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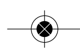
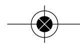
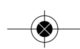
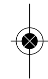
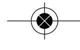


NATIONAL STRATEGIC PLAN FOR REPRODUCTIVE, MATERNAL, NEWBORN, CHILD AND ADOLESCENT HEALTH AND NUTRITION (NSP/RMNCAH-NUT) 2024-2030





PREFACE

The challenge of maternal, neonatal, infant, and child mortality, as well as with the improvement of sexual and reproductive health for adolescents, young people, the elderly, and other target groups, remains a critical public health concern in Cameroon. Despite significant progress made in recent years to reduce these mortality rates, current statistics remain alarming. The latest Demographic and Health Survey reported 406 maternal deaths per 100,000 live births, 28 neonatal deaths per 1,000 live births, 48 deaths per 1,000 live births among children under one year, and 80 deaths per 1,000 live births among children under five years old.

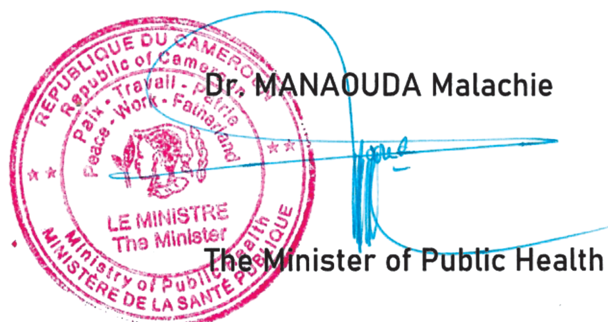
Each year, a considerable number of lives are lost, causing not only immense suffering within affected families but also imposing a socio-economic burden on our country. Confronted with this troubling reality, Cameroon has been firmly committed for over a decade to the global movement to combat maternal, neonatal, and child mortality. The country has aligned itself with the objectives of the Global Strategy for Women's, Children's, and Adolescents' Health (2016-2030) and the Health Sector Strategy 2020-2030, which is anchored in the National Development Strategy 2020-2030. In this national and international context, where the reduction of maternal, neonatal, and child mortality is among the highest health priorities, several strategic plans have been developed with the primary goal of reducing these mortality rates. While the progress achieved has been encouraging, the set objectives have yet to be fully attained.

Efforts must continue under the first phase of Universal Health Coverage, which, in line with the vision of the Head of State, aims to provide quality healthcare that is accessible to all. Mothers and children are a key focus in this initiative, with the Health Voucher Package and the provision of free malaria treatment for children under five years of age.

This National Strategic Plan, serving as our new roadmap, incorporates reproductive health for the elderly, a long-overlooked issue, as well as reproductive health in humanitarian contexts and nutrition-related aspects.

The plan highlights the primary causes of morbidity and mortality within these population groups and outlines strategic directions and high-impact interventions that must be implemented effectively.

As a guiding framework for all stakeholders involved in this effort, this plan should be the foundation upon which our collective efforts and energy converge to achieve our established goals. We therefore call upon all stakeholders, be they governmental, non-governmental, community-based, and individuals to take ownership of this plan and collaborate in a coordinated and inclusive manner to ensure its effective implementation.



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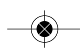
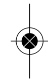

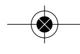

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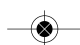

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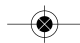

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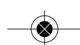


EXECUTIVE SUMMARY

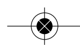
Cameroon is among the countries where maternal, newborn, child, adolescent and elderly health indicators remain a challenge despite the commitments made and actions taken. Indeed, Cameroon has ratified several international agreements of great importance and to date, several legal instruments and policies, both international and regional, have laid the foundations for the fight against maternal, neonatal and child mortality, as well as that of the elderly. Some of the most important instruments include:

- The resolutions of the International Conference on Population and Development (ICPD) in 1994: The ICPD adopted an ambitious Programme of Action aimed at promoting gender equality and the empowerment of women in all areas of life.
- The Millennium Development Goals (MDGs) in 2000-2015 and the SDGs in 2015-2030.
- The Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) in 1979.
- The Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in 2003, which strengthens legal protections for women in the African context.

Following these international and regional commitments, several strategies have been developed, with the main objective of responding to both national and international demands for gender equality and women's empowerment.

In addition, in response to the call of the African Union, Cameroon joined the Campaign for the Accelerated Reduction of Maternal and Neonatal Mortality in Africa (CARMMA) in 2010. In 2015, the country reaffirmed its commitment to intensify its efforts to achieve the Sustainable Development Goals (SDGs) relating to maternal and child health, set for the period 2015 to 2030.

While acknowledging that the expected results have not been fully achieved despite the efforts made, it is important to note the significant progress made in reducing maternal, neonatal and child mortality. Indeed, between 2011 and 2018 (DHS-2011 and 2018), pregnancy-related mortality ratio dropped from 782 deaths to 467 deaths per 100,000 live births for a projected target in 2030 of 140 deaths per 100,000 live births. During the same period, neonatal mortality ratio dropped from 31 to 28 deaths per 1,000 live births (for a projected target of 12 deaths per 1,000 births); Infant mortality [mortality of children under 1years of age] for the same period decreased from 62 to 48 deaths per 1000 live births, (the projected target in 2030 was 25 deaths per 1000 live births) and infant and child mortality decreased from 122 to 80 deaths per 1000 live births (for a projected target



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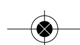
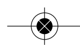


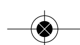
of 70 deaths per 1000 live births). Analysis shows that pregnancy-related, neonatal and child mortality rates have decreased at the national level, but the DHS 2018 highlights the persistence of significant regional disparities. These disparities highlight the need for special attention and targeted efforts to ensure equitable access and optimal quality of reproductive health services throughout the country. Regional disparities have particularly been observed in the Adamawa, North, Far North and East regions, which are the most affected. The causes of these various types of mortalities are direct, structural and organisational.
In order to improve reproductive health performance and achieve the SDGs, the Ministry of Public Health and its partners have developed a new National Strategic Plan for Reproductive, Maternal, Newborn, Child, Adolescent and Elderly Health and Nutrition (NSP/RMNCAH-Nut) 2024-2030. This plan has 4 important sections.

The first section of this plan presents a comprehensive overview of the reproductive health situation in Cameroon for each target, supported by data and a few key indicators for each target:

- Maternal health: Maternal mortality rate, coverage of antenatal and postnatal care, deliveries assisted by qualified personnel;
- Newborn health: Neonatal mortality rate, vaccination coverage, coverage of postnatal care, kangaroo mother care for premature newborns, early breastfeeding and exclusive breastfeeding for 6 months;
- Child health: Infant mortality rate, vaccination coverage, Integrated Management of Newborn and Childhood Illnesses (IMNCI), prevention and management of malaria;
- Adolescent and youth health: Contraceptive prevalence by modern methods among adolescent girls and young women, management of sexually transmitted infections (STIs) among adolescents, management of gender-based violence (GBV) and harmful cultural practices (early marriages and female genital mutilation);
- Health of women and men including older women and men: Family planning, management of STIs, HIV/AIDS, fight against cancers and sexual dysfunctions.

The second section of the plan, which is aligned with international guidelines and national development plans, presents the strategic framework and priority interventions to be implemented in a concerted manner at all levels of the health pyramid. These interventions aim to address the structural and organisational bottlenecks that hinder the fight against maternal, newborn and child mortality.

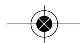




The vision of this plan is to make Cameroon "a country where maternal, newborn and child mortality, as well as morbidity related to reproductive health, are reduced to a minimum, particularly among the most vulnerable and disadvantaged populations."
This section of the document also specifies the overall objective of the 2024-2030 NSP/RMNCAH-Nut, which is to “contribute to the reduction of morbidity and mortality specific to reproductive health problems of mothers, newborns, children, adolescents/youth, as well as the elderly by 2030. "

To achieve this overall objective, the plan has three main strategic axes each with specific strategic objectives:

- Strategic Axis 1: Scaling up the Coverage of High Impact Interventions. This axis brings together the interventions that directly benefit the targets of the NSP/RMNCAH-Nut. It has two strategic objectives which are:
  - Strategic Objective No. 1.1.: Improving the coverage of high-impact RMNCAH-Nut interventions for mothers, newborns, children, adolescents, men and women including the elderly by 2030;
  - Strategic Objective No. 1.2.: Contributing to the reduction of harmful cultural practices among adolescents, women and men (gender-based violence, female genital mutilation and child marriage) by 2030.
- Strategic Axis 2: Strengthening Support Activities. This axis brings together cross-cutting interventions that concern all targets. It has two strategic objectives, notably:
  - Strategic objective No.2.1.: Improving the availability of quality RMNCAH-Nut services by 2030;
  - Strategic objective No.2.2.: Improving the accessibility and use of RMNCAH-Nut services by 2030.
- Strategic axis 3: Setting up effective mechanisms to support the implementation of the Strategic Plan. This axis aims to strengthen the governance and management of the 2024-2030 NSP/RMNCAH-Nut, as well as to increase the resilience of the healthcare system to the risks of public health emergencies. It includes the following strategic objectives:
  - Strategic objective No.3.1.: Strengthening the governance of the health system for RMNCAH-Nut by 2030;
  - Strategic objective No.3.2.: Strengthening the strategic steering of the implementation of the new RMNCAH-Nut Strategic Plan by 2030;
  - Strategic objective No.3.3.: Strengthening the resilience of the healthcare system to the risks of public health emergencies in order to improve the provision of reproductive health services.



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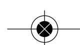
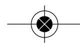
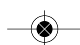


The fourth section presents the performance framework, the implementation framework, the monitoring and evaluation framework of the 2024-2030 NSP/RMNCAH-Nut and its budget.
Although the Ministry of Public Health ensures the leadership for the implementation of this strategic plan, it is important to acknowledge that the problem of maternal, newborn and child mortality is multifactorial and requires the implementation of multi-sector interventions and strategies. The various partner ministries will therefore contribute to the implementation of this multi-sector strategic plan in accordance with their respective mandates. The joint monitoring and evaluation framework that has been developed will make it possible to monitor progress in implementing the plan and measure its impact. The effective implementation of this plan requires adequate mobilisation of human, material and financial resources from all stakeholders.
The overall budget for the implementation of this plan is estimated at 308,553,646,283 (three hundred and eight billion, five hundred and fifty-three million, six hundred and forty-six thousand, two hundred and eighty-three) FCFA.





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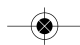

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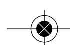

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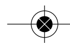
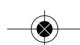
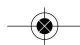




ABBREVIATIONS AND ACRONYMS

ACRONYM	DEFINITION
AFD	French Development Agency
AIDS	Acquired Immunodeficiency Syndrome
ANC	Antenatal Care
ARH	Adolescent Reproductive Health
ARI	Acute Respiratory Infection
ART	Antiretroviral Therapy
ATC	Approved Treatment Centre
AWP	Annual Work Plan
AYRH	Adolescent and Youth Reproductive Health
BCG	Bacille Calmette Guerin
BEmONC	Basic Emergency Obstetric and Neonatal Care
BUNEC	National Civil Status Registry
CAMNAFAW	Cameroon National Association for Family Welfare
CAPR	Regional Pharmaceutical Supply Centre
CARMMA	Campaign for Accelerating the Reduction of Maternal Mortality in Africa
CBCHS	Cameroon Baptist Convention Health Services
CBO	Community-Based Organisation
CDC	Center for Disease Control and Prevention
CDI	Community-Directed Interventions
CDVA	Contract, Development and Verification Agency
CEMAC	Central African Economic and Monetary Community
CEmONC	Comprehensive Emergency Obstetric and Neonatal Care
CENAME	National Supply Centre for Essential Drugs and Medical Consumables
CHRACERH	Hospital Centre for Research and Application in Endoscopic Surgery and Human Reproduction
CHW	Community Health Worker
CIRCB	Chantal Biya International Research Centre
COVID-19	Coronavirus Disease
CPC	Centre Pasteur of Cameroon
CSO	Civil Society Organisation
DAJC	Legal Affairs and Litigation Division
DCOOP	Cooperation Department
DEP	Studies and Projects Division
DGSN	General Delegation for National Security
DHC	District Health Committee
DHIS	District Health Information System
DHR	Department of Human Resources
DHS	Demographic and Health Survey
DLMEP	Department for the Control of Diseases, Epidemics and Pandemics
DMC	District Management Committee



DOSTS	Department of Health Care Organisation and Health Technology
DPML	Department of Pharmacy, Medicines and Laboratories
DPS	Department of Health Promotion
DROS	Division of Operational Research in Health
DSF	Department of Family Health
EmEONC	Emergency and Essential Obstetric and Neonatal Care
EmONC	Emergency Obstetric and Neonatal Care
EONC	Essential Obstetric and Neonatal Care
EPI	Expanded Programme on Immunisation
FCFA	Franc of the African Financial Community
FGM	Female Genital Mutilation
GAVI	Global Alliance for Vaccines and Immunisation
GBV	Gender-Based Violence
GDP	Gross Domestic Product
GESP	Growth and Employment Strategy Paper
GFF	Global Financing Facility
GIZ	Geselltshaft für Technishe Zusammenarbeit (German Technical Cooperation)
HC	Health Committee
HF	Health Facility
HIU	Health Information Unit
HIV	Human Immunodeficiency Virus
HPV	Human Papilloma Virus
HRH	Human Resources in Health
HSS	Health Sector Strategy
ICD	International Classification of Diseases
ICPD	International Conference on Population and Development
IDB	Islamic Development Bank
IDP	Internally Displaced Person
IEC	Information-Education-Communication
IHC	Integrated Health Centre
IHME	Institute of Heath Metrics and Evaluation
IMCI	Integrated Management of Childhood Illnesses
IMNCI	Integrated Management of Newborn and Childhood Illnesses
ITIN	Insecticide-Treated Mosquito Net
IUD	Intra Uterine Device
KFW	Kreditanstalt für Wiederaufbau (German Development Bank)
KMC	Kangaroo Mother Care
LANACOME	National Laboratory for Quality Control of Drugs and Expertise
LLIN	Long-Lasting Insecticide-Treated Mosquito Nets
LMIS	Logistics Management Information Systems
MAR	Medically Assisted Reproduction
MAR	Monthly Activity Report
MC	Management Committee
MCHNAW	Maternal and Child Health and Nutrition Action Week

MCHW	Multipurpose Community Health Worker
MDG	Millennium Development Goal
MHC	Medicalised Health Centre
MICS	Multiple Indicators Cluster Survey
MINADER	Ministry of Agriculture and Rural Development
MINAS	Ministry of Social Affairs
MINAT	Ministry of Territorial Administration
MINCOM	Ministry of Communication
MINDDEVEL	Ministry of Decentralisation and Local Development
MINDEF	Ministry of Defense
MINEDUB	Ministry of Basic Education
MINEE	Ministry of Energy and Water resources
MINEPAT	Ministry of Economy, Planning and Regional Development
MINEPIA	Ministry of Livestock, Fisheries and Animal Industries
MINESEC	Ministry of Secondary Education
MINESUP	Ministry of Higher Education
MINFI	Ministry of Finance
MINJEC	Ministry of Youth and Civic Education
MINJUSTICE	Ministry of Justice
MINPROFF	Ministry for Women's Empowerment and the Family
MIS	Malaria Indicator Survey
MOH	Ministry of Public Health
NACC	National AIDS Control Committee
NBCP	National Blindness Control Programme
NBTP	National Blood Transfusion Programme
NCaCC	National Cancer Control Committee
NDS	National Development Strategy
NGO	Non-Governmental Organisation
NHA	National Health Accounts
NHDP	National Health Development Plan
NHIS	National Health Information System
NIS	National Institute of Statistics
NMCP	National Malaria Control Programme
NPHL	National Public Health Laboratory
NPHO	National Public Health Observatory
NSAG	Non-State Armed Groups
NTBCP	National Tuberculosis Control Programme
NUT	Nutrition
OVC	Orphans and Vulnerable Children
PBF	Performance-Based Financing
PC	Paediatric Care
PEPFAR	President's Emergency Plan for AIDS Relief
PHEOCC	Public Health Emergency Operations Coordination Centre
PIG	Public Interest Group
PLHIV	People Living with HIV

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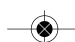
PLMNI	Multisector Programme to Fight against Maternal, Newborn and Child Mortality
PMTCT	Prevention of Mother-to-Child Transmission of HIV
PONC	Post Obstetric and Neonatal Care
PRSP	Poverty Reduction Strategy Paper
PSLMMNIJ	Strategic Plan to Fight against Maternal, Newborn, Infant and Child Mortality
PW	Pregnant Women
RDPH	Regional Delegation for Public Health
RFHP	Regional Fund for Health Promotion
RLA	Regional and Local Authorities
RMNCAH	Reproductive, Maternal, Newborn, Child and Adolescent Health
SBC	Social and Behaviour Change
SDG	Sustainable Development Goal
SOCAPED	Cameroon Paediatric Society
SOGOC	Society of Gynaecologists and Obstetricians of Cameroon
SOP	Standard operating procedures
SPDHRH	Strategic Plan for the Development of Human Resources in Health
SSM	Supply and Stock Management
STI	Sexually Transmitted Infection
SWOT	Strengths-Weaknesses-Opportunities-Threats
TFP	Technical and Financial Partners
TFR	Total Fertility Rate
TWG	Technical Working Group
UHC	Universal Health Coverage
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commission for Refugees
UNICEF	United Nations International Children's Emergency Fund
UTH	University Teaching Hospital
VTP	Voluntary Termination of Pregnancy
WHO	World Health Organisation



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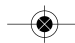

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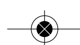

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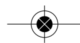
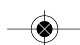




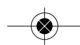
1 INTRODUCTION

Despite the commitments, actions taken and progress achieved, Cameroon is still among the countries where maternal, newborn, child and adolescent health indicators remain alarming. Cameroon has made several commitments on the global scene, including the International Conference on Population and Development (ICPD) in 1994, the Millennium Development Goals (MDGs) in 2000 and the MAPUTO Protocol in 2009. In addition, in 2010 and 2015, Cameroon joined the Campaign for the Accelerated Reduction of Maternal Mortality in Africa (CARMMA) initiated by the African Union. The country has also committed to accelerating its efforts to achieve the Sustainable Development Goals designed for 2015-2030. Based on these commitments, several strategies have been developed to achieve national and international objectives in the field of reproductive health, which has led to improvements in certain RMNCAH impact indicators.
Between 2011 and 2018, the pregnancy-related mortality ratio decreased from 782 deaths to 467 deaths per 100,000 live births. The neonatal mortality ratio decreased from 31 to 28 deaths per 1,000 live births over the same period; child mortality decreased from 62 to 48 deaths per 1,000 live births while infant mortality decreased from 122 to 80 deaths per 1,000 live births (DHS 2011 and 2018).

Regarding impact or coverage indicators, clear disparities are recorded between regions; the Adamawa, North, Far North and East regions have particularly low coverage.

The North West and South West regions, which have been plagued by civil war for more than five years, are experiencing major disruption to their health systems, with a subsequent lack of implementation of health programmes. Generally, despite the efforts made with the support of development partners, the expected RMNCAH results have not been achieved over the past decade. In fact, even though the RMNCAH impact indicators show a positive trend overall, they remain below national and international projections, thus emphasizing the need to intensify efforts if Cameroon is to achieve SDGs in RMNCAH by 2030.

Most of the objectives set at the national level have not been achieved. This situation is due to a combination of factors, namely the underfunding of RMNCAH-Nut interventions. In addition, the response implemented by the stakeholders involved in improving RMNCAH indicators is fragmented, incomplete and poorly integrated. Insufficient alignment of actions with RMNCAH-Nut priorities and poor coordination between stakeholders hamper the effectiveness of interventions, worsening the situation.



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Faced with these challenges, and to respond effectively to the problems associated with Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCAH), in 2013 the Government and its partners developed and launched the National Multi-sector Programme to control Maternal, Newborn and Child Mortality (PLMI). The vision of this programme was "To make Cameroon a Nation where universal access to quality care and services for women and children is a reality, and where avoidable maternal, neonatal and infant deaths are eliminated".

The Government and its partners, through DSF and PLMI, also drew up several major strategic documents over the period 2014-2020 (a total of six years), including (a) the Strategic Plan for Reproductive, Maternal, Newborn and Child Health (2014-2020) which mainly aimed at reducing: (i)maternal death rates by 29%, from 782 to 557 per 100,000 live births; (ii)infant and child mortality by 27%, from 122 to 89 deaths per 1,000 live births; and (iii) neonatal deaths by 23%, from 31 to 24 deaths per 1,000 live births by 2020; (b) the 2014-2020 Strategic Plan of the National Multi-sector Programme to fight against Maternal, Newborn and Child Mortality; (c) the National Strategic Plan for Adolescent and Youth Health in Cameroon (2015-2019); (d) the Operational Plan for Family Planning in Cameroon (2015-2020); (e) the National Operational Plan for Newborn Health in Cameroon (2016-2018); (f) the Investment Case to improve reproductive, maternal, newborn, child and adolescent health in Cameroon (2017-2020) (See Figure 1).

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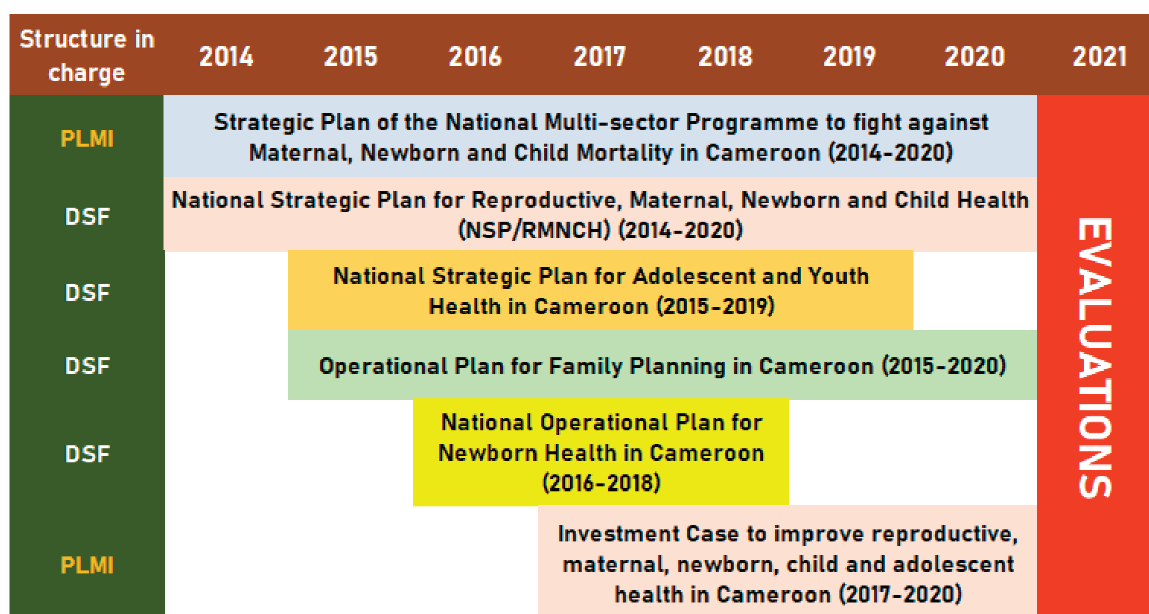

Figure 1: Summary of strategic and operational plans drawn up for RMNCAH by the MOH between 2014 and 2021

However, considering the inefficiency of the high number of plans drawn up between 2014 and 2020, an agreement was reached in May 2023 during discussions with

stakeholders to prevent the overlapping and diversity of RMNCAH planning documents (see Figure 1), with the aim to draw up a single strategic plan for the 2024-2030 period for all RMNCAH issues in Cameroon.

The 2024-2030 RMNCAH-Nut Plan proposes an integrated, coherent and effective approach to meet RMNCAH-Nut challenges. It aims to harmonise the efforts of the various stakeholders and optimise resources to achieve the objectives of reducing maternal, newborn and child mortality, while fighting against malnutrition.

This new RMNCAH-Nut 2024-2030 National Strategic Plan will be aligned with international guidelines and national development plans.
It is based on lessons learned from the implementation of previous national strategic plans and the Investment Case for Reproductive Health (RH), as well as international best practices. This approach will enable to consolidate effective strategies and introduce new, more relevant strategies to improve RMNCAH-Nut in Cameroon. This plan is the reference document that will guide the planning and implementation of RMNCAH-Nut interventions over the next six years. The Ministry of Public Health (MOH) led the process of developing this new National Strategic Plan through the Department of Family Health (DSF) and the National Multi-sector Programme to fight against Maternal, Newborn and Child Mortality (PLMI).

2 BACKGROUND

2.1. GENERAL INFORMATION ABOUT CAMEROON

2.1.1. Geographical situation

Cameroon is a Central African country with a surface area of 475,650 km², bordered to the West by Nigeria, to the South by Congo, Gabon and Equatorial Guinea, to the East by the Central African Republic and to the North by Chad and Nigeria.

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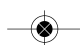
Source: NIS, BUCREP

2.1.2. Socio-demographic and cultural situation

Cameroon's population was estimated at 26,058,314 in 2022. Population Pyramid projections estimate a population of 34,051,102 by 2030.

Life expectancy at birth in Cameroon increased from 53.4 years in 1990 to 59.3 years in 2019, an increase of 5.9 years over this period. However, it is worth noting that during the 1990-2000 decade, marked by economic recession and the implementation of structural



adjustment programmes, life expectancy at birth decreased significantly, from 53.4 to 51 years. According to the United Nations, life expectancy in 2023 would be 54.4 years[1].

More than half of Cameroon's population (53.2%) lives in urban areas, and the regions with the highest demographic density are the Centre (19.6%), Far North (18%), Littoral (15.2%) and North (11%). The regions with the highest population density are Littoral (174.8 inhabitants/km2), and West (142.9 inhabitants/km2).

According to DHS-2018, either early or late, fertility remains high. The fertility level, measured by the Total Fertility Rate (TFR), is estimated at 4.8 children, which means every woman has an average of almost 5 children. Fertility levels are significantly higher in rural areas (6.0 children per woman) than in urban areas (3.8 children per woman). The North (TFR of 6.2) and Far North (5.9) regions have the highest fertility levels, whereas the Littoral (4.3) and South (4.1) regions have the lowest rates. Yaounde (3.5) and Douala (2.8) have the lowest fertility rates.

Cameroon has not yet entered its demographic transition phase, which is necessary to record the demographic dividend. Fertility is still high, despite the slight drop recorded between 1991 and 2018, with the total fertility rate decreasing from 5.8 to 4.8.

The structure of the population is not conducive to economic growth and development because it does not give the working population the opportunity to save and undertake profitable investments due to the heavy burdens arising from the dependent population (people who are not economically productive). The direct consequence is high demand for basic social infrastructure and services such as education, health, access to energy and potable water, food and land security.

Due to its geographical position, Cameroon lies at the crossroads of ancient migratory flows of Sudanese, Fulani, and Bantu peoples. The country is home to nearly 250 ethnic groups, which are categorized into five major cultural groups:

- The peoples of the semi-arid regions of the far north, including Sudanese, Hamitic, and Semitic groups, who are predominantly Muslim, Christian, or animist.
- The peoples of the western plateaus (West and North-West regions), classified as semi-Bantu, who are generally Christian or animist.
- The peoples of the coastal tropical forests (Littoral, South-West, and the coastal part of the South region), classified as Bantu, who are mostly Christian and animist.

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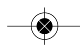
1 Nations Unies dans *Rapport de l'étude sur l'impact des politiques publiques liées à la pandémie de la covid-19 sur les entreprises, les femmes et les jeunes : cas du Burkina-Faso, du Cameroun, de la Côte d'Ivoire et du Sénégal* by Benjamin FOMBA KAMGA



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- The peoples of the equatorial tropical forest in the South (Centre, South, and East regions), including both Bantu and semi-Bantu, Sudanese, or Pygmy groups. In these communities, the predominant religions are Christianity and animism.

Table 1: Socio-demographic indicators

Total estimated population in 2022	26,058,314
0-14 years old	43.6%
Less than 25 years	64.2%
15-64 years old	53.5%
65 years and above	2.7%
25 years and above	37.6%
Average demographic growth rate	2.6%
Population density per Km²	48 inhabitants/Km²
Urbanisation rate	52%
Poverty rate	37.5% in 2014
Extended unemployment rate	5.7%
Overall underemployment rate	71%
Life expectancy at birth	59 years

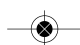
Source : BUCREP, 3rd RGPH

According to the World Bank, the literacy rate for young people aged 15 to 25 years was 86% in 2020, ranging from 89% among young men and 84% among young women. This rate is 78% among adolescents aged 15 years old and above.[2]

2.1.3. Political and administrative organisation

Cameroon has 10 regions, organised into 58 divisions and 360 subdivisions. Major institutional progress has been made over the past decade. The Senate, the upper house of parliament, was created and is fully functional. The same goes for the Constitutional Council. In addition, several legal instruments have been promulgated, including Law No. 2016/007 of 12 July 2016 relating to the Penal Code, which addresses RMNCAH issues, and Law No. 2019/024 of 24 December 2019 instituting the General Code of Regional and Local Authorities. In terms of local governance, the State initiated a transfer of powers

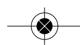
[2]https://donnees.banquemondiale.org/indicator/SL.UEM.INTM.ZS?locations=CM

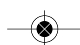


to the Councils in 2010. Based on the principle of evolution, this process intensified in 2018 with the transfer of 63 new powers from 21 ministries to councils.
The Law of 22 July 2004 on the Orientation of Decentralisation provides for the transfer of powers and resources to councils. For the health sector, Decree No. 2010/0246/PM specifies the powers transferred to councils. These include the construction, equipping and management of Integrated Health Centres (IHCs).
Therefore, effective implementation of decentralisation can play a crucial role in improving RMNCAH indicators, by strengthening local governance, optimising the allocation of resources, encouraging community participation and empowering local actors.

2.1.4. Humanitarian and security context

Cameroon is going through a period of multifaceted crises which are considerably worsening the humanitarian situation in the country. For several years now, the country has been experiencing a continuous influx of refugees from the Central African Republic (CAR), mainly in the East and Adamawa regions. Meanwhile, Boko Haram attacks are rampant in the Far North region, while the North West and South West regions are still plagued by socio-political grievances that have degenerated into armed conflict.
These crises have led to an alarming increase in humanitarian needs in Cameroon. In September 2022, the UN estimated that 3.9 million people would require humanitarian assistance in Cameroon, yet the resources available remained significantly inadequate.
The armed conflict raging in the North West and South West regions between Government forces and non-State armed groups (NSAGs) shows no sign of appeasement in the short or medium term. The situation is characterised by recurrent attacks, proliferation of NSAGs, military operations and movement restrictions imposed by the conflicting parties, creating an extremely difficult environment for humanitarian actors and severely limiting their access to affected populations.
The conflict in the North West and South West regions has led to massive population displacements to the West and Littoral regions, as well as to Yaounde. These internal displacements lead to an increase in humanitarian needs, particularly in terms of access to food, water, shelter and healthcare.
Given the scale and complexity of the crises affecting Cameroon, it is urgent to mobilise additional efforts and greater international solidarity to meet the growing humanitarian needs of the affected populations.
The Far North region continues to experience hostilities and violence. Non-state armed groups (NSAGs) regularly carry out attacks against civilians, causing further population displacements, particularly in the border areas with Nigeria.
In addition to these NSAG incursions, large-scale outbreaks of inter-community violence, such as those that occurred in the Logone Birni subdivision in August and





December 2021, are a constant threat to the security and stability of the region. These conflicts, often related to tensions between cattle herders and farmers over access to natural resources, are worsened by the effects of climate change and the growing pressure on local resources, especially water supplies.

This violence and tension has led to a significant increase in forced displacements. Between August 2021 and August 2022, the number of internally displaced persons (IDPs) in the Far North region disturbingly increased by 27,000 persons, from 358,372 to 385,372. Similarly, the number of returnees to the region has also increased significantly, reaching 138,152 in August 2022.

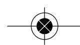
This increase in the number of IDPs and returnees is a serious challenge to the already limited humanitarian resources and services in the region, thus preventing the vulnerable populations to receive adequate support and meet their basic needs in terms of RMNCAH-Nut.

2.1.5. Economic situation

Since November 2021, Cameroon has been plagued with persistent inflation, largely fuelled by scarcity of resources and increasing prices of basic foodstuffs such as bread, wheat, vegetable oil and meat. These fluctuations are largely attributable to the disruption of the global supply chain caused by the COVID-19 pandemic and the instability resulting from the Russia-Ukraine conflict.

This unfavourable context has slowed down Cameroon's economic recovery, accentuating inflation-related pressures and the country's structural vulnerabilities. Although Cameroon's medium-term economic outlook remains relatively encouraging, risks such as internal political and social tensions, volatile commodity prices, dependence on external aid and global economic turmoil could hamper economic growth and seriously compromise the country's prospects. Real GDP growth is expected to average 4.2% over the 2023-2025 period, underpinned by increased activity in the secondary and tertiary sectors.

Between 2010 and 2019, Cameroon's economy has experienced an uneven growth. While it is worth pointing out a significant growth rate that increased from 3% to 4.5% on average over this period, the economy is still below the 5.5% target set in the Poverty Reduction Strategy Paper (PRSP). Though average, this performance undoubtedly shows the resilience of the economy against the various economic and security challenges the country has been experiencing.



In terms of inflation, Cameroon has managed to maintain a controlled rate of around 2% on average per annum, thus respecting the CEMAC convergence threshold of 3%.[3]. However, the overall structure of GDP distribution per sector has not changed favourably over the last decade, and forecasts of an increase in the primary sector have not materialised. In fact, the percentage of the primary sector, which was expected to reach 33.2%, has remained below 20%, mainly due to the decline in traditional agriculture in the face of increasing mechanisation. At the same time, the secondary sector, which accounted for 33% of GDP in 2010, declined significantly to 28.2% in 2018. In contrast, the tertiary sector, driven by the development of services, has experienced spectacular growth of more than 15 points, increasing from 41.2% to 57.1% over the same period.[4]
The downward trend in the primary and secondary sectors, long-established growth drivers, in favour of a dominant tertiary sector, even though it generates services, raises questions about the sustainability and resilience of the country's economic trajectory. In fact, the expansion of the tertiary sector, if not supported by a profound structural transformation and diversification of the economy, could weaken Cameroon in the face of external shocks and limit its long-term growth potential.

Table 2: Macro-economic indicators

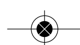
GDP per capita (FCFA)	358.100
Human development index/rank (2019)	0.563/153
GDP growth rate (2020)	3.5%
Capital expenditure in billions of FCFA (2021 financial year)	1132.9
Investment expenditure in billions of FCFA (2021 financial year)	1131.7
Total budgetary resources in billions of FCFA (2021 financial year)	5131.5
Percentage of budget allocated to health (2021)	3.8%

Sources: MOH, 2021 Financial Law, National Institute of Statistics 2020, AfBD 2020

2.1.6. Living conditions of the populations

According to the NIS, poverty rate decreased between 2001 and 2014, from 40.2% to 37.5%, against a backdrop of marked and growing regional disparities.

[3]NDS30, page 24-25.
[4]NDS30, page 25.



The rural areas of the Far North and North regions are the most affected by poverty, with respectively 72% and 55.8% of the population in these regions living on less than $1 a day, according to the extreme poverty threshold set by the World Bank. The poverty rate in urban areas is estimated at 4.8%.
The unemployment rate in Cameroon would be 6.1% higher in 2021 than in 2020, according to the National Institute of Statistics (NIS). Women (6.1%) are more affected by unemployment than men (5%), and the overall underemployment rate is 65% for the same period, 4 points less than in 2020. According to NIS (July 2021), this situation was due to the COVID-19 pandemic which had negative effects on employment or the cessation of activity in about three out of five households (54%).

2.2. SITUATION ANALYSIS OF THE HEALTH SYSTEM

2.2.1. Health status of the population

Cameroon's epidemiological profile is still marked by a high prevalence of communicable diseases, although these are declining. The most prevalent diseases are HIV/AIDS and malaria, which have also been the main causes of death for more than 10 years.
Moreover, non-communicable diseases have been on the rise in recent years, as shown by the increase in the number of deaths caused by strokes (21.7%) and ischaemic heart disease (32.8%)[5].

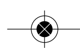
2.2.2. Organisation of the health sector in Cameroon

The health sector in Cameroon is organised as a pyramid comprising three levels (central, intermediate and peripheral) and three sub-sectors: (i) the public sub-sector; (ii) the private sub-sector (non-profit and for-profit institutions); and (iii) the traditional sub-sector. Each level of the pyramid has administrative, health and dialogue structures.

Table 3: Levels of the health system in Cameroon

Level	Administrative structures	Competencies	Health structures	Dialogue structures
Central	- Office of the Minister of Public Health - Secretariat General	- Drafting of the Health Sector Strategy	General hospitals, University Teaching Hospitals, Central	National Council for Health,

[5] Source: DHS 2018



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Level	Administrative structures	Competencies	Health structures	Dialogue structures
	- Departments and structures of the same level	- Coordination - Regulation	hospitals and health facilities of the same category, CENAME, CPC, CHRACERH, LANACOME, CIRCB, NPHO.	Hygiene and Social Affairs.
Intermediary	10 Regional Delegations for Public Health	Technical support to Health Districts	-Regional hospitals and health facilities of the same category - Level 2 referral Specialised Regional Hospital Centres - Regional funds for health promotion	Regional funds for health promotion
Peripheral	205 Health Districts[6]	Implementing health programmes	-District hospitals -Clinics -MHC-IHC -Health centres	DHC DMC HC MC

Sources : Human resources Development Plan: Situation and Diagnosis (2012); Health Sector Strategy 2020-2030.

2.2.3. Performance of the health system

The healthcare system in Cameroon is fragile and therefore does not effectively meet the needs of the population. Cameroon was ranked 158th out of 167 countries by the British think-tank Legatum Institute in 2021.
Cameroon's healthcare system is characterised by: (i) inadequate financial resources; (ii) inefficient health information system for objective decision-making; (iii) poor access to services and care, particularly for the most vulnerable populations; (iv) poor dissemination of technical documents and (v) poor coordination mechanisms. All of the above makes the system unfit and inefficient to provide quality services and care to the population, hence, the need to strengthen the pillars of the health structures and correct the weaknesses identified above in order to improve the performance of health services.

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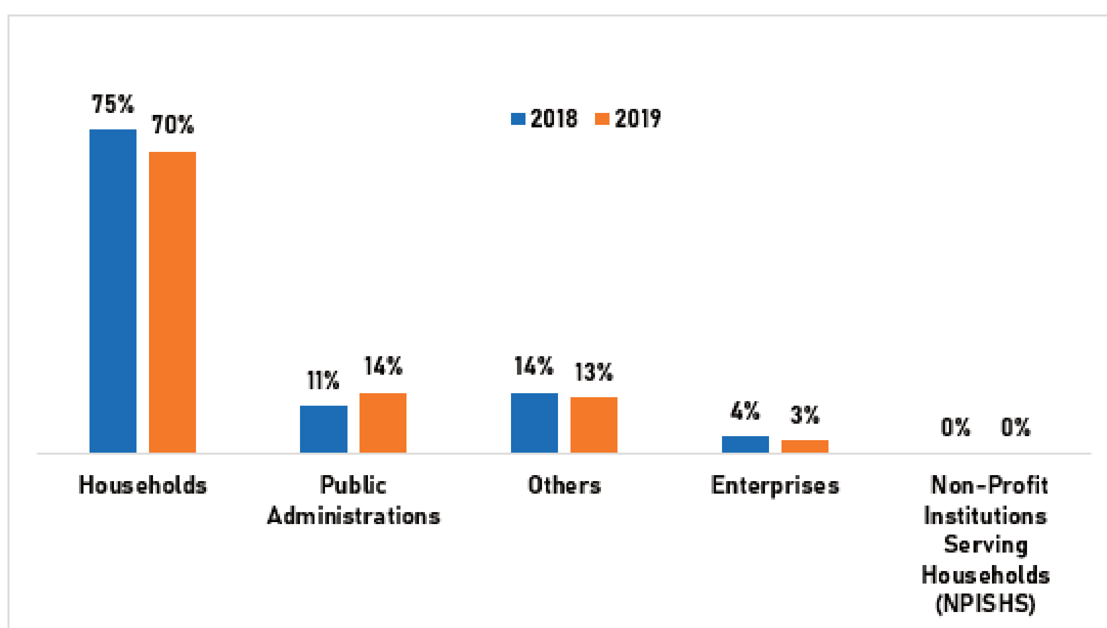
2.2.4. Health financing

Total health expenditure (THE) increased by 7%, that is, from FCFA 821 billion to FCFA 874 billion between 2018 and 2019. As a percentage of GDP, THE remained stagnant at around 4% during that period. Out-of-pocket expenditure remains the main source of health financing. Over these two years, they contributed about 71% of THE. State contribution increased from FCFA 93 (11%) to 118 billion (14%) between 2018 and 2019. As for multi- and bilateral partners, their respective contributions during these two years were FCFA 115 billion (14%) and 111 billion (13%).[7]



Source : NA 2018 and 2019.

Figure 2: Total health expenditure per source of funding

Source: NHA 2018 and 2019

Analysis of health expenditure per capita shows that between 2018 and 2019, there was a 5% increase in total health expenditure per capita. This expenditure increased from FCFA 34,589 to FCFA 36,305. Between these two years, current out-of-pocket expenditure per capita increased by 3%, from FCFA 24,419 to 25,176. Although there was an increase in absolute terms, per capita expenditure by bilateral and multilateral donors

[7] 2018-2019 National Health Accounts

decreased by 6% for current health expenditure (CHE) and by 5% for capital expenditure. [See Table 4]

Table 4: Total health expenditure per capita and per year from 2018 to 2019 in FCFA

Indicators (FCFA)	2018	2019
Total health expenditure per capita	35505.94	35913.04
Current health expenditure per capita	33776.95	34859.21
Government current health expenditure per capita	3241.59	3854.79
Current out-of-pocket expenditure per capita	24419.41	25175.79
Current expenditure on health by bilateral and multilateral partners per capita	4827.00	4549.00
Current expenditure on health from other sources per capita	1289.00	1281.00
Health investment expenditure per capita	728.99	1053.83
Government health investment expenditure per capita	687.00	1014.00
Rest of the World health investment expenditure per capita	42.00	40.00

Sources: NHA 2018 and 2020

Furthermore, the proportion of the State budget allocated by the Cameroon Government to the health sector has fluctuated between 3.3% and 5.9% since 2005 (NHA, 2019). This proportion remains far below the commitment made by African Heads of State at the Abuja Summit in April 2001 to allocate 15% of the national budget to health.

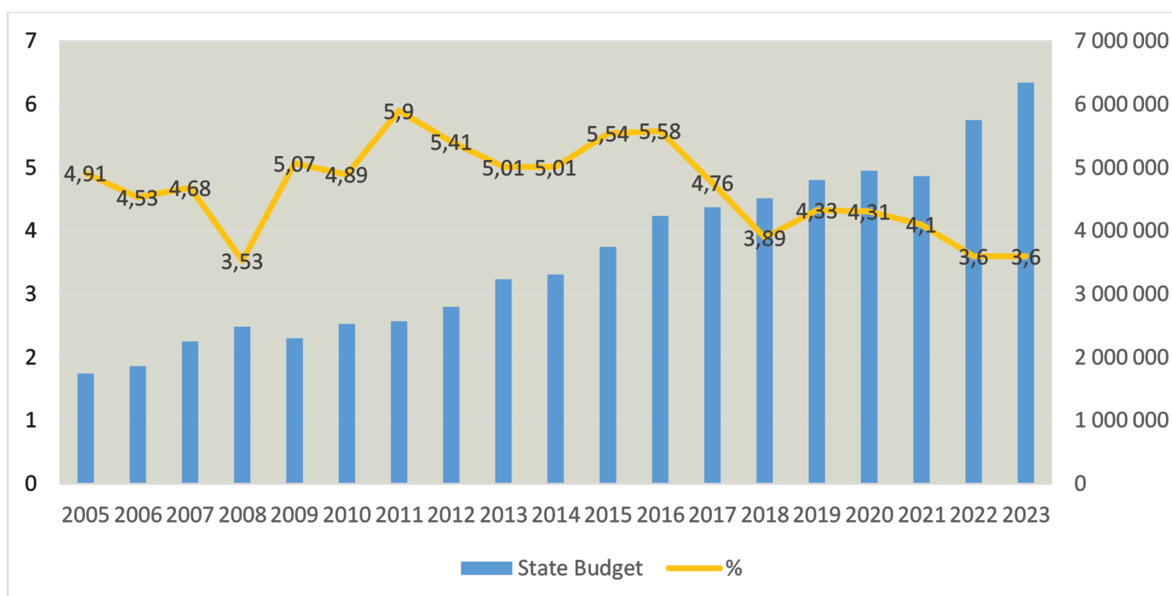


Figure 3: Budget allocated to health, in percentage, in the total Government budget in Cameroon from 2005 to 2023 in dollars (National Council for Statistics)

2.2.5. Infrastructure and equipment

In terms of infrastructure and equipment, as of 2023, Cameroon had 20 hospitals of 1st and 2nd categories, 18 Regional hospitals and health facilities of the same category, 200 Health Districts, 165 District Hospitals, 269 Medicalised Health Centres and 2,188 Integrated Health Centres. Significant efforts have been made to build health infrastructure, thus, the provision of health facilities is generally satisfactory at the national level. However, there are still some disparities in the distribution of the infrastructure constructed in the different regions of the country, because it does not take into account the health map, and the available data are not sufficient to assess the level of functionality of the health facilities.

Table 5: Distribution of health facilities per region

Regions	Health area	Health District	1st Cat. (General Hospitals)	2nd Cat. (Central Hospitals)	3rd Cat. (Regional Hospitals)	4th Cat. (DH)	5th Cat. (MHC)	6th Cat. (IHC)	Total
Adamawa	104	11	0	1	1	7	17	110	136
Centre	2,482	32	4	3	1	31	51	369	459
East	166	15	0	1	1	15	20	134	171
Far North	312	32	0	1	4	24	26	328	383
Littoral	190	24	2	1	2	18	37	140	200
North	150	15	1	1	2	11	11	223	249
North West	244	20	0	1	1	17	30	195	244
West	220	20	0	1	2	19	34	359	415
South	104	12	0	2	1	10	19	167	199
South West	117	19	0	1	3	13	24	163	204
Total	4,089	200	7	13	18	165	269	2,188	2,660

Source: Carte sanitaire programmatique, DOSTS, January 2023

In some regions, such as the Centre, Littoral and West, healthcare and services are mainly provided by the private sub-sector. This situation is partially caused by uncontrolled proliferation of private health facilities in the urban areas of these regions.

