for the equitable and rational deployment of HRH in accordance with the organic framework	MOH	X	X	X	X	X
	4.4.1.5. Ensuring the strengthening of the medical sector at the level of higher education	MINESUP	X	X	X	X	X
4.4.2: Improving the rational management of the health workforce	4.4.2.1. Strengthening mechanisms for decentralizing health human resources management	MOH	X	X	X	X	X
	4.4.2.2. Strengthen integrated mechanisms for continuous evaluation, supervision, monitoring and coaching of HRH at all levels of the health pyramid	MOH	X	X	X	X	X
	4.4.2.3. Develop mechanisms for motivating and retaining HRH, including those of the private sector and partner administrations.	MOH	X	X	X	X	X
HSS strategic sub-axis 4.5: Health information and health research							
Specific objective 4.5: Ensure the development of health research and the availability of quality health information for evidence-based decision-making at all levels of the health pyramid							

Targets: Increase the MAR promptness rate in DHIS2 from 56.6% to 80% Increase the MAR completeness rate in DHIS2 to 80% Improve the proportion of search results that have been returned from 70% to 80% Improve the percentage of authorized research projects whose results have been published from 90% to 100% Increase to at least 70% the proportion of deaths occurring in health care settings that have been declared to the competent Civil Status Center Increase to at least 70% the proportion of deaths whose cause has been identified and documented							
Implementation Strategy	Interventions	Responsible	2021	2022	2023	2024	2025
4.5.1 Strengthening the national health information system	4.5.1.1. Conduct baseline surveys for the monitoring and evaluation of the NHDP and HSS	MOH	X	X	X	X	X
	4.5.1.2. Systematizing birth and death registration	BUNEC MOH	X	X	X	X	X
	4.5.1.3. Strengthen the governance of the health information system and make quality routine data available	MOH	X	X	X	X	X
4.5.2 Strengthening Health Research	4.5.2.1. Building the capacity of those responsible for decentralized levels in the field of health research	MOH	X	X	X	X	X
	4.5.2.2. Strengthening the governance of human health research ethics	MOH	X	X	X	X	X
4.5.3 Improving the use of health data for decision-making at all levels	4.5.3.1. Publish research results produced in the health system at all levels and promote the use of evidence for decision-making	MOH	X	X	X	X	X

	4.5.3.2. Valuing research results and the national therapeutic heritage within the pharmaceutical industry	MOH			X	X	X
4.5.4: Strengthening mechanisms for collecting and making civil status data available	4.5.4.1. Systematize the registration of births and deaths in Health Facilities	BUNEC MINSANTE	X	X	X	X	X
	4.5.4.2. Strengthen the entry and reporting of routine data from DHIS-2 to SIGEC	BUNEC MINSANTE	x	X	X	X	X
	4.5.4.2. Institutionalize joint civil status-health supervision	BUNEC MINSANTE	X	X	X	X	X

STRATEGIC AXIS 5: GOVERNANCE & STRATEGIC STEERING							
Central component problem: Poor health system performance							
Strategic Outcome: Increase health system performance at all levels							
Strategic sub-axis 5.1: Governance							
Specific objective 5.1: Improving governance in the sector through strengthening standardization, regulation and accountability							
Targets: Improve the rate of achievement of the 2020-2030 HSS objectives from 32% to 80% Increase the proportion of the budget allocated to programmatic priorities from 0% to 100% Reduce by 50% the rate of loss of resources allocated to operational level structures Audit and control at least 60% of health structures per year							
Implementation Strategy	**Interventions**	**Responsible administration**	**2021**	**2022**	**2023**	**2024**	**2025**
5.1.1. Strengthening the legislative and regulatory framework for the sector	5.1.1.1. Develop texts relating to the establishment of coordination and M/E bodies for the implementation of the HSS and the NHDP at all levels of the health pyramid	MOH	X	X	X	X	X
	5.1.1.2. Develop and disseminate care protocols and normative documents in specific targeted areas (mental health, SONEU and post abortion care (PAC)	MOH	X	X	X	X	X
	5.1.1.3. Establish a legal and regulatory framework for Universal Health Coverage	MOH					
	5.1.1.4. Establish a legal and regulatory framework for structuring the traditional medicine sub-sector with a view to standardizing and promote local medicines	MOH					
5.1.2. Improving transparency and accountability	5.1.2.1. Develop mechanisms to strengthen the logical link between Planning and Programming at all levels of the health pyramid	MOH	X	X	X	X	X

	5.1.2.2. Put in place mechanisms to ensure social control at all levels of the health pyramid	MOH	X	X	X	X	X
	5.1.2.3. Strengthen internal and external controls/audits at all levels of the health pyramid	MOH	X	X	X	X	X
	5.1.2.4. Developing a culture of accountability and accountability at all levels of the health pyramid	MOH	X	X	X	X	X
5.1.3. Strengthening the involvement of implementation beneficiaries and stakeholders in the management process	5.1.3.1. Support DTCs in taking ownership of their roles in the management process of health structures (HDs, HAS, HFs)	MOH	X	X	X	X	X
5.1.4. Building the managerial capacities of heads and managers of health facilities	See RSS axis (sub-axis 4.4)		X	X	X	X	X

5.1.5. Strengthening the logical link between strategic planning, preparation, allocation and monitoring the execution of the budget	5.1.5.1 Develop a consistent mechanisms in the planning process from the operational to the central level	MOH	X	X	X	X	X
5.1.6. Improving working conditions and computerizing the managerial process	5.1.6.1 Develop mechanisms to strengthen logistics and working conditions at all levels of the health pyramid	MOH	X	X	X	X	X
Strategic sub-axis 5.2: Strategic management							
Specific objective 5.2: strengthen planning, supervision and coordination of interventions and strategic and health surveillance at all levels of the health pyramid							
Targets: Improve the rate of completion of inspection missions (central level) and integrated supervision (RDPH and HD) to 100% Get 100% of DRSP to fill in the projected performance monitoring dashboard in the NHDP Produce 01 annual health sector review report Ensure the linkage 100% of the AWP of health sector structures to the NHDP							
Implementation Strategy	**Interventions**	**Responsible administration**	**2021**	**2022**	**2023**	**2024**	**2025**
5.2.1: Strengthening the institutional framework for strategic steering	5.2.1.1. Develop action plans linked to the NHDP at all levels of the health pyramid, including partner administrations	MOH	X	X	X	X	X

	5.2.1.2. Make operational the mechanism for steering, coordinating and Monitoring and implementing of the NHDP	MOH	X	X	X	X	X
	5.2.1.3. Organize an annual sectoral or thematic health review with all stakeholders	MOH	X	X	X	X	X
	5.2.1.4. Organize the final evaluation of the NHDP	MOH	X	X	X	X	X
	5.2.1.5. Edit, publish and disseminate the results of reviews and evaluations to all stakeholders (CSOs, TFPs, private sector, , professional orders, structures of MOH and partner ministries)	MOH	X	X	X	X	X
5.2.2 Strengthening the strategic surveillance unit							
5.2.3 Reinforcing décentralisation and devolution	5.2.3.1 Improve the partnership framework between health structures and DTCs	MOH	X	X	X	X	X
	5.2.3.2 Improve the partnership framework between the structures of MOH and those of other administrations in the health sector	MOH	X	X	X	X	X
5.2.4 Strengthening National Partnership	5.2.4.1. Strengthening partnership with private actors, civil society and community actors	MOH	X	X	X	X	X

5.2.5 Improving alignment and harmonization of TFP interventions	5.2.5.1. Develop and implement a National Compact around the health sector strategy	MOH	X	X	X	X	X

CHAPTER 6: ANCHORING, OBJECTIVES AND STRATEGIC FRAMEWORK OF THE 2021-2025 NHDP

6.1. INSTITUTIONAL ANCHORING OF THE 2021-2025 NHDP

In 2009, Cameroon adopted a vision for 2035: "Cameroon: an emerging, democratic country united in its diversity". In this vision, the country has set itself four general objectives, including "Reducing poverty to a socially acceptable level".

The Growth and Employment Strategy Paper 2010-2020, the instrument for implementing the first phase of this vision, identified improving the health status of populations as an objective of both social development and economic growth[150]. In the same vein, the NDS30 which is the implementation document of the 2nd phase of this vision makes the development of Human Capital one of the main priorities of the country for the next decade. The health guidelines stemming from this document are based on the three fundamental principles:

- improving the governance of the health system,
- strengthening the technical platform of central and reference hospitals
- the enhancement of local therapeutic potentials[151].

To achieve both national and international health goals (contained in the NDS30 and SDGs respectively) and move towards Universal Health Coverage, the strategic orientation of the health sector is to: "Ensure equitable and universal access to basic health services and care and quality priority specialized care, with the full participation of the community and the involvement of other related sectors". This choice will result in the implementation of the following intervention packages:

- **The extension of essential basic health services and care**: major interventions in this area will therefore be oriented towards Primary Health Care (health promotion, disease prevention, curative management of common diseases of the community as well as emerging diseases such as hypertension, COVID-19 etc ...). The aim here is to offer essential and complementary care service packages (MPA and CPA) to fight against the main communicable and non-communicable diseases, and to deal effectively with public health events.
- **Improving the supply of priority specialized health services and care**: this component aims to increase the supply of services for the management of priority chronic diseases and public health events requiring specialized care or measures;
- **The involvement of communities and partner administrations**:
- **It is important to prioritize a multisectoral approach (OneHealth)** by federating the efforts of all stakeholders for an efficient resolution of health issues.

To render effective access to primary and specialized health care , the NHDP 2021-2025 focuses mainly on nutrition, strengthening the health system, improving maternal, newborn and child health, the management of surgical emergencies and public health events.

