NHDP

NATIONAL HEALTH DEVELOPMENT PLAN

(2021 - 2025)

Ministerio de Sanidad y Bienestar Social
República de Guinea Ecuatorial

Guinea Ecuatorial Salud

Ministerio de Sanidad y Bienestar Social
República de Guinea Ecuatorial

Guinea Ecuatorial Salud

Organización Mundial de la Salud

aecid
Agencia Española de Cooperación Internacional para el Desarrollo

FRS
Fundación de Religiosos para la Salud

CONTENTS

ABBREVIATIONS

IMCI	Integrated Management of Childhood Illnesses (IMCI)
PHC	Primary Health Care
ARV	Antiretroviral
EMOC	Emergency Obstetric Care
AFDB	African Development Bank
PC	Prenatal Control (Focused Prenatal Care)
EGDHS	Demographic and Health Survey
EGDHS	Equatorial Guinea Demographic and Health Survey
UNHCR	United Nations High Commissioner for Refugees
HMN	Health Metrics Network
EG	Equatorial Guinea
ICPGE	Malaria Control Initiative in Equatorial Guinea
ISCIII	Carlos III Health Institute
INEGE	National Institute of Statistics of Equatorial Guinea
INSESO	National Institute of Social Security
STI	Sexually Transmitted Infections
MOHSW	Ministry of Health and Social Welfare
NHIS	National Health Information System
HIS	Health Information System
MDGs	Millennium Development Goals
WHO	World Health Organization
UNAIDS	United Nations Joint United Nations Programme on HIV/AIDS
UNODC	United Nations Office on Drugs and Crime
NGO	Non-Governmental Organization
FP	Family Planning
EFP	Essential Family Practices
GDP	Gross Domestic Product
NPIP	National Public Investment Program
NACP	National AIDS Control Program
UNDP	United Nations Development Programme
PMTCT	Prevention of Mother-to-Child Transmission
PLWHA	People Living with HIV and AIDS
ART	Antiretroviral Treatment
TB	Tuberculosis
IPT	Intermittent Preventive Treatment for Malaria
UNICEF	United Nations Children's Fund
ES	Epidemiological Surveillance
HIV/AIDS	Human Immunodeficiency Virus/ Acquired Immune Deficiency Syndrome

INTRODUCTION

The Government of Equatorial Guinea is fully committed to the implementation of Sustainable Development Goal (SDG) No. 3 during the 2030 horizon, which is to "Ensure healthy lives and promote the well-being for all at all ages" and the Equatorial Guinea 2035 Agenda to ensure universal access to quality health services for the entire population and achieve healthy longevity.

In carrying out this political commitment, the Ministry of Health and Social Welfare (MOHSW) has benefited from the technical support of the World Health Organization (WHO) and the collaboration of other development partners to conduct a situation analysis of the National Health System (NHS) in order to update the National Health Policy and draw up a National Health Development Plan (NHDP) to guide the health program framework for the next five years.

The National Health Development Plan, which covers the period 2021-2025, is linked to development plans and programs at the international, continental, regional and sub-regional levels, namely: (i) the Sustainable Development Goals (SDGs) to Horizon 2030, (ii) the African Union (AU) Agenda 2063, (iii) the Organization for the Coordination of the Fight against Endemics in Central Africa (OCEAC), (iv) the National Economic and Social Development Plan to Horizon 2020, (v) the Second National Health Policy established to Horizon 2035, and (v) the Equatorial Guinea Agenda to Horizon 2035.

The NHDP includes a vision, mission and principles, values, goals, objectives and strategic orientations. It consists of four priority programs with 13 sub-programs, 51 expected results and 248 process indicators that make it possible to monitor the implementation of the successive annual operational plans during the five-year life of the NHDP.

The NHDP also contemplates the following objectives: (i) boost quality governance of the health system for greater service delivery and promotion of the culture

NHDP OBJECTIVES

- Quality governance of the health system
- Strengthened National Health System managementmechanisms
- Improved supply, demand and quality of health services
- Control of chronic communicable and non-communicable diseases strengthened
- A strengthened health surveillance system for emerging and re-emerging endemic diseases
- Quality and quantity of human resources in the health sector
- A financing model involving the private sector and development partners in health

of accountability, (ii) strengthen the organization and coordination and management mechanisms of the National Health System, (iii) improve the supply, informed demand, access and quality of health services for mothers and women, children, adolescents and men, (iv) strengthen the fight against endemic diseases (Malaria, Tuberculosis, HIV/AIDS, Hepatitis as well as neglected diseases), (v) strengthen the control of chronic communicable and non-communicable diseases, (vi) strengthen the health surveillance system and response to emerging and re-emerging endemic diseases and other public health events, (vii) substantially increase the quantity and quality of human resources in the health sector, giving priority to the national supply, including those in the diaspora, and (viii) develop a financing model that involves the participation of the private sector and other partners in health development.

The strategic orientations of the NHDP are as follows: (a) improving equitable access of the population to quality health services to ensure Universal Health Coverage (UHC), (b) increasing the utilization of quality health services for the entire population, (c) promoting better health status of the population and (d) strengthening health security and health emergency management and (e) governance and leadership in the National Health System.

The implementation of the NHDP requires the creation and implementation of a Steering Committee as a strategic body, with a multi-sectoral character that includes health sector development partners, and the creation and implementation of a National Technical Committee and a Coordinating Committee of Health Sector Development Partners.

The success of the NHDP, with all national and international commitments in health, requires the involvement of the **President of the Republic, Obiang Nguema Mbasogo, as the head of the National Government**, a planned intervention framework, a management towards measurable results, the availability of competent and sufficient human resources at all levels of the National Health System, a solid institutional framework for implementation, a strong strategic communication and a risk management of the implementation of priority programs based on a matrix approach.

NARRATIVE SUMMARY

The process of elaboration of the National Health Development Plan (NHDP) by the Ministry of Health and Social Welfare (MOHSW), and with technical support from WHO, was developed on the basis of a roadmap that contemplates the following stages: (i) situation analysis with a national team of MOHSW services and programs, (ii) updating of the 2002 National Health Policy and development of the NHDP through workshops focused on the seven pillars of the health system to deepen the analysis with complementary data and the adoption and prioritization of health problems, and (iii) development of the NHDP budget using the One Health tool, which offers the advantage of facilitating the estimation of actual program costs, formulating hypothesis linked to the goals set and the risks of implementation.

