Gender equity in health sector budgeting: Cameroon

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February 2020

Acknowledgements Our sincere thanks to Maria REESE (Sector Program Good Financial Governance, GIZ), Josselin GUILLEBERT (Point Focal P4H, Sector Program Universal Health Coverage, GIZ Cameroon) and Sebastian Silva LEANDER (Economist) for the time devoted to the preparation and coordination of this mission. Our thanks also to all the people we met in Yaoundé during technical interviews and during the workshops to launch and validate the study.

We particularly express our gratitude to the authorities of the Ministries of Finance and Health for their involvement and that of their teams in carrying out this EBT analysis.

Analyses, interpretations and conclusions, as well as possible errors, remain the sole responsibility of the authors.

TABLE OF CONTENTS

FIGURES

TABLES

LIST OF ABBREVIATIONS

AHC	Area Health Committee
AIDS	Acquired Immunodeficiency Syndrome
Amo	Compulsory health insurance
ANRP	National Pharmaceutical Regulatory Agency
APP	Administration Performance Project
APR	Annual Performance Report
ARV	Antiretrovirals
CA	Commitment authorization
CD	Communicable disease
CHS	Cameroonian Household Survey
CP-SFS	Health Financing Strategy Steering and Monitoring Committee
CSO	Organization of the Civil Society
CTAA	Central Treasury Accounting Agency
DFRW	Directorate of Financial Resources and Wealth
DH	District Hospital
DHC	District Health Committee
DHS	Demographic and Health Survey
DHS	District Health Service
DOHCT	Directorate of the Organization of Health Care and Technology
DTU	Decentralized Territorial Units.
EBT	Equity Budgeting Tool
EMCCA	Economic and Monetary Community of Central African States
EPI	Extended Vaccination Program
EXFU	External funding
Fcfa	Franc of the Financial Community in Africa
FDA	French Development Agency
Fosa	Health training
FRPS	Regional Fund for Health Promotion
Fs	Health training
Gavi	Global Alliance for Vaccine and Immunization
GDB	General Directorate of Budget
Gf	Global Fund
Gfp	Public Finance Management
GIZ	Deutsche Gesellschaft for Internationale Zusammenarbeit GmbH
GJSD	Growth and Jobs Strategy Document
GTN-SFS	National Technical Group in charge of the development of the Health Financing Strategy
GTP	General Treasurer Payor
HDI	Human Development Indexes
HFS	Health Funding Strategy
HFSD	Health Financing Strategy Document
HHR	Health Human Resources
HIV	Human Immunodeficiency Virus
HIV/AIDS	Immuno-Deficiency Acquired Syndrome
HSS	Health Sectoral Strategy
HSSC	Health Strategy Steering Committee
IHC	Integrated Health Centre
IMCI	Integrated Management of Childhood Illnesses
IMF	International Monetary Fund

IMPACT	International Medical Product Anti-Counterfeit Taskforce
IPW	Indigent and Vulnerable People
KfW	Kreditanstalt fer Wiederaufbau
LANACOME	National Laboratory for the Quality Control of Drugs and Valuation
MDG	Millennium Development Goals
MICS	Multiple Indicators Cluster Survey
MILDA	Long lasting insecticide treated mosquito net
MINEPAT	Ministry of Economy, Planning and Regional Development
MINPROFF	Ministry of Women and Family Promotion
MOF	Ministry of Finance
MOH	Ministry of Health
MTEF	Medium Term Expenditure Framework
NA	National Assembly
NACC	National Aids Control Committee
NEDPC	National Essential Drug Procurement Centre
NEDSS	National Essential Drug Supply System
NGO	Non-governmental organization
NHA	National Health Accounts
NHIS	National Health Information System
NHO	National Health Observatory
NIS	National Institute of Statistics
NRS	National Revenue Summary
NTD	Non-Transmissible disease
ONAPHARM	National Pharmaceutical Office
ONEEC	Obstetrical and Neonatal Emergency Essential Care
PAE	Public Administrative Establishment
PBF	Performance Based Financing
PC	Payment credit
PETS	Public Expenditures Tracking Survey
PHS	Public Health Service
PIB	Public Investment Budget
PLHIV	People living with HIV
PMO	Prime Minister's Office
PPBS	Planning, Programming, Budgeting and monitoring
PRPSS	Health System Performance Enhancer Project
RPHD	Regional Public Health Delegation
RPSC	Regional Pharmaceutical Supply Centre
SA	Settlement Act
SC/TS-HSS	Steering Committee of the Technical Secretariat of the Health Sector Strategy
SMA	Subdivision Medical Center
STI	Sexually Transmissible Infection
TFP	Technical and Financial Partner
TOR	Terms of Reference
UHC	Universal Health Coverage
Unfpa	United Nations Food and Population Fund
VAT	Tetanus vaccine
WB	World Bank
WHO	World Health Organization

EXECUTIVE SUMMARY

This report focuses on the assessment of budgetary equity in Cameroon. It is an application of the Equity Budgeting Tool (EBT) methodology developed in 2018 by the GIZ (Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ) GmbH), on behalf of the Ministry of Economic Cooperation and Development of the Federal Republic of Germany .

It emerges from the evaluation of gender equity in the health sector in Cameroon that the main challenge of the country is to translate into reality, therefore the results, its proactive policy in favor of gender in the health sector. This requires the ability to draw up a budget in accordance with the MTEF (Medium Term Expenditure Framework) and to faithfully execute this budget.

Summary of evaluation:

The following table illustrates the results of the evaluation:

	Questions	Assessment
I - BUDGET RESULTS		
1 -	Is access to health care equitable?	
2 -	Are there financial, cultural, physical barriers or other barriers that prevent women from accessing health services?	
3 -	Is the allocation of funds proportional to the needs and/or cost of specific interventions?	
4 -	Is public health spending currently at least as much for interventions specific to poor women and other most marginalized groups?	
5 -	Would women win or lose if public spending were reallocated to different interventions and/or to different parts of the country?	
6 -	Do public spending help reduce income inequality?	
7 -	Are there more cost-effective ways to achieve the same results?	
II - BUDGET PROCESSES		
1. Policy development and planning	Is gender equity clearly stated in the National Plan for Economic and Social Development?	
	Is fairness clearly stated in Sector Strategic Plans?	
	Is the necessary data available to inform planning? Are they used?	
	Are NGOs and CSOs that represent the rights of the most vulnerable involved in this stage of the process?	
2. Preparing and approving the budget	Is Gender equity clearly set out in the budget formulation guidelines (i.e., the President's Circular on the preparation of the state budget)?	
	Are sectoral departmental budgets prepared for sectoral objectives and performance indicators?	
	Is there information on gender equity considerations in the Finance Act and the ancillary documents presented to Parliament?	
	Is budget documentation available to citizens?	

	Questions	Assessment
	Are health programs or projects systematically evaluated with gender equity considerations? How are they selected to be included in the budget?	
	Are NGOs and CSOs that represent the rights of the most vulnerable involved in this stage of the process?	
3. Budget execution	Is the budget delivered in accordance with the budget approved by Parliament?	
	Are budget disbursements and executions recorded in the government's financial management information system? What is their level of disintegration?	
	Do budget transfers or budget changes during the year take gender equity into account in the health sector? Do they protect expenses from gender-friendly activities?	
	Are NGOs and CSOs the rights of the most vulnerable involved in this stage of the process?	
4. Monitoring and evaluation	Do budget implementation reports include gender equity measures? Are there any indicators of gender fiscal performance?	
	Are there external evaluations and analyses of ministry of health budget expenditures? Do they include gender equity indicators?	
	How do monitoring and evaluation reports influence future budget decisions? Are some programs cancelled or modified based on the results achieved for disadvantaged groups?	
	Are NGOs and CSOs that represent the rights of the most vulnerable involved in this stage of the process?	
	How is civil society involved in promoting budget transparency and performance?	

RECOMMENDATIONS

At the end of the mission on the analysis of health equity using the Equity Budgeting Tool (EBT), a set of concerns emerges leading to the following key recommendations. The monitoring of the implementation of these recommendations must be brought by the Ministry of Health to a level of responsibility sufficient to act on all of the services. The General Secretariat could be this relevant level.

EQUITY AND GOVERNANCE

Recommendation N° 1. Incorporate health equity concerns into key surveys in the country, including EDS[1], MICS[2], the Household Standard of Living Survey, and any other statistical surveys that may provide information on the issue, even if only partially (road safety, prisoners, ... for example).

Recommendation N° 2. Promote and disseminate the results of health equity research.

[1] EDS: Enquête démographique et de santé
[2] MICS: Multiple Indicators Cluster Survey

Recommendation N° 3. Produce a statistical directory on social gradients in health.

Recommendation N° 4. Simplify budgetary procedures that promote the fight against inequity as much as possible.

Recommendation N° 5. Put in place permanent control systems to reduce the loss of resources allocated to the reduction of inequities.

Recommendation N° 6. Modernize the essential drug and consumables supply system through more efficient procedures and computer systems that ensure traceability.

Recommendation N° 7. Train the stakeholders in the budget chain, those in the delivery of care and those in the production of decision-making information to integrate equity into their daily habits.

HEALTH POLICY THROUGH THE PRISM OF EQUITY, HOW TO TURN THE STRATEGY INTO CONCRETE FACTS

Recommendation N° 8. The political and strategic will expressed in the programmatic documents must be translated into concrete actions on the fight against health inequities and inequalities throughout the sector and at all levels of the health pyramid.

Recommendation N° 9. Thematic strategic plans and operational action plans must clearly reflect the consideration of equity in the country's health policy.

Recommendation N° 10. The Ministry of Health must take leadership on the promotion and implementation of equity in all public policies. This requires reducing leadership conflicts over health equity, harmful extra-national influence, and divergences in the economic and political interests of health actors.

Recommendation N° 11. The Ministry of Health must take the opportunity of using this study and its policy documents to accelerate the implementation of its equity policy.

EQUITY FUNDING

Recommendation N° 12. Provide and share detailed data on health equity funding. This recommendation involves both national actors and Cameroon's international technical and financial partners.

Recommendation N° 13. Include health equity concerns at all stages of the national budget dialogue.

Recommendation N° 14. Lead a national and international advocacy for the financing of health equity.

Recommendation N° 15. It is important that the country has a coherent funding framework such as COMPACT in order to reduce health inequalities.

Recommendation N° 16. The government must legislate on the mobilization of additional resources to reduce health inequities and inequalities through the taxation of certain economic sectors or the taxation of certain activities where the phenomenon of “free riders”is proven.

HEALTH EQUITY: A COMMUNITY CONCERN

Recommendation N° 17. Put the reduction of health inequity on the agenda of civil society, employers' and media organizations and incorporate these issues into the agenda of the work of the platforms for exchange between the state and the community.

Recommendation N° 18. Rely on family solidarity to develop mechanisms for pooling resources at the community level to improve the use of health services and better address inequities.

1. Context and justification

This report focuses on the analysis of budgetary equity in Cameroon. It is an application of the EBT (Equity Budgeting Tool) methodology developed in 2018 by the GIZ, on behalf of the Ministry for Economic Cooperation and Development of the Federal Republic of Germany. The methodology has been successfully piloted in Burkina Faso in April 2018.

2. Defining key concepts

The terms of reference in this study show that two concepts emerge as fundamentals, the clarification of which will improve the common understanding that should be the basis of this report. These are the concepts of equity and gender.

Health equity

"Health equity means that all people in all social groups have the same opportunities to achieve optimal health without being disadvantaged because of their social, economic, environmental and cultural conditions" (CCNDS[3] , 2015).

Equity "Refers to the characterization for each society of differences that are socially acceptable, taking into account values and living conditions" (Potvin et al., 2010).

Equity is an ethical principle closely linked to human rights and the pursuit of social justice, since the lack of political, social or economic power is a common feature of all groups facing social inequalities in health (REFIPS [4], 2017).

In the Equity Budgeting Tool's user guide, C. Picanyol and S. Silva-Leander (2018) suggest that pursuing fairness means addressing any difference that could lead to injustice. To link budgeting to fair outcomes, they organize equity analysis around four dimensions:

Economic: income-related;

Human: the social dimension (education, health, etc.);

Politics: accountability, political participation;

Sociocultural: social status, dignity

Protective: insecurity and vulnerability

In light of this structuring and taking into account the other perceptions of equity presented above we will analyze equity in the health budget in Cameroon.

Gender

The concept of "gender" is better understood in policy when associated with the term "approach." The "gender approach" is therefore the set of opportunities offered to men and women, the roles assigned to them socially and the relationships that exist between them.

