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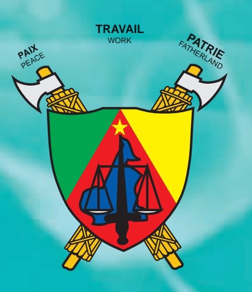

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Ministry of Public Health

INTEGRATED MONITORING AND EVALUATION PLAN

2016-2020

I.M.E.P.

AUGUST 2016

Integrated Monitoring and Evaluation Plan (IMEP)

2016-2020

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LIST OF ABBREVIATIONS AND ACRONYMS

AIDS	Acquired Immuno Deficiency Syndrome
ARV	Antiretroviral
AWP	Annual Work Plan
CAPR	Regional Pharmaceutical Procurement Centre
CBO	Community-Based Organization
CEmONC	Complete Emergency Obstetric and Neonatal Care
CHP	Complementary Health Package
CHRACERH	Hospital Centre for Research, Human Reproduction and Endoscopic Surgery
CICRB	Chantal Biya International Research Centre
CLTS	Community-Led Total Sanitation
COCSES	Operational Committee for Coordination and Monitoring/ Evaluation of the Implementation of the HSS
CORECSES	Regional Comittee for the Coordination and monitoring evaluation of the HSS implementation
CSM	Community-based self-monitoring
CSO	Civil society organisation
DGSN	General Delegation for National Security
DHS	Demographic Health Survey
DLMEP	Department of Disease, Epidemics and Pandemics Control
DMC	District Management Committee
DTC	Diagnostic and Treatment Centre
ECAM	Cameroon Household Survey
EmONC	
EPD	Epidemic Prone Diseases
EPI	Expanded Programme on Immunization
EXFIN	External Financing
FCFA	Franc of the Financial Community of Africa
FP	Family Planning
GAVI	Global Alliance for Vaccines and Immunization
GDP	Gross Domestic Product
GESP	Growth and Employment Strategy Paper
HC	Health Committe
HDC	Health District Committee
HDDP	Health District Development Plan
HRDP	Human Resource Development Plan
MINATD	Ministry of Territorial Administration and Decentralisation
MINCOM	Ministry of Communication
MINDEF	Ministry of Defence
MINEDUB	Ministry of Basic Education
MINEFOP	Ministry of Employment and Vocational Training
MINEPAT	Ministry of Economy, Planning and Regional Development
MINEPDED	Ministry of Environment, Nature Protection And Sustainable Development
MINEPIA	Ministry of Husbandry, Fisheries and Animal Industries
MINESUP	Ministry of Higher Education
MINFI	Ministry of Finance
MINFORPRA	Ministry of Public Service and Administrative Reform
MINJEC	Ministry of Youth Affairs and Civic Education
MINJUSTICE	Ministry of Justice
MINPROFF	Ministry of Women's Empowerment and the Family
MINRESI	Ministry of Scientific Research and Innovation
MINTP	Ministry of Public Works
MINTSS	Ministry of Labour and Social Security
MOH	Ministry of Public Health
MTEF	Mid term Evaluation Framework
NACC	National AIDS Control Committee
NCD	Non Communicable Disease
NGO	Non-Governmental Organization
NHAs	National Health Accounts
NHIS	National Health Information System
NIMSP-NCD	National Integrated and Multi-sector Strategic Plan for the control of Non Communicable Diseases
NIS	National Institute of Statistics
NMCP	National Malaria Control Programme
NPHO	National Public Health Observatory
NTD	Neglected Tropical Disease
PAC	Post Abortion Care
PETS	Public Expenditure Tracking Survey
PHC	Primary Health Care
PLWHIV	People living with HIV

HRH	Human Resources for Health
HSS	Health Sector Strategy
HSSIP	Health Sector Support Investment Project
IHC	Integrated Health Centre
IMCI	Integrated Management of Childhood illnesses
ISDR	Integrated Surveillance of Disease and Response
LANACOME	National Laboratory for the Quality Control of Drugs and Valuation
LLIN	Long lasting insecticide treated net
MC	Management Committee
MDG	Millenium Development Goal
MHC	Medicalised Health Centre
MHP	Minimum health Package
MICS	Multiple Indicators Cluster Survey
MINAC	Ministry of Arts and Culture
MINADER	Ministry of Agriculture and Rural Development
MINAS	Ministry of Social Affairs
PMTCT/PC	Prevention of Mother-to-Child Transmission of HIV/ Pediatric care
RCHDP	Regional Consolidated Health Development Plan
RDPH	Regional Delegation for Public Health
RLA	Regional and Local Authorities
RMNCAH	Reproductive, Maternal, Neonatal, Child and Adolescent Health
SC	Steering Committee
SDG	Sustainable Development Goal
SOPs	Standard Operating Procedures
STI	Sexually Transmitted Infection
SWAP	Sector-Wide Approach
TFPs	Technical and Financial Partners
TS-SC/HSS	Technical Secretariat of the Steering Committee of the Health Sector Strategy
UNDP	United Nations Development Programme
UNFPA	United Nations Fund for Population Advancement
WHO	World Health Organisation
MINATD	Ministry of Territorial Administration and Decentralisation

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PREFACE

The 2016-2020 National Health Development Plan will serve as a guide for the implementation of health actions during the next five years. In order to ensure the effective monitoring of planned interventions at all levels of the health pyramid, a 2016-2020 Monitoring and Evaluation Plan (IMEP) has been developed. This plan details monitoring and evaluation activities of the health system and will enable real-time assessment of performances in the short, medium and long-term of healthcare facilities.

This plan consists of, among others, dash boards that are sample indicators which shall enable heads of health facilities to follow up the progress of their results and gaps in relation to the performance values projected in the 2016- 2020 NHDP. It will ultimately measure the contribution of the health system in improving the health of the population.

However, certain obstacles may impede the implementation of 2016-2020 IMEP, notably: the low availability of workforce in charge of the integrated monitoring of activities of the 2016-2020 NHDP, especially at the operational level; the prompt execution of the baseline surveys as suggested in the NHDP; the weak capacity of the system to collect and complete indicators of partner ministries and the private sub-sector which carry out health actions.

The Government is committed, with the support of all key actors of the health system, to exploit all the opportunities to get rid of these obstacles. As such, branches of the steering and monitoring committee of the implementation of the health sector strategy, made up of the main actors of the health system, shall be instantly established at all levels of the health pyramid. Their main mission shall involve designing and proposing simple strategies for potential low performances recorded in the coordination structures.

I therefore urge all actors to master and make use of this document, which brings innovating elements to the practice of monitoring and evaluation in our country.

André MAMA FOUDA

Minister of Public Health

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CHAPTER 1: INTRODUCTION, BACKGROUND, RATIONALE AND OBJECTIVES OF THE IMEP

1.1. Introduction

Cameroon has just developed its 2016-2027 Health Strategy Sector. A participatory approach was adopted for the development of this reference document and its first National Health Development Plan (2016-2020 NHDP) in order to meet the multi-sector requirements without which the expected impact of interventions on the health of the population cannot be achieved.

The 2016-2020 NHDP described the different programmatic areas to be monitored during its validity period and also specified the key indicators (tracers) of expected performance in each programme. This plan specifies the main guidelines and operational procedures for monitoring performances in the sector and proposes possible solutions to bottlenecks that would limit performances of the health sector.

The integrated monitoring and evaluation plan focuses on the following major points:

- Background and rationale;
- Purpose and objectives ;
- Key indicators ;
- Implementation framework;
- Monitoring and evaluation frameworks;
- Financing of the NHDP.

1.2. Background and rationale

1.2.1 Background

According to results of the final evaluation of the implementation of the 2001-2015 HSS, the Integrated Monitoring and Evaluation Plan (IMEP) developed for this purpose was not validated, consequently it was not implemented. However, it should be emphasized that the 2011-2015 NHDP had a monitoring and evaluation framework that guided the development of monitoring and evaluation plans of the different priority programmes. Despite the existence of the framework, progress was poorly documented, with the exception of interventions of priority programmes. Baseline values and those of targets of the monitoring

indicators were not sufficiently documented, which, in addition to their high number, made monitoring difficult.

Moreover, the multiplicity of monitoring and evaluation sub-systems (existence of monitoring and evaluation systems and tools for each programme) did not facilitate the overall and coherent monitoring of all the interventions implemented in the health sector.

1.2.2. Rationale of the Monitoring and Evaluation Plan of the 2016-2020 NHDP

The difficulties encountered in the monitoring and evaluation of the performances projected in the 2011-2015 NHDP convinced all the stakeholders to prioritize the development of an IMEP in 2016. Indeed, following a situation analysis of the 2011-2015 NHDP monitoring and evaluation (M&E) system, several shortcomings were noted: (i) the existence of a great number of monitoring sub-systems; (ii) the lack of monitoring multi-sector coordination; and (iii) the existence of a great number of data collection tools that sometimes provide the same variables. This had a very negative impact on the performance of the National Health Information System (NHIS).

The main consequence of the organizational, structural and institutional shortcomings in the area of M&E is the low availability of relevant information for decision-making based on reliable evidence.

It was therefore necessary to select and regroup the most relevant indicators validated by key actors of the sector in a summary document. These indicators will enable to ensure the monitoring and evaluation of the performances achieved and provide appropriate corrective measures in a timely manner to remove any bottlenecks in view of an optimal achievement of the objectives of the 2016-2027 HSS. The first IMEP of the 2016-2027 HSS is therefore a summarizing tool, which establishes a synergy of the willingness of actors to monitor the performances of the implementation of the 2016-2020 NHDP.

In line with the prioritization of the interventions planned in the 2016-2027 HSS, IMEP 1 will lay emphasis on indicators relating to the strengthening of pillars of the health system, governance and strategic steering as well as on tracer indicators of interventions for the fight against morbidity and mortality related maternal and child health.

1.3. OBJECTIVES OF THE MONITORING AND EVALUATION PLAN OF THE 2016-2020 NHDP

1.3.1. Global objective of the 2016 -2020 NHDP

"Make priority quality essential and specialized health care and services accessible to at least 50% of the population by 2020".

This objective is expected to ensure that the populations, especially the most vulnerable, have geographical, financial and cultural access to priority quality essential and specialized health care and services.

1.3.2. General Objective of IMEP 1

Improving Monitoring and Evaluation of the Implementation of the 2016-2020 NHDP

1.3.3. Specific objectives

The specific objectives of IMEP 1 are:

- specifying the institutional and organizational framework for monitoring and evaluation of the 2016- 2020 NHDP;
- providing follow–up's simplified tools at all levels of the health pyramid ;
- enabling the assessment of the progress made at all levels;
- developing the indicator matrix, the performance framework, the dash board for the monitoring of the implementation of the NHDP at all levels of the health pyramid;
- defining monitoring and evaluation indicators and mechanisms of the NHDP;
- making a summary description of mid term and final monitoring and evaluation modalities of the NHDP.

CHAPTER 2: CURRENT SITUATION OF THE NHDP MONITORING/EVALUATION IN THE HEALTH SYSTEM

2.1 Introduction

Monitoring/evaluation is a core mission entrusted to the PPBS chain in partner ministries. In addition to having staff assigned for this task, each ministry carrying out health activities has an internal mechanism to collect and centralize information coming from the operational level and to inform decision-making. In the MOH, the Health Information Unit (HIU) in collaboration with the National Public Health Observatory (NPHO) carries out the centralization of this information. Most of the interventions planned in the 2016-2020 NHDP will be implemented by the MOH, and the level of functionality of the NHIS (ineffective during the implementation of the 2011-2015 NHDP) will be decisive for the successful implementation of the NHDP. In other words, the effectiveness of NHDP monitoring depends on the functionality of the NHIS on the one hand and the other hand the availability of information on the implementation level of interventions carried out by partner ministries and other key actors (health facilities of the private sub-sector). Given that some actions and interventions of the NHDP are cross-cutting, the achievement of the results projected in the NHDP will require a coherent implementation of health actions by the various ministries and administrations involved in health issues.

Monitoring/evaluation was one of the weaknesses identified during the implementation of the 2011-2015 health development plan. The poor performance recorded during the implementation of the plan was due, amongst others, to the lack of harmonized monitoring and evaluation tools for all levels of the health pyramid. To this was added: (i) poor coordination of the management of health information collected; (ii) existence of several independent health information sub-systems; and (iii) absence of an umbrella multi-sector coordination and monitoring body of the NHDP at the devolved level.

Given the above-mentioned bottlenecks that hampered the effective monitoring of stakeholder performances in the implementation of the 2011-2015 NHDP, it is important during this cycle to anticipate and resolve them.

2.2 Institutional and organizational framework of the NHIS

The organization and functioning of the NHIS is based on several legal instruments. These include Decree No. 2010/2952/PM of 1 November 2010 to lay down the creation, organization and functioning of the National Public Health Observatory; Decree No. 2013/93 of 3 April 2013 on the organization of the Ministry of Public Health, which, among other, attached the Health Information Unit to the Secretariat General and raised epidemiological surveillance to a sub-department of the DLMEP. The regional level benefitted from the creation of a health information and planning service. At the operational level, tasks relating to health information management are assigned to the health district without any real technical service in charge of the task. Moreover, the emergence of priority health programmes led to the establishment of parallel information sub-systems at the central and regional levels with practically autonomous structures (CTG, RTG, etc.).

From the above, it is observed that the monitoring system for the implementation of the 2016-2020 NHDP is relatively well organized institutionally at the central and intermediate level, but at the operational level (health district), there is no formal health information management service, which to some extent impedes the monitoring of the District Health Development Plan.

A NHIS strategic strengthening plan for the period 2009-2015 was developed in 2008, but its implementation was not effective. During the same period, nurses and nursing assistants represented 80% of the staff involved in the management of health information at the operational level and only 5% of these staff had received continuous training on the NHIS (ERSEN 2014).

This insufficiency is coupled with the low promotion of NHIS activities by its actors at all the levels of the health pyramid. Indeed, the management of health information is most often reserved for so-called "recalcitrant" personnel (ERSEN op.cit.). Given such a profile, adequate monitoring of NHDP interventions will be a challenge that needs to be met.

2.3 Indicatros and data collection system

With a multiplicity of health information sub-systems and data collection tools, the coordination of health information management is problematic. The NHIS survey in the Far North region revealed that there exist about twenty data collection tools to be filled out

monthly by health facilities. Filling out these many tools at the operational level is a tedious task for HF heads; which partly explains the low availability and quality of the data collected.
In the private sub-sector, most profit-making health facilities provide very little information on their activities and therefore do not provide statistical data. In addition, many illegal health facilities avoid the control of the system, hence the low completeness of factual and basic health information for decision-making.

CHAPTER 3: IMPLEMENTATION FRAMEWORK OF THE NHDP MONITORING AND EVALUATION PLAN

Within the framework of the implementation and monitoring/evaluation of the 2016-2027 HSS, some existing regulatory instruments will be modified and others will be drafted in order to ensure the effectiveness of the sector approach, transparency and the participation of all actors in the monitoring/evaluation of the performances carried out. The members, functioning and missions of the steering and monitoring committee for the implementation of the HSS will be specified in a Prime Ministerial Decree. The same applies to the missions of the various branches of this committee.

3.1. Central level

The Steering and Monitoring Committee for the Implementation of the HSS: this committee shall be responsible for the institutional monitoring/evaluation of the implementation of the NHDP. As such, it shall be responsible among others for the synergy of activities contributing to health development under the leadership of the MOH. At the central level, the steering and monitoring committee for the implementation of the new HSS will be set up with its two branches, which will assist it in its missions. It will have a technical monitoring committee in accordance with the recommendations of the strategic planning guide in Cameroon and a Technical Secretariat:

Technical Monitoring Committee : will be chaired by the Secretary General of MOH. The following will participate in the meetings of this technical committee: (i) the 10 regional delegates for public health; (ii) the head of planning of the PPBS chain of the MOH and partner ministries, (iii) health focal points of partner ministries, representatives of TFPs; (iv) the Coordinator of the Technical Secretariat of the Steering Committee; (v) heads of priority health programmes of the MOH; (vi) the head of the follow-up unit.

This committee can, if necessary, invite ad hoc experts such as: (i) Inspectors and Technical Advisers; (ii) Directors and Heads of Divisions; (iii) Programme heads; (iv) the Head of the Health Information Unit; (v) Technical Secretaries of thematic sub-committees; (vi) the coordinator of the NPHO; (Vii) heads of thematic groups of the steering and monitoring committee for the implementation of the HSS. (Vi) the head of the HIU, etc.

The Technical Monitoring Committee shall meet at least three times a year and its main task shall consist in the validation of technical files to be submitted to the steering committee. For greater efficiency and in view of the difficulties encountered by Regional Delegates for Public Health in monitoring the NHDP, a problem-solving contingency plan will be elaborated at each meeting of the technical committee and support shall be given to the delegates to resolve the bottlenecks that hinder the achievement of NHDP objectives at the regional level.

The Technical Secretariat of the steering committee*:* it is in charge of implementing decisions taken by the Steering committee. For better steering of the sector and effective monitoring of the 2016-2027 HSS indicators, the consolidation of data collected will be carried out at each level of the health pyramid by the various established coordination bodies. The summary of information at the central level will include data from: (i) the 10 regional coordination and monitoring committees for the implementation of the NHDP; (ii) the PPBS chain of the MOH and (iii) partner ministries of the health sector. Technical meetings of the TS/SC-HSS will enable in consolidating all the data and information resulting from the implementation of multi-sector interventions carried out at all levels of the health pyramid by the MOH and partner administrations.

This data will enable in filling out the national dashboard for the monitoring of the implementation of the 2016-2020 NHDP. Feedback to regions will be systematic and a copy of the follow-up report will be forwarded to the Monitoring Committee and RDPH.

The dashboard will include two types of indicators: indicators specific to MOH and those to be filled out by partner ministries. (See Table 3).

Within the framework of NHDP M/E, the TS/SC-HSS will also: (i) organize thematic or sector reviews; (ii) strengthen the sector approach and introduce a compact; (iii) design and deploy HDDP and RCHDP development tools; (iv) technical support for multi-year multisector work plans for HDs, RDPH and structures of the central-level; (v) monitor performances projected in the 2016-2020 NHDP; (vi) conduct rapid surveys in order to have baseline data to monitor the NHDP; (vii) assess the achievement level of results per strategic axis; (viii) mid-term and final evaluation of the implementation of the NHDP; (ix) develop a new HSS; and (x) strategic and logistical support for the functioning of thematic groups and multi-sector sub-committees in the sector. For greater coherence and efficiency, the Technical Secretariat of

the Steering Committee will be extended to other existing thematic multi-sector secretariats if need be.

3.2 Devolved level

At the devolved level, the Steering and Monitoring Committee for the implementation of the HSS will have two branches: (i) the Regional Coordination and Monitoring/Evaluation Committee for the Implementation of the HSS and (ii) and the Operational Coordination and Monitoring/Evaluation Committee for the Implementation of the HSS. The members, functioning and missions of all coordination and monitoring bodies for the implementation of the NHDP at all levels of the health pyramid shall be specified by a Prime Ministerial decree.

3.2.1 Intermediate level: The Regional Coordination and Monitoring/Evaluation Committee for the implementation of the HSS (CORECSES):

At the intermediate level, the Regional Coordination and Monitoring/Evaluation Committee for the implementation of the HSS will be the coordinating and monitoring body for the implementation of the 2016-2020 NHDP.

In this capacity, it will be responsible for: (i) developing the integrated Monitoring and Evaluation Plan of the RCHDP; (ii) monitoring indicators of the regional multi-sector dashboard; (iii) ensuring the relevance of the interventions proposed by partner ministries and their contribution to the achievement of the objectives set out in the RCHDP; (iv) providing technical support to Health Districts in the development of their HDDP AWPs and M&E plans; (v) compiling and consolidating monitoring data of the devolved level for the development of the RDPH progress report; (vi) providing feedback from the regional level to the health districts; (vii) participating in thematic and/or sector reviews; (viii) organizing formative and integrated supervisory missions, decentralized monitoring, and routine coordination meetings at the regional level.

For greater coherence and efficiency, the Technical Secretariat of CORECSES shall be extended to the other existing thematic multi-sector secretariats in the region. CORECSES will also ensure that the activities proposed in the different multi-annual and annual work plans of the HDs are coherent and focus on the achievement of the objectives of the RCHDP.

The governor shall preside over the meetings of CORECSES and the Regional Delegate for Public Health assisted by the Head of the Control Brigade of the RDPH shall be in charge of

the technical secretariat of the meetings. (The profile of other members of CORECSES is specified in Table 1).

3.2.2 Operational level: the Operational Committee for Coordination and Monitoring/ Evaluation of the Implementation of the HSS (COCSES)

COCSES shall be chaired by the Senior Divisional Officer/ Divisional Officer. The Head of the Health District shall be in charge of the technical secretariat. COCSES shall, among other things, be responsible for: (i) consolidating the AWPs of the health areas, (ii) developing the Monitoring/Evaluation Plan for the HDDP and ensuring that it conforms with this IMEP (iii) Providing technical support to DHC; (iv) developing the monitoring and evaluation dashboard of the HDDP ensuring the quality control of the data collected, analyzing it and periodically transmitting the monitoring report of indicators expected at the regional level.