In terms of results, the situation analysis of the National Health System highlighted the following major problems: (i) weak leadership and governance in the management of the health system, (ii) lack of a National Health Human Resources Development Plan, (iii) poor quality of available health infrastructure and medical equipment, (iv) irregular supply of electricity, drinking water, maintenance and inadequate means of communication in several hospitals and health centers, (v) poor logistics management system for drugs and other health products, (vi) poor health financing, below the 15% committed in Abuja in 2001, (vii) poor National Health Information System (NHIS) at all levels of the national health pyramid and (viii) poor coverage and utilization of care services at different levels towards the goal of the Major Program "Health for All by Horizon 2020".

The incidence of the weaknesses identified in the analysis of the seven pillars of the National Health System (NHS) on the health status of the population is worrisome with the following problems: (i) high maternal mortality, (ii) high neonatal, infant and child mortality, (iii) high mortality linked to communicable diseases and the persistence of neglected tropical diseases, (iv) high mortality linked to chronic non-communicable diseases, (v) high frequency of health risk behaviors among adolescents and young people of both sexes, and (vi) poor leadership in the coordination and management of the National Health System. The root causes of these problems are: (a) deficient supply of quality health services, (b) low utilization of available health services by the population, (c) an environment that is not very favorable to improving the health of the population, (d) insufficient preparation for adequate management of epidemics and disasters, and (e) weak leadership and management capacity of resources allocated to the health sector.

The limitations in the elaboration of the NHDP were mainly the insufficient statistical data - due to the failure to conduct the second EGDHSEGDHS in 2017 which has not allowed to have updated indicators to assess the achievements reached in the different programs and projects and to establish the baseline targets of the NHDP in 2021.

Based on health problems and their causes, the National Health Policy adopted in 2002 has been updated and the National Health Development Plan (NHDP) has been developed, which includes the following programmatic elements:

1) **Long-term vision:** which is the one set by the Government in the National Economic and Social Development Plan and which envisages that "All girls and boys, adolescents and young people, women and men enjoy good health through equitable access to quality services" and which is perfectly

linked to the Equatorial Guinea 2035 Agenda and the Astana Declaration of the International Conference on Primary Health Care (PHC) of October 2018.

2) **Mission:** which is to provide Equatorial Guinea with a health system that is powerful, resilient and able to guarantee universal access to quality health services in order to achieve an optimal health status that sustains the durability of economic growth and national development.

3) **Principles:** underpinning the vision of the National Health Policy and the NHDP in accordance with the Universal Health Coverage (UHC) objective of SDG No. 3 and the 2018 Astana Declaration on PHC.

4) **Values:** based on equity, social justice, national solidarity, sustainability, ethics, rigor, transparency and democracy.

5) **Goal:** which is to raise the health status of the population of the Republic of Equatorial Guinea to the highest and most equitable level, according to the resources available for the fulfillment of health commitments.

6) **Specific objectives which are:** (i) to promote quality governance of the health system for greater service delivery and promotion of the culture of accountability, (ii) to strengthen the organization and coordination and management mechanisms of the National Health System, (iii) to improve the supply, informed demand, access and quality of health services for mothers and women, children, adolescents and men, (iv) to strengthen the fight against endemic diseases (Malaria, Tuberculosis, HIV/AIDS, Hepatitis and other neglected diseases), (vi) strengthen the control of chronic communicable and non-communicable diseases, (vii) strengthen the health surveillance system and response to emerging and re-emerging endemic diseases as well as other public health events, (viii) substantially increase the quantity and quality of human resources in the health sector, giving priority to the national supply, including those in the diaspora, and (ix) develop a financing model that involves the participation of the private sector and other partners in health development.

7) **Targets towards SDG 3 Goals by 2030**, which aim (by 2030) to achieve universal access to integrated, continuous, equitable, equitable and person-centered quality healthcare with the following targets: (a) reduction of maternal mortality from 290 to 70 maternal deaths per 100,000 live births, (ii) reduction of neonatal mortality from 33 to 12 per 1,000 live births, (iii) reduction of infant and child mortality from 113 to 25 per 1. 000 live births, (iv) reduction of mortality linked to communicable diseases by 50%, (v) reduction of the prevalence of risk factors linked to non-communicable diseases by 50%, (vi) reduction of the prevalence of risk behaviors in adolescents and young people of both sexes by 50%, (vii) reduction of the population's vulnerability to epidemics, emergencies and other health events by 50%, and (viii) improvement of leadership in the coordination and management of the National Health System.

8) **Strategic orientations which are:** (a) improving equitable access of the population to quality health services to ensure Universal Health Coverage (UHC), (b) increasing the utilization of quality health services by the entire population, (c) promoting better health status of the population, (d) strengthening

health safety and health emergency management and (e) governance and leadership in the health sector.

The NHDP, prepared for the period 2021-2025, is linked to Development plans and programs at the international, continental, regional and sub-regional levels, namely:

a) **Sustainable Development Goals (SDGs) to Horizon 2030:** (i) SDG 3 concerning health is to "Ensure healthy lives and promote well-being for all at all ages", (ii) SDG 2 is to "End hunger, achieve food security and improved nutrition and promote sustainable agriculture", (iii) SDG 4 is to "Ensure inclusive, equitable and quality education and promote lifelong learning opportunities for all", (iv) SDG 5 is to "Achieve gender equality and empower all women and girls" and (v) SDG 6 is to "Ensure availability and sustainable management of water and sanitation for all".

b) **Agenda 2063 of the African Union (AU).** The NHDP strategies are aligned to the aspirations of a prosperous Africa, with inclusive growth and sustainable development so that the entire population is in good health and benefits from quality food and nutrition, accessible to all.

c) **Organization for the Coordination of the Fight against Endemic Diseases in Central Africa (OCEAC).** The strategic actions of the NHDP to combat the disease are clearly defined in the programmatic guidelines of the OCEAC, as the CEMAC Health Policy Executing Agency. Equatorial Guinea, through MOHSW, is involved in the process of drafting the Regional Strategic Plan for the fight against HIV/AIDS, Tuberculosis and Hepatitis, for the period 2019-2023.

d) **National Economic and Social Development Plan for Horizon 2020.** The vision and strategic orientations in health adopted in 2007, during the 2nd Conference, have been redirected in the National Health Policy and the NHDP.

e) **National Health Policy established for Horizon 2035.** The vision, mission, principles, objectives and strategic actions of the National Health Policy set at the 2035 horizon have been the second reference of elements to guide the programmatic framework of the National Health Development Plan.

f) **Agenda Equatorial Guinea at Horizon 2035**. The long-term objectives and strategic orientations in health and well-being, adopted during the 3rd National Economic Conference of 2019, were taken into account in the formulation of the priority programs, subprograms, results and indicators of the NHDP. The NHDP is developed in four priority programs that carry 13 subprograms, 51 expected results and 248 process indicators that allow tracking the implementation of the successive annual operational plans, as indicated in the summary table below.