2.2.6. Medicines and other pharmaceutical products

Pharmaceutical products are supplied by the National System for the Procurement of Essential Drugs and Medical Supplies (SYNAME).

The pharmaceutical sector is organised into two sub-sectors: private and public.

The public pharmaceutical sub-sector is organised into three levels: (i) central, with the National Centre for the Procurement of Essential Drugs and Medical Supplies (CENAME) and the technical departments of the MOH; (ii) regional, with the Regional Funds for Health Promotion (RFHP) and the Regional Delegations for Public Health (RDPH); and (iii) operational, with health facilities and community actors.

In this system, CENAME supplies to the RFHP and hospitals of 1st and 2nd categories, RFHP supplies to health facilities, which then supply to patients. In addition to health facilities, multipurpose community health workers distribute outpatient medications and commodities such as condoms, during home visits.

In the private sub-sector, local wholesale distributors obtain supplies from foreign purchasing offices, CENAME and national manufacturers, in order to supply to private

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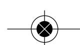


pharmacies and pharmacies of clinics and polyclinics that have obtained authorisation from the Cameroon Pharmaceutical Society.

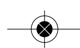
The management of maternal and reproductive health life-saving medicines and commodities is not different from that of SYNAME. At the central level, management is carried out by Technical Departments in collaboration with CENAME.
At the regional level, it is handled by the RDPH in collaboration with the RFHP, and at the peripheral level by Health Districts and health facilities.
With the support of several TFPs and State subsidies, certain therapeutic classes of drugs are currently provided free of charge (anti-tuberculosis drugs, antiretroviral drugs, artemisinin-based antimalarial drugs for children aged 0 to 5, anti-leprosy drugs, etc.).
Although TFP subsidies have helped in reducing the cost of essential health products such as obstetric kits, contraceptives and antimalarial drugs, dependence on external funding exposes the healthcare system to the risk of supply disruption if subsidies are stopped. No strategy has been developed to deal with this eventuality.

There is also a vast illicit network that supplies the street drugs market and could have connections with the legal sector. Many actors of the pharmaceutical industry evade the control of the Department of Pharmacy, Medicines and Laboratories (DPML).

The National Blood Transfusion Programme (NBTP) was set up in 2019 with the aim of ensuring self-sufficiency in quality blood products throughout the country.
Currently in Cameroon, an estimated 400,000 blood bags are needed to treat patients in health facilities every year. Blood and labile blood products are the best therapeutic option for patients. However, less than 25% of blood requirements are met each year, with almost 95% of replacement donations made by relatives or family members (not recommended by WHO) and less than 5% of voluntary, unpaid donations (recommended by WHO).

2.2.7. Human resources

Based on data from the Human Resources Development Plan (HRDP) and the third General Census of Human Resources (GCHR), the staff/population ratio in Cameroon remains below the WHO standard of 2.3 medical staff per 1,000 inhabitants. In fact, as Table 6 shows, the ratios of health personnel to population are 0.85 per 10,000 inhabitants for medical doctors and 0.05 per 5,000 inhabitants for midwives. These figures are below the set standards, which are 01 doctor per 10,000 inhabitants and 01 midwife per 3,000 inhabitants. The only exception is the ratio of nurses, which is 1.78 per



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5,000 inhabitants, well above the required standard of 01 nurse per 5,000 inhabitants. These statistics show the overall shortage of health personnel in Cameroon.

The human resources standards for health in Cameroon defined in the 2021-2025 National Health Development Plan (NHDP) for Primary Health Care facilities show that the functioning of IHCs and MHCs is not enough to continuously provide quality primary healthcare services to the population. The challenges include:

- Insufficient number of qualified staff in the health facilities, most of whom are in a precarious situation as they do not have work contracts;
- Poor distribution of health staff throughout the country;
- Non-compliance with job profiles;
- Lack of information on staff working in the private sector and even in partner administrations in the health sector.

The number of staff recruited in the civil service does not align with the number of staff retiring or the actual needs in the field. As a result, the gap between the needs and the workforce continues to widen over time. The number of medical staff working at the MOH was estimated at 38,207 in 2018 (table 2).

However, current staff management is limited in its response to demand from the health services (shortage of staff in terms of both quantity and quality). In addition to this shortage of qualified staff at first-contact health facilities, there is also a shortage of multipurpose community health workers (MCHWs), who unfortunately still do not have a statutory status in Cameroon. As a result, they are not officially integrated into the health pyramid, despite the fact that they are recognised as key actors in providing effective community healthcare and services.

Table 6: Number of medical staff per region

QUALIFICATION	SERVICES	CENTRE	SOUTH	WEST	ADAMAWA	EAST	NORTH	SOUTH WEST	FAR NORTH	LITTORAL	NORTH WEST	TOTAL	Ratio for the general population
	CENTRAL												
MEDICAL DOCTORS	5%	29%	5%	8%	4%	5%	3%	7%	4%	25%	5%	2,156	0.85
LABORATORY TECHNICIANS	1%	30%	6%	9%	5%	6%	4%	9%	6%	18%	8%	1,842	0.73
PHARMACISTS	9%	21%	7%	8%	6%	6%	5%	9%	6%	21%	5%	376	0.15

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NURSES	1%	23%	5%	11%	5%	5%	8%	8%	9%	18%	7%	8,981	1.78
DENTAL SURGEONS	1%	23%	10%	9%	6%	6%	4%	6%	8%	20%	7%	166	0.07
MIDWIVES AND BIRTH ATTENDANTS	14%	14%	5%	8%	5%	7%	7%	8%	13%	12%	7%	421	0.05
SANITARY ENGINEERS	17%	17%	4%	8%	8%	5%	4%	9%	9%	10%	8%	158	-
PUBLIC HEALTH ADMINISTRATORS	37%	14%	6%	4%	6%	4%	4%	5%	3%	11%	4%	188	-
ASSISTANT LABORATORY TECHNICIANS	15%	15%	5%	3%	13%	5%	2%	17%	2%	15%	8%	60	-
OTHERS	13%	6%	1%	3%	50%	3%	4%	4%	2%	10%	4%	4,042	-

Source [Directorate for Human Resources 2018]

According to the Cameroon Paediatric Society (SOCAPED), there were 49 paediatricians in Cameroon in 2022, distributed unevenly across the 10 regions as follows:

Table 7: Distribution of paediatricians and gynaecologists/obstetricians per region

	Far North	North	Adamawa	West	North West	South West	Littoral	Centre	South	East
PAEDIATRICIANS	03	02	00	06	02	04	66	62	03	01
GYNECOLOGISTS	07	09	10	19	06	14	97	116	14	07

During the same period, Cameroon had 313 gynaecologists, according to the Society of Gynaecologists-Obstetricians of Cameroon (SOGOC), distributed across the 10 regions as shown in table 7, the majority of them working in the public sector.

2.2.8. National health information system

A strategic plan to strengthen the National Health Information System (NHIS) for the 2009-2015 period was drawn up in 2008. The 2020-2024 National strategic plan for digital

health (NSPDH) was drawn up in 2020 but has not been implemented to any great extent. The availability of RMNCAH data disaggregated by region and even by health district makes it much easier to identify priority intervention areas. However, it is regrettable that the Monthly Activity Reports are not sufficiently used by the structures that produce them to inform local decision-making.

The MOH has a DHIS 2 (District Health Information Software) platform managed by the Health Information Unit, used to collect, process, analyse and visualize health data and indicators. Since 2018, the deployment of DHIS 2 has been extended to all health facilities in Cameroon. However, despite its nationwide implementation, the platform still faces a number of challenges, particularly with regard to the quality of the data generated (timeliness, consistency, completeness, etc).

Training in data entry, analysis and quality review has been provided to the actors involved in data management. However, further efforts are needed to improve: (i) data review and validation, (ii) the implementation of a regular feedback system to health facilities and (iii) the effective use of data for decision-making.

The integration of the DHIS2 tracker module for surveillance of resistance to antiretroviral drugs and opportunistic infections is a crucial priority. It is also important to strengthen the role of the National Public Health Observatory in the management of data aggregated at the national level in various sectors.

2.2.9. Governance and strategic steering

Management of the health system has been improved by the establishment of multi-sector coordination frameworks at all levels of the health pyramid, bringing together actors of the health sector with a view to a joint implementation of health interventions. However, the lack of funding to ensure the functioning of these coordinating bodies, set up mainly at the level of the RDPH and HDs, is one of the major obstacles to achieving the objectives defined in all the strategic plans drawn up, including that on RMNCAH.

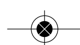
In terms of budget transparency, analysis of the data collected on the availability of budget information shows that financial data from the national budget are not available in all health facilities, and health facility managers are not always involved in drawing up and managing the budget allocated to their health facilities. In addition to the factors already mentioned, several major challenges hamper the effective implementation of the RMNCAH plans that have been drawn up. These challenges include [i] inadequate auditing and accountability: the poor implementation of auditing and accountability mechanisms hinders effective monitoring of the use of resources allocated for RMNCAH interventions. This situation can lead to mismanagement of resources and inefficiency in the implementation of interventions; [ii] lack of monitoring of budget expenditure: The

inability to monitor and thoroughly document budget expenditure on RMNCAH activities limits the ability to assess effectiveness and efficiency with regard to the use of funds allocated for this issue. This hinders the optimal use of available resources; [iii] mismatch between the implementation of interventions, the expenditure incurred and the performance indicators: this mismatch makes it impossible to accurately assess the impact of RMNCAH-Nut interventions.

To address all these challenges and achieve RMNCAH-Nut objectives, it is crucial to ensure better coordination and alignment between the budget allocation, the activities implemented, the resources spent and the results obtained. This will make it possible to assess the impact of the strategies used and identify bottlenecks and areas for improvement.

3 SITUATION ANALYSIS OF RMNCAH-Nut

This initial situation analysis is based on a literature review that relied primarily on demographic and health surveys, especially the 2018 survey. All the Strategic Plans drafted by the Ministry of Public Health on RMNCAH-Nut and related fields, the Investment Case to improve RMNCAH-Nut, as well as their evaluation reports were also exploited.
This section is divided into two main parts: firstly, a presentation of the situation with regard to the targets of the RMNCAH-Nut through their main indicators and the coverage rate of high-impact interventions, and secondly, the national response to challenges faced in the RMNCAH-Nut sector.



3.1 SPECIFIC SITUATION OF RMNCAH-NUT TARGETS

3.1.1 Overview of maternal health

3.1.1.1 Maternal mortality

According to the DHS 2018, maternal mortality ratio was estimated at 406 deaths per 100,000 live births over the 7 years preceding the survey. In contrast, the mortality of pregnant women (all causes combined) was 467 deaths per 100,000 live births.

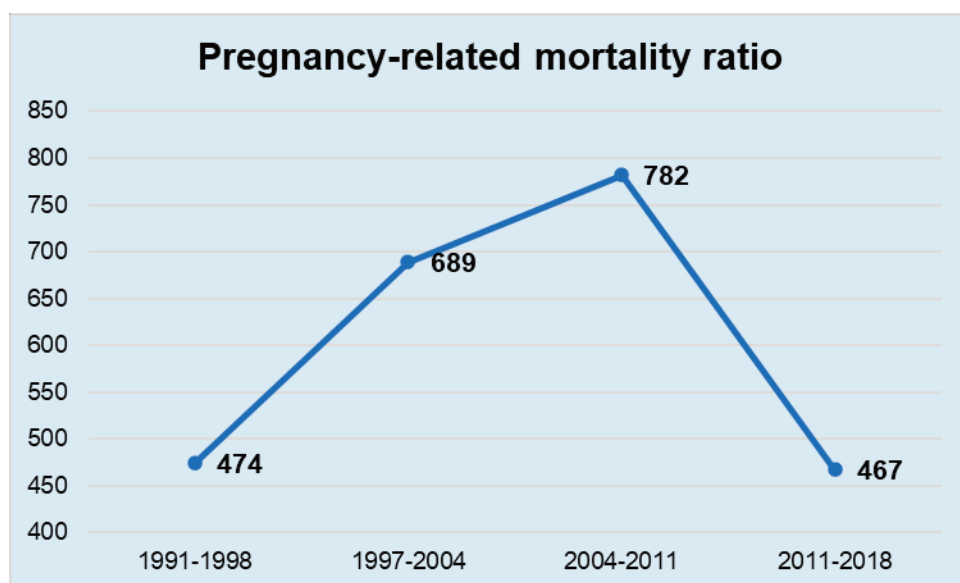
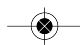


Figure 4: Trends in the mortality ratio link to pregnancy between 1991 and 2018 in Cameroon

The maternal mortality rate decreased by 39.1% between 2011 and 2018. This performance is well above the target projected in the 2014-2020 NSP/RMNCH, which set the number of maternal deaths per 100,000 live births at 557 in 2020. From this perspective, the target has therefore been significantly exceeded. However, according to the 2014-2020 Multi-sector Programme National strategic to fight against Maternal and Newborn Mortality (PLMI), Cameroon's target was to reduce the maternal mortality ratio to 140 per 100,000 live births by 2030.

Considering this, there is still a need to address a gap of 317 maternal deaths per 100,000 live births by 2030. It is worth pointing out that while the target set out in the PLMI is an ambitious one, it is still far below the global SDG target for maternal mortality, set at less than 70 deaths per 100,000 live births by 2030.



Causes of maternal deaths

Maternal mortality is a complex phenomenon with multiple causes. According to the annual report on Maternal and Perinatal Death Surveillance and Response (MPDSR) in 2020 in Cameroon, the causes of maternal deaths are of three types:

(i) Immediate causes (which may be direct and/or indirect);

(ii) Underlying causes linked to the effectiveness or otherwise the implementation of high-impact interventions on this mortality;

(iii) Deep structural causes, that are closely related to the pillars of the health system, the economic context, and socio-cultural and environmental factors.

According to the above-mentioned annual report, the direct causes of maternal mortality (for notified cases) are: haemorrhage 45.9%; eclampsia/pre-eclampsia 15.85%; post-partum infections 8.74%; uterine rupture and prolonged labour 5.46%, as well as complications of abortions and ectopic pregnancies.

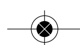
According to the same report, the indirect causes of maternal mortality include: cardiovascular disease, HIV/AIDS-related conditions, malaria and severe anaemia. Moreover, many women have difficulties accessing healthcare during pregnancy and childbirth. According to DHS-2018, 72% of women surveyed said they had experienced at least one problem accessing healthcare. The main problem encountered was the difficulty of obtaining money for treatment (67%). Other problems included the distance to the health facility (40%), obtaining permission to go for treatment (35%) and not wanting to go alone (28%).

3.1.1.2 Coverage of maternal health interventions

Reducing maternal mortality depends on the effective implementation of high-impact interventions and their level of coverage. The following sections describe some of these high-impact maternal health interventions selected in the 2014-2020 strategic plan:

- Pregnancy follow up through refocused antenatal care;
- Safe delivery;
- Emergency obstetric and neonatal care;
- Management of childbirth complications, especially indications for caesarean sections;
- Post-obstetric and neonatal care;
- Detection and management of obstetric fistulas.

Below, emphasis will be laid on the level of coverage and the determinants of each intervention.



a. Antenatal Care (ANC)

According to the 2022 Malaria Indicators Survey (MIS), 11% of women did not receive any pregnancy follow up. This rate is higher in rural areas (20%) than in urban areas (3.7%). There are also disparities based on the regions: in the West, Littoral and South West regions, almost all women received antenatal care (97% or more). In contrast, the North (74.1%), Far North (81.6%) and East (83.8%) regions have the lowest ANC rates. Other criteria related to the mother's level of education and the household's standard of living add to these regional disparities. The proportion of women receiving antenatal care increases with the level of education, ranging from a minimum of 60% among those with no education to a maximum of 99% among those with at least upper secondary education. Similarly, from the lowest to the highest level on the quintile of economic well-being, the percentage of women receiving antenatal care from a qualified health staff increased from 71% to 99%.

b. First antenatal care (ANC1)

According to the DHS-2018, only 41.3% of women attended their first antenatal care during the first trimester of pregnancy. This rate is higher in urban areas (53.9%) than in rural areas (29.9%).

c. Subsequent antenatal care (ANC4)

According to the DHS-2018, about seven out of ten women (65%) went for at least the recommended four antenatal care. Furthermore, 79% of women in urban areas compared with 52% in rural areas attended four or more antenatal care. In Yaounde and Douala, the rate was 88%.

At the regional level, the rate of ANC4 coverage between 2014 and 2020 remained low in the Far North (50% and 43.3% respectively) and North (46.80% and 47.1% respectively) regions. The objective of the 2014-2020 NSP/RMNCH was to increase the rate of ANC4 from 60% in 2014 to 80% in 2020. There is therefore a 15% gap in ANC4 not performed.

d. Antenatal care provided by qualified health personnel

In Cameroon, 89% of women aged 15-49 years received antenatal care from qualified health personnel[8]. Coverage of antenatal care provided by qualified health personnel is lower in rural areas (83%) than in urban areas (96%). The goal of the PSFMMNIJ/PLMI was to increase the proportion of expected ANC conducted by a qualified personnel in a health facility from 61% to 70% by 2020 (DHS 2011).

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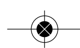
[8] (Malaria Indicators Survey 2022, p43).



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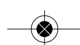


The rate of antenatal care provided by qualified health personnel increases based on the quintile of well-being. It is 68% for women in households in the lowest level of the quintile to 99% for those in households in the highest level. Coverage decreases with the child's birth rank and is lower in rural areas (79%) than in urban areas (95%). Coverage rises sharply based on the women's level of education. It varies from 3% among women with no education to 68% among those with higher education.

e. Tetanus vaccination

The status of women whose last live birth was protected against neonatal tetanus remained almost unchanged, from 73% to 71% between 2011 and 2018 (DHS 2018). This result is far below the target set in the 2014-2020 NSP/RMNCH, which set the proportion of pregnant women expected to receive the tetanus vaccine at 80% by 2020. There are some disparities between urban areas (78%) and rural areas (64%), as well as between regions, with a minimum of 50% in the Adamawa, 55.7% in the Far North, 62% in the North, and a maximum of 87% in the West.

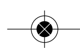
f. Preventing malaria in pregnant women

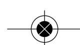
According to the 2022 MIS (p45), 46% of women received at least three doses of Intermittent Preventive Treatment (IPT). Results by region show that IPT 3+ coverage varies from 30% in the South region to 69% in the North West and South West regions. The South (30%), Centre (32.6%) and West (37%) regions have the lowest percentages of women who received at least three doses of sulphadoxine pyrimethamine. The objective of the 2014-2020 NSP/RMNCH was to increase the percentage of pregnant women who received at least 3 doses of IPT from 27% in 2014 to 80% in 2020. Therefore, there is a 34% gap that needs to be filled.

The use of LLINs by pregnant women has been increasing since 2004. The percentage was 2% in 2004 and increased to 20% in 2011, 61% in 2018 and 63% in 2022 among pregnant women aged 15-49 years (MIS 2022, p43).

g. PMTCT

The proportion of pregnant women that were tested positive for HIV before pregnancy has increased since 2014, from 23.7% to 49.6% in 2019. In 2019, this percentage was 31.9% in the Far North and 70.2% in the North West regions. According to the National AIDS Control Committee (NACC 2022 Report), this increase is part of the drive to achieve one of the objectives of the PMTCT programme, which is to keep HIV-positive mothers alive, and to reduce mother-to-child transmission (MTCT) to less than 2% at 6 weeks and less than 5% at 18 months (2024-2030 NSP/HIV).





In 2022, at the national level, 1,025,427 pregnant women were expected and 853,399 were received for ANC in health facilities or in delivery rooms, representing a completion rate of 83.2% (NACC 2022 Report).

Of the pregnant women received, 827,279 were screened, representing a performance rate of 96.9%. At the end of the screening tests, 824,710 knew their serological status, representing 99.7% of the pregnant women screened.

Of the pregnant women screened, 17,587 were HIV-positive, representing 74.7% of the expected target according to the 2023 Spectrum Estimation and Projection Package (EPP), and 15,950 were put on antiretroviral therapy (ART), representing a 90.1% success rate.

In a nutshell, in 2022:

- The healthcare system failed to reach 172,028 pregnant women, representing 16.8% of the target;
- 26,120 pregnant women who went for ANC did not get screened for HIV, representing 3.1% of pregnant women who went for ANC;
- Of the pregnant women screened, 2,569 did not withdraw their results and therefore do not know their serological status;
- 5,963 HIV+ pregnant women, corresponding to 33.3% of the HIV+ pregnant women projected in the 2023 Spectrum EPP were not screened;
- 1,637 HIV+ pregnant women were not put on ART, corresponding to 9.3% of identified HIV+ pregnant women. (NACC Annual Report, 2022)

The proportion of children born to HIV-positive mothers who have been diagnosed early with HIV is 76.6% (382/499 children); this result is below the rate of 90% set in the 2014-2020 NSP/RMNCH. In addition, the seropositivity rate of children exposed to HIV has decreased from 4.8% in 2019 to 4.3% in 2020. The objective of the 2014-2020 NSP/RMNCH, which was to reduce the rate from 8.40% in 2014 to 4.2% in 2020, has therefore been achieved (NACC).

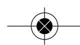
h. Deliveries / Obstetric and neonatal care

i. Place of delivery

According to DHS 2018, about 67% of deliveries took place in a health facility. Deliveries in urban areas take place more frequently in health facilities, unlike deliveries in rural areas, with 88% and 50% respectively. The Far North (38%), North (37%) and Adamawa (46%) regions recorded the lowest percentages.

ii. Delivery performed by qualified health personnel

According to the 2018 DHS, 69% of deliveries were performed by qualified health personnel, an improvement of 4 points as compared to 2011 (DHS 2011 and 2018): 16% by a medical doctor and 53% by a nurse, midwife or nursing assistant. There is an 11% gap



that needs to be filled. The objective of the 2014-2020 NSP/RMNCH was to increase the percentage of deliveries performed by qualified health personnel from 64% in 2014 to 80% in 2020. One in ten deliveries (10%) was performed by a traditional birth attendant and 3% of deliveries received no assistance at all. Deliveries performed by a skilled birth attendant are lower in the Adamawa (70%) and North (73%) regions.

i. Caesarean sections

In Cameroon, the caesarean section rate is low. According to the DHS 2018, only 4% of deliveries were done through caesarean section, which is inferior to the 5-15% recommended by WHO. The objective of the NSP/RMNCH was to increase the caesarean section rate from 3.8% in 2014 to 5% in 2020, representing a gap of 1% that needs to be filled. The percentage of deliveries through caesarean section is higher in urban areas (6%) than in rural areas (2%). The practice of caesarean delivery also varies per region.
The lowest proportions of deliveries done through caesarean section are recorded in the Far North (0.5%), North (0.6%), Adamawa (1.9%) and Centre regions excluding Yaounde (1.9%). In contrast, Douala recorded the highest percentage of deliveries performed through caesarean sections (11%). Generally, there are several reasons for this sub-optimal use of caesarean sections, the most recurrent of which is the malfunctioning of the referral and counter-referral system (lack of logistical and financial resources, staff negligence, cultural barriers).

j. Postnatal care

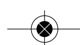
A significant proportion of maternal and newborn deaths that occur during the neonatal period occur in the first 48 hours after delivery. Therefore, It is highly recommended that women undergo a postnatal check-up within two days after childbirth.

i. Mothers who received postnatal care

According to DHS-2018, more than half of women (59%) who gave birth in the two years preceding the survey received a postnatal check-up in the first two days after delivery. However, 38% had never received any postnatal care. The objective of the NSP/RMNCH was to increase the rate of PNC1 coverage within 48 hours of delivery from 11.7% in 2014 to 50% in 2020, which represents good performance.

ii. Postnatal care provided by qualified health personnel

According to DHS-2018, in Cameroon, 56% of women received a postnatal check-up from qualified health personnel, namely a medical doctor (15%), nurse, midwife/birth attendant or nursing assistant (40%). Apart from these categories of qualified health personnel, in 3% of cases, it was a traditional birth attendant who provided postnatal care to the mother.



k. Management of obstetric fistulas

According to DHS 2018, few women (22%) aged 15-49 years know what obstetric fistula is and 0.3% of women reported having had a fistula. The objective of the 2014-2020 NSP/RMNCH was to reduce the percentage of women suffering from obstetric fistulas from 0.4% in 2014 to 0.20% in 2020. Therefore, there is still a 0.1% gap that needs to be filled to reduce the number of victims of obstetric fistulas.

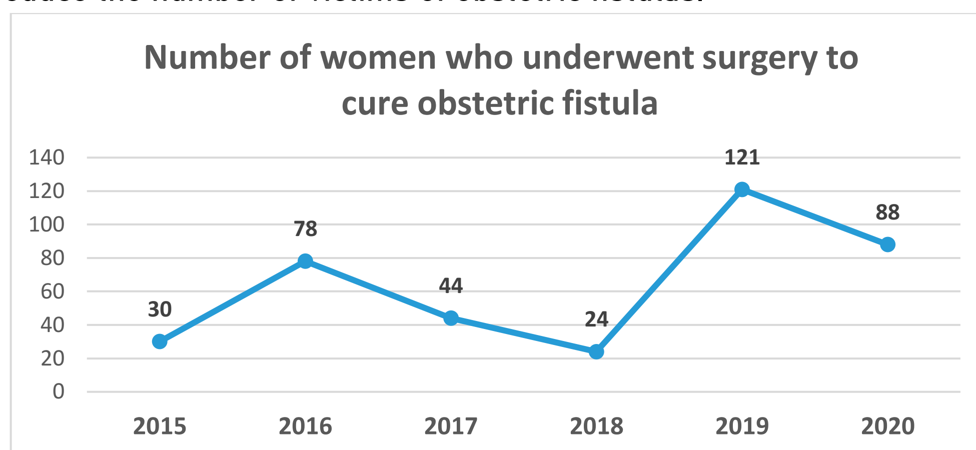


Figure 5: Number of women who underwent surgery to cure obstetric fistula.

(Source DSF/MOH)

The objective of the 2014-2020 NSP/RMNCH was to raise the proportion of women who underwent surgery to 60% by 2020, although the baseline value for this indicator in 2014 is unknown. The estimate made in 2015 was 20%. Although the National Institute of Statistics (NIS) reported an annual intake of 200 cases in 2022, this figure does not reflect the real incidence of this condition, as there were no reliable data on the number of cases of obstetric fistulas in 2022.

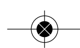
3.1.2 Newborn health

3.1.2.1. Neonatal mortality

Neonatal mortality in Cameroon reduced slightly between 2011 and 2018, from 31 to 28 deaths per 1,000 live births (DHS-MICS 2011 and 2018), whereas the projected national performance in 2020 was 24 deaths per 1,000 live births.

This mortality rate varies per region. The regions with the highest rates are: East (41), North (39), Adamawa (38), South (36) and West (33) per 1,000 live births.

Analysis of the available data shows that the neonatal mortality rate is relatively stable according to the household wealth level on the quintile of economic well-being. In fact,



the neonatal mortality rate for the lowest levels of the quintile is 30 deaths per 1,000 live births, while that of the highest levels of the quintile is 26 deaths per 1,000 live births.

Furthermore, there is a strong correlation between short inter-pregnancy intervals (less than two years) and high levels of neonatal mortality. In fact, the neonatal mortality rate is 47 deaths per 1,000 live births when the inter-pregnancy interval is less than two years, compared with 23 deaths per 1,000 live births when the interval is more than two years. In addition, the neonatal mortality rate in urban areas is 27 deaths per 1,000 live births, compared to 29 deaths per 1,000 live births in rural areas. Although small, these disparities highlight the need to strengthen the healthcare system and access to quality care, especially in rural areas.
Regarding weight at birth , newborns with low birth weight (including premature babies) and fat newborns have a higher risk of dying before one year compared with newborns with normal weight (2500g to 4000g) (79 ‰ versus 41 ‰) at birth.

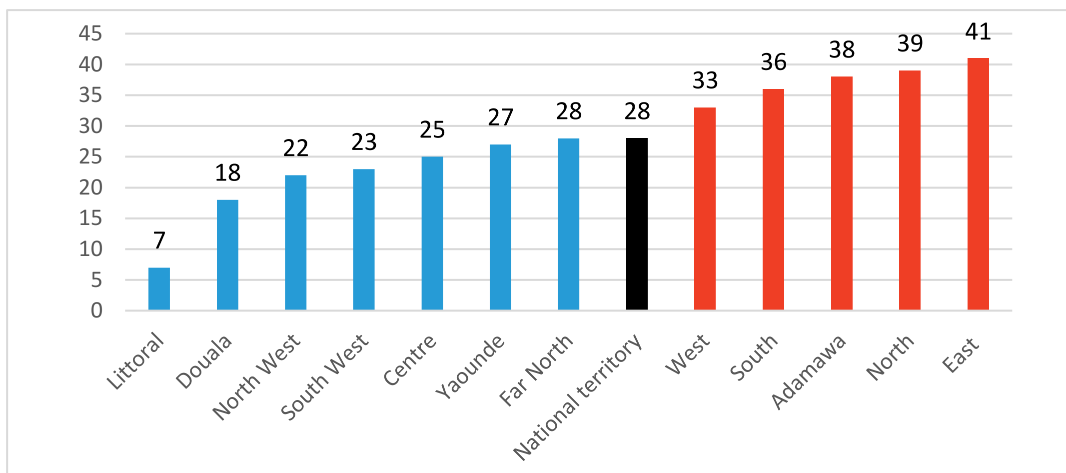


Figure 6: Neonatal mortality per region in 2018

(Source: Evaluation report of the Operational Plan on Newborn Health, 2020, page 3)

Stillbirths are estimated at 18.3 deaths per 1,000 live births (UN IHME Stillbirth Estimates 2020). Data on stillbirths were poorly provided at the national level during the period of implementation of the 2014-2020 SP/RMNCH. Intrapartum mortality is documented by the EmONC surveys, which unfortunately, are not carried out regularly, the latest dating from 2016 (RNA EmONC survey, 2016).

The most frequent direct causes of neonatal morbidity and mortality in Cameroon in 2020 were: asphyxia and neonatal infections both at 24.59%, followed by complications of prematurity with 22.95% (2020 MPDSR annual report, DSF). Other causes include foetal distress, congenital malformations, intrauterine growth retardation and neonatal jaundice. Indirect causes include undernutrition, low breastfeeding rates and HIV in

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pregnant women. Finally, systemic and structural causes also need to be taken into account.

3.1.2.2 Coverage of key newborn health interventions

Neonatal mortality depends on the effective implementation of four main high-impact interventions: deliveries attended by qualified health personnel, immediate and basic care for newborns, kangaroo mother care for premature and low-birth-weight newborns, as well as postnatal care.

a. Percentage of deliveries attended by qualified health personnel

(See point 3.1.1.2 - h) - see above)

b. Percentage of newborns receiving postnatal care

According to the DHS-2018, three out of five newborns (60%) received postnatal care within 48 hours after delivery. However, this performance is a decrease compared to the 2011 rate (69%) (DHS 2011).

Postnatal care is more frequently provided to newborns in health facilities than in the community (83% and 12% respectively).

The percentage of postnatal care is higher in urban areas (76%) than in rural areas (48%).

The percentage of newborns receiving postnatal care increases based on the mother's level of education, increasing from 31% among mothers with no education to 88% among those with higher educational level.

Postnatal care coverage increases from the lowest level to the highest level of the quintile of household wealth, increasing from 29% to 87%.

Regarding the type of healthcare providers, 58% of newborns received a postnatal check-up from a qualified healthcare provider (medical doctor/nurse/midwife/nursing assistant) within 48 hours after delivery. In 2% of cases, traditional birth attendants provided this care.

In addition, the overall risk of death is greater for newborns born to mothers aged under 20 years than for other mothers. Finally, the risk of dying between birth and the fifth birthday is estimated at 142 ‰ for children from the seventh delivery or more compared to 81 ‰ for those from the first, second or third delivery (DHS 2018).

c. Kangaroo mother care for premature newborns

According to the evaluation report of the 2016-2018 National Operational Plan for Newborn Health, the proportion of health facilities where Kangaroo mother care is operational in the targeted Health Districts was 4%, while the proportion of health facilities with Kangaroo units was 0.5%. These data show that the "Kangaroo Mother Care" method for premature and low-birth-weight newborns is very poorly implemented in our health system.

d. Early breastfeeding

Early breastfeeding done within one hour after delivery is an intervention that is effective, inexpensive and easy to implement and document. Its implementation rate remains low at national level and has not changed significantly between 1998 (37%) and 2018 (48%).

e. Newborns exclusively breastfed for 6 months

Although not widely implemented, this practice increased significantly between 2011 and 2018, from 20% to 40% (DHS 2011 and 2018). Data disaggregated per region are not available for this practice.

f. Visits to newborns by MCHWs in the community

Visits to newborns by MCHWs are not carried out in all 10 regions of the country. They are only carried out in two regions (Adamawa and Centre), and at a very low level (0.4% and 0.2% respectively, DHS 2011 and 2018).

3.1.3 Child health

3.1.3.1. Mortality among children under 5 years of age

Data from the DHS 2018 show a clear reduction in mortality among children under five years old. Between 2011 and 2018, the infant and child mortality rate decreased significantly, from 122 to 80 deaths per 1,000 live births, bringing it closer to the target set in the 2020 SP/RMNCH of 89 deaths per 1,000 live births.

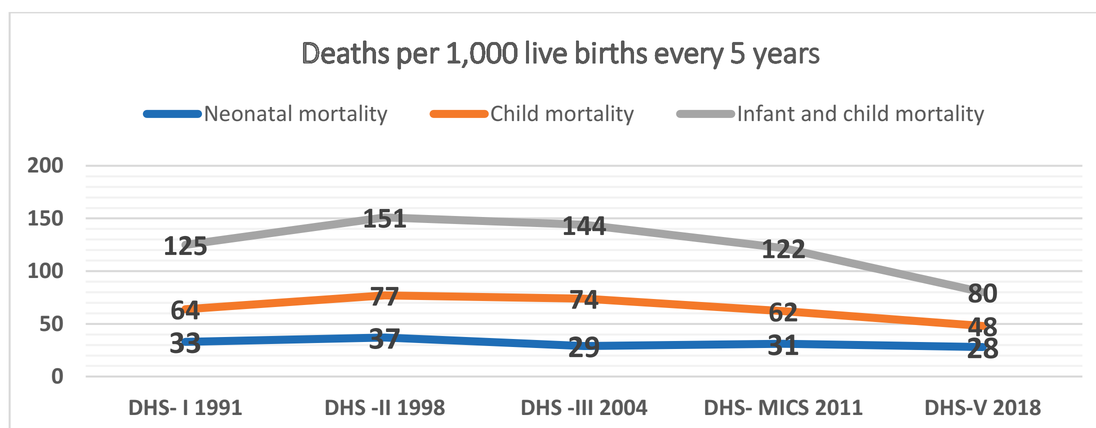
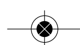


Figure 7: Trends of mortality rates in children under 5 years of age in Cameroon from 1991 to 2018



The most ambitious Sustainable Development Goal (SDG) was set at 25 deaths per 1,000 live births by 2030. To reach this target, it would be necessary to reduce the annual mortality rate by 2.2‰ each year.
Over the same period, the infant mortality rate reduced from 62 deaths ‰ live births to 48 ‰ live births.

According to the DHS 2018, the risk of dying before the age of 5 years significantly varies based on the place of residence. The mortality rate is higher in rural areas than in urban areas. The risk in rural areas (25 deaths ‰ live births) is almost twice as high as in urban areas (13 deaths ‰ live births). This disparity is particularly high in the post-neonatal period.
Similarly, infant and child mortality varies from 65 deaths ‰ live births in urban areas to 92 deaths ‰ live births in rural areas. Under 5 mortality is higher in the North (133), East (122), Far North (102), Adamawa (96), South (90) and Centre (85) regions.
The economic status of the household is also a crucial factor for the risk of child death. In fact, the risk of dying before the fifth birthday is 2.3 times higher for children from households in the lowest level of the quintile of economic well-being (111 ‰) than those from households in the highest level of the quintile (47 ‰) (DHS 2018).
These disparities could be explained by the quality of antenatal care services and delivery conditions, which are more appropriate in urban areas than in rural areas, as well as by the nutritional status and health of mothers and children. Improving health indicators for children under 5 is essential to reduce the prevalence of the main causes of mortality: malaria, anaemia and infections.

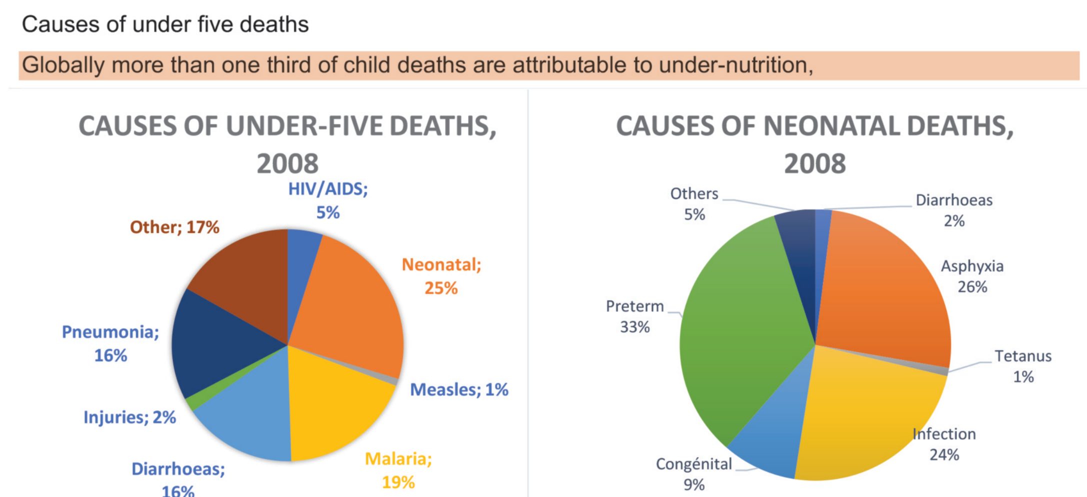
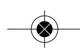


Figure 8: *Causes of mortality in children aged 5 years and below*

Source: Country Profile, Cameroon, Maternal, Newborn & Child Survival



Infant and child mortality rates are higher in the North and East regions with 133 and 122 deaths ‰ respectively. In contrast, the Littoral region and the city of Douala record the lowest levels (40 and 50 deaths ‰ respectively). Child mortality rate varies from a minimum of 25 deaths ‰ in the Littoral region to a maximum of 77 deaths ‰ in the East region. Infant and child mortality rate increased from 15 deaths ‰ in Yaounde and Douala to 61 deaths ‰ in the North region.
Child survival is strongly related to the mother's level of education. As a matter of fact, the infant mortality rate decreased from 64 deaths ‰ among children whose mothers have no level of education to 38 deaths ‰ among those whose mothers have a higher level of education.

3.1.3.2. Coverage of key interventions in children under 5 years of age

Reducing infant and child mortality depends on the effectiveness of certain high-impact interventions such as immunisation, Integrated Management of Newborn and Childhood Illnesses (IMNCI), nutritional status and the fight against anaemia.

a. Vaccination

The Expanded Programme on Immunisation (EPI) mainly targets children aged 0-11 months and generally includes a dose of BCG vaccine at birth and oral polio vaccine (OPV), doses of Pentavalent (DTP-HepB-Hib), OPV and monovalent rotavirus diarrhoea vaccine (Rotarix) at 6 and 10 weeks, and an appointment at 14 weeks for Pentavalent and OPV. From the age of 6 months, children receive vitamin A every six months; at 9 months, they receive the measles, rubella (RR) and yellow fever vaccines.

Data from the 2021 and 2022 annual activity reports of the Vaccination Sub-Directorate of the Ministry of Health (MINSANTE) show that the cumulative vaccination coverage for Penta 3 was 80.3%, a decline compared to the 81.2% recorded during the same period in 2020. However, it remains below the national target of 85%. The regions of the Far North, North, Adamawa, East, and South exhibit a satisfactory equity profile.

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The table below shows the percentage of vaccination coverage in Cameroon:

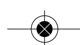


Table 8: Vaccination coverage in Cameroon from 2011 to 2020 (percentage)

VACCINE	2011	2018	2020
3rd dose of DTP vaccine	68%	72%	80.7%
Hepatitis B	65%		
Measles-rubella	71%	65%	74.1%
OPV3	70%	67%	80.3%
BCG vaccine	87%	87%	83.7%

Sources: DHS 2011 and 2018, DHIS2

b. Integrated Management of Newborn and Childhood Illnesses (IMNCI)

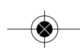
The Integrated Management of Newborn and Childhood Illnesses (IMNCI) approach in Cameroon is recommended to reduce morbidity and mortality related to diarrhoeal diseases, malnutrition, HIV, hepatitis, malaria and acute respiratory infections (ARI) in children and newborns.

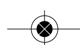
The 2014-2020 NSP/RMNCH estimated that 70% of health districts and 70% of health facilities would provide IMNCI services in accordance with national standards; to date, these data have not been documented by either the DHIS2 or the DHS 2018.

However, in 2018, 12% of children suffered from diarrhoea in the 2 weeks preceding the DHS and 52% were correctly treated, which represents a good performance compared to the expected rate of 42.3%. In addition, only 59% of children under 5 years of age with ARIs received appropriate counselling or treatment from a health professional. Financial inaccessibility to health care and services and long distances to health facilities are the main difficulties cited by women.

c. Malaria prevention and management

DHS 2018 data show a steady increase in the use of long lasting insecticide-treated nets (LLINs) since 2004, both among children under 5 years of age and pregnant women aged 15-49 years. The percentage of children under 5 years of age using LLINs increased from 1% in 2004 to 21% in 2011, then to 60% in 2018, before slightly dropping to 58% in 2022, compared to the 65% projected (2022 Malaria Indicators Survey, p43). This performance could explain the decrease in malaria parasite prevalence in children aged 6 to 59 months, which decreased from 30% to 24% between 2011 and 2018, and remained almost stable at 26% in 2022 (MIS 2022, p66). The percentage of children under 5years of age





with a recent malaria attack who took Artemisinin-based combination therapy (ACT) according to national standards increased from 21% to 46% (MIS 2022, p64). However, this result is still below the national target of 56.6%.

3.1.4 Reproductive health among adolescents and youth

Adolescents and youth face a number of sexual and reproductive health problems. These include STIs, HIV/AIDS, early or unwanted pregnancies, abortions, low use of contraceptive methods, alcoholism, drug and narcotics use, early and/or forced marriages, genital mutilation, breast ironing and gender-based violence. These problems are due to a number of factors, including: increased poverty, low levels of school enrolment among young girls, socio-cultural norms that are harmful to the health of girls and young women, poor access to healthcare, early onset of sexual activity, poor family supervision, poor reception by healthcare personnel, and no confidentiality of private information in health facilities (disclosure of personal information).

3.1.4.1. Overview of key indicators for adolescents and youth reproductive health

a. Prevalence of pregnancies among adolescents and youth

According to the 2018 Demographic and Health Survey, the percentage of adolescent girls aged 15 to 19 years who already had a child decreased from 25.2% in 2011 to 24% in 2018 and the percentage of young women aged 20 to 24 years who had given birth before the age of 18 decreased from 29.9% in 2011 to 28.3% in 2018.

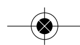
The 2015-2020 NSP on adolescent and youth health aimed at reducing by half (50%) the prevalence of early pregnancies. This indicator has slightly decreased in both age groups: 1.2% for teenage girls and 1.6% for young women.

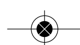
b. Unmet needs for family planning among adolescents and youth

According to DHS 2018, unmet needs for family planning among adolescent girls is high (26.4%) compared to the general population (23%).

c. Prevalence of STIs/HIV among adolescents and youth

According to the evaluation report of the 2015-2020 NSP on adolescent and youth health, HIV prevalence among adolescent girls aged 15-24 years decreased by 1.2% between 2011 (2.7%) and 2018 (1.5%), in contrast to boys of the same age group, whose trend was slightly upwards (0.6%) between 2011 (0.5%) and 2018 (1.1%). The objective of the 2015-2020 NSP on adolescent and youth health, which was to reduce the prevalence of STIs and HIV among adolescents and youth by 50%, has not been achieved, due to the deterioration of some indicators.





d. Prevalence of abortions among adolescents and youth

In Cameroon, abortion is punishable under Article 337 of the Criminal Code. This article punishes with imprisonment and a fine, the woman or young girl who has committed abortion as well as the health professional who performed the procedure. In legal terms, abortion is only legal in two very specific cases: where there is a risk to the life of the mother and in cases of proven rape (article 339).

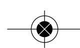
Despite this prohibition, abortion is common practice among the population. It is carried out clandestinely and affects both adults and teenagers. According to the results of the 1998 and 2004 Cameroon Demographic and Health Surveys, 1.7% of adolescent girls (aged 15-19 years) who had sexual intercourse, had an induced abortion. A study carried out in 2010 in Yaounde and Douala by the Cameroon National Association for Family Welfare (CAMNAFAW), the International Planned Parenthood Federation (IPPF) and the Ministry of Public Health revealed that 23.1% of abortions in Cameroon are induced and determined the abortion rate among women aged 15-35 years in Cameroon between 30 and 40%. The global poverty and moral crisis context that the country is facing seems to favour this practice. It was also noted that the use of contraceptive methods, particularly condoms, is relatively low among teenagers, especially girls (girls 52%, boys 68%, DHS 2018). These factors explain the prevalence of induced abortions in teenagers, following the high rate of unwanted pregnancies, especially in schools. In addition to the repression of abortion by public authorities, socio-cultural pressures towards girl-mothers, the high cost of modern contraceptive methods and the expenses associated with raising children in a situation of insufficient employment, mean that most abortions are performed clandestinely and often in very poor conditions. According to the same study, the cost for the management of women who had abortions varies between FCFA 31,000 and FCFA 70,000. The consequences of these abortions are generally infections, infertility, perforated uterus or bladder, leading in some cases to obstetric fistulas, ectopic pregnancies, tubal dysfunction and even death.

3.1.4.2. Coverage of interventions on adolescent and youth reproductive health

Improving reproductive health among adolescents and youth depends on whether certain interventions are implemented to (i) prevent unwanted pregnancies and induced abortions, (ii) prevent and manage sexually transmitted infections, and (iii) manage GBV and harmful cultural practices.

a. Provision of modern contraceptive methods to adolescents and young women

According to DHS 2018, the modern contraceptive prevalence rate among adolescents remains low, at 10.3% (compared to 19.5% in the general population).