In view of the international community's treatment of the concept of "gender", it is clear that it is aimed at promoting women's rights (World Conference on Human Rights in Vienna in 1993), women's power (Conference International Population and Development In Cairo in 1994), strengthening the

[3] NCCDS: National Health Determinants Collaboration Centre (Canada)
[4] Francophone International Network for Health Promotion

status of women and the active participation of women in all spheres of life (World Conference on Women in Beijing, 1995).

In view of the above, we will be looking at gender equity in the health budget to analyze the consideration of women (female human beings) in health policies.

3. Methodological approach

To produce the results sought in this study, we adopted a qualitative method in three phases: data collection, data analysis and data validation.

The data collected are qualitative and quantitative. The collection tools were interviews, documents, and observations.

The interviews were semi-direct on the basis of the guides developed according to the respective interlocutor and the depth of the information available. The documents covered in this study cover legal frameworks, public policy programming documents, budget frameworks, specific studies, technical reports, and national surveys. Each of these documents allowed us to have primary or secondary data. Secondary data were processed to support analyses and interpretations.

The "mirror effect"[5] was usedduring the launch and restitution meetings.

During the launch meeting, it was discussed to collect the perceptions of the actors on the purpose of the research on the basis of the terms of reference. These perceptions helped to define the scope of the study and to define the field of research.

During the validation workshop, by presenting the preliminary results, the participants could react in order to readjust the findings.

For this report, the analysis focused on gender equity, and therefore women's equity, in the health sector in Cameroon. The aim was to analyze the extent to which equity considerations are reflected in Cameroon's public budget for the health sector and how public spending on health affects various aspects of equity, particularly gender, in the health sector in Cameroon, using the equity budgeting tool. Cameroon's a gender-based national policy that was determined through the Multi-Sector Action Plan for the Implementation of Gender National Policy simplified the analysis.

For the drafting of this report, the authors first of all relied on the EBT Guidelines published by the GIZ in September 2018 and the various documents and reports produced during the Burkina Faso test analysis. Then the various strategy, planning, implementation and monitoring and evaluation documents for budgeting in the health sector in Cameroon were analyzed. A two-week mission to Yaoundé (January 13-24, 2020) met with key experts in the analysis, completed the collection of documents and organized and held the validation workshop with key stakeholders on the first findings of the analysis.

The report proposes a set of basic questions that analyze budget results and each step of the budget process. Thereby, areas that need to be strengthened are identified. In addition to an explanatory narrative for each question, the *"traffic lights"* system characterizing the repsonses by their degree of contributing to improving equity:

- **Green:** Budgetary processes and decisions take fairness into account;

[5] « The mirror effect is an analysis of the content of interviews, based on the expression of the company's actors, which allows them to present an image of their expressions in order to obtain validation, invalidation, enrichment or results. » N. Krief and V Zardet, *A quality data analysis and research-intervention,* SEOR "Management Science Research", *2013, 2 No. 95 pages 211 to 237.*

- **Orange:** Budgetary processes and decisions partially take equity into account;
- **Red:** There are no fairness considerations in the budget or budget processes and decisions.

4. Report plan

The report is structured in two parts:

Part 1 presents the results of the analysis of outcomes in the health sector.

Part 2 examines how gender equity considerations are integrated into the health sector budget process.

This report aims to provide decision makers and practitioners in Cameroon with an overview of gender equity in the health sector both in terms of budgetary outcomes and in the budget process itself. It also provides practitioners with a self-analysis tool that they can use in other sectors, for other population segments or for other specific parameters such as geographic location.

I. OUTCOMES

This part of the study presents the outcomes achieved through the public health policies implemented, crossed with the financing strategies used by the country. More specifically, it is a question of analyzing:

- Fair use of health services;
- Fair access to health services and care;
- Health funding through: efficient allocation of resources to vulnerable people, equity in funding, policy direction of funding and efficiency in resource consumption;
- Reducing inequalities in the health care system.

The main sources of information used in this study include national surveys, strategic planning documents, technical reports, and various studies.[6,7,8]

Overall, the analysis of health outcomes shows an average intake of health equity. Indeed, of the seven aspects examined five are orange, two red and none green. This is on the one hand mainly due to the fact that there is a disconnect between the policy options and the operational framework for implementing them. On the other hand, the lack of an information system on the analysis of health equity could be an explanatory factor in this situation.

1. USE OF HEALTH SERVICES

Key questions	Justifications	Color
Is access to health care equitable?	Access to people's health care is generally equitable. The limiting factors to access are partly attributable to the health system, which is open to taking care of men and women for specific or common interventions. Otherwise, the focus of the technical work of the operational level health facilities and the first reference based mainly on women-specific services.	

There are no specific legislative, regulatory or organizational provisions to limit inequitable access to health care between women and men. A review of some coverage indicators confirms that women and men have equitable access to health care.

Example (EDS 2019):

- Proportion of children aged 12 to 23 months who received all appropriate vaccines: 40.8% for boys and 42.3% for girls.
- Proportion of children aged 12 to 23 months who received no vaccine: 8.5% boys and 11% girls;

[6] EDS, MICS, etc.
[7] Health Sector Strategies, National Health Development Plan, The multi-sector plan for implementing gender policy, National Strategic Plan for Reproductive Health, Neonatal and Infant Kindergarten Etc.
[8] GFF Invest Case, Health Funding Study, etc.

- Coverage rate for HIV/AIDS testing: 94% for men and 93% for women;
- Prevalence of AIDS aged 15-49: 1.9% for men and 3.4% for women

It should be noted that most interventions do not collect or consolidate information on the use and coverage of health services by gender, which in this case limits the analysis of health equity.

For the interventions presented here, the difference in use and coverage between men and women is similar to the demographic structure of the country. Indeed, according to the 4th census of the population published in 2010, the population of Cameroon is 51% female and 49% men, which justifies the differences in accessibility indicators and confirms the equity analyzed by gender.

It is also relevant to analyze actual coverage on women-specific benefits. To this end, the DHS-MICS 2011 ((DHS: Demographic Health Survey; MICS: Multi Indicators Cluster Survey) presents the following results:

- 84.7% of women use NPCs (Prenatal Consultations): 95.6% of women in urban areas compared to 75% in rural areas, 87.8% for Adamaoua, 59% for the Far North, and 71.1% for the North in NPC;
- Vaccine coverage for maternal and neonatal tetanus is 59% for TV2 (Tetanus vaccine);
- 26% of pregnant women received at least two doses of Intermittent Preventive Treatment (IPT) for malaria and 41% of pregnant women sleep on MILDA (ECP-MILDA 2013, INS 2013), up from 17% in 2011 (DHS-MICS 2011, NIS 2012);
- On average 63.6% of children are delivered by a health worker;
- The percentage of women who have given birth in a health service is 61.2%.

Including:

- Adamaoua: 66.9% (compared to 34% in 2004),
- Far North: 76.9% (compared to 25% in 2004),
- 54.2% (compared to 21% in 2004).

While most of the barriers to access to care can be attributed to society (culture, poverty, etc.), it should be noted that the health system alone could improve these indicators, through communication actions more specific to the environments and better use of the financial resources allocated to these areas.

Interviews with the various stakeholders concerned show that the most deprived areas have, in recent decades, received significant funding to reverse the trend. Unfortunately, the expected results have not been achieved. Some stakeholders believe that the governance of the health system should be questioned in order to better understand the situation.

The application of the "EQUIST" (Equitable Impact Sensitive Tool) tool in the Cameroonian health system as part of the development of the GFF (Global Financing Facility) Invest Case 2017-2020 summarizes, as shown in the diagram below, women's access to health care and services in Cameroon.

Tableau 1. Analysis of reproductive health bottlenecks

Analyse des goulotsd'étranglement	Sévérité moins élevée					Sévérité élevée
	Disponibilité	Accessibilité physique	Accessibilité financière	Acceptabilité	Continuité	Qualité
Nutrition et soins du nouveau-né et enfants	17	67	64,9	67,13	60,7	16
Planning familial	30,66	15	64,9	56,13	57,6	27
Soins Anténatals	0	16	17,5	9,74	38,6	41
Immunisation plus	0	15	0	56,22	23,8	42
Accouchement par personnel qualifié	22,28	14	17,2	33,3	9,75	55
Prise en charge intégré des maladies de l'enfance (PCIME)	14,16	15	64	17,6	42,2	5,8
Soins Obstétricaux et Néonataux d'urgence (SONU)	89,71	89	58,7	18,46	62,1	0

Source: GFF Invest 2017-2020

Table 1 provides information on the main bottlenecks in the use of women-specific health services. If we consider only assisted delivery, it is clear that significant efforts must be made on all the criteria chosen by this study.

These data also confirm that the health system will be able to improve its budgetary performance by improving service delivery on a few women-specific interventions.

2. BARRIERS TO ACCESS TO HEALTH CARE

Key questions	Justification	Color
Are there financial, cultural, physical barriers or other barriers that prevent women from accessing health services?	Many barriers to women's access to health care and services remain. However, it has been noted that the country is willing to deal with this, including the development of specific initiatives, including the "Health Check", the PBF (Performance-Based Financing) and regulations facilitating the mobilization of funds for the benefit of women-specific interventions.	

The limiting factors of women's access to health care are endogenous and exogenous.

Internally within the health system, a study on the current state of maternal and child health conducted as part of the National Strategic Plan for Reproductive Health, Neonatal and Infantile Maternal (NSPS/SRMNI) 2014-2020, has identified a set of bottlenecks that can be summed up around poor

governance of the health system. These do not concern specific interventions dedicated to women but to the entire Cameroonian health system. These include:

- legal and institutional framework;
- the provision of care;
- on demand for services;
- governance of the system.

1. The legal and institutional framework

The legal and institutional framework for the protection of women's rights is still under construction. The multi-sector plan for the implementation of gender policy included the internalization of international conventions and protocols in the field. These include: the revision of the Penal Code and the Civil Code to better take gender into account and the development of a law on parity. Finalizing this legal framework with consideration of health concerns could address a range of specific women's health issues. It should be noted, however, that the work related to this is lacking in coordination between the Ministry of Women and Family Promotion and the Ministry of Public Health[9]. Indeed, there is no framework for coordination between the two ministries that would evolve regulations to improve health equity.

On the public health side, areas have been identified in which legislation should be legislated to improve women's access to health care. These include legislating on levirate, sororate, the right to caesarean section and other emerging concerns that may expose women to diseases or limit their access to health care.[10,11]

Otherwise, the regulatory framework within the health system would benefit from moving towards better coordination of health activities. Indeed, the legal vacuum existing with regard to referral concerning childbirths limits women's access to health care. This is precisely the case when a woman who needs a caesarean must be referred to a higher level health facility.

2. Barriers to the supply of care

- **The availability of inputs**

About of input management, there are many malfunctions in the supply chain of drugs and other medical supplies.. This situation undermines the policy of free and subsidy implemented by the government. The example of the "Health Check" project is sufficiently illustrative in this respect. Indeed, supposed to improve women's access to reproductive health care, this project is regularly compromised by shortages of input stocks.