Table 1: Summary of NHDP Priority Programs (2021-2025)

N°	PRIORITY PROGRAMS	SUBPROGRAMS	EXPECTED RESULTS	INDICATORS
1	Equitable access of the population to quality health services	1. Improvement of the supply and demand of quality health services.	4	15
		2. Improvement of maternal, women's and children's health services.	4	40
		3. Improving sexual and reproductive health services for adolescents and young people.	2	10
Subtotal 1		**3**	**10**	**64**
2	Health safety, emergencies and disasters and health resilience	1. Epidemic management according to the provisions of the International Health Regulations (IHR).	2	8
		2. Disaster management according to the provisions of the International Health Regulations (IHR).	1	3
Subtotal 2		**2**	**3**	**11**
3	Health promotion	1. Control of Communicable Diseases (CD).	14	80
		2. Control of Non-Communicable Diseases (NCDs).	2	12
		3. Fighting neglected tropical diseases (NTDs).	4	9
		4. Improvement of the environment and/or way of life of the population.	1	5
Subtotal 3		**4**	**21**	**106**
4	Strengthening leadership and governance in the health sector	1. Strengthening leadership and accountability in the health sector.	7	25
		2. Improvement of health financial management.	4	16
		3. Strengthening the management of health information.	4	16
		4. Health research.	3	10
Subtotal 3		**4**	**18**	**67**
TOTAL	4	13	51	248

The success of the NHDP requires the creation and implementation of a Steering Committee as a strategic body of the NHDP with a multi-sectoral character that includes the health sector development partners, the creation and implementation of the NHDP National Technical Committee and a Coordination Committee of the health sector development partners.

These management structures will have among other functions: (a) support the strengthening of the institutional set-

THE NHDP HAS 4 PRIORITY PROGRAMS

- Equitable access of the population to quality health services
- Security, emergencies and catastrophes and health resilience
- Health promotion
- Strengthening governance and leadership in the health sector

up of the health system's operational implementation structures, (b) approve the annual implementation work plans and management tools (procedures, indicators, budgets...), (c) institutionalize the monitoring and evaluation of the operational implementation plans that inform and document the members of the NHDP Steering Committee, (d) formulate relevant recommendations for the improvement of management quality, and (d) ensure the promotion of accountability in the management of the National Health System.

Based on the established results logical framework, the expected strategic results of the implementation of the NHDP, by the end of 2024, are as follows:

- Reduction of overall mortality from 5.2% to 3%%, reduction of maternal mortality from 290 to 145 per 100,000 live births, reduction of neonatal mortality from 33% to 16.5%, of infant mortality from 65% to 30% and of child mortality from 113% to 56.5%. At the malaria level, reduction of the percentage of deaths from 37% to 20% in the general population and from 28% to 14% in children under 5 years of age is expected.

- Reduced risks of early pregnancies, clandestine abortions and maternal deaths of adolescent girls through appropriate communication strategies and prevention measures available in and out of school.

- Reduction of HIV prevalence from 6.2% to 4%, increase in the number of patients under ARV treatment and condom use, and implementation of the mechanism for documented complaints about discrimination and stigmatization of people living with HIV, and resolved by a human rights ombudsman's office.

- Reduction of malaria prevalence from 10.9% to less than 5% on Bioko Island, from 46.2% to 23% on the mainland and from 24% to 10% on Annobón Island; use of insecticide-treated mosquito nets by 60% of the population and treatment of intermittent malaria (IPT) reaching at least 90% in all pregnant women.

- Consolidation of the elimination of neonatal tetanus and polio through the reinforcement of vaccination coverage, reaching at least 90% for all antigens. Also the elimination of onchocerciasis on the island of Bioko and the organization of campaigns to eliminate Lymphatic filariasis, Schistosomiasis and Geohelminthiasis.

- Significant reduction of the population's vulnerability to epidemics, health emergencies and other health events.

- Health system that has sufficient and competent human resources, equitably distributed, with a financing mechanism involving the public, quasi-public and private sectors and a strong governance system that ensures coordination and management of human, material and financial resources with a culture of accountabilitys.

The success of the NHDP depends on the following: (i) a personal involvement of the **President of the Republic, Obiang Nguema Mbasogo**, (ii) a planned intervention framework, (iii) a management with measurable results, (iv) the availability of competent human resources, (v) a strong institutional implementation Framework, (v) a strong strategic communication and (vi) an implementation risk management based on a matrix approach.

CHAPTER I: NHDS ELABORATION PROCESS AND STEPS

1.1 Stages of the NHDP roadmap

For the Ministry of Health and Social Welfare (MOHSW), this is its second experience in preparing a National Health Development Plan (NHDP) to ensure strategic and operational management of the National Health System. In order to carry out this process, a road map has been adopted that includes the following stages:

a) Situation analysis and response

The elaboration process began in 2017 with the constitution of a national team composed of MOHSW general directors, heads of services and national program directors; and the distribution of tasks under the leadership of the Minister of State for Health and Social Welfare and the technical advice of the World Health Organization (WHO), through a technical expert based in its Libreville office.

The working methodology was participatory with the distribution of the technical staff of the services and programs in a technical secretariat and seven working groups corresponding to the seven pillars of the National Health System: themes of the work of situation analysis and response for the elaboration of this NHDP, on the basis of the technical guidelines for data collection. Based on this collection, which lasted three months, the analysis of the problems in the seven pillars of the National Health System was initiated through the causal analysis of the problem tree, with the identification of immediate, underlying and deep causes, as well as the elaboration of the preliminary report of the priority problems identified in the seven pillars.