Modern contraceptive prevalence among adolescent girls decreased from 12.1% in 2011 to 10.3% in 2018, representing a decrease of 1.8%. Meanwhile, among adolescent girls and young women aged 15 to 24 years, a slight increase of 0.3% was observed, taking modern contraceptive prevalence from 16.1% to 16.4% over the same period.

b. Management of STIs and HIV in adolescents

The 2020-2023 National Strategic Plan for the fight against HIV/AIDS and STIs aimed to provide 80% of adolescents aged between 10 and 24 years with adequate skills to protect themselves from HIV. However, only 49.4% of girls and 65.3% of boys have achieved this objective (NACC 2023 Annual Reports). In addition, the same HIV National Strategic Plan (NSP) forecasted that by 2023, 92% of adults, adolescents and children living with HIV (PLHIV) who knew their HIV-status would be receiving antiretroviral therapy. Furthermore, according to NACC 2023 Annual Reports, only 62% of youth aged between 20 and 24 years received their treatment.

c. Management of GBV and harmful cultural practices

The objective of the 2015-2019 National Strategic Plan for Adolescent and Youth Health (NSPAYH) was to ensure that at least 60% of cases of gender-based violence (GBV) and cultural practices harmful to the reproductive health of adolescents and young people, were adequately managed by 2019. To date the available data for the performance of this data is not available.

3.1.5 Reproductive health of the elderly

Life expectancy at birth in Cameroon was 60.33 years in 2021. It is higher for women (62.02 years) than for men (58 years)[9]. The population of elderly people (aged 60-65 and above) tends to increase thanks to medical advances. This demographic change creates new challenges in terms of screening for and treating reproductive health problems in the elderly, including genital cancers, STIs/HIV, menopause/andropause and their complications, sexual dysfunction, etc.

In addition to the increase in life expectancy, other factors may increase the risk of occurrence of reproductive health problems in the elderly. These factors or conditions include:

- Retirement: Retirement can be more free time, which can lead to the adoption of risky sexual behaviour with new partners.
- Separation or divorce: Separation or divorce can encourage older people to get back together and adopt new sexual behaviours, increasing their risk of STIs and HIV.

[9] www.countryeconomy.com

- Widowhood: Widowhood can lead to loneliness and social isolation, which can encourage some older people to seek intimate contact to fill the emotional void, exposing them to risky sexual behaviour.

Opportunities for discussions offered by social media can also encourage the adoption of risky behaviour. However, research on this subject is limited[10].

According to 2011 DHS-MICS, 2.3% of people aged between 50 and 59 years had an STI, 2% had a urethral discharge, 2.3% had a genital sore or ulcer and 4.7% had an STI, discharge, sore or ulcer.

In addition, the "Decade for healthy ageing 2020-2030", which is the roadmap for accelerating medical and social management of the elderly, drawn up in 2020 as part of Universal Health Coverage in Cameroon, reveals the following problems:

- A drop in sexual desire is observed in 33% of elderly people, while 30.6% suffer from impotence;
- HIV-infection in urban areas: out of the 50% of elderly people screened, 8% are HIV-positive.

3.1.6 Reproductive health of vulnerable target groups

Vulnerable target groups include internally displaced people, people living with physical, mental or sensory disabilities, people living with HIV, vulnerable indigenous populations and street children. RMNCAH indicators are not disaggregated in the DHIS2 in accordance with the various vulnerability criteria.

3.2 DESCRIPTION OF CROSS-CUTTING INTERVENTIONS

Cross-cutting reproductive health (RH) interventions are characterised by their ability to address several RH targets simultaneously. These interventions include: Family planning and management of sexually transmitted infections, infertility, sexual dysfunctions, genital cancers and harmful cultural practices, PMTCT.

3.2.1. Family planning

3.2.1.1 Unsatisfied family planning needs

According to DHS 2018, about one out of four women (23%) aged 15-49 years and currently in a relationship has unmet needs with regard to family planning, including 15% who need to space their births and 8% who need to limit them. The objective of the SP/RMNCAH was to reduce the percentage of women of childbearing age with unmet

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[10] https://www.chudequebec.ca/a à-propos-de-nous/publications/revues-en-ligne/spiritualité -santé/réflexions/sexualité edes-personnes-agés-entre-négligence-e.aspx

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needs in terms of family planning from 17% in 2014 to 10% in 2020. This target has not been met, as there is a 13% gap in unmet needs.

3.2.1.2 Contraceptive prevalence among women of childbearing age

According to the 2018 Demographic and Health Survey (DHS), only 19% of women aged 15-49 years and living with a partner were using a contraceptive method when surveyed. Among these women, 15% were using a modern contraceptive method and 4% a traditional method. Changes in the use of contraceptive methods between 2004, 2011 and 2018, according to DHS data, are presented in table 9. In 2018, male condoms (5.2%), injectables (3.7%) and implants (2%) were the most commonly used modern methods in the general population (6%), (table 9).

However, the objective of the 2014-2020 NSP/RMNCAH was to increase the rate of use of long-term contraceptive methods from 4% in 2014 to 20% in 2020. There is therefore a gap of almost 12% to be filled.

3.2.1.3 Contraceptive prevalence of each method among women of childbearing age

According to the evaluation report of the 2014-2020 NSP/RMNCH, changes in the prevalence rates of the use of each contraceptive method by women of childbearing age between 2004 and 2018 are as follows.

Table 9: *Contraceptive prevalence of each method among women of childbearing age from 2004 to 2018 (DHS 2004, 2011, 2018)*

Contraceptive Methods used by women of childbearing age	Prevalence of each contraceptive method (%)		
	2004	2011	2018
Female sterilisation	0.9	0.4	0.3
Pills	1.3	1.6	1.1
IUD	0.2	0.2	0.9
Injectable	1.1	2.3	3.7
Male condom	9.7	10.8	5.2
Female condom	0.0	0.1	0.0
Implants	0.3	0.5	2.6

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3.2.1.4 Informed choice of the family planning method

According to DHS 2018, more than half of women using modern contraception received information allowing them to make an informed decision (56%).

3.2.2. Management of sexually transmitted infections (STIs), viral hepatitis and HIV/AIDS.

In DHS 2018, women aged between 15 and 49 years who had sexual intercourse during the last 12 months prior to the survey, reported having an STI or related STI symptoms. The reported prevalence of an STI or related symptoms in men (39%) is 11% lower than in women (43%) (DHS 2018, pp297-298).

However, counselling or treatment for STIs remains low among people aged 15-49 years who have experienced an STI. Only 43% of women and 48% of men who had been infected with an STI said they had sought counselling or treatment.

According to the 2018 Demographic and Health Survey (DHS), HIV prevalence among women and men aged 15 to 49 years is 2.7% (3.4% among women and 1.9% among men). In this age group, HIV prevalence is higher in urban areas (2.9%) than in rural areas (2.4%). There is also a regional disparity, with the highest prevalence rates in the South (5.8%) and East (5.6%) regions, and the lowest in the Far North (1.1%) region.

Among young people aged 15-24 years, 1.3% are HIV-positive, with a slight predominance of women (1.5%) compared to men (1.1%).

Cameroon is one of the most highly endemic countries for viral hepatitis. According to GAVI, 1.3% of the population is affected by hepatitis C, 8.3% suffers from hepatitis B[11].

Four curable sexually transmitted infections, namely syphilis (Treponema pallidum), gonorrhoea (Neisseria gonorrhoeae), chlamydia (Chlamydia trachomatis) and trichomoniasis (Trichomonas vaginalis), cause most STIs. There is also infection with the human papillomavirus, which is a risk factor for cervical cancer. STIs have a direct impact on sexual and reproductive health, in particular by causing stigmatisation, infertility, cancers and pregnancy complications, and by increasing the risk of HIV contamination. They are often responsible for cervicitis, pelvic inflammatory disease and infertility. Transmission of an STI from mother to child can result in stillbirth, neonatal death, low birth weight, prematurity, sepsis, conjunctivitis in the newborn or congenital malformations.

The risk factors for STIs usually identified are: low socio-economic status; multiple partners; unprotected sexual intercourse; young age and early onset of intercourse; tobacco, drugs and alcohol; prostitution, prison and the existence of a first STI.

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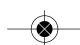
[11] https://www.gavi.org/fr/vaccineswork/hepatite-epidemie-cachee-cameroun



3.2.3. Prevention of Mother-to-Child Transmission of HIV (PMTCT)

The Prevention of Mother-to-Child Transmission of HIV (PMTCT) programme, integrated with Maternal, Newborn and Child Health (MNCH), offers a package of integrated services during antenatal care, childbirth and postnatal follow up of mother and child. This package of services includes: HIV screening/counselling (for pregnant women and their partners), antiretroviral therapy for pregnant women found to be HIV-positive, Cotrimoxazole prophylaxis, counselling on safer delivery and care for children exposed peri- and post-partum (ARV prophylaxis, early diagnosis).

Overall, 57% of women aged 15-49 years who had a live birth in the two years preceding the survey received counselling on HIV during an antenatal visit. In addition, half of the women (51%) did an HIV screening during an antenatal visit, received the screening results and post-test counselling; almost a quarter (24%) received the screening results but no post-test counselling (Table 13.8). Overall, 55% of women who had a live birth in the two years prior to the survey had received pre-test HIV counselling and were screened during an antenatal visit, and received the results (DHS 2018).

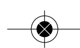
3.2.4. Management of infertility and sexual dysfunction

Infertility can result from various factors. In men, it is due to low sperm counts, hormonal fluctuations, sexual problems such as premature ejaculation or erectile dysfunction (in cases of diabetes or untreated sexually transmitted infections), excessive exposure to some chemicals, smoking and the effect of some drugs.

In women, the main causes include ovulation disorders due to hormonal variations, uterine anomalies, endometriosis (a thickening of the uterine walls), obesity, sexually transmitted infections and exposure to certain types of chemicals.

As for sexual dysfunction, it is influenced by both psychological and biological factors. Biological factors include genital dysfunction, systemic diseases such as diabetes or multiple sclerosis; drugs such as antidepressants, anti hypertensives and chemotherapy as well as hormonal changes, drug or alcohol abuse, and smoking.

Psychological and social factors include anxiety, depression, stress, relationship problems and partner compatibility, lack of sexual knowledge and cultural influences. Data on infertility and sexual dysfunction in Cameroon is almost non-existent. According



to the World Health Organisation (WHO), an estimated 20-30% of couples in Cameroon, as in many African countries, suffer from infertility. Although the 2014-2020 National Strategic Plan for Reproductive, Mother, Newborn and Child Health aimed to treat at least 80% of cases of sexual dysfunction and infertility, the achievement of this objective has yet to be confirmed due to a lack of accurate data.

3.2.5. Management of genital and breast cancers

In Cameroon, according to the 2020-2024 Strategic Plan for Cancer Prevention and Control, more than 15,700 new cases are diagnosed each year. Mortality is estimated at 10,533 deaths per year, with a high mortality/incidence ratio above 65%. This figure was estimated at 60% ten years ago.
In terms of incidence, women are the most affected, with 9,335 new cases of cancer each year, representing a standardised risk of 116.9 cases per 100,000 women, compared with a standardised risk of 100.5 cases per 100,000 men (incidence of 6,434 new cases each year).
As for annual incidence, the five main cancers are:

- Breast cancer (3,265 new cases);
- Cervical cancer (2,349 new cases);
- Prostate cancer (2,064 new cases);
- Liver cancer (919 new cases);
- Colorectal cancer (832 new cases)

Breast and cervical cancers are the two most common cancers in women. According to figures from the District Health Information Software (DHIS 2 2022), the regions with the highest number of suspected cases of breast, cervical and prostate cancers are the North West, West and Centre.

- Risk factors for cancers in Cameroon

According to the International Agency for Research on Cancer (IARC) [27,28,13] common risk factors for cancer were identified, as shown in the table below:

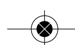


Table 10: 13 frequent risk factors for cancer

N°	Risk factor	N°	Risk factor
1	Active and passive tobacco use	8	Ionising radiation
2	Alcohol consumption	9	Atmospheric pollution
3	Unbalanced diet	10	Solar radiation (UV)
4	Overweight and obesity	11	Occupational exposure to carcinogens (wood dust, petroleum derivatives, chromium, tar, etc.)
5	Insufficient physical activity	12	Duration of breastfeeding less than 6 months
6	Use of exogenous hormones	13	Exposure to chemical substances in the general population (arsenic, benzene, etc.)
7	Infections		

Source: National Strategic plan for Prevention and Control of Cancer, (PSNPLCA) 2020-2024, page 20

3.2.6. Management of GBV and cultural practices harmful to the reproductive health of girls and women.

3.2.6.1 Management of gender-based violence (GBV)

In accordance with the 2022-2026 National Strategy to fight against Gender-Based Violence (GBV) (MINPROFF) and the United Nations Guidelines, acts of gender-based violence are a violation of universal human rights protected by international conventions and instruments. However, their interpretation varies from one country to another, as does the practical application of laws and policies to combat this social scourge.

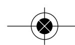
There are several types of GBV:

a. Physical violence

Physical violence is the most visible form of violence. It consists of harming a person's physical integrity. It includes violent acts such as slapping, shoving, kicking or grabbing roughly, biting and scratching, throwing objects, hitting with or without an instrument, punching, beating, strangling, injuring or killing, locking up or tying up the victim.

Data from the Fifth Demographic and Health Survey (DHS 2018) show that 39% of women aged 15-49 years said they had experienced physical violence since the age of 15 years from someone. Trends show that the percentage of women aged 15-49 years who experienced physical violence from any person in the last 12 months increased between 2004 and 2011, from 21% to 27%; then it decreased to 18% in 2018.

With regard to physical violence during pregnancy, among women aged 15-49 years who are currently pregnant or who have been pregnant in the past, 7% said they had experienced physical violence during pregnancy, regardless of the perpetrator. The percentage of women who had experienced physical violence during pregnancy varied



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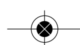


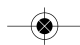
according to the region surveyed. The highest percentages were found in the Centre (excluding Yaounde) (15%), the North West (12%) and the South (10%) regions, and the lowest in the Far North (2%) and Adamawa (3%) regions.
Forced abortion and forced sterilisation (art. 39 of the Istanbul Convention), as well as female genital mutilation (art. 38 of the Istanbul Convention), are specific forms of physical violence.

b. Sexual abuse

Sexual abuse includes acts such as sexual harassment, complete or incomplete sexual intercourse without consent and/or under constraint, including rape.
Sexual harassment includes acts such as overly insistent approaches, saucy compliments, unwanted touching or kissing, harassment by exhibition or by showing pornographic images and films. Acts such as unwanted touching of the genital area, coercion to perform sexual acts with another person or third party, rape or attempted rape are forms of sexual abuse.
The percentage of women aged 15-49 years who had experienced sexual abuse at some point in their lives did not change between 2004 and 2011 (10% in both cases). However, according to DHS 2018, this percentage increased to 13% for women who reported having been victims of sexual abuse in their lifetime, and 5% of them reported having experienced such abuse recently, that is, in the last 12 months.

c. Psychological/emotional violence

Psychological violence manifests in both verbal and non-verbal forms while inflicting mental or emotional wounds to weaken, undermine and injure psychologically. It involves actions such as insults, denigration, humiliation, verbal attacks, scenes of jealousy, threats, control of activities, attempts to isolate from family and friends, and can go as far as confinement. It also includes the destruction of objects or acts of cruelty towards the victim's pets.
The 2014 MICS 5 survey shows that 47% of women aged 15-49 years who are currently in a relationship or who have broken up a relationship have experienced various forms of emotional violence from their husband/partner in the previous 12 months (of which 23% responded 'often' and 35% 'sometimes'). Emotional violence of this kind involved 42% of women being insulted or belittled by their husband/partner, 37% of women being humiliated in front of other people and 37% of women receiving threats against themselves or those close to them.
In addition, almost half of men (49%) said that they had used emotional violence against their wives in the form of insults or belittling in the last 12 months before the survey. About 30% said that they had used emotional violence against their wives in the form of



humiliation in front of other people or in the form of threats against them or those close to them.

d. Social violence

Social violence involves restrictions imposed on a person's social life, such as prohibiting or controlling contacts within the family and outside, or forced isolation. It may be legal, cultural, spatial or other.

e. Economic violence

Economic violence is the control of a person's economic resources through restriction, exploitation or sabotage. Resources may include money, food, transport and shelter. Economic violence occurs with other forms of violence. There are no data on economic violence in Cameroon.

The most common forms of economic violence include:

- Deprivation of income: This can take the form of confiscation of money or preventing someone from working.
- Imposition of a financially dependent status: Many women are forced into a "housewife" role, with no income of their own and entirely dependent on their spouse.
- Unpaid work: Unpaid domestic work, which is often disproportionate, and work in the family business without financial compensation are various forms of economic violence.
- The use of physical violence to prevent people from working: Threats or acts of physical violence can be used to force people to give up their jobs or not to look for work.

3.2.6.2 Management of Harmful Cultural Practices

a. Female Genital Mutilation (FGM)

This refers to procedures designed to deliberately alter the female genitalia or cause injury for reasons that are not medical but which claim to be culturally justifiable. They are classified into four broad categories.

With regard to FGM, a MINPROFF study carried out in 2009 with the support of UNFPA presents the situation analysis of this practice in Cameroon. The reasons for practising female genital mutilation (FGM) vary from one region to another and over time, and multiple socio-cultural factors within families and communities are involved. Although the national prevalence rate is 1.4%, according to DHS 2004, the trend in the most affected areas (the Far North and South West regions) is as high as 20%. This calls for urgent measures to be taken, including targeted interventions and the definition of relevant indicators to monitor the progress of the country's efforts to eliminate this scourge in Cameroon. To this end, the indicators available from national surveys and other studies are set out in the table below:

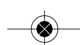


Table 11: Indicators of genital mutilation and other harmful cultural practices in Cameroon

INDICATORS	SCOPE	VALUE	YEAR	SOURCE
Prevalence of excised women	NATIONAL	1.4%		
Prevalence of Muslim excised women		2%		
	REGIONAL			
	Far North	5%		
	North	2%		
Prevalence of excised women	South West	2%	2004	HDSC III
Prevalence of breast ironing among young girls	NATIONAL	24%	2006	RENATA
Percentage of girls and women aged 15-49 years who have heard of FGM/C and think the practice should stop, 2004-2015	NATIONAL	84%	2016	UNICEF
Percentage of boys and men aged 15-49 years who have heard of FGM/C and think the practice should stop, 2000-2015	NATIONAL	85%	2016	UNICEF
Percentage of women aged 15-49 years who have undergone FGM and been circumcised by a health professional	NATIONAL	4%	2004	HDSC III

Recent and reliable data on the practice of genital mutilation in Cameroon are not available. Objectives have been formulated, but no results indicators have been assigned to these objectives to enable performance to be assessed at the end of the plan. The latest demographic health survey (DHS 2018) does not have any statistical data on FGM.

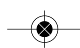
b. Child marriage

This refers to any type of marriage where one or both spouses are under the age of 18 years. It is contrary to the Universal Declaration of Human Rights, which states that: “Marriage shall be entered into only with the free and full consent of the intending spouses”. Girls are more likely to be married when they are still children and, as a result, to be forced to drop out of school, exposing themselves to other forms of violence.

The child marriage situation in Cameroon did not change significantly between 2014 and 2018. This is closely due to socio-cultural factors.

The percentage of women aged 15 to 19 years who entered their first relationship before the age of 15 slightly reduced from 6.2% to 6% between 2014 and 2018, a reduction of 0.2% in 4 years. Similarly, the percentage of women aged 20-24 years who entered their first union before reaching the age of 18 decreased from 31% to 30% between 2014 and 2018, a decrease of 1% in 4 years (DHS 2014 and DHS 2018).

The net secondary school attendance rate for both genders decreased between 2014 (52.7%) and 2018 (51%) (DHS-MICS 2014 and DHS 2018).



In view of the very poor performance achieved in 4 years, it is believed that the indicators projected in the multi-sector national action plan for the abandonment of child marriages in Cameroon will not be achieved. Indeed, considerable efforts must be made to achieve the SDG 5.3 target, which aims to eliminate all harmful practices such as child marriage, early or forced marriage and female genital mutilation by 2030.

c. Honour killings

Honour killings occur when women are executed in the name of the family's "honour", for example, for having sexual relations outside marriage or for not agreeing to an arranged marriage.

Besides these three, other harmful cultural practices are prevalent in Cameroon. These include forced marriages, breast ironing, the "Money Women" phenomenon where girls are given in marriage from the moment of conception, degrading widowhood rites, levirate and sororate marriages which, although prohibited by law, are still practised in communities.

3.2.7. Management of nutritional needs of RMNCAH-Nut target populations

3.2.7.1 Pregnant women

Pregnant women suffer from various preventable causes of morbidity, including anaemia in 40% of women (DHS 2018), overweight in 37% (DHS 2018) and malnutrition in about 40% of women (DHS 2018, P253). This high prevalence is partly due to poor access to health and nutrition promotion services before the fifth or sixth month of pregnancy, as revealed by the Demographic and Health Survey conducted in 2011 (DHS-MICS 2011) and malnutrition in about 50% of women (DHS-MICS 2011, P184).

To remedy this situation, it is crucial that women of childbearing age conceive in an optimal nutritional state. This implies adequate access to a healthy and diversified diet, as well as sensitization on good nutritional practices.

In addition, several factors contribute to the worsening of the nutritional situation of the mother-child couple. These include difficulties that households have in accessing food, the poor distribution of food supplies within households and no sensitisation on good nutritional practices.

It is therefore imperative to put in place multi-sector interventions aiming at improving the nutritional situation of pregnant women and children. These interventions should include nutrition sensitisation programmes, measures to improve access to food and the promotion of healthy nutritional practices.

3.2.7.2 Newborns and children

Growth problems: In Cameroon in 2018, 29% of children under 5 years of age were stunted or chronically malnourished and 14% of children were severely stunted. Wasting also affects 4% of children, and 2% in its severe form. Finally, underweight affects 11% of children under five, 3% of whom are severely underweight. In addition, 11% of children are overweight. The highest percentages of stunted children are found in the North (41%), Far North (37%), East (37%) and Adamawa (35%) regions. In contrast, prevalence is lower in Douala (9%) and Yaounde (11%). The prevalence of overweight/obesity increased from 5% in 2004 to 11% in 2018 (DHS 2018, p31).

Micronutrient deficiencies: About 3 in 5 children aged between 6 and 59 months (57%) suffer from anaemia, including 2% in the severe form. In addition, 35% are affected by vitamin A deficiency, 69% by zinc deficiency, 28% by vitamin B12 deficiency and 17% by folic acid deficiency. Iron deficiency is a common cause of anaemia and is estimated to be responsible for half of all anaemias in women and children. Anaemia can also be caused by malaria, hookworm, other helminthiasis, nutritional deficiencies, chronic infections and genetic diseases such as thalassaemia.

The Centre (excluding Yaounde) and East regions have the highest percentages of children aged between 6 and 59 months suffering from anaemia, with 65% and 64% respectively.

The North West region (44%) and Yaounde (43%) have the lowest rates. The prevalence of anaemia in children varies according to the mother's level of education: 43% of children aged 6-59 months suffering from anaemia have mothers with a higher level of education, compared to 65% of those whose mothers have no education. In addition, the percentage of children aged 6-23 months with anaemia is higher in households in the lowest quintile (66%) than in those in the highest quintile (44%) (DHS 2018).

- Nutrition intervention coverage for children

The three approaches commonly used to increase dietary micronutrient intakes are dietary diversification, micronutrient supplementation and food fortification. This strategic plan recommends the following:

Breastfeeding: Appropriate infant and young child feeding practices (IYCF) include early initiation of breastfeeding (that is, within one hour of delivery), exclusive breastfeeding for the first 6 months, continuous breastfeeding up to 2 years of age or beyond, and the introduction of safe and nutritionally adequate complementary foods from 6 months of age (WHO, 2008). Among children born in the two years prior to the DHS 2018, 92% were breastfed and almost half (48%) were breastfed within one hour of delivery. In addition, 40% of children aged 0-5 months were exclusively breastfed. In terms of the

implementation of key practices for optimal breastfeeding, 64.5% of infants continue to be breastfed for up to a year, while 23.2% continue to breastfeed for two years or more.

Dietary diversification: According to the National Food and Nutritional Security Survey for the Republic of Cameroon in 2021, 32.4% of households have a poorly diversified diet, consisting of no more than 4 food groups. Among these households, 7.8% have a diet made up of 0 to 2 food groups. Consumption of poorly diversified foods is more common in the Littoral (48.4%), Far North (39.1%) and North West (36.7%) regions. According to the same survey, only 12.1% of children surveyed had a minimum acceptable diet. The North, East and South regions had very low rates (3.0%, 5.0% and 5.1% respectively). The Adamawa, North West and South West regions have rates of about 20%. Rural areas are more affected (10.7%) than urban areas (16.6%). Income instability and the trend towards deterioration may explain the poor quality of the diets of the most vulnerable households.

Vitamin A supplementation: In the six months preceding the DHS 2011, 55.3% of children aged 6-59 months had received vitamin A supplements. In the regions surveyed, this percentage varied from a minimum of 36% in the South region to 72% in the East region (NIS[12]).

3.2.7.3 Women of childbearing age

Main indicators of nutritional status

According to DHS 2018, 38% of women of childbearing age are overweight (24% overweight and 14% obese), while 6.1% are underweight. In addition, there is a high and worrying prevalence of micronutrient deficiencies. Among women of childbearing age, 76.9% have a zinc deficiency, 39.7% have anaemia. Vitamin A, vitamin B12 and folic acid deficiencies affect 21.4%, 28.6% and 8.4% respectively.

Micronutrient deficiencies in women of childbearing age

About two out of five women aged 15 to 49 years (40%) suffer from anaemia, with iron deficiency being the main cause. Similarly, 77% of these women have a zinc deficiency, 29% a vitamin B12 deficiency and 8% a folic acid deficiency. Iron deficiency, which is responsible for about half of all cases of anaemia in women and children worldwide, remains a major public health problem. In addition to iron deficiency, other factors such as malaria, hookworm and other helminth infections, nutritional deficiencies, chronic

[12] Ministry of Public Health of Cameroon '**Rapport De Suivi des 100 Indicateurs Clés de Santé Au Cameroun' en 2017, p42**

infections and genetic diseases such as thalassaemia can also contribute to the development of anaemia.

Iron and folic acid supplementation

According to DHS 2018, from 2004 to 2018, there has been a noticeable change in the use of iron supplements among pregnant women; the percentage of women who received iron supplements increased from 73% to 79%. (DHS 2018, P170). Despite this encouraging trend, regional disparities remain, with the North (52%), Adamawa (60%) and Far North (70%) regions showing the lowest rates of use of iron supplements and antiparasitic drugs during pregnancy. Data from the 2018 Demographic and Health Survey (DHS) reveal that this target has been exceeded, with a rate of 79%, underlining a remarkable performance.

With regard to the combination of iron and folic acid (IFA) for at least 90 days, there has been a drop from 54.2% (DHS-MICS 2011, P185) to 49.2% (DHS 2018, P254), which corresponds to a gap of 19.8% in relation to the target set in the Strategic Plan to fight against Malnutrition (SP/PLMI). The 2014 target was to increase the proportion of pregnant women taking IFA for 90 days or more from 54.2% to 70% by 2020, but further efforts are still needed.

3.2.7.4 Adolescent girls

Main nutritional status indicators

Among adolescent girls aged 15 to 19 years, the prevalence of anaemia remains a cause for concern and was 42% in 2018. Similarly, overweight and obesity affected 18.4% of adolescent girls in 2018, compared to 16% in 2011, meanwhile thinness affects 10% of teenage girls.

Despite these worrying figures, access to and use of nutritional services by adolescent girls remain largely unknown. A recent survey conducted in the northern and eastern regions of Cameroon reveals that only 6.7% of adolescent girls aged 10 to 19 years have taken iron supplements in the past three months, and 25% have been dewormed.

According to DHS 2018, almost all children (96%) and women (97%) live in households in which the salt tested was iodized. From 2004 to 2018, the percentage of households with iodized salt remained stable, rising from 96% to 97%. This percentage varies from 89% in the Far North region to over 96% in the other regions. In terms of distribution by quintile of economic well-being, the percentage of households with iodized salt increased from 93% in the lowest quintile to 99% in the highest.

In summary, the burden of malnutrition in the majority of cases is the consequence of an inappropriate diet rich in energy but poor in micronutrients, combined with insufficient physical activity.

Limited access to healthy and sufficient food, inequitable distribution of food resources within households and no sensitisation on good nutritional practices further aggravate the nutritional situation of the mother-child couple.

3.3 NATIONAL RESPONSE TO RMNCAH-NUT ISSUES

The national response to RMNCAH-Nut problems requires multi-sector and multi-stakeholder collaboration and synergy. All the actors involved in this area, namely the Ministry of Public Health, other partner administrations, technical and financial partners, NGOs, civil society organisations and local communities, must work together to meet the major challenges of reproductive health. This section presents an overview of the main actions undertaken by these actors, as listed in the document review.

3.3.1 Public institutional Response

3.3.1.1 MOH institutional response

This mainly concerns Cameroon's political commitments in favour of RMNCAH-Nut, the regulatory measures adopted, the organisation put in place and the improvement in the provision of care and services to deal with this problem.

a. Political and regulatory measures

With regard to maternal, newborn and infant and child health, Cameroon adhered to several initiatives including:

- The International Conference on Population and Development (ICPD) in 1994;
- The adoption of the concept of reproductive health in 1999;
- Achievement of the Millennium Development Goals (MDGs) in 2000;
- The African Charter on Human and People's Rights relating to the Rights of Women and the Child (Maputo Protocol) in 2006;
- The Campaign for Accelerated Reduction of Maternal and Child Mortality in Africa (CARMMA) in 2010;
- The United Nations Secretary-General's Global Action Plan for Maternal and Child Health in 2011;
- The renewed commitment to child survival (A Promise Renewed) in 2012;
- The Sustainable Development Goals (SDGs) adopted by the United Nations in 2015;
- The new 2016-2030 Global Strategy for Women's, Children's and Adolescents' Health;
- The Revised Maputo Action Plan for the implementation of the 2016 to 2030 Continental Policy Framework on Sexual and Reproductive Health and Rights (SRHR);
- The FP2030 Initiative.

By respecting its international and national commitments, Cameroon can improve the health of mothers, children, adolescents, etc. and thus contribute to sustainable human development. This is a moral and ethical commitment by the nation to protect the health of its citizens, particularly the most vulnerable targets, and to strengthen international cooperation on issues of common interest.

d. Institutional Organisation

In accordance with its international commitments, Cameroon has taken measures at the national level for the organisation of the management of RMNCAH issues.

❖ *Departments, Programmes and Committees involved in RMNCAH-Nut*

Several departments of the central administration are involved in the various aspects of RMNCAH-Nut, but the most concerned are the Department of Family Health and the Department of Health Promotion.

The following are involved in RMNCAH-Nut activities:

- The Multi-sector Programme to fight against Maternal and Child Mortality (PLMI);
- The Expanded Programme on Immunisation (EPI);
- The National AIDS Control Committee (NACC);
- The National Malaria Control Programme (NMCP);
- The National Cancer Control Programme (NCaCP);
- The National Tuberculosis Control Programme (NTBCP);
- The National Blood Transfusion Centre (NBTC).

These structures are supposed to have devolved branches in the regions and health districts and have produced strategic documents that guide RMNCAH-Nut in Cameroon and supervise its implementation and evaluation.

❖ *Major strategic documents produced on RMNCAH-Nut*

The main strategic documents that have guided the implementation of RH and nutrition activities over the past decade are:

- The Roadmap for Reducing Mother and Child Mortality (2006-2015);
- The Strategic Plan Campaign for Accelerated Reduction of Maternal Mortality (2011-2013);
- The Strategic Plan for Reproductive, Maternal, Newborn and Child Health (2014-2020);
- The Multisector Strategic Plan to fight against Maternal, Newborn and Child Mortality in Cameroon (2014-2020);
- The Strategic plan to fight against obstetric fistula in Cameroon (2018-2023);
- The Operational plan for family planning in Cameroon (2015-2020);

- The National Strategic Plan for Adolescent and Youth Health in Cameroon (2015 - 2019);
- The National Strategic Plan for Community Health in Cameroon 2021-2025 (NSPCH);
- The National Operational Plan for Newborn Health in Cameroon 2016-2018;
- The Investment Case for Improving Reproductive Health, Maternal, Newborn, Child and Adolescent/Youth Health in Cameroon, 2017-2020;
- The National Strategic Plan for HIV/AIDS 2018-2023;
- The National Strategic Plan for Cancer Prevention and Control (NSPCaPC), 2020 - 2024;
- The Health Sector Strategy 2020- 2030;
- The National Health Development Plan, 2018;
- The Every New Born Action Plan (ENAP) Cameroon 2022-2025;
- The Adolescent Reproductive Health Communication Plan 2023-2026;
- The Operational Plan for the Elimination of Mother-to-Child Transmission of HIV/AIDS.

❖ *Strengthening the provision of quality RMNCAH-Nut care and services at different levels of the health pyramid*

RMNCAH-Nut services are provided at the community level, the health district level, the regional referral structures and the national referral structures.

a) Community level

Community-Directed Interventions (CDI) are implemented in the health areas of the ten regions, in particular by multipurpose community health workers (MCHWs). In 2022, there were 9574 MCHWs in the country. While the geographical coverage of the regions by MCHWs is complete, that of health districts is only 49.7%, as shown in Figure 13. This insufficient coverage, less than 50%, reveals a significant gap that needs to be filled[13].

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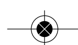
[13]National Strategic Plan for Community Health 2021-2025.



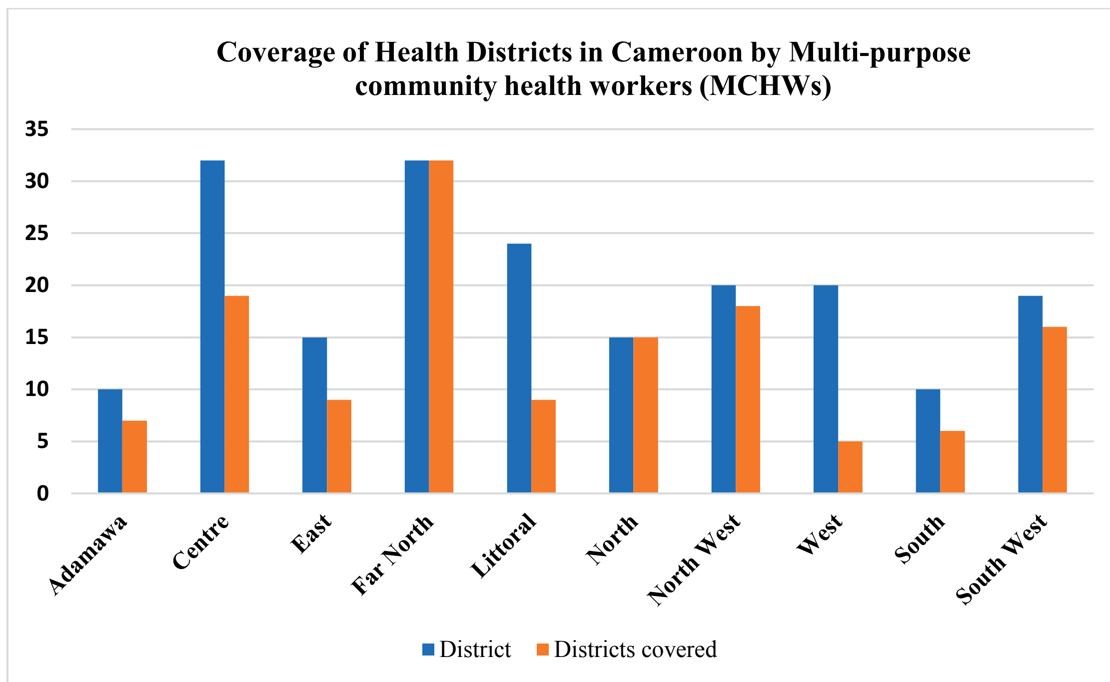


Figure 9: Coverage of HDs in Cameroon by MCHWs in 2022

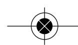
(Source: NMCP 2022 Activity Report)

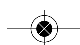
Information and data on CDIs should be reported on a monthly basis. Unfortunately, this information is not captured by DHIS 2 in a satisfactory manner.

Analysis of the evaluation report of the 2014-2020 NSP/RMNCH reveals insufficient community involvement in identifying danger/alarm signs in maternal health and family planning. This gap, which is particularly marked during pregnancy and childbirth, affects women's use of healthcare, promotion of the services offered and blood donation. The lack of community sensitisation and training of Multipurpose Community Health Workers (MCHWs) on family and community practices are among the factors contributing to this weakness.

In the provision of maternal health and family planning services, communication and social mobilisation exist at all levels to address certain health determinants and the emergence of certain social behaviours and practices that are harmful to health. Unfortunately, this cross-cutting intervention to promote behaviour change and the use of health services is neither sufficiently developed nor sufficiently documented in both healthcare and community settings. The low use of maternal health and family planning services is due to ignorance, harmful social and cultural practices and beliefs[14].

[14]National Strategic Plan for Community Health 2021-2025.





b) Health district, regional and central levels

The Health District, through the Minimum Package of Activities (MPA) provided by IHCs and MHCs and the Complementary Package of Activities (CPA) provided by District Hospitals and District Health Services, includes almost all the high-impact interventions of RMNCAH-Nut.

The performance evaluation of HDs in the area of RMNCAH-Nut is poorly documented in Cameroon. However, the literature review reveals key points, as described below:

- **Access to healthcare and services offered by health district structures**

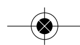
Cameroon, with its 203 health districts, has a good coverage in terms of health infrastructure, with 2,300 IHCs, 295 MHCs and 167 district hospitals in the public sub-sector, not to mention the many private sub-sector structures which reinforce the provision of care and services.

However, according to an evaluation carried out by DOSTS/MOH in 2022, geographical accessibility to healthcare and services is slightly low, with about 26.7% of the population having difficulty accessing healthcare and services. This situation is more marked in rural and semi-urban areas. This low level of access is due, among other things, to the geographical constraints and natural obstacles of landlocked regions, the poor condition of certain roads and the remoteness of health facilities, which are sometimes more than 10 or even 15 km away, making them less accessible to RMNCAH-Nut targets.

- **Performance indicators for RMNCAH-Nut services per target group**

According to surveys conducted by DSF/MOH with the support of UNFPA and NIS, the proportion of health facilities with adequate infrastructure, equipment and personnel for the provision of RMNCH services has increased from 3% in 2014 to 4% in 2020, for a strategic target set at 80% in 2020.

According to the evaluation report of the Strategic Plan to fight against maternal, newborn, infant and child mortality 2014-2020, in the absence of data to inform the indicator, "proportion of HFs with adequate infrastructure, equipment and personnel for the provision of RMNCH services", the indicator "percentage of HFs whose personnel have been trained in the provision of family planning services" was used as a proxy. In 2018, 59.4% of IHCs and MHCs, 83.6% of Regional and District Hospitals and 76.9% of Central Hospitals and those of the same category had personnel trained on FP. The percentage of first-level health facilities (IHCs and MHCs) with trained personnel is low (59.4%). This low proportion of FP-trained personnel affects the quality of services offered.



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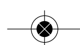


Permanent availability of EmONC services in Health Facilities

According to DHIS 2, regarding the availability of Emergency Obstetric and Newborn Care services (EmONC) in the 3rd and 4th quarters of 2020, Cameroon had a total of 124 EmONC services, equivalent to 2.21 services per 500,000 inhabitants, if the population is estimated at 28 million. The objective of the SP/RMNCH was to increase the rate of availability of EmONC services from 3 in 2014 to 5 per 500,000 inhabitants in 2020. There is therefore a performance gap of 2.79 EmONC services per 500,000 inhabitants.

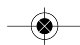
With regard to the reported availability of blood transfusion and caesarean section services per region and type of health facility, analysis of the data shows significant disparities in the availability of blood transfusion and caesarean section services per type of health facility and region. The availability of blood transfusion and caesarean section services is uneven across health facilities. One out of six health facilities offers blood transfusions, and one out of nine performs caesarean sections.

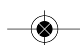
In terms of status, structures in the private not-for-profit sector stand out as offering a more comprehensive range of services, followed by the private for-profit sector and the public sector.

The South West, North West regions and Douala (Littoral) have the highest concentration of health facilities offering these types of services, highlighting geographical inequalities.

Causes of sub-optimal use of EmONC services

Women's use of EmONC services is limited by factors such as: geographical barriers (average radius of action, regional disparity); financial barriers (additional payments despite free services, including blood products, drugs price's, transport from home to the health facility); lack of information; socio-cultural barriers (limited decision-making power of the woman, influence on the decision by the husband, mother-in-law, etc.).





Service provision for child and newborn care

The performance is summarised in the table below:

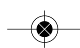
Table 11: Quality indicators for child and newborn care

Indicator	Rate
Proportion of neonatal deaths review	4%
Proportion of newborns whose cord care was performed with chlorhexidine 7.1% at birth in the health facility	33%
Percentage of personnel trained in newborn care by targeted health districts	12%
Percentage of facilities open to the public with personnel trained in newborn care 24/7	57%
Percentage of HFs complying with infection-prevention protocols in labour, delivery and neonatal wards	7%
Percentage of newborns delivered in a health facility whose birth declaration is drawn up and transmitted to the Civil Status Registration Centre	46%
Percentage of health facilities with a newborn resuscitation hospital kit	17%
Percentage of health facilities offering maternity services that have obtained BFHI (Baby-Friendly Hospital Initiative) certification	0%
Percentage of health facilities where kangaroo mother care is operational in targeted HDs	4%
Proportion of health facilities with kangaroo units	0.5%
Proportion of health facilities with newborn corners in maternity wards	0.4%
Percentage of communication professionals trained in newborn health	9%
Percentage of broadcasts on newborn health	42%
Home visits carried out to monitor newborns up to 7 days of age	0%
Proportion of households mobilised by post-partum MCHWs for mother and newborn follow-up	0%
Percentage of heads of faculties/training schools mobilised to improve training curricula on newborn health	0%
Proportion of quarterly coordination meetings on the monitoring of the implementation of the Operational Plan held by the Regional Committee for the fight against Maternal, Newborn and Child Mortality (MNCM) in the 10 regions	0%
Proportion of coordination meetings held every 6 months at the central level by the National Committee for the fight against MNCM on the monitoring of the implementation of the Operational Plan	50%
Proportion of districts with functional maternal and newborn death review committees	66%

Source: Evaluation Report of the national operational plan for newborn health 2016-2018

Provision of adolescent and youth care

According to the evaluation report of the 2014-2020 SP/MNCM, the indicator "proportion of health facilities per health district offering RMNCH services accessible and adapted to adolescents/youth" was replaced by the following proxy: "proportion of health facilities



with a service adapted for adolescent and youth health". This proportion dropped from 30.8% to 26.9% between 2015 and 2019. This reduction in healthcare service delivery points for adolescents and youth reflects the low availability of services for this target group, resulting in a high proportion of unmet needs.

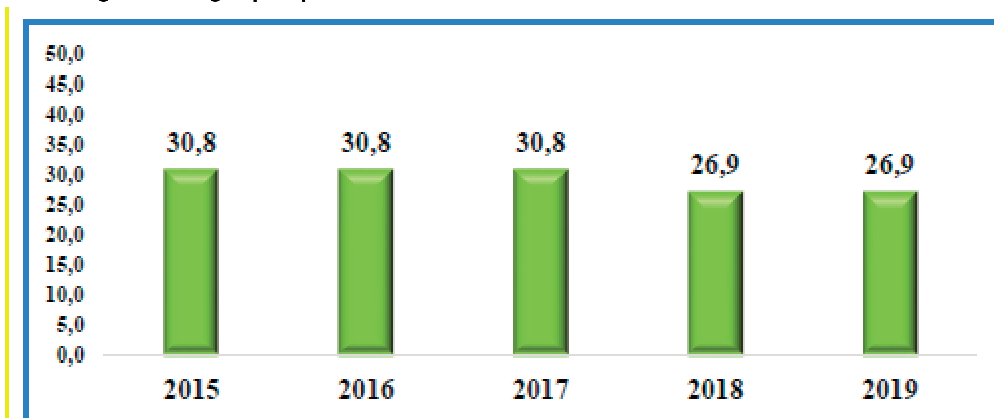


Figure 10: Levels and trends (%) of the offer adapted to adolescent and youth health (AYH)

(Source: Field data.)

Regarding the screening and appropriate management of **obstetric fistulas in young girls**, the 2014-2020 SP/MNCM targeted at least 60% of cases by 2020. According to data collected during the evaluation of this plan, the findings are described in the following table:

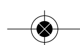
Table 12: Levels and trends in screening and appropriate management of obstetric fistulas in young girls.

Indicators	Baseline 2015 (%)	Reference Value 2019 (%)	Assessment of change (%)	Source
Percentage of health facilities that screened girls for obstetric fistula	7.7	11.5	+3.8	Field data
Percentage of health facilities that provided appropriate care for obstetric fistula in girls	11.5	15.4	+3.9	Field data

Source: 2014-2020 SP/MNCM

Provision of care for genital cancer in women and prostate cancer in men

Cameroon has adopted a National Strategic Plan for Cancer Prevention and Control for the 2020-2024 period. This strategic plan specifies the cancer awareness and screening actions to be carried out in the country. To this end, the National Cancer Control



Committee regularly organises sensitisation campaigns on modifiable cancer risk factors. These campaigns target the general public, notably on special days and events such as “Pink Month”.

In addition to the activities of the National Cancer Control Committee, civil society organisations (CSOs) also carry out cancer sensitisation campaigns. These campaigns target specific audiences, such as local communities, professional circles, schools and universities.

Since 2021, with the support of UNFPA, national screening and case management campaigns for reproductive cancers have been organised. These campaigns aim to improve access to screening and early management of reproductive cancers, which have a more favourable prognosis when detected at an early stage.

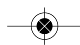
In 2015, Cameroon successfully completed the pilot phase for the introduction of the Human Papilloma Virus (HPV) vaccine for girls aged 9 to 13 years. This is one of the effective strategies for reducing the incidence of cervical cancer, which remains the second most common cancer in women. The Ministry of Public Health introduced this vaccine into the Expanded Programme on Immunisation in 2020 for girls aged 9 years. In 2023, the target was extended to 9-year-old boys. Current HPV vaccination coverage is 61% (EPI Report 2023). The cost of the bivalent and quadrivalent vaccine remains high for the Cameroonian population not targeted by EPI (FCFA 35,000 per dose).

Cameroon has no national screening programme for breast and cervical cancer. A few public hospitals and two (2) faith-based structures, notably Cameroon Baptist Convention Health Services (CBCHS) and Presbyterian Church in Cameroon Health Services (PCCHS), routinely screen and treat precancerous cervical conditions in certain towns (Bamenda, Mbingo, Kumbo, Douala, Mutengene, Kumba, Kribi, Bafoussam, Yaounde, Limbe). Sporadic screening campaigns are organized as an outreach strategy by the NCaCC and certain CSOs. However, many precancerous conditions cannot be treated due to the lack of equipment.