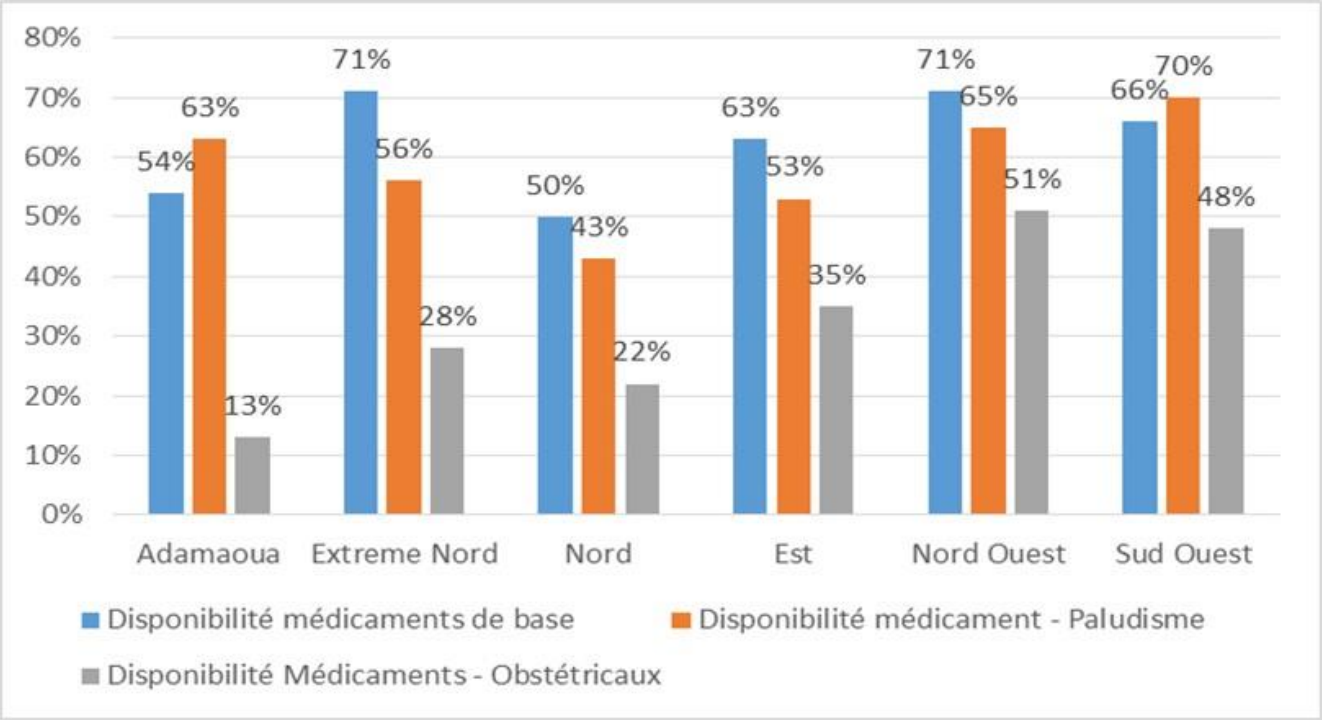
The current situation carried out in the context of the development of the GFF investment case for reproductive health, health of the mother of the newborn, child and adolescent in Cameroon for the period 2017-2020 shows in particular that the weakness in stock management, communication systems between players in the supply network (NEDPC , RHPF, HF...) and the high dependence of the health system on financing partners help to worsen stockshortages[12,13,14,15], mainly due to the generally very long time frames for mobilizing resources. .

[9] Convention on the Elimination of All Forms of Discrimination Against Women, Maputo Protocol, etc.
[10] Levirate: woman marries her late husband's brother
[11] Sororate: marriage between a man with his wife's sister
[12] NEDPC : National Essential Drug Procurement Centre
[13] RHPF: Regional Health Promotion Fund
[14] HF: Health facility
[15] Cameroon GFF Investment Case 2017-2020, page 50

This concern about breakdown of input is also raised in other initiatives such as the Performance Based Financing (PBF) [16]. Indeed, the disruption of inputs in the health facilities visited by the PBF experts is at the forefront of the concerns.

The diagram below illustrates this situation

Figure 1. Availability of Drugs

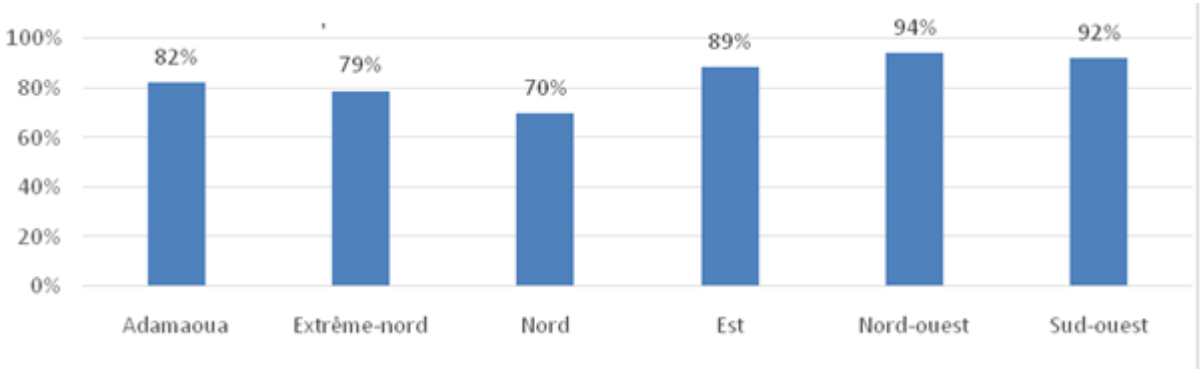


Source: GFF investment *case 2017-2020*

- **Availability of basic equipment in health facilities**

According to a WHO study in some parts of the country, the level of equipment for basic reproductive health facilities is satisfactory, with varying levels depending on the region. The Northwest and Southwest regions have a material availability index of more than 90% while it is 70% in the North.

Figure 2. Availability of basic equipment in health facilities



Source: Service Availability and Readiness Assessment (SARA), by WHO

- **Human Resources (HR)**

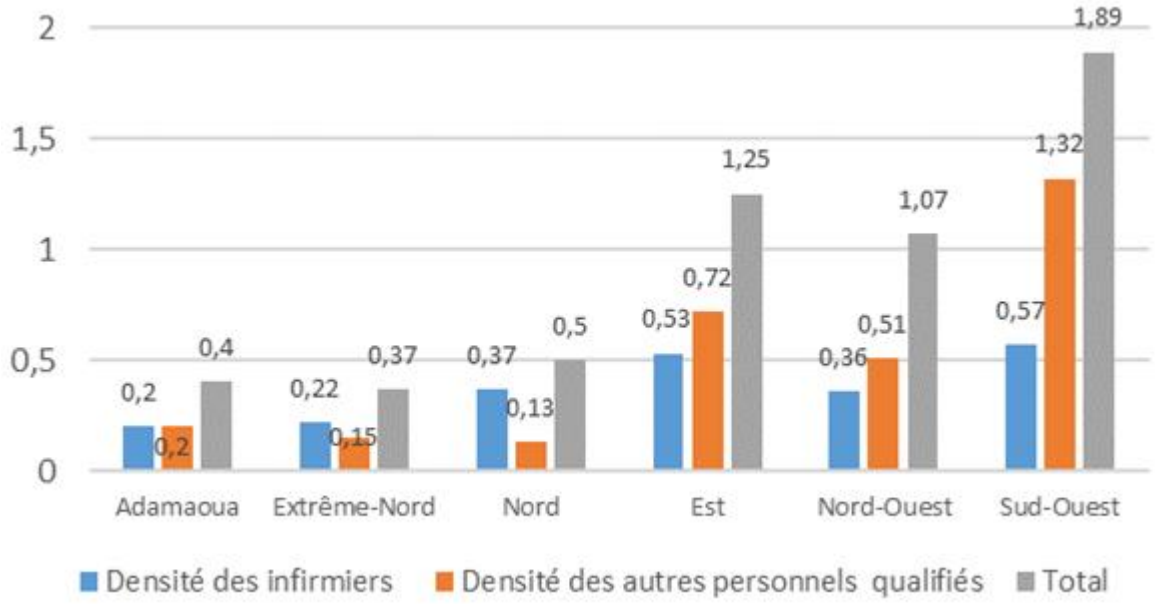
Cameroon's health care system in general suffers from a lack of quality human resources. Brain drain, recruitment policy, level of wage attractiveness, working conditions are the main factors limiting the mobilization of quality HR. As a result, women's health suffers.

[16] (Report on the 67th course on the PBF, Douala 2018).

Indeed, the closure of the training schools of Nurses Graduate Babies (Midwives) by the government between 1987 and 2011 led to a serious shortage of staff for qualified assistance during childbirth. Only 167 Midwives and related persons were registered across the country in 2011, with an estimated need of about 5400 (United Nations Population Fund, 2011). In addition, these personnel are very unevenly distributed throughout the country. For example, the density of health workers in the Southwest region was almost five times that of the Adamawa and Northern regions, and four times that of the Far North. These imbalances are beginning to be addressed through the implementation of CARMMA (2011-2013) during which it was decided to relaunch the training of midwives. In addition, the implementation of the health human resources development plan, which was developed after the census, made effective the training of midwives and the initiation of training of community health care providers.[17]

The diagram below is particularly representative of the lack of health workers, particularly in terms of the management of women's health.

Figure 3. Density of nurses and other qualified health professionals (per 1000 inhabitants)



Source: Primary Health Care Performance Initiative" (PHCPI 2016)

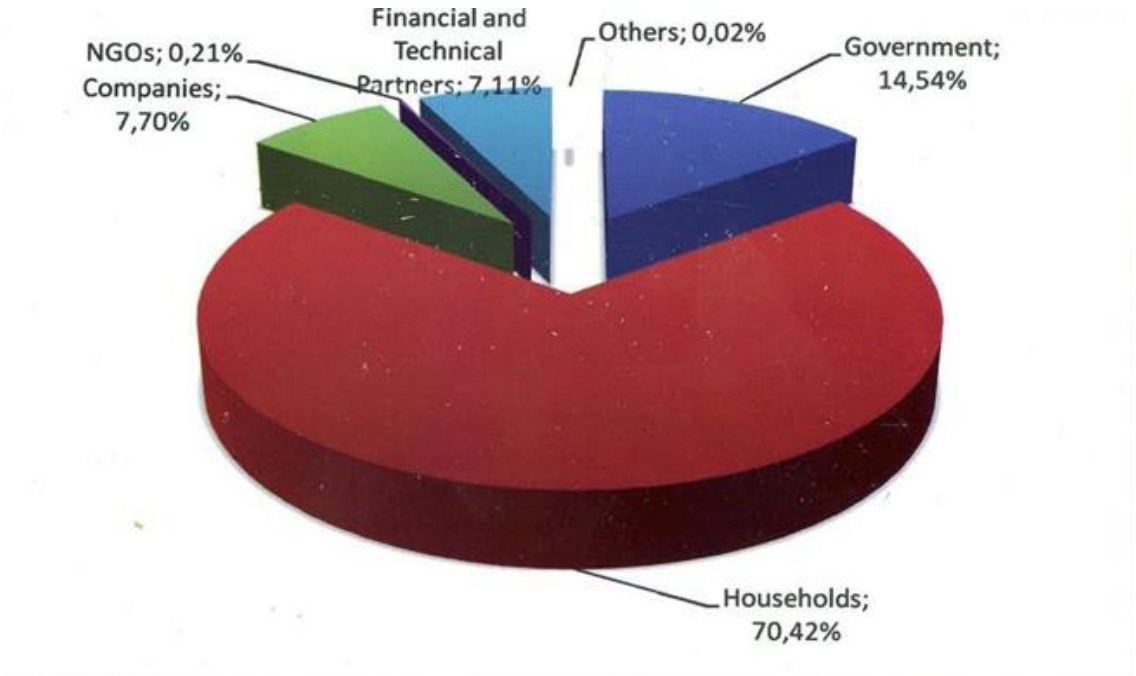
- **Funding**

Despite the measures taken by the government to improve the financial accessibility of health care and services for the population in general, and for women in particular, the bulk of health expenditure (over 70%) [18] is still borne by households.

The diagram below illustrates how the purchase of health interventions still constitutes a barrier to women's access to the health system.

Figure 4. Sources of funding for health spending

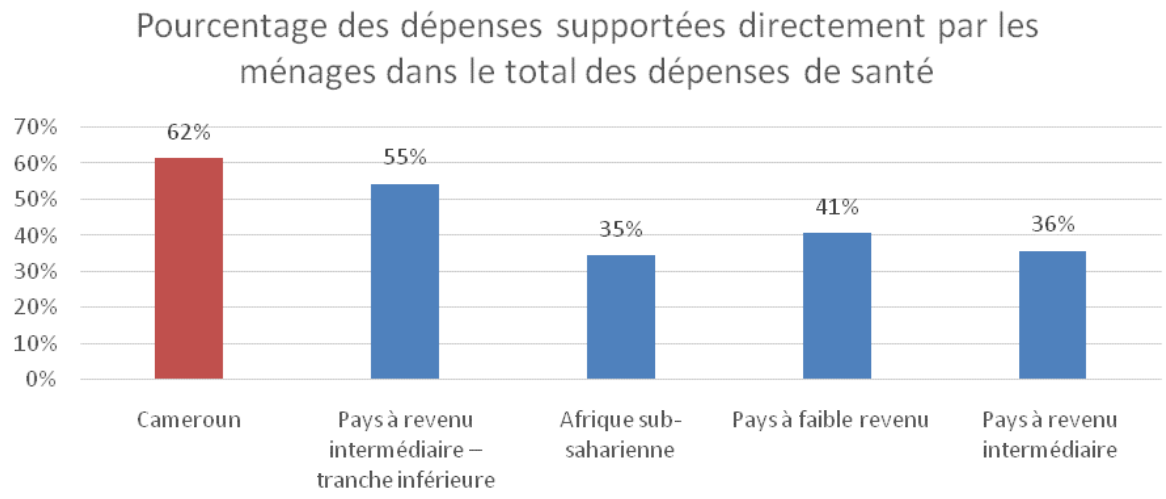
[17] CARMMA: Campaign on Accelerated Reduction of Maternal Mortality in Africa
[18] National Health Accounts Report 2012



Source: 2012 CNS

According to the more reliable data produced by the World Bank, the burden of household health spending is 62%, which is higher than the average for countries with the same level of income.