6.2. OBJECTIVES OF THE HEALTH DEVELOPMENT PLAN (NHDP) 2021-2025

6.2.1. OVERALL OBJECTIVE

Overall objective of the NHDP: To improve people's access to quality priority essential and specialized health care and services

In other words, Cameroon aims to offer universal access to quality essential health services, without any form of exclusion or discrimination. It is in this perspective that the 2021–2025 NHDP is firmly in accordance, which focuses on strengthening the health system and governance for the optimal implementation of high-impact interventions, capable of significantly reducing mortality and morbidity among all targets, with a particular focus on the most vulnerable (mother-child target).

The implementation of the NHDP will revolve around 3 vertical axes, namely:

(i) health promotion and nutrition,

(ii) disease prevention,

(iii) case management; and

2 transversal axes which are:

(iv) strengthening the health system and,

(v) governance and strategic management.

Table 2120: Description of strategic axes

OVERALL HSS GOAL 2020-2030: Contribute to the development of healthy, productive human capital capable of supporting strong, inclusive and sustainable growth					
Strategic focus	Strategic Objectives	Performance indicators	Baseline (2021)	Targets (2025)	Audit Sources
Health Promotion and Nutrition	Engaging people in healthy and favourable behaviours by 2027	% of households using improved toilets	57,9% (DHS EDS 2018 page 36)	75%	DHS, MICS, ECAM, studies
		% of women aged 15-49 who are overweight	13,6 % (DHS 2018-Page 252)	20%	DHS, MICS, STEPS
		Prevalence of tobacco use among those over 15 years of age (SDG 3.a.1)	4,3% (DHS 2018 Page xxxix)	3%	Survey GATS, DHS, MICS,
		Proportion of companies subjected to the obligation to have an	25% (MINTSS 2021)	40%	RAP MINTSS

OVERALL HSS GOAL 2020-2030: Contribute to the development of healthy, productive human capital capable of supporting strong, inclusive and sustainable growth					
Strategic focus	Strategic Objectives	Performance indicators	Baseline (2021)	Targets (2025)	Audit Sources
		established and functional Health and Safety Committee (HSC)			
		Chronic malnutrition rates among children under 5 years (SDG 2.2.1)	29% (DHS 2018 Page 221)	20%	DHS, MICS, ECAM, studies
Prevention of the disease	Reducing premature mortality from preventable diseases	Prevalence of hypertension in urban areas	H: 68.4% F: 53.8% DHS 2018 Page 433 and 434	H: 27% F: 27%	STEPS, DHS, MICS
		% of children 0-5 years sleeping under LLINs.	59,8% (EPC MILDA 2018)	90%	DHS-MICS, EPC MILDA, NCP Reports
		% of HIV-infected pregnant women receiving ART	63,91% (CNLS Annual Report 2020)	95%	CNLS Report
Case Management	Reduce overall mortality and case fatality in health facilities and in the community	Perioperative mortality rate in hospitals of 1st, 2nd, 3rd and 4th category	20% (Monitoring report of the 100 key health indicators in Cameroon in 2019- Focus on the SDGs Page 110)	10%	Studies/ Investigations
		Maternal mortality ratio (SDG 3.1.1)	406/100 000 NV (DHS 2018 Page xxxix)	300 / 100 000	DHS MICS PLMI Report
		Infant mortality rate	48/1000 live births (DHS 2018 page 157)	36/1 000	DHS-MICS
		Neonatal mortality rate (SDG 3.2.2)	28/1000 live births (DHS 2018 page 157)	17/1000	DHS-MICS
		Infant and child mortality rate (SDG 3.2.1)	79/1000 live births (DHS 2018 page 157)	62/1000	DHS-MICS

OVERALL HSS GOAL 2020-2030: Contribute to the development of healthy, productive human capital capable of supporting strong, inclusive and sustainable growth					
Strategic focus	Strategic Objectives	Performance indicators	Baseline (2021)	Targets (2025)	Audit Sources
		Direct intra-hospital obstetric case fatality rate	107 Deaths per 100,000 deliveries (Monitoring report of the 100 key health indicators in Cameroon in 2019-Focus on the SDGs Page 110)	96 deaths per 100,000 deliveries	Studies/Surveys
Strengthening the Health System	Increase the institutional capacities of health structures for sustainable and equitable access of populations to quality health care and services	Proportion of HDs that have reached the consolidation phase	ND*	25%	Study
Governance and strategic management	Improve the performance of the health system at all levels.	Rate of achievement of HSS 2020-2030 targets	32%	80%	Study

*For indicators without reference values, actions will be carried out at the beginning of the implementation of the NHDP, in order to determine them as quickly as possible and at the end of this work, the projected targets can be refined.

6.2.2. SPECIFIC OBJECTIVES

Health Promotion and Nutrition

For the health promotion and nutrition axis, this will be by 2025:

- Strengthen institutional capacity, coordination and community participation in the field of health promotion in 80% of HDs;
- Improve the living environment of the population in at least 70% of health districts;
- Develop promotional actions in at least 80% of HDs, in order to strengthen the health-promoting skills of individuals and communities;
- Engage 75% of families in essential family practices, including family planning.

Prevention of diseases

Regarding the prevention strategic axis of diseases it will be a question by 2025 to :

- Reduce in about 30% the incidence/prevalence of major communicable diseases (HIV, malaria and tuberculosis) and eliminate some NTDs (lymphatic filariasis and HAT);

- Reduce in about 90% of health districts, the risk of major public health events and diseases with epidemic potential, including zoonoses ;
- Increase coverage of high-impact prevention interventions by at least 80% for mother, newborn, and child targets in at least 80% of HDs;
- Reduce the prevalence of major non-communicable diseases by at least 10%.

Case Management

As for the case management axis, by 2025 it will be important to :

- ensure curative management according to standards of communicable and non-communicable diseases, as well as their complications in at least 80% of health facilities;
- ensure comprehensive management of maternal, newborn, child and adolescent health problems, according to standards in at least 80 % of health facilities;
- ensure the management of surgical emergencies, disasters and humanitarian crises, according to standard operating procedures (SOPs) in at least 80% of health districts;
- reduce by at least 20% the proportion of the population with at least one correctable disability.

Strengthening the health system

For the health system-strengthening axis, five objectives have been set for 2025, these include:

- reduce direct payments by households by at least 30% through a fair and sustainable financing policy;
- ensure the harmonious development of infrastructure, equipment and the availability of health care and service packages, according to standards, in at least 80% of health facilities in categories 3, 4, 5^{and} 6;
- Increase the availability and use of quality drugs and other pharmaceuticals by 50% in all health districts;
- Increase, according to prioritize needs, the availability of HRH in at least 80% of HDs, RDPH and central directorates;
- Ensure the development of health research and the availability of quality health information, for evidence-based decision-making at all levels of the health pyramid.

Governance and strategic management

In this strategic axis, the following two objectives have been selected:

- Improve governance in the sector through strengthening standardization, regulation and accountability;

- Strengthen planning, supervision, coordination, strategic and health monitoring at all levels of the health pyramid.

6.3. ALIGNING THE NHDP OBJECTIVES WITH THE SDGS

The 2021-2025 NHDP is aligned with the Sustainable Development Goals to which Cameroon has subscribed. At the level of each strategic axis, there are strategic sub-axes that take into account the health-related Sustainable Development Goals.

6.3.1. HEALTH PROMOTION AND NUTRITION AXIS

STRATEGIC SUB-AXIS 1.2: LIVING ENVIRONMENT OF POPULATIONS ***SPECIFIC OBJECTIVE: Improve the living environment of populations***
SDG target 3.9. By 2030, significantly reduce deaths and illnesses from hazardous chemicals and air, water and soil pollution and contamination **SDG target 6.1.** By 2030, ensure universal and equitable access to safe and affordable drinking water. **SDG target 6.2.** By 2030, ensure equitable access to adequate sanitation and hygiene for all and end open defecation, paying particular attention to the needs of women and girls and people in vulnerable situations **SDG target 7.1.** By 2030, ensure access to affordable, reliable and modern energy for all **SDG target 8.8.** Defend workers' rights, promote workplace safety and ensure the protection of all workers, including migrants, especially women, and those in precarious employment **SDG target 11.5.** By 2030, significantly reduce the number of people killed and affected by disasters, including water-related disasters, and significantly reduce the share of global gross domestic product accounted for by economic losses directly attributable to such disasters, with a focus on protecting the poor and people in vulnerable situations **SDG target 11.6.** By 2030, reduce the negative environmental impact of cities per capita, including by paying particular attention to air quality and municipal waste management **SDG target 13.1.** Strengthen resilience and adaptive capacity to climate hazards and climate-related natural disasters in all countries
STRATEGIC SUB-PRIORITY 1.3: STRENGTHENING THE HEALTH-PROMOTING SKILLS OF INDIVIDUALS AND COMMUNITIES ***SPECIFIC OBJECTIVE: to develop health promotion actions in order to strengthen the health-promoting skills of individuals and communities***
SDG Target 2.1. By 2030, end hunger and ensure that everyone, in particular the poor and people in vulnerable situations, including infants, has access to safe, nutritious and adequate food all year round **SDG Target 2.2.** By 2030, end all forms of malnutrition, including by achieving by 2025 the internationally agreed targets on stunting and wasting in children under 5 years of age, and meet the nutritional needs of adolescent girls, pregnant and lactating women and older persons **SDG target 3.5.** Strengthening the prevention and treatment of substance abuse, including alcohol and alcohol **SDG target 3.6.** By 2020, halve the number of road traffic deaths and injuries nationally **SDG target 5.2.** Eliminate from public and private life all forms of violence against women and girls, including trafficking, sexual, and other types of exploitation

SDG target 5.3. Eliminate all harmful practices, such as child, early and forced marriage and female genital mutilation

STRATEGIC SUB-AXIS 1.4: ESSENTIAL FAMILY PRACTICES, FAMILY PLANNING, ADOLESCENT HEALTH PROMOTION AND POSTABORTION CARE

SPECIFIC OBJECTIVE: Encourage families to adopt essential family practices, including family planning,

SDG target 3.7: By 2030, ensure universal access to sexual and reproductive health care services, including family planning, information and education, and ensure that reproductive health is integrated into national strategies and programmes

SDG target 5.6: Ensure universal access to sexual and reproductive health care and the enjoyment of reproductive rights for all, as decided in the Platform for Action of the International Conference on Population and Development and the Beijing Platform for Action and the outcome documents of subsequent review conferences.