Concerning cancer diagnosis, medical imaging services are available in most 1st to 4th category health facilities. The basic equipment consists of a standard Os-Poumon X-ray machine and an ultrasound machine. The CT and MRI scanners recommended for cancer assessment are only available in general and central hospitals, and in 03 regional hospitals (Ebolowa, Garoua and Bafoussam). Medical imaging is developed in the private sector, but remains concentrated in the cities of Douala and Yaounde.

Cameroon no longer has a functional nuclear medicine department, as was the case at the Yaounde General Hospital between 1990 and 2000.

Cancer Management is multidisciplinary, and requires institutionalized multidisciplinary consultation meetings. In Cameroon, only the Douala and Yaounde General Hospitals have such a platform. Nonetheless, cancer management is generally already underway



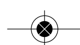
in most health facilities. Cameroon has no national guidelines for the management of the most common cancers. Aggregate statistical data on the number of cancer cases managed are not available at national level.
Since the radiotherapy services at the Yaounde General Hospital and Douala General Hospital are not functional, Cameroon currently has only one functional radiotherapy service in the private sector (Cameroon Oncology Centre, Douala), even though over 50% of cancer patients require radiotherapy for their treatment. The provision of radiotherapy services therefore falls far short of demand, and costs are high. Equipment is over-used, and waiting times are as long as 3 months. A solution is urgently needed.
Systemic cancer treatments include chemotherapy and targeted therapies. They are provided in medical oncology units. Since 2005, the Ministry of Public Health has partially subsidised the purchase of anticancer drugs. However, the budget allocated to the purchase of anticancer drugs is insufficient, as less than 10% of national needs are covered. Targeted therapies and support drugs, whose efficacy has transformed the prognosis of most cancers, are often unavailable due to their high cost.

Table 13: Health facilities with a Medical Oncology Unit

No.	Health facility	Start date of operation
1	YGH	11 June 1993
2	DGH	2012
3	YCH	2013
4	DLH	2000
5	Mbingo Baptist Hospital	2006
6	Bonassama DH	March 2017
7	Saint Martin de Porres	April 2019
8	HGOPED	March 2020
9	Mother and Child Centre of the Chantal Biya Foundation	2000

(Source: National Strategic Plan for Cancer Control and Prevention 2020-2024)

In Cameroon, palliative care is not included in either the minimum package of activities or the complementary package of activities provided by health training institutions. For the past four years, the MOH has been supporting and subsidising the Cameroon Palliative Care Conference, a platform for discussions among palliative care stakeholders in Cameroon. Very few public health facilities have a palliative care unit, and the uninterrupted supply of opioids is a recurring problem, making it difficult to manage severe pain. Holistic cancer care that includes the management of physical, psychological, social and spiritual problems of patients is not available in most health facilities.



Provision of infertility treatment for couples

Since 2016, Cameroon has been equipped with a Hospital Centre for Research and Application in Endoscopic Surgery and Human Reproduction (CHRACERH), which is dedicated to medically assisted procreation (MAP) in Cameroon. In 2022, the CHRACERH medical team declared the birth of the 300th baby at the centre since its inauguration.
There are also a number of private centres that perform MAP, but aggregate statistics on MAP activities in Cameroon are not available. The Law No. 2022/014 of 14 July 2022 on medically assisted procreation in Cameroon has been enacted.

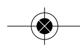
Reproductive Health and Family planning services and commodities

- Availability of essential RMNCAH-Nut commodities

According to the evaluation report of the 2014-2020 SP/MNCM, the proportion of health facilities without a stockout of essential MNCH commodities (13) for at least 03 days was 84% in 2020, against a strategic target of 90% for the same period. This probably explains the virtual stagnation in contraceptive prevalence in Cameroon over the past two decades.

- Availability of modern contraceptive methods

Assessing the availability of contraceptives is a crucial element in measuring access to family planning. Insufficient availability of contraceptives can lead to a reduction in their use and, consequently, an increase in unwanted pregnancies and unsafe abortions, thus contributing to an increase in maternal mortality.
The evaluation report of the 2014-2020 SP/MNCM analysed the percentage of health facilities that had not experienced a stock-out of at least three modern contraceptive methods in the last three months. This analysis was carried out taking into account the different categories of health facilities, namely Integrated Health Centres (IHCs), Medicalized Health Centres (MHCs), Regional Hospitals and District Hospitals.
A study carried out in 2020 by UNFPA on the availability of contraceptives and vital maternal health products at service delivery points in Cameroon revealed worrying disparities. The analysis shows that 49.2% of Integrated Health Centres (IHCs) and Medicalized Health Centres (MHCs) have not experienced a contraceptive stock-out in the last three months. This percentage is 54.8% for Regional Hospitals and decreases to 46.2% for District Hospitals. These figures show that nearly half of all health facilities in Cameroon are experiencing stock-outs of contraceptive products.
This low availability of contraceptive products reduces their rate of use and, consequently, the contraceptive prevalence in family planning, which is one of the pillars of the reduction in maternal mortality.



- Availability of health facilities offering modern contraceptive methods

The proportion of health facilities offering at least 03 modern contraceptive methods increased from 81.8% to 94.6% between 2014 and 2018, representing an equivalent to a performance improvement of +12.8%. However, regional disparities remain, highlighting the need to step up action in certain areas.

Management of nutritional disorders

National nutrition priorities currently focus on interventions targeting newborns, children and, to some extent, pregnant women. Apart from the provision of iron and folic acid supplementation, interventions targeting adolescents, non-pregnant women of childbearing age and pregnant women have been given less attention. Furthermore, the health sector currently lacks a strategic plan that defines the objectives and areas of intervention in the field of nutrition. Recommendations on maternal and adolescent nutrition are incomplete, fragmented and published in different documents, and are not systematically updated in line with changes in scientific evidence. Consequently, in view of the crucial life stages of adolescence and motherhood, this 2024-2030 RMNCAH-Nut National Strategic Plan aims to draw up a comprehensive inventory of key interventions to fight against malnutrition in women, namely:

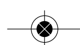
- Counselling on healthy and balanced nutrition for mothers, infants and children in health facilities and during outreach strategies;
- Micronutrient enrichment of staple foods and condiments;
- Iodisation of cooking salts;
- Institutionalisation of the 10 steps for successful breastfeeding in health facilities;
- Iron and folic acid supplementation (IFAS) for pregnant women, adolescents, menstruating women and post-partum women.

❖ *Human resources involved in RMNCAH-Nut*

- Initial training and production of RMNCAH-Nut human resources

Cameroon trains more than 5,000 paramedical staff each year, as well as about 600 general practitioners and specialists (paediatricians, obstetricians and gynaecologists, radiologists, oncologists, etc.) working in the areas of RMNCAH-Nut (DHR/MOH).
Specialising in the care of pregnant women and newborn babies, midwives are key actors in reproductive health. They provide comprehensive support throughout pregnancy and the post-partum period, helping to improve maternal and child health.

Midwives are an essential resource for reproductive health. To build capacity in maternal and child health, 1,644 midwives and birth attendants were trained between 2014 and 2020 (DHR/MOH), to help improve the use and quality of RMNCAH care and services.



- Recruitment of Human Resources for RMNCAH-Nut

Despite a general situation characterised by a low rate of recruitment of health workers on the job market, both in the public and private sectors, leading to unemployment and an exodus of professionals to other countries, it is important to highlight the significant effort made by the government to strengthen human resources in maternal and child health. The Ministry of Public Service has recruited 325 midwives and birth attendants for the Ministry of Public Health in 2018 and 2019:[15][16]

- Availability of human resources for RMNCAH-Nut

Public health facilities are facing a shortage of human resources, particularly concerning specialised personnel (RMNCAH-Nut). The last exhaustive census of healthcare personnel dates back to 2011, which makes it impossible to accurately assess the current shortage of qualified human resources in this crucial area.

- Continuous training of RMNCAH-Nut personnel and stakeholders

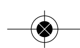
Continuous training of RMNCAH-Nut personnel is not always effective. There is little aggregated data at national level on this aspect. For example, the proportion of staff trained in programme and project management in the field of Adolescent and Youth Health (AYH) is low and varied little between 2015 and 2019 (from 19.2% to 26.9%). (Evaluation report of the strategic plan of Adolescent and youth reproductive health)

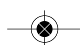
❖ *RMNCAH-Nut Financing*

Total health expenditure (THE) increased from FCFA 821 billion to FCFA 874 billion between 2018 and 2019, an increase of 7%. As a percentage of GDP, Total Health Expenditures remained stagnant at around 4% during the same period. Out-of-pocket expenditure remains the main source of funding for healthcare. Over these two years, households contributed about 71% of Total Health Expenditures. State contribution increased from FCFA 93 (11%) to 118 billion (14%) between 2018 and 2019, while the contribution of multi- and bi-lateral partners between these two years was about FCFA 115 (14%) and 111 billion (13%), respectively. (Ref: NHA p18).

[15] Decision No. 000789 MINFOPRA/SGIDDRHE/SDC/SCDB of 27 May 2020

[16] https://www.edukamer.info/minfopra-resultats-definitifs-du-recrutement-de100-sages-femmes-maieuticiens-2022/





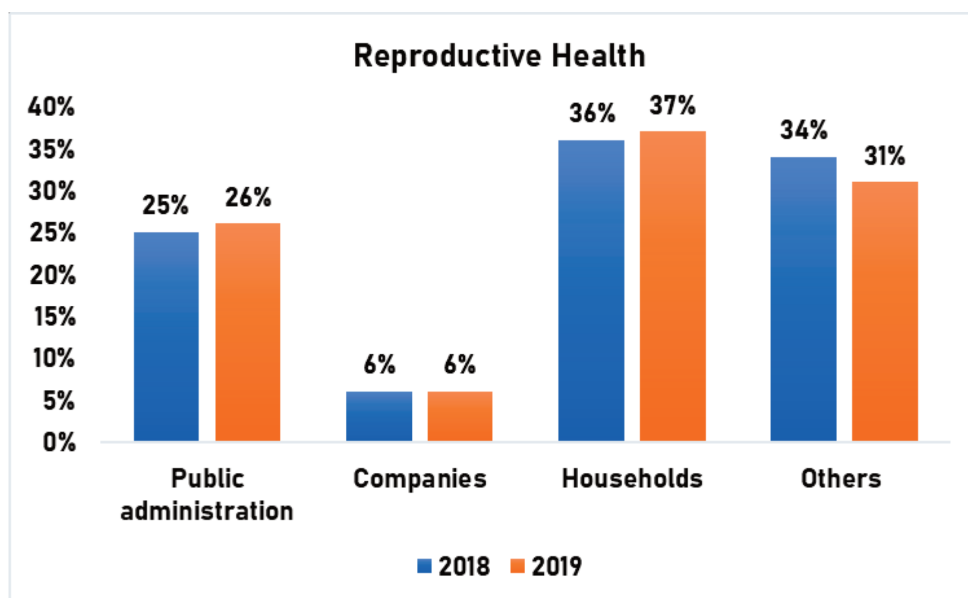


Figure 11 : Evolution of the total health expenditure (in %) per source of funding from 2018 to 2019

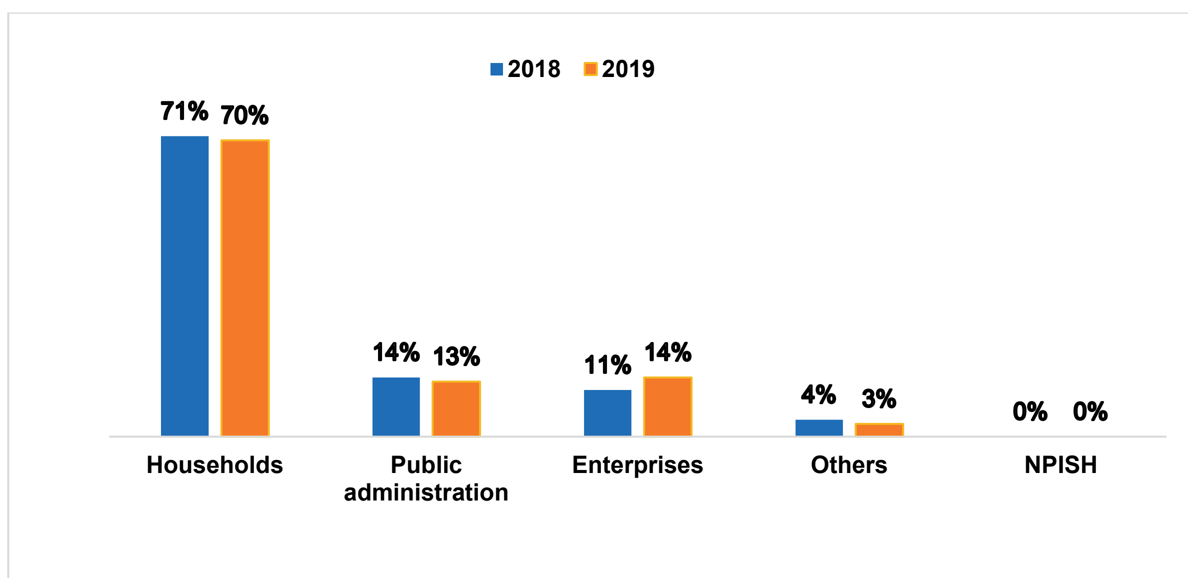


Figure 12 : Evolution of the total health expenditure per source of funding from 2018 to 2019

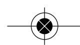


Table 14: Evolution of Current Health Expenditure per Disease Category according to CIM 10 over the period 2018-2019 in FCFA

Disease Category	2018	%	2019	%
Infectious and Parasitic Diseases	375,717,919,810	47%	423,996,295,761	50%
Reproductive Health	94,147,950,737	12%	82,281,688,193	10%
Nutritional Deficiencies	15,859,946,207	2%	24,331,040,478	3%
Non-Communicable Diseases	75,126,444,217	9%	70,770,541,921	8%
Trauma	5,277,145,637	1%	5,797,816,583	1%
Other Diseases/Conditions and Diseases/Non-Specified Conditions (n.e.c.)	237,564,852,967	30%	241,583,326,925	28%
Current Health Expenditure (CHE)	803,694,259,575	100%	848,760,709,860	100%

Source: Cameroon Health Accounts for 2018 and 2019, March 2023

The highest expenditure was on Infectious and Parasitic Diseases, with FCFA 375 billion in 2018 and FCFA 423 billion in 2019 (that is an increase by 13%), respectively accounting for 47% and 50% of the Current Health Expenditure of each respective year. Expenditure on Other Non-specified Diseases/Conditions, although down from FCFA 327 billion in 2018 to FCFA 241 billion in 2019 (that is, a decrease by 3%), represents the second highest item of expenditure, accounting for 30% of CHE in 2018 and 28% in 2019[17].

The allocation of State resources for RMNCAH shows a changing trend, marked by a sharp decline between 2018 and 2022. In fact, State contributions peaked at FCFA 4.22 billion in 2018 before plummeting to FCFA 0.36 billion in 2022.

[17] Cameroon Health Accounts report, 2018 - 2019

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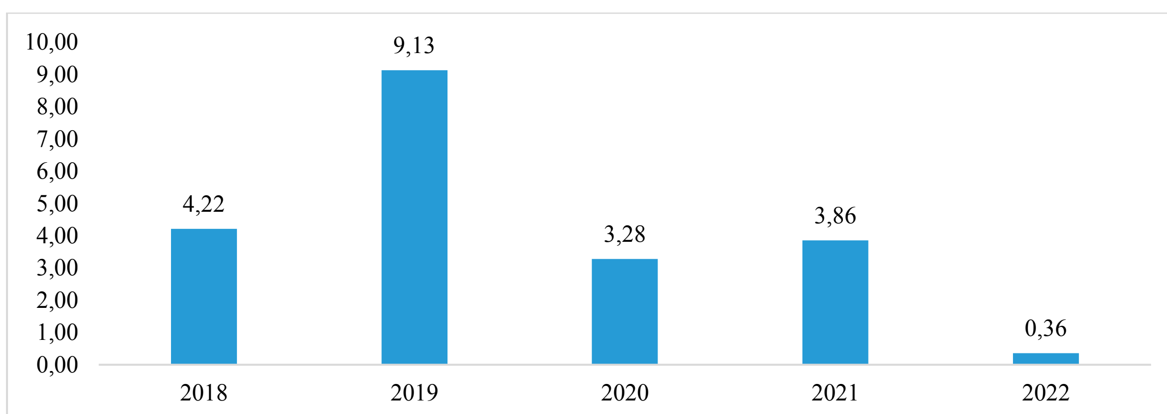

Figure13: Evolution of State contribution (in billions of FCFA) to RMNCAH-Nut over the period 2018-2022

Source: RMNCAH-Nut resources mapping, 2021 PLMI/MOH

Concerning donors, their contributions increased between 2018 (32.16 billion) and 2021 (47.54 billion), and decreased between 2020 and 2022 (12.20 billion), (Figure 14). It is worth noting that only the first quarter of 2022 was considered when collecting the budget data.
The analyses also show that the main TFP contributions (Graph 16) come from the GF (24.9%), USAID (20.3%), AFD (17.9%) and PEPFAR (11.7%).

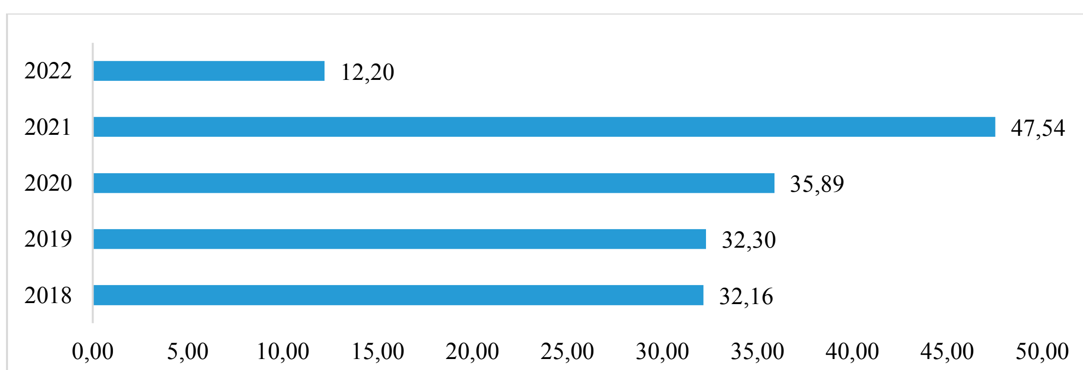

Figure14: Evolution of TFP contribution (in billions of FCFA) to RMNCAH-Nut over the period 2018-2022

Source: RMNCAH-Nut resources mapping, 2021, PLMI/MOH

Many other technical and financial partners are making low contributions to improving the health of women, children and adolescents.

Globally, resources allocated for health in general and RMNCAH in particular are insufficient.

Table 15: Current Health Expenditure on Reproductive Health per source of funding over the period 2018-2019 (FCFA)

	DHIS.2 Reproductive Health			
	2018	%	2019	%
Public Administration	23,427,690,193	25%	21,213,960,774	26%
Enterprises	5,539,858,008	6%	5,323,780,381	6%
Households	33,572,398,283	36%	30,540,437,705	37%
Bilateral and multilateral partners	31,608,004,253	34%	25,203,509,333	31%
TOTAL	94,147,950,737	100%	82,281,688,193	100%

Source: Cameroon Health Accounts for 2018 and 2019, March 2023

Current Health Expenditure related to Reproductive Health decreased by 13%, from FCFA 94,147,950,737 in 2018 to FCFA 82,281,688,193 in 2019. Resources allocated for Reproductive Health mainly come from Households (36% in 2018 and 37% in 2019), Bilateral and multilateral partners (34% in 2018 and 31% in 2019) and Public Administration (25% in 2018 and 26% in 2019).

f. Improvement of financial accessibility to RMNCAH-Nut services

Regarding Maternal Health and Family Planning, the State and its Technical and Financial Partners developed financial mechanisms to enhance supply and boost demand, such as the “Performance-Based Financing” (PBF), “Obstetric Kits” and “Health Voucher” projects that are briefly described here.

➢ ***Obstetric Kits project***

The actions of this project mainly focused on: (i) the provision and use of delivery plans and partographs for a better planning and monitoring of labour, (ii) the pre-positioning of delivery and c-section kits for a prompt management of obstetric emergencies, and (iii) the active management of the 3rd phase of labour to reduce post-partum haemorrhage risks.

All these actions were accompanied by (i) the building of capacities of health staff, (ii) sensitization activities and community mobilisation, and (iii) the auditing of maternal deaths in health facilities. In Cameroon, the strategy for the pre-positioning of Emergency Obstetric Kits was initially developed as part of the “*Projet d'Approche*

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Solidaire en Santé Génésique (PASSAGE)" implemented in the northern regions since 2011.
According to the managers of the Health Solidarity Fund, the implementation of this strategy (pre-positioning of Obstetric Kits) mainly benefited women users. Apart from their financial contribution for the purchase of Obstetric Kits (OK), they should not be required to pay any other fees, except fees related to a possible blood transfusion. Unfortunately, no report to date provides enough information on the outcomes and impacts of implementing this strategy.
In the Survey on Care Providers' Satisfaction with the Implementation of Emergency Obstetric Kits in Maroua Health Districts[18], it was found that delivery rates in health facilities had increased by more than 70% six months after introducing the use of OK .

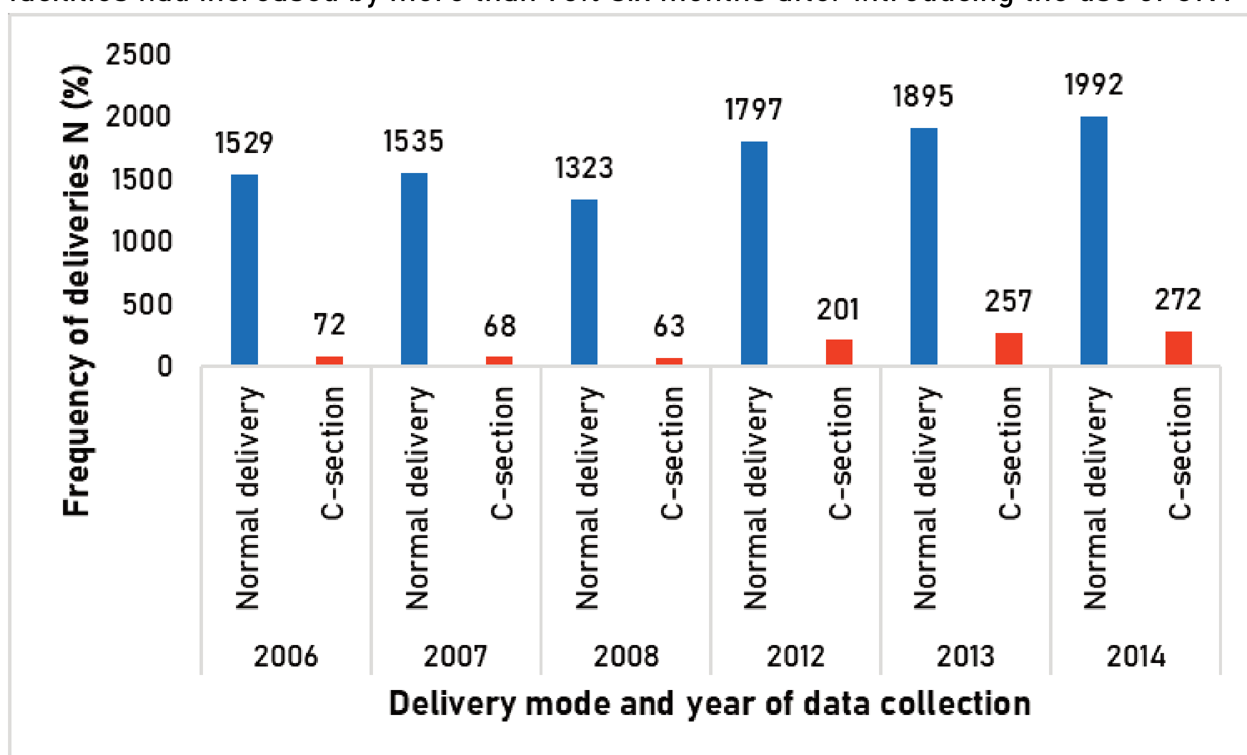

Figure 15 : Annual frequency of simple deliveries and c-sections at the Maroua Regional Hospital before (2006-2008) and during the use of SOK (2012-2014).

Despite its positive effects on the beneficiaries, the obstetric kits OK project, according to the authors, faced major challenges which negatively impacted the financial motivation and the morale of health personnel, as well as the financial viability of health facilities. These obstacles may ultimately compromise the quality of care.

[18] Réduire la mortalité maternelle au Cameroun. Stratégie de pré-positionnement des « kits obstétricaux », Dr Dominique LANDREAU, MINSANTE, 2013.

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Health Voucher project

Considered by leading authorities to be the first step towards Universal Health Coverage (UHC), health voucher also known as "gift voucher" is a prepayment mechanism designed to help reduce neonatal and maternal mortality through a better management of pregnant women. This mechanism entails the implementation of a prepayment system which allows for complete pregnancy follow-up, a safe delivery and postnatal follow-up for up to 42 days after delivery. "The pregnant woman, holder of a health voucher purchased at FCFA 6 000, receives all care included in the voucher free of charge, in all Health Voucher project accredited health facilities".

It is worth recalling that the actual cost of the health voucher is FCFA 60,000 and that FCFA 54,000 are paid by the French Development Agency (AFD) and the German Development Bank (KfW). The Health Voucher project is an initiative of the Government of Cameroon, which was launched thanks to a joint financing from AFD and KfW, initiated in May 2015 to initially cover the three northern regions of Cameroon.

The project intended to improve access to obstetric and neonatal care by financially supporting demand for care through a subsidy for healthcare services. It also provided a set of maternal and newborn health services provided by accredited health centres and hospitals.

The Health Voucher project was therefore implemented within a context where financial determinants for accessing care, in particular Emergency Obstetric and Neonatal Care (EmONC), were disproportionately higher and worrying with regard to the standard of living of the population.

For instance, the cost of a normal delivery stood at FCFA 15 260, that of episiotomy at FCFA 32 813, while the fees for surgical interventions were about FCFA 30 000 in the northern region.

These tariffs represented a high financial burden for the most vulnerable populations, and they are "three times greater than the average monthly income of the first poverty quintile".

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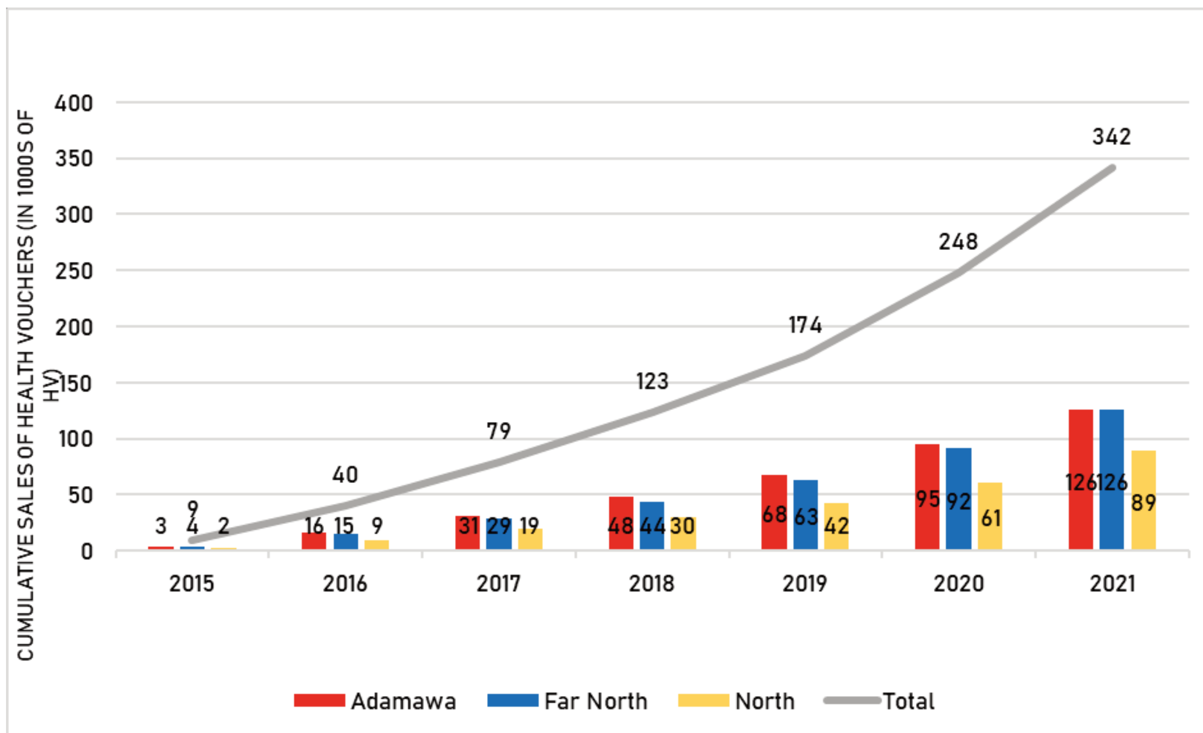
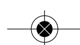


Figure 16: Cumulative Sales of Health Vouchers per year and per region

Source: Final Report of the MOH/AFD/KFW Joint Programme

According to the Final Report of the MOH/AFD/KfW Joint Programme, 173,000 vouchers were sold by the end of 2019 since 2015, but the number hit 250,000 by the end of 2020, then 340,000 by the end of 2021. The sales rate for 2022 was projected at 170,000 sales (85,454 during the first half), beyond the target of 150,000 units. The Joint Programme Coordination Unit managed to push the acceptance rate among pregnant women upwards, at 55% for the three regions in the first half of 2022, by comparing the number of health vouchers sold to the number of pregnant women expected in these regions. Among women who purchased health vouchers, the utilisation rate is very high: 86.17% use them for their first antenatal care (ANC1). This achievement is reflected in the actual take-up rate of about 50%. These figures suggest a real impact of the health voucher system on the pregnancy follow-up rate in the three regions, even though only 13.29% of deliveries are actually carried out under health vouchers. This implies that women who use health vouchers mainly use them for antenatal care.
Finally, according to an exploratory survey[33] carried out among some national and foreign stakeholders involved in the project suggests four main difficulties which would impact on the operationality of the programme: the persistence of cultural resistances (e.g., use of traditional birth attendants), administrative delays in reimbursing treatment



fees, the inability of health facilities to provide the required technical platform, and the difficult reconciliation of strategies implemented by the various stakeholders.
The Health Voucher project ended its activities late 2022. The strategy was capitalised by the Government of Cameroon as part of the implementation of Phase I of the UHC.

➢ *Performance-Based Financing (PBF) and RMNCAH-Nut*

One of the major objectives of the Health System Strengthening Performance Project (HSSPP) in Cameroon is to improve maternal, child and adolescent health through the PBF approach. PBF contributed to the improvement of RMNCAH data through the purchase of quantitative outputs previously verified by the regional Contract Development and Verification Agencies (CDVA). This funding also contributed to the evaluations of the quality of services, carried out by intermediate and operational regulators".
A study conducted by the Department of Family Health in 2021[19] revealed that PBF contributed to assess the status of RMNCAH-Nut indicators on the ground and to take appropriate decisions to improve the health system performance (particularly in maternal, child and adolescent health).

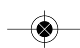
➢ *Universal Health Coverage (UHC) Project*

The First Phase of the Universal Health Coverage project was officially launched on 12 April 2023 in Mandjou, in the East Region, by the Minister of Public Health. The aim is to "provide Cameroonian population with quality healthcare which is accessible to all".
In phase 1, UHC targets children under 5 years of age, pregnant women and persons of all ages suffering from diseases such as kidney failure, tuberculosis and HIV. The care basket covers preventive, promotional and curative aspects. This will be scaled up over time to cover the entire population.

e. Health Information System and RMNCAH-Nut data

Many key RMNCAH-Nut indicators are provided by major demographic health surveys, such as DHS 2018, which is the most recent one. The DHIS 2 database has been operational at the MOH since 2018. It helps to inform the routine data of Health Districts, primarily collected from the Monthly Activity Reports (MAR).
However, several routine data items are missing from the DHIS 2 system, and those available are sometimes of poor quality (low data reporting rate). Sustained efforts are

[19]Contribution of PBF to the progress of RMNCAH indicators. Rapport d'analyse des données issus du portail PBF volet sante mère, enfant et adolescent. DSF/MINSANTE, 2021.



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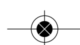


needed to improve the quality and completeness of this data in order to strengthen the monitoring and evaluation of maternal, newborn and child health programmes.

For example, the following 03 indicators are not captured in the various 2018 DHS reports and the DHIS 2 database:

- Proportion of premature newborns who reach the age of 01 year (2020 target: 30%);
- Rate of premature births among live newborns (NSP/RMNCAH-Nut target: reduce from 10% in 2014 to 5% in 2020);
- Percentage of health facilities with no shortages of newborn resuscitation kits (target: 50% in 2020).

It is also regrettable that deaths and their causes are not systematically reported and recorded in the DHIS 2.

Furthermore, epidemiological surveillance of cancers, which is essential for decision-making in the fight against cancer, is no longer effective in Cameroon since 2012, when the use of the Yaounde cancer register was discontinued. However, some data on suspected cases of breast, cervical and prostate cancers is included in the DHIS 2.

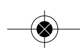
Only 61% of newborns are registered at birth in Cameroon. The lowest registration rates are found in the Far North (38.2%) and East (56%) Regions[20].

f. Securing reproductive health products

According to the Reproductive Health Commodity Security Strategic Plan 2022-2026, the factors contributing to the weakness of the reproductive health products supply system include the following:

- Recurring stock-outs in central and regional warehouses, reflecting shortcomings in the drug procurement process;
- Insufficient qualified human resources;
- Insufficient logistical data;
- Insufficient cost recovery;
- Multiple supply channels.

[20] Report on best practices and concrete measures to guarantee access to birth registration, ANAPRODH, https://www.google.com/search?q=Enregistrement+universel+des+naissances+au+Cameroun&client=firefox-b-d&ei=Q2qVZJ_LLt6nkdUP3M-AkAk&ved=0ahUKEwjf0GIjtn_AhXeU6QEHdwnAJIQ4dUDCA8&uact=5&oq=Enregistrement+universel+des+naissances+au+Cameroun&gs_lcp=Cgxnd3Mtd2l6LXNlcnAQAzIFCAAQogQyBQgAEKIEOgQIABBHOgYIABAHEB5KBAhBGABQsQ5YxSlgIzloAHACeACAAfMBiAGyEJIBBjAuMTEuMpgBAKABAaABAsABAcgBCA&sclient=gws-wiz-serp#ip=1



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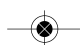


In addition, CENAME, which has difficulty satisfying its customers (16%), should benefit from specific support measures to make it more competitive and capable of retaining its main customers (the Regional Fund for Health Promotion (RFHP)).

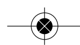
Faced with these challenges, the Government of Cameroon, through the MOH, with the support of TFPs, has undertaken a number of initiatives, such as:

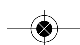
- The development of regulatory instruments (decision governing the organisation and functioning of SYNAME, Decision No. 5367/D/MINSANTE/SG of 20/12/2023 to make enforceable the SOPs related to the integration of oxytocin into the EPI cold chain);
- The automation of management data, the setup and deployment of the electronic Logistics Management Information System (eLMIS) in supply chain structures;
- The revision of the standard operational manual for the management of drugs and other health products;
- The Country Compact, which is a strategy to finance reproductive health products, with the government contributing 5% in the first year (2023) and an additional 1% each year.

Appropriate pricing, which takes into account the costs involved in providing services, is essential to ensure a sustainable supply of contraceptives. At the same time, efforts made by authorities to regulate prices with drug approval help to stabilise the market and ensure that products are accessible. This social approach allows to obtain significant price reductions from manufacturers of generics and specialties. Drugs are also exempt from customs duties, VAT and IT tax, all measures designed to make them more affordable.

Despite these incentives, local production of drugs remains low. Indeed, Cameroon is below (3.56%) the African average for purchases of local drugs (11.69%). This low local production of drugs can be explained by low competitiveness among local producers compared to international competitiveness due to the high cost of production factors (obtaining finance from banks, energy, customs, transport), and by low commitment from the State. In addition, a significant share of the population continues to buy illegal pharmaceutical products on the street.

The high cost of drugs and the absence of a universal health insurance system are pushing the populations and stakeholders towards counterfeit and poor-quality street drugs. The sector is also experiencing difficulties in the drug management system in terms of supply, storage, distribution, supervision, monitoring-evaluation, pharmacovigilance and quality control.





3.3.1.2 Response from other public institutional stakeholders

Several public administrations are involved in activities related to RMNCAH-Nut. However, access to documents on their interventions is still limited. The following administrations have been identified: MINPROFF, MINEDUB, MINESUP, MINJUSTICE, MINJEC, MINESEC.

a. Development of strategic documents related to RMNCAH-Nut

The document review enabled to find a few strategic documents in some public administrations, including:

- The National Strategy for the Fight against Gender-Based Violence in Cameroon, MINPROFF, 2021-2026;
- The Budgeted Multi-sector National Action Plan for the Abandonment of Child Marriage in Cameroon, 2020-2024, UNICEF and MINPROFF;
- The National Action Plan for the Elimination of Female Genital Mutilation in Cameroon, 2022-2026, MINPROFF.

b. Actions related to Family Planning

In the Evaluation Report of the 2014-2020 NSP/RMNCAH-Nut, interviews with officials from other sectors (MINEDUB, MINESUP, MINJUSTICE, MINJEC, MINSEC), revealed that sensitization and the distribution of condoms to their target population are the most frequently carried out FP interventions.

c. Actions to prevent GBV and Harmful Cultural Practices

These have mainly been carried out by MINPROFF:

- *Legal framework*

There is a set of national and international legal instruments that punish the perpetrators of GBV. However, one may deplore: (i) the unawareness of the population of the rights and mechanisms for defending and protecting GBV victims, (ii) the high cost and delays in court procedures, (iii) poor collaboration among sectors and (iv) corruption.

- *Production of communication materials*

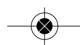
A "Guide to the medical and psychosocial management of GBV and HP survivors" was developed, which is due to be updated as part of the implementation of the Regional SWEDD project in Cameroon. Also, the "Practical guide for gender integration in the daily interventions of psychosocial workers" was developed by the NGO "FESADE" with the technical and financial support of UN WOMEN.

- *Advocacy to end GBV and Harmful Cultural Practices*

Advocacy actions are geared towards members of parliament, including REFAMP (network of women ministers and members of parliament), council officials in high-prevalence areas, traditional and religious leaders (including priests, pastors, etc.), to boost their commitment and increase local initiatives to eliminate these scourges.

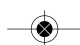
- *Capacity building for stakeholders*

To prevent gender-based violence (GBV), many capacity-building activities were organised in several regions:



- Capacity building for 100,000 adolescent boys and girls on Comprehensive Sexuality Education (CSE) in schools, out of schools and in communities in the 03 northern regions (Far North, North, Adamawa), the East region and in humanitarian zones with a view to preventing GBV.
- Capacity-building for 501 social workers (State devolved services, health personnel, magistrates, law enforcement officers, community private structures, CSOs, etc.) on listening and sensitisation techniques, community approaches to the management of GBV cases, psychosocial care and case management tools;
- Capacity building for 150 actors in adolescent reproductive health, including 50 trainers of trainers (10 Regions), 8 service providers and 20 supervisors, as well as for 105 adolescent/youth peer counsellors;
- Training of 1,096 teachers on the topic of Gender-Based Violence.
- Community sensitization to end GBV and Harmful Cultural Practices:
- Facilitation of 4,420 educational talks, 15 radio programmes, 25 round tables and conferences on the factors and consequences of Gender-Based Violence and the remedies available, for 2,510 people, including 1,790 women and girls, as part of the "16 days of activism to end violence against women" campaign.
- Creation of 36 men's clubs committed to the fight against maternal mortality, GBV and Harmful Cultural Practices. The members of these clubs (360) sensitised the community on these issues and reached out to about 13,500 household members in the East and Centre regions.
- 31,479 students in 10 schools in the Adamawa Region were sensitised by peer educators on the development of responsible behaviours to prevent violence and drug use. 18,438 students were also sensitised by peer educators in the East region;
- A total of 689 adolescent and young girls and boys were sensitised on GBV, HIV and FP in schools in the Mfoundi, Mefou-Akono, Nyong-Ekele and Mifi Divisions.

Many actions to fight against female genital mutilations were carried out by the Government of Cameroon, with the support of development partners and civil society organizations such as: ALVF, AFFADA, ALDEPA, CIPCRE, ACAFEJ, ACAFEM, ARF, IAC Cameroon, AJSB etc., religious leaders (CIDIMUC,), community leaders and the Inter-



African Committee on the Fight against Harmful Cultural Practices (CI-AF). The results of these actions enabled to popularize these issues. These actions focused on advocacy and legislation, sensitisation, study/research and training.

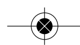
The existence of a Department of Family Health dedicated to vulnerable target populations in the MOH organisational chart shows the Government's determination to address their problems. In addition, Cameroon has signed a framework agreement with the UNHCR on the management of refugees in public health facilities; and a national strategic plan for the management of refugees within the national health system has been developed for 2021-2025 period.

3.3.2 Actions by technical and financial partners

Generally, the favourable trend in maternal health indicators shows the effectiveness of high-impact interventions implemented on the ground with the support of major projects such as the PRPSS/PBF (WB-GFF), the AFD/KFW joint programme (health vouchers), PASMNI (IDB), PASSaR (GIZ-KFW) and projects run by UNFPA and UNICEF.

3.3.3 Community participation

This section is intended to provide an overview of the community response as expressed through the involvement of community participatory bodies, multipurpose community health workers (MCHWs) and NGOs/associations. Very little aggregated data at regional or national level is available on the community response to RMNCAH-Nut.
Due to low community involvement and the limited material, financial, human and organisational resources of the community system to support maternal health and family planning interventions, there was no community response as regards the coordination and follow-up of the Roadmap for the Reduction of Maternal, Newborn and Child Mortality 2008-2015 at both central and regional level, or even in HDs.
Community-based organisations, including Health Committees (HCs) in health areas, have not been sufficiently involved in the implementation of the Roadmap, the promotion of RMNCAH-Nut activities, and the strengthening of its information system, particularly the monitoring of births and deaths. Data on activities carried out at community level are not always coordinated and not sufficiently documented, and are not often reported in the NHIS. Home visits were irregular and did not allow to follow up irregular attendees and lost-to-follow up for ANC, PNC and immunization.
Concerning social mobilisation for the Adolescent and Youth Reproductive Health: the proportion of personnel trained and involved in IEC/CBC/C4D communication in relation to AYH has almost doubled during the implementation period of the NSPAYH 2015-2020, increasing from 26.9% in 2015 to a peak of 50.0% in 2019.



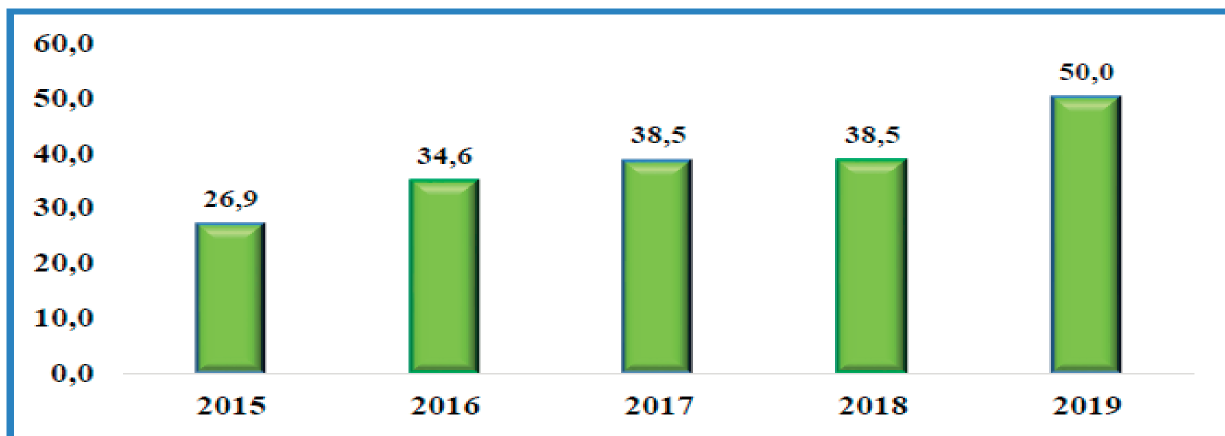


Figure 17: Distribution (%) of personnel trained and involved in IEC/CBC/C4D communication over the period 2015-2019

(Source NSPAYH 2015-2020)

Sensitisation activities should be carried out among adolescents and youth on: early pregnancy, sexual violence, risks associated with multiple partners, early sexual intercourse, contraceptive methods, STIs, obstetric fistulas, unsafe abortions as well as drugs and other addictive substances. The field survey conducted during the evaluation of the plan shows that few sensitisation activities were carried out during this period[21]. In addition, for most health problems affecting adolescents and youth, there were significant disparities in the proportions of stakeholders who carried out sensitisation activities. Sensitisation activities on STIs and the use of modern contraceptive methods were the activities most frequently carried out (50% and 46.2% of the stakeholders surveyed respectively)[29]. Furthermore, only 3 out of 20 stakeholders (15.4%) interviewed said that they had carried out several sensitisation activities related to obstetric fistula in 2019. This proportion has nevertheless increased significantly compared to the reference year of 2015 (3.8%), despite some obstacles related to high financial dependence on donors, low involvement in health programmes by the youth and sociocultural stereotypes.
During this survey, one TFP said that they had trained 450 peer educators in implementing activities for behaviour change with community associations.

3.3.4 Private sector activities

The private sector, through its outpatient and inpatient services, biological investigations and medical imaging, distribution and dispensing of drugs and pharmaceuticals, and training, covers more than 50% of healthcare services and contributes to the reduction

[21] National Strategic Plan for Adolescent/Youth Health 2015-2020

of maternal mortality[22]. Unfortunately, this contribution, which is poorly documented, does not always meet the requirements for the transfer of powers by the State, which are: compliance with the rules and regulations in force governing the opening and establishment of health facilities, compliance with health policy and strategies implemented in the context of maternal health and family planning, compliance with guidelines as well as standards and procedures in the provision of services and training, and participation in strengthening the NHIS, including the monitoring of maternal deaths.