To reinforce the work dynamics of the elaboration of the situation analysis, two national consultants were recruited for a period of 5 months whose presence expedited, considerably, the process of organizing the first national technical validation workshop and the first draft in December 2018 in Luba.

b) Elaboration of the NHDP

Relying on the regular technical support of the expert from the WHO Libreville office, the elaboration process was accelerated and strengthened. Also with the constitution of a national team and the organization of workshops as a first action focused on the seven pillars of the Health System to carry out and deepen the situation analysis with complementary data and the adoption of the priority health problems with their respective specific problems and root causes.

The second action of this stage was the updating of the 2002 National Health Policy to the health needs of the population with objectives aligned to the SDGs in 2030 and the Equatorial Guinea 2035 Agenda.

The third action was the identification and elaboration of the priority programs of the NHDP for the period 2021-2025 that take as a reference the strategic guidelines of the National Health Policy marked in the Equatorial Guinea Agenda to the 2035 horizon.

The fourth action was the organization, in September 2019, of the national workshop for the technical validation of the three NHDP products namely: (i) the situational analysis of the National Health System, (ii) the National Health Policy and (iii) the four priority programs.

The fifth action is the submission of the NHDP documents to the Board of Directors of the Ministry of Health and Social Welfare for approval and adoption by the Government as official reference tools.

c) NHDP budgeting using the One Health tool

The One Health tool was chosen by WHO and other development partners to assist countries in the preparation and analysis of budgets for development programs and plans such as the NHDP. One Health offers the advantage of estimating the real costs of programs by formulating possible assumptions linked to the targets set for a period and the risks of implementation, for example, in the case of economic crises.

To facilitate the budget estimation of programs such as the NHDP, which is the subject of this document, a logical framework has been prepared and annexed, which includes a quantification of the activities of the different strategies of the subprograms that are already binding.

1.2. Involvement of stakeholders and partners in the NHDP elaboration process

The elaboration of the NHDP, for the period 2021-2025, has been developed with a participatory approach through the involvement of several health partners, namely:

a) The Government of Equatorial Guinea through the Minister of Health and Social Welfare who led the entire NHDP elaboration process.

b) WHO, UNICEF, UNFPA and Spanish Cooperation, which participated in all stages of the NHDP elaboration and technical validation.

c) The Ministries of Finance, Economy and Planning, Social Affairs and Gender Equality, Education and Science, Interior and Local Corporations, as health partners.

1.3. Limitations in the elaboration of the NHDP

The NHDP is a great opportunity for the Ministry of Health and Social Welfare and development partners to plan and implement the health issues outlined in the Equatorial Guinea 2035 Agenda. However, insufficient statistical data, due to the failure to conduct the second EGDHS in 2017, did not allow for updated indicators to assess the achievements reached in the different programs and projects. This situation seriously hindered the establishment of baseline indicators in the NHDP programs.

The data from the only EGDHS, conducted in 2011, are almost obsolete to serve as a baseline reference in health planning and decision making. Also, the deficient capacity of the National Health Information System, characterized by the absence of elaboration and dissemination of the Health Statistical Yearbook, the periodic epidemiological bulletin and a health journal, hindered the availability and use of quality health data throughout the NHDP elaboration process.

NHDP ROADMAP (MILESTONES)

1. Situation analysis and response.
2. Working groups according to the 7 pillars of the National Health System.
3. Updating of the National Health Policy.
4. Elaboration of priority programs.
5. National workshop to validate NHDP products.
6. Presentation to the MOHSW Board of Directors.
7. Elaboration of the NHDP budget.
8. Participation of stakeholders and development partners.