Figure 5. Percentage of household spending in total health spending



Source: World Bank, World Development Indicators, 2013

There is a glimmer of hope on the horizon for alleviating the difficulties of funding health care by women in particular. In this register, many initiatives have been taken by the Government in recent years. These include:

- The extension of the PBF: to improve efficiency through strategic purchasing, improving health information and upgrading health facilities through greater autonomy;
- The "Health Checks" initiative: for a large subsidy of reproductive health costs;
- The development of the UHC (Universal Health Coverage): for the pooling of resources for the benefit of the poorest.

All of these initiatives are aimed at reducing inequities because they are all geared primarily towards women-specific interventions and helping to improve women's access to health care and service.

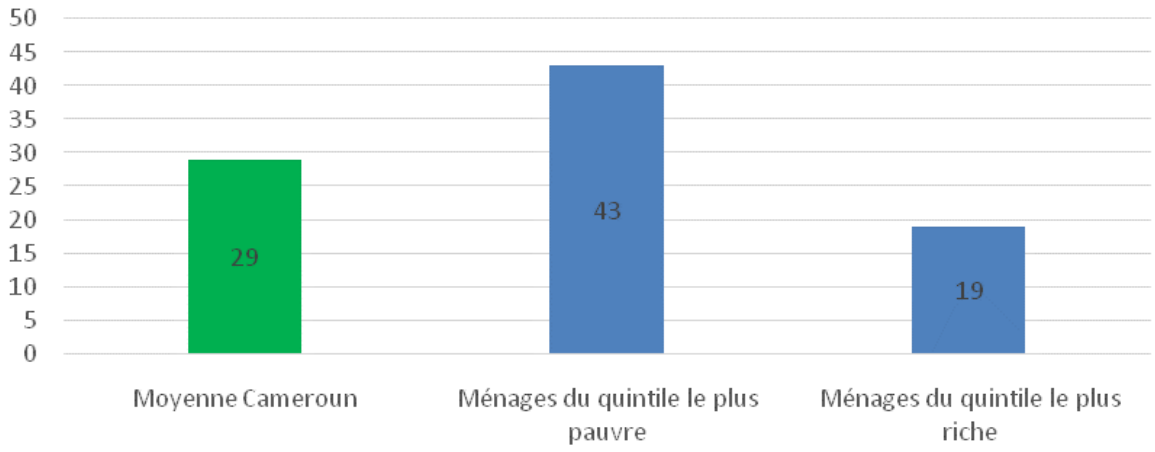
3. Barriers related to demand for service

- **Physical accessibility**

According to a survey conducted by the PBF in 2016 on a part of the national territory, physical access to health facilities is impaired by the remoteness of health facilities (10%) as well as transport-related problems (7.4%). On average, the time to get to the nearest Health facilityis 29 minutes (PHCPI 2016), with huge disparities between regions. While it is only about twenty minutes in the Littoral, it is almost an hour in the southwest. The remoteness of the HF is reported more in the North (17.1%) Adamaoua (9.1%).

The diagram below illustrates the level of physical access to Cameroon's health facilities following the results of CHS 3.

Figure 6. Average time to get to the nearest health center



Source: INS, ECAM 3, 2007

- **Sociocultural barriers**[19]

Certain cultural beliefs and practices are barriers to the use of care. Recent data show, for example, that 22.8% of women who do not use contraception in the Adamawa region cite the opposition of the husband or one third report the family as the reason for their non-use. This proportion is 16.4% in the North and 15.5 in the Far North.

In addition, 4.6% of women who give birth at home do so because they feel it is normal to do so. The North is the region with the highest (5.2%) practice, followed by the Far North (4.5%) and Adamaoua (2.5%).

In addition, 16.2% of women in the Northern Region report that they consult traditional practitioners or take traditional self-medication as their first use of care. They account for 5.6% in the Far North.

4. Administration and governance

- **Management/coordination**

According to the state of play in the development of the SRMRIA 2014-2020 Strategic Plan, [20]three main factors are responsible for the deterioration of the governance of the health system and the quality of women-specific care. These include:

[19] GFF Investment case 2017-2020
[20] SRMIA: Reproductive Health, Kindergarten, Juvenile and Adolescent

- Lack of transparency in the management and accountability of stakeholders;
- the practice of corruption at all levels of the health pyramid; [21]
- poor enforcement of control and discipline mechanisms.

According to the same source, ineffectiveness and inefficiency in the implementation of planned activities at all levels are caused by:

- Inadequate coordination of contributions from various partners at all levels of the health pyramid;
- Inadequate financial resources for coordination of interventions;
- The government's weak leadership in operationalizing action plans;
- Inadequate involvement of key players in the planning and integrated financing of SRMNI's activities.

- **Health information**

Despite recent developments in the health information system with the implementation of DHIS2[22], the production and use of information for decision-making needs remains a major challenge for Cameroon's health system. The level of information disaggregation to facilitate gender analysis in health policy and funding remains very low. Indeed, of the 300 indicators on average that the MRA (Monthly Report of Activities) in basic health facilities and first reference level, only about 26% disintegrate the data into Men/Women. These include indicators on vaccination, HIV/AIDS, malaria and the main causes of consultation, hospitalization and death.

3. EFFICIENT ALLOCATION TO VULNERABLE PEOPLE

Key Questions	Justification	Color
Is the allocation of funds proportional to the needs and/or cost of specific interventions?	The budget structure shows that the allocation of resources takes into account interventions specific to vulnerable groups. However, it is difficult to follow the translation of these wishes displayed in the actual allocation of resources given the quality of the financial information system. Otherwise, resources from external funding, which go to priority interventions, are less visible.	

This issue calls for the efficient allocation of resources, which is a health funding strategy to mitigate the adverse effects of internal competition due to the very nature of health interventions. To address this concern within the framework of Cameroon's health system, we wanted to address it through the prism of funding sources. This is how the analysis focuses on funding from the state budget and external funding.

1. Funding from the state budget

[21] Cameroon's health pyramid includes: central, intermediate and operational level
[22] DHIS: District health Information System Software

Cameroon introduced program-based budgeting in 2013. Since then, in the search for allocative effectiveness as well as the visibility of funding for interventions, the Ministry of Health has had two budget structures.

From 2013 to 2017, the Ministry of Public Health organized its interventions through four programs:

Tableau 2. Structure of the Ministry of Health's budget programs between 2013 and 2016

Program	Action
Mother, child and adolescent health	Improving Maternal Health
	Improving child health
	Adolescent health
Diseases control and Health promotion	Improving the availability of essential drugs, reagents and devices
	Disease prevention and health promotion
	Comprehensive and integrated disease management
	Strengthening the Community system
	Strengthening the fight against malnutrition
Service ability of the Health District	Strengthening human resources
	Improving partnership and developing resources and financing
	Upgrading of 1st, 2nd and 3rd grade health facilities
	Strengthening the provision of services and care
Governance and improved working conditions	Improving the managerial process
	Strengthening ethics, regulating the control of the health sector
	Strategic management of the health sector

While in this structure it is possible to directly identify the resources allocated to women's health through the program's "Mother's Health" action, this information is insufficient because other interventions related to the specificity of women or the construction and equipment of maternity units remained drowned in other programs, in particular, the management of HIV/AIDS in pregnant women (the "Disease control" program), construction and equipment Mother and Child Centre (The Health Program) and disease prevention activities in the disease control program.

Moreover, in this structure, it was difficult to capture the costs of remuneration of staff directly assigned to benefits specifically for women because the information system did not allow the salary budget to be broken down.

Since 2018, the structure of the Budget of the Ministry of Public Health has been changed and is now presented as shown in the table below.

Tableau 3. Structure of the Ministry of Health's budget programs between since 2017

Program	Action
Disease prevention	Malaria prevention
	Prevention of HIV/AIDS, Tuberculosis, STIs and Viral Hepatitis
	Preventing mother-to-child transmission of HIV
	Epidemic Potential Disease Prevention (MAPE)
	Prevention of Chronic Non communicable Diseases (NTM)
	Prevention of Neglected Tropical Diseases (TMD)
	Prevention of other diseases.
Health promotion	Promotion of healthy behaviors
	Strengthening family planning
	Improving people's living environment
	Strengthening community participation
	Promoting adolescent health
Management of illness cases	Implementation of high-impact curative interventions in mothers, newborns, children and adolescents
	Emergency and disaster response
	Management of HIV/AIDS, tuberculosis, STIs and viral hepatitis
	Malaria management
	Management of Chronic Non communicable Diseases (NTM)
	Management of neglected tropical diseases and other diseases
	Infrastructures and Equipment for Health facilities
Governance and institutional support in the health sector	Strategic management of the sector
	Management of drugs, laboratory reagents, medical devices and other pharmaceutical products
	Improving the supply of health care services
	Development of Health Human Resources
	Strengthening of funding for Health and the Partnership
	Development of the health information system and health research
	Internal monitoring and audit of structures

In this new structuring, we can see an increase in actions (26 against 15 for the first structuring), guided by the need to bring more readability to the action of health sector. Otherwise, this new presentation allows, through five actions, to better track funding for women-specific health interventions. These include:

- Malaria prevention: in this action, priority interventions are linked to the prevention of malaria in pregnant women through MILDA (Long-Term Action Mosquito Net) and IPT (Intermittent Preventive Treatment);
- Preventing mother-to-child transmission of HIV;
- Strengthening family planning;
- Youth promotion: here, although interventions for young boys such as drug use remain, the bulk of the resources allocated to this program addresses pregnancy issues.
- Implementation of high-impact curative interventions in mothers, newborns, children and adolescents

Despite this change in the structure of budgetary programs, not all the resources in the State budget for women-specific interventions are traced back to the level of these five actions. In particular, the issue of specific medicines, specific salaries, as well as those of health infrastructure and equipment remain.

2. External financing

The existing information system does not allow for the consolidation and faithful tracing of the financing of technical and financial partners. Only a portion of these are in the Ministry of Health's budget, where they usually appear as global provisions. A closer analysis of the budgets of the various health programs could make this external funding more readable. The World Bank's planned review of reproductive health funding, which is currently under way, is expected to respond.

In the end, efficient allocations of resources to vulnerable people in general and women in particular cannot, as the health funding information system currently stands, be comprehensively traced despite the improvements to the budget structure.

4. FAIR FUNDING FOR HEALTH INTERVENTIONS

Key question	Justification	Color
Is public health spending currently at least as much for interventions specific to poor women and other most marginalized groups?	Analysis of the mapping of health funding in Cameroon shows that interventions specific to vulnerable people (women, children, poor people) are well taken into account. However, the quality of the available data does not allow us to decide on the proportions allocated to each of the population categories respectively.	

Over the past decade, the Cameroonian government, in line with the priorities of the international community, has taken many actions to mobilize more funding for the care of vulnerable people. The most significant of these actions are the PBF and the "Health check".

1. The PBF (Performance-Based Financing)

As part of its cooperation with the World Bank in the field of health, Cameroon has set up a financing mechanism based on the principle of purchasing results called PBF in the northern, far-north and Adamaoua regions which has the worst health performance. This approach aims to improve the availability, quality and financial accessibility of health care. The main interventions focus on maternal and child health.

After achieving satisfying results in the neediest regions, the PBF is being rolled out throughout the country and covers a wider range of services. At its core, financed solely by the resources made available to the country by the World Bank, the PBF is now open to the state's own resources, which in the long run should guarantee its sustainability.

2. The "Health check" project

The "Health Check" project is a mechanism for financing the health of pregnant women and children based on the principle of buying the vouchers. Indeed, through this mechanism, the woman will pay only 6,000 Fcfa (9,15 €)for all obstetric and neonatal care related to a pregnancy; which represents on average 10% of the actual cost of these services.