3.3.5 Stakeholders perception of the implementation of the 2014-2020 RMNCAH-Nut Strategic Plan and SWOT analysis

3.3.5.1 Results of interviews with key RMNCAH-Nut stakeholders

As part of the development of this strategic plan, a team of health experts conducted targeted interviews with some of the key stakeholders involved in the RMNCAH-Nut in Cameroon in order to gather their opinions on the expired 2014-2020 RMNCH Strategic Plan and its implementation. The stakeholders surveyed included high-level experts from the MOH (07), MINJEC (01), MINPROFF (01), MINFI (01), TFPs (05) and a CSO representative (01). Among other things, this survey enabled to:

- Determine the main areas of intervention of stakeholders involved in the RMNCAH-Nut and the objectives to be achieved;
- Assess stakeholders perceptions of the level of priority given to the RMNCAH-Nut at national level;
- Assess stakeholders perceptions of the level of resources mobilised to implement RMNCAH-Nut interventions;
- Draw up a SWOT analysis on the organisation of RMNCAH-Nut;
- Identify the main challenges related to the fight against maternal, newborn and child mortality and to RMNCAH-Nut;
- Identify bottlenecks in accessing RMNCAH-Nut care and services;
- Appreciate best practices in RMNCAH-Nut;
- Identify appropriate strategies and high-impact interventions to be included in the new NSP.

At the end of this evaluation, the main results were as follows [23]:

- Eight RH components were adapted to the needs of the target populations.

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[22] National Multi-sector Programme to Combat Maternal, Newborn and Child Mortality in Cameroon Strategic plan 2014-2020

[23] Evaluation Report of the NSP/RMNCAH 2014-2020, MOH, 2021.

- The survey enabled to determine the areas and components of RMNCAH-Nut benefiting from the highest number of interventions carried out by health system stakeholders (maternal and child health, FP, etc.);
- The Government will therefore have to extend its focus to neglected areas or components such as "the management of the reproductive health of the elderly", or entrust them to new stakeholders wishing to invest or work in RMNCAH-Nut.

With regard to the priority given by the State to RMNCAH-Nut, all of the respondents (20) acknowledged that the State gives high priority to RMNCAH-Nut. This is justified by the existence of a Department of Family Health, a Programme to fight against Maternal and Child Mortality, a National Multi-sector Committee to combat Maternal Mortality, the recruitment of midwives/birth attendants to increase the availability of HRH in health facilities, and the introduction of UHC, health voucher and obstetric kits as mechanisms for subsidising RMNCAH-Nut services. In addition, RMNCAH-Nut appeared to be an important issue and one of the national priorities identified in the country's strategic documents (NSD 30, HSS, NDHP, etc.). Most (3/5) of the TFPs interviewed considered that the level of priority given to RMNCAH-Nut was "average" because of the mismatch observed between the discourse of political/institutional leaders and the level of funding mobilised for RMNCAH-Nut.

According to the interviewees, one of the main challenges towards achieving the objectives of RMNCAH-Nut is therefore the sustainable mobilisation of adequate funding to improve the RMNCAH-Nut indicators.

In addition, a number of other organizational bottlenecks (e.g. poor coordination of RMNCAH-Nut interventions at all levels of the health pyramid) and structural bottlenecks (low funding, inadequate quantity and quality of human resources) were identified by the stakeholders interviewed.

The strengths, weaknesses and challenges identified by the stakeholders interviewed for the improvement of RMNCAH-Nut are set out in the SWOT analysis.

Despite these shortcomings, and despite the slowdown observed in the implementation of the plan in 2020 due to the COVID-19 pandemic, the effectiveness of the 2014-2020 NSP/RMNCH is estimated at 70%, with good performance, according to the evaluators, particularly with regard to the strengthening of community health. This result was achieved through various strategies, such as building the capacities of providers, equipping health facilities, providing motorbike ambulances and making commodities available, and also through the contribution of EmONC monitoring.

According to the evaluators, the implementation of the 2014-2020 NSP/RMNCH has undoubtedly contributed to the reduction of maternal (782 to 406 per 100,000 LB), newborn and infant (122‰ to 80 ‰ LB) and child (62‰ to 48‰) death rates. It has also contributed to improved monitoring of indicators, promptness in corrective actions, review of maternal and perinatal deaths and implementation of recommendations. The

implementation of the 2014-2020 NSP/RMNCH activities also yielded a number of shortcomings such as: the centralisation of activities and resources, delay in the implementation of activities, failure to respect deadlines while implementing the programme, and the instability of human resources in the field.

3.3.5.2 SWOT analysis OF RMNCAH-Nut Interventions

The table below shows issues relating to the supply, demand and governance of RMNCAH-Nut.

Areas	Strengths	Weaknesses	Opportunities	Threats
Access to and use of services		• Inaccessibility of RH services for adolescent girls in some Districts; • Low availability of services dedicated to adolescents in health facilities; • Limited access to healthcare for some communities and targets (vulnerable populations, especially adolescents under 16 years);	• Implementation of the Health Voucher project in the North, East and South regions. • Implementation of Phase I of Universal Health Coverage;	• Insecurity in the Far North (Boko Haram), East and Adamawa (influx of Central African refugees), North West and South West regions, which hinders access to RMNCAH-Nut care and services;
Service provision	• Technical platforms available and acceptable in some health facilities; • Availability of trained staff (EmONC, ENC, IMCI, FP, ARH, etc.) • Progressive appropriation of some priority maternal, newborn and child health	• Lack of regular capacity-building for RMNCAH-Nut staff; • Lack of standards and procedures documents that has an impact on the quality of management of RMNCAH-Nut issues in health facilities;	• Implementation of the Health Voucher project in the North, East and South regions. • Existence of obstetric kits; • Availability of support from technical and financial partners;	• Insecurity in the Far North (Boko Haram), East and Adamawa (influx of Central African refugees), North West and South West regions, which hinders the provision of RMNCAH-Nut care and services • Occurrence of a pandemic

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	interventions by healthcare providers			
Community engagement	• Knowledge on the benefits of RMNCAH-Nut • Training of peer educators and mobilisers by other administrations; • Setting up of a comprehensive sexuality education programme in the out-of-school environment by the administrations	• Lack of knowledge among users on the existence of some services dedicated to (dealing with) RMNCAH-Nut problems; • Unsatisfactory level of public knowledge about reproductive health issues, particularly the consequences of early marriage, genital mutilation, unsafe abortion and fistula.	• Existence of digital platforms (WhatsApp and Facebook) for communication and sensitisation on RH;	• Insecurity in the Far North (Boko Haram), East and Adamawa (influx of Central African refugees), North West and South West regions, which hinders access to RMNCAH-Nut care and services.
Management and governance	**Planning**			
	• Availability of strategic guidelines documents (NDS30, HSS, NHDP)	• Poor implementation of the RMNCAH-Nut strategic plans drawn up at all levels		
	Coordination and monitoring-evaluation			
	• Use of DHIS2 for data collection • Effective monitoring of activities in EmONC network health facilities; • Capacity-building and supervision of health personnel and peer educators in RH;	• Absence of a performance monitoring plan; • Poor functioning of coordination bodies • Absence of an evaluation report on the expired plan • Absence of a mid-term evaluation.		
	Leadership			

	• Policy guidelines	• Failure to consider other administrations in the implementation of the expired NSP/RMNCAH; • Lack of managerial skills of those responsible for reproductive health services at all levels;	• Commitment of development partners; • Growing interest in RMNCAH-Nut issues among civil society stakeholders and youth organisations.	• Financial dependence on donors for the implementation of several RMNCAH-Nut activities; • Poor involvement of regional and local authorities in some key interventions, such as the referral/evacuation system.

3.4 MAJOR PROBLEMS OF RMNCAH-NUT AND RELATED CAUSES

The situation analysis conducted based on the document review and key informant interviews shows that the persistence of maternal, newborn, child and elderly morbidity and mortality is due to a number of major problems grouped into 05 components, namely: strategic management, governance, high-impact interventions, provision of care and services, and resilience to public health emergencies.

➢ LOW IMPLEMENTATION OF PREVIOUS STRATEGIC PLANS RELATED TO RMNCAH, COMBINED WITH SUB-OPTIMAL STRATEGIC MANAGEMENT

The implementation of the 2014-2020 NSP/RMNCH contributed to a reduction in maternal (782 to 406 per 100,000 LB), newborn and infant (122‰ to 80 ‰ LB) and child (62‰ to 48‰) death rates. At the institutional level, several committees and sub-groups were set up, namely: the Maternal and Perinatal Death Surveillance and Response committees and family planning, obstetric fistulas, adolescent reproductive health, newborn and PMTCT sub-groups. The implementation of the 2014-2020 NSP/RMNCH was followed up through regular supervisions, the organisation of coordination meetings at various levels, and meetings of the RMNCAH technical committees and sub-working groups. The establishment of these monitoring mechanisms enabled to improve the monitoring of indicators and the quality of data, to speed up the handling of problems and to implement a number of recommendations, thereby contributing to reducing maternal and perinatal mortality.

However, many dysfunctions were observed during the implementation of the RMNCH plans drawn up between 2014-2020. These include:

- Poor ownership and operationalisation of the plans drawn up by all stakeholders;

- The low level of funding for RMNCH interventions, resulting in an implementation rate less than 30% for 2014-2020 NSP activities, thus slowing progress towards achieving the objectives set out in this plan;
- The lack of a plan for monitoring indicators and of a mid-term evaluation highlighted the limitations of the monitoring and evaluation of the 2014-2020 NSP, thus hampering the ability of stakeholders to adjust interventions during the implementation of the above-mentioned plan;
- Insufficient consideration of the multi-sector approach in the implementation of the plans drawn up;
- Low implementation of the 2014-2020 NSP/RMNCH;
- Failure to respect the timeline, and late start in implementing 2014-2020 NSP/RMNCH activities;

➢ SUB-OPTIMAL GOVERNANCE OF THE VARIOUS ASPECTS OF RMNCAH-Nut

Many shortcomings were identified in the governance of RMNCAH, including:

- Insufficient mobilisation of all stakeholders around the issue of RMNCAH-Nut;
- Failure to draw up, or inadequate application of legal and regulatory instruments relating to RH issues;
- Institutional weaknesses related to inadequate organisation and functioning of structures managing RMNCAH-Nut activities;
- Limited managerial capacities of some of the managers of health facilities dedicated to RMNCAH-Nut;
- The persistent quantitative and qualitative shortage of health workers in the RMNCAH-Nut area;
- Insufficient and unsustainable funding for RMNCAH-Nut;
- Insufficient development of partnerships in support of RMNCAH-Nut;
- Sub-optimal coordination by stakeholders;
- Inadequate mobilisation of community participation;
- Frequent stock-outs of essential drugs and commodities for RMNCAH-Nut;
- Insufficient collection, analysis and use of RMNCAH-Nut data for informed decision-making at all levels of the health pyramid;
- Inadequate promotion of quality assurance for RMNCAH-Nut services;
- Inadequate operational research on RMNCAH-Nut issues.

➢ INSUFFICIENT COVERAGE OF PROMOTIONAL, PREVENTIVE, CURATIVE AND REHABILITATIVE INTERVENTIONS IN FAVOUR OF RMNCAH-Nut TARGETS

All the strategic objectives set for RMNCAH-Nut interventions were not achieved. This is due to a series of obstacles that can be grouped by RMNCAH-Nut targets as follows:

- Maternal health:

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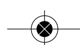


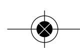
Shortcomings in the quality of antenatal care, labour, delivery and management of obstetric complications;

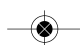
- Newborn health:
  Poor management of neonatal complications, such as infections asphyxia, low birth weight and prematurity.
- Newborn and child health:
  Inadequate prevention and management of nutritional problems and most common illnesses in early childhood.
- Adolescent and youth health:
  Insufficient efforts to reduce risky behaviour among adolescents, to reduce the conditions that encourage violence, unwanted pregnancies, abortions, child marriages, genital mutilation and the non-use of reproductive health services.
- Concerning the health of women in general, as well as men and the elderly:
  Insufficient strengthening of family planning activities, prevention and management of STI/HIV, early detection and management of genital cancers and genital fistulas as well as problems of infertility and sexual dysfunction.

➢ LIMITED AVAILABILITY, ACCESSIBILITY AND USE OF RMNCAH-Nut CARE AND SERVICES

Many obstacles still hinder the access of target populations to RMNCAH-Nut interventions. These include:

- Low provision and uneven distribution of RMNCAH-Nut services throughout the country;
- Poor quality of RMNCAH-Nut care and services, resulting in low acceptance by beneficiaries;
- Persistent financial barriers preventing the most vulnerable from accessing RMNCAH-Nut care and services;
- Persistent sociocultural behaviours against RMNCAH-Nut;
- The evolution of inadequate demographic growth trends compared to the demographic dividend;
- Persistent difficult economic conditions, with high poverty rates and underemployment;
- Persistent insecurity in certain regions, hindering access to care and services by the target populations, therefore exposing them to increased morbidity and mortality.





➢ LOW RESILIENCE OF RMNCAH-Nut SERVICES TO PUBLIC HEALTH EMERGENCIES

The implementation of the 2014-2020 NSP/RMNCH was adversely affected by the outbreak of the COVID-19 pandemic in Cameroon between 2019 and 2021, which occurred against a backdrop of security instability that was already undermining the healthcare system in some regions. This twofold crisis undermined a healthcare system that was ill-prepared to deal with such emergencies. The pandemic:

- led to a considerable weakening of RMNCAH-Nut services, worsening existing difficulties. This had a direct impact on the quality and availability of emergency response services;
- affected the quality of our healthcare system's preparedness to respond appropriately to public health emergencies.

4 CONCEPTUAL FRAMEWORK

4.1 STRATEGIC GUIDELINES OF THE PLAN

4.1.1 Regulatory framework

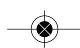
At national level, this 2024-2030 RMNCAH-Nut Strategic Plan is aligned with the guidelines of the 2020-2030 Health Sector Strategy (HSS), which aim at contributing to the development of healthy, productive human capital capable of ensuring strong, inclusive and sustainable growth.

At the international level, NSP/RMNCAH-Nut is aligned with the United Nations new “2016-2030 Global Strategy for Women's, Children's and Adolescents' Health”, which aims at achieving “by 2030, a world in which every woman, child and adolescent in every setting realises their rights to physical and mental health and well-being, has social and economic opportunities, and can fully participate in building prosperous and sustainable societies".

Finally, the 2024-2030 NSP/RMNCAH-Nut is built on the new version of the “Maputo Plan of Action for the Implementation of the Continental Policy Framework on Sexual and Reproductive Health and Rights (SRHR)” for 2016-2030. This 2024-2030 NSP/RMNCAH-Nut is also the instrument for the operationalisation of SDGs and the United Nations 2016-2030 Global Strategy for Women's, Children's and Adolescents' Health, whose overall objective is “to improve maternal and reproductive health in Africa and to contribute to a mortality rate below 70/100,000 live births”.

4.1.2 Vision

Cameroon, a country where maternal, newborn, infant and child mortality, as well as morbidity among adolescents/youth, women and the elderly, in relation to reproductive



health, are reduced to a strict minimum, including among the most vulnerable and disadvantaged populations.

4.1.3 Mission

The mission of this plan is to promote the universal achievement of sexual and reproductive health and rights, thereby contributing to the reduction of maternal and child mortality (SDG3.1 and 3.2), ending the AIDS epidemic (SDG3.3) and ensuring universal access to sexual and reproductive health (SDG3.7) as well as to reproductive health and rights (SDG5.6).

4.1.4 GOAL

By 2030 Contribute to improving the health of populations

4.1.5 General objective

By 2030, contribute to the reduction of morbidity and mortality specific to reproductive health problems in mothers, newborns, children, adolescents/youth, women and men.

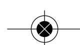
4.1.6 Strategic axes

Our logical framework for interventions is structured around three (03) strategic axes:
1) Extending the coverage of high-impact interventions to reduce morbidity and mortality in mothers, newborns, children, adolescents, men and women, including the elderly;
(This strategic axis covers all interventions that directly benefit RMNCAH-Nut targets).

2) Strengthening the pillars of the health system to create an environment conducive to achieving the impact of RMNCAH-Nut;
(This is a support axis, bringing together cross-cutting interventions that concern all the targets.)
3) Establishing effective mechanisms to support the implementation of the 2024-2030 RMNCAH-Nut Strategic Plan.
(Strategic axis 3 organises and ensures appropriate management and effective monitoring of the implementation of the NSP/RMNCAH-Nut).

4.1.7 Guiding Principles

The international community has agreed that the right to health includes the right to have control over one's health and body, including sexual and reproductive rights. In this



prospect, the guiding principles are therefore proposed, prioritizing the central role of patients in all relevant interventions. These principles are:

a) QUALITY and AVAILABILITY

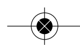
Health facilities, trained providers and RMNCAH-Nut products are available, so that individuals can fully exercise their choice from a wide range. The de-medicalisation of certain basic procedures and products will be considered. Individuals have access to high-quality services and information related to RMNCAH-Nut that are perfectly appropriate from a scientific and medical point of view. Quality of care is a multifaceted term. It includes, but not limited to: a comprehensive choice of quality services and products; clear and medically accurate information, including risks and benefits; technically competent and equipped providers; and customer-provider interactions compliant with informed choice, privacy and confidentiality, as well as customer preferences and needs.

b) EQUITY, ACCESSIBILITY, AFFORDABILITY AND NON-DISCRIMINATION

Geographical and financial access for all to RMNCAH services irrespective of sex, age and religion, with particular attention to the most disadvantaged populations and vulnerable groups, is essential. More free services and targeted subsidies are also crucial to ensure equity and universal access to services. Individuals also have the ability to access comprehensive and high-quality information and services, without facing discrimination, coercion and violence. The quality, accessibility, affordability, acceptability and availability of RMNCAH-Nut information and services must not vary according to criteria unrelated to medical indications, such as age, geographical location, language, ethnicity, disability, HIV status, sexual orientation, property, marital or other status. A human rights-based approach will be used here.

c) COLLABORATION AND MULTI-SECTOR APPROACH

Given the multi-factor nature of the causes of maternal, newborn, child and adolescent morbidity/mortality, all the sectors concerned will be involved in implementing the strategic plan. A consultation and coordination dynamics will be put in place at all levels with a view to better channelling the efforts of the sectors concerned in order to achieve the best results. The involvement of different sectors and stakeholders (related administrations, technical and financial partners, civil society stakeholders, professional associations, denominational organisations, community-based organisations, regional and local authorities, households, traditional practitioners, private sector) is imperative to address the underlying causes of high mortality in the various target groups.



d) INTEGRATION

Every effort must be made to ensure coherent and efficient implementation, building on all the opportunities offered by other programmes in order to better meet the needs of the various target groups. The aim is to capitalise on comparative advantages in the planning, implementation, monitoring, supervision and evaluation of RMNCAH-Nut interventions. In this regard, visibility in the mobilisation and use of resources by the various ministries and partners must be strengthened.

e) TRANSPARENCY AND ACCOUNTABILITY

Individuals may easily have access to factual information on the design, provision, implementation and evaluation of services, programmes and policies pertaining to sexual and reproductive health, including data from the Government. Individuals have the right to seek personal and systemic remedies and reparations when those in charge fail to fulfil their obligations regarding information, services and products related to sexual and reproductive health.

4.1.8 Theory of change

Cameroon is one of the countries where maternal, newborn and child health indicators remain worrying despite the commitments made, the actions taken and the progress achieved. The development of the 2024-2030 national strategic plan for reproductive, maternal, newborn, infant, child, adolescent and nutritional health will draw, as necessary, on lessons learned from the implementation of previous national strategic plans, the Investment Case for Improving RH and international experiences in the field of RH, so as to perpetuate strategies that work and introduce new and more relevant strategies to improve RMNCAH-Nut in Cameroon.

The possible interactions from inputs should produce the desired impact, which is reduced morbidity and mortality caused by RMNCAH-Nut-related problems. The effect required to produce this impact is to obtain optimal coverage of promotional, preventive and curative interventions for all target groups.

To achieve this, several strategies need to be put in place. These include:

- improving the supply of RMNCAH-Nut care and services;
- effectively implementing evidence-based high-impact interventions in priority areas;
- removing the financial, socio-cultural and geographical barriers that limit access to RMNCAH-Nut care and services;
- improving the ongoing use of RMNCAH-Nut care and services.

The table below shows the possible interactions from the inputs to the desired impact:

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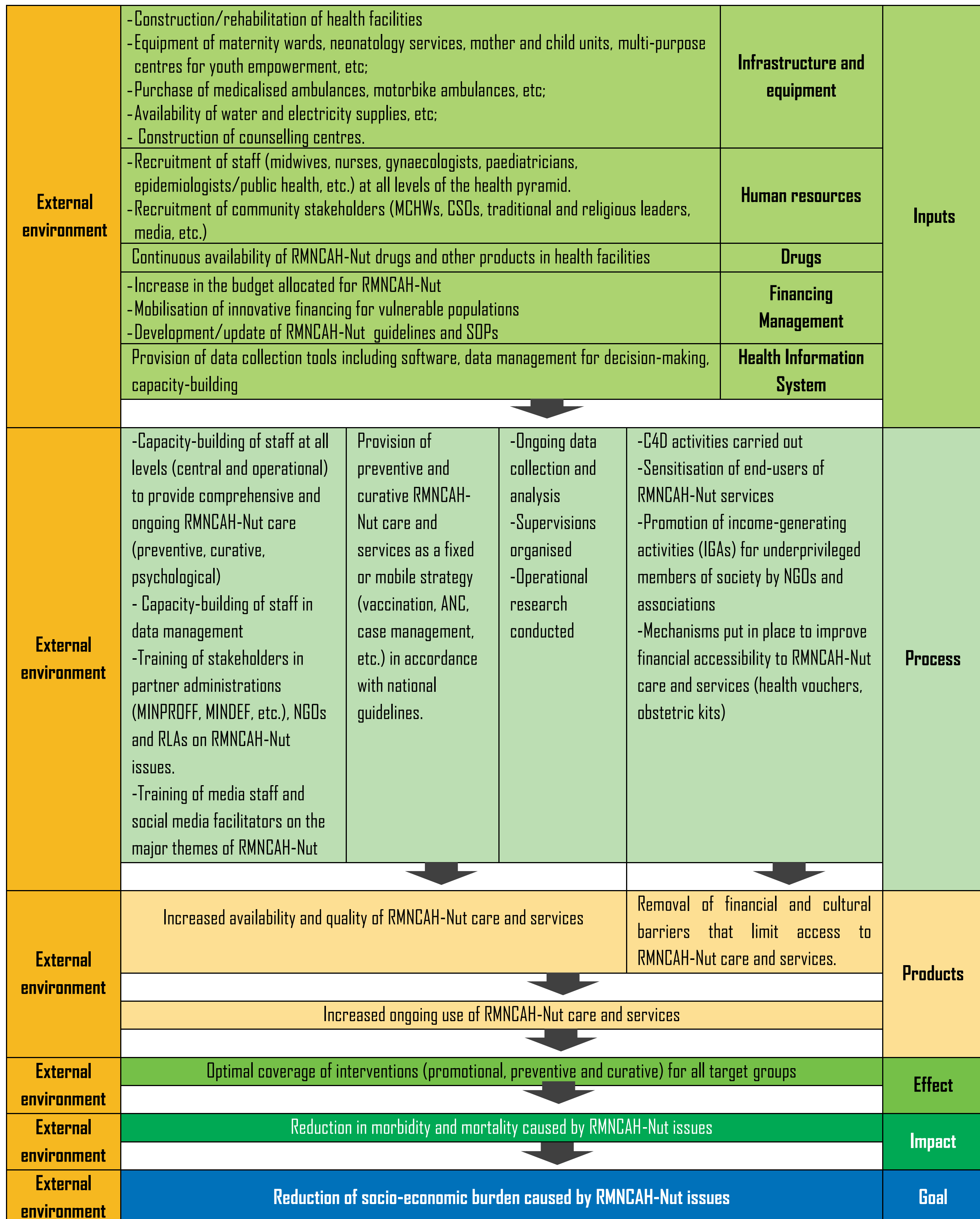


The changes projected in this theory are based on an analysis of causal relationships. It is important to remember that external factors (socio-cultural, economic, geographical, security, etc.) can facilitate or hinder the achievement of the desired performance.

4.2 LOGICAL FRAMEWORK FOR INTERVENTIONS

- STRATEGIC AXIS 1: SCALING UP THE COVERAGE OF HIGH-IMPACT INTERVENTIONS TO REDUCE MORBIDITY AND MORTALITY IN MOTHERS, NEWBORNS, CHILDREN, ADOLESCENTS, MEN AND WOMEN, INCLUDING THE ELDERLY

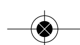
1.1.1 4.2 HORIZONTAL LINKAGE

1.1.1.1 STRATEGIC AXIS 1: EXPANSION OF HIGH-IMPACT INTERVENTION COVERAGE TO REDUCE MORBIDITY AND MORTALITY AMONG MOTHERS, NEWBORNS, CHILDREN, ADOLESCENTS, MEN, WOMEN, AND THE ELDERLY

STRATEGIC OBJECTIVE 1.1: By 2030, improve the coverage of high-impact RMNCAH-Nut interventions for mothers, newborns, children, adolescents, men, women, and the elderly.

1.1.1.2 SPECIFIC OBJECTIVES – TARGET: MOTHERS/WOMEN OF REPRODUCTIVE AGE

1.1.1. By 2030, achieve 95% coverage of quality antenatal care (ANC) among expected pregnant women.
1.1.2. By 2030, achieve 80% coverage of quality postnatal care (PNC) for expected deliveries.
1.1.3. By 2030, ensure that 80% of deliveries take place in a health facility.
1.1.4. By 2030, achieve a contraceptive prevalence rate of 30% among women of reproductive age.
1.1.5. By 2030, increase screening and management of obstetric fistula in 80% of targeted health districts (HDs).
1.1.6. By 2030, improve the prevention and management of STIs, hepatitis, and HIV among women of reproductive age in at least 80% of HDs.
1.1.7. By 2030, enhance screening and management of breast and cervical cancer in at least 30% of HDs.
1.1.8. By 2030, improve the management of infertility among women in 100% of regional and central hospitals.
1.1.9. Improve the nutritional status of pregnant and breastfeeding women by at least 50% in health facilities.



1.1.1.3 SPECIFIC OBJECTIVES - TARGET: NEWBORNS

1.1.10. By **2030**, ensure that **80%** of targeted health facilities at all levels provide quality care and services for newborns.
1.1.11. By **2030**, ensure the prevention of mother-to-child transmission (PMTCT) of HIV, syphilis, and hepatitis B among **100%** of pregnant women attending ANC.
1.1.12. By **2030**, ensure that **90%** of pregnant women attending ANC receive tetanus vaccination.

1.1.1.4 SPECIFIC OBJECTIVES - TARGET: CHILDREN

1.1.13. By **2030**, ensure that at least **90%** of children receiving consultations benefit from high-impact preventive interventions.
1.1.14. By **2030**, strengthen the Integrated Management of Childhood Illness (IMCI) approach in at least **80%** of targeted HDs, both in health facilities and communities.

1.1.1.5 SPECIFIC OBJECTIVES - TARGET: ADOLESCENTS/YOUTH

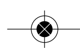
1.1.15. By **2030**, reduce the prevalence of risky sexual behaviors among at least **25%** of adolescents/youth.
1.1.16. By **2030**, ensure the prevention and management of at least **25%** of STI/HIV cases among adolescents and youth.
1.1.17. By **2030**, promote Adolescent and Youth-Friendly Health Services (AYFHS) in **80%** of administrative departments.
1.1.18. By **2030**, increase modern contraceptive prevalence to at least **30%** among adolescents/youth.
1.1.19. Improve the nutritional status of at least **50%** of adolescents and youth.

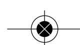
1.1.1.6 SPECIFIC OBJECTIVES - TARGET: MEN, WOMEN, AND ELDERLY PERSONS

1.1.20. Improve the nutritional status of at least **50%** of men, women, and elderly persons receiving care in health facilities.

1.1.1.7 SPECIFIC OBJECTIVES - TARGET: WOMEN/ELDERLY WOMEN

1.1.21. By **2030**, ensure appropriate management of sexual dysfunction and menopause-related disorders for at least **80%** of women attending district and regional hospitals.
1.1.22. By **2030**, ensure proper infertility management for at least **80%** of women attending consultations in targeted district and regional hospitals.
1.1.23. By **2030**, ensure adequate management of at least **60%** of diagnosed gynecological cancers in hospitals.





1.1.1.8 SPECIFIC OBJECTIVES - TARGET: MEN/ELDERLY MEN

1.1.24. By 2030, ensure proper management of at least 50% of cases of sexual dysfunction and STI/HIV among men attending health facilities.
1.1.25. By 2030, ensure the proper management of at least 60% of diagnosed male reproductive cancers in Category 1 to 4 hospitals.

1.1.2 STRATEGIC OBJECTIVE 1.2: By 2030, contribute to reducing harmful cultural practices among adolescents, women, and men (Gender-Based Violence, Female Genital Mutilation, and Child Marriage).

1.1.2.1 SPECIFIC OBJECTIVES

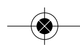
1.2.1. By 2030, ensure that at least 30% of targeted community groups in each district adopt attitudes favoring the reduction of GBV and harmful cultural practices.
1.2.2. By 2030, make evidence-based data available in 80% of HDs to monitor the magnitude of GBV and harmful practices.
1.2.3. By 2030, improve access to and utilization of medical and psychological care services for GBV survivors and victims of harmful practices in 60% of HDs.
1.2.4. By 2030, strengthen the effective enforcement of institutional and legal frameworks to eliminate impunity for GBV and harmful practices in 60% of administrative departments.

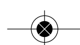
1.1.3 STRATEGIC AXIS 2: STRENGTHENING SUPPORT ACTIVITIES TO ENHANCE AVAILABILITY, ACCESSIBILITY, AND UTILIZATION OF QUALITY REPRODUCTIVE HEALTH SERVICES

1.1.3.1 STRATEGIC OBJECTIVE 2.1: **By 2030, improve the availability of quality RMNCAH-Nut services and care for all target groups.**

1.1.3.2 SPECIFIC OBJECTIVES

2.1.1. By 2030, improve access to quality RMNCAH-Nut services by equipping at least 80% of HD health facilities with adequate infrastructure, logistics, and equipment.
2.1.2. By 2030, ensure that 80% of health facilities at all levels of the health system generate and utilize quality RMNCAH-Nut data to guide decision-making.
2.1.3. By 2030, increase funding allocated to RMNCAH-Nut interventions by at least 5%.
2.1.4. By 2030, reduce the quantitative and qualitative deficit of qualified RMNCAH-Nut human resources by 30% at all levels of the health system.
2.1.5. By 2030, improve the availability of quality essential medicines and products for RMNCAH-Nut in at least 90% of HD health facilities.





2.1.6. By **2030**, increase by **30%** the number of HDs offering at least **50%** of the Community-Based Package of Activities.

1.1.3.3 STRATEGIC OBJECTIVE 2.2: **By 2030, improve accessibility and utilization of RMNCAH-Nut services.**

1.1.3.4 SPECIFIC OBJECTIVES

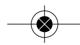
2.2.1. By **2030**, enhance equitable financial accessibility for at least **50%** of the most vulnerable populations in targeted HDs.
2.2.2. By **2030**, strengthen communication and logistics to reduce cultural and geographical barriers for at least **50%** of RMNCAH-Nut target groups in targeted HDs.

1.1.4 STRATEGIC AXIS 3: ESTABLISHING EFFECTIVE MECHANISMS TO SUPPORT THE IMPLEMENTATION OF THE 2024-2030 RMNCAH-Nut STRATEGIC PLAN

1.1.4.1 STRATEGIC OBJECTIVE 3.3: **By 2030, strengthen the resilience of the health system against public health emergencies to improve the delivery of reproductive health services.**

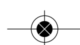
1.1.4.2 SPECIFIC OBJECTIVES

3.3.1. By **2030**, ensure at least **80%** of planned interventions for public health emergency preparedness impacting RMNCAH-Nut.
3.3.2. By **2030**, ensure the implementation of essential RMNCAH-Nut interventions during public health emergencies.



4.3 RISK ANALYSIS AND MANAGEMENT

RISK	RISK LEVEL	RISK MITIGATION STRATEGY
Ongoing or growing insecurity in the North and Far North regions	Moderate to high	▪ Involvement of NGOs and local associations specialised in reaching out to populations, in particular children, mothers, teenagers and pregnant women in difficult-to-access areas, thanks to their presence in conflict zones.
Continuous lack of qualified human resources in health in remote targeted areas	Moderate to high	▪ In 2019, the Government of Cameroon adopted a plan for the recruitment of ‘seasonal staff’ by RLAs, which should help to retain staff in remote areas ▪ The decentralisation of the training of midwives in the different regions enhances their availability on the local job market. ▪ The delegation of tasks and mentoring also help solve the problem of lack of specialised staff.
Deterioration of the medical equipment supplied to HFs	Poor	▪ The MOH is currently implementing a maintenance policy of hospital equipment ▪ The HF personnel must be trained on the appropriate use and preventive maintenance of medical equipment ▪ Increase advocacy for the recruitment and deployment of maintenance engineers and technicians in public HFs
Occurrence of an outbreak such as COVID-19 or other public health emergency during the implementation period of the plan	Moderate	▪ Implementation of a continuity service plan including epidemiological surveillance and preparedness and response in 2024-2030 RMNCAH-Nut interventions.
Low financial mobilisation for the implementation of RMNCAH-Nut interventions	Moderate	▪ There is always a budget allocated to the Mother and Child Health. Advocacy for the mobilisation of domestic and external funding must continue, as well as the establishment of innovative mechanisms to finance reproductive health.



5 IMPLEMENTATION FRAMEWORK

5.1 INSTITUTIONAL FRAMEWORK TO MONITOR THE IMPLEMENTATION OF THE PLAN

The implementation of the NSP/RMNCAH-Nut will be done progressively, starting with priority regions with high mortality rates, and eventually reaching all 10 regions of the country. Furthermore, this implementation will be ensured by structures and bodies established by the Ministry of Public Health at all levels of the health pyramid.

➢ CENTRAL LEVEL

The National Multi-sector Programme to fight against Maternal and Child Mortality (PLMI) will coordinate the multi-sector implementation, monitoring and evaluation of this plan through the RMNCAH-Nut National Committee and also in charge of the Technical Secretariat. To this end, several thematic working groups were created in order to accurately address the various RMNCAH-Nut problems identified. These groups include: the FP/Contraceptive Safety Multi-sector Working Group (MWG), the Newborn Health MWG, the PMTCT MWG, the Management and Prevention MWG, the Obstetric Fistula Control MWG, the Mother and Child Health Multi-sector Technical Working Group (MCH-TWG) created to support the Steering and Monitoring Committee in the implementation of the Sector Strategy on maternal and child health.

The Department of Family Health (DSF) will coordinate activities designed to address RMNCAH-Nut issues at the MOH. Competent departments in each ministry involved in the operationalisation of this NSP/RMNCAH-Nut will be designated, empowered and supported by the PLMNI

➢ INTERMEDIATE AND OPERATIONAL LEVEL

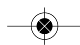
The Regional Delegates for Public Health (RDPH), the regional RH focal persons and the Health District Framework Teams will be responsible for the effective implementation of the plan on the field.

They will coordinate these activities, supervise the personnel and monitor the various indicators. Partners of the Ministry of Public Health and the Civil Society concerned by the promotion of RMNCAH-Nut will be involved at the different levels of its implementation, through their equivalent representations at each level of the health pyramid.

5.2 ROLE OF STAKEHOLDERS

5.2.1 Roles and responsibilities of the Ministry of Public Health

The MOH is in charge of leading the implementation of this Strategic Plan. This section deals with the role of the stakeholders involved.



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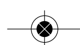


5.2.1.1 CENTRAL LEVEL

The central level is responsible for technical leadership and for providing broad guidelines for the implementation, monitoring and evaluation of the Strategic Plan. It is responsible for resource mobilisation and advocacy for RMNCAH-Nut. As part of the Steering and Monitoring Committee for the implementation of the Health Sector Strategy of the Ministry of Public Health, the Multi-sector Working Group, under the leadership of the PLMI is responsible for the programming, monitoring and evaluation of the implementation of maternal and child health interventions, particularly in partner ministries, CSOs, NGOs, etc.

Department of Family Health (DSF)

The Department of Family Health will facilitate, supervise and coordinate within the MOH all technical activities related to the health response. It will carry out the following activities:

- Advocate for increased resource mobilization for RMNCAH-Nut.
- Ensure the operationalisation and monitoring of the implementation of the 2024-2030 NSP/RMNCAH-Nut at all levels of the health pyramid.
- Facilitate the capacity-building of personnel at all levels by developing technical guidelines, standards, protocols and training manuals in collaboration with other relevant technical departments.
- Design and develop, in collaboration with the other relevant departments, IEC/SBC materials for different target groups and disseminate them.
- Collaborate with the medicines and commodities procurement system to identify needs.
- Identify and propose disaggregated indicators for monitoring/evaluation of the implementation of activities and update data collection tools when necessary.
- Review and adapt the community-based management information system (CBMIS) in collaboration with health information structures and health districts.
- Identify research topics in RMNCAH-Nut, support their execution and exploitation of the findings, in collaboration with other relevant structures.

Department of Financial Resources and Property (DRFP)

Integrate the interventions of the Strategic Plan into the MOH programme budget in order to adequately allocate a budget for RMNCAH-Nut.

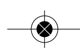
Health Information Unit

It will monitor the evaluation of RMNCAH-Nut indicators from routine data in the health information and management system (HMIS), including community level data.

Department of Pharmacy, Drugs and Laboratories (DPML)

In collaboration with the Department of Family Health, DPML is in charge of the regulation and continuous availability of essential RMNCAH-Nut drugs and other commodities (reagents and consumables) by ensuring that they are:

- Included in the official list of essential drugs
- Ordered in sufficient quantity and on time



- Of good quality
- Distributed on time at service delivery points
- Well managed within the national procurement system

Division of Operational Research in Health (DROS)

It will work with DSF to identify research topics in RMNCAH-Nut, conduct studies in the field of RMNCAH-Nut and widely disseminate the findings.

Department of Human Resources (DHR)

It ensures the effective implementation of the human resources development plan. To this end, it will ensure the permanent availability of qualified RMNCAH-Nut personnel in health facilities by:

- Taking into account national standards in this area
- Arranging for additional staff to be recruited as positions become available and redeploying existing staff in a rational manner, while giving priority to the districts with the greatest need for RMNCAH-Nut personnel
- Providing accelerated continuous training to fill current gaps in RMNCAH-Nut, particularly at the operational level.

Department of Healthcare Organisation and Technology (DOSTS)

It is responsible for controlling quality standards when purchasing RMNCAH-Nut equipment, ensuring the technical quality of RMNCAH-Nut care by implementing guidelines and protocols for care and finally, making sure that RMNCAH-Nut is taken into account when Community-Directed Interventions are carried out.

Department for the Control of Diseases, Epidemics and Pandemics (DLMEP)

This department will be in charge of the capacity-building of the personnel at all levels of the health pyramid in the fight against RH-related infections by developing technical guidelines, standards, protocols and training manuals in collaboration with DSF and DOSTS.

Department of Health Promotion (DPS)

The DPS will work with DSF to facilitate all aspects of communication for the development related to RMNCAH, Maternal Nutrition, Infant and Young Child Feeding (IYCF) and potable water, personal and environmental hygiene.
DPS will undertake the following activities:

- Facilitate the capacity building of the personnel at all levels by developing/revising technical guidelines, standards, protocols and nutrition training manuals in collaboration with other relevant technical departments.

- Design and develop, in collaboration with other relevant departments, IEC/SBC materials including maternal, infant and young child feeding
- Work with the commodities supply system to determine the needs in nutritional commodities/equipment for anthropometric measurements/kitchen equipment
- Identify, propose and share disaggregated indicators to monitor/evaluate the implementation of maternal, infant and young child nutrition activities.
- Conceive grids to be used during health inspection of the different health structures providing RMNCAH-Nut services
- Provide training on the management of acute malnutrition.

Department of Cooperation (DCOOP)

- Ensure that stakeholders are in phase with Government strategies, and create synergy among partners to avoid duplication and efficiently support the Government.

The Sub-Department for Mental Health will particularly focus on the monitoring of youth to avoid risky behaviours, including:

- Fight against drugs in schools
- Advocate to increase the number of addiction centres at the regional level
- Advocate to increase the number of mental health units/services in health district hospitals, regional hospitals and addiction centres in 2nd and 3rd category hospitals, especially in humanitarian crisis areas.

5.2.1.2 REGIONAL LEVEL

The Regional Delegation for Public Health will facilitate, supervise, monitor and coordinate all technical activities to achieve the objectives of the Strategic Plan.
It will focus on the following activities:

- Disseminate the RMNCAH-Nut national strategic plan in health districts.
- Provide technical support for the effective and integrated operationalisation and implementation of the plan
- Coordinate, monitor and supervise RMNCAH-Nut activities in the regions.
- Conduct operational research and build the capacities of districts in this area.
- Provide support to health districts in collecting, analysing and using data for decision-making.
- Ensure that data is centralised and communicated to the higher level.
- Identify training needs and build the capacities of the personnel in RMNCAH-Nut.
- Establish and monitor a quality assurance system for RMNCAH-Nut care and services.

5.2.1.3 THE DISTRICT LEVEL

District Health Service

District Health Services will be in charge of the following:

- Disseminate the RH National Strategic Plan to all stakeholders in health districts (NGOs, religious organizations and others)

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- Provide technical support for the effective and integrated operationalisation and implementation of the RMNCAH-Nut plan.
- Coordinate, monitor and supervise RMNCAH-Nut activities in all districts.
- Conduct operational research on RMNCAH-Nut in the districts.
- Ensure regular data collection, analysis and their use in decision-making.
- Ensure that RMNCAH-Nut data is sent regularly and on time to the regional level.
- Identify the needs in RMNCAH-Nut in terms of training and ensure the capacity building of personnel in health facilities and the community.
- Provide technical support to RMNCAH-Nut stakeholders for the implementation of quality assurance mechanisms
- Monitor and review maternal, newborn and child mortality in health facilities (public and private) as well as in the community.
- Ensure that health activities in general, and RMNCAH-Nut activities in particular, are taken into account in the budget of councils.

Health facilities (health centres, MHC and hospitals)

These structures will be in charge of:

- Including RMNCAH-Nut activities in the action plan of health facilities.
- Providing quality RMNCAH-Nut care and services to the public
- Monitoring the quality of personnel performance
- Ensuring timely and sufficient availability of all RMNCAH-Nut commodities
- Monitoring and reviewing maternal, neonatal and child mortality in health facilities (public and private) as well as in the community.
- Ensuring the routine collection, consolidation, preliminary analysis and use of data in decision-making.
- Making sure that RMNCAH-Nut data is sent regularly and on time to the higher level
- Working closely with the community for the provision of services.

5.2.2 Roles and responsibilities of other ministries and actors

5.2.2.1 MINEPAT and MINFI

- Integrate interventions from the RMNCAH-Nut strategic plan into the programme budget of each partner ministry to increase financial resources available for RMNCAH-Nut
- Prioritise health and specifically RMNCAH-Nut in the allocation of budgets
- Advocate for an increase in the health budget and that of RMNCAH-Nut in particular.

5.2.2.2 Ministry of Communication (MINCOM)

- Support communication activities concerning RMNCAH-Nut to target populations.
- Design/Produce/Broadcast radio and TV spots on RMNCAH-Nut
- Design/Produce/Distribute RMNCAH-Nut flyers, produce RMNCAH-Nut micro programmes in local languages within community radio stations

- Build the capacities of journalists to produce programmes on RMNCAH-Nut
- Organise communication and advocacy activities with opinion leaders, public authorities and other partners regarding RMNCAH-Nut

5.2.2.3 Ministry of Higher Education (MINESUP)

- Provide initial training for doctors (caesarean section, EmONC), specialists, paediatricians and obstetrician-gynaecologists
- Provide training for midwives in partnership with the MOH
- Ensure the care of adolescents and pregnant women in the eight University medical Centres

5.2.2.4 Ministry of Secondary Education (MINESEC)

This ministry targets adolescent students. In addition, schools are ideal places to learn how to properly manage sexual and family life and to prevent deviations and addictions of all kinds. As such, this ministry will be in charge of supervising the youth in schools on sexual and reproductive health (SRH) by:

- Promoting universal access to education, especially for girls
- Ensuring the effective inclusion of RMNCAH-Nut in the curricula of vocational training schools (for MINESUP)
- Creating IEC forums for RMNCAH-Nut in the student programme (e.g. maintaining health clubs in schools)
- Contributing to educating the youth in schools on life skills and family life, especially through health clubs
- Facilitating access to RMNCAH-Nut care in health facilities for students

5.2.2.5 Ministry of Basic Education (MINEDUB)

Through its educational programme on healthy living, it will:

- Lay the educational foundations of best practices to promote and educate on global and sexual health (self-awareness, prevention of sexual violence).
- Ensure the implementation of preventive components of high-impact interventions for children’s health (vaccination, deworming, vitamin A supplementation, etc.).

5.2.2.6 Ministry of Women's Empowerment and the Family (MINPROFF)

This ministry will be in charge of:

- Ensuring community engagement and outreach on RMNCAH-Nut;
- Strengthening the promotion of RMNCAH-Nut within Women’s Empowerment Centres;

- Building the capacities of women and family support associations in communication techniques and tools for the adoption of essential family practices on maternal and child health;
- Strengthening advocacy for gender-responsive budgeting;
- Disseminating the counselling guide;
- Promoting pre-nuptial, marriage and family education;
- Strengthening advocacy on the budgeting of psychosocial care;
- Facilitating the implementation of programmes to fight against domestic and family violence, including shelters;
- Facilitating the mobilisation of vulnerable groups for income-generating activities;
- Strengthening community organisation for the promotion of RMNCAH-Nut including referral of obstetric and neonatal emergencies through community facilitators;
- Disseminating legal and regulatory instruments;
- Promoting the inclusion of gender and sexual rights in reproductive health.
- Carrying out advocacy for the establishment of laws and regulations to promote RMNCAH-Nut.

5.2.2.7 Ministry of Youth Affairs and Civic Education

This ministry will be in charge of:

- Sensitising and coaching youth/adolescents on their sexual and reproductive health (SRH) in multi-purpose centres for youth empowerment and other youth mentoring structures;
- Facilitating the socio-economic integration of youth/adolescents
- Building the capacities of youth mentors in RMNCAH-Nut

5.2.2.8 Ministry of Justice (MINJUSTICE)

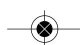
This ministry will be in charge of:

- Implementing laws/regulations for the registration of maternal and neonatal deaths (vital statistics);
- Implementing laws/regulations concerning RMNCAH-Nut (traditional birth attendants, sexual health of the youth, adolescent(s) and the elderly...).
- Ensuring the implementation of sexual and reproductive rights for citizens.