CHAPTER II: SITUATION ANALYSIS

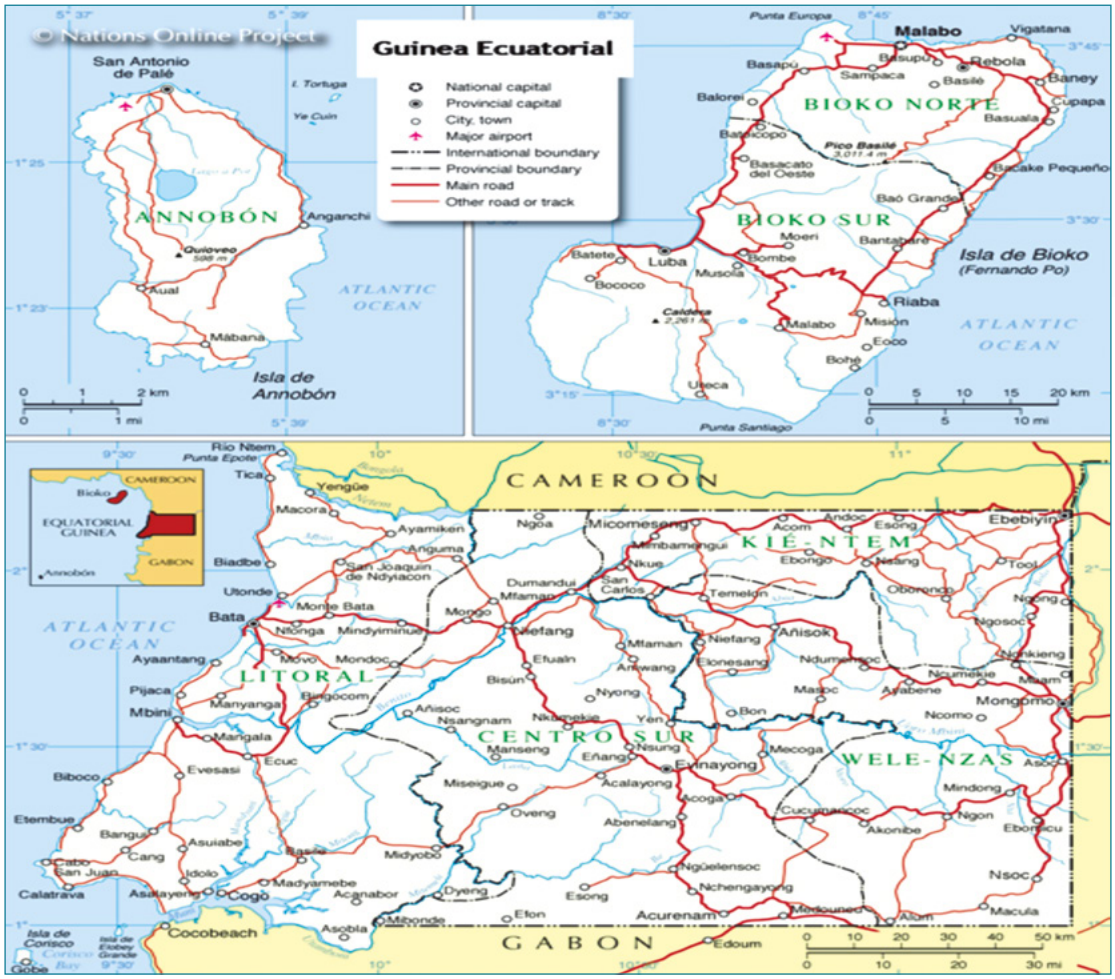
2.1. Country Profile

The Republic of Equatorial Guinea is located in the south of the Gulf of Guinea, west of Central Africa. It occupies 0.09% of the surface area of the African continent, with its 28,051.46 km² divided between two clearly distinct regions: one continental and the other insular. The country is divided into 2 regions, 8 provinces, 19 districts, 36 municipalities, 63 urban districts, 416 neighborhood communities and 835 village councils.

The results of the 4th General Population and Housing Census of 2015 revealed that the resident population of Equatorial Guinea is made up of five main ethnic groups: The Fang, Bubi, Ndowe, Bisio and Annobonese and totals 1,225,377 inhabitants, with 52.4% men and 47.6% women; 12.4% represent expatriates.

Most of the population is concentrated in the provinces of Litoral and Bioko Norte, which are home to 30.0% and 24.5%, respectively. The main points of attraction are the districts of Malabo and Bata, as political and economic capitals of the country.

Figure 1: Map of Equatorial Guinea



2.2. Socioeconomic Situation

Oil exploitation is the country's main source of income and has contributed 76.1% of the average GDP since 1997. The growth of the national economy is essentially explained by the continuous increase in oil production, moving the economy from the "okume" cycle to the "black gold" cycle. However, GDP has been weak in recent years due, in large part, to a trend decline in the predominant hydrocarbon sector with effects on public investment and resulting in a deep contraction of the large construction sector and the Public Administration (18).

2.3. Health status of the population

2.3.1. General mortality and life expectancy

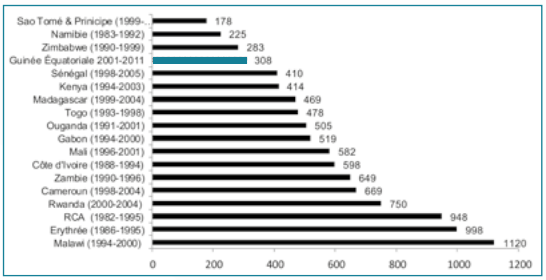
The general mortality rate for adults (15-49 years), for the period 2001-2011, is 5.2%, being 4.0% for women and 6.4% for men. In men, the rates go from 3.9% (15-19 years), the 5.1% (30-34 years) and to a maximum of 12.5% at ages 45 to 49 years. Among women, rates vary from 2.9% (15-19 years), to 5.3% (30-34 years), to a maximum of 7.6% among those aged 45-49 years). Life expectancy at birth is 59 years (23).

2.3.2. Maternal and Women's Health

In Equatorial Guinea, fertility among women remains high at 5.1 children per woman, making it one of the highest in Central Africa. It is also among the earliest in child bearing with 176 births per 1,000 women aged 15-19 years, with a general fertility rate (GFR) estimated at 181 births per 1,000 women of childbearing age and a crude birth rate (CBR) estimated at 36 births per 1,000 persons (23).

The results of the 1994 General Population and Housing Census estimated the maternal mortality rate at 352 per 100,000 live births. The EGDHS - 2011 estimated the same rate at 308 per 100,000 live births; and later WHO and UNFPA, during the MDG assessment in 2013, made an adjusted estimate placing that rate at 290/100,000 live births. The latter data placed Equatorial Guinea among the sub-Saharan African countries that are achieving a greater reduction in maternal mortality, reaching MDG 5 in 2015 (14), as shown in the following graph.

Graph 1: Map of Equatorial Guinea



Source: *EDSGE- I/2011*

The results of the 2016 assessment of the availability, utilization and quality of Emergency Obstetric Care (EmOC) services in Equatorial Guinea indicate that maternal deaths are due to direct causes: hemorrhage (30.46%), ectopic pregnancy (22.15%), preeclampsia and eclampsia (15. 23%), prolonged/dystopic labor (14.16%), abortion complications (9.37%), puerperal sepsis (2.13%) and other obstetric complications (5.22%); and indirect causes during pregnancy such as Malaria, Anemia, HIV/AIDS, Tuberculosis and Hepatitis (20).

The strengthening of Primary Health Care (PHC), based on the operationalization of the health district that includes the EmOC, should be part of the priorities in maternal and neonatal health to promote universal access to quality maternal and neonatal health services at all levels of the health pyramid.

The situation of cervical cancer (CC) is

equally worrisome, although with some reduction in prevalence from 6.1% in 2007 to 4.72% in 2016, based on routine results from two CC early detection, prevention and treatment projects carried out in this period in the country (2).

2.3.3. Infant morbidity and mortality

Depending on certain sociodemographic characteristics, the perinatal mortality rate is generally estimated at 37%, with variations, placing it at 35% for the 15-19 age group and reaching 113% in mothers aged 40-49 years (23). The risk of perinatal mortality is 1.7 times higher when the interval since the previous pregnancy is less than 15 months. The risk of perinatal mortality is 35.5%, being lower in the island region than in the mainland (32% vs. 39%) (23).

The EGDHS-2011 places neonatal mortality at 33%, infant mortality at 65%, and infant and child mortality at 113% in the same period (23). Malaria, acute respiratory infections, acute diarrheal diseases, and HIV/AIDS are the leading causes of infant mortality (23).

Of births occurring in the five years prior to the EGDHS, 12% had low birth weight (less than 2,500 grams) and during the two weeks prior to the survey, 6% of children under 5 years of age suffered from acute respiratory infections (ARI) and 32% of children had fever and 21% had diarrhea (23).