SDG target. 16.9: By 2030, guarantee legal identity for all, in particular through birth registration

6.3.2. DISEASE PREVENTION AXIS

STRATEGIC SUB-AXIS 2.1: PREVENTION OF COMMUNICABLE DISEASES

SPECIFIC OBJECTIVE: To reduce the incidence/prevalence of major communicable diseases (HIV, malaria and tuberculosis) and to eliminate certain NTDs (lymphatic filariasis and HAT)

SDG target **3.3.** By 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne and other communicable diseases

STRATEGIC SUB-AXIS 2.2: MAPE AND PUBLIC HEALTH EVENTS SURVEILLANCE AND RESPONSE TO DISEASES WITH EPIDEMIC POTENTIAL, ZOONOSES AND PUBLIC HEALTH EVENTS

SPECIFIC OBJECTIVE: **To reduce the risk of major public health events and diseases with epidemic potential, including zoonoses**

SDG target **1.5.** By 2030, build resilience and vulnerability of the poor and people in vulnerable situations and reduce their exposure to and vulnerability to extreme weather events and other economic, social or environmental shocks and disasters

3.b.1 Proportion of target population that has received all national program vaccines

3.d.1 International Health Regulations (IHR) implementation and preparedness for health emergencies

STRATEGIC SUB-AXIS 2.4: PREVENTION OF NONCOMMUNICABLE DISEASES

SPECIFIC OBJECTIVE: Reduce the incidence/prevalence of major non-communicable diseases

SDG Target **3.4.** By 2030, reduce premature mortality from non-communicable diseases by one third through prevention and treatment and promote mental health and well-being

6.3.3. CASE MANAGEMENT AXIS

STRATEGIC SUB-AXIS 2.3: NERMS AND PMTCT

SPECIFIC OBJECTIVE: To increase coverage of high-impact prevention interventions for maternal, newborn and child targets

SDG Target **3.2.** By 2030, eliminate preventable deaths of newborns and children under 5 years of age, with all countries aiming to reduce neonatal mortality to no more than 12 per 1,000 live births and under-5 mortality to no more than 25 per 1,000 live births

STRATEGIC SUB-AXIS 3.2: MERMATERNAL, NEONATAL, INFANT AND ADOLESCENT HEALTH CONDITIONS
SPECIFIC OBJECTIVE: To provide comprehensive and standard-based care for maternal, newborn, child and adolescent health problems at the community level and in health facilities
Target 3.1. By 2030, reduce the global maternal mortality ratio to below 70 per 100,000 live births

6.3.4. AXIS STRENGTHENING THE HEALTH SYSTEM

STRATEGIC SUB-AXIS 4.1: FINANCING HEALTH
SPECIFIC OBJECTIVE: Reduce direct payments to households through a fair and sustainable financing policy
Target 3.8. Ensure universal health coverage for all, including protection against financial risks and access to quality essential health services and safe, effective, quality and affordable essential medicines and vaccines
STRATEGIC SUB-AXIS 4.3: MEDICINES AND OTHER PHARMACEUTICAL PRODUCTS
SPECIFIC OBJECTIVE: To increase the availability and use of quality medicines and other pharmaceuticals in all health districts
3.b.3 Proportion of health facilities with a consistently available package of affordable essential medicines
STRATEGIC SUB-AXIS: 4.4 HUMAN RESOURCES IN HEALTH
SPECIFIC OBJECTIVE: Increase the availability of HRH in health facilities
3.c.1 Health workforce density and distribution
STRATEGIC SUB-AXIS 4.5: HEALTH INFORMATION AND HEALTH RESEARCH
SPECIFIC OBJECTIVE: Ensure the development of health research and the availability of quality health information for evidence-based decision-making at all levels of the health pyramid
3.b.2 Total net official development assistance for medical research and basic health care

CHAPTER 7: IMPLEMENTATION FRAMEWORK

The NHDP 2021-2025 is a variation of the Health Sector Strategy 2020-2030, which is an operationalization of the National Development Strategy 2020-2030.

The implementation of the NHDP 2021-2025 will be carried out according to a multisectoral approach (ministerial and interministerial) at all levels of the health pyramid (central, intermediate and peripheral), through the various coordination mechanisms of the health sector. The main topics will be:

(i) Strengthening the institutional and organizational framework for monitoring and evaluating the NHDP at the ministerial and interministerial levels and at all levels of the health pyramid;

(ii) strengthen partnership and coordinated resource mobilization around the implementation of the NHDP;

(iii) Make available the matrix of indicators, the performance framework, the dashboard for monitoring the implementation of the NHDP for each level of the health pyramid;

(iv) enable all actors in the health sector to measure progress;

(v) strengthen the alignment of partners with national priorities,

(vi) strengthen mutual accountability in achieving health outcomes.

7.1. INSTITUTIONAL FRAMEWORK FOR IMPLEMENTATION

The implementation of the NHDP 2021-2025 will be ensured in accordance with the guidelines of Law No. 2007/006 of 26 December 2007 on the financial regime of the State supplemented by Law No. 2018/012 of 11 July 2018 on the financial regime of the State and other public entities. This law institutionalizes program-based budgeting with clear objectives to be achieved after a set period. It focuses on performance and the effective, equitable and efficient use of public resources. Thus, in an economic context with limited resources, the transition from a logic of means to a logic of performance constitutes a lever to facilitate the achievement of the results of the NHDP. The same applies to Law No. 2019/024 of 24 December 2019 on the General Code of Decentralized Territorial Collectivities, which defines the general legal framework, the rules of organization and operation as well as the specific regime of local authorities in the health sector. The 1998 Framework Health Act completes this list.

The NHDP 2021-2025 will be coordinated, monitored and implemented in accordance with the guidelines of Decree No. 2021/1541/PM of 23 March 2021 on the creation, organization and functioning of the National Monitoring and Evaluation Committee for the implementation

of the NDS30. The structures in charge of the strategic management and operational monitoring of the HSS 2020-2030 and the NHDP 2021-2025 are: (i) the National Monitoring and Evaluation Committee for the implementation of the National Development Strategy 2020-2030 (NCME/NDS30);

(ii) the technical coordination unit;

(iii) the "Health" Sub-Committee of the National Monitoring and Evaluation Committee of the implementation of the National Development Strategy 2020-2030 and

(iv) the Technical Secretariat of the "Health" Sub-Commission.

The National Monitoring and Evaluation Committee for the implementation of the National Development Strategy 2020-2030 (NCMENDS30)

The National Monitoring and Evaluation Committee for the implementation of the National Development Strategy 2020-2030 (NCME/NDS30) is the main body responsible for monitoring as well as providing technical and operational supervision of all work relating to the implementation of the DS30. Chaired by the Minister in charge of planning, the NCME/NDS30mission is to support the various sectors in the development of their respective sectoral strategies, to ensure intersectoral collaboration, as well as the monitoring and evaluation of the NDS30 and sectoral strategies. It also ensures the implementation of the NDS30 and sectoral strategies within administrations through Strategic Performance Frameworks and strategic plans. The NCME/NDS30 is assisted by a technical coordination unit and sectoral secretariats. All of its missions are listed in Box 1 below [152].

Box 11: Missions of the National Monitoring and Evaluation Committee for the implementation of the National Development Strategy 2020-2030

The NCME/NDS30 ensures the follow-up and technical supervision of all work relating to the implementation of the NDS30. As such, it is responsible in particular for:

- ensuring the finalization of the projects and reforms initiated under the GESP, as well as the operationalization of the government's commitments working to achieve the objectives of the vision of emergence by 2035;
- monitoring the process of carrying out strategic studies for the operationalization of the NDS30 and in particular feasibility studies of the plans and reforms identified in the strategy;
- updating and monitoring the NDS30 and the sectoral strategies through, in particular, the production and validation of semi-annual and annual reports on the implementation of the sectoral strategies;
- Monitoring and optimizing collaboration with the administrations concerned the process of appropriation by Cameroon of the clauses of the major international agendas (SDGs, Agenda 2063, etc.);
- submitting to the Prime Minister, Head of Government, for arbitration proposals for prioritizing Government interventions in all sectors, with a view to ensuring the

intersectoral coherence of these interventions with the strategic objectives pursued by the NDS30;
- ensuring the implementation of the NDS30 and sectoral strategies within administrations through Strategic Performance Frameworks and strategic plans;
- Ensuring the consultation, mobilization and awareness raising, as appropriate, of all institutional actors directly concerned, including Development Partners, for the implementation of the NDS30.

Source: Article 2 of Decree No. 2021/1541/PM of 23 March 2021 on the establishment, organization and functioning of the National Monitoring and Evaluation Committee for the implementation of the NSDS30

The Technical Coordination Unit

The technical coordination unit is the linchpin that ensures the preparation of the NCME/NDS30 sessions. To this end, it is responsible for coordinating the activities of the sectoral secretariats and ensures the production of monitoring reports on the implementation of sectoral strategies. All of its missions are set out in Box 2 below.