The Health Check is a component of the Common *Basket* Program set up by the Government of Cameroon in cooperation with France (AFD-C2D) and Germany (KfW). Other components, including

rehabilitation and equipment, also focus on improving the provision of health care for women-specific benefits.

Through these two examples, it can be concluded that the country is orienting its health resources equally for both women and other vulnerable strata as well as for other segments of the population. In the absence of comprehensive data, it is not possible to assess the weight of funding allocated to each segment of the population, particularly women.

5. REORIENTATION OF POLICY OPTIONS

Key questions	Justification	Color
Would women win or lose if public spending were reallocated to different interventions and/or to different parts of the country?	The health information system in general and budgetary in particular does not facilitate a rational referral of funding towards priorities revealed by the health context. Decision-making in this direction is more a matter of managerial instinct.	

In the parts developed below and in the following section devoted to the analysis of the budgetary process, it appears that the political choices made by the country are aimed at providing the best possible response to inequities in the past. However, in order to reduce the gaps between the different segments of the population more significantly, it is important that efficiency (allocative and technical) issues be addressed.

On a constant budget, allocative efficiency is achieved when the combination of physical and human resources funded by this budget produces the most health gains. The aim here is to direct decisions on the allocation of resources to activities that enable the health system to better meet the health needs of the population.

To examine this aspect, we looked at the orientation of resources according to the health context of the country, the populations and regions most in need, as well as very *"cost effective" interventions.*

Concerning accounting for health data in the allocation of resources, a break was noted between strategic planning and budgeting for interventions. In fact, there is no benchmark of unit costs to assess the cost of the objectives pursued. It is certainly true that the malaria control program, the expanded immunization program and the HIV / AIDS control program have the tools to draw up financial programs based on the targets pursued. This approach is not generalized for other health interventions. In addition, the multitude of financial planning and programming tools does not allow a global visibility on the costing of health interventions. We could also note the lack of technical convergence between national planning and programming tools with those of programs and projects funded by external partners (Global Fund and GAVI, for example)

To illustrate this last point, the malaria strategic plan uses the “One health tool” for to perform costing of its interventions. The costs thus obtained are macro in nature since they are obtained using calculations whose main variables are macroeconomic. To take them into account in the national budget, an appropriate variation should be made, based on the diagram of the national budget structure, which is not always done. This logical break, which concerns all the priority programs, penalizes the architecture of the budget information system and deteriorates the quality of decision-making information.

In view of the above, it appears that the decision to redirect funding to other interventions or other intervention areas would effectively enable vulnerable people in general and women in particular, to benefit from better care. However, in the current context of decision-making information in Cameroon, the orientation towards such strategies is more instinctive than rational.

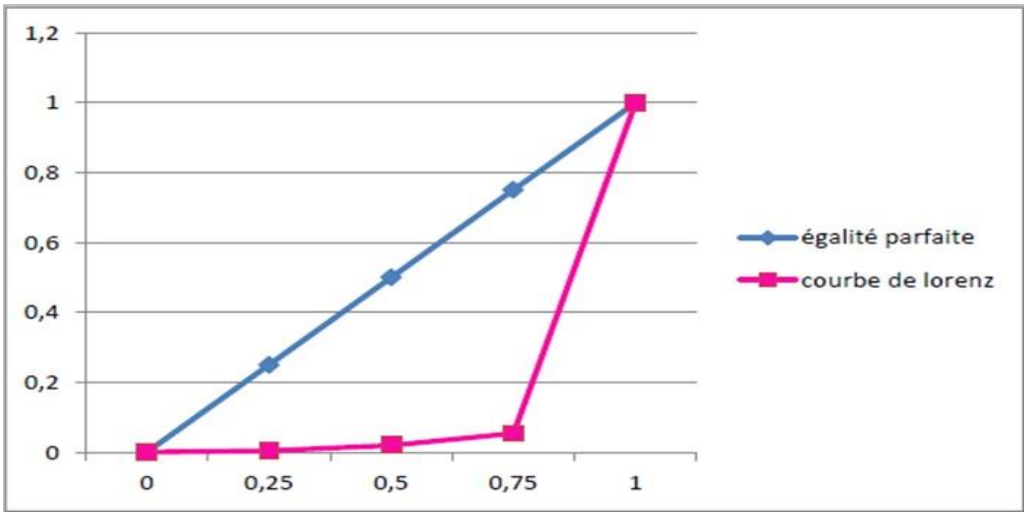
6. REDUCING INEQUALITY

Key questions	Justification	Traffic light
Do public spending help reduce income inequality?	According to the results of the CHS IV survey (2014) the Gini index in Cameroon remains very high (0.44) which does not promote the reduction of inequalities overall. The lack of accurate data makes it impossible to comment on the effects of health financing policies on reducing inequality.	

Inequality is measured by the Gini index, which measures the degree of concentration of consumption. This index varies from zero to one, and the further away it is from zero, the greater the inequality. The Gini index varied in Cameroon from 0.404 in 2001, then 0.39 in 2007 and 0.44 in 2014 or 5 percentage points more in seven years; reflecting a worsening of consumer inequality among the population. This inequality is more pronounced in rural areas than in urban areas. [23]

Inequality is also examined through the distribution of household consumption. The share of consumption of the poorest 20% of the population is declining, from 6.2% to less than 5% between 2001 and 2014. At the same time, it is the wealthiest households that benefit, since the share of the consumption of the 20% of the wealthiest households is 49% in 2014.

Figure 7. Lorenz Curve on Health Equity in Cameroon



[23] ECAM IV 2014

The Lorenz curve, based on data from the CHS III (200), shows that income inequality has indeed increased. If we add the weight of direct payments on health funding, we could conclude that the current model of health care funding does not reduce inequality and thus promote income redistribution.

These data show that subsidies and free measures initiated by the government benefit the richest more than the poorest. The figure below illustrates this very well.

7. EFFICIENCY IN RESOURCE CONSUMPTION

Key questions	Justification	Traffic light
Are there more cost-effective ways to achieve the same results?	By acting on the effectiveness and efficiency of resources allocated to vulnerable people, the country intends to improve health outcomes	

Experience in the implementation of the PBF and the "Cheque santé" project has made it possible to relax budgetary procedures and thus improve the effectiveness of funding for subsidized interventions.

Indeed, the circular on the implementation of the State budget for the 2020 financial year has relaxed the conditions for the release of funds to finance specific interventions for women and the most vulnerable. Thus, the provisions below contribute to this purpose.

259. Performance purchase credits under the PBF are executed by unlocking on the basis of invoices issued monthly by the beneficiary structures and centralized by the PBF Project Management Unit. These invoices are paid quarterly by bank transfer into the accounts of health workers, regional health delegations and health districts.

260. For health workers who do not have access to banking services, their subsidies will be paid into the accounts of the main health facilities with which they have sub-contracts. These funds will be returned to them under the terms of those sub-contracts, in accordance with the provisions of the PBF operational manual. These credits are subject to the IRNC at a rate of 11%.

261. Expenses related to the Health Check are carried out in the process of unlocking on a quarterly basis, against presentation of the expenditure brief by the Regional Health Promotion Funds and an employment account from the previous quarter.

In the same vein, MOH has set up a system for transferring investment credits to DTC, which is mobilized on the basis of the real needs of the land validated by the populations at the base under the coordination of MINEPAT. This approach supports improving the allocative efficiency of resources.

The establishment of the CSU also helps to improve efficiency in the financing of specific interventions.

It remains true, however, that these measures are all new, their effectiveness remains to be demonstrated.

II. BUDGET PROCESS

In this section, we examine whether there are areas in Cameroon's budget process that can be strengthened to contribute to fairer results.

The results are based on:

- The review of the literature, including the National Development Plan (Strategy Document for Growth and Employment (DSCE)," the multi-sector plan for implementing the national gender policy, the 2016-2027 Health Sector Strategy (HSS) and the National Health Development Plan 2016-2020 (NHDP) and the Citizens 'Budget, the President's circular on the preparation of the State budget, the annual budget of the State, the MTEF (Medium Term Expenditure Framework) of the Ministry of Health, the annual budget of the Ministry of Health, the APP of the Ministry of Health, the APR of the Ministry of Health.

- Existing diagnostic documents in Cameroon, including the Assessment of Public Expenditure and Financial Responsibility (PEFA) and the Open Budget Survey (OSR).

- Other reports analyzing the budget process, such as the IMF staff report for the 2018 Article IV consultations and the second review of the IMF Extended Credit Facility agreement;

- Budget data from the BOOST database from 2006 to 2016;

- Interviews with key interlocutors conducted between 13 and 24 March 2020 in Yaoundé and Fada (see appendix to the full list of people we met);

- Self-assessment carried out during the workshop by the participants on January 23, 2018 in Yaoundé. They were asked to comment on the proposed evaluations in order to approve or modify them by providing additional elements.

The analysis follows the questions of the four stages of the budget process listed in the guidelines.

STEP 1: POLICY DEVELOPMENT AND PLANNING

Question	Analysis and sources of information	Assessment
Is gender equity clearly stated in the National Plan for Economic and Social Development?	Gender equity is clearly stated in the Growth and Employment Strategy Document :: • It appears in the human development strategy and is indicators. • Strategic actions plan to reduce maternal mortality by three-quarters, HIV/AIDS prevalence by 50% and reduce the malaria-related death rate to less than 10%. In addition, there is a multi-sector plan for the implementation of the national gender policy (2016-2020) aimed at improving women's access to health services, including reproductive health, specifically: • Reduce the maternal mortality rate by at least 50%; • Reducing the prevalence of HIV and AIDS from 6.8% to 3% among women; • Ensure comprehensive management of infected pregnant women and girls; • Ensure health and nutrition education for women and girls; • Reduce maternal mortality from malaria by one-third; • Improving contraceptive prevalence for women of childbearing age; • Ensure the involvement of men and boys in the management of reproductive health issues and HIV/AIDS/STIs.	

Question	Analysis and sources of information	Assessment
Is fairness clearly stated in Sector Strategic Plans?	The main health sector planning documents, the 2016-2027 Health Sector Strategy (HSS) and the National Health Development Plan 2016-2020 (NHDP), address gender concerns in the health sector expressed in the GJSD. In the HSS, gender equity is reflected in anchoring and strategic concerns, including linking to the SDGs. There are 4 specific targets out of a total of 19 that are in favor of women: • O.S. 1.3. : By 2027, develop promotional activities in at least 80% of HD (Health District) to strengthen the health-promoting skills of individuals and communities. With the female-specific tracer: Increasing the decline in teen pregnancies from 25.2% (MICS5, data 2014) to 14% (2027). • O.S. 1.4. By 2027, get 75% of families to adopt essential family practices, including family planning. With a women-specific tracer: a modern contraceptive prevalence rate that would rise from 21% (MICS5) to 35% (2027). • O.S. 2.3. : By 2027, increase coverage of high-impact prevention interventions by at least 80% for mother, newborn and child targets in at least 80% of HD (Health Districts). With two tracers for women: (1) Increase the percentage of pregnant women who received at least 3 doses of IPT (Intermittent Preventive Treatment) during pregnancy from 26% (MICS5) to 75% (20 27) and (2) increase the percentage of pregnant women infected with HIV and ON ART from 59.3% (NACC Report 2015) to 95% (2027). • O.S. 3.2. By 2027, ensure comprehensive and standard management of maternal, newborn, child and adolescent health problems at the community level and in at least 80% of health facilities. With two gender-specific tracers (1) increasing the rate of skilled birth from 64.7% (MICS5) to 95% in 2027 and (2) the rate of HD with a trained health workforce with the IMCI approach from 32.5% in 2015 to 40% in 2027. These four specific objectives are included in the two planning cycles of HNDP1 (2016-2020) and HNDP2 (2021-2027).	

Question	Analysis and sources of information	Assessment
Is the necessary data available to inform planning? Are they used?	The National Health Information System is developed on the basis of WHO guidelines. It is the basic element of the collection of health information. The Statistical Information Unit produces comprehensive health statistics data (more than 300 indicators) that are more than 80% complete. Their update is fairly regular. The statistical information contained in the MAR (Monthly Activity Report) of health training is not sufficiently disaggregated to make the data specific to women and men appear. The result is a difficulty in finding comprehensive health information about gender in health statistics.	
Are NGOs and CSOs that represent the rights of the most vulnerable involved in this stage of the process?	Civil society has been involved in the development of the HSS. The same applies to the sectoral strategies of the National Program to control Diseases (Malaria, HIV, Tuberculosis, etc.) However, the 2017 Open Budget Survey indicates that Cameroon offers low opportunities for the public to engage in the budget process, and gets 7 out of 100, compared to a global average of 12. In the region, Chad, Côte d'Ivoire, Burkina Faso and Niger score 0 out of 100, while Benin and DRC have the best results with 9 out of 100.	