Most of the children born in the five years prior to the survey (81%) were breastfed. Only 21% were breastfed within the first hour of birth and 60% were fed before being breastfed. The same source indicates that only 7% of children under 6 months received exclusive breastfeeding and 52% between 6-9 months received complementary foods (23).

Among children under five years of age, 26% were underweight in relation to their age and therefore suffer from stunting or chronic malnutrition; and 3% suffer from acute malnutrition (23). Severe stunting accounts for 9% of cases. It should also be noted that chronic malnutrition is more frequent in rural areas (32%) than in urban areas (20%) (23).

Routine EPI data from 2016 indicate low coverage of Pentavalent, placing it at 35%, polio at 31%, for the third dose, and measles at 29%. The results of the 2016 independent external evaluation reflect that only 24% of children have been fully vaccinated (16). EPI data indicate the increase in vaccination coverage reaching 46% for pentavalent, 34% for polio, and 39% for measles, during 2018.

2.3.4. Adolescent and youth health

The health of young people and adolescents is characterized by a fertility that increases rapidly with age, from 12% at age 15 to 60% at age 19, being higher in rural areas with 53% and in the continental region of the country with 48%. According to the 2011 EGDHS, more than two adolescents out of 5 (43%) would have already started their reproductive life, 37% of them have had at least one child and 6% of adolescents are pregnant for the first time. The same source indicates that 14% of women between 25 and 49 years of age had already had sexual relations before the age of 15 (23).

Regarding adolescent sexuality, the average age of first sexual intercourse is 16 years for women between 25 and 49 years of age and 18 years for men in the same age range. There is little difference between rural areas, with 17 years for women and 18 years for men, and urban areas, with an average of 18.1 years for men and 16.9 years for women (23).

There is currently an increasing trend in the use of alcohol, drugs and tobacco among adolescents and young people. This is a

situation of great concern because of the consequences for the National Health System and for the community in general.

In terms of HIV, the overall prevalence is 6.2%, the level of knowledge among young people between 15 and 24 years of age is 18% in men and 19% in women; the use of condoms in the last risky sexual relations is 29.1% for men and 23.5% for women (23).

2.3.5. People with rehabilitatable pathologies

Routine statistical data from the National Health Information System (NHIS) for 2016 indicate that the pathologies subject to rehabilitation are part of the specific problems, such as degenerative diseases of the bone-my articular system (BMS) which have the highest incidence in the population with 1,534 cases and represent 68.0%, followed by encephalopathies with 166 cases and 7.4%, and psychomotor developmental delay with 158 cases and 7.0% (7).

2.4. National Health System Profile

2.4.1. National Health System and Policy

Based on the National Health Policy adopted in 2002 and during the II National Economic Conference held in November 2007, six strategic objectives were approved in the National Economic and Social Development Plan for Horizon 2020:(i) strengthen the organization and coordination and management mechanisms of the health system, (ii) improve the supply, demand, access and quality of services, (iii) improve the health of mothers and women, children and adolescents, (iv) strengthen the fight against endemic diseases, (malaria, tuberculosis, HIV/AIDS, filariasis and other neglected diseases), (v) strengthen the control of chronic diseases and (vi) develop the surveillance and response system.

The National Health System (NHS) is pyramidal, with administrative and/or management structures and care structures at three hierarchical levels. The care model is also structured in three levels: (i) primary consisting of health centers and health posts, (ii) secondary, consisting of district and provincial hospitals, and (iii) tertiary, consisting of regional hospitals and specialized care structures. The current system needs to be strengthened to consolidate what has been achieved and ensure health resilience in the face of epidemics and emergencies.

2.4.2. Response of the National Health System

2.4.2.1. Health Sector Leadership and Governance

DSince 2002, the country has had a National Health Policy to guarantee equitable access to health services for the population. However, this policy needs to be updated in order to comply with the Government's commitments in the area of health, in view of the Sustainable Development Goal 3 (SDG) in 2030 and the Equatorial Guinea 2035 Agenda, in order to improve the health and well-being of the population. On the other hand, there is poor monitoring of health interventions at the strategic level, either due to lack of planning or insufficient coordination mechanisms.

The lack of a programmatic framework based on results, which is a reference at all levels of the health system, seriously weakens planning, monitoring and evaluation due to the limited use of indicators for appropriate decision making. It should be noted that one of the consequences is the lack of plans for the operationalization of the health district.

Table 1: Priority problems of leadership and governance of the health system

LEADERSHIP AND GOVERNANCE OF THE HEALTH SYSTEM PRESENT THE FOLLOWING PROBLEMS, WHICH CAN BE SEEN BELOW
• Weak legal and judicial provisions in health system management . • Weak programmatic and management framework of the health system. • Deficient coordination of the interventions of development partners and private initiative in health. • Deficient decentralization of resource management and decision making in health. • Deficient implementation of health sector reforms. • Deficient mechanism for accountability and control of health management. • Deficient participation in health policy dialogue (NGOs, associations, private sector).

2.4.2.2. Human Resources for Health

Human resources are the asset of the health system, since the efficient and effective use of other resources to achieve the health and well-being of the population depends on them. Aware of this reality, the Government of Equatorial Guinea is deploying efforts in the initial and continuous training of health professionals, through national and international training institutions and through the implementation of training plans and programs in the UNGE and MOHSW.

Within the framework of the implementation of these programs, in the last 15 years it has been possible to train general practitioners, specialist doctors, graduates in nursing, university graduates in nursing, health technical assistants, PhD in Social Sciences, Masters degrees in the following areas; Public Health, Data Management, Clinical Research, Global Health, Clinical Auditing, Human Resources Management, Hospital Administration and health assistants in different a (Nursing, Laboratory, Pharmacy, Statistics), among others (1).

The national health system has 2,222 health professionals as at 2018, as shown in Table No. 2. On the other hand, the density of health personnel is 1.81 per 1,000 inhabitants, a very low percentage if we want to achieve SDG No. 3 in 2030 if we compare it with the 4.45 per 1,000 inhabitants recommended by WHO. This low density of health personnel in relation to the population is justified by the quantitative insufficiency of professionals trained and employed by the Ministry of Civil Service and Administrative Reform for the health sector.