5.2.2.9 Ministry of Decentralisation and Local Development

This ministry will be in charge of:

- Facilitating the mobilisation and coordination of partners at a decentralised level in favour of RMNCAH-Nut within the framework of the multi-sector approach.



- Facilitating the provision of financial resources from the state budget resulting from decentralisation
- Encouraging the population to get involved in RMNCAH-Nut
- Ensuring the registration of maternal deaths and births (vital statistics) as well as the mobilisation of Regional and Local Authorities for RMNCAH-Nut
- Encouraging actors in their missions of registering civil status documents (births, marriages, deaths) at the level of Regional and Local Authorities, including monitoring maternal and neonatal deaths, for example, and organising the care of indigent people through councils.

5.2.2.10 Ministry of Energy and Water Resources (MINEE)

This ministry will be in charge of:

- Ensuring the availability of potable water, sanitation and electricity in health facilities and communities.

5.2.2.11 Ministry of Agriculture and Rural Development (MINADER)

This ministry will be in charge of:

- Promoting food security for all.

5.2.2.12 Ministry of Social Affairs (MINAS)

This ministry will be in charge of:

- Ensuring the provision of RMNCAH-Nut services to vulnerable populations (OVC, disabled persons, vulnerable indigenous populations and the elderly);
- Facilitating the social reintegration of vulnerable people (OVC, disabled people, vulnerable indigenous populations and the elderly) through IGAs
- Advocating for national solidarity, including improving the health of mothers and children
- Ensuring the dissemination of the Convention on the rights of the child, including birth registration which is a right. To this effect, it will work closely with BUNEC.

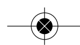
5.2.2.13 Ministry of Livestock, Fisheries and Animal Industries

This ministry will be in charge of:

- Safeguarding food security (an important pillar in the fight against malnutrition) through the production of essential animal proteins and fishery products.

5.2.2.14 Councils and Regional and Local Authorities

- Encouraging the mobilisation of partners at the decentralised level for RMNCAH-Nut.



- Facilitating the mobilisation of additional financial resources at local level (taking into account RMNCAH-Nut interventions in the budgets of devolved services) and provide support/lead communities in the funding of health care (e.g. development/setting up of mutual health insurance schemes).
- Encouraging the population to get involved in RMNCAH-Nut
- Facilitating the collection of data relating to 'vital statistics', in particular the registration of maternal deaths and births.
- Supporting the community in the effective referral/evacuation of obstetric emergencies.

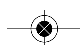
5.2.3 Roles and responsibilities of the community

The local development committee, representing civil society, through its health committee/management committee, will be responsible for implementing activities and supervising the community-based RMNCAH-Nut activities in health areas, with the technical support of integrated health centre personnel. The interventions will focus on:

- Facilitating the development, implementation and monitoring of RMNCAH-Nut action plan of the community;
- Identifying and managing the community personnel; multipurpose community health workers;
- Mobilising local resources for RMNCAH-Nut activities;
- Setting up and monitoring a system for collecting and regularly sending data on community-based activities to the higher level;
- Encouraging the community (community-based organisations, associations, leaders, etc.) to be involved in RMNCAH-Nut activities;
- Reviewing and notifying deaths in the community;
- Ensuring the community-based distribution of essential and basic RMNCAH-Nut products;
- Organising home visits and community-based services;
- Supporting community leadership.

Opinion leaders (traditional, political, religious etc.) should get involved by contributing to:

- Facilitating the mobilisation of populations in favour of RMNCAH-Nut (e.g: transfer/evacuation of obstetric emergencies)
- Facilitating the mobilisation of additional financial resources at the local level
- Facilitating the collection of data relating to 'vital statistics', in particular the registration of maternal deaths and births.
- Facilitating Community-Directed Interventions



5.2.4 Roles and responsibilities of technical and financial partners

To effectively support Government action, they will:

- Ensure complementarity between them and other actors by providing technical and financial support to the Government for the implementation of the RMNCAH-Nut plan;
- Ensure transparency in the management of all funds;
- Advocate for RMNCAH-Nut as a fundamental right of target populations;
- Raise funds/mobilise financial and technical resources;
- Strengthen supply of medicines and commodities;
- Support the implementation of RMNCAH-Nut action plans under the leadership of the Government;
- Align with Government strategies and create synergy among partners to avoid duplication and efficiently support the Government.

5.2.5 Roles and responsibilities of the Civil Society, NGOs, CBOs, professional and religious associations

Their role will be to efficiently support Government action by:

- Advocating for RMNCAH-Nut as a fundamental right of target populations;
- Creating a partnership with opinion leaders and other stakeholders for RMNCAH-Nut;
- Organising and/or facilitating community-based activities;
- Ensuring the mobilisation of financial resources for RMNCAH-Nut;
- Designing IEC/SBC materials for the use of RMNCAH-Nut services
- Ensuring the collaboration with the Government in the provision of RMNCAH-Nut services.

6 PERFORMANCE, MONITORING AND EVALUATION

6.1 PERFORMANCE FRAMEWORK

6.1 PERFORMANCE FRAMEWORK

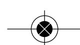
6.1.1 Impact indicators

Overall objective: By 2030, contribute to the reduction of morbidity and mortality specific to reproductive health problems of mothers, newborns, children, adolescents/young people, women and men.	Maternal mortality ratio (deaths per 100,000 NV
	Neonatal mortality rate (deaths per 1000 NV)
	Child mortality rate (deaths per 1000 NV
	Annual incidence of obstetric fistulas
	Specific mortality rate for reproductive cancers
	Incidence of cervical cancer
	Incidence of obstetric fistulas

6.1.2 Outcome or impact indicators (OUTCOMES)

6.1.2.1 Improved coverage of high-impact SRMNIA-Nut interventions

Strategic Objective 1.1: Improve coverage of high-impact SRMNIA-Nut interventions for mothers, newborns, children, adolescents, men and women, including the elderly	Coverage of high-impact interventions for health
	Coverage of high-impact interventions for newborn health
	Coverage of high-impact child health interventions
	Coverage of high-impact interventions for the health of adolescents and young people
	Coverage of high-impact interventions for men's, women's and older people's health
Strategic Objective 1.2: By 2030, contribute to the reduction of harmful cultural practices among adolescent girls and women (gender-based violence, female genital mutilation and child marriages).	Proportion of women aged 15-49 who said they had at some time experienced violence, in the form of emotional, physical and/or sexual abuse, at the hands of a current or most recent husband/partner
	Proportion of women aged 15-49 who said they had been sexually abused by someone at some point in their lives
	% of physical violence among women aged 15 to 49
	Prevalence of physical violence during pregnancy
	Prevalence of sexual violence among women aged 15 to 49
	Prevalence of female circumcision
	Prevalence of women circumcised by a health professional
	Percentage of girls married before age 15 or Prevalence of child marriage
	Prevalence of female genital mutilation/cutting (FGM/C) in children



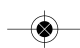
	girls aged 0 to 14
	Proportion of information bulletins on GBV and NCPs produced and distributed in health facilities
	Number of cases notified and ECP for FGM expected to be treated in health facilities
	Number of GBV survivors and NCPs supported in the MOE of the IGAs
	Number of cases of GBV and NCBs managed at targeted delivery points
	Proportion of GBV victims who have received the necessary legal support.

6.1.2.2 Improving the availability of high-quality SRMNIA-Nut services

Strategic objective 2.1: By 2030, improve the availability of quality SRMNIA-Nut services and care for all target groups	Ratio of SONEU services per inhabitant
	of FOSAS with the equipment to provide quality NRMIS-N services
	Proportion of health facilities with adequate infrastructure, equipment and staff to provide care
	Percentage of health facilities regularly reporting data on key MNIS indicators
	% of ROs trar smitting data on time to SRMNIA
	Percentage of the State budget allocated to health
	Percentage of MINSANTE budget allocated to SRMNIA-Nut
	Ratio of human resources available in FOSAS to the general population
	Doctor/popu ation ratio
	Nurse/popula tion ratio.
	Midwife/pop ulation ration
	Percentage of CMAs, CSIs and HDs with at least 50% of the required technical staff
	% of quality health products (medicines, vaccines, contraceptives, medical devices) in accordance with the standards defined in the PMA and PCA available from wholesalers such as CENAME
	% of quality, ow-cost SRMNIA-N medicines and inputs available at the last mile

6.1.2.3 Improving access to and use of NRIS-NUT services

Strategic objective 2.2: By 2030, improve the accessibility and use of SRMNIA-Nut services.	Proportion of women benefiting from CHEQUE SANTE compared to the expected number of pregnant women
	Rate of increase in current expenditure on health per capita
	Increase in the Proportion of communities having adopted at least one measure to reduce cultural barriers in the target areas
	Proportion of pregnant women referred/accompanied to FOSAS by traditional birth attendants
	Proportion of SRMNIA emergency cases transported by motorbike taxi from remote areas to health facilities

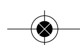


6.1.2.4 IMPROVING GOVERNANCE

Strategic Objective	Indicator
Strategic Objective 3.1: By 2030, strengthen health system governance for the SRMNIA-Nut	Rate of increase in the number of targeted media professionals trained in communication on SRMNIA-N
	Rate of increase in communication activities about the SRMNIA-Nut carried out by those trained in the target media
	Rate of increase in international commitments adopted and implemented in Cameroon
	Proportion of central and decentralised service managers who have a compendium of basic regulations on the SRMNIA-Nut
	Proportion of children under 5 whose births have been registered
	Proportion of children under 5 with a birth certificate
	Rate of increase in planned partnerships signed to implement the plan's initiatives
	Proportion of multi-sector thematic meetings on the SRMNIA-Nut held out of the planned number
	% of heads of structures (DS, DRSP and central level) trained in management and leadership
	of health facilities accredited to provide quality SRMNIA-Nut care and services
	% of planned studies and research carried out

6.1.2.5. Improved strategic management of the implementation of the strategic plan

Strategic objective	Indicator
Strategic objective 3.2: By 2030, strengthen the strategic management of the implementation of the new SRMNIA-Nut Strategic Plan.	Proportion of regions with a platform for multisectoral exchange between stakeholders to facilitate the coherence and convergence of actions taken in favour of the SRMNIA-Nut
	% of structure managers (DS and DRSP) trained in techniques for planning, monitoring and evaluating SRMNIA-Nut PM interventions
	Number of mid-term evaluations
	Number of SRMNIA-N annual performance reviews
	Number of annual operational plans (AOP) drawn up for the SRMNIA
	% of ROs that have incorporated the priorities of the SRMNIA SP into their POA



6.1.2.6. Preparing to respond to public health emergencies

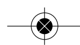
Strategic objective 3.3: By 2030, strengthen the resilience of the health system to the risks of public health emergencies in order to improve the delivery of reproductive health services.	Proportion of DRSPs with an emergency preparedness and response plan for MNDIS-Nut
	Proportion of health facilities with at least one staff member trained in the delivery/continuity of essential MERS-Nut services in the event of a public health emergency
	Proportion of simulation exercises carried out compared with the planned number to test the resilience of SRMNIA-Nut services
	Proportion of emergency situations in which SRMNIA interventions Essential nuts were deployed in time to meet the needs of the most vulnerable.

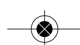
6.2 TERMS AND CONDITIONS FOR MONITORING AND EVALUATION

6.2.1 General principles and support measures

Given the importance of monitoring/evaluation in the implementation of the NSP/RMNCAH-Nut, the authorities should commit to take all the necessary steps to ensure that the general principles and support measures below are applied:

- Effective involvement of all stakeholders: the M&E process will require the participation of all entities involved in the implementation of the NSP/RMNCAH-NUT: the Ministry of Public Health, through its various levels (central, intermediate, peripheral), development partners, other ministries concerned by the interventions, the civil society, local authorities, the private sector, etc.
- Extensive use of information and communication technologies;
- Adoption of simple, flexible monitoring and evaluation procedures;
- Strengthening and revitalization of the monitoring and evaluation entities;
- Provision of all the resources necessary to operate properly;
- Prioritising the holding of meetings of these entities in order to obtain better results.





6.2.2 Terms and conditions for monitoring

The achievement of the objectives of this strategic plan will be monitored using the following mechanisms:

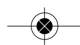
- Coordination involves the harmonious distribution of tasks to ensure that they are carried out effectively and efficiently. It prevents one or more people from doing the same job at the same time and in the same place. It also promotes a more effective implementation of the activities related to the NSP/RMNCAH-Nut;
- Monitoring consists of the systematic collection, regular analysis and interpretation of data relating to the implementation of activities, making it possible to assess progress and adjust strategies.
- Supervision is a continuous process consisting of guiding, training, supporting and encouraging the initiatives of staff on the work site so that they can carry out their work effectively and in accordance with the guidelines;
- Joint supervision usually brings together MOH teams and their partners in order to jointly monitor the implementation of activities in the field and assess the progress made;
- Inspection aims to ensure compliance with standards and internal control of implementation;
- Control involves comparing results with expectations, analysing the resources used and, if necessary, taking corrective actions to achieve the expected results.

6.2.3 Terms and conditions for Evaluation

Evaluation is the checking of the extent to which the objectives set have been achieved in relation to the resources available, while making a value judgement on the extent to which the objectives have been achieved. A mid-term evaluation and a final evaluation of this Plan shall be carried out.

The structure in charge of M&E at each level of the health system shall:

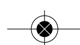
- Monitor the implementation of the Plan on a daily basis;
- Ensure compliance with the monitoring and evaluation schedule of the Plan;
- Collect intermediate data on the implementation of the Plan in order to provide input for the various meetings at the higher level;
- Participate in activities relating to the monitoring and evaluation of the Plan;
- Carry out annual and mid-term reviews of indicators;
- Ensure the dissemination of the various monitoring and evaluation reports produced by the Ministry of Public Health.



Monitoring and evaluation procedures for the NSP/RMNCAH-Nut are grouped according to the level of the health pyramid.

MAIN TERMS AND CONDITIONS FOR MONITORING AND EVALUATION AT EACH LEVEL OF THE HEALTH SYSTEM				
Central level				
Activities	Terms and conditions	Frequency	Elements to be monitored	Structure(s) in charge
General Assembly of the Health Solidarity Fund	Monitoring	Every six months	Monitoring of the implementation and results over the period	MOH
MOH/TFPs meeting	Monitoring	Quarterly	Monitor compliance with TFP commitments in the NSP/RMNCAH-Nut and coordinate the interventions of TFPs and the MOH	MOH/DCOOP/PLMNI
Technical monitoring committee for the implementation of the NSP/RMNCAH-Nut /Joint annual review	Monitoring	Annually	Monitoring of indicators: Sector dashboard and future guidelines for the ongoing NSP/RMNCAH-Nut	SG/DSF/PLMNI
Joint supervisions in the field	Monitoring	Quarterly	Inputs, processes, outputs, effects, impact(s)	DSF/PLMNI/TFPs
Inspection/Control	Monitoring	Every six months and on request	Ensure compliance with standards, approve or disapprove results based on allocated resources	IG
Technical meeting of DSF, local TFPs and other health cluster meetings	Monitoring	As needed	Monitoring of the implementation and results over the period	SG/DSF
Supportive supervision	Monitoring	Quarterly	Capacity-building based on instructions given to services	DSF/PLMNI/TFPs
Mid-term evaluation of NSP/RMNCAH-Nut	Evaluation	After 3 years	Inputs, processes, outputs, effects	SG/DSF/PLMNI
Final evaluation of the NSP/RMNCAH-Nut	Evaluation	At the end of the NSP/RMNCAH-Nut	Inputs, processes, products, effects, impact(s)	MOH/SG

Intermediate level				
General Assembly of the RFHP	Monitoring	Every six months	Monitoring of the implementation and results for the period	Governor/RDPH
Coordination meeting of RDPH/Local TFPs and other stakeholders of the health sector	Monitoring	Quarterly	Monitoring of the implementation and results over the period	RDPH/TFPs
Supportive supervision	Monitoring	Quarterly	Capacity-building based on instructions given to services	RDPH/TFPs
Mid-term evaluation of NSP/RMNCAH-Nut	Evaluation	After 3 years	Inputs, processes, outputs, effects	RDPH/TFPs
Final evaluation of the NSP/RMNCAH-Nut	Evaluation	At the end of the NSP/RMNCAH-Nut	Inputs, processes, products, effects, impact	RDPH/TFPs
Inspection/Control	Monitoring	Every six months and on request	Ensure compliance with standards, approve or disapprove results based on allocated resources	RDPH/TFPs
Audit meeting on RMNCAH-Nut deaths	Monitoring	Every six months and on request	Review of deaths and proposals for corrective measures	RDPH/TFPs
Health district level				
DHC General Assembly	Monitoring	Quarterly	Monitoring of the implementation and results over the period	Mayor/District Director
Coordination meetings of the Health area	Monitoring	Monthly	Monitoring of the implementation and results over the period	Head of district/TFPs
Review meeting of the Health area RMNCAH-Nut data	Monitoring	Monthly	Monitoring of the implementation and results over the period	District Head
Supportive supervision	Monitoring	Monthly	Capacity-building based on instructions given to services	DMT to HC and HC to community
Inspection/Control	Monitoring	Every six months and on request	Ensure compliance with standards, approve or disapprove results based on allocated resources	DMT/TFPs
Audit meeting on RMNCAH-Nut deaths	Monitoring	Every six months and on request	Review of deaths and proposals for corrective measures	District Head



Main terms and conditions for monitoring and evaluation at the Health Area/HF level				
General Assembly of the HC	Monitoring	Quarterly	Monitoring of the implementation and results over the period	Mayor/District Director
Coordination meetings of the Health area	Monitoring	Monthly	Monitoring of the implementation and results over the period	Head of Centre/TFPs
Review meeting of the Health area RMNCAH-Nut data	Monitoring	Monthly	Monitoring of the implementation and results over the period	Head of Centre/TFPs
Supportive supervision	Monitoring	Monthly	Capacity-building based on instructions given to services	Head of Centre to community
Audit meeting on RMNCAH-Nut deaths	Monitoring	Monthly and on request	Review of deaths and proposals for corrective measures	Head of health centre

7 BUDGET

The estimated budget for the NSP/RMNCAH-Nut was based on determining the types of operational activities and estimating the unit costs for each type of operational activity planned. The costs of implementation of past strategic plans by the Ministry of Public Health and technical and financial partners were used to estimate expenditure. The types of activities required to be implemented were identified and estimated for each strategic intervention. These activities include: technical meetings, technical workshops, training, missions, study trips, sensitisation and screening campaigns, ceremonies, production and distribution of documents, acquisition of IT equipment, communication, rolling stock including fuel and maintenance expenditure, studies and surveys, allowances/salaries, operating and investment costs.

Over its seven-year implementation period from 2024 to 2030, the overall budget for the NSP/RMNCAH-Nut stands at FCFA 308,553,666 billion. Majority of this budget (58%) is allocated to increasing the coverage of high-impact interventions for the direct beneficiaries of the Plan, while 40% is devoted to strengthening the pillars of the health system and 2% to ensuring its resilience in the event of any public health emergencies.

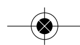


Table 16 : Breakdown of the Budget per Strategic Axis and Year of Implementation

STRATEGIC AXIS	2024	2025	2026	2027	2024	2029	2030	Amount	%
1) Scaling up the coverage of high-impact interventions to reduce morbidity and mortality in mothers, newborns, children, adolescents, men and women, including the elderly	17,896,111,484	19,685,722,633	21,475,333,781	23,264,944,930	28,633,778,375	32, 21,000,672	35,792,222,969	178,961,114,844	58
2) Strengthening the pillars of the health system to create an environment conducive to achieving the impact of RMNCAH-Nut	12,342,145,851	13,576,360,436	14,810,575,022	16,044,789,607	19,747,433,362	22,215,862,532	24,684,291,703	123,421,458,513	40
3) Setting up effective mechanisms to support the implementation of the 2024- 2024 National Strategic Plan for RMNCAH-Nut	617,107,293	678,818,022	740,528,751	802,239,480	987,371,668	1,110,793,127	1,234,214,585	6,171,072,926	2
TOTAL	30,855,364,628	33,940,901,091	37,026,437,554	40,111,974,017	49,368,583,405	55,539,656,331	61,710,729,257	308,553,646,283	100

Table 17: Breakdown of the Budget per Strategic Objective and Year of Implementation

	2024	2025	2026	2027	2024	2029	2030	Amount
STRATEGIC AXIS 1 : Scaling up of the coverage of high-impact- interventions for the reduction of the morbidity and mortality of mothers, newborns, children, adolescents, men and women, including the elderly								
1.1. Strategic objective 1: By 2030, improve coverage of high-impact RMNCAH- NUT interventions for mothers, newborns, children, adolescents, men and women, including the elderly	16,106,500,336	17,717,150,370	19,327,800,403	20,938,450,437	25,770,400,538	28,991,700,605	32,213,000,672	16,065,003,359
1.2. Strategic objective 2: By 2030, contribute to reducing harmful cultural practices among adolescents, women and men (Gender-based violence, female genital mutilation and child marriage).	1,789,611,148	1,968,572,263	2,147,533,378	2,326,494,493	2,863,377,838	3,221,300,067	3,579,222,297	17,896,111,484
TOTAL OF STRATEGIC AXIS 1 :	17,896,111,484	19,685,722,633	21,475,333,781	23,264,944,930	28,633,778,375	32,213,000,672	35,792,222,969	178,961,114,844

STRATEGIC AXIS 2 : Strengthening of the pillars of the healthcare system to create an environment conducive to achieving the impact of RMNCAH-Nut								
2.1. Strategic objective 1: By 2030, improve the availability of quality RMNCAH-Nut services	7,405,287,511	8,145,816,262	8,886,345,013	9,626,873,764	11,848,460,017	13,329,517,519	14,810,575,022	74,052,875,108
2.2. Strategic objective 2: By 2030, improve the accessibility and use of RMNCAH-Nut services	4,936,858,341	5,430,544,175	5,924,230,009	6,417,915,843	7,898,973,345	8,896,345,013	9,873,716,681	49,368,583,405
TOTAL OF STRATEGIC AXIS 2 :	12,342,145,851	13,576,360,436	14,810,575,022	16,044,789,607	19,747,433,362	22,215,862,532	24,684,291,703	123,421,458,513

STRATEGIC AXIS 3 : Setting up of effective mechanisms to support the implementation of the 2024 National Strategic Plan for RMNCAH-Nut								
3.1. Strategic objective 1: By 2030, strengthen the governance of the healthcare system for RMNCAH-Nut	246,842,917	271,527,209	296,211,500	320,895,792	394,948,667	444,317,251	493,685,834	2,468,429,170
3.2. Strategic objective 2: By 2030, strengthen the strategic steering of the implementation of the new Strategic Plan for RMNCAH-Nut	246,842,917	271,527,209	296,211,500	320,895,792	394,948,667	444,317,251	493,685,834	2,468,429,170
3.3. Strategic objective 3: By 2030, strengthen the resilience of the health system to the risks of public health emergencies in order to improve the provision of reproductive health services	123,421,459	135,763,604	148,105,750	160,447,896	197,747,334	222,158,625	246,842,917	1,234,214,585
TOTAL OF STRATEGIC AXIS 3	617,107,293	678,818,022	740,528,751	802,239,480	987,371,668	1,110,793,127	1,234,214,585	6,174,272,926

OVERALL TOTAL	30,855,364,628	33,940,901,091	37,026,437,554	40,111,974,017	49,368,583,405	55,539,656,331	61,710,729,257	308,553,646,283

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Table 18: Breakdown of the Budget per Specific Objective of Strategic Axis 1 and per Target Beneficiaries

SPECIFIC OBJECTIVE	TARGET	2024	2025	2026	2027	2028	2029	2030	Amount
STRATEGIC AXIS 1 : Scaling- up of the coverage of high-impact- interventions for the reduction of the morbidity and mortality of mothers, newborns, children, adolescents, men and women, including the elderly									
1.1. Strategic objective 1: By 2030, improve the coverage of high-impact RMNCAH- NUT interventions for mothers, newborns, children, adolescents, men and women, including the elderly		16,106,500,336	17,717,150,370	19,327,800,403	20,938,450,437	25,770,400,538	28,991,700,605	32,213,000,672	161,065,003,359
1.1.1. By 2030, achieve 80% coverage of quality ANC	MOTHER	805,325,017	885,857,518	966,390,020	1,046,922,522	1,288,520,027	1,449,585,030	1,610,650,034	8,053,250,168
1.1.2. By 2030, achieve 80% coverage of quality PNC	MOTHER	805,325,017	885,857,518	966,390,020	1,046,922,522	1,288,520,027	1,449,585,030	1,610,650,034	8,053,250,168
1.1.3. By 2030, achieve 80% coverage of births attended by skilled personnel	MOTHER	2,415,975,050	2,657,572,555	2,899,170,060	3,140,767,566	3,865,560,081	4,348,755,091	4,831,950,101	24,159,750,504
1.1.4. By 2030, increase contraceptive prevalence in women of childbearing age	MOTHER	402,662,508	442,928,759	483,195,010	523,461,261	644,260,013	724,792,515	805,325,017	4,026,625,084
1.1.5. By 2030, reduce the prevalence and complications of obstetric fistula	MOTHER	2,415,975,050	2,657,572,555	2,899,170,060	3,140,767,566	3,865,560,081	4,348,755,091	4,831,950,101	24,159,750,504
1.1.6. By 2030, improve STI/hepatitis/HIV prevention and management for women;	MOTHER	402,662,508	442,928,759	483,195,010	523,461,261	644,260,013	724,792,515	805,325,017	4,026,625,084
1.1.7. By 2030, contribute to reducing the incidence of breast and cervical cancer;	MOTHER	805,325,017	885,857,518	966,390,022	1,046,922,522	1,288,520,027	1,449,585,030	1,610,650,034	8,053,250,168
TOTAL OF THE MOTHER TARGET		8,053,250,168	8,858,575,185	9,663,900,202	10,469,225,220	12,885,200,269	14,495,850,302	16,106,500,338	80,532,501,680

SPECIFIC OBJECTIVE	TARGET	2024	2025	2026	2027	2024	2029	2030	Amount
STRATEGIC AXIS 1 : Scaling- up the coverage of high-impact- interventions for the reduction of the morbidity and mortality of mothers, newborns, children, adolescents, men and women, including the elderly									
1.1. Strategic objective 1: By 2030, improve coverage of high-impact RMNCAH- NUT interventions for mothers, newborns, children, adolescents, men and women, including the elderly		16,106,500,336	17,717,150,370	19,327,800,403	20,938,450,437	25,770,400,538	28,991,700,605	32,213,000,672	161,065,003,359
1.1.1. By 2030, improve the quality of newborn management	NEWBORN	2,254,910,047	2,480,401,052	2,705,892,056	2,931,383,061	3,607,856,075	4,058,838,085	4,509,820,094	22,549,100,470
1.1.2. By 2030, improve the Prevention of Mother-to-Child Transmission of HIV (PMTCT);	NEWBORN	483,195,010	531,514,511	579,834,012	628,153,513	773,112,016	869,751,018	966,390,020	4,831,950,101
1.1.3. By 2030, reduce the incidence of neonatal tetanus	NEWBORN	483,195,010	531,514,511	579,834,012	628,153,513	773,112,016	869,751,018	966,390,020	4,831,950,101
TOTAL OF THE NEWBORN TARGET		3,221,300,067	3,543,430,074	3,865,560,081	4,187,690,087	5,151,080,108	5,798,340,121	6,442,600,134	32,213,000,672
1.1.1. By 2030, ensure healthy child growth	CHILD	628,153,513	690,968,864	753,784,216	816,599,567	1,005,045,621	1,130,676,324	1,256,307,026	6,281,535,131
1.1.2. By 2030, strengthen child management using the IMNCI approach (health facilities and communities in at least 80% of target health districts)	CHILD	1,465,691,531	1,612,260,684	1,758,829,837	1,905,398,990	2,345,106,449	2,638,244,755	2,931,383,061	14,656,915,306
TOTAL OF THE CHILD TARGET		2,093,845,044	2,303,229,548	2,512,614,052	2,721,998,557	3,350,152,070	3,768,921,079	4,187,690,087	20,938,450,437
1.1.1. By 2030, reduce the incidence/prevalence of risky sexual behaviours in at least 25% of adolescents/youth	ADOLESCENTS	112,745,502	124,020,053	135,294,603	146,569,153	180,392,804	202,941,904	225,491,005	1,127,455,024
1.1.2. By 2030, prevent and manage at least 25% of STI/HIV	ADOLESCENTS	563,727,512	620,100,263	676,473,014	732,845,765	901,964,019	1,014,709,521	1,127,455,024	5,637,275,118

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cases in adolescents and young people									
1.1.3. By 2030, promote Adolescent and Youth- friendly Health Services (AYFS)	ADOLESCENTS	225,491,005	248,040,105	270,589,206	293,138,306	360,785,608	405,883,808	450,982,009	2,254,910,047
1.1.4. By 2030, improve contraceptive prevalence in adolescents/youth;	ADOLESCENTS	225,491,005	248,040,105	270,589,206	293,138,306	360,785,608	405,883,808	450,982,009	2,254,910,047
TOTAL OF THE ADOLESCENT/YOUTH TARGET		1,127,455,024	1,240,200,526	1,352,946,028	1,465,691,531	1,803,928,038	2,029,419,042	2,254,910,047	11,274,550,235
1.1.1. By 2030, contribute to reducing the incidence of breast and cervical cancer	OLDER WOMEN	193,278,004	212,605,804	231,933,605	251, 26,405	309,244,806	347,900,407	386,556,008	1,932,780,040
1.1.2. By 2030, manage sexual dysfunction and menopausal disorders	OLDER WOMEN	386,556,008	425,211,609	463,864,210	503,522,810	618,489,613	695,800,815	773,112,016	3,865,560,081
1.1.3. By 2030, manage infertility in women	OLDER WOMEN	386,556,008	425,211,609	463,864,210	504,522,810	618,489,613	695,800,815	773,112,016	3,865,560,081
TOTAL OF THE OLDER WOMEN TARGET		966,390,020	1,063,029,022	1,159,668,024	1,256,307,026	1,546,224,032	1,739,502,036	1,932,780,040	9,663,900,202
1.1.1. By 2030, make available RH service packages tailored to the specific needs of men	OLDER MEN	322,130,007	354,343,007	386,556,008	418,769,009	515,408,001	579,834,012	644,260,013	3,221,300,067
1.1.2. By 2030, manage STIs/HIV, sexual dysfunction and urinary tract cancers	OLDER MEN	322,130,007	354,343,007	386,556,008	418,769,009	515,408,001	579,834,012	6,440,260,013	3,221,300,067
TOTAL OF THE OLDER MEN TARGET		644,260,013	708,686,015	773,112,016	837,538,017	1,030,816,022	1,159,668,024	1,288,520,027	6,442,600,134

Table 19: Breakdown of the Budget per Specific Objective of Strategic Axis 1, Strategic Objective 2

OBJECTIF SPECIFIQUE	CIBLE	2024	2025	2026	2027	2024	2029	2030	MONTANT
AXE STRATEGIQUE 1 : Extension de la couverture des interventions à haut impact pour la réduction de la morbi-mortalité de la mère, du nouveau-né, de l'enfant, de l'adolescent, de l'homme et de la femme y compris les sujets âgés									
SPECIFIC OBJECTIVE	TARGET	2024	2025	2026	2027	2024	2029	2030	Amount
STRATEGIC AXIS 1 : Scaling- up of the coverage of high-impact- interventions for the reduction of the morbidity and mortality of mothers, newborns, children, adolescents, men and women, including the elderly									
1.2. Strategic objective 2: By 2030, contribute to reducing harmful cultural practices in adolescents, women and men (Gender-based violence, female genital mutilation and child marriage).		1,789,611,148	1,968,572,263	2,147,533,378	2,326,494,493	2,963,377,838	3,221,300,067	3,579,222,297	17,896,111,484
1.2.1. By 2030, encourage communities to adopt behaviours conducive to reducing GBV and harmful cultural practices		178,961,115	196,857,226	214,753,338	232,649,449	286,337,784	322,130,007	357,922,230	1,789,611,148
1.2.2. By 2030, make evidence-based data available to monitor the extent of GBV and harmful practices		178,961,115	196,857,226	214,753,338	232,649,449	286,337,784	322,130,007	357,922,230	1,789,611,148
1.2.3. By 2030, improve the accessibility and use of medical management and psychological support services for GBV survivors and victims of harmful practices		1,252,727,804	1,378,000,584	1,503,273,365	1,628,546,145	2,004,364,486	2,254,910,047	2,505,455,608	12,527,278,039
1.2.4. By 2030, strengthen the effective implementation of the provisions of the institutional and legal framework to abolish impunity for GBV and harmful practices		178,961,115	196,857,226	214,753,338	232,649,449	286,337,784	322,130,007	357,922,230	1,789,611,148
TOTAL OF STRATEGIC AXIS 1 :									178,961,114,844

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Table 20: Breakdown of the Budget per Specific Objective of Strategic Axis 2, Strategic Objective 2

SPECIFIC OBJECTIVE	TARGET	2024	2025	2026	2027	2024	2029	2030	Amount
STRATEGIC AXIS 2 : Strengthening of the pillars of the healthcare system to create an environment conducive to achieving the impact of RMNCAH-Nut									
2.1. Strategic objective 1: By 2030, improve the availability of quality RMNCAH-Nut services		7,405,287,511	8,145,816,262	8,886,345,013	9,626,873,764	11,848,460,017	13,329,517,219	14,810,575,022	74,052,875,108
2.1.1. By 2030, strengthen high-quality RH infrastructure, logistics and facilities for essential secondary and tertiary care in RMNCAH-Nut		3,702,643,755	4,072,908,131	4,443,172,506	4,813,436,882	5,924,230,009	6,664,758,760	7,405,287,511	37,026,437,554
2.1.2. By 2030, strengthen the Health Information System for RMNCAH-Nut		370,264,376	407,290,813	44,317,251	481,343,688	592,423,001	666,475,876	740,528,751	3,702,643,755
2.1.3. By 2030, ensure sustainable funding for RMNCAH-Nut through the mobilization and efficient use of national and external resources;		370,264,376	407,290,813	44,317,251	481,343,688	592,423,001	666,475,876	740,528,751	3,702,643,755
2.1.4. By 2030, reduce the quantitative and qualitative deficit in qualified human resources in RMNCAH-Nut;		1,481,057,502	1,629,163,252	1, 77,269,003	1,925,374,753	2,369,692,003	2,665,903,504	2,962,115,004	14,810,575,002
2.1.5. By 2030, improve the availability of essential drugs and products (blood products) for RMNCAH;		740,528,751	814,581,626	888,634,501	962,687,376	1,184,846,002	1,332,951,752	1,481,057,502	7,405,287,511
2.1.6. By 2030, strengthen community activities (CDIs).		740,528,751	814,581,626	888,634,501	962,687,376	1,184,846,002	1,332,951,752	1,481,057,502	7,405,287,511
2.2. Strategic objective 2: By 2030, improve the accessibility and use of RMNCAH-Nut services		4,936,858,341	5,430,544,175	5,924,230,009	6,417,915,843	7,898,973,345	8,886,345,013	9,873,716,681	49,368,583,405
2.2.1. By 2030, ensure equitable financial access for targets to RH care and services		3,949,486,672	4,344,435,340	4,739,384,007	5,134,332,674	6,319,178,676	7,109,076,010	7,898,973,345	39,494,866,724
2.2.2. By 2030, reduce cultural and geographical barriers to RMNCAH-Nut care and services		987,371,668	1,086,108,835	1,184,846,002	1,283,583,169	1,579,794,669	7,109,076,010	1,974,743,336	9,873,716,681
TOTAL OF STRATEGIC AXIS 2									123,421,458,513

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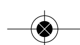
Table 21: Breakdown of the Budget per Specific Objective of Strategic Axis 3, Strategic Objective 3

SPECIFIC OBJECTIVE	TARGET	2024	2025	2026	2027	2024	2029	2030	Amount
STRATEGIC AXIS 3 : Setting up of effective mechanisms to support the implementation of the 2024- 2024 National Strategic Plan for RMNCAH-Nut									
3.1. Strategic objective 1: By 2030, strengthen the governance of the healthcare system for RMNCAH-Nut		246,842,917	271,527,209	296,211,500	320,895,792	394,948,667	444,317,251	493,685,834	2,468,429,170
3.1.1. By 2030, strengthen communication for the mobilization around RMNCAH-Nut issues		12,342,146	13,576,360	14,810,575	16,044,790	19,747,433	22,215,863	24,584,292	123,421,459
3.1.2. By 2030, strengthen policy, legal and regulatory measures for RMNCAH-Nut.		12,342,146	13,576,360	14,810,575	16,044,790	19,747,433	22,215,863	24,584,292	123,421,459
3.1.3. By 2030, promote civil status registration ;		12,342,146	13,576,360	14,810,575	16,044,790	19,747,433	22,215,863	24,584,292	123,421,459
3.1.4. By 2030, strengthen the public-private partnership for RH;		12,342,146	13,576,360	14,810,575	16,044,790	19,747,433	22,215,863	24,584,292	123,421,459
3.1.5. By 2030, improve the multi-sector coordination of quality RMNCAH-Nut administrative structures.		49,368,583	54,305,442	59,242,300	64,179,158	78,989,733	88,863,450	98,737,167	493,685,834
3.1.6. By 2030, improve the managerial skills of at least 80% of managers in RMNCAH-Nut structures		74,052,875	81,458,163	88,863,450	96,268,738	118,484,600	133,295,175	148,105,750	740,528,751

3.1.7 By 2030, promote the quality assurance of RH services		24,684,292	27,152,721	29,621,150	32,089,579	39,494,867	44,431,725	49,368,583	246,842,917
3.1.8. By 2030, promote basic and operational research in RMNCAH-Nut in Cameroon		49,368,583	54,305,442	59,242,300	64,179,158	78,989,733	88,863,450	98,737,167	493,685,834
3.2. Strategic objective 2: By 2030, strengthen the strategic steering of the implementation of the new Strategic Plan for RMNCAH-Nut		246,942,917	271,527,209	296,211,500	320,895,792	394,948,667	44,317,251	493,685,834	2,468,429,170
3.2.1. By 2030, strengthen the implementation framework and establish the role of key stakeholders.		37,026,438	40,729,081	44,431,725	48,134,369	59,242,300	66,647,588	74,052,875	370,264,376
3.2.2. By 2030, strengthen the commitment and approval of stakeholders in the implementation of the Plan		37,026,438	40,729,081	44,431,725	48,134,369	59,242,300	66,647,588	74,052,875	370,264,376
3.2.3. By 2030, ensure the Supervision, Monitoring and Evaluation of the implementation of the Plan.		172,790,042	190,069,046	207,348,050	224,627,054	276,464,067	311,022,075	345,580,084	1,727,900,419
3.3. Strategic objective 3: By 2030, strengthen the resilience of the health system to the risks of public health emergencies in order to improve the provision of reproductive health services.		123,421,459	135,763,604	148,105,750	160,447,896	197,474,334	22,158,625	246,842,917	1,234,214,585
3.3.1. By 2030, ensure the implementation of essential RMNCAH interventions in public health emergencies		123,421,459	135,763,604	148,105,750	160,447,896	197,474,334	22,158,625	246,842,917	1,234, 24,585
TOTAL OF STRATEGIC AXIS 3 :									6,171,072,926



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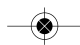

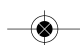

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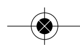

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9 APPENDICES

9.1 APPENDIX 1: LOGIC FRAMEWORK

STRATEGIC OBJECTIVE 1.1.: By 2030, improve the coverage of high-impact RMNCAH-Nut interventions for mothers, newborns, children, adolescents, men and women, including the elderly.