Indeed, COCSES meetings chaired by the Senior Divisional Officer/Divisional Officer shall be opportunities to present not only the performances of the HD but above all an opportunity to assess the quality of the data, to ensure the coherence of interventions programmed in the various ministries of the sector and which contribute to the achievement of the objectives projected in the NHDP. These meetings will also help to correct the observed malfunctioning that could compromise the achievement of the expected results of the HD. Finally, the Senior Divisional Officer/Divisional Officer shall be the appropriate intermediary to ensure and reinforce the synergy of the interventions carried out at the operational level and the multi-sector resolution of the identified health problems.

CHAPTER 4: MONITORING/EVALUATION FRAMEWORK: TOOLS

The main tools recommended for the monitoring/evaluation of the implementation of the 2016-2020 NHDP include: the operational matrix of indicators, the performance framework and the dashboard.

4.1. Operational matrix of indicators

The operational Monitoring/Evaluation matrix is a table that summarizes performance indicators of the 2016-2020 NHDP. It makes it possible to harmonize the calculation method and the comprehension of the content of each indicator by all the actors of the health system. All actors (at all levels) involved in M&E will therefore have a referential that they can use. Seven criteria are used to describe each indicator in this matrix, notably: (i) name of the indicator; (ii) its usefulness; (iii) its method of calculation; (iv) method of data collection; (V) persons in charge of collection; (vi) source of data collection; (vii) timing / frequency of data collection.

Impact indicators shall be used to assess the long-term impact of health actions on the population. The effect indicators, on the other hand, will make it possible to assess, in the medium term, the progress made in the use of health services and the behavior changes observed. The effect and impact indicators are therefore the basis of the performance framework for the monitoring and evaluation of the NHDP. Finally, indicators of direct achievement will ensure the execution and implementation level of the planned interventions.

Table 1: Operational matrix of M/E indicators of the 2016-2020 NHDP

Name	What does this indicator measure?	How it is calculated?	Collection sources	Collection level[1]	Collection Method	Frequency
STRATEGIC AXIS 1 : HEALTH PROMOTION						
Tracer Indicator						
% of household members using individual improved toilets	Evaluates the use of improved toilets in households as a disease prevention strategy related to the dangers of open defecation	**Numerator** : Number of people living in households, using the individual improved toilet **Denominator:** Total population of Cameroon	DHS	Central	Surveys	Every 5 years
Prevalence of obesity in urban areas (Percentage of urban population whose body mass index is greater than or equal to $30kg/m^2$)	Assesses the extent of obesity in urban areas	**Numerator:** Number of persons obese (i.e. with a BMI greater than or equal to 30 kg / m^2) in urban areas. **Denominator:** total number of people at risk in urban areas	DHS	Central	Surveys	Every 5 years
Percentage of targeted companies that apply health and occupational safety principles	Determines the level of the implementation of occupational safety measures for the prevention of occupational diseases and accidents in workplaces	**Numerator:** Number of evaluated formal sector companies that apply health and safety principles at work. **Denominator:** Total number of targeted companies	DHS	Central	Surveys	Every 5 years
Chronic malnutrition in children below 5 years of age	Determines the extent of chronic malnutrition in children below 5 years of age	**Numerator**: Number of children aged 0 to 59 months whose weight for age index is below -2 Z scores1. **Denominator** : Total number of children aged 0 to 59 months examined	DHS	Central	Surveys	Every 5 years

[1] Two criteria were taken into account when assigning an indicator to given level of the health pyramid, these include: the ease for this level of the health pyramid to fill out this indicator with regards to its missions; and (ii) its ability to carry out corrective actions to improve this indicator if its value is below what is expected, or indentify strategies to maintain this value to its best level, if it is satisfactory.

Name	What does this indicator measure?	How it is calculated?	Collection sources	Collection level[1]	Collection Method	Frequency
Strategic sub axis 1.1: Institutional and community capacities and co-ordination in the field of health promotion						
Tracer indicators						
Proportion of HDs with functional DHC[(a)]	Determines the functionality of dialogue structures at the operational level	**Numerator:** Number of HDs with an AWP developed with the participation of DHC members and having organized at least one coordination meeting documented and validated by them the previous semester. **Denominator** : Total number of assessed HDs	DOSTS annual report, report of RDPH, NHIS,	Regional	Surveys	Proportion of HDs with functional DHC
Tracer indicators						
Percentage of the MOH budget allocated to health promotion interventions	Evaluates the commitment and level of investment of MOH on health promotion interventions	**Numerator:** budget allocated for health promotion interventions. **Denominator** : Total State budget	DRFP report	Central	Assessment reports	Annual
Proportion of Health Districts having at least 3 CSO affiliated to the regional CSO platform and have contributed in the implementation of the Annual Work Plan (AWP)	Determines the functionality of CSOs of HDs and that of the regional platform of CSOs in the implementation of health interventions; also assesses the participation of CSOs in the implementation of health activities	**Numerator:** Number of CSOs affiliated to the regional platform of CSOs involved in the implementation of health activities planned in the AWP of the HD for the evaluation period. **Denominator** : Total number of CSOs	DPS report, RDPH, DCOOP, HD	Regional	Survey, study	Annual
Percentage of HDs having at least 3 polyvalent CHWs trained for the provision of community MHP	Measures the availability in health districts of qualified versatile CHWs for the dispensation of Community MHP	**Numerator** : Number of CHWs trained and recruited for the delivery of MHP activities at the community level **Denominator** : Total number of CHWs	DPS report DOSTS, HR	Regional	Survey, study	Annual
Availability of updated regulatory instrument governing community participation in heath interventions	Determines the level of a legal framework for community participation		DPS report DAJC, DOSTS	Central	document review	Every two years

Name	What does this indicator measure?	How it is calculated?	Collection sources	Collection level[1]	Collection Method	Frequency
Goal achievement rate of the multiannual health promotion plan	Determines the rate of achievement of the planned objectives in the National Strategic and Multi-sector Plan for health promotion	**Numerator** : Number of achieved goals of the multi-annual plan for health promotion **Denominator** : Total number of goals of the plan	DPS report, RDPH, TS-SC/HSS	Central	Survey, study	Annual
Proportion of health districts where at least 50% of secondary schools implement health promotion activities	Determines the capacity of schools to develop and implement health promotion activities	**Numerator** : Number of secondary schools with an implementation report on activities in accordance with their health promotion AWP **Denominator** : Total number of targeted schools	DPS report MINEDUB, MINESEC, MINSESUP , MINTSS	Operational	Study	Every two years
Proportion of Health Districts having implemented at least 50% of the activities stated in their Annual Work Plan (AWP)	Determines the level of implementation of community interventions that are inscribed in the annual work plans of the HDs	**Numerator** : Number of HDs that have implemented at least 50% of the activities of the planned integrated community directed intervention package **Denominator** : Total number of evaluated HDs	DPS report	Regional	Survey study	Annual
Sub strategic -axis 1.2: Living Environment						
Tracer indicators						
Percentage of households using solid fuel as first source of domestic energy used for cooking	Determines the level of household exposure to the toxic substances contained in the smoke from solid combustibles	**Numerator:** Number of households using solid combustibles as main source of domestic energy for cooking. **Denominator** : Total number of targeted households	MICS, DHS	Central	Studies	Every 3 to 5 years
Percentage of households with access to potable water	Determines the proportion of the population with access to potable water	**Numerator:** Number of households that have access to a potable water source. **Denominator** : Total number of registered households	DPS, DHS, MICS, ECAM	Central	Survey study	Every 3 to 5 years

Name	What does this indicator measure?	How it is calculated?	Collection sources	Collection level[1]	Collection Method	Frequency
Tracer indicators						
Percentage of HDs implementing CLTS[(a)]	Determines the level of community mobilization for basic environmental hygiene and the sanitation	**Numerator** : Total number of HDs implementing CLTS **Denominator** : Total number of targeted HDs	DPS, DHS, MICS, ECAM	Regional (Northern Regions)	Survey, study	Annual
Proportion of Health Districts that have a public health engineering technician	Determines the availability of personnel trained in hygiene and sanitation in the HD	**Numerator** : Number of HDs with at least one staff trained in sanitary engineering **Denominator** : Total number of assessed District	DPS report, HRD	Regional	Document review	Every year
Achievement rate of activities provided for in the health plan of targeted companies over the last 12 months	Determines the level of implementation of health promotion activities and safety in the working environment	**Numerator** : Number of activities implemented in the health plan of companies during a period **Denominator** : Total number of planned activities in target companies during the same period	MINTSS, DPS, DCOOP	Central	Survey, study	Annually
Strategic sub axis 1.3: Strengthening healthy behaviours of individuals and communities						
Tracer indicators						
Prevalence of pregnancies among adolescent girls	Determines the effectiveness of measures implemented to prevent the occurrence of early pregnancy	**Numerator** : Number of pregnant girls aged 15 to 19 years **Denominator** : Total number of girls aged 15 to 19 years	MICS5	Regional	Survey, study	Every 2 to 3 years
Prevalence of smoking in persons aged 15 and above	Determines the extent of tobacco exposure in subjects aged 15 years and above	**Numerator** : Number of people aged 15 and above consuming tobacco **Denominator** : Total number of people aged 15 and above	World Health Statistics, WHO, DPS, GATS	Central	WHO report, Studies	Every 3 to 5 years

Name	What does this indicator measure?	How it is calculated?	Collection sources	Collection level[1]	Collection Method	Frequency
Tracer indicators						
Percentage of HDs having an integrated Communication plan for health promotion and disease prevention	Determines the ability of HDs to organize communication activities for health promotion and disease prevention	**Numerator** : Number of HDs with an integrated communication plan for health promotion and disease prevention **Denominator:** Total number of assessed HDs	DPS	Regional	Research / survey	Annually
Annual number of contra band food products seized	Assesses the effectiveness of food safety control	Numbering	DPS, ANOR	Operational	Operating documents	Annual
Proportion of HDs having community teams trained in first aid	Determines the availability of first aid teams (availability of service delivery and pre-hospital care) useful during the management of road accident cases	**Numerator** : number of HDs that have community teams trained in first aid during a given period **Denominator** : Total number of districts assessed during the same period	DOSTS, DLMEP, NPHO, MINTRANSPORT, Fire fighters	Regional	Studies	Every two years
Number of victims (injured or dead) of inter urban road accidents	Determines the effectiveness of road safety measures in place	Counting of road accident cases	MINTRANS PORT Reports CONAROUTE Report	Central	Exploitation of documents	Annual
Proportion of local councils/health districts with conventional developed sites for sports and physical activities	determines the availability of developed areas for sports and physical activities in RLAs	**Numerator** : Number of RLAs with at least one developed and conventional space for the practice of sports and physical activities **Denominators:** Total number of targeted RLAs	CU, MINSEP	Regional	Study	Annual
Percentage of approved centres for sports and physical activities having a trained sports instructor	Determines the availability of qualified human resources to supervise the practice of sports and physical activities in accredited centres	**Numerator** : Number of approved centres with a qualified instructor **Denominator** : Total number of accredited centres for the practice of sports and physical exercises assessed	DPS reports, MINSEP	Regional	Survey, Study	Annually

Name	What does this indicator measure?	How it is calculated?	Collection sources	Collection level[1]	Collection Method	Frequency
% of children aged 6 to 23 months having received food from at least four food groups in the previous day	Measures the level of adoption of practices relating to balanced diet among parents of children aged 6 to 23 months	**Numerator** : Number of children aged 6 to 23 months who consumed foods from at least four food groups during the day preceding the survey **Denominator** : Total number of children aged 6 to 23 months assessed	DPS Reports	Operational	Survey, study	Every 2 years
Prevalence of dental decay in primary school pupils	Determines the extent of oral diseases in schools	**Numerator** : Number of children in schools with at least one decayed tooth **Denominator** : Total number of children examined for the period in question	MINEDUB / MOH Reports	Operational	Survey, study	Every 5 years
Strategic sub axis 1.4: Essential family practices, family planning, promotion of adolescent health and post abortion care						
Tracer indicators						
Modern contraceptive prevalence rate in women of childbearing age	Enables in estimating the proportion of women of childbearing age (15 to 49 years) or married couples whose FP needs are satisfied by modern methods	**Numerator** : Number of sexually active women of childbearing age (15-49 years) using or whose partner is using a modern contraceptive method X 100 **Denominator:** Total number of women of childbearing age (15-49 years)	DSF report PLMI, MICS	Regional	Surve y, study	Every 3 to 5 years
Propotion of unmet needs in FP	Determines the system's ability to make available contraceptives for married women or those in a relationship who no longer want children and those who want to wait for one or several years before having another child	**Numerator** : Number of women aged 15 to 49 years married or in a relationship, who want to space out births or limit the number of children, but who are not currently using any contraceptive method **Denominator** : Total number of married women or in a relationship aged 15-49 years who are fertile and want to space out births or limit the number of children	MICS	Regional	Surve y, study	Every 2 years

Name	What does this indicator measure?	How it is calculated?	Collection sources	Collection level[1]	Collection Method	Frequency
Tracer indicators						
Proportion of DHs having a technical personnel trained in EFP[(a)]	Determines the availability of human resources qualified for the promotion of EFP	**Numerator** : Number of HDs with at least one provider trained in EFP **Denominator:** Total number of assessed HDs	DSF	Regional	Surve y study	Annual
Percentage of households implementing at least 7 out of 15 essential family practices[(a)]	Determines the level of adoption of healthy behaviors and practices in the community	**Numerator:** Number of households applying at least 7 of the 15 essential family practices. **Denominator** : Total number of households assessed	DPS reports MINPROF	Operational	Surve y, study	Annual
STRATEGIC AXIS 2: DISEASE PREVENTION						
Tracer indicators						
Prevalence of Hypertension (HPT) in adults aged 15 years and above in urban areas	Determines the extent of hypertension in urban areas i.e. the proportion of people aged 15 years and above with a systolic blood pressure of ≥140mmHg or diastolic blood pressure of ≥90 mHg	**Numerator** : Number of patients above 15 years with hypertension **Denominator** : Total number of patients at risk and aged 15 and above	MOH (DLMEP)	Central	Survey, study	At least every 5 years
Strategic sub axis 2.1: Prevention of Communicable Diseases						
Tracer indicator						
Incidence of HIV	Determines the extent of new cases of HIV infections	**Numerator** : Number of new HIV cases during the period evaluated **Denominator** : Total population at risk during the same period	RDSP-HIV, DHS	Regional	Survey, study	Every 3 to 5 years
Prevalence of HIV	Determines the extent of HIV in the general population	**Numerator** : Number of HIV+ persons **Denominator** : Total population	DHS	Regional	Survey, study	Every 5 years

Name	What does this indicator measure?	How it is calculated?	Collection sources	Collection level[1]	Collection Method	Frequency
Prevalence of viral Hepatitis B	Determines the extent of viral hepatitis B in the general population	**Numerator:** Number of Hepatitis B infected persons. (that is, number of persons screened HBs Ag positive) **Denominator** : Total population	DHS	Regional	Serological survey, study	Every 5 years
Coverage of preventive chemotherapy for onchocerciasis (CDTI) coverage)	Determines the capacity of the system to prevent the occurence of onchocerciasis and its complications	**Numerator** : Number of people who received preventive treatment **Denominator** : Total population at risk	DLMEP report, Programs	Operational	NOCP Technical Report	Annual
Incidence of smear-positive pulmonary tuberculosis (PTB+)	Determines the number of new cases of smear positive TB and relapses during a given period	**Numerator** : Number of new TB cases and relapses during a given period **Denominator** : Total population at risk during the same period	PNLTB reports, DLMEP	Regional	Survey, Review, Monitoring	Annual
Tracer Indicators						
Percentage of HDs having carried out and documented at least 75% of IEC/C4D activities included in their Integrated Communication Plan	Determine the capacity of the system to promote health and sensitize the population on the different means of disease prevention (Assessment of the level of implementation of the awareness-raising activities included in the Integrated Communication Plan of the HD).	**Numerator** : Nomber having carried out and documented at least 75% of IEC/C4D activities included in their Integrated Communication Plan **Dénominateur**: Total number of the assessed districts	Reapports of Health Districts,	Régional	étude	Semestrielle
Percentage of inmates aged 15-49 years having screened for HIV in the last 12 months and who collected their results	Determines the effectiveness of the PICT strategy (HIV Provider Initiated counseling and testing) in prisons	**Numerator:** Number of persons aged 15-49 years living in prisons who were screened and who collected their results. **Denominator:** Total number of persons aged 15-49 years living in prisons who did the test	DPS, NACC	Regional	Study	Annual

Name	What does this indicator measure?	How it is calculated?	Collection sources	Collection level[1]	Collection Method	Frequency
Percentage of people aged 15-49 years having screened for HIV in the last 12 months and collected their results	Determines the effectiveness of the PICT strategy (HIV Provider Initiated counseling and testing)	**Numerator** : Number of persons aged 15-49 years who were screened for HIV and withdrew their result **Denominator:** Total number of persons aged 15-49 years having completed a test	DPS, NACC	Operational	Study	Annual
Proportion of households with an LLIN for 2 persons	Determines the availability of LLINs in households	**Numerator** : Number of households with an LLIN for two persons for the evaluated period **Denominator** : Number of surveyed households	NMCP report, LLIN distribution logbook	Central	Study	Every 3 years
Proportion of children below 5 years of age of the North and the Far North Regions who received preventive treatment for seasonal malaria	Determines the capacity of the system to ensure the prevention of seasonal malaria in children below 5 of age in areas prone to seasonal malaria	**Numerator:** Number of children below 5 years of age exposed to seasonal malaria who received preventive treatment during a given period. **Denominator** : Total number of children below 5 years of age exposed to seasonal malaria during the same period	DLMEP report, NMCP report,	Operational	Data compilation	Annual
Strategic sub axis 2.2: EPDs and public health event, monitoring and response to epidemic prone diseases, zoonoses and public health events						
Tracer indicators						
Proportion of HDs with confirmed measles outbreaks which organized response according to national guidelines	Determines the functionality and preparedness of the surveillance/alert and response to epidemics in the HDs	**Numerator** : Number of HDs which experienced measles outbreaks and organized response **Denominator:** Total number of HDs with measles outbreaks	DLMEP reports, EPD notification sheet, EPD Report	Regional	Review of epidemiological surveillance reports	Weekly, Monthly

Name	What does this indicator measure?	How it is calculated?	Collection sources	Collection level[1]	Collection Method	Frequency
Proportion of measles outbreak reported and investigated	Determines the I capacity of the health system to provide epidemiological surveillance for measles	**Numerator** : Number of reported and investigated measles outbreaks **Denominator** : Total number of reported measles outbreaks	DLMEP reports, EPD notification sheet, EPD Report	Regional	Operating reports epidemiological surveillance	Weekly, Monthly
Tracer indicators						
Proportion of CERPLE (Regional epidemics prevention and control centres) with minimal operational capacity required to monitor EPDs/public health events and response[a]	Determines both the availability of institutional capacity and the preparedness of the RDPH to manage emergencies or public health events (EPDs).	**Numerator** : Number of RDPH having CERPLE with minimum operational capacity required to monitor EPDs/public health events and response **Denominator** : Total number of CERPLE	RDPH, DLMEP	Central	Review of activity reports	Annual
Proportion of RDPH with reference laboratories operating in an EPD surveillance network	Determines the availability and functionality of the reference laboratory network for EPD surveillance	**Numerator** : Number of RDPH having atleast reference laboratories operating in an EPD surveillance network **Denominator** : Total number of RDPH	DPML, NPHL	Central	Studies	Annual
Proportion of RDPH with an updated annual epidemic risk zone mapping and operational response plans	Provides a comprehensive overview of the health vulnerability of health districts. Assess the extent of the areas at risk of epidemics with a view to organizing the responses accordingly in the health districts in these areas	**Numerator:** Number of RDPH with annual epidemic risk maps and operational response plans **Denominator** : Total number of RDPH	DLMEP report	Central	Studies	Annual
Number of children left out during routine immunization	Appreciates the ability of DS to immunize all their target population		DSF, DLMEP, EPI	Regional	Decentralized monitoring, EPI Review	Annual

Name	What does this indicator measure?	How it is calculated?	Collection sources	Collection level[1]	Collection Method	Frequency
Proportion of HDs which have inputs for response to the other EPDs not covered by the EPI over the last three months	Determines the availability of pre-positioned inputs in HDs for response to EPDs not targeted by the EPI	**Numerator:** Number of HDs with inputs for a response to other EPDs not targeted by the EPI. **Denominator** : Total number of HDs	DPML report	Regional	Supervision	Every semester
Sub strategic axis 2.3: RMNCAH and PMTCT						
Tracer indicator						
Immunization coverage with the reference antigen (Penta3)	Determines the level of immunization of children aged 0-11 months on PENTA 3	**Numerator** : Number of children aged 0-11 months who received PENTA 3 over a given period **Denominator** : Number of children below one year expected for the same period	MPR, MICS, EPI activity report	Operational	Monitoring decentralized EPI Review	Monthly, Yearly
ANC coverage rate 4	Measures the level of attendance and recruitment of pregnant women to prenatal consultation	**Numerator** Total number of pregnant women who attended at least 4 antenatal visit during a given period **Denominator:** Number of expected pregnancies for the period evaluated during the same period	DSF PLMNI	Operational	Review of data	Annually
Measles' Immunization coverage in /rubella vaccine	Determines the proportion of children (EPI target) who have completed the routine immunization	**Numerator** : Number of children aged 0-11 months immunized against measles and rubella during a given period **Denominator** : Total number of children aged 0 to 11 months expected during the same period	EPI report	Operational	Compilation of immunization data	Annual
Proportion of HIV-infected pregnant women on ART	Determines the ability of the system to ensure the PMTCT of HIV	**Numerator** : Total number of HIV-infected pregnant women on ART during a given period **Denominator** : Total number of HIV-positive pregnant women during the same period	PDSP-HIV NACC	Operational	Compilation of HIV management data	Quarterly