Table 2: Health professionals status as at 2018

REGIONS/PROVINCES	POPULATION	ROFESIONAL CATEGORIES											TOTAL
		DOCTORS	PHARMACISTS	STOMATOLOGISTS	DIPLOMA NURSES	ATS	MIDWIVES	BIOLOGISTS	DEGREED NURSES	GENERAL TECHNICIANS	HEALTH ASSISTANTS	COMMUNITY NURSING ASSISTANTS	
Insular Region	**340.362**	**46**	**4**	**4**	**23**	**62**	**36**	**1**	**6**	**19**	**484**	**10**	**695**
Bioko North	300.374	42	4	4	23	60	30	1	4	19	430	6	623
Bioko South	34.674	3	0	0	0	1	3	0	2	0	33	4	46
Annobón	5.314	1	0	0	0	1	3	0	0	0	21	0	26
Continental Region	**885.015**	**64**	**3**	**2**	**133**	**99**	**68**	**1**	**94**	**14**	**828**	**221**	**1.527**
Litoral	367.348	49	3	2	115	70	29	1	86	12	364	48	779
Centro Sur	141.986	4	0	0	2	9	13	0	2	0	95	43	168
WeleNzas	192.017	5	0	0	10	11	11	0	6	1	218	56	318
KieNtem	183.664	6	0	0	6	9	15	0	0	1	151	74	262
Total nacional	**1.225.377**	**110**	**7**	**6**	**156**	**161**	**104**	**2**	**100**	**33**	**1312**	**231**	**2.222**

Source: Civil service health census.

The distribution of health personnel by categories, in this table, indicates a low number of professionals, with only 4.95% of physicians, 0.31% of pharmacists, 0.27% of stomatologists, 0.09% of biologists, 7.0% of university graduates in nursing, 7.24% of health technical assistants, 4.68% of midwives, 4.50% of graduates in nursing, 1.48% of technicians in general, 50.04% of health assistants and 10.39% of community nursing assistants (7). These percentages reveal the quantitative insufficiency of personnel, evidenced by a ratio of health personnel per inhabitant that is still very low, with only one physician for every 11,140 inhabitants, one graduate in nursing for 12,254 inhabitants, one university graduate in nursing for 7,855 inhabitants and one midwife for 11,782 inhabitants (7).

The geographical distribution of the same personnel among the professional categories suffers a great disparity in the two regions, with a greater concentration in the cities of Malabo and Bata, to the detriment of the other districts that present ample needs to offer quality health services.

Despite the efforts made by the Government in the training of health professionals, MOHSW does not have a human resources training plan, nor coordination mechanisms with the Ministry of Finance, Economy and Planning, Ministry of Education, Science and Sports, nor with the Ministry of Civil Service, to ensure the availability of competent personnel to meet the needs of health service delivery centers at all levels.

On the other hand, it should be noted that the organizational structure of MOHSW, as a legal instrument that establishes the organizational and functional bases of the Department, does not meet current needs. Therefore, its updating in the very short term is necessary to assume leadership functions in planning, coordination, monitoring and evaluation of health personnel and to ensure the optimal functioning of the structures at the different levels of the national health pyramid.

Table 3: Priority problems in the management of human resources for health (HRH)

LACK OF A NATIONAL PLAN FOR HUMAN RESOURCES DEVELOPMENT IN HEALTH, WHICH IS JUSTIFIED BY THE FOLLOWING
• Lack of staff forecasting and training plans for all categories. • Lack of periodic evaluation of health personnel at all levels of the health system. • Insufficiency (quantitative and qualitative) of personnel in all services and programs. • Deficient functioning of the MOHSW organizational structure at all levels.

2.4.2.3. Health Infrastructure, Equipment and Maintenance

Equatorial Guinea has a well-proportioned geographical map of health infrastructure, compared to the size of the population, with 18 public hospitals, 109 health centers and 387 health posts. Although most of these last two categories are not functioning due to lack of personnel, equipment and essential medicines. Despite these efforts, infrastructure development in the health sector does not yet have established standards in accordance with the needs and size of the population.

The deficient coordination and coordination between MOHSW, the Ministry of Public Works and Urbanization and the National GE-project Office, as responsible for the design, execution, monitoring and control of health works, means that MOHSW (as direct beneficiary) receives deliveries of works and equipment that sometimes do not meet all the required technical conditions. The lack of a sanitary map is another major

weakness in the development of infrastructure that meet the standards required in the coming years.

The management of the design of health infrastructure, the procurement of equipment and materials, as well as preventive and corrective maintenance are not always based on international norms and standards, which sometimes leads to serious operational problems. Most of the infrastructure are maintained only for general cleaning.

The absence of physical inventories of the equipment and materials installed does not allow for obtaining real data on their stock and physical condition. In addition, there is a lack of a national policy on the acquisition and maintenance of biomedical equipment.

In relation to the supply of drinking water in health facilities, there is an irregular supply with abrupt and long-lasting interruptions; a situation that forces facilities to be supplied by traditional wells, despite the existence of treatment plants and the existing urban drinking water network in the district capitals.

On the other hand, there is little availability of means of communication in many health facilities (telephones, internet, radio frequency) to guarantee the exchange between professionals and decision-makers and to ensure a constant improvement of the chain for patient referral and counter-referral.

The General Directorate of Health Infrastructure and Logistics does not have medium and senior technicians in technical management, logistics and maintenance of biomedical equipment, to such an extent that the possibilities of this unit are limited to ensure the fulfillment of its mission (coordination, planning, execution, supervision and control of infrastructures and equipment).

***Table 4:** Infrastructure, equipment, maintenance and essential services problems*

DEFICIENT QUANTITY AND QUALITY OF AVAILABLE BIOMEDICAL EQUIPMENT AND HEALTH INFRASTRUCTURE, WHICH IS JUSTIFIED BY THE FOLLOWING
• Limited technical capacity of the General Directorate of Health Infrastructure and Logistics. • Verticalized procurement of equipment by most MOHSW programs and services. • Irregular supply of potable water in several hospitals and health centers. • Irregular supply of electricity in some health facilities. • Deficient means of communication (telephones, internet, radio frequency) and audiovisual materials in health facilities and in the community. • Deficient maintenance systems for health facilities and biomedical equipment.