Box 22: Mission of the technical unit coordinating the implementation of the National Development Strategy 2020-2030

The Technical Coordination Unit assists the NCME/NDS30 in carrying out its missions. As such, it is responsible for:

- Preparing the meetings of the Committee and drawing up minutes;
- Ensuring technical and operational monitoring of the implementation of the NDS30;
- Centralizing strategic studies for the operationalization of the NDS30;
- Preparing draft monitoring and evaluation reports on the implementation of the NSD30;
- Ensuring, together with the structures concerned, the production on the basis of the statistics necessary for the monitoring of the NSD30 in all sectors;
- ensuring the establishment of sectoral databases in liaison with the sectoral sub-commissions and the administrations directly concerned;
- Ensuring, in liaison with the structures concerned, the alignment of all interventions with the NSD30 and their coherence;
- Ensuring that sectoral and spatial planning instruments are aligned with the NSD30;
- Coordinating the activities of the Sectoral Technical Secretariats and ensuring in particular the production of Monitoring Reports on the implementation of sectoral strategies;
- Proposing to the NCME/NDS30 any measure likely to improve the implementation of the NSD30.
- Performing any other task prescribed by the NCME/NDS30 within the scope of its purpose.

Source: **Article 7.-(1) of Decree No. 2021/1541/PM of 23 March 2021 on the establishment, organization and functioning of the National Monitoring and Evaluation Committee for the implementation of the NDS30**

Sub-Committee on Health of the National Monitoring and Evaluation Committee of the implementation of the National Development Strategy 2020-2030

The main mission of the sectoral sub-committee "health" is the orientation, coordination, supervision, harmonization and supervision of the work relating to the Sectoral Health Strategy and the NHDP. It is coordinated by the Secretary General of MOH and the members who compose it are the Secretary General of the partner administrations namely: MINEPAT, MINFI, MINESUP, MINDEF, DGSN, MINRESI, MINJUSTICE, MINNAS, MINEE, MINEPDED, MINTSS, MINPROFF. In addition to the latter, there are representatives of the organizations under supervision: LANACOME, CENAME, ONSP, IMPM, CNPS. The list of members is completed by representatives of the private sector and civil society: the National Order of Physicians of Cameroon (ONMC), the National Order of Pharmacists of Cameroon (OANC), the National Order of Dental Surgeons of Cameroon (ONCDC), the Order of Medical and Health Professions (OPMS), the National Order of Opticians of Cameroon (ONOC). Reporting within this commission is provided by the Technical Secretariat of the Sub-Commission on Health (ST/HSS), the Strategic Planning and Forecast Division of MINEPAT (SPFD).

Technical Secretariat of the Sub-Committee on Health (ST/HSS).

The Technical Secretariat of the Health Subcommittee is responsible for producing monitoring reports on the implementation of the HSS 2020-2030. These follow-up reports will then be submitted to the CNSE/NHD30 "Health" sub-committee for validation, and may subsequently be used by the technical coordination unit as part of the preparation of the CNSE/NHD30 sessions. In detail, the missions of the Technical Secretariat of the Health Subcommittee (ST / HSS) are listed in Box 3 below

Box 3Health" Sub-Commission, a contextualization of Article 12.-(2) of Decree No. 2021/1541/PM of 23 March 2021 on the creation, organization and functioning of the National Monitoring and Evaluation Committee for the implementation of the NHD30

- Prepare the meetings of the health subcommittee and draw up the minutes
- identify and monitor health sector issues, reforms and flagship projects;
- ensure the coherence of interventions within the health sector;
- set up in collaboration with the actors concerned, a sectoral information system;
- prepare semi-annual and annual reports on the implementation of the health sector strategy / NHDP;
- prepare the technical tools necessary to carry out the missions of the CNSE/NDS30 in the Health sector;
- Carry out all other tasks entrusted to it by the Sub-Commission on Health.

In addition to the missions outlined above, the ST-HSS will pay particular attention to ensuring:

(i) technical support to health sector administrations in the areas of planning, coordination, monitoring and evaluation of the NHDP;

(ii) technical support to health sector administrations, including MOH, in the operationalization of the NHDP at all levels of the health pyramid;

(iii) the consolidation of the outputs of health sector administrations (journal reports, PPA, CDMT, PTA, RAP) with a view to producing sectoral information;

the alignment between the strategic orientations of the HSS/NHDP and the strategic performance frameworks of the health sector administrations;the implementation of the reforms essential to the achievement of the objectives, enlisted in the HSS and the NHDP.

7.2. COORDINATION AND IMPLEMENTATION MECHANISMS AT THE MINISTERIAL LEVEL

The NHDP 2021-2025 will be implemented in the country through operational plans developed at all levels of the health pyramid (central, intermediate and peripheral) with the full participation of all stakeholders.

Central level

At the central level, the structures in charge of planning and programming of health sector administrations will ensure the development of planning tools to implement NHDP interventions. The orientations of the NHDP resulting from the HSS are declined in the Strategic Performance Frameworks of the administrations of the health sector in Programs, Actions and Activities. The declination of activities into tasks with budgets is done on a three-year basis through the Mid-Term Expenditure Frameworks (MTEF). Each year, health administrations draw up a budgeted annual work plan (BAWP) which should form the basis for drawing up quarterly business plans.

The coordination mechanisms at this level will rely on the management and dialogue platforms of the different health sector administrations.

Deconcentrated levels

At the decentralized level of the health pyramid, each regulatory structure of the health sector should develop its document of contextualization and operationalization of the NHDP according to the one health logic. These are the District Health Development Plan (DHDP) at the peripheral level and the Consolidated Regional Health Development Plan (CRHDP) at the intermediate level. The goal is to federate the efforts of all stakeholders for more efficiency in the implementation of interventions. These documents must then be broken down into AWP. It should be noted that, as part of the health system strengthening project, Ministry of Health actors have adopted the performance-based financing approach for the implementation of NHDP interventions. Health structures at all levels of the pyramid are expected to draw up a performance contract with a business plan for the implementation of their activities. [153]

For the sake of efficiency, two bodies will ensure the coordination and monitoring and evaluation of the implementation of the HSS and the NHDP at the decentralized level. These are: the Regional Committee for Coordination and Monitoring and Evaluation of HSS Implementation (CORECSES) for the regional level and the Operational Committee for Coordination and Monitoring and Evaluation of HSS Implementation (COCSES) for the peripheral level.

- ***Intermediate level***

The regional delegations will have to ensure the coordination and monitoring and evaluation of the implementation of the HSS and the NHDP in their respective areas of competence through the PRCDS. This multisectoral document should allow PRSPs and their partners (partner administrations, DTCs, CSOs and TFPs), to have a common health monitoring and monitoring and evaluation framework for the region: this is the Regional Committee for Coordination and Monitoring and Evaluation of the implementation of HSS (CORECSES). It should be set up and chaired by the Governor of the region pending the effectiveness of the guidelines of the law on decentralization, which grants the President of the Region the mandate to develop health and social action in their DTCs. Its main missions will be:

(i) the validation of Regional Consolidated Health Development Plan (RCHDP) with all stakeholders under the coordination and supervision of ST/HSS;

(ii) multisectoral coordination and monitoring of the implementation of the NHDP 2021-2025 at the regional level;

(iii) validation of the RCHDP integrated Monitoring and Evaluation plan and the RDPH multisectoral monitoring dashboard.

The Regional Delegate of Public Health (RDPH) will act as Technical Secretary of this committee. The Technical Secretariat of CORECSES (ST/CORECSES) will also ensure:

(i) the compilation of data at the decentralized level for each strategic axis;

(ii) feedback from the regional level to health districts and,

(iii) validation and consolidation of HD progress reports.

For the sake of efficiency, the ST/CORECSES in collaboration with the Regional Delegation of Public Health will have to provide technical support to the Health Districts in the development of their Health Development Plans (HDPs), their AWPs and the monitoring dashboards of these AWPs by ensuring that the activities proposed in the different HDs and AWPs of the HD are coherent and convergent towards the achievement of the objectives of the NHDP.

All other key actors of the existing multisectoral thematic subcommittees in the region will be integrated into the regional committee for the coordination and monitoring of HSS implementation. The Chief of the RDPH Care Monitoring Brigade will work in synergy with the RFHP and the regional coordinators of priority programmes to this end. A text of the hierarchy

will specify the provisions inherent to the organization; the functioning and missions of CORECSES.

- *Peripheral level*

The District Health Development Plan will allow the district management team to bring together all the actors of the health sector around a single working and monitoring and evaluation platform, taking into account the orientations of the General Code of the DTCs. To this end, the Operational Committee for Coordination and Monitoring and Evaluation of the Implementation of the HSS (COCSES) should be set up and chaired by the Divisional and Sub-Divisional Officers pending the effectiveness of the guidelines of the law on decentralization, which grants mayors the mandate to develop health and social action in their communes. The Head of the Health District (HDs) will act as technical secretary of this committee. The mission of the Technical Secretariat of COCSES (ST/COCSES) will be to develop the DHDP and AWPs while ensuring that these two documents are aligned with the NHDP. The same is true of the DHDP follow-up plan, which will have to be anchored in the IEMP program. It will also ensure the operational monitoring of the indicators included in the HDs multisectoral scoreboard. In addition, it will periodically transmit information on the monitoring and evaluation indicators of its AWPs/DHDP to CORECSES. The ST/COCSES in collaboration with the District Health Service will mainly ensure the consolidation of the AWPs of the health areas as well as the organization of supervision missions and multisectoral coordination meetings in the HD. The Head of Health Office (HHO) of the DHS will work in synergy with CSOs and local actors.