STEP 2: PREPARING AND APPROVING THE BUDGET

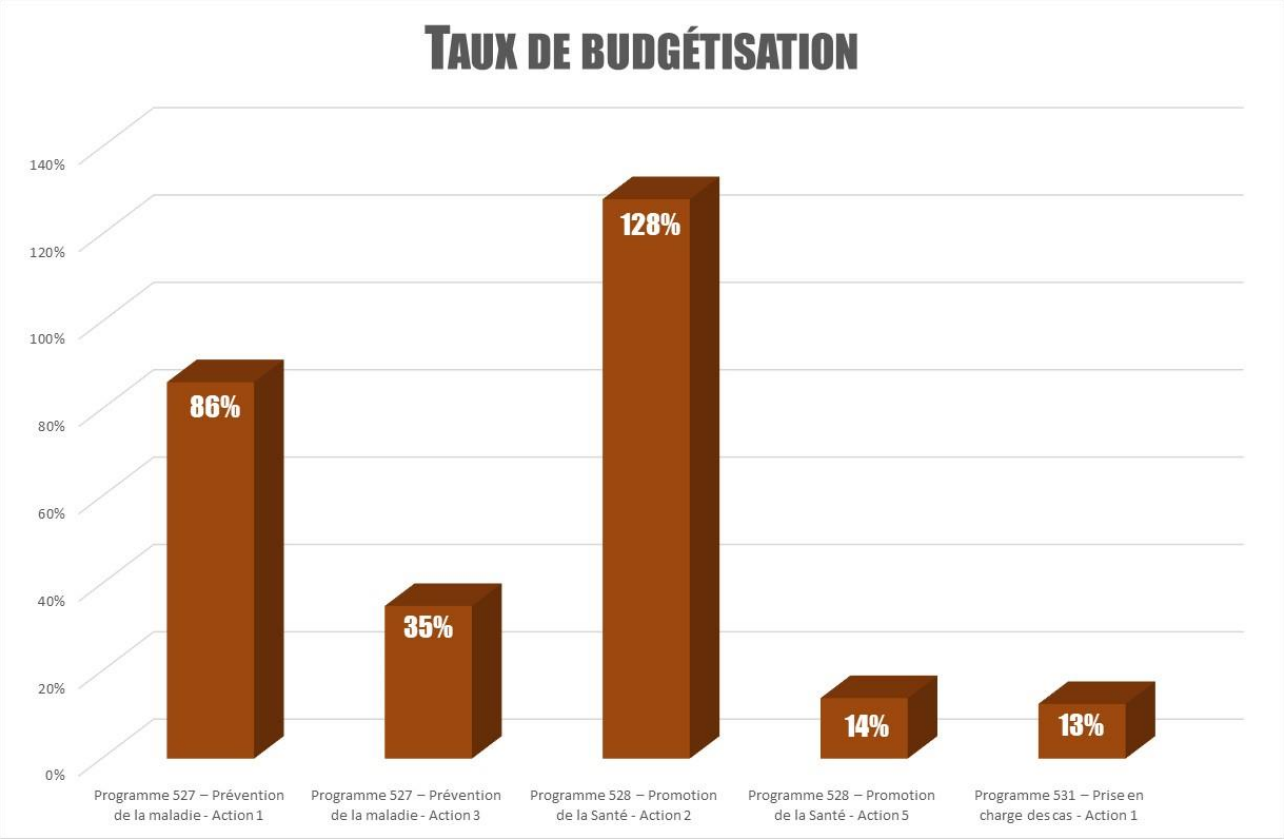
Question	Analysis and sources of information	Assessment
Is Gender equity clearly set out in the budget formulation guidelines (i.e., the President's Circular on the preparation of the state budget)?	Gender equity is clearly and regularly expressed in the President's Circular on the preparation of the state budget. Thus, for the 2018, 2019 and 2020 budgets, under the social objectives of public action, it is chosen to "Implement the Multisectoral Plan of National Gender Policy".	
Are sectoral departmental budgets prepared for sectoral objectives and performance indicators?	Program-based budgeting was first introduced in 2013, with performance indicators. Thus, through the Administrations Performance Projects (PPPs), minitries budgets are developed based on sector objectives and performance indicators. The Ministry of Health's Budget contains the objectives of the HSS and its performance indicators. The following pro-women goals and indicators are clearly expressed: **Program 527 - Disease Prevention.** • Goal 01: Increase the proportion of pregnant women on intermittent preventive treatment (IPT) of malaria. *Indicator: The proportion of pregnant women attending antenatal clinics who received at least three doses of IPT increased from 39.8% to 65%.* • Goal 03: Reduce the rate of mother-to-child transmission of HIV to less than 50%. *Indicator: Mother-to-child transmission rate of HIV at 6 weeks is less than 5%.* **Program 528 - Health Promotion.** • Goal 02: Improve access and use of family planning services. *Indicator: To increase the percentage of women of childbearing age (15-49 years) who* are married or *not* who use or whose sexual partner uses at least one modern contraceptive *method (regardless of the method used) from 23% to 35%.* • Goal 05: Reducing risky behaviors among adolescents (aged 10-19). *Indicator: Reduce the prevalence of pregnancy among adolescents from 25.6% to 15%.* **Program 531 - Management of illness cases.** • Goal 01: Implementation of high-impact curative interventions in mothers, newborns, children and adolescents. *Indicator: To increase the management of cases and complications related to the*	

Question	Analysis and sources of information	Assessment
	health of the mother, newborn, child and adolescent from 68.5% to 70%. Unfortunately, budget allocations are less than the stated needs for achieving objectives in the planning phase and the sectoral MTEF.	

Tableau 4. Analysis of differences between MTEF Health, APP and APR

Budget 2018	CDMT 2018 (a)	Initial budget (b)	Revised Budget (c)	Consumed budget (d)	Completion rate (d/a)	Budget execution rate (d/c)	Review rate (c/b)	Budget rate (b/a)
Program 527 - Disease Prevention - Action 1 *(Increasing the proportion of pregnant women on intermittent preventive treatment (IPT) of malaria)*	18 710	16 128	15 533	15 533	83%	100%	96%	86%
Program 527 - Disease Prevention - Action 3 *(Reducing mother-to-child transmission of HIV to less than 50%)*	246	86	22	85	35%	386%	26%	35%
Program 528 - Health Promotion - Action 2 *(Improving Access and Use of Family Planning Services)*	3 399	4 354	2 684	1 807	53%	67%	62%	128%
Program 528 - Health Promotion - Action 5 *(Prevalence of Teen Pregnancy)*	166	23	18	22	13%	122%	78%	14%
Program 531 - Case Management - Action 1 *(Implementation of High Impact Curative Interventions in Mothers, Newborns, Children and Adolescents)*	1 070	134	127	134	13%	106%	95%	13%
Total	23 591	20 725	18 384	17 581	75%	96%	89%	88%

Figure 8. Analysis of differences between MTEF and Health APP



Source: Exploitation of 2018 APP, MTEF and APR data

Question	Analysis and sources of information	Assessment
Is there information on gender equity considerations in the Finance Act and the ancillary documents presented to Parliament?	Fairness is not explicit in the budget law. However, in the budget as in the Ministry of Health's APP attached to the Finance Act, the APP includes gender concerns in program actions with objectives and indicators (see Appendix C).	
Is budget documentation accessible to citizens?	The evaluation according to the Open Budget Index (OBI) of the International Budget Partnership (OBI) shows that Cameroon publishes online the pre-budget report and the budget voted by Parliament. Similarly, the Finance Bill, the Amending Finance Act, and budget implementation reports are available on the website of the Directorate General of Budget. Since the 2019 financial year, there has been a Citizens' Budget in Cameroon. However, budgetary documentation specific to the Ministry of Health is not available on the Ministry of Health website. And there is no Health Citizen Budget.	
Are health programs or projects systematically evaluated with gender equity considerations? How are they selected to be included in the budget?	There is no actual assessment at the time of budget preparation. However, there is a review, evaluation and relevance work to allow for budgeting. The annual work plan review allows the decision to renew or withdraw the various projects and programs for the next planning or programming cycle. For this, there is a monitoring and evalution unit. Strategic alignment is an ongoing concern in this case. So the gender aspect is implicitly introduced. Gender concerns are contained in the priority actions of mother-child programs.	
Are NGOs and CSOs that represent the rights of the most vulnerable involved in this stage of the process?	Once the budget call circular is prepared, it is the departments that prepare the budget and NGOs and CSOs are generally no longer involved. NGOs are invited to the budget launch ceremony. They are invited to other major meetings at the Ministry of Finance level. At the Ministry of Health level, NGOs are not involved in the Budget preparation step. However, they may be associated with the development of MTEF or in specific projects or programs. NGOs are not involved by Parliament in the adoption step of the Budget.	

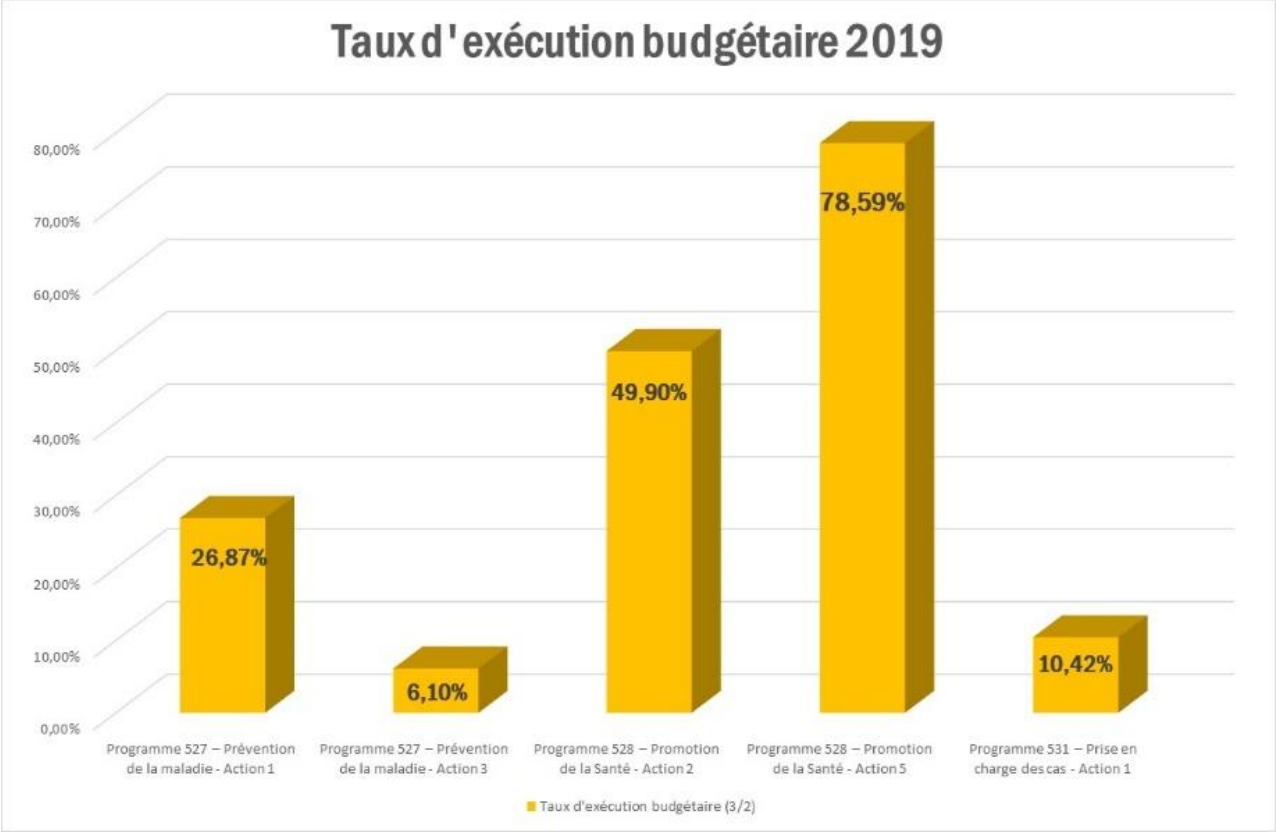
STEP 3: BUDGET EXECUTION

Question	Analysis and sources of information	Assessment
Is the budget delivered in accordance with the budget approved by Parliament?	In terms of the general state budget, both the 2017 PEFA Report and the 2018 PER (Public Expenditure Review) conclude that while official budget implementation rates are high, they mask weaknesses in budgetary accounting. The 2017 Assessment of Public Expenditure and Fiscal Responsibility (PEFA) notes that a high level of public spending still needs to be regularized and that certain practices in budget implementation (cash advances, unblocking funds, advances and direct payments by the National Hydrocarbons Corporation (NHC), for example), had until very recently hampered the reliability of expenditure allocation data. As a result, official accounting and financial documents do not fully reflect the reality of the allocation of expenditures. At the level of the budget of the Ministry of Health, the budget implementation rate for the year 2019 is 53.48% (Source Ministry of Finance). This low rate of budget implementation is even more important in terms of budgetary appropriations for women's program actions (24.65% in total).	