Specific objectives	Interventions	Structure(s) in charge	IMPLEMENTATION PERIOD						
			2024	2025	2026	2027	2024	2029	2030
Target: Mothers/women of childbearing age									
1.1.1. **By 2030, achieve quality ANC coverage among 95% of expected pregnant women**	Build the capacities of ANC care providers in accordance with national guidelines	DSF, PLMI, RDPH, HD, HF, TFP	x	x	x	x	x	x	x
	Enhance pregnant women follow-up by MCHWs in the community as well as their referral to health facilities	HD, HF, TFP	x	x	x	x	x	x	x
	Strengthen communication actions to bring about social and behaviour change	DSF, PLMI, RDPH, HD, HF, RLA, CSO, community leaders	x	x	x	x	x	x	x

Specific objectives	Interventions	Structure(s) in charge	IMPLEMENTATION PERIOD						
			2024	2025	2026	2027	2024	2029	2030
	among the population in favour of ANC								
1.1.2. By 2030, achieve quality PNC coverage for 80% of expected deliveries.	Strengthen communication campaigns to bring about social and behaviour change among women, men, families and the community regarding the importance of postnatal consultations.	DSF, PLMI, RDPH, HD, HF, RLA, CSO, community leaders	x	x	x	x	x	x	x
	Build the capacities of ANC care providers	DSF, PLMI, RDPH, HD, HF, TFP	x	x	x	x	x	x	x
1.1.3. By 2030, achieve 80% coverage of deliveries in a health facility.	Improve the quality of essential obstetric and neonatal care (EONC) and emergency obstetric and neonatal care (EmONC) in public and private health facilities.	DSF, PLMI, RDPH, HD, HF, TFP	x	x	x	x	x	x	x
	Strengthen the implementation of EmONC monitoring								
	Scale up national EmONC mapping		x	x	x	x	x	x	x
	Enhance the motorbike ambulance strategy to rapidly transfer women with childbirth complications	DSF TFP	x	x	x	x	x	x	x
	Strengthen mentoring in maternal health	DSF, PLMI, RDPH, HD TFP	x	x	x	x	x	x	x

Specific objectives	Interventions	Structure(s) in charge	IMPLEMENTATION PERIOD						
			2024	2025	2026	2027	2024	2029	2030
	at all levels of the health pyramid								
	Strengthen the patient referral and counter-referral system	DSF, PLMI, RDPH, HD, HF, RLA, CSO, community leaders	x	x	x	x	x	x	x
	Strengthen communication campaigns to bring about social and behaviour change among the population on the advantages of giving birth in health facilities with the assistance of skilled health personnel	DSF, PLMI, RDPH, HD, HF, RLA, CSO, community leaders	x	x	x	x	x	x	x
	Improve the availability of blood and its derivatives	National Blood Transfusion Committee (NBTC), DSF, DPML, PLMI	x	x	x	x	x	x	x
	Motivate traditional birth attendants to refer pregnant women to health facilities	HD, HF, TFP	x	x	x	x	x	x	x
1.1.4. By 2030, achieve 35% contraceptive prevalence among women of childbearing age	Make FP commodities available at the last mile	DSF, PLMI, CENAME, RFHP, HF, TFP NTC-UHC	x	x	x	x	x	x	x
	Improve the quality of FP services for women, particularly those living with a disability, with HIV/AIDS/hepatitis, or suffering from obstetric fistulas, etc.	DSF, PLMI, RDPH, HD, HF, MINJEC, MINESUP, MINAS, MINPROFF, MINESEC, RLA	x	x	x	x	x	x	x
	Enhance the integration of FP services in youth-friendly centres, school	DSF, PLMI, RDPH, HD, HF, MINJEC, MINESUP, MINAS MINSEC, RLAs	x	x	x	x	x	x	x

Specific objectives	Interventions	Structure(s) in charge	IMPLEMENTATION PERIOD						
			2024	2025	2026	2027	2024	2029	2030
	infirmaries, university medical centres, HIV management facilities, private sector facilities, denominational organisations, etc.								
	Enhance community FP (Implement a community commitment plan for FP)	DSF, PLMI, RDPH, HD, HF, RLA, CSO, community leaders, TFP	x	x	x	x	x	x	x
	Strengthen the involvement of RLAs in FP interventions	DSF, PLMI, RDPH, HD, DOSTS, DPML HF, MINDEVEL TFP	x	x	x	x	x	x	x
	Promote the DMPA-SC self-care/self-injection approach in the community	DSF, PLMI, RDPH, HD HF, TFP, MCHW	x	x	x	x	x	x	x
1.1.5. By 2030, increase the rate of screening and treatment of obstetric fistulas in 80% of targeted HDs.	Develop financing mechanisms to improve prevention, management and social reintegration of women with obstetric fistula.	DSF, PLMI, RDPH, HD, HF, RLA, CSO, MINPROFF, MINASS, community leaders	x	x	x	x	x	x	x
	Improve the quality of prevention, management and socio-professional reintegration of women with obstetric fistula	DSF, PLMI, MINPROFF, MINAS, RDPH, HD, HF TFP	x	x	x	x	x	x	x
	Organise obstetric fistula repair campaigns in targeted health districts	DSF, PLMI, RDPH, HD, HF TFP, NTC-UHC	x	x	x	x	x	x	x
	Draw up an operational plan	DSF, PLMI, MINPROFF, MINAS, RDPH, HD, HF	x	x	x	x	x	x	x

Specific objectives	Interventions	Structure(s) in charge	IMPLEMENTATION PERIOD						
			2024	2025	2026	2027	2024	2029	2030
	for the management and prevention of obstetric fistula	TFP, MCHW							
	Increase the involvement of men inSRH activities	DSF, PLMI, MINPROFF, MINASS, RDPH, HD, HF TFP, MCHW	x	x	x	x	x	x	x
	Strengthen coordination and collaboration between the various stakeholders involved in the fight against obstetric fistula	DSF, PLMI, MINPROFF, MINAS, RDPH, HD, HF TFP, RLA, CSO, MCHW	x	x	x	x	x	x	x
	Scale up the mapping of approved obstetric fistula management centres throughout the country	DSF, PLMI, MINPROFF, MINAS, RDPH, HD, HF TFP	x	x	x	x	x	x	x
1.1.6. By 2030, improve the prevention and management of STIs/Hepatitis/HIV among women of childbearing age in at least 80% of HDs.	Step up STI/Hepatitis/HIV and cervical cancer sensitisation and prevention campaigns using the Social and Behaviour Change (SBC) approach.	DSF, PLMI, RDPH, HD, TFP, DPML, DOSTS, DROS, MINESEC, MINJUSTICE, MINAS, MINJEC	x	x	x	x	x	x	x
	Build the capacities of multipurpose community health workers (MCHWs) to step up sensitisation, screening and referral to 1st category health facilities (HFs) for STIs, hepatitis and HIV	DSF, PLMI, RDPH, HD, TFP, DPML, DOSTS, DROS, MINESEC, MINJUSTICE, MINAS, MINJEC	x	x	x	x	x	x	x

Specific objectives	Interventions	Structure(s) in charge	IMPLEMENTATION PERIOD						
			2024	2025	2026	2027	2024	2029	2030
	Build the capacities of health facilities to screen for and manage STIs/Hepatitis/HIV	DSF, PLMI, RDPH, HD, TFP, DPML, DOSTS, DROS, MINESEC, MINJUSTICE, MINAS, MINJEC	X	X	X	X	X	X	X
	Strengthen HIV/STI/Hepatitis sensitisation and screening services for all target groups (prisons, universities and the community) using the SBC approach	DSF, PLMI, RDPH, HD, TFP, DPML, DOSTS, DROS, MINESEC, MINJUSTICE, MINAS, MINJEC	X	X	X	X	X	X	X
	Provide the SBC service package as fixed and outreach strategies in order to fight against STI/HIV/Hepatitis	DSF, PLMI, RDPH, HD, TFP, DPML, DOSTS, DROS, MINESEC, MINJUSTICE, MINAS, MINJEC	X	X	X	X	X	X	X
1.1.7. By 2030, increase screening and management of cases of breast and cervical cancer in at least 30% of HDs.	Build the capacities of midwives on breast and cervical cancer screening.	DPML, DOSTS, DROS, MINESEC, MINJUSTICE, MINASS, MINJEC	X	X	X	X	X	X	X
	Build the capacities of health facilities of category 1 and 2 to diagnose and correctly manage cases of female genital cancers.	MOH, NCaCC, DOSTS, NTC-UHC, RDPH, HD, TFP	X	X	X	X	X	X	X
	Build the capacities of community health workers on screening and referral of breast and cervical cancers	DSF, DPML, DOSTS, DROS, MINESEC, MINJUSTICE, MINASS, MINJEC, CNLCa	X	X	X	X	X	X	X
	Organise sensitisation	NCaCC, DSF, PLMI, RDPH, HD, TFP	X	X	X	X	X	X	X

Specific objectives	Interventions	Structure(s) in charge	IMPLEMENTATION PERIOD						
			2024	2025	2026	2027	2024	2029	2030
	campaigns on the prevention of breast and cervical cancers								
	Build the operational capacities of laboratories to improve breast and cervical cancer diagnosis (protocols, SOPs and diagnostic equipment, equipment and other management commodities, etc.).	NCaCC, NPHL, DSF, PLMI, RDPH, HD, TFP, DPML	x	x	x	x	x	x	x
1.1.8. By 2030, improve the management of infertility among women in 100% of regional and central hospitals	Build the capacities of healthcare service providers in the prevention and management of infertility	DSF NCaCC, PLMI, TFP	x	x	x	x	x	x	x
	Strengthen services for the management of sexual pathologies responsible for infertility at all levels of the health pyramid	DSF, PLMI, DOSTS, DPS, DPML	x	x	x	x	x	x	x
	Build the operational capacities of laboratories to improve infertility diagnosis in regional, central and general hospitals (protocols, SOPs, diagnostic equipment and other management	DSF, DPML NCaCC, NPHL, DSF, PLMI, RDPH, HD, TFP	x	x	x	x	x	x	x

Specific objectives	Interventions	Structure(s) in charge	IMPLEMENTATION PERIOD						
			2024	2025	2026	2027	2024	2029	2030
	commodities, etc.).								
	Organise sensitisation campaigns on the prevention of infertility	DPS, NCaCC, DSF, PLMI, RDPH, HD, TFP, CSO	x	x	x	x	x	x	x
1.1.9. Improve by 50% the nutritional status of pregnant and breastfeeding women received in health facilities.	Reinforce deworming as well as IFA and micronutrient supplementation.	DPS, DSF, DLMEP	x	x	x	x	x	x	x
	Organise SBC activities for mother/child nutrition as part of ANC/PNC.	DPS, DSF, DLMEP, HF, CSO, TFP	x	x	x	x	x	x	x
	Reinforce the supplementation of multiple micronutrients, calcium, and energy and protein balanced food.	DPS, DSF, DLMEP, HD	x	x	x	x	x	x	x
Newborn target									
1.1.10. By 2030, ensure that 80% of health facilities targeted at all levels provide quality newborn care and services.	Build the capacities of healthcare providers in high-impact interventions (Essential Newborn Care (ENC), resuscitation of the newborn, management of paediatric AIDS, KMC, oxygen therapy) on site in maternity wards and delivery rooms in targeted health facilities.	DSF, PLMI, DPS RDPH, HD HF TFP	x	x	x	x	x	x	x

Specific objectives	Interventions	Structure(s) in charge	IMPLEMENTATION PERIOD						
			2024	2025	2026	2027	2024	2029	2030
	Strengthen the referral and counter-referral system for a better management of newborns	DSF, PLMI, DPS, RDPH, HD HF, TFP	x	x	x	x	x	x	x
	Carry out supportive supervision of health care providers trained in neonatal care	DSF, PLMI RDPH, HD	x	x	x	x	x	x	x
	Institutionalise the 10 steps towards successful breastfeeding in health facilities	DOSTS, DSF NTC-UHC, RDPH TFP	x	x	x	x	x	x	x
	Provide health facilities with appropriate equipment for better management of newborns (bag + mask, oxygen extractor, oxygen goggles, kangaroo bags, etc.).	DOSTS, DSF NTC-UHC, RDPH TFP	x	x	x	x	x	x	x
	Build the capacities of MCHWs to provide Kangaroo mother care (KMC), identify cases of prematurity in the community and refer newborns from the community to health facilities.	RDPH HD, HF, TFP	x	x	x	x	x	x	x
	Advocate among RLAs to involve them in the fight against the complications of prematurity	RDPH HD, NTC UHC	x	x	x	x	x	x	x
	Train trainers on KMC at central,	DSF RDPH, TFP	x	x	x	x	x	x	x

Specific objectives	Interventions	Structure(s) in charge	IMPLEMENTATION PERIOD						
			2024	2025	2026	2027	2024	2029	2030
	regional and district levels								
	Organise sensitisation campaigns for community leaders, socio-cultural association leaders and corporate leaders on the causes and complications of prematurity.	RDPH, HD TFP	x	x	x	x	x	x	x
	Extend civil status registration offices into health facilities	MINATD, RDPH, HD, BUNEC, BUNEC regional agencies	x	x	x	x	x	x	x
1.1.11. By 2030, prevent mother-to-child transmission of HIV/AIDS /hepatitis B (PMTCT) in 100% of pregnant women received for ANC.	Build the capacities of healthcare providers in PMTCT **(HIV/AIDS/Syphilis/Viral Hepatitis B)** in HFs.	DSF, PLMI, DPS, RDPH, HD, HF TFP	x	x	x	x	x	x	x
	Build the capacities of MCHWs to prevent mother-to-child transmission, screen, refer and monitor HIV+ pregnant women.	RDPH, HD, HF, DOSTS TFP	x	x	x	x	x	x	x
1.1.12. By 2030, ensure that 90% of pregnant women received for ANC have been vaccinated against tetanus.	Strengthen the follow-up of tetanus vaccination in pregnant women	DSF, EPI, PLMI, DPS, RDPH, HD, HF, TFP, MCHW	x	x	x	x	x	x	x
	Build the capacities of healthcare providers in the prevention and management of neonatal tetanus	DSF, PLMI, DPS, RDPH, HD, HF TFP	x	x	x	x	x	x	x
Child target									
1.1.13. By 2030, ensure	Organise sensitisation	DSF, PLMI, DPS, RDPH, HD HF, TFP	x	x	x	x	x	x	x

Specific objectives	Interventions	Structure(s) in charge	IMPLEMENTATION PERIOD						
			2024	2025	2026	2027	2024	2029	2030
coverage of high-impact preventive interventions in at least 90% of children received for consultations	campaigns (commemoration world days such as breastfeeding, prematurity, etc.) as well as RMNCAH-Nut (MNCHAW) service delivery campaigns.								
	Build the capacities of healthcare providers to manage malnutrition	RDPH, HD TFP	x	x	x	x	x	x	x
	Promote essential family practices (EFPs) for children at community level	RDPH, HD TFP	x	x	x	x	x	x	x
	Train MCHWs to identify and refer cases of malnutrition to health facilities	RDPH, HD, TFP	x	x	x	x	x	x	x
	Build the capacities of stakeholders of other sectors to prevent and manage cases of chronic malnutrition	DPS, RDPH, HD, HF TFP	x	x	x	x	x	x	x
	Improve the quality of the overall management of children, particularly those aged 6 to 9 years	DPS, RDPH, HD, HF TFP	x	x	x	x	x	x	x
	Reinforce Prevention Control and Promotion of Healthy Child Growth actions	DPS, RDPH, HD, HF TFP	x	x	x	x	x	x	x
	Advocate with other sectors involved in the	DPS, RDPH, HD, HF TFP	x	x	x	x	x	x	x

Specific objectives	Interventions	Structure(s) in charge	IMPLEMENTATION PERIOD						
			2024	2025	2026	2027	2024	2029	2030
	fight against chronic malnutrition								
	Map out priority intervention areas according to the infant and child mortality.	DSF, RDPH TFP	x						
	Step up vitamin A and folic acid supplementation campaigns in schools	RDPH, HD, HF TFP	x	x	x	x	x	x	x
	Increase sensitisation of parents on the IMNCI approach	EPI, RDPH, HD, HF, TFP	x	x	x	x	x	x	x
	Organise mobile and outreach strategies to provide IMNCI	EPI, RDPH, HD, HF, TFP	x	x	x	x	x	x	x
1.1.14. By 2030, enhance child care based on the IMNCI approach (health facilities and communities) in at least 80% of targeted HDs	Organise vaccination campaigns	EPI, RDPH, HD, HF, TFP	x	x	x	x	x	x	x
	Organise the search for the lost-to-follow up	EPI, RDPH, HD, HF, TFP, MCHW	x	x	x	x	x	x	x
	Build the operational capacities of healthcare service providers in districts and health facilities (update tools, supply inputs, technical platforms, etc.).	DSF RDPH TFP	x	*					
	Build the capacities of healthcare service providers in health facilities as well as those of MCHWs in the community (use	DSF RDPH TFP		*			*	*	

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Specific objectives	Interventions	Structure(s) in charge	IMPLEMENTATION PERIOD						
			2024	2025	2026	2027	2024	2029	2030
	of the ICATT electronic tool)								
Adolescent/youth target									
1.1.15. By 2030, reduce the prevalence of risky sexual behaviour in at least 25% of adolescents/youth	Strengthen Comprehensive Sexuality Education (CSE) training in schools/universities/extra-curricular activities.	MOH/MINJEC/MINPROFF/MINESEC/MINESUP/MINAS	x	x	x	x	x	x	x
	Mobilise all stakeholders (parents of adolescents/youth, teachers, educators, healthcare providers, NGO leaders, community association leaders, community leaders and the adolescents/youth themselves as actors and beneficiaries, etc.) for the promotion of CSE.	MOH/MINJEC/MINESEC/MINESUP/MINAS/MINPROFF/CSO	x	x	x	x	x	x	x
1.1.16. By 2030, prevent and treat at least 25% of STI/HIV cases among adolescents and youth.	Build the operational capacities of health facilities and youth support structures (MCYE CPFF, CESO and CSOs) to manage STIs/HIV in adolescents/youth.	MOH/MINPROFF/MINJEC/MINAS/MINESUP/CSO	x	x	x	x	x	x	x
	Organise an annual HPV vaccination campaign to prevent cervical cancer in adolescents	MOH/MINPROFF/MINJEC/MINAS/MINESUP/CSO	x	x	x	x	x	x	x

Specific objectives	Interventions	Structure(s) in charge	IMPLEMENTATION PERIOD						
			2024	2025	2026	2027	2024	2029	2030
	Build the operational capacities of health facilities and youth support structures (CMPJ CPFF, CESO and CSO) to provide care in cases of sexual dysfunction in adolescents/youth.	MOH/MINPROFF/MINJEC/MINAS/MINESUP/CSO	x	x	x	x	x	x	x
1.1.17. By 2030, promote Adolescent and Youth Friendly Health Services (AYFHS) in 80% of administrative divisions	Scale-up adolescent reproductive health units.	MOH/MINJEC/MINPROFF/MINESUP/MINAS/CSO	x	x	x	x	x	x	x
	Help schools and universities to improve their infirmaries (equipment, human resources, supervision, etc.),	MOH/MINESEC/MINESUP	x	x	x	x	x	x	x
	Provide comprehensive sexuality education in youth-friendly centres and other AYRH service delivery points	MOH/MINESEC/MINEDUB/MINJEC/MINPROFF/MINAS/MINESUP/CSO	x	x	x	x	x	x	x
	Strengthen SBC activities concerning AYRH	MOH/MINESEC/MINJEC/MINPROFF/MINESUP/MINAS/CSO	x	x	x	x	x	x	x
	Increase the range of ARH services, including GBV care, in youth-friendly centres and other ARH service delivery points	MOH/MINESEC/MINJEC/MINPROFF/MINESUP/MINAS/CSO	x	x	x	x	x	x	x
	Strengthen ARH in social media as well as referrals to appropriate health facilities	MOH/MINESEC/MINJEC/MINPROFF/MINESUP/MINAS/CSO	x	x	x	x	x	x	x

Specific objectives	Interventions	Structure(s) in charge	IMPLEMENTATION PERIOD						
			2024	2025	2026	2027	2024	2029	2030
	and delivery points								
	Build the operational capacities of youth centres to provide sexual information and education to adolescents/youth on risky behaviour, counselling on the follow up of pregnancy and the distribution of condoms and ARVs.	MOH/MINESEC/MINJEC/MINPROFF/MINESUP/MINAS/CSO	x	x	x	x	x	x	x
	Strengthen the management of menstrual hygiene in adolescent (sensitization, strengthen capacities of health personal, equipment donations in URHYA)	MOH/MINESEC/MINJEC/MINPROFF/MINESUP/MINAS/CSO	x	x	x	x	x	x	x
1.1.18. By 2030, improve modern contraceptive prevalence in at least 35% of adolescents/youth	Organise workshops to implement the commitments of the FP2030 Initiative	MOH/MINESEC/MINJEC/MINPROFF/MINESUP/MINAS/CSO	x	x	x	x	x	x	x
	Ensure that contraceptive products are available to the last mile	MOH/ TFP/CSO	x	x	x	x	x	x	x
	Build the capacities of health care and service providers to offer quality FP services	MOH/MINESEC/MINJEC/MINPROFF/MINESUP/MINAS/CSO	x	x	x	x	x	x	x
	Strengthen SBC for FP	MOH/MINESEC/MINJEC/MINPROFF/MINESUP/MINAS/CSO	x	x	x	x	x	x	x

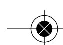
Specific objectives		Interventions	Structure(s) in charge	IMPLEMENTATION PERIOD						
				2024	2025	2026	2027	2024	2029	2030
1.1.19.	Improve the nutritional status of at least 50% of adolescents and young people.	Organize CSC activities in support of adolescents and young people nutrition.	DHP, DFH, HF, CSO, TFP	x	x	x	x	x	x	x
MEN, WOMEN AND ELDERLY TARGET										
1.1.20.	Improve the nutritional status of at least 50% of men, women, and elderly persons received in health facilities (FOSA).	Organize CSC activities in support of men, women, and elderly persons nutrition.	DHP, DFH, HF, CSO, TFP	x	x	x	x	x	x	x
women including the elderly target										

Specific objectives	Interventions	Structure(s) in charge	IMPLEMENTATION PERIOD						
			2024	2025	2026	2027	2024	2029	2030
1.1.21. By 2030, provide appropriate treatment for sexual dysfunction and menopausal disorders to at least 80% of women received in district and regional hospitals.	Build the capacities of multi-purpose community health workers in breast and cervical cancer screening.	MOH/MINPROFF/MINAS/CSO	x	x	x	x	x	x	x
	Build the operational capacities of category I and 2 health facilities on the proper treatment of cases of female genital cancer	MOH	x	x	x	x	x	x	x
	Reinforce the screening for breast and cervical cancers in all HFs	MOH (NCaCC, DOSTS, UHC-NTC, RDPH, HD,	x	x	x	x	x	x	x
	Organise sensitisation campaigns on the prevention of breast and cervical cancers	MOH (NCaCC, DSF, PLMI, RDPH, HD), TFP	x	x	x	x	x	x	x
	Build the operational capacities of laboratories to improve the diagnosis of breast and cervical cancers (protocols, SOPs and diagnostic equipment, equipment and other management commodities, etc.).	MOH (NCaCC, NPHL, DSF, PLMI, RDPH, HD), TFP	x	x	x	x	x	x	x
1.1.22. By 2030, provide appropriate infertility treatment	Mobilise and build the capacities of the community and CBOs to identify signs of sexual dysfunction and	MOH	x	x	x	x	x	x	x

Specific objectives	Interventions	Structure(s) in charge	IMPLEMENTATION PERIOD						
			2024	2025	2026	2027	2024	2029	2030
to at least 80% of women coming to targeted districts and regional hospitals.	menopausal disorders								
	Improve sexual pathology management services in district, regional, central and general hospitals (technical treatment documents, materials, inputs, case management equipment, etc.).	MOH (NCaCC, DOSTS, CTN-UHC RDPH, HD, DSF), TFP	x	x	x	x	x	x	x
	Mobilise and build the capacities of providers in targeted health facilities to diagnose and treat sexual dysfunction and menopausal disorders	MOH	x	x	x	x	x	x	x
1.1.23. By 2030, provide appropriate treatment to at least 60% of cases of reproductive cancers in women screened in hospitals.	Enhance reproductive cancer care services in district, regional, central and general hospitals.	MOH (NCaCC, NPHL, DSF, PLMI, RDPH, HD), TFP	x	x	x	x	x	x	x
Men including the elderly									
1.1.24. By 2030, provide proper treatment to at least 50% of cases of	Build the SBC capacities of MCHWs to promote men's reproductive health as well as screening for	MOH/MINAS/MINDEF/CSO	x	x	x	x	x	x	x

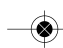
Specific objectives	Interventions	Structure(s) in charge	IMPLEMENTATION PERIOD						
			2024	2025	2026	2027	2024	2029	2030
sexual disorders or STIs/HIV in men received in health structures.	male sexual dysfunction.								
	Reinforce reception services in HFs to inform and guide men to the appropriate services for their sexual problems.	MOH/MINAS	x	x	x	x	x	x	x
	Provide fixed and outreach strategy packages of RMNCAH-Nut services (STI/hepatitis/HIV sensitization and prevention campaigns)	MOH (DSF, PLMI, RDPH, HD, TPF)/MINAS	x	x	x	x	x	x	x
	Improve the community care and service package of MCHWs for STI/HIV screening	MOH (DSF, PLMI, RDPH, HD), TFP	x	x	x	x	x	x	x
	Build the operational capacities of health facilities for screening and treatment of STIs/HIV in men	MOH (DSF, PLMI, RDPH, HD), TFP	x	x	x	x	x	x	x
	Provide HIV counselling and testing to all target groups in prisons, universities and the community	MOH (DSF, PLMI, NACC, RDPH, HD)/MINAS, TFP	x	x	x	x	x	x	x
1.1.25. By 2030, ensure that at least 60% of cases of detected reproductive cancers in	Provide fixed and outreach strategies for genital cancer sensitization and prevention campaigns	MOH (DSF, PLMI, RDPH, HD, TPF)/MINAS	x	x	x	x	x	x	x
	Increase screening for prostate cancer	MOH/MINAS	x	x	x	x	x	x	x

Specific objectives	Interventions	Structure(s) in charge	IMPLEMENTATION PERIOD						
			2024	2025	2026	2027	2024	2029	2030
men seen in category 1 to 4 hospitals are treated according to standards.	in men in all health facilities								
	Build the operational capacities of laboratories to improve the diagnosis of genital cancers (Protocols, SOPs and diagnostic equipment for genital cancers, equipment and other treatment commodities, etc.).	MOH (NCaCC, NPHL, DSF, PLMI, RDPH, HD), TFP	x	x	x	x	x	x	x
	Enhance genital cancer and sexual pathology treatment services in district, regional, central and general hospitals (technical treatment documents, materials, equipment and commodities for genital cancer treatment, etc.)	MOH (NCaCC, DOSTS, UHC-NTC RDPH, HD), TFP	x	x	x	x	x	x	x



STRATEGIC OBJECTIVE No. 1.2.: By 2030, contribute to the reduction of harmful cultural practices in adolescents, women and men (gender-based violence, female genital mutilation and child marriages).

SPECIFIC OBJECTIVES	INTERVENTIONS	Structure (s) in charge	IMPLEMENTATION PERIOD						
			2024	2025	2026	2027	2028	2029	2030
1.2.1. By 2030, encourage at least 30% of targeted community groups in each district to adopt attitudes conducive to the reduction of GBV and Harmful Cultural Practices.	Build the capacities of key community actors identified in targeted priority HDs in the fight against GBV and Harmful Practices	MOH MINPROFF, TFP	x	x	x	x	x	x	x
	Strengthen the legal framework and the collaboration between key actors involved in the fight against GBV and Harmful Practices at the level of RLAs to be more effective in this fight.	MOH MINPROFF, RLA, TFP	x	x	x	x	x	x	x
	Request financial support from RLAs for the organisation of multi-sector coordination meetings in the fight against GBV and Harmful Practices	MOH MINPROFF, RLA, TFP	x	x	x	x	x	x	x
1.2.2. By 2030, make evidence-based data available in 80% of HDs to monitor the extent of GBV and Harmful Practices.	Set up an information system on GBV and Harmful Practices and promote the sharing of information, particularly among stakeholders and decision-makers.	MOH MINPROFF, , PTF	x	x	x	x	x	x	x
	Reinforce the coordination and operation of local committees to combat FGM	MOH MINPROFF, RLA, TFP	x	x	x	x	x	x	x
1.2.3. By 2030, improve access to and use of medical and psychological care services for GBV survivors and victims of Harmful Practices (HPs) in 60% of HDs.	Strengthen community communication about the existence of medical and psychological care services for GBV and HPs.	MOH MINPROFF, RLA, TFP	x	x	x	x	x	x	x
	Set up collaboration platforms at all levels between the various stakeholders (legal services, social services, medical services, etc.) to provide integrated care for GBV and HPs.	MOH MINPROFF, MINATD, MINJUSTICE, TFP	x	x	x	x	x	x	x
	Build the capacities of healthcare providers in the medical and psychological care of GBV and HPs.	MOH MINPROFF, TFP	x	x	x	x	x	x	x
1.2.4. By 2030, strengthen the effective application of the provisions of the	Advocate with decision-makers/authorities at all levels of the health system for the implementation of repressive measures against the perpetrators of harmful cultural practices	MOH MINPROFF, TFP	x	x	x	x	x	x	x
	Educate people on the means of recourse in the event of GBV and HPs	MOH MINPROFF, , TFP	x	x	x	x	x	x	x



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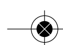
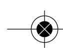


SPECIFIC OBJECTIVES	INTERVENTIONS	Structure (s) in charge	IMPLEMENTATION PERIOD						
			2024	2025	2026	2027	2028	2029	2030
institutional and legal framework with a view to putting an end to unpunished acts of GBV and HPs in 60% of administrative divisions.	Provide support to victims of GBV and HPs in their efforts to assert their rights	MOH MINPROFF, TFP	x	x	x	x	x	x	x
	Disseminate the provisions of the legal framework to stakeholders	MOH MINPROFF, MINATD, MINJUSTICE, TFP	x	x	x	x	x	x	x

➢ STRATEGIC AXIS 2: STRENGTHENING SUPPORT ACTIVITIES TO IMPROVE THE AVAILABILITY, ACCESSIBILITY, AFFORDABILITY AND USE OF QUALITY REPRODUCTIVE HEALTH CARE AND SERVICES

STRATEGIC OBJECTIVE No. 2.1.: By 2030, improve the availability of quality RMNCAH-Nut care and services for all target groups)

SPECIFIC OBJECTIVES	INTERVENTIONS	Structure(s) in charge	IMPLEMENTATION PERIOD						
			2024	2025	2026	2027	2028	2029	2030
2.1.1. By 2030, improve access to quality RMNCAH-Nut services by providing at least 80% of health facilities in the health districts with adequate infrastructure, logistics and equipment.	Evaluate and prioritise requirements for RMNCAH-Nut logistical, material, and medical and technical equipment	DSF, PLMI, UHC-NTC,TP	x	x	x	x	x	x	x
	Evaluate and prioritise requirements for RMNCAH-Nut laboratory equipment, materials and commodities	DSF, PLMI, UHC-NTC,TP	x	x	x	x	x	x	x
	Draw up a plan for equipping and maintaining medical and technical equipment in RMNCAH-Nut at the HD and RDPH level	DSF, PLMI, UHC-NTC,TPF	x			x			x
	Increase the availability of BEmONC and CEmONC services according to prioritised needs	DSF, PLMI, UHC-NTC, TP	x	x	x	x	x	x	x
	Provide health facilities with essential RMNCAH-Nut equipment and materials in accordance with the norms and standards defined by the MOH	DOSTS, DSF, PLMI; UHC-NTC,TPF	x	x	x	x	x	x	x
	Ensure curative and preventive maintenance and replacement of essential equipment based on situation analysis	DOSTS, PLMI, UHC-NTC,TFP	x	x	x	x	x	x	x
	Build the capacities of healthcare providers to improve the use of RMNCAH-Nut equipment	PLMI, UHC-NTCTFP	x	x	x	x	x	x	x



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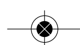
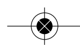


SPECIFIC OBJECTIVES	INTERVENTIONS	Structure(s) in charge	IMPLEMENTATION PERIOD						
			2024	2025	2026	2027	2028	2029	2030
	Promote the digitalisation of services and telemedicine to improve the supply of and demand for RMNCAH-Nut care and services.	DSF, PLMI ; UHC-NTC, TFP	x	x	x	x	x	x	x
	Construct and/or renovate HFs in health districts, according to the needs of the health map, targeting the needs of RMNCAH-Nut	DSF, PLMI, UHC-CTN, TFP	x			x			x
	Reinforce the blood bank/depot supply system in accordance with the pre-established plan	NBTC	x	x	x	x	x	x	x
	Increase the range of Specialised Services for infertility and sexual dysfunction as well as medically assisted reproduction (MAP) in regional referral hospitals.	DSF, RDPH, HD, HF	x	x	x	x	x	x	x
	Increase the availability of integrated management services for adolescents/youth in HFs, multi-purpose centres for youth empowerment and in the community	DSF, PLMI ; NTC UHC, TFP	x	x	x	x	x	x	x
	Strengthen the patient referral and counter-referral system	DSF, PLMI, RDPH, HD, HF, TFP	x	x	x	x	x	x	x
2.1.2. By 2030, ensure that 80% of health facilities at all levels of the health pyramid can produce and use high-quality RMNCAH-Nut information to guide decision-making.	Carry out audits on the quality and validation of RMNCAH-Nut data at all levels of the health pyramid	DSF, PLMI, RDPH, HD, HF, TFP	x	x	x	x	x	x	x
	Train the healthcare personnel providing RMNCAH-Nut services in data collection and management.	DSF, PLMI, RDPH, HD, HF, TFP	x	x	x	x	x	x	x
	Strengthen reviews/audits of maternal, neonatal deaths and stillbirths in all HFs	DSF, PLMI, RDPH, HD, HF, TFP	x	x	x	x	x	x	x
	Provide support for the harmonisation and popularisation/dissemination of RMNCAH-Nut data collection tools	DSF, PLMI, RDPH, HD, HF, TFP	x	x	x	x	x	x	x
	Enhance the digital collection of RMNCAH-Nut data based on prioritised needs (tablets, computers, fleets, etc.)	PLMI, HIU, DSF, RDPH, HD, HF	x	x	x	x	x	x	x
2.1.3. By 2030, increase by at least 5% the funding allocated to RMNCAH-Nut interventions.	Advocate for an increase in the budget allocated to health and RMNCAH-Nut with the Government.	MOH	x	x	x	x	x	x	x
	Advocate for the establishment of innovative and sustainable funding mechanisms for RMNCAH-Nut with the Government and TFPs	MOH	x	x	x	x	x	x	x
	Advocate for the mobilisation of resources for RMNCAH-Nut with regional and local authorities (RLAs)	MOH	x	x	x	x	x	x	x



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SPECIFIC OBJECTIVES	INTERVENTIONS	Structure(s) in charge	IMPLEMENTATION PERIOD						
			2024	2025	2026	2027	2028	2029	2030
	Draw up a funding plan to mobilise RMNCAH-Nut resources	DRFP, DSF, PLMI	x						
	Build the technical capacities of local elected representatives to ensure the viability of municipal health services and improve the use of resources allocated to health.	MOH, TFP	x	x	x	x	x	x	x
	Strengthen the system and tools for the management of RMNCAH-Nut funding (financial and material accounting, auditing and procurement)	DRFP, DSF, PLMI, RLA, TFP	x	x	x	x	x	x	x
	Set up a technical and financial audit system for the management structures of RMNCAH-Nut to ensure accountability and consistency between expenditure and results achieved.	DRFP, DSF, PLMI, RDPH	x	x	x	x	x	x	x
	Advocate for the effective implementation of UHC (legislative and financial framework)	DSF, PLMI ; UHC-NTC, TFP	x	x	x	x	x	x	
	Extend the subsidy mechanism for the management of RMNCAH-Nut targets (e.g. health vouchers in all regions)	DSF, PLMI ; NTC UHC-, TFP	x	x	x	x	x	x	
	Advocate to include other RMNCAH-Nut targets in the expansion of the healthcare basket under UHC with the Government, NGOs and TFPs.	DSF, PLMI ; UHC-NTC, TFP	x	x	x	x	x	x	
	Set up and use an exchange platform to improve the use of internal and external financial resources when implementing RMNCAH-Nut interventions.	DRFP, DSF, PLMI , UHC-NTC,TFP	x	x	x	x	x	x	
	Advocate for an effective increase in the resources allocated to RMNCAH-Nut at the operational level based on pre-established criteria with DRFP.	DSF, DRFP	x	x	x	x	x	x	x
	Advocate for MOH to access the platforms to monitor the effective use of funds allocated to health with MINFI and MINEPAT.	MOH	x	x	x	x	x	x	x
	Advocate for the promotion of income-generating activities to empower vulnerable members of society in all regions with the Government, NGOs and TFPs	MOH	x	x	x	x	x	x	x
2.1.4. By 2030, reduce by 30% the quantitative and qualitative deficit in	Advocate for the development and application of mechanisms to retain healthcare personnel working in remote areas, where access is difficult or where there is insecurity.	DHR	x	x	x	x	x	x	x
	Advocate for effective decentralisation in the recruitment of the necessary qualified	MOH	x	x	x	x	x	x	x

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SPECIFIC OBJECTIVES	INTERVENTIONS	Structure(s) in charge	IMPLEMENTATION PERIOD						
			2024	2025	2026	2027	2028	2029	2030
qualified human resources in RMNCAH-Nut at all levels of the health pyramid.	RMNCAH-Nut personnel according to the needs identified with the Government.								
	Ensure that qualified personnel (midwives, gynaecologists, paediatricians) are available based on priorities, particularly in difficult-to-access or insecure areas.	DHR	x	x	x	x	x	x	x
	Strengthen the initial and ongoing training of healthcare personnel on high-impact interventions (IMCI, EmONC, FP, newborn care, including kangaroo mother care, nutrition/supplementation, Management and Prevention of STIs/HIV, blood transfusion, patient reception, on-site training on Low Dose High Frequency (LDHF) mentoring).	DHR, DSF	x	x	x	x	x	x	x
	Train pools of trainers on RMNCAH-Nut in the 10 regions	DSF, PLMI	x	x	x	x	x	x	x
	Build the capacities of MCHWs, CSOs, etc. on the implementation of RMNCAH-Nut interventions according to field needs.	DSF, PLMI, RDPH, HD	x	x	x	x	x	x	x
	Build the capacities of traditional birth attendants to increase the use of RMNCAH-Nut services	DSF, PLMI, RDPH, HD	x	x	x	x	x	x	x
	Update the norms and standard document (personnel, etc.) in RMNCAH-Nut	DSF, DHR	x						
	Implement mechanisms to reward health facility personnel for their performance in RMNCAH-Nut at all levels of the health pyramid .[24]	, DSF, PLMI, RDPH, HD	x	x	x	x	x	x	x
	Support the periodic review of training curricula for healthcare workers to align with the new national and international recommendations on RMNCAH-Nut	DHR					x		
	Build the capacities of trainers and teachers in healthcare training schools in the area of RMNCAH-Nut	DHR	x	x	x	x	x	x	x
	Carry out accreditation activities and coercive checks on training establishments to ensure that teacher profiles comply with standards	DHR	x	x	x	x	x	x	x
	Train and/or retrain health workers in HFs on priority areas to deliver RMNCAH-Nut care and services in accordance with standards (family planning, EmONC, neonatal resuscitation, Kangaroo mother method, PMTCT, antenatal and postnatal	DHR, DSF, PLMI, RDPH	x	x	x	x	x	x	x

[24] For example "Quality Contest" and "E-learning"

SPECIFIC OBJECTIVES	INTERVENTIONS	Structure(s) in charge	IMPLEMENTATION PERIOD						
			2024	2025	2026	2027	2028	2029	2030
	care, IMCI, care for adolescents/youth as well as men and the elderly)								
2.1.5. By 2030, improve the availability of quality medicines and essential products for RMNCAH-Nut in at least 90% of health facilities in the health districts.	Assess the need for RMNCAH-Nut drugs, including contraceptives, laboratory reagents and blood products	DSF, PLMI, TFP, DPML	x	x	x	x	x	x	x
	Build the technical capacities of targeted stakeholders at regional and operational levels in the rational management of RMNCAH-NUt medicines and commodities and in their prescription	DSF, PLMI, TFP	x	x	x	x	x	x	x
	Reinforce the security system of RMNCAH-Nut stock of essential products (shops, cold chain, etc.) in targeted structures at regional and operational level	DSF, PLMI, RDPH, HD, TFP	x	x	x	x	x	x	x
	Organise a national consolidation workshop for the quantification of RMNCAH-Nut products for all levels of the health pyramid	DSF, PLMI, RDPH, HD, TFP	x	x	x	x	x	x	x
	Advocate the mobilisation of funds for the purchase of RMNCAH-Nut commodities over the planned period with all stakeholders.	DRFP, DSF, PLMI, RDPH,HD, TFP	x	x	x	x	x	x	x
	Strengthen the national blood supply system with blood and its derivatives	NTBS, DSF, PLMI, RDPH, HD, TFP	x	x	x	x	x	x	x
	Reinforce the quality control of RMNCAH-Nut essential medicines and commodities	DSF, PLMI, RDPH, HD, TFP	x	x	x	x	x	x	x
	Step up the implementation and use of an interconnected platform for the various existing inventory software applications (interconnected LMIS) at all levels	DSF, HIU, RDPH, HD, TFP	x	x	x	x	x	x	x
	Set up and ensure the proper functioning of a collaboration platform between CENAME, RFHP, accredited private wholesale distributors and health facilities, to ensure proper management of stocks and supplies.	DSF, PLMI, RDPH, HD, TFP	x	x	x	x	x	x	x
	Intensify advocacy to mobilise funding for RMNCAH-Nut vaccines with GAVI and the Government	EPI	x	x	x	x	x	x	x
	Enhance the quality control of vaccines	LANACOME	x	x	x	x	x	x	x
	Mobilise resources to ensure that essential and life-saving RH medicines and commodities are always available[25] to the last mile.	DSF, PLMI, RDPH, HD, TFP	x	x	x	x	x	x	x

[25] Essential medicines; Emergency medicines; Vital medicines

SPECIFIC OBJECTIVES	INTERVENTIONS	Structure(s) in charge	IMPLEMENTATION PERIOD						
			2024	2025	2026	2027	2028	2029	2030
	Build the capacities of service providers on MPA and CPA	DSF, PLMI, RDPH, HD, TFP	x	x	x	x	x	x	x
	Strengthen technical facilities for the delivery of MPA and CPA	DOSTS, DSF, PLMI ; UHC-NTC,TFP	x	x	x	x	x	x	x
	Strengthen the referral and counter-referral system for RMNCAH-Nut services (motor bike ambulance, communication tools, etc.)	DOSTS, DSF, PLMI ; UHC-NTC,TFP	x	x	x	x	x	x	x
	Ensure the functionality of multi-sector technical platforms for discussions on RMNCAH-Nut	DSF, PLMI, RDPH, HD, TFP	x	x	x	x	x	x	x
	Collaborate with mobile network operators to identify connection points in villages in order to better disseminate information on RMNCAH-Nut in the community.	DSF, PLMI, RDPH, HD, TFP	x	x	x	x	x	x	x
	Promote the community self-care approach	DSF, PLMI, RDPH, HD, TFP	x	x	x	x	x	x	x
	Subcontract RMNCAH-Nut services to NGOs in difficult-to-access areas (geographical access, insecurity, etc.).	DSF, PLMI, RDPH, HD, TFP	x	x	x	x	x	x	x
2.1.6. By 2030, increase by 30% the number of health districts offering at least 50% of the package of activities for community service providers.	Reinforce the implementation of Community-Directed Interventions packages to promote RMNCAH-Nut	DOSTS, DSF, PLMI, RDPH, HD, TFP	x	x	x	x	x	x	x
	Train or retrain Multipurpose Community Health Workers on RMNCAH-Nut service packages	DSF, PLMI, RDPH, HD, TFP	x	x	x	x	x	x	x
	Implement the maternal and child health and nutrition action weeks (MCHNAW)	DPS, DRSP, HD, TFP	x	x	x	x	x	x	x
	Strengthen social and behaviour change (SBC) to promote RMNCAH	DSF, PLMI, RDPH, HD, TFP	x	x	x	x	x	x	x

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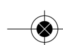


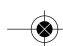
STRATEGIC OBJECTIVE No. 2.2.: By 2030, improve accessibility and use of RMNCAH-Nut services

SPECIFIC OBJECTIVES	INTERVENTIONS	Structure (s) in charge	IMPLEMENTATION PERIOD						
			2024	2025	2026	2027	2028	2029	2030
2.2.1. By 2030, improve equitable access to finance for at least 50% of the most vulnerable target groups in the targeted HDs	Reinforce the monitoring of subsidy mechanisms for healthcare costs for priority targets in pregnant women (health vouchers, obstetric kits, user fees) and children under 5 years of age (malaria, HIV).	DSF, PLMI; UHC-NTC, TFP	x	x	x	x	x	x	x
	Accelerate the implementation of universal health coverage	UHC-NTC, TFP	x	x	x	x	x	x	x
	Enhance the implementation of mutual health insurance schemes	DSF, PLMI; UHC-NTC, TFP	x	x	x	x	x	x	x
	Strengthen health insurance mechanisms	CTN-UHC	x	x	x	x	x	x	x
2.2.2. By 2030, Strengthen communication and logistics to reduce cultural and geographical barriers for at least 50% of RMNCAH-Nut targets in targeted HDs.	Revise RMNCAH-Nut normative documents according to the SBC approach.	DSF, PLMI, RDPH, HD, HF	x	x		x			x
	Build the capacities of those involved in the promotion of RMNCAH-Nut on Social and Behaviour Change	DSF, PLMI, RDPH, HD, HF	x	x	x	x	x	x	x
	Strengthen the provision of RMNCAH-Nut care and services using mobile and outreach strategies	DSF, PLMI, RDPH, HD, HF	x	x	x	x	x	x	x
	Strengthen logistics for referral of RMNCAH-Nut targets in landlocked districts	DSF, PLMI; NTC UHC, TFP	x	x	x	x	x	x	x

➢ STRATEGIC AXIS 3: SETTING UP EFFECTIVE MECHANISMS TO SUPPORT THE IMPLEMENTATION OF THE 2024-2030 RMNCAH-Nut STRATEGIC PLAN

STRATEGIC OBJECTIVE No. 3.1. By 2030, strengthen governance of the RMNCAH-Nut healthcare system

SPECIFIC OBJECTIVES	INTERVENTIONS	Structure(s) in charge	IMPLEMENTATION PERIOD						
			2024	2025	2026	2027	2028	2029	2030
3.1.1. By 2030, step up communication to mobilise 100% of key stakeholders around	Train or retrain public media staff and social network facilitators on RMNCAH-Nut main issues	DSF, PLMI, TFP	x	x	x	x	x	x	x
	Advocate to mobilise civil society, local elected representatives and regional and local authorities around RMNCAH-Nut	MOH	x	x	x	x	x	x	x
	Organise support forums to operationalise/update RMNCAH-Nut	MOH		x					



SPECIFIC OBJECTIVES	INTERVENTIONS	Structure(s) in charge	IMPLEMENTATION PERIOD						
			2024	2025	2026	2027	2028	2029	2030
RMNCAH-Nut issues	activities of partner administrations (MINPROFF, MINDEF, MINAS, MINCOM, MINEE, MINJEC, MINATD, DGSN, MINEPAT, MINEDUB, MINESEC, MINESUP) and NGOs.								
	Mobilise RMNCAH champions in all districts to fund and implement RMNCAH-Nut activities	DSF, PLMI, RDPH, HD, TFP	x	x	x	x	x	x	x
3.1.2. By 2030, adopt and implement 80% of policy, legal and regulatory measures in favour of RMNCAH-Nut in accordance with Cameroon's international commitments.	Conduct high-level advocacy on the importance of RMNCAH-Nut (House of parliament, senior Government authorities, embassies, political figures, etc.).	MOH	x	x	x	x	x	x	x
	Strengthen regulatory measures to protect teenagers from exposure to risky behaviour	MOH/MINJEC	x	x					
3.1.3. By 2030, promote the production of civil status certificates for at least 90% of children under the age of 5 in all regions	Build the capacities of HFs managers in the registration of civil status documents	DSF, PLMI, RDPH, HD, RLA, TFP	x	x	x	x	x	x	x
	Educate expectant mothers and their families on civil status registration	DSF, PLMI, RDPH, HD, RLA, TFP	x	x	x	x	x	x	x
	Reinforce community communication on civil status registration	DSF, PLMI, RDPH, HD, RLA, TFP	x	x	x	x	x	x	x
3.1.4. By 2030, strengthen public-private partnership in support of RH for at least 80% of targeted key stakeholders	Strengthen support for private health facilities to provide quality RMNCAH-Nut services	DSF, PLMI, RDPH, HD, TFP	x	x	x	x	x	x	x
	Strengthen the mechanism for capturing the contribution made by private companies as part of their corporate social responsibility.		x	x	x	x	x	x	x
3.1.5. By 2030, improve Multi-sector Coordination with 100% of the key RMNCAH-Nut stakeholders	Provide funding for the functionality of coordination frameworks at both central and regional levels and health districts, including the national committee to combat maternal and child mortality	DSF, PLMI, RLA, TFP	x	x	x	x	x	x	x
	Strengthen the coordination of actors, resource mobilisation and monitoring and evaluation of the implementation of interventions concerning GBV and HPs at MINPROFF, MOH and MINAS	PLMI, DSF, TFP	x	x	x	x	x	x	x

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SPECIFIC OBJECTIVES	INTERVENTIONS	Structure(s) in charge	IMPLEMENTATION PERIOD						
			2024	2025	2026	2027	2028	2029	2030
	Strengthen the consideration of GBV and HP issues in coordination bodies	MOH, MINPROFF	x	x	x	x	x	x	x
	Formalise partnerships with all stakeholders involved in RMNCAH-Nut	MOH	x	x	x	x	x	x	x
3.1.6. By 2030, build the managerial capacities of at least 80% of RMNCAH-Nut managers	Build institutional and non-governmental capacities to implement evidence-based policies	MOH	x	x	x	x	x	x	x
	Strengthen the operationalisation of the strategic plan at all levels of the health pyramid	DSF, PLMI, TFP	x	x	x	x	x	x	x
	Establish performance-based management mechanisms in HFs that provide RMNCAH-Nut services	DSF, PLMI, RDPH, HD, TFP		x				x	
	Develop an integrated RMNCAH-Nut monitoring plan	MOH	x	x	x	x	x	x	x
	Set up positive (to reward good practices) and negative (to discourage bad practices) sanction mechanisms for heads of RMNCAH-Nut structures	MOH		x				x	
	Conduct supportive supervision in all structures related to RMNCAH-Nut, at all levels of the health pyramid	MOH	x	x	x	x	x	x	x
3.1.7. By 2030, promote quality assurance of RH services in at least 80% of targeted HFs	Scale up HF accreditation system to all regions to ensure quality coverage of RMNCAH-Nut interventions	NTC	x	x	x	x	x	x	x
	Establish a regular internal and external system to monitor the quality of RMNCAH-Nut care and services	DSF, PLMI, RDPH, HD, TFP	x	x	x	x	x	x	x
	Enhance the integration of RMNCAH-Nut services at all HF contact points (maternal and neonatal health, FP, STIs/HIV, violence management, cancer screening, FGM management)	DSF, PLMI, RDPH, HD, RLA, TFP	x	x	x	x	x	x	x
	Review RMNCAH-Nut Norms and Standards	DSF, PLMI, TFP	x	x	x	x	x	x	x
	Develop and distribute RMNCAH-Nut integrated clinical guidelines in electronic and non-electronic form	DSF, PLMI, TFP	x	x	x	x	x	x	x
	Develop and implement the RMNCAH-Nut-monitoring and evaluation Plan	MOH	x	x	x	x	x	x	x
	Implement a monitoring system to ensure the satisfaction of those who benefited from RMNCAH-Nut interventions [registers, suggestion boxes or telephone hotlines for recording of complaints]	MOH	x	x	x	x	x	x	x
	Conduct customer satisfaction surveys and use the results to improve service quality	MOH	x	x	x	x	x	x	x
	Implement a system to evaluate the performance of monitored HFs	DSF, PLMI, RDPH, HD, TFP	x	x	x	x	x	x	x
	Advocate for the mobilisation of funding in RMNCAH-Nut research	MOH	x	x	x	x	x	x	x

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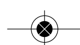
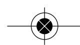


SPECIFIC OBJECTIVES	INTERVENTIONS	Structure(s) in charge	IMPLEMENTATION PERIOD						
			2024	2025	2026	2027	2028	2029	2030
3.1.8. By 2030, promote basic and operational research in the field of RMNCAH-Nut in Cameroon in 80% of targeted health facilities.	Conduct studies and document good practices on RMNCAH-Nut	MOH	x	x	x	x	x	x	x
	Disseminate basic and operational research results	MOH	x	x	x	x	x	x	x
	Establish formal partnerships with health research institutions	MOH		x				x	
	Develop research priorities for RMNCAH-Nut	MOH	x	x	x	x	x	x	x
	Disseminate RMNCAH-Nut research results	MOH	x	x	x	x	x	x	x
	Conduct an assessment of the current referral system for mothers, newborns and child health services	MOH	x	x	x	x	x	x	x
	Develop clear guidelines for RMNCAH-Nut service providers based on evaluation results	MOH	x	x	x	x	x	x	x