Table 2222: Coordination structures for the implementation of the NHDP

LEVEL OF INTERVENTION	ORGANS/STRUCTURES AND FREQUENCY OF MEETINGS	COMPOSITION	
INTERMINISTERIAL	NATIONAL COMMITTEE FOR MONITORING AND EVALUATION OF THE IMPLEMENTATION OF THE NATIONAL DEVELOPMENT STRATEGY 2020-2030 (NCME/NDS30) **Meeting frequency:** Semi-annual	**President:** Minister in charge of Planning **Members:** - SG of ministerial departments - President of the Technical Committee for Monitoring the Programmes - SG National Commission for the Promotion of Bilingualism and Multiculturalism - PS of the Human Rights Commission of Cameroon - 02 representatives of the PM's services - the Director General of Planning and Regional Development (MINEPAT) - the Director General of Economy and Public Investment Planning of the Ministry in charge of public investment programming	**Members:** - Director General of the Budget of the Ministry in charge of Finance - Director General of Taxes of the Ministry in charge of Finance - Director General of Customs of the Ministry in charge of Finance - Director General of the National Institute of Statistics - DG of BUCREP - the SP of the Technical Committee for Monitoring the Programmes - PS of the National Council of Decentralization; - 05 DTC representatives - 03 representatives of representative organizations of the private sector - 05 representatives of civil society
	TECHNICAL COORDINATION UNIT **Frequency of meetings:** Quarterly	**President:** Director General of Planning and Regional Development (MINEPAT) **Technical Coordinator:** Head of the Division of Strategic Planning and Forecast Division **Members:** 01 PM Service Representative - Director of Spatial Planning and Development of	- Director of North-South Cooperation and Multilateral Organizations of the Ministry in charge of Technical Cooperation; - Head of Division and Forecasting and Preparation of Programs and Projects of the Ministry in charge of public investment programming - Head of Division of Economic Analysis and Policies at the Ministry

LEVEL OF INTERVENTION		ORGANS/STRUCTURES AND FREQUENCY OF MEETINGS	COMPOSITION	
			Border Areas of the Ministry in charge of Spatial Planning - Head of Division of Demographic Analysis and Migration of the Ministry in charge of spatial Planning - Director of Infrastructure and Support for Regional and Local Development of the Ministry in charge of Spatial Planning	in charge of the Economy; - Head of the Forecasting Division of the Ministry in charge of Finance; - Head of the Budgetary Reform Division of the Ministry of Finance; - Head of Department of Statistical Coordination of Cooperation and Research of the NIS - Head of Department of Economic Syntheses of the NIS
		SUBCOMMITTEE ON HEALTH **Frequency of meetings:** Quarterly	**President: SG MOH** **Members:** SG MINEPAT, MINFI, MINESUP, MINDEF, DGSN, MINRESI, MINJUSTICE, MINAS, MINEE, MINEPDED, MINTSS, MINPROFF, MINSEP	Representing LANACOME, CENAME, ONSP, IMPM, CNPS, private sector, OSC, ONMC, OANC, ONCDC, ONPMS and ONOC. **Rapporteurs:** ST/HSS (Technical Secretariat of the Health Sectoral Sub-Commission) DPPS representative at MINEPAT
		Technical Secretariat of the Health Sector (ST/HSS)	**COORDINATOR:** Public Health Expert	**TECHNICAL STAFF:** (i) a statistician; (ii) an accountant; (iii) a planning expert, (iv) a monitoring and evaluation expert; (v) Computer engineer; (vi) an expert in health economics; (vii) public finance expert; (viii) two public health physicians (epidemiology/health system option).
MINISTERIAL	**Central level**	Management Dialogue Platform **Frequency of meetings** Quarterly	President: Minister Vice President: SG Members Program Managers Responsible for actions	Rapporteurs Director of Financial Resources Head of Division of Studies and Projects

LEVEL OF INTERVENTION		ORGANS/STRUCTURES AND FREQUENCY OF MEETINGS	COMPOSITION	
			Coordinator of Management Control Management controllers HSS Technical Secretariat Other members	Head of the Monitoring Unit
	Regional level	CORECSES **Frequency of meetings:** Quarterly	**PRESIDENT**: Governor **TECHNICAL SECRETARIAT** : RDPH .	**MEMBERS**: Regional Delegates of partner ministries at MOH, (MINAS, MINPROFF, MINEDUB, MINESEC, MINADER, MINEPIA, MINEE, MINEPDED, MINJEC, MINTSS, MINSEP); responsible for the prison infirmary at the regional level; manager of the RFHP; Representative of the Regional CSO Platform
	Operational level	COCSES **Frequency of meetings:** Quarterly	**PRESIDENT:** **Prefect**/Sub-Prefect **TECHNICAL SECRETARIAT** : Head of Service of the Health District;	**MEMBERS** :(i) President of COSADI; (ii) Members of the ECD; (iii) divisional delegates of partner ministries; (iv) members of the District Framework Team; (v) heads of the DTCs and Civil society Organizations affiliated to the regional CSO platform.

CHAPTER 8: MONITORING AND EVALUATION FRAMEWORK

The final evaluation of the 2016-2020 NHDP highlighted the strengths and weaknesses in terms of monitoring and evaluation. With regard to the forces, the availability of the Integrated Monitoring and Evaluation Plan (IMEP) is noted. To this, we can add the use of DHIS-2 at all levels of the health pyramid as a tool for collecting and reporting routine data.

With regard to shortcomings, the following are deplored:

- the absence of a results chain that shows the link between results, effects and expected impacts;
- Non-compliance with the periodicity of epidemiological investigations;
- the multiplicity of data collection tools, which increases the burden of data exploitation;
- the poor implementation of mechanisms to ensure the validity and reliability of indicators;
- the lack of integrated reporting on progress against goals and targets and the fairness and effectiveness of the system.
- the lack of deployment and use of the monitoring and evaluation software for DHDPs and RHDP, although the latter has been developed;
- insufficient follow-up to recommendations emanating from monitoring and evaluation activities;
- lack of a methodology for assessing the performance of finance, human resources, procurement, M&E and other systems at all levels and at a well-defined periodicity;
- Insufficient mechanisms for the use of performance review results at the central level.

To compensate for these shortcomings, an Integrated Monitoring and Evaluation Plan (IMEP) accompanies the NHDP. These include: direct output indicators, outcome and impact indicators that will make it possible to gradually assess the levels of implementation of planned activities and achievement of the objectives of the NHDP. Implementation will be monitored both at the level of MOH and at the level of partner administrations. This situation requires strong intra- and inter-ministerial coordination. The indicators detailed in the IMEP are summarized in tables 23 and 24 below:

Tableau 23 : Indicateurs retenus dans le cadre du suivi-évalaution du PNDS 2021-2025

HEALTH PROMOTION AND NUTRITION		
1) Proportion of HDs with functional District Health Committee (DHC) 2) Number of CHWs per inhabitant 3) Community MAR completeness rate 4) Proportion of HDs which fill the community MAR 5) Proportion of DTC budget allocated to HFs as part of decentralization 6) Proportion of RFHP budget allocated in support of DHC 7) % of households using improved toilets 8) Proportion of households that use solid combustible as primary energy source for cooking 9) Proportion of households with access to safe drinking water 10) Mortality rates due to unsafe water, poor sanitation and poor hygiene (access to inadequate WASH services) (SDG 3.9.2.) 11) Proportion of HDs implementing CLTS 12) Proportion of companies that have a functional Health and Safety Committee	13) Frequency of fatal and non-fatal occupational accidents (SDG 8.8.1)) 14) Proportion of households living in decent housing 15) Proportion of households with access to sanitation 16) Daily production capacity (m^3/day) 17) Drinking water supply rate (%) 18) Sewage management infrastructure service rate 19) Proportion of municipal refuse regularly collected and adequately disposed of out of total municipal refuse generated (SDG 11.6.1) 20) % of vulnerable people who have adopted a climate change resilience mechanism 21) Prevalence of pregnancies among adolescents aged 15-19 years 22) Prevalence of smoking among individuals aged 15 years and older 23) Chronic malnutrition rate among pregnant and lactating women 24) Prevalence of food insecurity (SDG 2.1.2) 25) proportion of targets reached during awareness-raising activities on the fight against drug consumption in school and outside of school	26) Road traffic mortality rate (SDG 3.6.1) 27) Proportion of schools with potable water supply 28) Rate of chronic malnutrition among under 5 years old children 29) Modern contraceptive prevalence rates among women of childbearing age (15-49 years) (SDG 3.7.1.) 30) Proportion of unmet FP needs 31) Adolescent fertility rate 15-19 per 1,000 adolescent girls (SDG 3.7.2) 32) Proportion de femmes âgées de 20 à 24 ans mariées ou en couple avant l'âge de 15 ans 33) Proportion of women aged 20-24 who are married or in a couple before the age of 15 or 18 (SDG 5.3.1) 34) Proportion of women and girls aged 15 years and older who have been in a couple who have experienced physical, sexual or psychological violence inflicted in the past 12 months by their current or former partner (SDG 5.2.1.) 35) Proportion of children who have suffered at least one form of violence or abuses 36) % of live births occurred in HFs that resulted to the establishment of a birth certificate

DISEASE PREVENTION

1. HIV incidence
2. HIV prevalence
3. Prevalence of viral hepatitis B
4. Coverage of preventive chemotherapy for onchocerciasis
5. Malaria prevalence rate in children under 5 years old
6. % of pregnant women infected with HIV and on ART
7. Prevalence rate of communicable diseases in prisons
8. Incidence of tuberculosis
9. % of children of school age dewormed
10. Proportion of measles epidemics notified and investigated
11. Proportion of the target population having received all the vaccines provided for by the EPI
12. Vaccination coverage with the reference antigen (Penta3)
13. Vaccination coverage in RR1
14. Improve the Index of the main capacities required according to the International Health Regulations (IHR)
15. Coverage rate in ANC 4
16. Rate of mother-to-child HIV transmission (proportion of children exposed to HIV)
17. Proportion of newborns weighing less than 2500 g
18. Proportion of pregnant women who received at least 3 doses of IPT during their pregnancy (% IPT3)
19. % of DH and similar who offer CESOM according to standards (9 functions)
20. Prevalence of type 2 diabetes in adults aged 18 and over
21. Mortality rate attributable to cardiovascular diseases, cancer, diabetes or chronic respiratory diseases
22. Hospital prevalence of hypertension
23. Incidence of cervical cancer from 21% to 12%
24. % of soldiers returning from an OPS having benefited from support and psychological assistance
25. Percentage of targets reached during awareness campaigns on the prevention of disability and disabling illnesses in children