Name	What does this indicator measure?	How it is calculated?	Collection sources	Collection level[1]	Collection Method	Frequency
Proportion of children aged 0-5 sleeping under an LLIN	Determines the use of LLINs in children aged 0-5 years	**Numerator** : Number of children aged 0-5 years sleeping under LLINs during a given period **Denominator** : Estimated number of children aged 0-5 years during the same period	NMCP report, MICS, DHS	Operational	DHS, Routine	Every three years
Mother-to-child transmission rate of HIV (percentage of HIV- exposed children)	Determines the implementation level of PMTCT	**Numerator:** Total number of HIV-positive children born to HIV-positive mothers. **Denominator** : Total number of children born to HIV-positive mothers	Routine data DLMEP, NACC	Regional	Study	Annually
Proportion of newborn with low birth weight (below 2.500 grammes)	Enables to assess the nutritional status of the mother	**Numerator** : Number of newborns with less than 2500g at birth during the period evaluated **Denominator** : Total number of live births registered during the same period	DHS, MICS, PHIA	Operational	Study, Surveys	1 to 5 years
Proportion of pregnant women having received at least 3 doses of IPT during pregnancy (% IPT3)	Determines the level of malaria prevention in pregnant women	**Numerator:** Number of pregnant women who received at least 3 doses of IPT during pregnancy during a given period. **Denominator** : Number of pregnant women who attended ANC during the same period	RMA report, NMCP	Operational	NMCP supervision	Monthly, Annually
Proportion of District Hospitals with at least one staff trained in the delivery of high impact interventions in mother and child health	Determines the availability of HR able to delever of high impact interventions in mother and child health	**Numérateur**: Number of HD shaving at least one staff trained in the delivery of high impact interventions in mother and child health **Dénominateur:** Nombre total number of assessed Health Disctricts	Report PLMI, Report DRH	Operational	Compilation of routine data	Annual

Name	What does this indicator measure?	How it is calculated?	Collection sources	Collection level[1]	Collection Method	Frequency
Proportion of HDs that deliver CEmONC according to standards (9 functions)[(a)]	Determines the availability of CEmONC service delivery in HDs (availability of nine complete CEmONC functions)	**Numerator** : Number of HDs delivering the 9 CEmONC functions during a period **Denominator**: Total number of HDs evaluated during the same period	DSF report	Regional	Study	Annual
Proportion of children who attended PNC services within 48 hours following delivery.	Determines the capacity of the health system to carry out early management of the newborn health problems	**Numerator**: Number of children received in PNC within 48 hours following birth during a given period. **Denominator:** Total number of live births during the same period	DSF report on deliveries in health facilities, MICS, consultation logbooks	Operational	Compilation of routine data	Annually, 3 to 5 years
Strategic sub axis 2.4: prevention of non-communicable diseases						
Tracer indicators						
Prevalence of Diabetes type 2 among adults aged at least 18 years in urban areas	Determines the extent of diabetes type 2 in urban areas	**Numerator** : Number of persons living in urban areas aged 18 and above with moderate fasting glycemia (defined by the value of fasting blood sugar between 110 mg/dl and 126 mg / dl) **Denominator** : Total population of targeted subjects aged 18 years and above	DPS report, DLMEP report	Central	STEPS survey	3 to 5 years
Tracer indicators						
Proportion of RDPH which organized at least one annual NCD (hypertension, diabetes, cancers, etc.) prevention and screening campaign	Evaluates availability of NCD prevention service offered in the RDPH	**Numerator** : Number of RDPH which organized at least one annual NCD prevention campaign **Denominator:** Total number of RDPH	DLMEP	Central	Operating documents	Annual

Name	What does this indicator measure?	How it is calculated?	Collection sources	Collection level[1]	Collection Method	Frequency
Proportion of RDPH which organized at least one awareness and screening campaign for sickle cell disease	Enables to determine the strategies deployed by the health system for the prevention of sickle cell disease	**Numerator** : Number of RDPH which organized at least one sickle cell disease prevention campaign per year **Denominator:** Total number of RDPH	DLMEP report	Central	Document review	Annual
STRATEGIC AXIS 3: CASE MANAGEMENT						
Tracer indicators						
Peri-operative mortality in 1st , 2nd , 3rd and 4th category hospitals	Enables to determine the quality of the management of medical and surgical cases in 1st, 2nd, 3 rd and 4th category hospitals	**Numerator** : Number of persons who died in the operating room or following surgery in 1st , 2nd , 3rd and 4th category health facilities during a given period **Denominator** : Number of medical and surgical cases admitted in 3rd and 4th category health facilities during the same period	DLMEP Report, DOSTS reports	Operational	Review of HF logbooks and activity reports	Every semester
Specific malaria mortality rate in children below 5 years of age	Enables to determine the effectiveness of the prevention and management of malaria in children below 5 years of age	**Numerator** : Number of deaths of children below 5 years of age due to malaria during a given period **Denominator** : Total number of children below 5 years of age who suffered from this disease during the same period	NMCP report DLMEP	Central	Surveys, Studies	Annuall
Intra hospital direct obstetrical lethality rate	Enables to determine the quality of the management of pregnant women in health facilities	**Numerator** : Number of patients who died in hospital following a pregnancy complication during a given period **Denominator:** Total number of pregnant women admitted at the health facility during the same period	DSF report, PLMNI report	Operational	Review of routine data	Every 6 months

Name	What does this indicator measure?	How it is calculated?	Collection sources	Collection level[1]	Collection Method	Frequency
Maternal mortality ratio	Measures the probability for a woman to die because of pregnancy (obstetric risk)	**Numerator** : Annual number of maternal deaths due to causes related to pregnancy or aggravated by pregnancy or its management, during pregnancy or childbirth or within 42 days of the end of pregnancy, regardless of the duration of the pregnancy or the type of pregnancy for a given period **Denominator** : Number of live births during the same period	DHS, DSF, PLMNI	Central	Surveys	Every 5 years
Neonatal mortality rate	Measures the probability for a newborn to die before 28 days during the period taken into account	**Numerator** : Number of newborn deaths that occurred during the first 28 days of life for a period of one year or another period **Denominator** : Total number of live births over the same period	DHS, DSF, PLMNI	Central	DHS, MICS, ECAM	Every 3 to 5 years
Child mortality rate	Determines the probability for a child born in a specific place during a specific year to die before reaching the age of one year	**Numerator:** Number of children born alive who died before the age of one year during a given period. **Denominator** : Total number of live births during the same period	DHS, DSF, PLMNI	Central	Surveys, DHS, MICS, ECAM	Every 3 to 5 years
Child and infant mortality rate	Determines the probability for a child born in a particular place during a specific year to die before reaching the age of five during the period considered	**Numerator** : Number of deaths of children born alive from 0 to 4 years of age during a given period **Denominator** : Number of children aged 0-4 years recorded during the same period	DHS, DSF, PNLMNI	Central	Surveys, DHS, MICS, ECAM	Every 5 years

Name	What does this indicator measure?	How it is calculated?	Collection sources	Collection level[1]	Collection Method	Frequency
Strategic sub axis 3.1: curative management of communicable and non-communicable diseases						
Tracer indicators						
Treatment success rate for smear-positive tuberculosis patients	Determines the effectiveness and quality of tuberculosis management (diagnosis, screening, treatment according to national standards)	**Numerator** : number of new smear positive pulmonary TB cases treated and cured **Denominator** : Total number of smear positive pulmonary TB patients on treatment	NTBCP report	Operational	Review of routine TB manageme nt data	Annually
Proportion of cases of Buruli ulcer cured without complications	Determines the effectiveness of the management of cases of Buruli ulcer	**Numerator** : Number of cases of Buruli ulcer cured without complications during a given period **Denominator** : Total number of cases of Buruli ulcer treated during the same period	NTDs Report, Survey report, NHIS	Operational	Review of program data	Annually
Tracer indicators						
Satisfaction index of beneficiaries of health services and care	Assesses the capacity of the system to provide health care and services that meet or exceed the patient's expectations	See Appendix 7	DROS, HIU report	Central	Surveys	Every 4 years
Proportion of targeted hospitals in the 4th, 5th and 6th categories with 75% of the technical staff following protocols for communicable diseases case management (Malaria, AIDS, TB)	Determines the level of mastery and use of treatment protocols of communicable diseases in 4th, 5th and 6th category hospitals	**Numerator**: Number of targeted 4th, 5th and 6th category hospitals of which at least 75% of staff apply SOPs for the treatment of major communicable diseases during a given period. **Denominator** : Total number of 4th, 5th and 6th category hospitals assessed during the same period	DLMEP, NMCP reports	Regional	Evaluation of professional practices	Quarterly

Name	What does this indicator measure?	How it is calculated?	Collection sources	Collection level[1]	Collection Method	Frequency
Proportion of targeted DHs of which 75% of the technical staff implement protocols for the management of the main NCDs (Buruli ulcer, leprosy)	Determines the level of mastery and use of protocols for the management of major NCDs (Buruli ulcer, leprosy) in DHs	**Numerator** : Number of DHs of which 75% of the technical staff implement protocols for the management of the major NCDs (Buruli ulcer, leprosy) during a given period **Denominator** : Total number of DHs evaluated during the same period	DLMEP, DOSTS report	Regional	Evaluation of professional practices	Monthly
% of targeted MHCs and DHs of which 75% of the technical staff implement guidelines for task shifting in the management of hypertension and diabetes	Measures the capacity of the health system to provide quality management for hypertension and diabetes at the operational level	**Numerator** : Number of MHCs and DHs of which 75% of the technical staff implement guidelines for task shifting for the management of hypertension and diabetes **Denominator** : Total number of MHCs and DHs targeted during a period	DOSTS, DLMEP report	Regional	Evaluation of professional practices	Every semester
Proportion of RDPH that have organized at least one annual screening and awareness campaign for hypertension / diabetes out of health facilities, including World Days for the fight against these diseases	Determines the capacity of the health system to take every opportunity to raise awareness and detect those at risk of hypertension/diabetes. Also determines the acceptance and level of support of the population for screening of hypertension and diabetes on the days these diseases are commemorated worldwide	**Numerator** : Number of people at risk screened for hypertension/diabetes on the days these diseases are commemorated worldwide **Denominator** : Total number of people sensitized during these days	DLMEP, DOSTS report	Operational	Review of screening campaign data for HTA / Diabetes	Annually
% of targeted MHCs and DHs of which 75% of the technical personnel use standards/protocols for the management of major non-communicable diseases (diabetes, mental health, Hypertension)	Determines the quality of the management of diabetes and hypertension cases in 4th and 5th category hospitals	**Numerator** : Number of MHCs and DHs of which 75% of targeted technical personnel implement validated protocols for the management of cases of diabetes and hypertension during a given period **Denominator** : Total number of MHCs and DHs evaluated during the same period	DLMEP report	Regional	Evaluating practices professional	Every semester

Name	What does this indicator measure?	How it is calculated?	Collection sources	Collection level[1]	Collection Method	Frequency
% of targeted IHCs and MHCs which managed at least 80% of children below 5 years of age suffering from diarrhea/ARI with the IMCI approach	Determines the system's ability to offer low cost quality health care for children below 5 years	**Numerator** : Number of targeted IHCs and MHCs that managed at least 80% of children below 5 years with the IMCI approach during a given period **Denominator** : Total number of IHCs and MHCs evaluated during the same period	DSF, PLMNI reports,	Regional	Evaluating practices professional	Annually
Percentage of assessed District and Regional Hospital staff who use valid palliative treatment protocols.	Measures the level of mastery and use of palliative care regimens in 2nd and 3rd category hospitals	**Numerator** : Number of 2nd and 3rd category hospitals which adhere to validated care protocols for the dispensation of palliative care in a given period **Denominator**: Total number of 2nd and 3rd category hospitals evaluated during the same period.	Report from DLMEP, General Inspectorates, DOSTS	Central	Evaluation of professional practices	Every two years
Strategic sub-axis 3.2 : Maternal, neonatal, infant, child and adolescent health						
Tracer indicators						
Rate of deliveries in a health facility	Enables to appreciate the capacity of the system to protect women against the risk related to home deliveries	**Numerator** : Number of deliveries in health facilities in a given period **Denominator**: Total number of expected deliveries during the same period	DSF, PLMNI, MICS reports, delivery room registers	Operational	Use of routine data	Monthly
Proportion of cases of obstetric fistula repaired	Measures the availability of obstetric fistula management	**Numerator** : Number of fistula cases notified and repaired **Denominator:** Total number of reported cases	DSF, PLMNI reports	Operational	Use of routine data	Quarterly

Name	What does this indicator measure?	How it is calculated?	Collection sources	Collection level[1]	Collection Method	Frequency
Rate of Caesarean sections	Measures the capacity of the system to manage pregnancy- related complications	**Numerator** : Total number of caesarean sections registered during a given period. **Denominator:** total number of deliveries in the HF	DSF, PLMNI reports	Operational	Use of routine data	Monthly
Proportion of IHCs which completed at least half of the planned outreach/mobile strategies	Measures the system's capacity to provide health care and services to populations living in difficult-to- access or remote areas	**Numerator** : Number of IHCs which completed at least 50% of the planned outreach/mobile strategies in a given period. **Denominator:** Total number of IHCs evaluated during the same period	DOSTS reports	Operational	Review of IHC/MHC reports	Monthly
Percentage of DHs with at least 1 health provider trained in clinical IMCI	Measures the availability of IMCI service delivery	**Numerator** : Number of DHs with at least one staff member trained in clinical IMCI within a given period **Denominator:** Total number of district hospitals evaluated during the same period.	DSF, PLMNI reports	Regional	Evaluation studies of professional practices, supervisory report	Every two years
Proportion of targeted MHCs and DHs with 75% of technical staff using validated protocols for the management of maternal and child health conditions	Measures the level of mastery and use of protocols for the management of maternal and child health conditions	**Numerator** : Number of MHCs and DHs with 75% of the staff evaluated using validated protocols for the management of maternal and child health conditions in a given period **Denominator**: Total number of MHCs and DHs evaluated during the same period	DSF, PLMNI Reports, General Inspectorates, DOSTS	Operational	Evaluation studies of professional practices	Every two years
Proportion of DHs with user-friendly services for the management of adolescent health conditions	Measures the availability of service delivery for the management of adolescent health	**Numerator** : Number of DHs with user-friendly services for the management of adolescents in a given period **Denominator**: Total number of district hospitals evaluated during the same period	DPS, DSF, PLMNI reports	Regional	Survey, study	Annual

Name	What does this indicator measure?	How it is calculated?	Collection sources	Collection level[1]	Collection Method	Frequency
Proportion of children born to HIV positive mothers and put on ART	Evaluates the capacity of the system to manage HIV-positive pregnant women and their children with ART	**Numerator** : Total number of children born to HIV-positive mothers on ART in a given period **Denominator**: Total number of children born to HIV-positive mothers during the same period	RSDP-HIV, NACC, DSF reports	Operational	Use of CNLS routine data (document review)	Annual
Strategic sub-axis 3.3 : Emergencies and public health events						
Tracer indicators						
Proportion of targeted DHs having managed at least 80% of medical and surgical emergencies according to SOPs in the past 6 months	Measures the quality of management of cases of medical and surgical emergencies	**Numerator** : Number of DHs having managed at least 80% of medical and surgical emergencies according to standards within 6 months before the survey **Denominator**: Total number of district hospitals evaluated during the same period.	Technical Supervision report or from IGSMP	Regional	Survey, evaluation studies of professional practices	Every two years
Availability of a budgeted national public health events management plan and corresponding annual implementation reports	Measures the capacity of the health system to anticipate the occurrence of EPDs and public health events		DLMEP, DOSTS reports	Central	Document review	Annual
Proportion of District Hospitals with medicines / consumables for effective management of the most common medical and surgical emergencies	Evaluates the availability of inputs for the management of emergency cases in the DH.	**Numerator** : Number of DHs that have not experienced a stock-out of drugs/consumables used to manage the most common cases of medical and surgical emergencies **Denominator**: Total number of district hospitals evaluated during the same period.	DPML, DOSTS report	Central	Supervision report,	Annual

Name	What does this indicator measure?	How it is calculated?	Collection sources	Collection level[1]	Collection Method	Frequency
Proportion of RDPH that conducted at least one emergency simulation exercise per year	Measures the level of preparedness of regions for the management of emergencies	**Numerator** : Number of regions having conducted an emergency simulation exercise per year during a given period **Denominator**: Total number of regions assessed during the same period	DOSTS, DLMEP, MINATD (DPC) reports	Central	Supervision, document review	Every three years
Percentage of RDPH with Rapid Intervention and Response Teams (RIRTs)	Enables to monitor the availability of IRRT and the prepositioning of equipment for effective management of epidemics and disasters	**Numerator** : Number of RDPH with multi-sector investigation and rapid response teams in a given period **Denominator**: Total number of RDPH evaluated during the same period	DLMEP, DOSTS, MINATD reports	Central	Supervision, document review	Every two years
Strategic sub-axis 3.4 : Management of disabilities						
Tracer indicators						
Proportion of cataract patients whose sight was restored after surgery	Assesses the level of restoration of visual impairments	**Numerator** Number of patients with cataract whose sight was restored after surgery **Denominator**: Total number of cataract cases that benefitted from corrective surgery during the same period	DLMEP Report	Central	Survey	Annual
Proportion of RHs and CHs having provided medical management of least 70% of the cases of correctable motor disability according to SOPs	Evaluates the capacity of the system to manage correctable motor disability	**Numerator** : Number of RHs and CHs that have provided medical management of at least 70% of the cases of correctable motor disability according to SOPs **Denominator:** Total number of RHs evaluated	DLMEP	Central	Evaluation of professional practices	Every two years
Proportion of DHs having an operational physiotherapy ward[(a)]	Assesses the availability of rehabilitation services	**Numerator** : Number of DHs with a physiotherapy ward in a given period **Denominator:** Total number of district hospitals evaluated during the same period	DOSTS	Central	Supervision, document review	Every two years

Name	What does this indicator measure?	How it is calculated?	Collection sources	Collection level[1]	Collection Method	Frequency
Proportion of RDPH that organized at least one cataract surgery campaign per year	Evaluates the capacity of the system to manage cataract	**Numerator** : Number of RDPH that organized at least one cataract surgery campaign per year **Denominator:** Total number of RDPHevaluated	DLMEP	Central	Survey	Every two years
STRATEGIC AXIS 4 : STRENGHTENING OF HEALTH SYSTEM						
Tracer indicators						
Global Health Care Availability Index	This index enables to assess, monitor and evaluate the functionality of the health system's pillars	Calculated based on a SARA survey	SARA survey report	Central	Survey	Every 5 years
Strategic sub-axis 4.1 : Health financing						
Tracer indicators						
% of health expenditure borne by households	Assesses the burden of health expenditure borne by households	**Numerator**: Total amount of health expenditure borne by households. **Denominator**: Total amount of health expenditure	NHAs, WHO reports	Regional	Survey	Annual
Proportion of the population covered by health risk sharing mechanisms	Assesses the population's acceptance of health risk sharing mechanisms. Also enables to estimate the number of persons not liable to out-of-pocket payments	**Numerator** : Population covered by a health risk sharing mechanism **Denominator**: Target population	Annual reports : DPS, MINTSS, MINFI, MINEPAT	National	Survey	Every two years
Tracer indicators						
Proportion of the national budget allocated to Health Sector	Enables to assess the political will for solving population's health issues	**Numerator** : State budget allocated to health **Denominator :** overall State budget	Finance Law, Settlement Bill	Central	Review of reports	Annual
Availability of an approved financial information analysis report	Assesses the impact of the use of financial resources for a better allocation of resources in the future		DRFP, HIU, reports	Central	Review of reports	Annual

Name	What does this indicator measure?	How it is calculated?	Collection sources	Collection level[1]	Collection Method	Frequency
Availability of a framework instrument granting autonomous management of the revenue allocated to the HFs of the devolved level	Assesses the effectiveness and level of decentralization in managing the revenues allocated to HFs		Annual reports : DOSTS, DRFP, DAJC, TS/SC-HSS	Central	Document review	Annual
Availability of a report validating the distribution key of MOH budget among the various programmes	Enables to appreciate the volume of funding allocated to HSS priority interventions		DRFP report	Central	Document review	Annual
Proportion of health districts having integrated the performance-based financing approach (PBF)	Assesses the level of implementation of PBF in Cameroon	**Numerator** Number of health districts having integrated the performance-based financing approach (PBF). **Denominator**: Total number of health districts	NTC report	Regional	Surveys, studies	Annual
Availability of a report on the National Health Accounts	Assesses the capacity of the system to generate health information that can guide decisions in health policy		NIS, HIU	Central	Surveys	Every two years
Strategic sub-axis 4.2 : Care and service delivery						
Tracer indicators						
Proportion of HDs serviced[(a)]	Enables to assess the evolution of the HDs towards their autonomy	**Numerator**: Number of HDs having reached the autonomous phase during the assessed period **Denominator**: total number of health districts assessed during the same period	DOSTS reports	Central	Studies	Every two years
Availability of a national infrastructure development plan (construction/rehabilitation/extensi on/ equipment and maintenance)	Assesses the capacity of the system to plan infrastructural development (assesses the projected management of infrastructure in the health system)		DEP Report	Central	reports, supervision	Annual