Tableau 5. Delivering the 2019 budget

Budget 2019	Initial budget (1)	Revised Budget (2)	Consumed budget (3)	Budget implementation rate (3/2)	Review rate (2/1)
Program 527 - Disease Prevention - Action 1 *(Increasing the proportion of pregnant women on intermittent preventive treatment (IPT) of malaria)*	13 019	12 987	3 490	26,87%	99,75%
Program 527 - Disease Prevention - Action 3 *(Reducing mother-to-child transmission of HIV to less than 50%)*	1 089	1 075	66	6,10%	98,71%
Program 528 - Health Promotion - Action 2 *(Improving Access and Use of Family Planning Services)*	4 057	3 949	1 971	49,90%	97,34%
Program 528 - Health Promotion - Action 5 *(Prevalence of Teen Pregnancy)*	61	57	45	78,59%	93,44%
Program 531 - Case Management - Action 1 *(Implementation of High Impact Curative Interventions in Mothers, Newborns, Children and Adolescents)*	7 696	7 841	817	10,42%	101,88%
Total	25 922	25909	6 388	24,65%	99,95%

Figure 9. Delivering the 2019 budget



Source: Exploitation of 2019 Budget Data

Question	Analysis and sources of information	Assessment
Are budget disbursements and executions recorded in the government's financial management information system? What is their level of disintegration?	The Ministry of Finance's Budget Information System has detailed budget information on budget implementation and disbursements on own resources. Including the budget of the Ministry of Health. This information is available to Ministry of Health officials in charge of budget management. The level of disintegration is as fine as possible, and corresponds to the state's accounting plan. On the other hand, financial information on partner financing is not available in the information system.	
Do budget transfers or budget changes during the year take gender equity into account in the health sector? Do they protect expenses from gender-friendly activities?	The Ministry of Health is exempt from all budgetary regulation procedures. The program with the IMF requires a plan for social expenses, including health. In other words, the budget of the Ministry of Health must not be below a certain threshold, both in the vote of the budget and in the course of a change in the state budget during the year. In fiscal year 2019, fiscal regulation measures have had very little impact on the appropriations for women's program actions	

	at the Ministry of Health. A total of 99.95% of these credits were maintained.	
Are NGOs and CSOs the rights of the most vulnerable involved in this stage of the process?	NGOs and CSOs are by no means represented at this stage of the budget cycle.	

STEP 4: BUDGET MONITORING AND EVALUATION

Question	Analysis and sources of information	Assessment
Do budget implementation reports include gender equity measures? Are there any indicators of gender fiscal performance?	The Annual Performance Report (APR) analyzes in detail the budgetary and programmatic performance of all program actions enshrined in the Finance Act and the Administration Performance Project (APP) of each ministry. In this analysis, each program action is used to describe the context of implementation, the major activities carried out and to justify the outcome and use of resources. Thus, for the 2017 and 2018 fiscal years, each of the women's equity measures in the budget is analyzed, its budget implementation rate is provided as well as performance indicators. Contrary to what was observed during the 2017 PEFA evaluation, APPs and FDAs are now published on the Ministry of Finance's website, therefore available to the public.	
Are there external evaluations and analyses of ministry of health budget expenditures? Do they include gender equity indicators?	We found no external evaluation of the Ministry of Health's budget expenditure analysis including gender equity indicators. Several evaluation reports have been carried out on spending in the health sector in Cameroon in recent years. For the record: ▪ The October 2017 OPM (Oxford Policy Management Ltd) report on the analysis of the tax space for health in Cameroon; ▪ The World Bank's 2018 Public Expenditure Review, with a strong component on the Health sector; ▪ Analysis of the Budgetary Area and Allocative and Technical Efficiency in Cameroon (2016). However, these assessments generally focus on the budget process and addressed very little aspects of the analysis of results.	
How do monitoring and evaluation reports influence future budget decisions? Are some programs cancelled or modified based on the results achieved for disadvantaged groups?	The interlocutors did not declare having canceled or modified programs according to the results obtained. In the APR, while there are contradictions between the financial realization of the actions, their technical achievements and the analysis of the results,the same actions are renewed. As an illustration, in the 2018 APR, we have: ▪ For Action 01 of Program 527 *(Proportion of pregnant women attending antenatal clinics and receiving at least three doses of IPT),*the financial achievement rate is 96.31%, the technical achievement rate is 127.57% and the analysis concludes that "Failure *to* achieve the *distribution targets of MILDA (Long-Term is mainly due (1) to the late use of antenatal consultations(NPC) by pregnant women; and (2)*	

Question	Analysis and sources of information	Assessment
	the low attendance rate of the CPN, which is 64% of the expected women." ▪ For Action 03 of Program 527 *(Mother-to-Child Transmission Rate at 6 Weeks is Less than 5%),* the financial achievement rate is 99.65%, the technical achievement rate is 46.72% and the analysis concluded as *"Inadequate in the follow-up of hospital appointments for pregnant PHA women undergoing treatment".*	
Are NGOs and CSOs that represent the rights of the most vulnerable involved in this stage of the process?	NGOs and civil society organizations are not associated by the Ministry of Health for budget monitoring and evaluation. However, in independent evaluations, NGOs and CSOs are interviewed to provide a citizen's perspective on the results of budget implementation and the achievement of results. Similarly, NGOs and CSOs are given the opportunity to conduct independent evaluations, although in this case their access to information remains to be improved.	
How is civil society involved in promoting budget transparency and performance?	Through associations involved in the sector, civil society participates independently in the evaluation of the implementation of health sector activities. These include the evaluation of services in health facilities or the availability of drugs throughout the country. These assessments are carried out in collaboration with community associations at the Health District level. The associations' reports are made public and sent to the Ministry of Health as well as to the Regionals Delagation. Civil society assessments often face the difficulty of accessing the budget statistics they need.	

III. GENDER BUDGET EQUITY MATRIX IN THE HEALTH SECTOR: CAMEROON

In this chapter, the results of the evaluation presented in Chapters I and II and the sources of information are presented in a single table. The documents used for the evaluation were obtained mainly from the Cameroonian administration, either directly or through the websites of the various ministries and services. A lot of information was also obtained from the Technical and Financial Partners (PTFs).

	Questions	Source of information	Assessment
1. Policy development and planning	Is gender equity clearly stated in the National Plan for Economic and Social Development?	Document of The Growth and Employment Strategy (DSCE) and the multi-sector for the implementation of national gender policy in Cameroon.	
	Is fairness clearly stated in Sector Strategic Plans?	The 2016-2027 Sector Health Strategy (SSS) and the National Health Development Plan 2016-2020 (PNDS).	
	Is the necessary data available to inform planning? Are they used?	The follow-up report of the 100 key health indicators in Cameroon (2019), Health Statistics of the Health Information Unit (CIS), interviews with key interlocutors.	
	Are NGOs and CSOs that represent the rights of the most vulnerable involved in this stage of the process?	Interviews with key stakeholders.	
2. Preparing and approving the budget	Is Gender equity clearly set out in the budget formulation guidelines (i.e., the President's Circular on the preparation of the state budget)?	Circular of the President of the Republic on the preparation of the state budget.	
	Are sectoral departmental budgets prepared for sectoral objectives and performance indicators?	CDMT Health, Finance Act, Health PPA.	
	Is there information on gender equity considerations in the Finance Act and the ancillary documents presented to Parliament?	Finance Act and Health PPA.	
	Is budget documentation available to citizens?	Website of the Ministry of Finance and the Ministry of Health, the evaluation according to the Open Budget Index (OBI) of the World Bank.	
	Are health programs or projects systematically evaluated with gender equity considerations?	Interview with key interlocutors, self-assessment.	

	Questions	Source of information	Assessment
	How are they selected to be included in the budget?		
	Are NGOs and CSOs that represent the rights of the most vulnerable involved in this stage of the process?	Evaluation according to the World Bank's Open Budget Index (OBI); interviews with key informants; self-assessment.	
3. Budget execution	Is the budget delivered in accordance with the budget approved by Parliament?	PEFA 2017indicator; RDP 2018; Budget statistics from the Ministry of Finance; RAP Health; Self-assessment.	
	Are budget disbursements and executions recorded in the government's financial management information system? What is their level of disintegration?	PEFA 2017; Interviews with key stakeholders Self.	
	Do budget transfers or budget changes during the year take gender equity into account in the health sector? Do they protect expenses from gender-friendly activities?	PEFA 2,017; Budget implementation statistics provided by the Ministry of Finance, interviews with key informants; Self-assessment.	
	Are NGOs and CSOs the rights of the most vulnerable involved in this stage of the process?	Interviews with key stakeholders; Self.	
4. Monitoring and evaluation	Do budget implementation reports include gender equity measures? Are there any indicators of gender fiscal performance?	RAP; Self-assessment.	
	Are there external evaluations and analyses of ministry of health budget expenditures? Do they include gender equity indicators?	RDP 2018; OPM 2017; talks with key interlocutors; Self-assessment.	
	How do monitoring and evaluation reports influence future budget decisions? Are some programs cancelled or modified based on the results achieved for disadvantaged groups?	RAP; Interviews with key stakeholders Self.	
	Are NGOs and CSOs that represent the rights of the most vulnerable involved in this stage of the process?	Interviews with key informants, OBI Report, Self-assessment.	
	How is civil society involved in promoting budget transparency and performance?	Interviews with key informants, OBI Report, Self-assessment.	

	Questions	Source of information	Assessment
5. Budget results	Is access to health care equitable?	DHS, MICS HSS, NHDP, The multisectoral plan for the implementation of the national gender policy, National Strategic Plan for Reproductive Health, Maternal Neonatal and Infant, GFF Invest Case, Study on health financing,	
	Are there financial, cultural, physical barriers or other barriers that prevent women from accessing health services?	DHS, MICS HSS, NHDP, The multisectoral plan for the implementation of the national gender policy, National Strategic Plan for Reproductive Health, Maternal Neonatal and Infant.	
	Is the allocation of funds proportional to the needs and/or cost of specific interventions?	GFF Invest Case, Study on health financing, GFF Invest Case, Study on health financing, MTEF, APP, APR	
	Is public health spending currently at least as much for interventions specific to poor women and other most marginalized groups?	GFF Invest Case, Study on health financing, GFF Invest Case, Study on health financing, MTEF, APP, APR	
	Would women win or lose if public spending were reallocated to different interventions and/or to different parts of the country?	DHS, CHS	
	Do public spending help reduce income inequality?	DHS, CHS	
	Are there more cost-effective ways to achieve the same results?	Interviews, circular on the implementation of the 2020 budget	

CONCLUSIONS

Cameroon expresses in its policy documents as well as in its strategy and planning documents a real willingness to face the challenge of women's access to health services and care.

The main limitation of this assessment is the difference in nature between the health needs of women and men.

In practice, there is no gender discrimination or special privilege of women over men, or vice versa, for access to health. Limiting factors, where they exist, are only partially attributable to the health system which is designed to care for women and men only according to their health needs. And if the main part of the minimum activity package (LDC) and the complementary activity package (PCA) are focused on specific services for women, it is because the most important health needs of the population are maternal, reproductive, neonatal and child health.

The budget structure fairly clearly reflects the priority given to specific interventions for vulnerable groups. However, the identification of these in the actual allocations still needs to be improved at the level of the financial information system, particularly with regard to external financing.

The budgeting process confirms the political will to achieve equitable access to health care and services, but also a great difficulty in translating this political will into the downstream phases of the process, particularly during the budget implementation, monitoring and evaluation.