CASE MANAGEMENT

Therapeutic success rate for smear-positive tuberculosis patients
Malaria-specific mortality rate in children under 5 years old
Proportion of Buruli ulcer cases cured without complications
Perioperative mortality rate in 4th category hospitals
Proportion of live births resulting in the establishment of a birth declaration
Direct intra-hospital obstetric case fatality rate
Percentage of older people who benefit from health and psychosocial assistance
Proportion of newborns who received postnatal care within 48 hours of birth
Proportion of cases of obstetric fistulas repaired
Cesarean delivery rate
Maternal mortality rate
Neonatal mortality rate
Child mortality rate
Infant and child mortality rate
Percentage of pregnant women diagnosed with syphilis in ANC and who receive treatment according to the standards
Proportion of deliveries attended by qualified personnel
Proportion of live births resulting in a birth declaration
Proportion of public health emergencies for which the Incident Management System has been activated at the national level
Proportion of District Hospitals offering blood transfusion according to standards
Proportion of DS with a medical ambulance and whose referral versus referral system is functional
Proportion of Regional Emergency Operations Centers that have the required HRH
Proportion of patients suffering from cataract and having regained visual acuity greater than 3/10 one week after surgical intervention
Number of disabled people cared for in functional rehabilitation centers

HEALTH SYSTEM STRENGHTHENING		
Proportion of HD having reached the consolidation phase	Percentage of HD who deliver the full PAC	Percentage of health structures equipped with at least 50% of human resources according to standards
Proportion of health expenditure borne by households	Frequency of patients treated in military medical structures and training	Proportion of doctors per capita
Rate of people covered by a social health protection mechanism	Proportion of front-line health establishments (IHC and MHC) which issue the complete MAP	Number of students trained per year in human and animal health
Proportion of the health budget in the national budget (SND30)	Proportion of health facilities that have a basic set of essential medicines available and sustainably affordable	MAR promptness rate in DHIS2
Proportion of mutual social security companies covering at least three (03) risks	Share of street drugs in the total drug supply	Completion rate of RMAs in DHIS2
Proportion of the employed active population covered for at least three (03) risks	Share of traditional medicines in the total supply of medicines	Proportion of search results that have been returned
Proportion of HDs built to standards		Percentage of authorized research projects whose results have been published
Proportion of HDSs built to standards		Proportion of deaths occurring in healthcare settings and declared
		Proportion of deaths whose cause was identified and documented
GOVERNANCE AND STRATEGIC STEERING		
Rate of achievement of HSS 2020-2030 objectives	% of health structures audited and controlled per year	% of RDPH having completed the projected performance monitoring dashboard in the NHDP
Proportion of budget allocated to programmatic priorities	Rate of completion of inspection missions (central level) and integrated supervision (RDPH and HD)	Availability of annual health sector review reports
Rate of loss of resources allocated to operational level structures		% of AWP of health sector structures linked to the NHDP

CHAPTER 9: FUNDING OF THE NDSP

This chapter presents the funding forecasts for the implementation of the NHDP 2021-2025:

the projected costs of the NHDP 2021-2025,

the analysis of the funding gaps and,

the financial sustainability strategies and impact assessments.

9.1 PROJECTED COSTS OF THE 2016-2020 NHDP

9.1.1 ASSUMPTIONS AND ESTIMATION METHOD

The estimation of real health financing needs was carried out with the One Health tool on the same methodological basis as in the 2020-2030 Health Sector Strategy. This tool allows the estimation of the costs of interventions in the field of health, based on the targets set, and integrates the analysis of bottlenecks and the budgeting of corrective actions. This provides a holistic estimate of health financing needs. This cost estimate is based on programmatic data and existing targets.

Unit costs for each intervention were determined from the interventions selected in the plan, using the ingredients approach, or a standardized cost approach, applied to estimate direct input costs. The ingredients approach embodies a bottom-up method of calculating costs. It consists of first, isolating the interventions defining each activity, then identifying, quantifying and calculating the inputs necessary for the production of the target unit. This work is carried out through the average unit cost of each intervention. In addition to direct input costs for drugs and supplies, unit costs include a portion of programme costs. These costs are necessary to support the implementation of interventions (training, supervision, monitoring and evaluation, equipment, advocacy and communication, mass media and awareness-raising) that are not directly related to the number of people receiving care.
Input costs were obtained from market prices (taking into account inflation), information available in United Nations system supply databases and surveys.
This costing has taken into account an analysis of the determinants in terms of availability of essential inputs, human resources, accessibility, use of health services by the population, adequate coverage and effective coverage with a view to achieving the objectives set for the period 2021-2025 in the NDS30 and HSS 2020-2030.

On the one hand Budgeting takes into account the envisaged reforms in the health sector in terms of construction, rehabilitation and equipment of health infrastructure and, on the other hand, the government strategies adopted to deal with certain public health emergencies (Cameroon's COVID-19 Response Strategy economic and social resilience in the context of COVID-19) with a view to achieving the Sustainable Development Goals (SDGs) by 2030.

Also, this cost estimate is based on programmatic data and existing targets, as well as the expected coverage of the interventions selected as part of the implementation of the NHDP. The projections were made on the basis of the ordinary least squares method. The adjustment curve equation from which the values of the projection years will be determined are estimated. Depending on the trend, a linear, exponential, logarithmic, polynomial or power curve was used.[1]

9.1.2 NHDP Funding Scenarios

As part of the cost estimate for the 2021-2025 phase of the NHDP, three scenarios were proposed:

- A ***minimum scenario*** that is based on maintaining the gains in terms of coverage of interventions with a slight increase of around 5% on coverage.
- A ***medium scenario*** based on the expected coverage in the NHDP. Indeed, on the basis of existing data up to 2025, projections were made from the base year of the data to 2025 using the ordinary least squares method described above.
- A maximum ***scenario*** is based on maximum coverage projections, bringing to 100 % all expected coverage in 2025, which was 80%, and an increase of 20 points on intervention coverage between 0 and 79 %.

The cost per scenario is shown in the table below:

Table 24: Estimated 2021-2025 NHDP Budget by Scenario

SCENARIO	Cost in XAF	Cost in USD
Minimum (pessimistic)	**2,129,732,675,354**	**3 872 241 228**
Medium (tendential)	**2,764 912, 565, 105**	**5,027,113,755**
Maximum (optimistic)	**3,035,004,087,392**	**5,518,189,250**

From the analysis of the different scenarios, the minimum scenario tilt to the current economic constraints. As for the medium or trend scenario, it offers more realistic opportunities for resource mobilization. The maximum scenario is the ideal scenario requiring more resources. The latter scenario is often used when there is no resource problem in the country.

[1] The **ordinary least squares method** (**MCO**) is the technical name for the mathematical regression in Statistics, and more particularly linear regression. This is a commonly used model in Econometrics.
This involves adjusting a scatterplot $\{Y_i, X_i\}_{i=1,\ldots,n}$ according to a linear relation, taking the form of the matrix relation $Y=X\beta+\varepsilon$where ε is an error term. The least squares method consists of minimizing the sum of the squares of the deviations, weighted deviations in the multidimensional case, between each point of the regression cloud and its projected, parallel to the y-axis, on the regression line.

When the matrix X breaks down into $[1, X_1]$, referred to as univariate linear regression (Linear regression). When there are several regressors in the matrix X, we are dealing with a Multiple linear regression.

The medium or trend scenario is chosen for the 2021-2025 NHDP because it is more realistic and achievable, subject to an acceptable effort to mobilize resources.

9.1.3 ANALYSIS OF THE ESTIMATED COST OF THE 2021-2025 NHDP

- **Distribution of the Budget by strategic axis and by year**

The programming is proposed according to the financing forecasts of the plan on the basis of the five (5) strategic axes. The estimated overall cost of implementing the NHDP 2021-2025 amounts to **2,764,912,565,105** FCFA or approximately **5,027,113,755 USD.**[2] The annual average is **XAF 552,982,513,021**.

***Table 25:* Annual budget by strategic axis**

Health Promotion and Nutrition	15,286,581,168	24,347,383,644	27,268,798,449	27,365,837,992	31,016,977,976	**125,285,579,229**
Prevention of the disease	58,598,877,386	84,767,144,676	129,270,519,103	129,686,901,648	149,547,777,619	**551,871,220,431**
Case Management	101,814,668,845	129,993,739,871	183,208,816,983	196,801,349,670	224,284,498,224	**836,103,073,592**
Strengthening the health system	161,257,078,381	217,225,864,136	254,820,155,654	177,646,128,094	208,892,174,321	**1,019,841,400,586**
Strategic Management and Governance	14,345,110,608	20,095,979,793	59,996,202,797	60,321,363,307	77,052,634,762	**231,811,291,267**
TOTAL	**351,302,316,388**	**476,430,112,119**	**654,564,492,986**	**591,821,580,711**	**690,794,062,901**	**2,764,912,565,105**

The figure below shows the annual evolution of the financing requirement for the 2021-2025 phase of the NHDP.