Name	What does this indicator measure?	How it is calculated?	Collection sources	Collection level[1]	Collection Method	Frequency
Percentage of the population living within a radius of less than 5 km of a health facility (IHC, MHC and DH)	assesses the geographical access to health services and care	**Numerator**: Total population living within a radius of 5 km from a HF within a given period **Denominator**: total population of Cameroon through out the same period	DOSTS reports	Central	Studies, surveys	Annual
Percentage of IHCs, MHCs and DHs constructed according to standards and the infrastructure development plan	Helps assess the quality of infrastructure of the operational level	**Numerator** : Number of IHCs, MHCs and DHs constructed according to standards and the infrastructure development plan over a given period **Denominator**: total number of IHCs, MHCs and DHs whose construction was planned during the same period	DEP, DOSTS reports, hospital reform	Central	Reports	Annual
Percentage of IHCs, MHCs and DHs rehabilitated	Helps assess the quality of infrastructure of the operational level	**Numerator** : Number of IHCs, MHCs and DHs rehabilitated for a given period **Denominator**: total number of IHCs, MHCs and DHs whose rehabilitation was planned during the same period	DEP, DOSTS reports, hospital reform	Central	Reports	Annual
Percentage of DHs with at least two versatile and trained maintenance workers in the following fields :medical biology, electricity/refrigeration, plumbing, computer sciences, furniture	Assesses HDs' capacity to ensure continuous maintenance (prevention and repair works) of technical equipment	**Numerator :** Number of DHs with at least two versatile and trained maintenance workers in the following fields : medical biology, electricity/refrigeration, plumbing, computer sciences, furniture during a given period **Denominator:** Number of DHs evaluated during the same period	DOSTS report	Central	Activity reports	Annual

Name	What does this indicator measure?	How it is calculated?	Collection sources	Collection level[1]	Collection Method	Frequency
Proportion of RDPH that signed contracts with maintenance structures in the following areas: medical biology, electricity/refrigeration, plumbing	Assesses the projected management of equipment at regional level	**Numerator :** Number of RDPH that signed contracts with maintenance structures in the following areas: medical biology, electricity/refrigeration, plumbing at a given period **Denominator:** Total number of RDPH evaluated during the same period	RDPH reports	Regional	Activity reports	Annual
Percentage of DHs equipped according to standards	Enables to assess the availability of quality equipment in DHs	**Numerator :** Number of DHs equipped according to standards and in accordance with the National Health Infrastructure Development Plan over the period assessed **Denominator:** Total number of DHs assessed within the same period	DEP Report	Central	Activity reports	Annual
Proportion of RDPH with an approved regional blood transfusion structure	Assesses the availability of blood transfusion services at the devolved level	**Numerator :** Number of RDPH with an approved regional blood transfusion structure **Denominator:** Total number of RDPH in the same period	DLMEP/DEP /NBTP report	Central	Activity reports	Annual
Percentage of DHs providing at least 75% of CHP interventions	Enables to monitor the availability and scaling-up of complementary services and care at the operational level	**Numerator** : Total number of DHs that provide 75% of CHP interventions in a given period **Denominator**: Total number of DHs evaluated during the same period	Studies, Audits	Regional	reports Supervision	Annual

Name	What does this indicator measure?	How it is calculated?	Collection sources	Collection level[1]	Collection Method	Frequency
Percentage of public IHCs and MHCs which provide at least 80% of MHP interventions	Assesses the availability of primary health services and care delivery at the operational level	**Numerator :** Number of public IHCs and MHCs which provide at least 80% of MHP interventions **Denominator:** Total number of IHCs and MHCs assessed during the same period	DLMEP, DOSTS reports	Operational	Study, supervisions reports	Annual
Percentage of schools infirmaries and University health centres with a first aid kit	Assesses the availability of case management services and care in schools and universities	**Numerator :** Number of schools infirmaries and University health centres with a first aid kit in a given period **Denominator:** Total number of schools infirmaries and University health centers assessed during the same period	MINEDUB, MINESEC, MINESUP reports	Operational	Study, field visit reports	Annual
Percentage of HDs whose level of viability was assessed	Assesses the level of viability of HDs	**Numerator :** Number of HDs whose level of viability was assessed in a given period **Denominator:** Total number of HDs assesssed during the same period	DOSTS, TS-SC/HSS	Regional	Studies	Every three years
Strategic sub-axis 4.3 : Drugs and other pharmaceutical products						
Tracer indicators						
Proportion of blood transfusion needs met	Assesses the availability of blood products (especially blood bags) in HFs	**Numerator:** number of patients who received blood or its derivatives during a given period **Denominator:** Total number of patients who required transfusion (Blood and its derivatives) during the same period	MAR, Activity Reports PNTS, DPML	Central	Survey, study, document review	Annual
Average number of stock-out days of essential tracer drugs per quarter in the District Hospital	Assesses the availability of essential drugs in HFs	**Numerator** : Average number of stock-out days of essential tracer drugs in District Hospital during the quater **Denominator**: Total number of District hospitals evaluated	DPML reports	Central	Review of Drug Management Tools in HFs	Every six months

Name	What does this indicator measure?	How it is calculated?	Collection sources	Collection level[1]	Collection Method	Frequency
Tracer indicators						
Availability of the updated National Pharmaceutical Master Plan (PMP) and the activity report of the year before the assessment of the implementation of this plan	Assesses the availability of an updated plan for the implementation of a national drug policy		Report from DPML and General Inspectorate of Pharmaceutical Services and Laboratories	Central	Reports	Annual
Availability of a regulatory instrument to create and organize the National Laboratory Network and annual reports of data transmission activities	Assesses the institutional framework of the National Laboratory Network		Report from DPML and General Inspectorate of Pharmaceutical Services and Laboratories	Central	Reports	Annual
Proportion of regions that produced an annual activity report on pharmacovigilance	Assesses the efficiency of the pharmacovigilance system in Cameroon	**Numerator :** Number of regions that submitted a pharmacovigilance activity report annually during a given period **Denominator:** Total number of regions assessed during the same period	Report from DPML and General Inspectorate of Pharmaceutical Services and Laboratories	Central	Reports	Annual

Name	What does this indicator measure?	How it is calculated?	Collection sources	Collection level[1]	Collection Method	Frequency
Percentage of pharmaceutical products controlled before and after marketing in pharmacies and public hospitals	Assesses the capacity of the system to ensure quality control of pharmaceutical products in circulation in the country	**Numerator :** Number of pharmaceutical products controlled before and after marketing in a given period **Denominator:** Total number of lots of pharmaceutical products imported and produced in the country during this period	Report from DPML and General Inspectorate of Pharmaceutical Services and Laboratories	Central	Reports	Quarterly
Average number of stock-out days of essential tracer drugs in RFHP per quarter	Assesses the functionality of the supply system at the decentralized level		DPML report	Central	Use of drug management tools	Annual
Proportion of RDPH which organized seizures and destruction of illicit drugs annually	Assesses the capacity of the health system to combat the use of illicit drugs and products	**Numerator :**Number of RDPH which organized seizures and destruction of illicit drugs annually during a given period **Denominators** : Total number of RDPH during the same period	DPML, IGSPL report	Central	Reports on the destruction of illicit drugs	Annual
Strategic sub-axis 4.4 : Human resources for Health						
Tracer indicators						
Percentage of MHCs, IHCs and DHs with at least 50% of the required technical staff	Assesses the coverage level of HHR needs in health structures at the operational level	**Numerator**: number of MHCs, IHCs and DHs with at least 50% of the required technical staff during a given period **Denominator**: total number of MHCs, IHCs and DHs during the same period	HRD report	Regional	Studies, use of supervision report	Annual

Name	What does this indicator measure?	How it is calculated?	Collection sources	Collection level[1]	Collection Method	Frequency
Tracer indicators						
Percentage of targeted RDPH and DHS officials who received training/capacity building in management	Assesses the capacity and skills of heads of health facilities to implement the managerial process	**Numerator** : Number of RDPH and DHS officials who received training or capacity building in management during a given period **Denominators** : Total number of RDPH and DHS assessed during the same period	HRD report	Central	Studies, use of supervision reports	Annual
Percentage of MHCs and DHs in northern Regions, East and South regions with at least one midwife	Assesses the coverage level of midwivery needs in MHCs and DHs in regions with high maternal mortality rates	**Numerator :**number of MHCs and DHs in northern Regions, East and South regions with at least one midwife during a given period **Denominator:** the total number of MHCs and DHs in the aforementioned regions during a given period	HRD report	Central	Studies, use of supervision reports	Annual
Proportion of RDPH that sent consolidated and complete data of the HRH, including that of the private and traditional sub-sector to the DHR annually	Enables you to assess the availability of HRH at the operational level. It also enable to assess the capacity of RDPH to regularly review the situation of HRH in the regions.	**Numerator:** Number of RDPH that annually forwarded consolidated and comprehensive data on HRH in the region, including those of the private and traditional sub-sector during a given period **Denominator:** Total number of RDPH during the same period	RDPH Report	Central	Studies, use of supervision reports	Annual
% of doctors in MHCs and DHs with at most four years experience who benefited from at least continuous training in the targeted areas (CemONC, mental illness, diabetes, etc.)	Assesses the ability of the system to build the capacities of young medical doctors to help them provide quality care to the population in priority domains	**Numerator :** Number of medical doctors in MHCs and DHs with a maximum of four years experience and who received at least a continuing training in priority domains **Denominator:** Total number of medical doctors in MHCs and DHs with a maximum of four years experience	DHR Activities Report	Central	Studies, use of supervision reports	Every two years

Name	What does this indicator measure?	How it is calculated?	Collection sources	Collection level[1]	Collection Method	Frequency
Proportion of RDPH with IT tool for managing and monitoring career profiles (Regional SIGIPES)	Assesses the level of decentralization in managing HRH careers and the functionality of the HRH career management system at the devolved level	**Numerator :** Number of RDPH with IT tools for monitoring career profiles. **Denominator:** Total number of RDPH	DHR report	Central	Use of RDPH activity reports	Annual
Proportion of targeted MHCs and DHs with 75% of staff using validated protocols for the management of maternal and child health conditions	Assesses the level of mastery and use of protocols for the management of maternal and child health conditions	**Numerator :** Proportion of targeted MHCs and DHs with 75% of technical staff assessed using validated protocols for the management of maternal and child health conditions **Denominator:** Total number of MHCs and DHs assessed during the same period	DSF, PLMI Reports, General Inspectorates, DOSTS	Central	Evaluation of professional practices	Every two years
HRH Satisfaction Index	Assesses the capacity of the system to meet the needs of its staff	See Appendix 7	DHR report	Central	Census	Annual
Percentage of insecured and difficult-to-access IHCs, MHCs and DHs with at least 50% of human resources on duty since 3 years	Assesses equity in the distribution of HRH and the implementation of retention mechanisms in difficult-to-access health facilities	**Numerator :** Number of difficult-to-access IHCs, MHCs and DHs with at least 50% of human resources for health on duty during the last 3 years **Denominators :** Total number of difficult-to-access IHCs, MHCs and DHs assessed	DHR report	Central	Study, survey	Every two years
Strategic sub-axis 4.5 : Health Information and Health research						
Tracer indicators						
MAR promptness rate in HDs	Enables to assess the system's capacity to report on time	**Numerator :** Number of MARs forwarded on time **Denominator:** Number of MAR expected	HIU activity report	Central	Monitoring and Supervision Reviews	Monthly

Name	What does this indicator measure?	How it is calculated?	Collection sources	Collection level[1]	Collection Method	Frequency
MAR completeness rate in HDs	Enables to assess the availability and completeness of MAR transmission	**Numerator :** Total number of complete MARs forwarded over a given period **Denominator:** Number of MARs forwarded during the same period	HIU activity report	Central	Monitoring and Supervision Reviews	Monthly
Proportion of research results reported	Assesses the capacity of the system to share research findings	**Numerator :** Number of authorized projects and whose results were restituted **Denominator:** Total number of authorized projects	DROS Activity Report, Ethics Committee	Central	Research reviews, use of activity reports	Annual
Proportion of research results used for decision-making	Assesses the system's capacity to use factual data for decision-making	**Numerator :** Number of research findings used for decision-making in a given period **Denominator:** Total number of research findings validated during the same period	DROS Activity Report, Ethics Committee	Central	Studies, Use of research reports	Annual
Percentage of baseline surveys carried out to monitor the implementation of the 2016-2020 NHDP	Assesses the capacity of the system to ensure the availability of baseline data indicators in order to ensure effective monitoring and evaluation of the NHDP (availability of baseline data indicators)	**Numerator :** Number of baseline surveys carried out. **Denominator:** Number of baseline surveys planned	Report from TS-SC/HSS and Technical Departments	Central	Reports on NHDP implementation monitoring reports	Annual
Proportion of RDPH officials who benefited from capacity building to carry out research projects	Assesses HRH capacity to carry out health research at the operational level	**Numerator** : Number of RDPH officials trained in health research during a given period **Denominator**: Total number of RDPH officials during the same given period	DROS, DHR report	Central	Reports on NHDP implementation monitoring reports	Annual

Name	What does this indicator measure?	How it is calculated?	Collection sources	Collection level[1]	Collection Method	Frequency
STRATEGIC AXIS 5 : STRATEGIC GOVERNANCE & STEERING						
Tracer indicators						
Achievement rate of the 2016-2020 NHDP objectives	Assesses the implementation level of NHDP objectives and, subsequently, the satisfaction level of the populations	**Numerator :** Number of NHDP objectives reached **Denominator:** Total number of NHDP objectives	Steering Committee, RDPH, DMO	Central	Surveys	Annual
Strategic sub-axis 5.1 : Governance						
Tracer indicators						
Corruption perception index in the sector	It enables to assess efficiency in fighting against corruption in the health sector		NACC	Central	Survey	Every two years
Tracer indicators						
Availability of an updated regulatory instrument governing the organization and functioning of NHDP steering, coordination and M/E bodies at all levels	Enables to specify the organization, role and missions of the actors involved in the coordination and M/E of the NHDP at all levels of the health pyramid		DAJC, TS-SC/HSS	Central	Document review	After twelve years
Availability of updated legal / regulatory texts governing the organization, functioning of public hospitals and case management	Assesses the implementation and institutional framework process to build a health system that can meet the needs of the populations		DAJC, DOSTS reports	Central	Document review	Every four years
Proportion of accredited DHs and others ranking as such (that is, with care quality assurance and health services system)	Assesses the capacity of HFs to comply with the accreditation criteria developed (also assesses the level of implementation of quality care in HFs)	**Numerator :** Number of accreditated DHs that established a care and health service quality assurance system during a given period **Denominator:** Total number of assessed DHs and others ranking as such during the same period	TS/SC-HSS, DOSTS reports	Central	Evaluation of professional practices	Annual

Name	What does this indicator measure?	How it is calculated?	Collection sources	Collection level[1]	Collection Method	Frequency
Proportion of RHs whose annual technical and financial reports validated by the members of the Hospital Management Board are sent to the RDPH	Assesses accountability, transparency and participation of beneficiaries in the financial and technical management of health facilities	**Numerator :** Number RHs whose annual technical and financial reports validated by the HMC members are forwarded **Denominator:** Total number of RHs	Reports from technical departments	Regional	Reports	Annual
Proportion of dispatching wholesalers and pharmacies inspected	Assesses the capacity of the system to ensure the quality of the drugs available on the market	**Numerator :** Number of wholesalers and pharmacies inspected **Denominator:** Total number of targeted wholesalers and pharmacies	Annual report of MOH General Inspectorates	Regional	Assessment studies of professional practices	Annual
Proportion of GHs, CHs and RHs that have undergone an external audit	Enables to assess the technical, administrative and financial quality of management in health facilities	**Numerator :** Number of GHs, CHs and RHs which were audited by an external firm **Denominator:** Total number of GHs, CHs and RHs	DLMEP, general inspectorates, DRFP, DHR	Central	Reports	Annual
Proportion of category 1 and 2 hospitals that have transmitted to MINSANTE and/or published their technical activity report online	Assesses the accountability of health facilities	**Numerator:** number of 1st and 2nd category hospitals that published their activity reports online or forwarded it to the MOH during a given period **Denominator:** Total number of 1st and 2nd category hospitals evaluated during the same period	Hospital reports	Central	MOH website	Annual
Proportion of Central Departments, Health API and RDPH that produced an annual performance report	Assesses the capacities of the central technical structures to produce documents that reflect the performance achieved	**Numerator :** Number of Central departments, Health API and RDPH which produced an annual performance report during a given period **Denominator:** Total number of Central Departments, Health API and RDPH during the same period	Reports from Technical Departments	Central and regional	Reports	Annual

Name	What does this indicator measure?	How it is calculated?	Collection sources	Collection level[1]	Collection Method	Frequency
Proportion of category 1 to 4 health facilities that implement RRIs	Assesses the actions taken to combat corruption in category 1 to 4 health facilities	**Numerator :** Number of category 1 to 4 HFs implementing RRI during a given period **Denominator**: Total number of targeted category 1 to 4 HFs during the same period	Reports from General Inspectorates	Central	Reports	Annual
Availability of a report on the implementation of the activities of the PPBS chain (taking into account NHDP actions in the MTEF, respecting the budget distribution key as projected in the MTEF, etc.)	Assesses the coherence between the activities planned in the different elaborated plans and the budget allocated		TS/SC-HSS report	Central	Reports	Quarterly
Strategic sub-axis 5.2 : Strategic steering						
Tracer indicators						
Execution rate of RDPH and HDs integrated supervision missions	Assesses the functionality of the managerial process and the instruments that ensure compliance and rigorous implementation of directives layed down by hierarchy at all levels	**Numerator :** Number of integrated supervision missions carried out by RDPH and HDs during a given period **Denominator:** Number of RDPH and HDs integrated supervision missions planned during the same period	TS/SC-HSS, DEP report	Regional	Reviews, reports	Every six months
Proportion of the recommendations of the coordination meetings (steering committee and weekly coordination meetings of MOH) that have been carried out	Enables to assess the level of implementation of the recommendations and decisions made by the coordinating bodies to lift the obstacles that hamper the achievement of the objectives set out in the NHDP	**Numerator :** Number of recommendations from coordination meetings (steering committee and MOH weekly coordination meetings) implemented during a given period **Denominator:** Total number of recommendations of Steering/Coordination meetings issued during the same period	TS/SC-HSS, follow-up Committee reports	Central	Reviews, reports	Every six months

Name	What does this indicator measure?	How it is calculated?	Collection sources	Collection level[1]	Collection Method	Frequency
Tracer indicators						
Proportion of HDs whose HDDPs are aligned to the NHDP	Assesses the effectiveness of strategic alignment of HDDPs to the NHDP	**Numerator :** Number of HDs whose HDDPs are aligned to the NHDP **Denominator:** Total number of HDs	TS/SC-HSS, DEP report	Regional	Document review, supervision report	Annual
Proportion of RDPH that have developed regional consolidated health development plans aligned to the NHDP 2016-2020	Assesses the capacity of RDPH and the devolved level to plan health development based on the NHDP strategic guidelines	**Numerator :** Number of RDPH which developed a consolidated Regional Health Plan and AWPs aligned to the 2016-2020 NHDP **Denominator:** Total number of RDPH	TS/SC-HSS report	Central	Document review, supervision report	Annual
Availability of the approved prison health policy document and the annual reports of health activities in prisons	Assesses the institutional and regulatory framework for prison health		TS/SC-HSS, MINJUSTICE report	Central	Document review	Annual
Proportion of health districts and RDPH that have organized at least 3 meetings to coordinate and monitor the implementation of their AWPs and have produced an annual report	Enables to assess the efforts to coordinate activities implemented at the devolved level and the capacity of HDs and RDPH to involve all stakeholders (civil society, partner ministries, TFPs) in managing health issues	**Numerator :** Number of HDs and RDPH that produced at least 3 reports of coordination and monitoring meetings for the implementation of their AWP and a consistent annual report within the year **Denominator:** Total number of HDs and RDPH	TS/SC-HSS, DEP/CPP reports	Regional	Document review, supervision report	Annual
Proportion of HDs with the final evaluation report of their HDDP	Assesses the capacity of HDs to evaluate the implementation of the interventions planned at the RDPH	**Numerator :** Number of HDs with the final evaluation report of their HDDP **Denominator:** Total number of HDs	TS/SC-HSS report	Regional	Document review, supervision report	After 4 years
Proportion of RDPH with the final evaluation report of their CRHDPs	Assesses the capacity of the intermediate level to evaluate the implementation of the planned interventions at the RDPH	**Numerator :** Number of RDPH with the final evaluation report of their CRHDPs **Denominator:** Total number of RDPH	TS/SC-HSS report	Central	Document review, supervision report	After 4 years

Name	What does this indicator measure?	How it is calculated?	Collection sources	Collection level[1]	Collection Method	Frequency
Proportion of HDs and RDPHs with at least 80% of indicators in the Performance Tracking Dashboard	Assess the capacity of health structures at the decentralized level to organize the monitoring of the NHDP indicators and to inform the level of implementation of the planned interventions in their health development plan.	**Numerator :** Number of HDs and RDPH that filled in the monitoring dashboard of the performances projected in the NHDP **Denominator:** Total number of RDPH and HDs	TS/SC-HSS, CPP, RDPH reports	Central	Document review, supervision reportDecentralized monitoring	Half-yearly
Level of achievement of targets projected in the Integrated Monitoring and Evaluation Plan (IMEP)						
Availability of an annual report on the sector or thematic health review	Assesses the implementation level of the NHDP monitoring and evaluation modalities	.	TS/SC-HSS, DEP report	Central	Document review, supervision report	Every two years
Availability of mid-term and final reports of the NHDP	Assesses the capacity of the system to plan and assess the level of achievement of the results projected in the NHDP	**Numerator :** Number of HDs and RDPH that have mid-term NHDP evaluation report **Denominator:** Total number of RDPH and HDs	TS/SC-HSS report	Central	Document review, supervision report	Every 2.5 years
Proportion of HDs and RDPH with mid-term and final evaluation reports of the NHDP 2016-2020	Assesses the capacity of the system to share and disseminate information on the M/E of NHDP implementation at the devolved level	**Numerator :** Number of HDs and RDPH that have the final NHDP evaluation report **Denominator:** Total number of RDPH and HDs	TS/SC-HSS report	Regional	Document review, supervision report	After 5 years
Availability of the annual strategic surveillance report	Assesses the health system's capacity to anticipate and reduce the risks and factors of the achievement of the set objectives		TS/SC-HSS report	Central	Document review, supervision report	Annual

Name	What does this indicator measure?	How it is calculated?	Collection sources	Collection level[1]	Collection Method	Frequency
Percentage of agreements signed and respected between MOH and CBOs working in the health sector	Assesses the mastery, use and compliance of the NHDP (the only reference framework) by actors in the health system	**Numerator :** Number of signed agreements whose objectives were achieved **Denominator:** total number of agreements signed	Reports from DCOOP, Technical Departments	Central	Reports	Annual
Achievement rate of the National Compact objectives	Appreciates the performance of the partnership in the implementation of the PNDS, in the mobilization and use of resources.	**Numerator :** Number of objectives projected by the National Compact **Denominator:** Number of objectives achieved	Reports from General Inspectorates, DCOOP, Technical Departments	Central	Document review, supervision report	Annual

(a) See appendix 3 for the definition

4.2. Performance framework

Given the limited resources and institutional capacities, a list of 41 key indicators, tracers of the health system was validated by the stakeholders. These indicators will enable, on the one hand, to monitor progress made by strategic axes on a periodical basis and on the other hand, to assess the level of performance or achievement of the NHDP objectives. The following performance framework presents the baseline value for each indicator when data is available and projects the progress of performance.