STRATEGIC OBJECTIVE No. 3.2.: by 2030, strengthen the strategic steering of the implementation of the new RMNCAH-Nut Strategic Plan

SPECIFIC OBJECTIVES	INTERVENTIONS	Structure(s) in charge	IMPLEMENTATION PERIOD						
			2024	2025	2026	2027	2028	2029	2030
3.2.1. By 2030, strengthen the Implementation Framework and Materialise the role of at least 80% of key actors	Set up an exchange platform between the PLMI and DSF to enhance coherence and convergence of the actions carried out in favour of RMNCAH-Nut by these two structures	DSF, PLMI, TFP	x					x	
	Set up a system to regularly update the mapping of all actors involved in RMNCAH-Nut	MOH	x	x	x	x	x	x	x
	Ensure that the monitoring meetings for the implementation of the NSP/RMNCAH-Nut are functional and sustainable at all levels of the health pyramid	MOH	x	x	x	x	x	x	x
3.2.2. By 2030, strengthen the adherence and ownership of at least 80% of key stakeholders for the implementation of the Plan	Organise training workshops for heads of RMNCAH-Nut structures, on the techniques of planning, monitoring and evaluation of RMNCAH-Nut interventions	MOH	x	x	x	x	x	x	x
	Advocate to strengthen support in the implementation of the NSP/RMNCAH-Nut with the Government and its development partners	MOH	x	x	x	x	x	x	x
	Conduct SBC activities with RMNCAH-Nut care providers and recipients to strengthen their adherence in the implementation of the NSP/RMNCAH-Nut	MOH	x	x	x	x	x	x	x
3.2.3. By 2030, carry out at least	Conduct studies to identify baseline data for strategic plan indicators that were not provided	MOH	x	x	x	x	x	x	x



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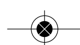
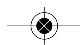


SPECIFIC OBJECTIVES	INTERVENTIONS	Structure(s) in charge	IMPLEMENTATION PERIOD						
			2024	2025	2026	2027	2028	2029	2030
80% of planned interventions for the supervision, monitoring, and evaluation of the implementation of the Plan.	Develop monitoring plans and dashboards for the performance indicators of NSP/RMNCAH-Nut at all levels of the health system including community level	MOH	x	x	x	x	x	x	x
	Conduct annual reviews to assess the level of implementation of the developed NSP/RMNCAH-Nut	DSF, PLMI, TFP	x	x	x	x	x	x	x
	Conduct a mid-term review of the implementation of the developed NSP/RMNCAH-Nut	DSF, PLMI, TFP				x			
	Conduct a final evaluation of the implementation of the developed NSP/RMNCAH-Nut	DSF, PLMI, TFP							x
	Enhance the functionality of committees responsible for monitoring maternal and neonatal deaths and stillbirths, and organise appropriate response to address the causes of death at all levels of the health pyramid	DSF, PLMI, RDPH, HD, TFP	x	x	x	x	x	x	x
	Make available monitoring data to stakeholders on a periodic basis	MOH, MINPROFF	x	x	x	x	x	x	x

STRATEGIC OBJECTIVE No. 3.3: By 2030, strengthen the resilience of the health system to public health emergency risks in order to improve the provision of reproductive health services

SPECIFIC OBJECTIVES	INTERVENTIONS	Structure(s) in charge	IMPLEMENTATION PERIOD						
			2024	2025	2026	2027	2028	2029	2030
3.3.1. By 2030, achieve at least 80% of planned interventions to ensure the response and preparedness to public health emergencies that can influence RMNCAH-Nut	Support epidemiological surveillance of health and humanitarian risks to identify RMNCAH-Nut priority needs and focus response interventions appropriate to targets.	DSF, PLMI, RDPH, HD, TFP	x	x	x	x	x	x	x
	Build the capacities of RH stakeholders in a context of humanitarian crisis	DSF, PLMI, RDPH, HD, TFP	x	x	x	x	x	x	x
	Develop a preparedness and response plan to address RMNCAH-Nut needs in emergency situations (Minimum Emergency Mechanism)	DSF, PLMI, RDPH, HD, TFP	x		x		x		x
	Develop/update standard documents for the delivery/continuity of RMNCAH-Nut essential services in the event of public health emergencies (protocols, SOPs, etc.)	DSF, PLMI, RDPH, HD, TFP	x			x			x
	Acquire and reposition RMNCAH-Nut emergency kits in high-risk areas	DSF, PLMI, RDPH, HD, TFP	x	x	x	x	x	x	x
	Perform public health emergency simulation exercises to assess the resilience of RMNCAH-Nut services	DSF, PLMI, RDPH, HD, TFP	x		x		x		x



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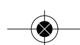
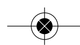


3.3.2. By 2030, ensure the implementation of essential RMNCAH interventions in public health emergency settings	Strengthen communication on the availability of RMNCAH-Nut services in affected areas	DSF, PLMI, RDPH, HD, TFP	x		x		x		x
	Organise case management	DSF, PLMI, RDPH, HD, TFP	x		x		x		x

9.2. APPENDIX 2: PERFORMANCE FRAMEWORKK

GENERAL OBJECTIVE	INDICATORS	Reference value	Source	Frequency of collection	PROJECTION OF IND		
					2024	2025	2026
1. By 2030, contribute to reducing the morbidity and mortality specific to reproductive, maternal, newborn, child, adolescent/youth, women and men health problems.	Maternal mortality ratio (deaths per 100,000 live births)	406	DHS 2018	Every 5 years	400	357	313
	Neonatal mortality rate (deaths per 1000 live births)	28	DHS, 2018	Every 5 years	26	25	23
	Infant and child mortality rate (deaths per 1000 live births)	80	DHS, 2018	Every 5 years	78	73	67
	Annual incidence of obstetric fistulas	2000 cases/Year Most recent NA	MICS 2014[26]	Every 5 years	2000		
	50) Specific mortality rate for reproductive cancers	65 %	NSPCaC 2020-2024	Every 5 years			
	Incidence of cervical cancer	2349 new cases/year	NSPCaC 2020 - 2024 Cancer Registers, NSPCaC	Annual			2400 new cases/year
	Incidence of obstetric fistula	NA	Community survey	Every 3 years			

26 tps://cameroon.unfpa.org/fr/news/une-campagne-de-solidarit%C3%A9-nationale-lanc%C3%A9e-pour-eliminer-la-fistule-obst%C3%A9tricale-au-cameroun



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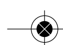


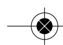
9.2.1 Results indicators

Improving the coverage of high-impact RMNCAH-Nut interventions

Strategic objective 1.1. : Improve coverage of high-impact RMNCAH-Nut interventions for mothers, newborns, children, adolescents, men and women, including the elderly

SPECIFIC OBJECTIVES	INDICATORS	Reference value	Source	Frequency of collection	PROJECTION OF INDICATORS						
					2024	2025	2026	2027	2028	2029	2030
MOTHER TARGET											
1.1.1. By 2030, achieve quality ANC coverage for 95% of expected pregnant women	Coverage rate in ANC	87 %	DHS 2018	Every 5 years							
	Coverage of ANC 1 done before 12 weeks of amenorrhoea	41 %	DHS 2018	Annual	50 %	55 %	60 %	65 %	70 %	75 %	80 %
	% of women who did at least four antenatal visits Coverage rate ANC 8	65 %	DHS 2018	Annual	67 %	69 %	71 %	73 %	75 %	77 %	80 %
	Proportion of pregnant women who received VAT2+	71 %	DHS 2018	Annual	72 %	74 %	75 %	76 %	78 %	79 %	80 %
	Proportion of pregnant women who received IPT 3	46 %	MIS 2022	Every 5 years	43 %	45 %	48 %	51 %	55 %	57 %	60 %
	Proportion of pregnant women using LLINs	63 %	MIS 2022	Every five years	65 %	67 %	66 %	68 %	70 %	72 %	75 %
	Proportion of pregnant women who received Iron-folic acid	NA	DHIS 2	Annual	+ 10 % baseline	+ 15%	+ 20 %	+ 25 %	+ 30 %	+ 35 %	+ 40%
1.1.2. By 2030, achieve quality PNC coverage for 80% of expected deliveries	Proportion of women who received PNC within 02 days (or 48 hours) after delivery (PNC 1)	67 %	DHS 2018	Annual	68 %	69 %	71 %	73 %	75 %	77 %	80 %
1.1.3. By 2030, achieve 80% coverage of births attended by	Proportion of births attended by skilled personnel	69 %	DHS 2018	Annual	70 %	73 %	74 %	75 %	76 %	78 %	80 %
	Proportion of births attended using a partogram.	NA	DSF annual report[27]	Annual	+ 10 % baseline	+ 15%	+ 20 %	+ 25 %	+ 30 %	+ 35 %	+ 40%

27 Service registers of targeted health facilities



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SPECIFIC OBJECTIVES	INDICATORS	Reference value	Source	Frequency of collection	PROJECTION OF INDICATORS						
					2024	2025	2026	2027	2028	2029	2030
skilled personnel	Proportion of births attended using an obstetrical kit	NA	DSF annual report[28]	Annual	+ 10 % baseline	+ 15%	+ 20 %	+ 25 %	+ 30 %	+ 35 %	50 %
1.1.4. **By 2030, increase by 50% contraceptive prevalence in women of childbearing age**	Contraceptive prevalence in women of childbearing age using a modern method	15 %	DHS 2018	Annual	17 %	19 %	20 %	26 %	28 %	29 %	30 %
	Proportion of women of childbearing age who use DMPA-SC.	NA	Service registers	Annual	+ 10 % baseline	+ 15%	+ 20 %	+ 25 %	+ 30 %	+ 35 %	30 %
1.1.5. **By 2030, increase the rate of detection and management of obstetric fistula in 80% of targeted HDs.**	Proportion of women who know what obstetric fistula refers to	22 %	DHS 2018	Annual	25 %	30 %	35 %	40 %	45 %	50 %	60 %
	Percentage of women screened for obstetric fistula	0.3 %	DHS 2018	Annual	0.2 %	0.2 %	0.2 %	0.1 %	0.1 %	0.1 %	0.1 %
	Proportion of women with obstetric fistulas who received standard care	NA	DSF Report	Annual	+ 10 % baseline	+ 15%	+ 20 %	+ 25 %	+ 30 %	+ 35 %	80 %
1.1.6. **By 2030, improve STI/hepatitis/HIV prevention and treatment for women of childbearing age in at least 80% of HDs**	Prevalence of STIs in women of childbearing age	18 %	DHS 2018	Annual	15 %	13 %	11 %	9 %	7 %	6 %	5 %
	Prevalence of HIV in women of childbearing age	3.4 %	DHS 2018	Annual	2.7 %	2.3 %	2 %	1.7 %	1.5 %	1.3 %	1.1 %
	Prevalence of hepatitis in pregnant women	8.3 %	CAMPHIA 2017	Annual	7.8 %	7.3 %	6.8 %	6.3 %	5.8 %	5.3 %	5 %
	Prevalence of Syphilis in pregnant women	13.95 %	ES 2020	Annual	12.95 %	11.95 %	10.95 %	9.95 %	8.95 %	8.50	8 %
1.1.7. **By 2030, increase screening and case**	% of women aged 15-49 screened for cervical cancer	4 %	DHS 2018	Annual	10 %	25 %	30 %	35 %	40 %	45 %	50 %
	Number of women of childbearing age vaccinated against HPV	42 %	2023 EPI	Annual	48 %	54 %	60 %	66 %	72 %	78 %	**80 %**

[28] Ibid

SPECIFIC OBJECTIVES		INDICATORS	Reference value	Source	Frequency of collection	PROJECTION OF INDICATORS						
						2024	2025	2026	2027	2028	2029	2030
	management of breast and cervical cancers in at least 30% of HDs			Report								
		Number of cases of breast cancer and cervical cancer managed	NA			10 %	14 %					30 %
1.1.8.	**By 2030, improve infertility management for women in 100% of regional and central hospitals**	Proportion of infertility cases resulting in a live birth	NA	Source[29]	Annual	4 %	5 %	6 %	7 %	8 %	9 %	10 %
1.1.9.	**Improve by 50% the nutritional status of pregnant and breastfeeding women received in health facilities.**	Proportion of pregnant and breastfeeding women who received IFA and micronutrient supplements	NA	Source = Health facility activity registers	Annual	40 %	50 %	60 %	70 %	80 %	90 %	100 %

Specific objectives		INDICATOR	Reference value	Source	Frequency of collection	PROJECTION OF INDICATORS						
						2024	2025	2026	2027	2028	2029	2030
NEWBORN TARGET												
1.1.10.	**By 2030, ensure that 80% of targeted health facilities at all levels provide quality newborn care and services.**	Proportion of newborns who received post-natal care within 48 hours of birth	60 %	DHS 2018	Annual	65 %	67 %	70 %	72 %	75 %	77 %	80 %
		Percentage of premature and low-birth-weight babies managed using Kangaroo Mother Care	NA	MAR	Annual	65 %	67 %	70 %	72 %	75 %	77 %	80 %
		Proportion of newborns receiving post-natal care in the community according to national standards	22.9% in 2014	Community surv	Annual	25 %	30 %	35 %	40 %	45 %	50 %	55 %

[29] Registers of infertility cases in category 1 and 2 hospitals

Specific objectives	INDICATOR	Reference value	Source	Frequency of collection	PROJECTION OF INDICATORS						
					2024	2025	2026	2027	2028	2029	2030
			ey report								
	Proportion of cases of newborn asphyxia effectively managed	NA	MAR	Annual	+ 10 % baseline	+ 15%	+ 20 %	+ 25 %	+ 30 %	+ 35 %	+ 40%
	Percentage of newborns who were properly followed up between the 6th and 10th day after birth	27.8 % In 2014	MAR	Annual	30 %	33 %	37 %	41 %	44 %	47	50% ?
	Proportion of premature babies who reached one year of age	10.5 % in 2014	MICS / DHS	Annual	12 %	15 %	18 %	21 %	24 %	27 %	30% ?
	Coverage rate of Polio 0 vaccination for newborns	75 %	EPI report	Annual	77 %	79 %	80 %	83 %	85 %	87 %	90 %
	Coverage rate of BCG vaccination among newborns	87 %	EPI report	Annual	88 %	88 %	88 %	89 %	89 %	89 %	90 %
	Proportion of newborns breastfed within one hour of birth	48 %	UNICEF[30]	Annual	50 %	55 %	60 %	65 %	70 %	75 %	80 %
	Proportion of premature and low-birth-weight babies managed using Kangaroo Mother Care	30 %	DHIS 2	Annual	35 %	40 %	45 %	50	55 %	60 %	70 %
1.1.11. **By 2030, ensure prevention of mother-to-child transmission of HIV/AIDS/hepatitis B in 100% of pregnant**	Proportion of newborns born to HIV-positive mothers diagnosed with HIV at an early stage.	64.4 %	UNICEF 2021 [31]	Annual	65 %	70 %	75 %	80	85 %	87 %	90 %
	Number of pregnant women screened for HIV during ANC and outreach strategies	83 %	DHIS 2 2022	Annual	100 %	100 %	100 %	100 %	100 %	100 %	100 %
	Number of pregnant women screened for syphilis during ANC	NA	DHIS 2 2022	Annual	100 %	100 %	100 %	100 %	100 %	100 %	100 %

[30] Cameroun 2020 : https://web.facebook.com/unicefcameroon/posts/3587242784643461/
[31] https://unitaid.org/assets/BookletUCPOC-2021-03-17-FR-FINAL.pdf

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Specific objectives	INDICATOR	Reference value	Source	Frequency of collection	PROJECTION OF INDICATORS						
					2024	2025	2026	2027	2028	2029	2030
women who received antenatal care.	Number of pregnant women screened for hepatitis B during ANC	NA	DHIS 2 2022	Annual	100 %	100 %	100 %	100 %	100 %	100 %	100 %
	Coverage of early diagnosis of exposed children (PCRv 1, PCR 2 and serology)	84 %	DHIS 2 2022	Annual	100 %	100 %	100 %	100 %	100 %	100 %	100 %
	Coverage of viral load test for HIV+ pregnant and breastfeeding women	NA	DHIS 2 2022	Annual	+ 10 % baseline	+ 15%	+ 20 %	+ 25 %	+ 30 %	+ 35 %	+80 %
	Percentage of pregnant and breastfeeding women whose partners were screened and treated for HIV/syphilis/viral hepatitis B	NA	DHIS 2 2022	Annual	+ 10 % baseline	+ 15%	+ 20 %	+ 25 %	+ 30 %	+ 35 %	+ 40%
	Rate of HIV+ pregnant and breastfeeding women using a modern contraceptive method	15.7 %	DHIS 2 2022	Annual	50 %	60 %	70 %	80 %	90 %	100 %	100 %
1.1.12. **By 2030, ensure that 90% of pregnant women received for ANC have been vaccinated against tetanus**	Percentage of women whose last live birth was protected against neonatal tetanus (DHS 2018; P. 213)	71 %	DHS 2018	5 years	71.1	72 %	73 %	74 %	80 %	85 %	90 %
Specific objectives	**INDICATOR**	**Reference value**	**Source**	**Frequency of collection**	**PROJECTION OF INDICATORS**						
					2024	**2025**	**2026**	**2027**	**2028**	**2029**	**2030**
CHILD TARGET											
1.1.13. **By 2030, ensure coverage of high-impact preventive interventions**	Percentage of children aged 12-23 months who received 8 basic vaccines (%).	52 %	EPI report	Annual	60 %	65 %	70 %	75 %	80 %	85 %	90 %
	Coverage of exclusive breastfeeding of children aged 0-5 months	40 %	DHS 2018	Annual	45 %	47 %	50 %	53 %	55 %	57 %	60 %

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Specific objectives	INDICATOR	Reference value	Source	Frequency of collection	PROJECTION OF INDICATORS						
					2024	2025	2026	2027	2028	2029	2030
for at least 90% of children attending consultations.	Coverage of Vaccination in Penta 3	79 %	EPI report[32]	Annual	80	83 %	85	87 %	88 %	89 %	90 %
	Coverage of vaccination against Measles and Rubella I	71 %	DHS 2018 /	Annual	75 %	77	79 %	81	83 %	84 %	85 %
	Coverage rate of vaccination against Measles and Rubella I	74 %	EPI Annual report[33]	Annual	76 %	78 %	80 %	82 %	84 %	85 %	86 %
	Proportion of use of LLINs in the under-fives	58 %	MICS 2022	Annual	65 %	67 %	70 %	72 %	75 %	77 %	80 %
	Percentage of children aged 6 to 9 months with anaemia	57 %	DHS 2018	Annual	50 %	45 %	40 %	35 %	30 %	25 %	20 %
	Percentage of children living in a household where iodised salt is used	96 %	DHS 2018	Annual	97 %	97.4 %	97.7 %	98 %	98.4 %	98.7 %	99 %
1.1.14. **By 2030, strengthen child care using the IMCI approach (health facilities and communities) in at least 80% of targeted health districts.**	Proportion of health facilities in targeted health districts using the IMCI approach according to national standards	NA	DSF annual report	Annual	+ 10 % baseline	+ 15%	+ 20 %	+ 25 %	+ 30 %	+ 35 %	+ 40%
	Proportion of children under 5 with an episode of diarrhoea for whom counselling or treatment was sought from a healthcare provider	51.6 %	DHS 2018	Annual	55 %	60 %	65 %	70 %	75 %	78	80 %
	Proportion of children under 5 with an episode of diarrhoea who were given fluids prepared using ORS+ZINC	17.9 %	DHS 2018	Annual	20 %	25 %	30 %	35 %	40 %	45 %	50 %
	Percentage of children under 5 with AKI symptoms for whom counselling or treatment was sought from a healthcare provider	59 %	DHS 2018	Annual	60 %	63 %	69 %	73 %	75 %	77 %	80 %

[32] WUENIC 2018 (http://onsp.minsante.cm/profiles_information/index.php/Cameroon:Immunization?lang=fr)

[33] http://onsp.minsante.cm/sites/default/files/publications/316/PEV%20%20GTC-PEV%20%20Rapport%20ANNUEL%202021_OK_Update%20%281%29.pdf

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Specific objectives	INDICATOR	Reference value	Source	Frequency of collection	PROJECTION OF INDICATORS						
					2024	2025	2026	2027	2028	2029	2030
	Percentage of children under 5 with fever (in the two weeks prior to the survey) for whom counselling or treatment was sought from a healthcare provider (Artemisinin-based combination therapy (ACT) according to the national protocol)	61 %	DHS 2018	Annual	25 %	35 %	45 %	55 %	65 %	75 %	80 %
Specific objectives	INDICATOR	Reference value	Source	Frequency of collection	PROJECTION OF INDICATORS						
					2024	2025	2026	2027	2028	2029	2030
ADOLESCENTS/YOUTH TARGET											
1.1.15. By 2030, reduce the prevalence of risky sexual behaviour in at least 25% of adolescents/ youth	Prevalence of early pregnancies (15-19 years old)	24 %	DHS 2018	Annual	22 %	21 %	19 %	17 %	15 %	12 %	10 %
	Prevalence of induced abortion in adolescents aged 15-19 years old	1.7 %	DHS, 2004	Annual	1.6 %	1.5 %	1.4 %	1.3 %	1.2 %	1.1 %	**1 %**
1.1.16. By 2030, prevent and treat at least 25% of STI/HIV cases in adolescents and youth.	Prevalence of HIV in youth aged 15-24 years old	1.3 %	DHS 2018 NACC Report	Annual	1.27 %	1.25 %	1.2 %	1.0 %	0.8 %	0.6 %	0.5 %
	Prevalence of STIs in youth aged 15-24 years old	20.7 %	DHS 2018 NACC Report	Annual	20 %	18 %	16 %	15 %	13 %	12 %	10 %
	Percentage of adolescent girls and young women (aged 20-24) with HIV on ART	62 %	NACC report	Annual	65 %	68 %	71 %	74 %	76 %	78 %	80% ?
	Proportion of STI cases properly managed in targeted health facilities	NA	Evaluation of PF	Bi annual			72 %	74 %	76 %	78 %	80 %
1.1.17. By 2030, promote Adolescent and Youth-friendly	Immunisation rate of adolescent girls aged 9-13 years against the Human Papilloma Virus	HPV = 56.8 %	2023 EPI Report	Annual	60 %	70 %	75 %	80 %	85 %	87 %	90 %
	Human Papilloma Virus immunisation rate in	HPV1= 26.1%	2023 EPI	Annual	30 %	40 %	50 %	55 %	60 %	65 %	70 %

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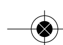
Specific objectives	INDICATOR	Reference value	Source	Frequency of collection	PROJECTION OF INDICATORS						
					2024	2025	2026	2027	2028	2029	2030
Health Services (AYFS) in 80% of administrative divisions	adolescents aged 9-13 years old		Report								
	Number of AYFS provided per type of point of delivery	NA		Annual	+10 %	+15 %	+20 %	+25 %	+30 %	+35 %	+40 %
	Number of destitute young adolescents supported through the implementation of IGAs	NA		Annual	+10 %	+15 %	+20 %	+25 %	+30 %	+35 %	+40 %
	Rate of complete immunisation of adolescent girls against Human Papilloma Virus before the age of 15 years	5.89 %	WHO/UNICEF[34]	Annual		60 %			70 %		90 %
	Percentage of health facilities and other points of delivery providing adolescent and youth-friendly services	NA	RDPH/HD activity report	Annual	50 %	55 %	58 %	60 %	68 %	75 %	80 %
1.1.18. By 2030, improve contraceptive prevalence in at least 30% of adolescents/youth	Prevalence of modern contraceptive methods in adolescents/youth	10.3 %	DHS 2018	Annual	10 %	12 %	15 %	18.7 %	22.5 %	26.3 %	30 %

Specific objectives	INDICATOR	Reference value	Source	Frequency of collection	PROJECTION OF INDICATORS						
					2024	2025	2026	2027	2028	2029	2030
OLDER WOMEN											
1.1.19. By 2030, provide appropriate treatment for sexual dysfunction and menopausal disorders to at least 80%	% of cases of sexual dysfunction and menopausal disorders in women treated according to standards in health facilities	NA	Professional practice evaluation reports	Annual	25 %	33 %	50 %	66 %	70 %	75 %	**80 %**

[34] Joint Reporting Form on Immunization (JRF). 2021 https://immunizationdata.who.int/pages/coverage/hpv.html?CODE=CMR&ANTIGEN=&YEAR

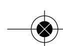
	of women received in district and regional hospitals.											
1.1.20.	**By 2030, provide appropriate infertility treatment to at least 80% of women received in targeted district and regional hospitals.**	% of cases of infertility in women treated according to standards in health facilities	NA	Professional practice evaluation reports	Annual	25 %	33 %	50 %	66 %	70 %	75 %	**80 %**
1.1.21.	**By 2030, appropriately treat at least 60% of cases of reproductive cancers in women screened in hospitals**	% of cancer cases screened according to standards and treated in category 1, 2, 3 and 4 hospitals	NA	Activity reports of HFs	Annual	25 %	30 %	40 %	45 %	50 %	55 %	**60 %**

Specific objectives		INDICATOR	Reference value	Source	Frequency of collection	PROJECTION OF INDICATORS						
						2024	2025	2026	2027	2028	2029	2030
TARGET: MEN including THE ELDERLY												
1.1.22.	**By 2030, treat at least 50% of cases of STI/HIV and sexual dysfunction in men received in health facilities**	% of STI/HIV cases and sexual dysfunction in men properly treated	NA	Professional practice evaluation reports	Annual	+10 % baseline	+15 %	+20 %	+25 %	+30 %	+35 %	+40 %
1.1.23.	**By 2030, provide treatment according to standards for**	% of cases of cancer detected early and received in category 1 and 2 hospitals referred from lower-level health facilities.	NA			30 %	35 %	40 %	45 %	50 %	55 %	**60 %**



Specific objectives	INDICATOR	Reference value	Source	Frequency of collection	PROJECTION OF INDICATORS						
					2024	2025	2026	2027	2028	2029	2030
at least 60% of cases of reproductive cancers detected in men received in category 1 to 4 hospitals.	% of cancer cases detected and properly treated in category 1 and 2 hospitals	NA	Activity reports of HFs	Annual	25 %	30 %	40 %	45 %	50 %	55 %	**60 %**

Strategic objective 1.2. : By 2030, contribute to reducing harmful cultural practices in adolescent girls and women (Gender-based violence, female genital mutilation and child marriages).											
Specific objectives	**INDICATOR**	**Reference value**	**Source**	**Frequency of collection**	**PROJECTION OF INDICATORS**						
					2024	**2025**	**2026**	**2027**	**2028**	**2029**	**2030**
1.2.1. By 2030, encourage at least 30% of targeted community groups in each district to adopt behaviours conducive to reducing GBV and harmful cultural practices.	Proportion of women aged 15-49 years who reported having experienced violence, in the form of emotional, physical and/or sexual abuse, by a current or most recent husband/partner	44 % (Physical: 34%; Sexual; 10%; Emotional: 29%)	DHS 2018	5 years	44 % 34 % 10 % 29 %	39 % 29 % 10 % 27 %	33 % 24 % 9 % 25 %	30 % 21 % 9 % 24 %	26 % 18 % 8 % 22 %	22 % 16 % 8 % 21 %	20 % Physical: 15%; Sexual: 7%; Emotional : 20 %
	Proportion of women aged 15-49 years who said they had been sexually abused by someone	13 %	DHS 2018	5 years	13 %	12 %	11 %	10 %	9 %	8 %	7 %
	% of physical violence in women aged 15 to 49 years	39 %	DHS 2018	5 years	39 %	35 %	30 %	25 %	20 %	15 %	10 %
	Prevalence of physical violence during pregnancy	7 %	DHS 2018	5 years	7 %	6 %	5 %	4 %	3 %	2 %	**2 %**
	Prevalence of sexual abuse in women aged 15 to 49 years	13 %	DHS 2018	5 years	13 %	12 %	11 %	9 %	7 %	6 %	**5 %**
	Prevalence of female genital mutilation	1.4% in 2014	Survey	5 years	1.2 %			1 %			**0.5 %**
	Prevalence of women excised by a health professional	4% in 2014	Survey	5 years	3.5 %			2 %			**0.1 %**
	Percentage of girls married before	6 %	DHS 2018	6 %	6 %	6 %	5 %	5 %	5 %	4 %	**4 %**



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	the age of 15 years or prevalence of child marriage										
	Prevalence of female genital mutilation (FGM) in girls aged 0 to 14 years	1 %	Source[35]	1 %				0.5 %			**0.1 %**
1.2.2. By 2030, make evidence-based data available in 80% of health districts to monitor the extent of GBV and harmful practices	Proportion of newsletters on GBV and harmful cultural practices produced and disseminated in health facilities	NA	HIU, MINPROFF, MINJUSTICE, MINAS	4	4	4	4	4	4	4	**4**
	Number of reported cases and management of FGM in health facilities	NA	RDPH and health districts activity reports.	Annual	20 %	25 %	30 %	40 %	50 %	65 %	80 %
1.2.3. By 2030, improve access to and use of medical and psychological care services for GBV survivors and victims of harmful practices in 60% of HDs	Number of GBV and harmful cultural practices survivors supported in the implementation of IGAs	NA	RDPH and health districts activity reports	Annual	20 %	25 %	30 %	40 %	50 %	65 %	80 %
	Number of cases of GBV and harmful cultural practices managed at targeted points of delivery	NA	RDPH and health districts activity reports	Annual	20 %	25 %	30 %	40 %	50 %	65 %	80 %
1.2.4. By 2030, strengthen the effective implementation of the provisions of the institutional and legal framework to abolish impunity for GBV and harmful practices in 60% of administrative divisions.	Proportion of GBV victims who received the necessary legal support.	NA	RDPH and health districts activity reports	Annual	20 %	25 %	30 %	40 %	50 %	65 %	80 %

[35] Excision Parlons-en - 2024 https://www.excisionparlonsen.org/cameroun/

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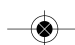
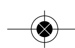


Strategic objective 2.1. : By 2030, improve the availability of quality RMNCAH-Nut services

Specific objectives	INDICATOR	Reference value	Source	Frequency of collection	PROJECTION OF INDICATORS						
					2024	2025	2026	2027	2028	2029	2030
2.1.1. By 2030, improve access to quality RMNCAH-Nut services by providing at least 80% of health facilities in the health districts with adequate infrastructure, logistics and equipment.	Ratio of BEmONC services per inhabitant	2.21 / 500,000 inhabitants	DHIS 2, 2020	Annual	5/500 000	5.5/500 000	6/500 000	7/500 000	8/500 000	9/500 000	10/500 000
	Percentage of HFs with the equipment required to provide quality RMNCAH-Nut services	4 %	DSF, 2020	Annual	10 %	20 %	30 %	40 %	50 %	60 %	70 %
	Percentage of HFs with the equipment required to provide quality RMNCAH-Nut services	4 %	DSF, 2020	Annual	10 %	20 %	30 %	40 %	50 %	60 %	70 %
2.1.2. By 2030, bring at least 80% of health facilities at all levels of the pyramid to produce and use quality RMNCAH-Nut information to guide	% of health facilities which forward data on key RMNCAH-Nut indicators on a regular basis	NA	CIS reports	Annual	30 %	40 %	50 %	60 %	70 %	80 %	90 %
	Percentage of HDs which submit RMNCAH-Nut data on time	NA	CIS reports	Annual	30 %	40 %	50 %	60 %	70 %	80 %	90 %



	decision-making											
2.1.3.	**By 2030, increase by at least 5% the funding allocated to RMNCAH-Nut interventions.**	Percentage of government budget allocated to health	3.6 %	Financial Law, 2013	Annual	3.8 %	4 %	4.5 %	5 %	5.5 %	6 %	7 %
		Percentage of the MOH budget allocated to RMNCAH-Nut	NA	AWP MOH	Annual		+1 %	+2 %	+3 %	+4 %	+5 %	+5 %
2.1.4.	**By 2030, reduce by 30% the quantitative and qualitative deficit in qualified human resources in RMNCAH-Nut at all levels of the health pyramid.**	Ratio of human resources available in HFs to the general population	NA	Report on the General Census of Health Personnel	2 years		+5 %	+10 %	+15 %	+20 %	+25 %	+30 %
		Medical doctor/population ratio	1/10535	PDRH, MOH, 2012	5 years	1/9000	1/8000	1/7000	1/6000	1/5500	1/5200	1/5000
		Nurse/population ratio	1/1023	PDRH, MOH, 2012	5 years	1/1000	1/900	1/800	1/700	1/650	1/600	1/500
		Midwife/population ratio	0.05/5000	DRH, MOH, 2022	5 years	0.05/5000	0.10/5000	0.20/5000	0.40/5000	0.50/5000	0.80/5000	1/5000
		Percentage of MHCs, IHCs and DHs with at least 50% of the required technical staff	NA	MOH Survey	Annual	50 %	52 %	55 %	60 %	65 %	70 %	80 %
2.1.5.	**By 2030, improve the availability of quality drugs and essential products (blood products) for RMNCAH-Nut in at least 90% of health**	% of quality health products (drugs, vaccines, contraceptives, medical devices) in accordance with the standards defined in the MPA and CPA available from wholesalers such as CENAME.	NA	CENAME activity report	Annual	70 %	75 %	80 %	85 %	90 %	95 %	100 %

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	facilities in the health districts.	% of quality, low-cost RMNCAH-Nut drugs and commodities available to the last mile	NA	RFHP activity report	Annual	70 %	75 %	80 %	85 %	90 %	95 %	100 %
		Proportion of facilities without stock-outs of RMNCAH-Nut drugs for 3 days	NA	RFHP activity report	Annual	40 %	45 %	50 %	60 %	65 %	70 %	80 %
2.1.6.	**By 2030, increase by 30% the number of HDs providing at least 50% of the package of activities for community service providers**	Proportion of HDs which implement the integrated package of RMNCAH-Nut care and services at the community level	NA	RDPH activity report	Annual	+10 %	+12 %	+15 %	+17 %	+20 %	+25 %	+30 %

9.1.1.2 Improving accessibility and use of RMNCAH-Nut services

Strategic objective 2.2. : By 2030, improve access to and use of RMNCAH-Nut services												
Specific objectives		INDICATOR	Reference value	Source	Frequency of collection	PROJECTION OF INDICATORS						
						2024	2025	2026	2027	2028	2029	2030
2.2.1.	**By 2030, improve equitable financial access for at least 50% of the most vulnerable target groups in targeted HDs**	Proportion of women benefiting from the HEALTH VOUCHER compared to the expected number of pregnant women	NA	RFHP	Annual	30 %	40 %	50 %	60 %	70 %	80 %	90 %
		Rate of increase in current health expenditure per capita	FCFA 36,305	2019 NHA		+05 %	+10 %	+20 %	+25 %	+30 %	+40 %	+50 %
2.2.2.	**By 2030, strengthen communication and**	Increase in the proportion of communities having adopted at least one measure to reduce	NA	CHWs activity reports compile	Annual	05 %	08 %	10 %	15 %	18 %	20 %	25 %

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logistics to reduce cultural and geographical barriers for at least 50% of RMNCAH-Nut targets in targeted HDs	cultural barriers in the target areas		d by HDs								
	Proportion of pregnant women referred/accompanied to HFs by traditional birth attendants	NA	HFs activity reports, MCHWs activity reports compiled by HDs	Annual	30 %	40 %	50 %	60 %	70 %	80 %	90 %
	Proportion of RMNCAH-Nut emergency cases transported by motorbikes from remote areas to health facilities	NA	HFs activity reports, MCHWs activity reports compiled by HDs	Annual	10 %	15 %	20 %	25 %	30 %	35 %	40 %

9.1.1.3 Improving governance

Strategic objective 3.1. By 2030, strengthen the governance of the healthcare system for RMNCAH-Nut

Specific objectives	INDICATOR	Reference value	Source	Frequency of collection	PROJECTION OF INDICATORS						
					2024	2025	2026	2027	2028	2029	2030
3.1.1. **By 2030, strengthen communication to mobilise 100% of key stakeholders around the issues of RMNCAH-Nut.**	Rate of increase in the number of targeted media professionals trained on RMNCAH-Nut communication	NA	Reports	Annual	10 %	12 %	15 %	20 %	25 %	30 %	40 %
	Rate of increase in communication activities on RMNCAH-Nut carried out by the persons trained in the target media	NA	Reports	Annual	10 %	12 %	15 %	20 %	25 %	30 %	40 %
3.1.2. **By 2030, adopt and implement 80% of**	Rate of increase in international commitments adopted and	NA	DAJC, DSF, MOH, MINJUSTICE MINPROFF	Annual	1 %	3 %	4 %	5 %	7 %	8 %	10 %

Specific objectives	INDICATOR	Reference value	Source	Frequency of collection	PROJECTION OF INDICATORS						
					2024	2025	2026	2027	2028	2029	2030
policy, legal and regulatory measures in favour of RMNCAH-Nut in accordance with Cameroon's international commitments.	implemented in Cameroon										
	Proportion of heads of central and operational services which have a compendium of the basic regulatory instruments on RMNCAH-Nut	NA	DAJC, DSF, MOH	Annual	50 %	55 %	60 %	65 %	70 %	75 %	80 %
3.1.3. By 2030, promote the production and registration of civil status documents for at least 90% of children under 5 in all regions.	Proportion of children under 5 whose births were registered in the civil status registry	62 %	DHS 2018	Annual	65 %	70 %	75 %	80 %	85 %	90 %	95 %
	Proportion of children under 5 with a birth certificate	49 %	DHS 2018	Annual	50 %	55 %	60 %	65 %	70 %	75 %	80 %
3.1.4. By 2030, strengthen public-private partnerships in favour of RH for at least 80% of targeted key stakeholders	Rate of increase in planned partnerships signed for the implementation of the plan's interventions	NA	DCOOP-MOH Annual Report	Annual	1 %	3 %	4 %	5 %	7 %	8 %	10 %
3.1.5. By 2030, improve Multi-sector Coordination among 100% of key stakeholders in the RMNCAH-Nut sector	Proportion of multi-sector thematic meetings on RMNCAH-Nut held out of the planned number	NA	MOH Annual Report	Annual	100 %	100 %	100 %	100 %	100 %	100 %	100 %

Specific objectives	INDICATOR	Reference value	Source	Frequency of collection	PROJECTION OF INDICATORS						
					2024	2025	2026	2027	2028	2029	2030
3.1.6. **By 2030, improve the managerial skills of at least 80% of heads of RMNCAH-Nut structures**	% of heads of structures (HDs, RDPH and central level) trained in management and leadership	NA	MOH Annual Report	Annual	100 %			100 %			100 %
3.1.7. **By 2030 promote quality assurance of RH services in at least 80% of targeted health facilities**	% of health facilities accredited to provide quality RMNCAH-Nut care and services	NA	MOH Annual Report	Annual	20 %	30 %	40 %	50 %	60 %	70 %	80 %
3.1.8. **By 2030, promote basic and operational research in the field of RMNCAH-Nut in Cameroon in 80% of the targeted health facilities.**	-% of planned studies and research carried out	NA	MOH Annual Report	Annual	20 %	30 %	40 %	50 %	60 %	70 %	80 %

9.1.1.4 Improving the strategic steering of the implementation of the strategic plan

Strategic objective 3.2. : Strengthen the strategic steering of the implementation of the new RMNCAH-Nut Strategic Plan											
Specific objectives	INDICATOR	Reference value	Source	Frequency of collection	PROJECTION OF INDICATORS						
					2024	2025	2026	2027	2028	2029	2030
3.2.1. **By 2030, strengthen the implementation framework and establish the role of at least 80% of key stakeholders**	Proportion of regions with a platform for multi-sector exchange between stakeholders to facilitate the coherence and convergence of actions carried out	NA	RDPH, DSF	Annual	50 %	55 %	60 %	65 %	70 %	90 %	100 %

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	in favour of RMNCAH-Nut.									
3.2.2. **By 2030, strengthen the commitment and ownership of at least 80% of key stakeholders in the implementation of the Plan**	% of heads of structures (health districts and RDPH) trained in techniques for planning, monitoring and evaluating RMNCAH-Nut interventions	NA	DSF, PLMI, RDPH	Annual	50 %	55 %	60 %	65 %	70 %	90 %	100 %
3.2.3. **By 2030, carry out at least 80% of the interventions planned for the Supervision, Monitoring and Evaluation of the implementation of the Plan.**	Number of mid-term evaluations	NA	DSF, PLMI, RDPH					1			
	Number of annual performance reviews of RMNCAH-Nut	NA	DSF, PLMI, RDPH	Annual	1	1	1	1	1	1	1
	Number of annual operational plans (AOP) for RMNCAH-Nut drawn up	NA	DSF, PLMI, RDPH	Annual	1	1	1	1	1	1	1
	% of HDs that integrated the priorities of NSP/RMNCAH-Nut in their AOP	NA+	DSF, PLMI, RDPH	Annual	100 %	100 %	100 %	100 %	100 %	100 %	100 %

9.1.1.5 Preparedness and response to public health emergencies

Strategic objective 3.3. : By 2030, strengthen the resilience of the health system to the risks of public health emergencies in order to improve the provision of reproductive health services.											
Specific objectives	INDICATOR	Reference value	Source	Frequency of collection	PROJECTION OF INDICATORS						
					2024	2025	2026	2027	2028	2029	2030
3.3.1. **By 2030, carry out at least 80% of planned interventions for the implementation of essential RMNCAH-Nut interventions in public**	Proportion of RDPH with a preparedness and response plan for RMNCAH-Nut needs in emergency situations	NA	DLMEP, PHEOCC , DSF	Annual	**10 %**	**20 %**	**25 %**	**30 %**	**40 %**	**45 %**	**50 %**
	Proportion of health facilities with at least one staff member trained in the delivery/continui	NA	DLMEP, PHEOCC , DSF	Annual	**10 %**	**20 %**	**25 %**	**30 %**	**40 %**	**45 %**	**50 %**

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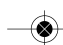
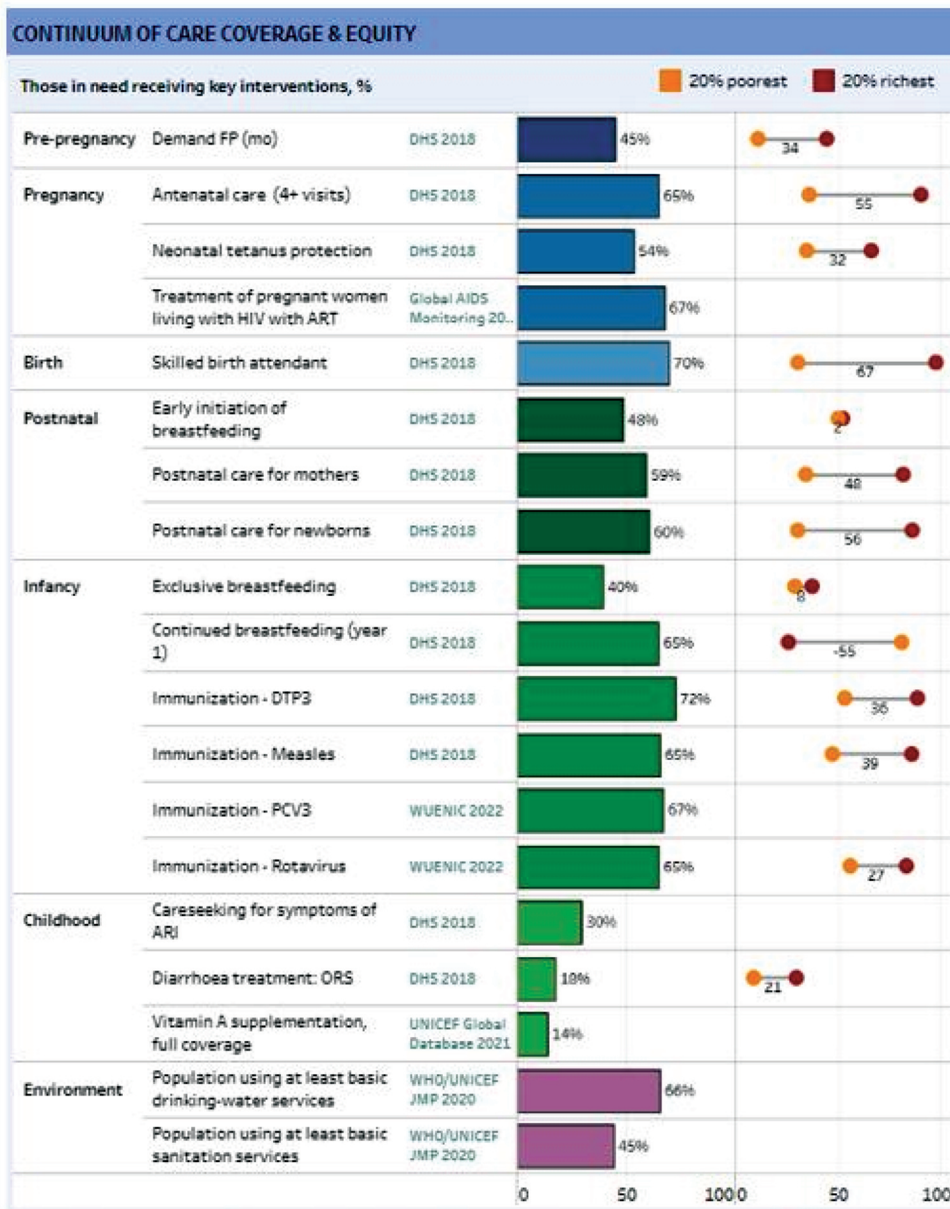
health emergencies.	ty of essential RMNCAH-Nut services in the event of a public health emergency										
	Proportion of simulation exercises carried out compared with the planned number, to test the resilience of RMNCAH-Nut services	NA	DLMEP, PHEOCC , DSF	Annual	10 %	20 %	30 %	40 %	50 %	60 %	70 %
3.3.2. By 2030, ensure the implementati on of essential RMNCAH-Nut interventions in public health emergencies	Proportion of emergencies in which essential RMNCAH-Nut interventions were deployed on time to meet the needs of the most vulnerable.	NA	DLMEP, PHEOCC , DSF	According to needs	100 %	100 %	100 %	100 %	100 %	100 %	100 %



9.3. APPENDIX 2: CONTINUUM OF CARE COVERAGE AND EQUITY



Source: Re-analysis of the latest DHS and MICS survey data carried out by the International Center for Health Equity at the Federal University of Pelotas, Brazil, 2022.

Notes: Demand FP (mo) = Demand for family planning satisfied with modern methods; Chart shows national-level datapoints that correspond to the equity data where available.