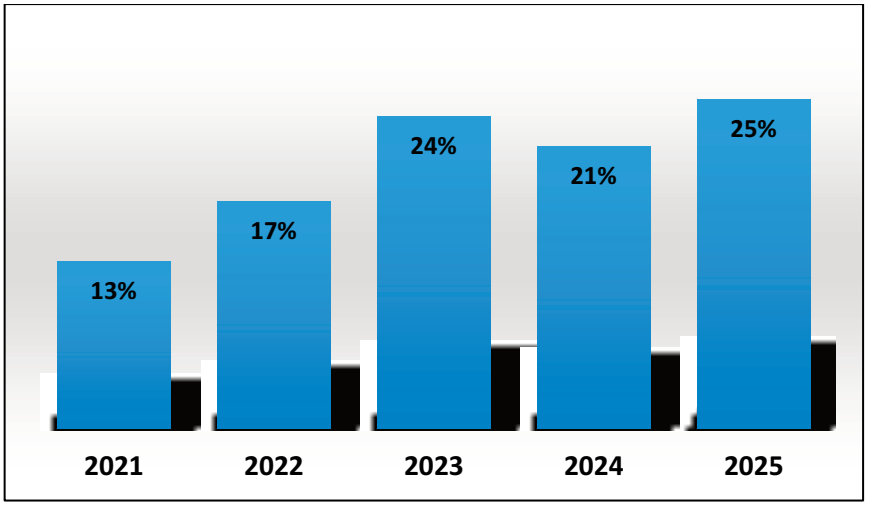


Figure 13: ***Proportion per year of the budget forecasts of the NHDP 2021-2025***

This figure shows an increasing evolution in the cost of interventions in 2021, 2022 and 2023 (respectively 13%, 17% and 24%), before slumping in 2024 (21%), then rising again in 2025 (25%).

The decrease in the budget in 2024 is explained by the end of the implementation of the National Response Plan against COVID-19 in 2023.

- **Analysis of the distribution of the Overall Cost by strategic axes**

The figure below shows the distribution of the budget by strategic axis of the NHDP.

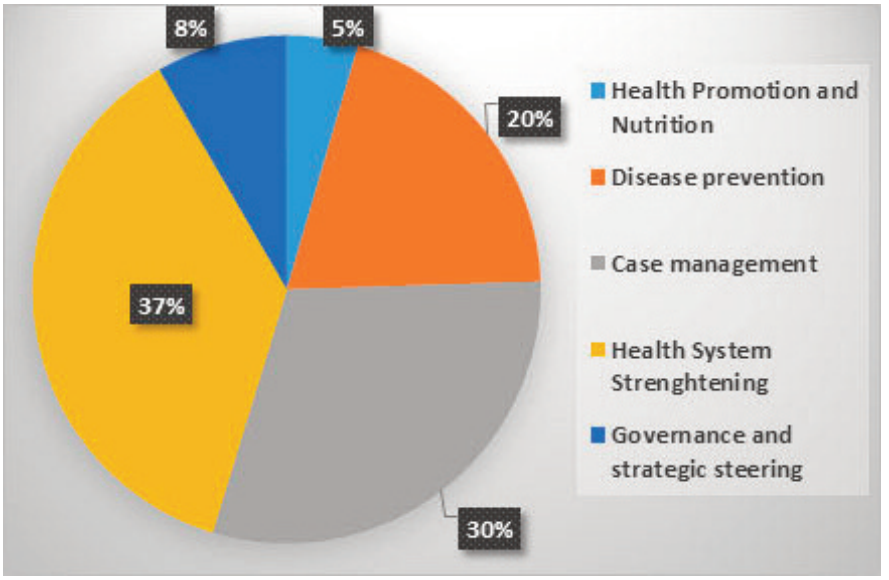


Figure 14: ***Budget Distribution by Strategic Axis***

It emerges from this figure above that the strategic axis "strengthening the health system" represents ***37%*** of the budget, which is explained by the fact that this axis includes all the major pillars of the health system: health infrastructure, medicines, human resources, health financing and the health information system. Faced with the increase in demand for health services and care and the improvement in geographical and financial accessibility to quality health care, the importance of the weight of this axis is explained.

The budgetary weight of the strategic axis "***case management***" is ***30%*** of the budget of the NHDP. This is justified by the fact that this component includes, among other things, the management of different pathologies (diagnosis and treatment): communicable and non-communicable diseases, high-impact interventions for maternal, newborn, child and adolescent health, etc.

The strategic axis "***disease prevention***" represents ***20%*** of the budget estimates, which is justified by taking into account current health concerns such as the prevention of communicable, non-communicable and vaccine-preventable diseases including COVID-19.

The strategic axes "steering and governance" and "***promotion of health*** and nutrition***"*** represent the rest of the projected budget ***(13%)*** with ***respectively 8%*** and ***5%.***

- **Breakdown of the overall cost by strategic sub-axis of the NHDP**

The table below shows the distribution and evolution of the shares of each sub-axis in the overall budget in absolute terms.

Table 26: Distribution of the 2021-2025 NHDP budget by strategic axes and sub-axes

STRATEGIC AXES	STRATEGIC SUB-AXES	2021	2022	2023	2024	2025	TOTAL	%
Health Promotion and Nutrition	Institutional, community and coordination capacities for health promotion	3 873 242 971	6 902 904 691	10 260 414 531	11 552 681 645	13 636 461 390	46 225 705 229	**2%**
	Living environment of the populations	4 320 302 944	4 746 556 044	5 203 899 778	5 694 108 997	6 219 047 654	26 183 915 417	**1%**
	Building health-promoting skills	5 362 591 682	10 747 003 329	9 613 531 394	7 667 240 789	8 426 597 804	41 816 964 997	**2%**
	Essential family practices and family planning, adolescent health promotion and post abortion care	1 730 443 571	1 950 919 581	2 190 952 746	2 451 806 561	2 734 871 128	11 058 993 586	**0,40%**
Prevention of the disease	Prevention of communicable diseases	12 504 415 380	14 848 690 026	54 970 600 093	57 576 916 638	73 255 656 520	213 156 278 658	**8%**
	Epidemic Prone Diseases and public health events surveillance and response to epidemic-prone diseases, zoonoses and public health events	7 389 425 791	23 475 695 296	16 418 850 478	8 916 462 532	7 774 403 469	63 974 837 564	**2%**
	RMNCAH/PMTCT	32 273 784 900	37 189 881 650	42 902 787 843	48 757 377 675	54 996 484 354	216 120 316 423	**8%**
	Prevention of non-communicable diseases	6 431 251 315	9 252 877 703	14 978 280 689	14 436 144 804	13 521 233 276	58 619 787 786	**2%**

Case Management	Curative management of communicable and non-communicable diseases	55 343 973 065	66 030 218 614	114 677 934 651	122 021 299 701	143 394 562 440	501 467 988 471	**18%**
	Maternal, neonatal, infant and adolescent conditions	22 701 383 630	27 429 857 629	32 462 198 696	37 786 602 818	43 364 314 855	163 744 357 629	**6%**
	Emergencies, disasters and humanitarian crises	2 909 198 403	14 491 705 360	12 789 481 327	12 419 501 981	11 597 297 510	54 207 184 581	**2%**
	Management of disability	20 860 113 746	22 041 958 267	23 279 202 309	24 573 945 170	25 928 323 418	116 683 542 911	**4%**
Strengthening the health system	Health financing	4 584 836 183	5 187 402 803	5 737 910 139	6 640 868 652	7 742 609 623	29 893 627 400	**1%**
	Provision of services and care	57 353 688 865	67 312 113 883	70 257 938 774	30 954 778 902	32 442 399 942	258 320 920 365	**9%**
	Drugs and other pharmaceutical products	36 814 226 718	58 443 371 039	90 250 794 057	67 076 126 665	83 924 510 843	336 509 029 324	**12%**
	Health Human Resources	46 758 638 662	65 219 919 168	65 584 346 237	55 883 914 000	59 183 078 659	292 629 896 726	**11%**
	Health Information and Health Research	15 745 687 953	21 063 057 244	22 989 166 447	17 090 439 873	25 599 575 255	102 487 926 771	**4%**
Strategic Management and Governance	Governance	14 187 444 545	19 872 097 933	59 820 493 366	60 148 820 353	76 876 708 361	230 905 564 558	**8%**
	Strategic management	157 666 062	223 881 860	175 709 431	172 542 955	175 926 401	905 726 709	**0,03%**
TOTAL BUDGET OF THE NDSP 2021-2025		**351 302 316 388**	**476 430 112 119**	**654 564 492 986**	**591 821 580 711**	**690 794 062 901**	**2 764 912 565 105**	**100%**

The table below shows the distribution and evolution of the shares of each sub-axis in the overall budget in relative terms.