Table 2 : Performance Framework of the NHDP

Indicator	Baseline			Targets				
	Value	Year	Reference	2016	2017	2018	2019	2020
STRATEGIC AXIS 1 : HEALTH PROMOTION								
HSS performance indicators								
% of household members using individual improved toilets	34.9%	2014	MICS 5					37%
Prevalence of obesity in urban areas (Percentage of urban population whose body mass index is greater than or equal to $30kg/m^2$)	23.50%	2015	Kingue et al.					22.5%
Percentage of targeted companies that apply health and occupational safety principles	NA							40%
Chronic malnutrition in children below 5 years of age	14.8%	2014	MICS 5					10%
Strategic sub-axis 1.1 : Institutional, community and coordination capacities in health promotion								
Proportion of HDs with functional DHC	65%	2015	2015 Road map and 2013-2015 MTEF	70%	75%	80%	85%	90%
Strategic sub-axis 1.2 : Living environment of the population								
Percentage of households using solid fuel as first source of domestic energy used for cooking	80.4%	2015	MICS 5	78%	76.5%	75%	72.5%	70%
Percentage of households with access to potable water	72.9%	2015	MICS 5	73.5%	74%	75%	76.5%	78%
Strategic sub-axis 1.3 : Strengthening of healthy behaviours of individuals and communities								
Prevalence of pregnancies among adolescent girls	25.2%	2014	MICS 5	24%	22%	19%	17%	14%
Prevalence of smoking in persons aged 15 and above	6%	2013	GATS	6%	5.5 %	5.5 %	5.5 %	5%

Indicator	Baseline			Targets				
	Value	Year	Reference	2016	2017	2018	2019	2020
Strategic sub-axis 1.4 : Essential family practices, family planning, adolescent health and post abortion care								
Modern contraceptive prevalence rate in women of childbearing age	21%	2014	MICS 5	22%	24%	25%	27%	30%
Propotion of unmet needs in FP	18%	2014	MICS 5			16%		14%
STRATEGIC AXIS 2 : DISEASE PREVENTION								
HSS performance indicators								
Prevalence of Hypertension (HPT) in adults aged 15 years and above in urban areas	29%	2015	Kingue et al.					28%
Strategic sub-axis 2.1 : Prevention of Communicable Diseases								
Incidence of HIV	45 499 new cases	2015	2015 report on HIV and AIDS estimates and projections in Cameroon	45,076	42,141	40,267	38,087	35929
HIV prevalence	4.3%	2011	(DHS-MICS 2011)	4.1%		3.70%		3.3%
Prevalence of Viral hepatitis B	11.90%	2015 CPC data		11%		9%		3.50%
Coverage of onchocerciasis preventive chemotherapy (CDTI coverage)	80%	2015	2015 NTDs Activity report	84%	85%	86%	87%	90%
Incidence of smear-positive pulmonary tuberculosis (PTB+)	117 new cases per 100 000 inhabitants	2015	2016-2017 TB/HIV joint concept note	102.5	88	73.5	59	45
Strategic sub-axis 2.2 : EPDs and public health events. Surveillance and response to EPDs, zoonoses and public health events								
Proportion of HDs with confirmed measles outbreaks which organized response according to national guidelines	34%	2014	2014 DLMEP Report	70%	80%	90%	95%	95%

Indicator	Baseline			Targets				
	Value	Year	Reference	2016	2017	2018	2019	2020
Proportion of measles outbreak reported and investigated	50%	2014	2014 DLMEP Report	70%	80%	90%	95%	95%
Strategic sub-axis 2.3 : RMNCAH and PMTCT								
Immunization coverage with the reference antigen (Penta3)	84.50%	2015	2015 EPI, MOH report	85%	86%	88%	90%	92%
ANC coverage rate 4	58.8%	2014	MICS5	62%	65%	68%	71%	74%
Measles' Immunization coverage in /rubella vaccine	80%	2014	MICS 5	81%	82%	83%	85%	86%
Proportion of HIV-infected pregnant women on ART	84.4%	2015	NACC Report	85%	86%	86.5%	87%	88%
Proportion of children aged 0-5 sleeping under an LLIN	54.80%	2014	MICS 5	85%	86%	88%	89%	90%
Mother-to-child transmission rate of HIV (percentage of HIV- exposed children)	6.5%	2014	2014 NACC report	6%	5.5%	5%	4.5%	4%
Proportion of newborn with low birth weight (below 2.500 grammes)	9%	2014	MICS5	7%	7%	6%	6%	6%
Proportion of pregnant women having received at least 3 doses of IPT during pregnancy (% IPT3)	26%	2014	MICS 5	35%	40%	45%	50%	55%
Strategic sub-axis 2.4 : Prevention of Non-communicable Diseases								
Prevalence of Diabetes type 2 among adults aged at least 18 years in urban areas	6.60%	2015	Kingue et al.			6%		5.8%
STRATEGIC AXIS 3 : MANAGEMENT OF CASES								
HSS performance indicators								
Peri-operative mortality in 1st , 2nd , 3rd and 4th category hospitals	NA	2015		15% decrease by the deadline				

Indicator	Baseline			Targets				
	Value	Year	Reference	2016	2017	2018	2019	2020
Specific malaria mortality rate in children below 5 years of age	45%	NMCP report	2015			38%		31%
Intra hospital direct obstetrical lethality rate	1.50%	2015	EmONC Survey			1.13%		0.75%
Maternal mortality ratio	782/100,000	2011	DHS- MICS	740	700	666	626	580
Neonatal mortality rate	28/1000	2014	MICS 5	27	26	25	24	23
Child mortality rate	60/1,000	2014	MICS 5	58	56	54	51	48
Child and infant mortality rate	103/1000	2014	DHS-MICS	99	95	91	87	83
Strategic sub-axis 3.1 : Curative management of communicable and non communicable diseases								
Treatment success rate for smear-positive tuberculosis patients	84%	2013	2013 cohort, NTBCP report	85%	85.5%	86%	86.5%	87%
Proportion of cases of Buruli ulcer cured without complications	80%	2015	NTDs Activity report	82%	84%	86%	88%	90%
Strategic sub-axis 3.2 : Maternal, neonatal, infant, child and adolescent health conditions								
Rate of deliveries in a health facility	61.3%	2014	MICS 5	65%	66%	67%	68%	70%
Proportion of cases of obstetric fistula repaired	NA			75% increase by deadline				
Rate of Caesarean sections	2.4%	2014	MICS 5	3%	4%	5%	6%	8%

Indicator	Baseline			Targets				
	Value	Year	Reference	2016	2017	2018	2019	2020
Strategic sub-axis 3.3 : Emergencies and public health events								
Proportion of targeted DHs having managed at least 80% of medical and surgical emergencies according to SOPs in the past 6 months	NA			13%	40%	53%	100%	100%
Strategic sub-axis 3.4 : Management of disabilities								
Proportion of cataract patients whose sight was restored after surgery	NA			25%	50%	85%	85%	90%
STRATEGIC AXIS 3 : HEALTH SYSTEM STRENGHENING								
Strategic sub-axis 4.1 : Health financing								
HSS performance indicators								
Global Health Care Availability Index	NA							30%
% of health expenditure borne by households	70.6%	2012	2012 NHA	69%	67%	65%	63%	60%
Proportion of the population covered by health risk sharing mechanisms	3%	2011	2011 DHS MICS	5%	7%	10%	15%	20%
Strategic sub-axis 4.2 : Care and service delivery								
Proportion of HDs serviced	NA				20%	25%	30%	35%
Strategic sub-axis 4.3 : Drugs and other pharmaceutical products								
Proportion of blood transfusion needs met	18%	2015	WHO	20%	30%	40%	50%	60%

Indicator	Baseline			Targets				
	Value	Year	Reference	2016	2017	2018	2019	2020
Average number of stock-out days of essential tracer drugs per quarter in the District Hospital	6 days	2015	MOH Report	5.5 days	5 days	4 days	3 days	2 days
Strategic sub-axis 4 Human Resources for Health								
Percentage of MHCs, IHCs and DHs with at least 50% of the required technical staff	40%	2013	Annual HRDP implementation reports, HRH Census	42%	43%	45%	48%	50%
Strategic sub-axis 4.5 : Health Information and research in health								
MAR promptness rate in HDs	0%	2015	NHIS	75%	75%	75%	80%	80%
MAR completeness rate in HDs	0%	2015	NHIS	100%	100%	100%	100%	100%
Proportion of research results reported	NA			5%	5%	10%	15%	30%
Proportion of research results used for decision-making	NA			5%	5%	10%	15%	20%
STRATEGIC AXIS 5 : STRATEGIC GOVERNANCE & STEERING								
HSS performance indicators								
Achievement rate of the 2016-2020 NHDP objectives	0%	2015					70%	100%
Strategic sub-axis 5.1 : Governance								
Corruption perception index in the sector	7.56%	2010	National anti-corruption plan			7%		6%
Strategic sub-axis 5.2 : Strategic steering								
Execution rate of RDPH and HDs integrated supervision missions	NA			20%	25%	30%	40%	50%
Proportion of the recommendations of the coordination meetings (steering committee and weekly coordination meetings of MOH) that have been carried out	75%	2015	TS/SC-HSS annual reports		75%	75%	100%	100%

4.3. MONITORING OF DIRECT ACHIEVEMENT INDICATORS

Direct achievement indicators were selected based on a realistic principle of feasibility (relevance, availability, sustainability and periodicity of sources) in addition to their relevance in relation to the main directives of the NHDP. These indicators will be monitored at all levels of the health pyramid using a dashboard.

Indeed, the dashboard is a tool that will provide the manager with an overview of the status and trends of the indicators (see Appendices 3, 4 and 5). He will be informed on the level of achievement of the projected targets and will be able to make decisions subsequently. In other words, the dashboard will provide answers to the following 2 key questions: What has been done so far? What are our prospects?

Table 3: Monitoring indicators IMEP 1

Indicator	Baseline			Targets				
	Value	Year	Reference	2016	2017	2018	2019	2020
STRATEGIC AXIS 1: HEALTH PROMOTION								
Strategic sub-axis 1.1: Institutional, community and coordination capacities in health promotion								
Tracer indicators								
Percentage of the MOH budget allocated to health promotion interventions	ND			6%	7%	7%	7%	7%
Proportion of Health Districts having at least 3 CSO affiliated to the regional CSO platform and have contributed in the implementation of the Annual Work Plan (AWP)	ND			30% increase by deadline				
Percentage of HDs having at least 3 polyvalent CHWs trained for the provision of community MHP	1%	2015	Routine data DOSTS	Equals to 50% by deadline				
Availability of updated regulatory instrument governing community participation in heath interventions	0	2015	DAJC report			1		
Goal achievement rate of the multiannual health promotion plan	0			50%	75%	75%	75%	75%
Proportion of health districts where at least 50% of secondary schools implement health promotion activities	ND			50%	60%	70%	75%	75%
Proportion of Health Districts having implemented at least 50% of the activities stated in their Annual Work Plan (AWP)	76%	2015	Programme Activity Report	40%	50%	60%	70%	80%
Strategic sub-axis 1.2: Living conditions of the population								
Tracer indicators								
Percentage of the MOH budget allocated to health promotion interventions	22 - 2 %	2012	DPS report	26%	30%	34%	38%	40%

Indicator	Baseline			Targets				
	Value	Year	Reference	2016	2017	2018	2019	2020
Proportion of Health Districts having at least 3 CSO affiliated to the regional CSO platform and have contributed in the implementation of the Annual Work Plan (AWP)	ND			Equals to 50% by deadline				
Percentage of HDs having at least 3 polyvalent CHWs trained for the provision of community MHP	ND			75%	75%	75%	75%	75%
Strategic sub-axis 1.3: Strengthening healthy behaviours of individuals and communities								
Tracer indicators								
Percentage of HDs having an integrated Communication plan for health promotion and disease prevention	ND			20%	40%	60%	70%	80%
Annual number of contra band food products seized	ND			1	1	1	1	1
Proportion of HDs having community teams trained in first aid	ND			10/189	50/189	100/189	189/189	189/189
Number of victims (injured or dead) of inter urban road accidents	3,071	2013	CONAROUTE report	0	0	0	0	0
Proportion of local councils/health districts with conventional developed sites for sports and physical activities	ND			5%	10%	20%	30%	40%
Percentage of approved centres for sports and physical activities having a trained sports instructor	ND			10%	15%	20%	25%	30%
% of children aged 6 to 23 months having received food from at least four food groups in the previous day	ND			25% increase by deadline				
Prevalence of dental decay in primary school pupils	ND				4% reductio n	5% reduction	7% reduction	9% reduction

Indicator	Baseline			Targets				
	Value	Year	Reference	2016	2017	2018	2019	2020
Strategic sub-axis 1.4: Essential family practices, family planning, promotion of adolescent health, and post-abortion care								
Tracer indicators								
Proportion of DHs having a technical personnel trained in EFP[(a)]	ND				Equals to 50% by deadline			
Percentage of households implementing at least 7 out of 15 essential family practices[(a)]	ND				15%	20%	25%	30%
STRATEGIC AXIS 2: Disease Prevention								
Strategic sub-axis 2.1: Prevention of communicable diseases								
Tracer indicators								
Percentage of HDs having carried out and documented at least 75% of IEC/C4D activities included in their Integrated Communication Plan	ND			80%	80%	80%	80%	80%
Percentage of inmates aged 15-49 years having screened for HIV in the last 12 months and who collected their results	ND				80%	82%	85%	90%
Percentage of people aged 15-49 years having screened for HIV in the last 12 months and collected their results	W:25,1% M: 22.5%	2014	MICS 5	W: 26.1%; M:23.4%	W: 27.1%; M:24.3 %	W: 28.1%; M:25.2%	W: 29.1%; M:26.1%	W: 30.1% M: 27%
Proportion of households with an LLIN for 2 persons	37.4%	2014	MICS 5	40%	50%	60%	80%	95%
Proportion of children below 5 years of age of the North and the Far North Regions who received preventive treatment for seasonal malaria	ND			25%	30%	40%	60%	85%

Indicator	Baseline			Targets				
	Value	Year	Reference	2016	2017	2018	2019	2020
Strategic sub-axis 2.2: EPDs and public health events, Surveillance and response to epidemic-prone diseases, zoonoses and public health events								
Tracer indicators								
Proportion of CERPLE (Regional epidemics prevention and control centres) with minimal operational capacity required to monitor EPDs/public health events and response[(a)]	ND			50%	60%	75%	100%	100%
Proportion of RDPH with reference laboratories operating in an EPD surveillance network	ND			60%	65%	70%	75%	80%
Proportion of RDPH with an updated annual epidemic risk mapping and operational response plans	ND			100% to deadline				
Number of children left out during routine immunization	ND			Yearly increase of 10%				
Proportion of HDs which have inputs for response to the other EPDs not covered by the EPI over the last three months	ND			50%	50%	50%	75%	100%
Strategic sub-axis 2.3: RMNCAH and PMTCT								
Tracer indicators								
Proportion of District Hospitals with at least one staff trained in the delivery of high impact interventions in mother and child health	61%	2015	EmONC surveys	65%	70%	80%	90%	95%
Proportion of HDs that deliver CEmONC according to standards (9 functions)[(a)]	61.3%	2014	MICS 5			66%		70%
Proportion of children who attended PNC services within 48 hours following delivery.	68.5%	2014	MICS 5	70%	75%	80%	85%	90%

Indicator	Baseline			Targets				
	Value	Year	Reference	2016	2017	2018	2019	2020
Strategic sub-axis 2.4: Prevention of non-communicable diseases								
Tracer indicators								
Proportion of RDPH which organized at least one annual NCD (hypertension, diabetes, cancers, etc.) prevention and screening campaign	ND			25%	50%	90%	100%	100%
Proportion of RDPH which organized at least one awareness and screening campaign for sickle cell disease	ND			25%	50%	90%	100%	100%
STRATEGIC AXIS 3: CASE MANAGEMENT								
Strategic sub-axis 3.1: Curative management of communicable and non-communicable diseases								
Tracer indicators								
Satisfaction index of beneficiaries of health services and care	67%	2010	PETS2-2010	68%	70%	75%	80%	85%
Proportion of targeted hospitals in the 4th, 5th and 6th categories with 75% of the technical staff following protocols for communicable diseases case management (Malaria, AIDS, TB)	ND			30%	40%	60%	65%	75%
Proportion of targeted DHs of which 75% of the technical staff implement protocols for the management of the main NCDs (Buruli ulcer, leprosy)	ND			30%	40%	60%	65%	75%
% of targeted MHCs and DHs of which 75% of the technical staff implement guidelines for task shifting in the management of hypertension and diabetes	ND			30%	40%	60%	65%	75%
Proportion of RDPH that have organized at least one annual screening and awareness campaign for hypertension / diabetes out of health facilities, including World Days for the fight against these diseases	ND			40% increase by deadline				

Indicator	Baseline			Targets				
	Value	Year	Reference	2016	2017	2018	2019	2020
% of targeted MHCs and DHs of which 75% of the technical personnel use standards/protocols for the management of major non-communicable diseases (diabetes, mental health, Hypertension)	ND					40%	50%	60%
% of targeted IHCs and MHCs which managed at least 80% of children below 5 years of age suffering from diarrhea/ARI with the IMCI approach	31%	2012	WHO Cameroon Annual 2010 report quoted by the 2012 RASS	32%	33%	34%	35%	40%
Percentage of assessed District and Regional Hospital staff who use valid palliative treatment protocols	ND			30%	40%	60%	65%	75%
Strategic sub-axis 3.2: Maternal, newborn, child and adolescent conditions								
Tracer indicators								
Proportion of IHCs which completed at least half of the planned outreach/mobile strategies	ND			75%	75%	100%	100%	100%
Percentage of DHs with at least 1 health provider trained in clinical IMCI	31%	2015	DPS report	31.50%	32%	32.50%	33%	35%
Proportion of targeted MHCs and DHs with 75% of technical staff using validated protocols for the management of maternal and child health conditions	ND			75% by deadline				
Proportion of DHs with user-friendly services for the management of adolescent health conditions	ND			20% increase over the period 2016-2020				
Proportion of children born to HIV positive mothers and put on ART	34%	2015	PMTCT, NACC Progress report	50%	70%	80%	90%	90%