Indeed, Cameroon has a kind policy adopted by the Government and regularly recalled by the President of the Republic in the budgetary preparation circular. This political will translates into strategic options clearly identified in the NSP and taken up in the form of actions in budgetary programs. The budgeting of these program actions is not yet sufficiently aligned with the programming adopted in the MTEF. At the budget implementation stage, there are significant gaps between the budgets voted by parliament and the resources actually made available to programs for women, thus calling into question the political will yet clearly expressed. Finally, there is insufficient attention to monitoring and evaluating budget implementation to make the necessary adjustments.

In short, Cameroon's main challenge is to translate its proactive gender policy in the health sector into action, and thus the results. This requires the ability to develop a budget that is in line with the MTEF and to faithfully deliver that budget.

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APPENDIX A: TERMS OF REFERENCE

BRIEF INFORMATION ON THE PROJECT

It was recalled that the objective of this assignment is to analyze to what extent equity considerations are reflected in Cameroon's public budget for the health sector and how public spending on health impacts of various dimensions of equity, in particular gender, in the health sector of Cameroon by using the Equity Budgeting Tool.

CONTEXT

German development cooperation is committed to the implementation of the 2030 Agenda and its Sustainable Development Goals (SDGs). Reducing inequalities and *leave no one behind* are critical for the achievement of the 2030 Agenda and a crosscutting challenge in all sectors.

In 2018, GIZ has responded to these challenges by commissioning, developing and testing a **new and innovative Equity Budgeting Tool (EBT)[24], on behalf of Germany's Federal Ministry for Economic Cooperation and Development**. Equity Budgeting is an approach to fiscal policy-making that places equity concerns at the center of governments' financial processes and decisions. It assesses budget allocations in the light of public policy commitments towards reducing inequalities and the 2030 Agenda principle of leaving no one behind (LNOB).

More precisely, the EBT covers several dimensions of the budgeting process including the budget execution. It helps users and policy makers to:

- Better understand the relevance of equity aspects during budget preparation;
- Gain better knowledge about the effects of public spending on disadvantaged groups;
- Gain better understanding of who is to win and who is to lose from fiscal policy measures;
- Highlight misallocation of funds detrimental to the reduction of inequalities (e.g. subsidies on gas, favourism);
- Better address issues of equity budgeting through a clearer visualization of data.

Summing up, the objective of the EBT it to help advisors, policy makers, CSOs and independent analysts and advisors to identify whether reducing inequalities is reflected in the budget planning process and in the actual public expenditure. Further, the tool helps to identify entry points to engage with governments in a dialogue about reducing inequality and policy choices to that end.

The development of the EBT was initiated by GIZ Sector Programmes *Good Financial Governance*, *Promoting Gender Equality and Women's Rights* and *Realizing Human Rights including Children and Youth Rights in Development Cooperation* and validated in Burkina Faso, in cooperation with GIZ programmes in the country. In Burkina Faso, the EBT was piloted in the education sector, focusing on children.

Background of involved GIZ programmes:

The **Sector Programme Good Financial Governance (GFG)** advises the Federal Ministry for Economic Cooperation and Development (Bundesministerium für Wirtschaftliche Zusammenarbeit und Entwicklung, BMZ) on issues related to public financial management, including budget expenditure management and reforms, public revenues, supreme audit institutions, as well as transparency initiatives, and carries out conceptual and methodological work in these fields. The Sector Programme aims to enhance the expertise and capacities of German Development Cooperation to implement the Good Financial Governance (GFG) approach on national and international level. In its support to GFG in sectors, the Sector Programme intends to use the results of the

[24] The tool can be accessed under: https://mia.giz.de/qlink/ID=245234000.

equity assessment as an input to its wider support to Good Financial Governance in the health sector in cooperation with the aforementioned programmes in Cameroon.

The **Sector Programme Universal Health Coverage** (UHC) is commissioned by the BMZ to provide the German contribution to the international UHC agenda as well as support evidence-based positioning on the topics of UHC and health systems strengthening (policy and expert advice). As part of its mandate to promote active participation and contributions by the BMZ in global health networks, the SP UHC coordinates the German activities in the P4H Network for Health Financing in order to make progress in establishing and expanding social health protection at national and regional level. The SP UHC works towards expanding the UHC portfolio at country level, strengthening national commitment to UHC through targeted advice and increasing multisectoral implementation.

Its interest in gender equity budgeting is reflected in the following module indicator: "The UHC plans adopted by ten countries contain approaches towards achieving gender equality refined by the sector project." In this regard, the SP UHC would place a special focus on integrating outcomes and recommendations of the EBT analysis in national regulations and plans. This could comprise, but not be limited to: a) adding elements of equality and inclusion in health financing to existing regulations; b) including specific instructions on the inclusion of gender equality (gender specific outcomes, outputs and indicators) to annual budget guidelines and budget circular. Gender equity budgeting in health should place special attention on varying health needs of men and women and therefore should include gender-responsive health needs assessments.

In Cameroon the GIZ **Maternal Health programme (PASaR)**, commissioned by BMZ, supports the improvement of the provision of quality health services especially in sexual and reproductive health and rights. Key health indicators such as maternal and infant mortality, which in Cameroon are 782 per 100,000 women and 101 per 1,000 live births respectively, are at or below the level of other African countries, although the country economic situation is relatively good. PASaR places a particular emphasis on comprehensive approaches to strengthening the health system, which should improve not only family planning and reproductive health, but also the quality of health services as a whole. The project supports the development of Regional Funds for Health Promotion (RFHP), which contribute to improve the availability of modern contraceptives in health facilities at a subsidized price. The RFHP are also the future regional pillars of the UHC architecture. In this perspective, the P4H focal point in Cameroon provides technical support to the MOH to consolidate the RFHP and set up a sustainable UHC strategy

THE CONTRACTOR WILL PROVIDE THE FOLLOWING WORK:

The assignment comprises the following tasks:

A) Coordination agreement

- Before starting the assignment the contractor and the second contracted consultant are asked to agree on the division of labour of tasks and the coordination of activities, according to their qualification and experience. The agreement should comprise 1-2 pages signed by both contracted consultants. The contractor is responsible for the coordination of the assignment and for the final quality control. The second contracted consultant will report to the contractor.

B) Preparation

- Identification and compilation of data sources: The contractor shall compile access / pathways to raw data of statistical offices, household surveys, MinSanté's MTEF (CDMT), latest Project de Performance Annuelle (PPA), online repositories, relevant country strategies, PEFA reports and, if applicable, novel data sources (e.g. big data, social media mining),
- Inception workshop: In order to validate its research methodology and data sources, the contractor shall organize a one-day inception workshop within the first three weeks of this assignment. This workshop shall bring together relevant stakeholders (such as relevant sector ministries, civil society and GIZ PAMFIP, GIZ Maternal Health Programme in Cameroon and GIZ Sector Programme Good Financial Governance).

C) Report and follow-up

- Statistical analysis and reporting: Based on the methodology of the Equity Budgeting Tool, the contractor shall prepare a report of max. 30 pages that combines key statistics and other types of findings on (gender) inequalities in Cameroon's public budget and expenditure patterns for the health sector. Specifically, the report shall:
  a. Analyse sectoral policy commitment to (gender) specific equity matters;
  b. Assess whether (gender) equity dimensions are reflected in the (health) budget;
  c. Determine which persons and groups in society stand to gain or lose from the fiscal policy;
  d. Analyse whether expenditure as budgeted reaches women;
  e. Give recommendations for policy engagement/participation and enhanced accountability on inequality matters in the budget cycle.
- Policy recommendations: Based on the report, the contractor shall formulate budget policy recommendations on the CDMT and PPA for the respective ministries. The policy recommendations can either be presented as part of the report or as a separate policy document/brief.
- Validation workshop: The contractor shall validate the results of analysis and policy recommendations with relevant stakeholders through a one-day validation workshop. This workshop shall involve relevant stakeholders (including representatives of Ministry of Health, Ministry of Finance and the Ministry of the Economy, Planning and Regional Development and the two GIZ Programmes on *Good Financial Governance* and on *Health* in Cameroon). The validation workshop should take place at least 2 weeks before the finalisation of the assignment.
- Recommendations for the adaption of the EBT: In addition to the report, the contractor should provide a written report of at least four pages with recommendations to GIZ on how the Equity Budgeting Tool and its underlying methodology could be improved, including whether a sector-specific adaptation of the tool is advisable.

SUMMARY OF DELIVERABLES:

- 1 coordination agreement with the second contracted consultant to be submitted 4th October
- 1 Inception Report and Meeting (in-person, half-day, in Yaoundé City)
- 1 Draft Report presenting findings and recommendations of the equity assessment
- 1 Workshop for validation of results and policy recommendations with relevant stakeholders (in-person, full-day, in Yaoundé)
- 1 Final report incorporating stakeholder feedback.
- 1 short report with recommendations on the usability of the EBT, including particularities/lessons of the application of the tool in the health sector, and recommendations on how the tool can be further improved

For all further details, a focal team will be defined with GIZ Cameroon/Germany. The contractor shall ensure regular communication with the focal person and seek feedback to clarify the assignment whenever necessary. Before the start of the mission, a short handover of the tool by its developer will be organized for the contractor. Moreover, remote technical assistance will be offered to a limited extent in case concrete application questions arise.

APPENDIX B: LIST OF PEOPLE YOU MEET

No	Name and First Names	Organization	Function
01	Guy EKANI NDONGO	CIS	CEA2
02	Etienne YEMEK	Consultant	
03	Serge Clotaire BILLONG	Consultant	
04	Maureem MBU OBI	FESADE	
05	Gabriel ATANGANA BINEGUE	Fondation Médicale Ad Lucem au Cam.	
06	Caroline FOUDA	GIZ/PAMFIP	Conseiller Technique
07	Laurene TEUMA	GIZ/PASAR	
08	Philipp DECKING	GIZ/PMPFIP	Conseiller Technique
09	Yannick KOUENGENG	MINEPAT	Cadre DPPS/DGPAT
10	Ariane SIEWE	MINEPAT	Chef de la Cellule de la Programmation des Investissements Publiques et des CDMT / DPPPP
11	Arnaud BAYEGUE	MINEPAT	PIP/CDMT
12	THYONG Epse NDONGO	MINEPAT	Sectoriel Préparation du BIP (SDP)
13	Ransome NGAHJIEH	MINFI	DGB/DPB
14	Rosalie OMBGA	MINFI	DGB/DREF
15	Solomon BUDZEE	MINFI	DGB/DREF
16	Sophie BOUMSONG	MINFI	DGB/DREF
17	Lucie ANKUONG FANG	MINFIN	CSA
18	Rufine NGOSSO	MINPROFF	
19	Jeanne MEBOE	MINPROFF	CIS
20	Alain NDZANA BILOA	MINPROFF	DAG
21	Francis OWONA ETOGA	MINSANTE	Chargés d'Étude Assistant à la Cellule de la Planification et de la Programmation (DEP)
22	Ibrahim MOHAD KONTCHA	MINSANTE	Chargés d'Étude Assistant à la Cellule de la Planification et de la Programmation
23	George Éric EBOLO	MINSANTE	Chef Bureau de Préparation du Budget d'investissement
24	Dr P.MACHE PENTONE	MINSANTE	Chef CCP - DEP
25	Dr Jeannette AFOUNDE	MINSANTE	Chef Service de la Santé des Adolescents et Autres Groupes cibles/DSF/MINSANTE Point Focal Genre du MINSANTE
26	Hans Ferry WANDJI	MINSANTE	CIS
27	Salvador TALA	MINSANTE	CIS
28	Barthélémy PAZIMI GACKE	MINSANTE	CSB
29	Ibrahim MAHAMED KONTCHA	MINSANTE	DEP
30	NDZIE Epse MENOUNGA	MINSANTE	DEP/CCP
31	Rostand Serge BOFIA	MINSANTE	DEP/CCP
32	Dr Fanne MAHAMAT	MINSANTE	DPS
33	Dr Flaubert FOUAKENG	MINSANTE	DPS
34	Dr Charlotte MOUSSI	MINSANTE	DRSP/CE
35	Archange Michel ANGOS	MINSANTE	Rep/DOSTS.CSPM
36	Eliséee Amour II EYENGA NDJOMO	MINSANTE	Sous-directeur du Budget et du Financement
37	Richard BUTARE	OMS	DPS/MINSANTE
38	Rosette MATIO EBAH	PC/Chèque santé	
39	Iness HIEFOU TIWA	Positive Génération	
40	Yohana DUKHAN	TTL Santé	World Bank