Table 27: Distribution of budget weight by strategic axis and sub-axis

STRATEGIC AXES	STRATEGIC SUB-AXES	2021	2022	2023	2024	2025
Health Promotion and Nutrition	Institutional, community and coordination capacities for health promotion	25%	28%	38%	42%	44%
	Living environment of the populations	28%	19%	19%	21%	20%
	Building health-promoting skills	35%	44%	35%	28%	27%
	Essential family practices and family planning, adolescent health promotion and post abortion care	11%	8%	8%	9%	9%
Percentage *of "Health Promotion"* in the overall budget		**4%**	**5%**	**4%**	**5%**	**4%**
Prevention of the disease	Prevention of communicable diseases	21%	18%	43%	44%	49%
	Surveillance and response to EPD, zoonoses and public health events	13%	28%	13%	7%	5%
	RMNCAH/PMTCT	55%	44%	33%	38%	37%
	Prevention of non-communicable diseases	11%	11%	12%	11%	9%
Percentage *of "Disease Prevention"* in the overall budget		**17%**	**18%**	**20%**	**22%**	**22%**
Case Management	Curative management of communicable and non-communicable diseases	54%	51%	63%	62%	64%
	Maternal, neonatal, infant and adolescent conditions	22%	21%	18%	19%	19%
	Emergencies, disasters and humanitarian crises	3%	11%	7%	6%	5%
	Disability care	20%	17%	13%	12%	12%
Percentage of " *Case Management*" in the overall budget		**29%**	**27%**	**28%**	**33%**	**32%**
Strengthening the health system	Health financing	3%	2%	2%	4%	4%
	Provision of services and care	36%	31%	28%	17%	16%
	Drugs and other pharmaceutical products	23%	27%	35%	38%	40%
	Health Human Resources	29%	30%	26%	31%	28%
	Health Information and Health Research	10%	10%	9%	10%	12%
Percentage of " *Health System Strengthening*" on the overall budget		**46%**	**46%**	**39%**	**30%**	**30%**
Strategic Management and Governance	Governance	98,9%	98,9%	99,7%	99,7%	99,8%
	Strategic management	1,1%	1,1%	0,3%	0,3%	0,2%
Percentage of " *Strategic Management and Governance*" on the overall budget		**4%**	**4%**	**9%**	**10%**	**11%**

9.1.4 PROJECTED IMPACT

The OneHealth tool used baseline data and expected coverage projections to calculate the costs associated with the objectives set and to project the impact in terms of reducing maternal, newborn and child mortality. However, the trade-offs in the volume of funding for HSS interventions will have consequences for the expected results.

- **Neonatal mortality and additional lives saved**

According to the results of the Demographic and Health Survey (EDS-2018), the neonatal mortality rate was estimated at 28.02 deaths per 1000 live births (NV). Based on projected coverage and interventions to be implemented, the neonatal mortality rate will increase from 28.02 to 20.9 deaths per 1000 NV in 2025. The interventions to be implemented under the NHDP will prevent 7,188 additional deaths out of the 18,226 deaths expected, a reduction of 39.44%.

- **Under-5 mortality and additional lives saved**

In 2018, the infant and child mortality rate in Cameroon was estimated at 80 per thousand live births (DHS 2018). Based on projected coverage and interventions to be implemented, the under-5 mortality rate would increase from 80 to 51.61 deaths per 1000 NV in 2025. The interventions to be implemented under the NHDP will prevent 21,642 additional deaths out of the 50,226 deaths of children under 5 years of age expected, a reduction of 43.09%.

- **Maternal mortality and additional lives saved**

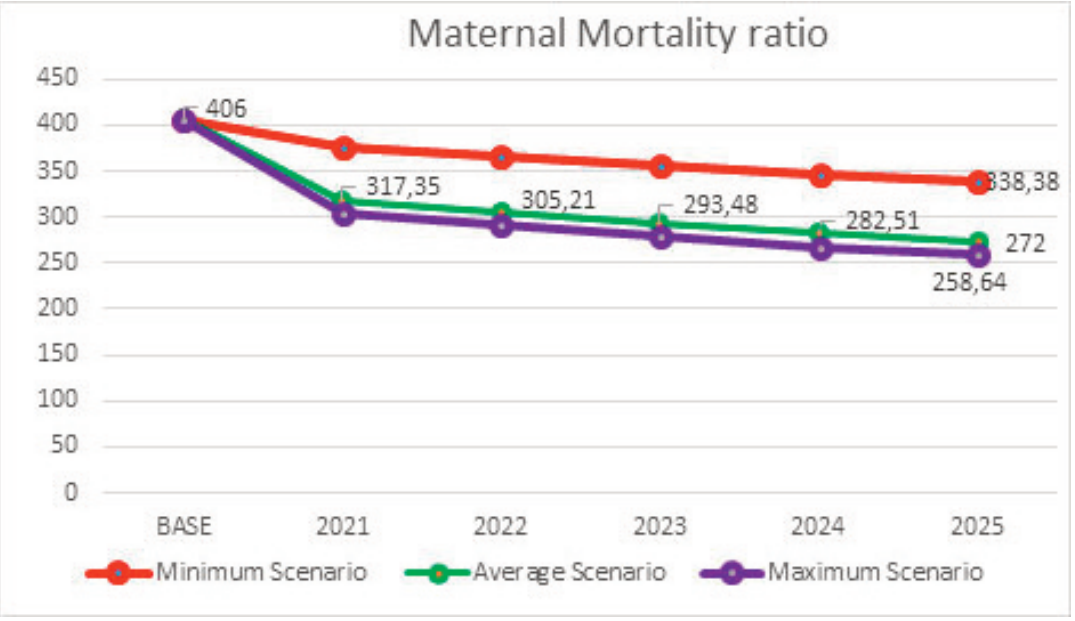
According to DHS 2018, the maternal mortality ratio was estimated at 406 deaths per 100,000 live births. Based on projected coverage and interventions to be implemented, the maternal mortality ratio would increase from 406 to 272 deaths per 100,000 live births in 2025. The interventions to be implemented under the NHDP will prevent 2,821 additional deaths out of the 13,086 deaths of women expected, a reduction of 49.25%.

***Table 28:* Number of lives saved (medium scenario)**

Additional lives saved from	2 021	2 022	2 023	2 024	2 025
Newborns	3 400	4 411	5 383	6 315	7 188
Children under 5 years old	7 165	9 405	11 363	12 963	14 455
Mothers	795	907	1 016	1 118	1 216

***Table 29:* Summary of mortality rates (medium scenario)**

Summary of mortality rates	Base	2021	2022	2023	2024	2025
Maternal mortality ratio (deaths per 100,000 live births)	**406**	317,4	305,2	293,5	282,5	272
Neonatal mortality rate (deaths per 1,000 births)	**28,02**	24,23	23,12	22,05	21,04	20,09
Infant mortality rate	**47,5**	40,46	38,5	36,69	35,05	33,49
Infant mortality rate (deaths per 1,000 births)	**80**	67,77	64,17	60,95	58,2	55,61



➢ **Estimating productivity gains from under-5 survival**

There is a relationship between child health and economic development. Indeed, a well-cared for (healthy) child will be better educated, and more productive in the future. On the other hand, poor health in childhood leads to a loss of productivity of parents at the time of illness, and in the long term leads to disorders in adulthood. In poor families, this contributes greatly to maintaining the vicious cycle of poverty in future generations. The implementation of the NHDP will reduce the under-5 mortality rate by 30.2% from 80 per 1000 to 55.61 per 1000.

Econometric analyses estimate that a 5% reduction in the child mortality rate leads to a 1% increase in productivity over [3] the average product (GDP). Cameroon's GDP is estimated in 2020 at 23,486.5 billion FCFA. The implementation of high-impact interventions on reducing under-5 mortality will enable the country to generate a productivity gain of about 1,432 billion FCFA during the 05 years of reduction in infant and child mortality.

9.2 ANALYSIS OF FUNDING GAPS

A budget review over the last five financial years shows that the State has allocated to the Ministry of Public Health an average of 200.239 billion FCFA as a budget to finance health spending over the said period. This average would be even higher if all the resources budgeted for health expenditure of other administrations and structures under trusteeship could be captured. However, the allocated budget for the MOH is as follows:.

Exercise	Budgetary resources allocated to MOH
2018	175 239 590 200
2019	207 943 062 000
2020	213 651 000 000
2021	197 121 500 000

[3] Wealthier is Healthier (Pritchett-Summers 1996)

2022	207 240 000 000

On the other hand, the average funding requirement per year for the NHDP is 552.985 billion per year if we refer to the table below summary by year of the resources expected to finance health spending from 2021 to 2025.

Exercise	Financing requirement
2021	**351 302 318 409**
2022	**476 430 114 141**
2023	**654 564 495 009**
2024	**591 821 582 735**
2025	**690 794 064 926**

More specifically, the funding gap is increasing from 2021 to 2025, compared to the average annual budget per fiscal year allocated to MOH, and is as follows:

Exercise	Financing requirement	Average budget MOH	Funding gap
2021	**351 302 318 409**	200 239 030 440	**- 151 063 287 969**
2022	**476 430 114 141**	200 239 030 440	**- 276 191 083 701**
2023	**654 564 495 009**	200 239 030 440	**- 454 325 464 569**
2024	**591 821 582 735**	200 239 030 440	**- 391 582 552 295**
2025	**690 794 064 926**	200 239 030 440	**- 490 555 034 486**

It is clear that the budgetary projection of Chapter 4 alone cannot make it possible to fill the funding gaps of the NHDP.

As a reminder, the history of budgeting shows us that for the last 5 financial years, the share of resources allocated to MOH is decreasing from year to year and is on average less than 5% compared to the overall budget of the State as follows.

Exercise	State budget	Budget du MOH	Share of the MOH budget in the overall State budget
2 018	4 513 500	173 239	3,84%
2 019	4 805 500	207 943	4,33%
2 020	4 951 700	213 651	4,31%
2 021	4 865 200	197 121	4,05%
2 022	5 752 400	207 240	3,60%

To remain in line with the commitments made in Abuja (15% of the national budget must be allocated to health financing), by increasing this budgetary proportion, the State would contribute significantly to closing the gaps thus identifying and reducing the direct contribution of households to health expenditure.

9.3 FINANCIAL SERVICING STRATEGY

The financing of the various interventions selected in the NHDP will be mobilized in a concerted manner with the State, its development partners, NGOs and the private sector. The development of a mid-term expenditure framework for the health sector, to which the

NATIONAL COMPACT will be based, will allow for greater mobilization of financial resources from national and international partners.

The updated health financing strategy will detail aspects related to revenue collection, pooling of resources and procurement of interventions. This process is backed by the ongoing multisectoral reflection on a Universal Health Coverage system. Ultimately, this strategy will ensure the financial sustainability of the health sector while reducing the direct participation of households and development partners in line with the guidelines of the NDS30.

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