Indicator	Baseline			Targets				
	Value	Year	Reference	2016	2017	2018	2019	2020
Strategic sub-axis 3.3: Emergencies and public health events								
Tracer indicators								
Availability of a budgeted national public health events management plan and corresponding annual implementation reports	0	2015				1		1
Proportion of District Hospitals with medicines / consumables for effective management of the most common medical and surgical emergencies	ND			50%	100%	100%	100%	100%
Proportion of RDPH that conducted at least one emergency simulation exercise per year	2/10	2015	DLMEP report	5/10	7/10	10/10	10/10	10/10
Percentage of RDPH with Rapid Intervention and Response Teams (RIRTs)	ND			5/10	7/10	10/10	10/10	10/10
Strategic sub-axis 3.4: Management of disabilities								
Tracer indicators								
Proportion of RHs and CHs having provided medical management of least 70% of the cases of correctable motor disability according to SOP s	ND			75% by deadline				
Proportion of DHs having an operational physiotherapy ward	ND			75% by deadline				
Proportion of RDPH that organized at least one cataract surgery campaign per year	ND			75% by deadline				

Indicator	Baseline			Targets				
	Value	Year	Reference	2016	2017	2018	2019	2020
STRATEGIC AXIS 4: STRENGTHENING THE HEALTH SYSTEM								
Strategic sub-axis 4.1: Health financing								
Tracer indicators								
Proportion of the national budget allocated to Health Sector	5.5%	2015	Finance Law			6.50%		8%
Availability of an approved financial information analysis report	2	2015	NHA 2012	1	1	1	1	1
Availability of a framework instrument granting autonomous management of the revenue allocated to the HFs of the devolved level	0	2015	DAJC report			1		
Availability of a report validating the distribution key of MOH budget among the various programmes	0	2015	DRFP report		1	1	1	1
Proportion of health districts having integrated the performance-based financing approach (PBF)	13.6%	2015	PBF report	15%	20%	70%	80%	100%
Availability of a report on the National Health Accounts	1	2012	NHA 2012			1		1
Strategic sub-axis 4.2: Healthcare and services provision								
Tracer indicators								
Availability of an updated legal/regulatory instrument governing the organization and operation of public hospitals (Hospital reform)	0	2015	DOSTS MOH report		1			
Percentage of the population living within a radius of less than 5 km from a health facility (IHC, MHC and DH)	80.6%	2007	ECAM 3	81.5%	83%	85%	88%	90%
Percentage of IHCs, MHCs and DHs constructed according to standards and in accordance with the infrastructure development plan	1%	2015	DEP MOH report	2%	5%	10%	20%	30%

Indicator	Baseline			Targets				
	Value	Year	Reference	2016	2017	2018	2019	2020
Percentage of IHCs, MHCs and DHs rehabilitated	1%	2015	DEP MOH report	2%	5%	10%	20%	30%
Percentage of DHs with at least two versatile maintenance agents trained in the following fields (biomedical, electricity/refrigeration, plumbing, IT, carpentry)	ND		DRH MOH report	8%	26%	53%	100%	100%
Proportion of RDPH that signed contracts with biomedical, electricity/refrigeration and plumbing maintenance structures	0	2015	DEP MOH report	8%	26%	53%	100%	100%
Percentage of DHs equipped based on standards and in accordance with the National Health Infrastructure Development Plan	ND		DEP MOH report		40%	45%	45%	50%
Proportion of RDPH with an approved regional blood transfusion structure	0/10	2015	NBTP MOH report			1/10	3/10	5/10
Percentage of DHs providing at least 75% of CHP interventions	10%	2015	2015 CEmONC Survey	15%	25%	50%	75%	80%
Percentage of public IHCs and MHCs providing at least 80% of MHP interventions	ND					70%		75%
Percentage of school infirmaries/university health centres with a first-aid kit	ND			20%	25%	50%	75%	75%
Percentage of HDs whose level of development was assessed	ND				50%	100%	100%	100%
Strategic sub-axis 4.3: Drugs and other pharmaceutical products								
Tracer indicators								
Availability of the updated National Pharmaceutical Master Plan (PMP) and the activity report of the year before the assessment of the implementation of this plan	0	2015	DPML MOH report		1			

Indicator	Baseline			Targets				
	Value	Year	Reference	2016	2017	2018	2019	2020
Availability of a regulatory instrument to create and organize the National Laboratory Network and annual reports of data transmission activities	0	2015	DPML MOH report			1		1
Proportion of regions that produced an annual activity report on pharmacovigilance	ND		DPML MOH report	50%	75%	100%	100%	100%
Percentage of pharmaceutical products controlled before and after marketing in pharmacies and public hospitals	ND		DPML MOH report	Equals to 25% by deadline				
Average number of stock-out days of essential tracer drugs in RFHP per quater	6 days	2016	2015 DPML report	5.5 days	5 days	4 days	4 days	2 days
Proportion of RDPH which organized seizures and destruction of illicit drugs annually	ND				100%	100%	100%	100%
Strategic sub-axis 4.4: Human Resources for Health								
Tracer indicators								
Percentage of targeted RDPH and DHS officials who received training/capacity building in management	ND			Equals to 100 % of DMOs trained by deadline				
Percentage of MHCs and DHs in northern Regions, East and South regions with at least one midwife	ND			Equals to 50% by deadline				
Proportion of RDPH that sent consolidated and complete data of the HRH, including that of the private and traditional sub-sector to the DHR annually	ND			50%	100%	100%	100%	100%
% of doctors in MHCs and DHs with at most four years experience who benefited from at least continuous training in the targeted areas (CemONC, mental illness, diabetes, etc.)	ND			5%	10%	15%	20%	30%
Proportion of RDPH with IT tool for managing and monitoring career profiles (Regional SIGIPES)	0	2015	Health Information Unit		5/10	8/10	10/10	10/10

Indicator	Baseline			Targets				
	Value	Year	Reference	2016	2017	2018	2019	2020
Proportion of targeted MHCs and DHs with 75% of staff that apply approved protocols for the management of maternal and child health conditions	ND			80% reached by deadline				
HRH Satisfaction Index	ND			30% increase by deadline				
Percentage of insecured and difficult-to-access IHCs, MHCs and DHs with at least 50% of human resources on duty since 3 years	ND			20% increase by deadline				
Strategic sub-axis 4.5: Health Information and Research in Health								
Tracer indicators								
Percentage of baseline surveys carried out for monitoring the implementation of the 2016-2020 NHDP	ND				100%			
Proportion of RDPH officials who benefited from capacity building to carry out research projects	ND				100%	100%	100%	100%
STRATEGIC AXIS 5: GOVERNANCE & STRATEGIC STEERING								
Strategic sub-axis 5.1: Governance								
Tracer indicators								
Availability of an updated regulatory instrument governing the organization and functioning of NHDP steering, coordination and M/E bodies at all levels	0		DAJC report		1			
Availability of updated legal / regulatory texts governing the organization, functioning of public hospitals and case management	0	2015	Rapport DOSTS MINSANTE		1			
Proportion of accredited DHs and those ranking as such (with a quality assurance system for healthcare and services)	0%					30%	50%	70%

Indicator	Baseline			Targets				
	Value	Year	Reference	2016	2017	2018	2019	2020
Proportion of RHs whose annual technical and financial reports validated by the members of the Hospital Management Board are sent to the RDPH	ND				100%	100%	100%	100%
Proportion of dispatching wholesalers and pharmacies inspected	ND					25%	30%	40%
Proportion of GHs, CHs and RHs that have undergone an external audit	ND		/	40% of GHs, CHs and RHs audited by 2020				
Proportion of category 1 and 2 hospitals that have transmitted to MINSANTE and/or published their technical activity report online	ND			100% each year				
Proportion of Central Departments, Administrative and Public Institutions (API) in health and RDPH that produced an annual performance report	ND			100% each year				
Proportion of category 1 to 4 health facilities that implement RRIs	ND			20% increase per year				
Availability of a report on the implementation of the PPBS chain activities (intergration of NHDP interventions in the MTEF, respect of the budget distribution key as per the MTEF, etc.)	0	2015	TS/SC-HSS Report	1 report per year				
Strategic sub-axis 5.2: Strategic steering								
Tracer indicators								
Proportion of HDs whose HDDPs are aligned to the NHDP	ND		TS/SC-HSS annual Report	100%	100%	100%	100%	100%
Proportion of RDPH that have developed regional consolidated health development plans aligned to the NHDP 2016-2020	0%	2015	TS/SC-HSS annual Report		100%	100%	100%	100%
Availability of the approved prison health policy document and the annual reports of health activities in prisons	0	2015	TS/SC-HSS annual Report			1		

Indicator	Baseline			Targets				
	Value	Year	Reference	2016	2017	2018	2019	2020
Proportion of health districts and RDPH that have organized at least 3 meetings to coordinate and monitor the implementation of their AWPs and have produced an annual report	ND				50%	75%	75%	75%
Proportion of HDs with the final evaluation report of their HDDP	0	2015	Report TS/SC-HSS					100%
Proportion of RDPH with the final evaluation report of their CRHDPs	0	2015	Report TS/SC-HSS					100%
Proportion of HDs and RDPHs with at least 80% of indicators in the Performance Tracking Dashboard	0%		TS/SC-HSS annual Report		100%	100%	100%	100%
Level of achievement of targets projected in the Integrated Monitoring and Evaluation Plan (IMEP)					25%	50%	75%	100%
Availability of an annual report of the sector or thematic health review	1	2013	TS/SC-HSS annual Report			1	1	1
Availability of mid-term and final reports of the NHDP	0%		TS/SC-HSS annual Report			100%		
Proportion of HDs and RDPH with mid-term and final evaluation reports of the NHDP 2016-2020	0%		TS/SC-HSS annual Report					100%
Availability of the annual strategic surveillance report	0		TS/SC-HSS Report	1	1	1	1	1
Percentage of agreements signed and respected between the MOH and CSOs working in the health sector	ND			100%	100%	100%	100%	100%
Achievement rate of the National Compact objectives	0%	2015	TS/SC-HSS Report	25%	50%	75%	85%	100%

CHAPTER 5: ORGANISATIONAL FRAMEWORK OF MONITORING/EVALUATION

5.1 Operational organisation of M&E

The performance of NHDP monitoring depends on the functioning of the NHIS, which will be the main data source for its M&E. In the long run, a single multi-sector and M&E coordination body will be established at all the levels of the health pyramid, to replace the plethora of focal points of health priority programmes and thematic sub-committees. Regarding MOH indicators included in the IMEP, only the most relevant of the three vertical and the two cross-cutting components approved by all stakeholders were included in the NHDP multi-sector monitoring dashboard. Indicators of partner ministries will be regularly monitored like those of the MOH.

The monitoring and evaluation of the implementation of the 2016-2020 health development plan will therefore be participatory and multi-sector (see Table 4).

Three major points need to be considered to give the best chances of success to the implementation of the 2016-2020 IMEP. These are: (i) setting up the IMEP monitoring and evaluation bodies at all levels of the health pyramid; (ii) defining roles, responsibilities and procedures for monitoring the NHDP; (iii) mobilizing high quality financial and human resources for effective monitoring.

Table 4: Overall summary of the NHDP implementation steering, coordination and monitoring bodies

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

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

5.2. Roles and responsibilities of key stakeholders (see Chapter 3)

The monitoring of the implementation of the 2016-2020 NHDP will be under the institutional responsibility of the Steering Committee (SC). This Steering Committee will have a Technical Monitoring Committee and a Technical Secretariat at the central level, then regional and operational branches to assist the central level in its tasks. The Steering Committee (SC) will also be responsible for ensuring the synergy of activities contributing to the development of health. This synergy of activities is led by the MOH and partner ministries involved in the implementation of health actions.

5.3 Data management tools

- *HFs registries and monthly data collection forms (MAR)*

Harmonized HFs registries shall be the main source of data collection for the 2016-2020 NHDP. The harmonized Monthly Activity Report (MAR) of the NHIS will be the tool for summarizing and transmitting HF data to Health Districts. However, in rural Health Districts with limited geographical access, HF heads in Health Areas will forward their MAR to the head of the main HF of the Health Area after the analysis of their performances. The head of the main HF will, in turn, ensure the transmission of the MAR to the HD in charge of their compilation and feedback. In other Health Districts, HFs will collect and analyse their data prior to their transmission to HDs.

Under the coordination of the HIU in collaboration with the TS/SC-HSS and those responsible for priority health programmes, the content of the MARs will be reviewed periodically for approval of the NHDP monitoring and evaluation indicators to be provided.

- *The central data bank of the NHIS: the DHIS-2*

NHIS data collected in HFs will be directly entered and analysed in the DHIS-2 currently being used. At various levels of the health pyramid, access to the data bank will be granted by the HIU to the various stakeholders for efficient management and optimal use of available information.

- *Multi-sector dashboard*

The 2016-2020 IMEP multi-sector dashboard is a second-level collection tool that is developed from the NHDP performance framework. This tool, properly completed by all stakeholders in the sector, systematically and instantaneously assesses the performances of each Health District and RDPH. The analysis of bottlenecks that could be the cause of the poor performance observed will provide appropriate solutions to identified monitoring problems.

For other data not collected by the NHIS standard circuit, particularly those from the partner ministries, specific tools for primary data collection will be developed to be analysed during multi-sector coordination meetings.

5.4. Type, site, frequency of collection and method of calculating indicators

IMEP indicators matrix specifies the type, site, frequency and the method of calculating each indicator.

5.5 Procedures for data processing and analysis

Operationally, the tasks of HFs will be as follows: collection, compilation and analysis of data, subsequent decision-making and transmission of data collected to Health Districts to be entered into the DHIS-2.

At each level of the health pyramid, calculated indicators will be analysed and discussed at the steering committee meetings and also during the coordination and monitoring meetings at the devolved level. During these meetings, performances will be analysed, corrective measures to be undertaken will be recommended and dashboards filled in by all the stakeholders. Particular emphasis will be laid on feedback to data producing structures.

5.6. Data transmission procedures

5.6.1. Background

As a reminder, data collected in the HFs will be transmitted periodically (weekly, monthly, quarterly, annually) to Health Districts. Health Districts will enter data into DHIS-2, analyse and produce performance indicators per Health Area. Once approved by the districts with their access rights to the DHIS-2, data will be transmitted to the RDPH, to be analysed before compilation and transmission to the central level.

In addition to HFs data, those from partner ministries will also be compiled at the Health District level and taken into account in the analysis of its performance. The report resulting from this analysis will be forwarded to the Technical Secretariat of the Coordination and Monitoring Committee of the HSS implementation and to the RDPH. Once evaluated, the Committee will forward its report to the Technical Secretariat of the Health Sector Strategy of the Steering Committee for exploitation, summary and feedback first to the various Regions and then to the CPP.

5.6.2. Data transmission frequency

Health data of all HFs in Health Areas as well as those of partner ministries will be forwarded to the Health District by the 5th of the month. These data must be entered, approved and analysed by Health Districts by the 10th of the month. Feedback from the HD to HFs is

imperative. RDPH will have to analyse the performance of the HD by the 15th of the month. Lastly, the HIU, the NPHO and the TS/SC-HSS, various central technical structures with regard to their missions will be responsible for exploiting the health information available for strategic decision-making and feedback to RDPH by the 28th of the month. Information will also be made available to other key stakeholders in the health system (central level health structures, TFPs, NGOs, CSOs etc.).

5.6.3 Data quality control

The control of quality of collected data will be done at all the levels of the health pyramid. This will involve reviewing data and audits, verifying the traceability, relevance, completeness and accuracy of data available. This requires archiving (soft and hard copy) of data and a good keeping of statistics and reports at all levels, mainly in HFs and Health Districts. A copy of the HF report will be forwarded to the Health District and another kept in the HF.

5.7 SUPERVISION OF M&E DATA MANAGEMENT

5.7.1. Joint Supervisions

Joint supervisions with development partners will be organized once a year to address harmonization, coordination and advocacy issues and to accelerate the mobilization of resources to achieve the objectives set out in the NHDP.

5.7.2. Facilitating supervision

Facilitating supervision will focus on coaching actors at all levels of the system. It will be necessary for them to master IMEP and its tools, namely: the matrix of indicators, the performance framework and the dashboard. This supervision will also involve bringing health facilities at all levels of the health pyramid to achieve M&E and develop a culture of accountability and resilience. These supervisions will equally assess the level of achievement of the objectives and the implementation of the recommendations of the previous supervision.

5.7.3. Distant supervisions

In order to implement the HSS successfully, distant supervisions will also be carried out after the results of the dashboards of Health Areas, Districts and Regions have been used.

5.8. Data sharing and dissemination

As a reminder, information on the M&E of the NHDP will be shared with all stakeholders involved in the performance achieved in the sector (TFP, Technical Departments, Health Programmes, CSOs, CBOs, DCT, RCT) through:

- The regional quarterly coordination meetings (HSS Regional Coordination and implementation):
- Periodic review of data;
- The steering committee statutory meeting at the central level;
- Statistical yearbooks of each Health District and Region.

CHAPTER 6 : MONITORING-EVALUATION MECHANISM

6.1. Monitoring of the NHDP

6.1.1. At the central level

Monitoring of the NHDP implementation will be in line with the projected progress of the 2016-2027 HSS performance framework. Under the supervision of the Steering Committee and the Technical Monitoring Committee, the TS/SC-HSS will coordinate the monitoring-evaluation of the NHDP implementation at all the levels of the health pyramid through the following interventions:

- Supervision (Joint, Thematic, General);
- The bi-annual/annual sector or thematic review;
- Technical and logistical support to sub-committees and thematic groups.

The purpose of the joint supervision mission is to monitor the NHDP implementation process in the field. It will involve TS/SCP-HSS experts, MOH experts, Technical and Financial Partners and possibly partner ministries as need arises. This supervision will focus on indicators of direct achievement. At the end of the supervision, a plan to monitor the implementation of the operational recommendations adopted will be developed in a participatory manner. The implementation of this plan will be monitored by CORECSES with the use of an appropriate software.

Calculated indicators will be analysed and discussed during the sector or thematic reviews organized by the TS/SC-HSS. During these reviews, performances will be analysed and the dashboards filled in. Problems, weaknesses, bottlenecks will be identified and corrective measures will be recommended.

The strategic support of the multi-sector thematic groups and sub-committees will consist in assisting actors of the thematic groups in monitoring the NHDP implementation.

6.1.2. Monitoring NHDP at the regional level

At the regional level, the NHDP implementation will be carried out through: (i) routine coordination of regional activities, multi-sector coordination of the regional TS/SC-HSS; (ii) decentralized monitoring in Health Districts; (iii) joint supervision; (iv) quarterly review and

data validation from Health Districts, regional hospitals and others ranking as such; (v) supervision of interventions.

6.1.3. At the operational level

The COCSES will be chaired by the Divisional Officer and under the technical leadership of the CMO. Its members will include the Chairperson of the DHC, the members of the District Core Team, RLA officials and civil society organizations affiliated to the regional CSO platform, and Divisional Delegates from partner ministries. They will be involved in monitoring the NHDP implementation through the following main interventions:

- Integrated supervision;
- Decentralized monitoring;
- Coordination and monitoring meetings on the implementation of interventions (multi-sector coordination).

Monitoring of the NHDP at the operational level will focus mainly on monitoring the HDDP/AWP implementation. At the end of supervision, a monitoring plan of the recommendations will be developed in a participatory manner.

6.2. Process for evaluating the NHDP implementation

In accordance with its missions, the TS/SC-HSS will carry out the evaluation process of the National Health Development Plan under the supervision of the Steering Committee and with the participation of other stakeholders in the health sector.

The NHDP evaluation will focus on quantitative and qualitative aspects and will be carried out through an iterative process and through three interventions (Figure 1):

- Monitoring interventions;
- Mid-term evaluation;
- Final evaluation

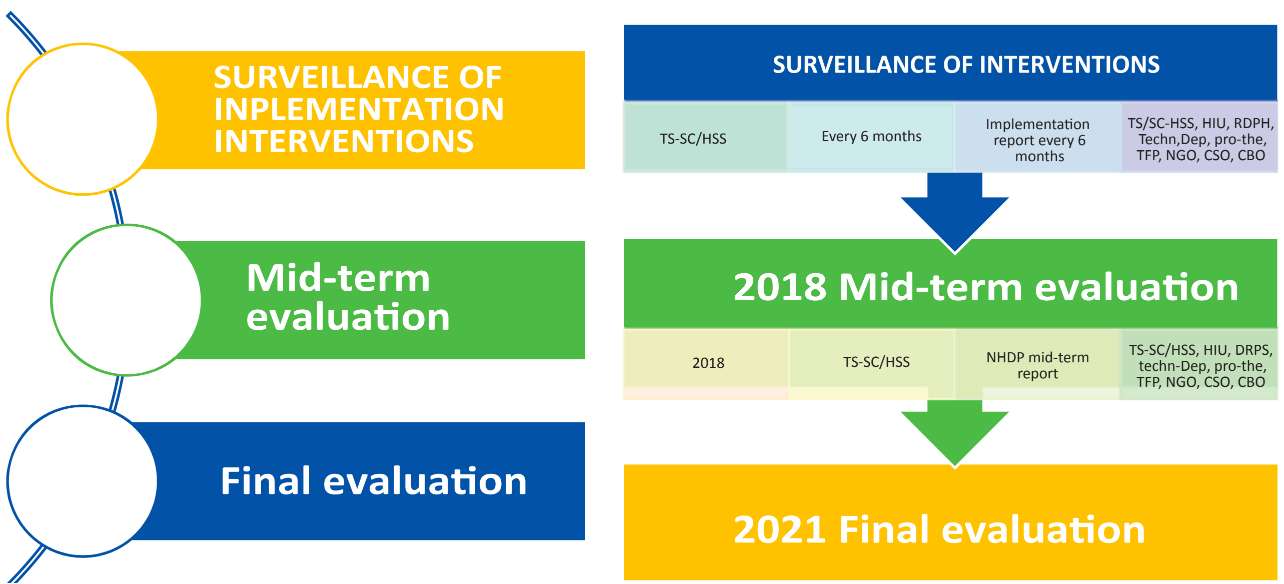


Figure 1: NHDP assessment methods

6.2.1 Evaluation team

The NHDP implementation will be evaluated by experts of the HSS Technical Monitoring Committee, under the coordination of the Technical Secretariat of the Steering Committee of the HSS that will mobilize the group of experts for baseline surveys, monitoring of interventions, mid-term and final evaluations. They will work under the supervision of the Secretary General of the MOH and under the technical coordination of the Technical Secretariat of the Steering Committee of the Health Sector Strategy.

6.2.2 NHDP assessment methods

The evaluation of the NHDP implementation is made up of 3 parts: (I) monitoring progress in the NHDP implementation, (ii) mid-term evaluation and (iii) final evaluation.

- *Monitoring progress in the NHDP implementation*

Monitoring progress in the NHDP implementation is a sequential method of interventions that will assess the monitoring process in the NHDP implementation; this will give the possibility to anticipate possible problems or bottlenecks and to refocus the 2016-2020 NHDP implementation on the projected progress set by the 2016-2027 HSS performance framework.

This will assess the level of achievement of the 2016-2020 NHDP process indicators per component, sub-component and interventions. The results will be discussed during HSS

steering committee meetings. Specific monitoring tools will be developed by the TS-SC/HSS based on the IMEP performance framework.

NOTE: Several basic IMEP data could not be provided. To this end, rapid surveys and appropriate studies will be carried out at the beginning of the cycle to obtain the basic data necessary for an NHDP optimal evaluation.

Mid-term evaluation

A mid-term evaluation will be carried out by the multi-sector and multidisciplinary technical team in 2018 (see 6.2.1 evaluation team) under the general supervision of the MOH and the coordination of the MOH SG. The objective of the mid-term evaluation prepared by the TS/SC-HSS will be submitted to the Steering Committee for approval. The technical working group set up for this purpose will assess the level of expectation of the specific objectives set out in the NHDP and will organize the follow-up of recommendations made to ensure the achievement of the NHDP final objectives. This team will also identify opportunities to be taken to proceed effectively towards the NHDP strategic objectives.

At mid-term, this evaluation will enable to assess progress made in improving the health conditions of the population and to analyse them. The evaluation team will identify weaknesses and major trends that created bottlenecks and opportunities for the achievement of the NHDP targets in the NHDP and, to this end, propose concrete and relevant actions. Results of the mid-term evaluation will help to reorientate the use of resources mobilized and reframe the action of stakeholders involved in the NHDP implementation at all levels.

Final evaluation of the NHDP implementation

The final evaluation of the NHDP implementation will be done in early 2021. This will be a global and national evaluation done by experts of the technical team set up by the HSS Steering Committee (see section 6.2.1). It will also exploit results of the large-scale surveys (DHS, ECAM and MICS) that will be carried out. This evaluation will assess the NHDP impact on the system and the health of the population. The observed performance will help in identifying the gaps which the TS/SC-HSS can use to review the development of NHDP 2 (2021-2027). It will be necessary to assess the performance rate of the health system in general. More specifically, this evaluation will assess the viability of Health Districts and the analysis of impact indicators to assess the level of achievement of the objectives. It will also

involve analysing the changes obtained, learning lessons, bringing out what is left to be done and agreeing on the new strategic orientations for planning the second cycle of the 2020-2027 HSS.

6.2.3. Evaluation schedule

Table 5: Evaluation schedule

Evaluation criteria	Frequency	Year	Data source	Collection site
Monitoring	Every six months	2016, 2017, 2018, 2019, 2020	Rapid survey, studies and baseline surveys, Decentralised monitoring, routine coordination, multi-sector coordination	District, Region, thematic programme, technical department, partner ministries
Annual evaluation	yearly	2016, 2017, 2018, 2019, 2020	Rapid survey, studies and baseline surveys, six-month reviews, sequential evaluation, multi-sector coordination Supervision and monitoring	Central District, Region, thematic programme, technical department, partner ministries
Mid-term evaluation	After 30 months	2018	National survey: ECAM, DHS, MICS	Central
Final evaluation	After 60 months	2021	National survey: ECAM, DHS, MICS	Central

CHAPTER 7: BUDGET OF THE INTEGRATED MONITORING/EVALUATION PLAN

7.1. Implementation cost of the 2016-2020 IMEP

The implementation cost of the 2016-2020 IMEP is FCFA 9,084,800,000, that is, an annual average of FCFA 1.5 billion. It is important to note that these costs have already been taken into account when estimating the overall cost of the 2016-2020 NHDP and therefore does not represent an additional cost to its implementation.

7.1.1. Breakdown of costs per year

Apart from 2016 which marks the finalization and adoption of strategic planning documents by the government, IMEP funding remains relatively stable, with a maximum of FCFA 2.27 billion in 2017. Indeed, the year 2017 marks the beginning of the implementation of IMEP with the development and implementation of the planning and monitoring-evaluation tools (HDDP, CRHDP, AWP, Dashboard, etc.). The year 2020, year of the NHDP evaluation, equally shows a higher cost with FCFA 2.14 billion.

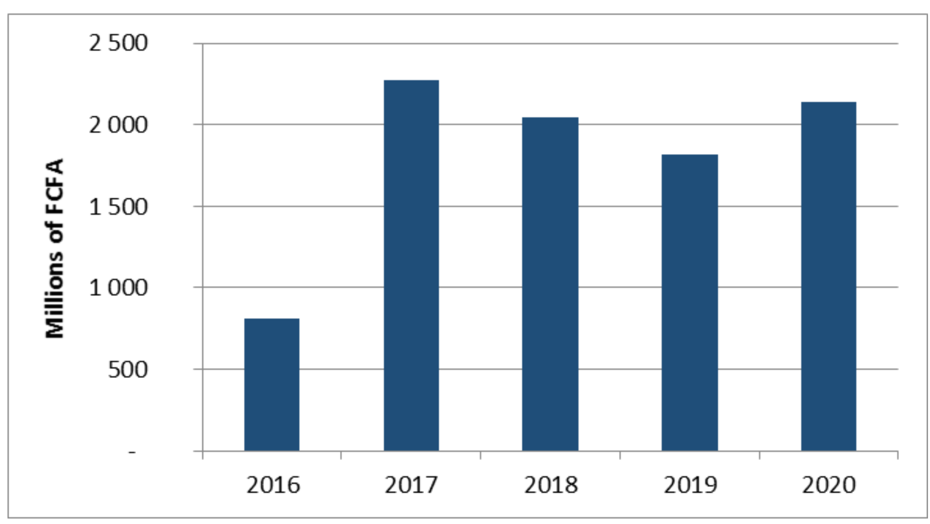


Figure 2 : Breakdown of IMEP costs from 2016-2020

7.1.2. Breakdown of costs per level of the health pyramid

The graph below shows the proportion of the budget to be allocated to each level of the health pyramid. Budgets allocated at the central, regional and operational levels represent 41%, 16% and 43% respectively. Consequently, the largest proportion of the budget will be allocated at the operational level (Health District). This reflects the will of the MOH to strengthen monitoring/evaluation at this level, which mostly accounts for the improvement of key indicators in the health system.

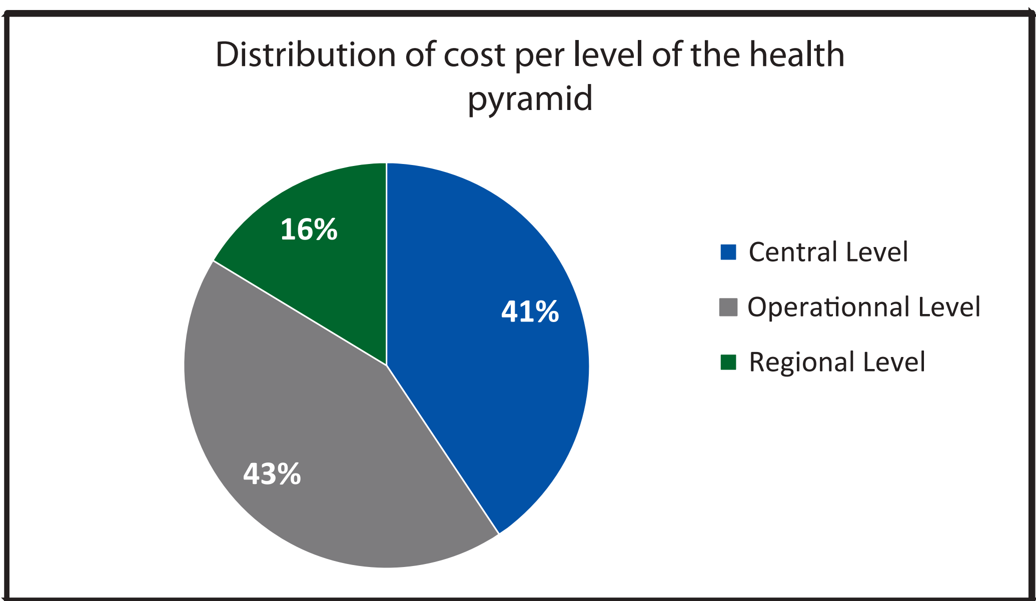


Figure 3: Breakdown of IMEP costs per level of the health pyramid

7.2. Detailed budget per intervention

Table 6: Detailed budget per intervention per year

Level of the pyramid	Interventions / Activités	2016	2017	2018	2019	2020
Central level	Support to the development and monitoring-evaluation of the AWP/HDDP, CRHDP at the devolved level	*24 800 000*	*578 000 000*	*124 800 000*	*124 800 000*	*124 800 000*
	Technical and logistical support to the 7 thematic groups	*10 000 000*	*56 000 000*	*56 000 000*	*56 000 000*	*56 000 000*
	Study and baseline survey	*250 000 000*	*250 000 000*	*250 000 000*	*250 000 000*	*250 000 000*
	Coordination meeting of the Steering Committee	*10 000 000*	*20 000 000*	*20 000 000*	*20 000 000*	*20 000 000*
	Follow-up meeting on reforms and statutory instruments	*10 200 000*	*10 200 000*	*10 200 000*	*10 200 000*	*10 200 000*
	Data review and validation	*45 000 000*	*45 000 000*	*45 000 000*	*45 000 000*	*90 000 000*
	Sector review			*80 000 000*		*90 000 000*
	Thematic review	*35 000 000*	*35 000 000*	*35 000 000*	*35 000 000*	*70 000 000*
	Monitoring the AWP and PPA implementation		*60 000 000*	*60 000 000*	*60 000 000*	*60 000 000*
	Joint general supervision	*40 000 000*	*40 000 000*	*40 000 000*	*40 000 000*	*40 000 000*
Total at the central level		***425 000 000***	***1 094 200 000***	***721 000 000***	***641 000 000***	***811 000 000***
Régional level	Regional coordination meeting (data review and validation)	*78 952 000*	*78 952 000*	*78 952 000*	*78 952 000*	*78 952 000*
	Regional sector review			*150 000 000*		*150 000 000*
	Regional thematic review		*70 000 000*	*70 000 000*	*70 000 000*	*70 000 000*
	Monitoring the AWP and PPA implementation (Regional and District)		*80 000 000*	*80 000 000*	*80 000 000*	*80 000 000*
	Joint supervision at the regional level	*37 800 000*	*37 800 000*	*37 800 000*	*7 800 000*	*37 800 000*
Total at the regional level		***116 752 000***	***266 752 000***	***416 752 000***	***266 752 000***	***416 752 000***
Opérationnal level	Decentralized monitoring		*378 000 000*	*378 000 000*	*378 000 000*	*378 000 000*
	District coordination meeting (data review and validation)	*266 680 000*	*168 540 000*	*168 540 000*	*168 540 000*	*168 540 000*
	Monitoring the AWP and PPA implementation (District and Health Area)		*189 000 000*	*189 000 000*	*189 000 000*	*189 000 000*
	General supervision of Health Areas and the District Hospital		*175 000 000*	*175 000 000*	*175 000 000*	*175 000 000*
Total at the operational level		*266 680 000*	*910 540 000*	*910 540 000*	*910 540 000*	*910 540 000*
Overall total		***808 432 000***	***2 271 492 000***	***2 048 292 000***	***1 818 292 000***	***2 138 292 000***

APPENDICES

APPENDIX 1: viability criteria of HDs

Assessing the viability of HDs will be based on the following three variables:

- Technical and operational viability
- Institutional viability
- Financial viability

Each variable will be broken down into criteria; and each criterion will have a weighing score based on the modalities that will be defined later. This will help assess the level of development of each variable whose weighted average will enable to obtain a value to classify HDs.

Each HD will belong to one of the following classes depending on the score obtained:

- Health District at the start-up /operationalization phase;
- Health District at the consolidation/functional phase;
- Health District at the automous/viability phase.

The tool for assessing viability will be developed from the following elements:

VARIABLES	**CRITERIA DEVELOPMENT ELEMENTS**
Technical and operational viability	Infrastructure
	Equipment-logistic-technology
	Human resources
	Management process
	Partnership for health
	Governance
Institutional viability	Regulations
	Standardization
	Standard operating procedures
Financial viability	Community financing, (indirect or renewable)
	Institutional funding

APPENDIX 2: Rapid evaluation criteria of the viability level of a DH

Component	Criteria	Min score	Max score	
Technical viability				
Availability of technical human resources	DHS staff	0	2	0: No Medical Doctor at the HD 1: 1 Medical Doctor at HD + 1 CBS + 1 CBAF 2: Full team in accordance with the organizational chart of the MOH
	Technical staff in IHCs	0	2	0: Number of staff required < 50 % 1: Number of staff required ≥ 50 % or < 75% 2: Number of staff required ≥ 75 %
	Technical staff at the DH	1	2	Rural DH: 1 Minimum requirements: Major sub criteria: 1 Medical Doctor +1 Anaesth + 2 Lab Tech + 1 X-Ray Tech + 5 nurses[2] Minor sub criteria: 1 nutritionist + 1 physiotherapist 2 Desired requirements: Major sub criteria: 2 Medical doctors +1 Anaesth + 2 Lab Tech + 1 X-Ray Tech + 5 nurses Minor sub criteria: 1 nutritionist, + 1 physiotherapist
	Technical staff at the DH	1	2	Urban DH 1. Minimum requirements: Major sub criteria: At least 5 Medical doctors +1 Anaesth + 5 Lab Tech + 2 X-Ray Tech + 10 nurses Minor sub criteria: 1 nutritionist + 1 physiotherapist 2. Desired requirements: Major sub criteria at least 10 medical doctors +1 Anaesth + 10 Lab Tech + 4 X-Ray Tech + 15 nurses Minor sub criteria : 1 nutritionist + 1 physiotherapist
Packages of care and service provision	Availability of MHP in (IHCs/MHCs)	1	4	1 The IHC/MHC provides less than 50% of MHP interventions 2 The IHC/MHC provides between 50% and 75% of MHP interventions 3 The IHC/MHC provides between 75% and 85% of MHP interventions 4 The IHC/MHC provides more than 85% of MHP interventions
	Availability of CHP	1	4	1 The DH provides less than 50% of CHP interventions 2 The DH provides between 50% and 75% of CHP interventions

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

Component	Criteria	Min score	Max score	
				3 The DH provides between 75% and 85% of CHP interventions 4 The DH provides more than 85% of CHP interventions
Infrastructure	Availability of a quality infrastructure in IHCs/MHCs	1	3	1 IHC/MHC with a fence and a leak proof roof 2 IHC/MHC with a fence, a leak proof roof, clean walls, clean toilets and a potable water point 3 IHC/MHC upgraded to infrastructure standards
	Availability of a quality infrastructure in the DH	1	3	1. DH with a fence and a leak proof roof 2. DH with a fence, a leak proof roof, clean walls, clean toilets and tap water 3. DH upgraded to infrastructure standards,
	Health coverage	1	3	1. Less than 25% of HAs with an IHC 2. Between 25% and 50% of HAs with at least an IHC 3. Less than 50% of HAs with at least an IHC
Equipment	minimum equipment in IHCs	0	3	At least: 1 functional microscope + 1 functional tensiometer + sterilizer + delivery kit + delivery table + isothermal box + complete minor surgery box + 4 observation beds + 1 solar energy source (electric) + scale +1 functional refrigerator
				0: Less than 50% of IHCs with the aforementioned equipment, 1: 25 ≤ 50% of IHCs; 2: 50 ≤ 80% of IHCs; 3: 80% and more in IHCs/MHCs with the aforementioned equipment
	Minimum equipment in DHs	0	3	At least 10 services are available (paediatrics, surgery, internal medicine, gynaecology, maternity, IEC and demonstration rooms, outpatient clinics and functional operating room, laboratory with 4 functional services (parasitology, biochemistry, bacteriology, immunology), functional radiology service, mortuary, pharmacy, 5 services offering at least 75% of the health package
				0: Less than 25% of available services and equipment; 2: 25 ≤ 75 % of available services and equipment 3: More than 80% of available services and equipment
Maintenance of infrastructure and equipment	Availability of two versatile and maintenance workers trained in biomedical, electricity/refrigeration, plumbing, computer and furniture maintenance	0	3	1: Lack of versatile technicians to maintain equipment and infrastructure at the HD (irregular maintenance of infrastructure) 1: Presence of only one of the two versatile technicians required to maintain the HD equipment and infrastructure 2: Presence of the two versatile technicians required to maintain the HD equipment and infrastructure 3: Availability of a depreciation plan for infrastructure and equipment and presence the two versatile technicians required to maintain the HD equipment and infrastructure
Logistics	Availability of a 4x4 vehicle in	0	2	0: HD without a 4x4 vehicle in good condition for supervision 2: HD with a 4x4 vehicle in good condition for supervision

Component	Criteria	Min score	Max score	
	good condition			
	Availability of at least one motorcycle in good condition for the implementation of strategies in each HA to carry out the outreach and mobile strategies	1	3	1: less than 50% of HAs have a motorbike in good condition 2: less than 75% of HAs have a motorbike in good condition 3: more than 75% of HAs have a motorbike in good condition
Drugs, reagents and essential medical devices	Availability of essential drugs in IHCs/MHCs/DHs	0	2	0: IHCs/MHCs/DHs with stock-outs of essential drugs for more than 7 days in the past 3 months 1: IHCs/MHCs/DHs with stock-outs of essential drugs for less than 7 days in the past 3 months 2: IHCs/MHCs/DHs without stock-outs of essential drugs for the past 3 months
	Promoting the use of generic drugs in DHs	1	2	1: Less than 50% medical doctors in DHs prescribe generic drugs 2. More than 50% medical doctors in DHs prescribe generic drugs
Standard operating procedures	Availability of standard operating procedures to provide quality care and services in HFs at the operational level	1	3	1:At least 50% of operational level HFs have standard operating procedures and updated protocols for case management 2:At least 75% of operational level HFs have standard operating procedures and updated protocols for case management 3:All operational level HFs have standard operating procedures and updated protocols for case management
Governance				
Regulation	Respect of regulation in health facilities at the operational level	1	2	1: Existence of internal regulations in health facilities at the operational level 2: Availability of the latest six-month report on compliance with provisions of these internal regulations by health facilities staff at the operational level
	Fight against corruption at the operational level	1	3	1: Existence of a suggestion box in all HFs at the operational level 2: Existence of a suggestion box and a report on the collection of concerns of HF users signed by all the stakeholders. 3: Availability of a survey report on the satisfaction of HF users of the HD
Training and research	Continuing training	1	4	1 Availability of a statement of needs in continuous training in the IHC/MHC/DH 2: Availability of a statement of needs in continuous training in IHCs/MHCs with a request for capacity building for healthcare and service providers in the hospital and in the District health service

Component	Criteria	Min score	Max score	
				3: At least 30% of the staff identified in IHCs/MHCs have benefitted from capacity building 4: At least 50% of the staff identified in IHCs/MHCs have benefitted from capacity building in the areas targeted by the HF.
	Operational research	0	2	0: No research carried out 1: Availability of a research protocol 2: Availability of a research protocol with at least one research report submitted to the RDPH
Funding	Community and institutional funding	1	3	1:HFs with 25% to 49% of the funding needed for the implementation of the agreed AWP 2:HFs with 50% to 74 % of the funding for the implementation of the agreed AWP 3:HFs with 75% to 100% of the funding available for the implementation of the agreed AWP
	Functional DHC	0	2	0: Non-functional DHC 2: Functional DHC
	Functional HMC	0	2	0: Non-functional HMC 2: Functional HMC
	Functional HC	0	2	0: Not all the HAs have a functional HC 1: 50% of HAs with a functional Health Committee 2: At least 75% of HAs with a functional Health Committee
Management process	Health viability plan and/or AWP	0	4	0: No plan is available throughout the period evaluated 1: Existing plan but not aligned to the NHDP 2: Existing plan aligned to the NHDP 4: Existing plan aligned to the NHDP and developed by all key stakeholders of the HD
	M/E	0	4	0: No available dashboard to follow up AWP of HD 1: Existing M/E plan but not aligned with the IMEP of the NHDP 2: Dashboard of the integrated follow-up of available performances 3: HD M/E plan aligned to the IMEP and multisector dashboard for the monitoring of the available performances 4: Availability of the HD M/E plan in line with the IMEP and a multi-sector dashboard for the monitoring of performances; used for the M/E of performances.
	IHCs/MHCs supervision	1	3	1: Less than 50% of IHCs/MHCs were supervised at least once in the previous year 2: 75 % of IHCs/MHCs were supervised at least twice in the previous year 3: 100% of IHCs/MHCs were supervised at least twice in the previous year. Same for the district hospital healthcare and service providers.
Performance achieved	Use of curative care (NC/inhabitant /year)	1	3	1 : if utilization rate is below 1; 2: if utilization rate is above 1 but below 2; 3: if utilization rate >2
	ANC coverage (%)	0	3	0: < 25%; 1: 25 ≤ 50%;

Component	Criteria	Min score	Max score	
				2: 50 ≤ 80%; 3: ≥ 80%
	TB cure rate (%)	0	3	0: < 25%; 1: 25 ≤ 50%; 2: 50 ≤ 80%; 3: ≥ 80%
	ANC coverage (%)	0	3	0: < 25%; 1: 25 ≤ 50%; 2: 50 ≤ 80%; 3: ≥ 80%
	Assisted deliveries (%)	0	3	0: < 25%; 1: 25 ≤ 50%; 2: 50 ≤ 80%; 3: ≥ 80%
	DTC3 coverage (%)	0	3	0: < 25%; 1: 25 ≤ 50%; 2: 50 ≤ 80%; 3: ≥ 80%
	Patients referred among hospitalized patients	0	3	0: if referral rate is < 25%; 1: if referral rate is below 25% and 50%, 2 if referral rate is between 50% and 80%; 3: 50 ≤ 80%; 3: if referral rate ≥80%
	Hospitalization rate in the DH (%)	0	3	0 :<1%; 1: 1≤3%, 2: 3 ≤ 5%; 3: 5 - 10%
	Caesarean sections (%)	0	3	0: rate < 1%; 1: rate between 4% and 5% 2: rate between 6% and 9%; 3: rate between 10% and 15%
Overall Total		18	85	

HD classification grid

- HD in start-up/operationalization phase: performance between 18 and 25 points.
- HD in consolidation/functional phase: performance between 26 and 75
- HD in automous/viability phase: performance between 76 and 80

APPENDIX 3: Operational definitions of concepts used in the NHDP

1. Standard on the number of versatile CHWs: one CHW/1,000 inhabitants (rural area) and 1 CHW/2,50 inhabitants 0 (urban area). To date, this number is not accurately known; during the timeframe covered by this NHDP, it should be ensured that each district has at least 3 CHWs; and gradually, to ensure that the standard for the number of CHWs per district is respected.

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

3. HDs implementing CLTS: HDs in which at least the following conditions are met: (I) each household has an improved toilet (no open air defecation); (ii) availability of a water point at the toilet entrance for handwashing.

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

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

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

7. Minimum technical platform for the management of medical and surgical emergencies in a District Hospital: emergency services with at least 1) a functional ambulance, 2) a complete tensiometer, 3) a small surgery box , (4) steam and heat sterilization equipment, (5) oxygen, (6) emergency drugs, (7) personnel capable of managing Hypertension and diabetes complications, 8) staff trained in EmONC/CEmOC.

8. Accredited DHs: Health facilities with quality assurance system and health services. FP, EmONC/CEmOC, PAC, emergency obstetric surgery, management of HIV/AIDS, malaria, Tuberculosis, Hypertension, Diabetes, RANC.

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

10. CSOs from HDs affiliated to the regional CSO platform that contributed to the implementation of the AWP of the HD were those that conducted at least 2 interventions in the AWP during the period evaluated.

11. A health facility will be considered as applying the principles of occupational safety and health places if it complies with at least four of the following ten principles:

1. Existence of an occupational medical service;

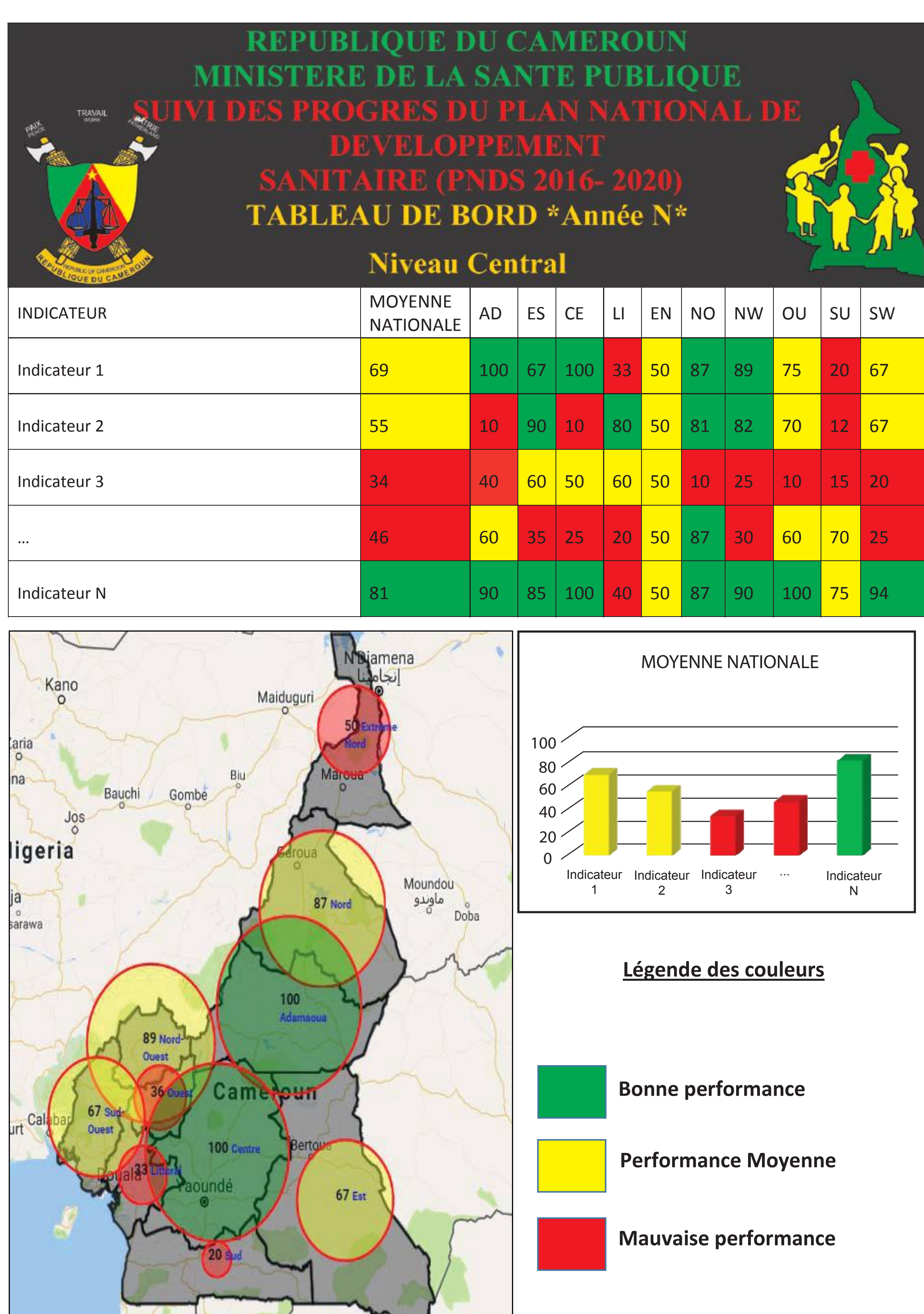
2. Existence of a functional SHC (Safety and Hygiene Committee);

3. Existence of a system for reporting occupational risks (occupational diseases and occupational accidents);

4. Regular production of an annual activity report by the occupational health service;

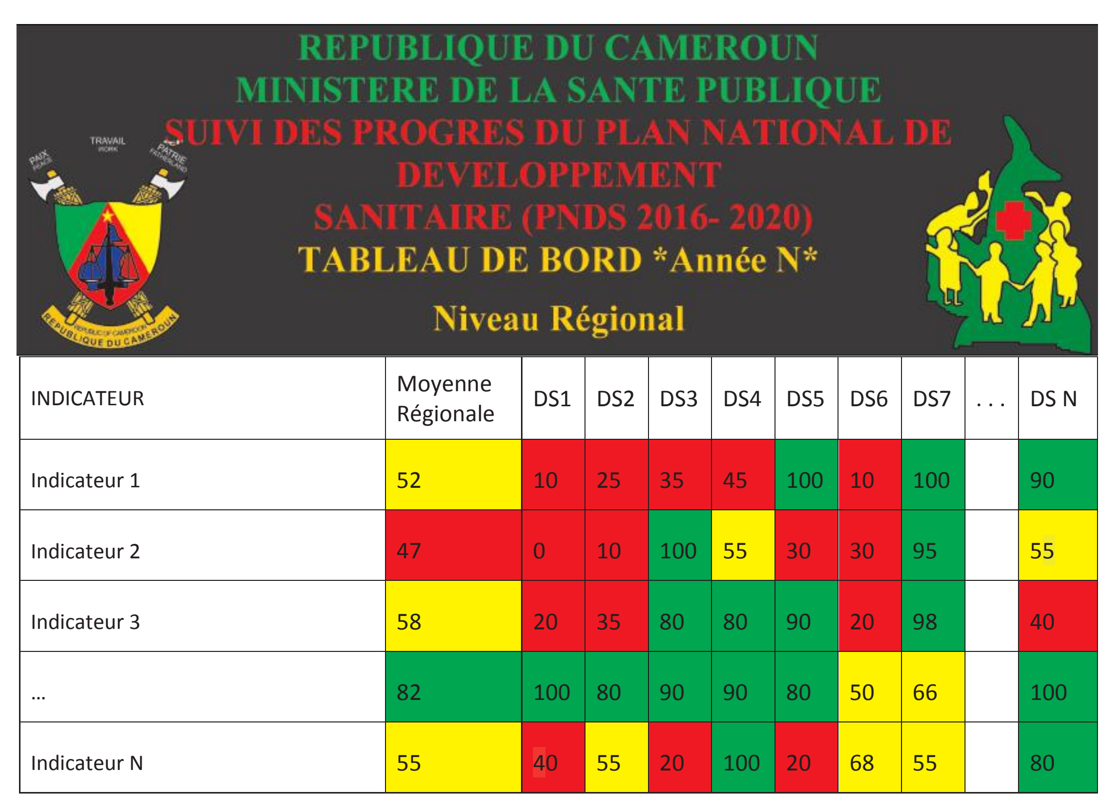
5. Existence of individual prevention methods (providing workers with personal protective equipment, where appropriate *, etc.);
6. Existence of collective prevention methods (alarm, safety nets, light signals), where appropriate*

APPENDIX 4: IMEP dashboard at the central level

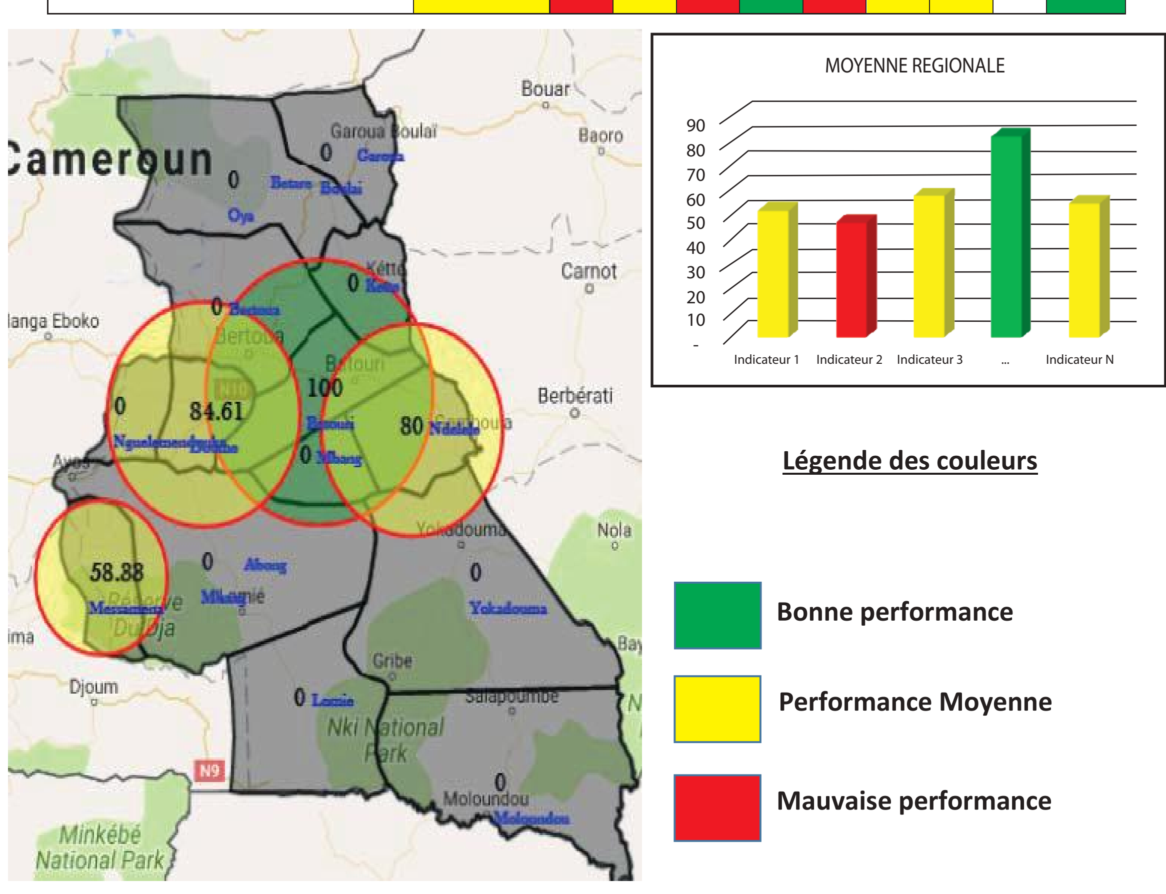


INDICATEUR	MOYENNE NATIONALE	AD	ES	CE	LI	EN	NO	NW	OU	SU	SW
Indicateur 1	69	100	67	100	33	50	87	89	75	20	67
Indicateur 2	55	10	90	10	80	50	81	82	70	12	67
Indicateur 3	34	40	60	50	60	50	10	25	10	15	20
…	46	60	35	25	20	50	87	30	60	70	25
Indicateur N	81	90	85	100	40	50	87	90	100	75	94

APPENDIX 5: IMEP dashboard at the intermediate level



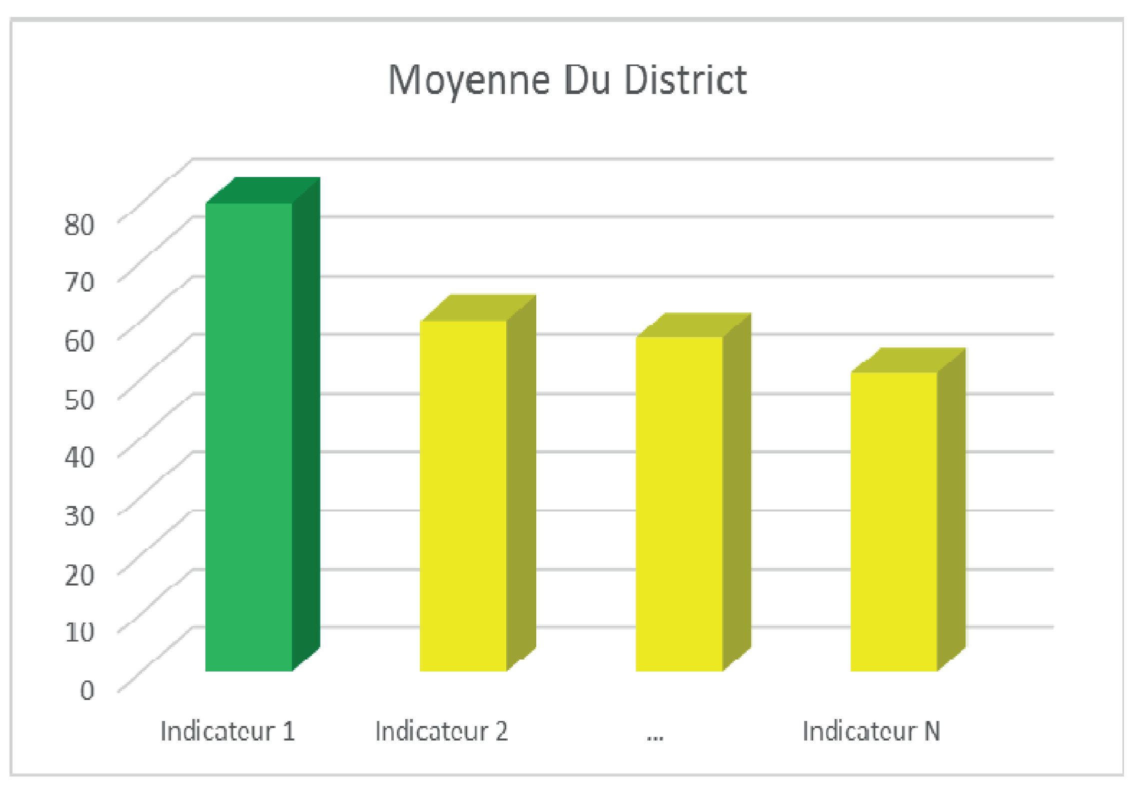
INDICATEUR	Moyenne Régionale	DS1	DS2	DS3	DS4	DS5	DS6	DS7	. . .	DS N
Indicateur 1	52	10	25	35	45	100	10	100		90
Indicateur 2	47	0	10	100	55	30	30	95		55
Indicateur 3	58	20	35	80	80	90	20	98		40
…	82	100	80	90	90	80	50	66		100
Indicateur N	55	40	55	20	100	20	68	55		80



APPENDIX 6: IMEP dashboard at the operational level

REPUBLIQUE DU CAMEROUN
MINISTERE DE LA SANTE PUBLIQUE
SUIVI DES PROGRES DU PLAN NATIONAL DE DEVELOPPEMENT SANITAIRE (PNDS 2016- 2020)
TABLEAU DE BORD *Année N*
Niveau Opérationnel

INDICATEUR	Moyenne Du District	FOSA 1	FOSA 2	FOSA 3	FOSA 4	…	FOSA N
Indicateur 1		100	10	90	100		100
Indicateur 2		50	20	50	90		90
…		20	50	50	85		80
Indicateur N		0	100	20	35		100



Légende des couleurs

APPENDIX 7: CONSTRUCTION METHODOLOGY OF THE SATISFACTION INDEX [3]

Multiple Correspondence Analysis

The aim of the MCA is to study the existing associations between the various criteria of the variables or to look for groups of individuals that look alike in a given metric. This method exclusively uses categorical variables and falls within the set of factor analysis methods. It is a combination of two other factor analysis methods: Factor Analysis of Correspondences (FAC) and Principal Component Analysis (PCA). A FAC is performed on the Burt table (from the complete disjunctive table) and two PCAs are performed on the marginal profiles columns and marginal profiles rows of this table. These profiles, from the FAC, are characterized by their factorial coordinates.

The interpretation tools in MCA are the quality of representation of an individual or variable point (assessed by the square cosine) and the contribution of a point to the formation of a factorial axis. An individual or variable point that has a square cosine “close” to zero along a factorial axis is very poorly represented by this axis and well represented if the cos2 is “close” to one. The relative contribution of a point to the formation of an axis is the part of the inertia of this axis explained by the point. The clarity of the factor analysis is improved by adding points with a “strong” contribution. Factorial coordinates are data which define the position of the points projected on the plan generated by the factorial axes.

Construction of the indicator

The construction of the indicator of satisfaction of beneficiaries of health services is based on a multidimensional approach and aims at defining a composite indicator for each beneficiary of the sample. A preliminary MCA is carried out and at the end of this, variables with a “poor” quality of representation are recoded while individuals are in extra. The final variables contributing to the construction of the indicator are thus selected. A final MCA is performed to obtain the weighting coefficients that are the scores standardized on the first factorial axis.

The functional form of the indicator for a beneficiary b is defined as follows: $I_b = \frac{\sum_{k=1}^{K} \sum_{j=1}^{J_k} w_{jk}^{b} s_{jk}^{b}}{K}$

where W_{jk}^{b} is the weighting coefficient of the modality j and the variable k for beneficiary b, that is, the value of the score (coordinate) obtained in the MCA and standardized by the first proper value; the indicator of the modality j of the variable k for the beneficiary b and **K** the number of the categorical indicator (variables). After obtaining the coordinates of the individual points on the factorial axes after the application of the MCA, a Hierarchical Ascending Classification (HAC) is performed on the individuals with all the factorial coordinates.

HAC is a technique that aims at classifying individuals on the basis of a number of resemblances so that two individuals belonging to the same class regroup at most and differ from two others belonging to two different classes.

[3]Survey on monitoring public expenditure and the level of satisfaction of beneficiaries in the education and health sectors in Cameroon (PETS2)

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World Health Organization
unicef
UNFPA
United Nations Population Fund
CLINTON
HEALTH ACCESS
INITIATIVE