2.4.2.4. Management of drugs and other medical devices

Regarding the management of medicines and other health products, there are several legal instruments such as Law No. 4/1985, dated October 24, which creates the National Service of Traditional Medicine, Law number 3 / 2003, dated November 18, which regulates the pharmaceutical practice in the country, Ministerial Order No. 1/2016 which regulates the control of imports and the price of medicines and Decree No. 73/2018, dated April 18, for the Licensing and registration of medicines. There is also a National Pharmaceutical Policy pending approval and a National List of Essential Medicines, updated in 2018.

Today, the country has very few professionals with a degree in Pharmacy and there is

no initial and continuous training plan for professionals in the pharmaceutical sector. Pharmacy activity is being carried out by pharmacy technicians and assistants and, mostly, by health assistants.

The system lacks standards and procedures that respect the logistics management chain of medicines and other health products. There is no national committee for the selection of essential drugs to lead the procurement process, nor is there a single drug supply system for public and private health facilities, given that the pharmaceutical sector has few suppliers officially operating in the country.

On the other hand, the current management of pharmacies in public hospitals by the Center for the Provisioning of Medicines (CENTRAMED) seriously limits the population's access to medicines because they are branded and therefore expensive compared to the purchasing power of most patients.

The country does not have a pharmaceutical industry, so all pharmaceutical products are imported without quality guarantees because Equatorial Guinea does not have a quality control system.

Despite the existence of the National Directorate of Traditional Medicine and the National Association of Traditional Doctors of Equatorial Guinea (ASOMETRAGE), there is a deficient integration of Traditional Medicine in the Health System, the absence of a control mechanism for the products used in Traditional Medicine and the mixture of Spiritism practices that seriously undermine the practice of this branch of medicine.

In the analysis of the logistic management of medicines and other health products, the problems outlined below, to be solved within the framework of the present NHDP, were detected.

***Table 5:** Management of drugs and other medical devices*

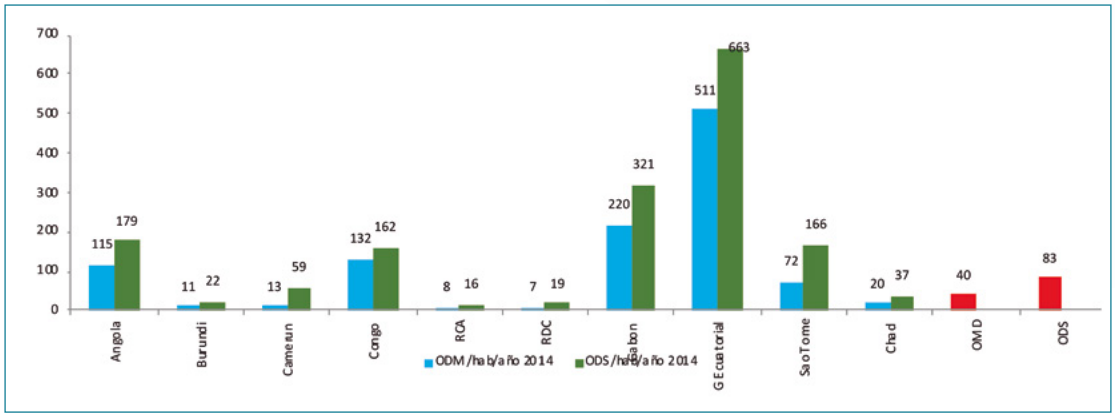
THE DEFICIENT LOGISTICS MANAGEMENT SYSTEM FOR MEDICINES AND OTHER HEALTH PRODUCTS AND OTHER HEALTH PRODUCTS, WHICH IS JUSTIFIED BY THE FOLLOWING
• Frequent stock-outs of medicines and other health products.
• Poor financial accessibility of the population to medicines and other health products.
• Lack of management of the consumption of medicines and other health products in service delivery centers.
• Lack of quality control of medicines and other health products in the country.
• Lack of coordination between MOHSW, CENTRAMED and wholesale importers of medicines and other health productss.
• Deficient use of Natural and Traditional Medicine as a therapeutic alternative.

2.4.2.5. Health Financing

The National Health System does not have National Health Accounts that include the concepts of expenditure and income of health functions (human resources training, health and health insurance administration, prevention and public health services, health products dispensed to patients, auxiliary health care services, long-term care services, curative and rehabilitation care services), which does not allow for budget forecasts of expenditure and income in the health sector, for a better budgetary allocation of the State's GDP to health financing.

According to WHO estimates, in 2014, the per capita and per year expenditure on health in Equatorial Guinea was US$663, placing the country above the threshold of US$86 recommended by the SDGs, to achieve universal health coverage (UHC). Based on this reality, the country is making high expenditures for health and yet does not achieve significant results, compared to other countries in the sub-region that are achieving better coverage with little investment.

***Figure 2:** Total health expenditure per capita and per country, 2014 in Central Africa*



Source: (http://apps.who.int/nha/database/Home/Index/

In 2012, government-financed health spending reached 54.3% of all expenditures against financial risk in health; and the share borne by the population was 45%, made in the form of direct payment (8). This fact shows that the population is bearing more than 20% of the recommended health expenditures per household (8).

The current policy of cost recovery for the provision of services in public hospitals and health centers continues to be ineffectively applied. Only 20% of collections are allocated to the operation of hospitals and health centers, while 80% is paid into the State Treasury (8). This situation hinders the independent management of public health facilities and affects the application of the

free services decreed by the government.

According to the same source (8), INSESO's health insurance covers only about 6.8% of the population (civil servants, employees and/or workers of affiliated private companies and private affiliates). It should be noted that the mechanism of purchasing health services as a third party payer is underdeveloped in the country, only in INSESO health facilities and in a small part of public and private health structures.

The financing of the population's health is facing the following problems stated below.

Table 6: Problems of financing the health of the population

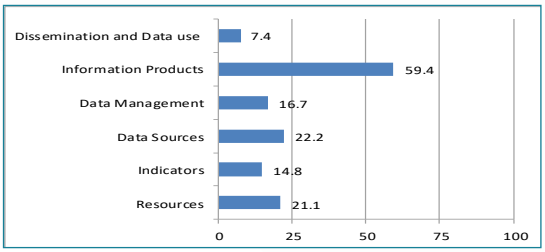
HEALTH FINANCING BELOW THE 15% COMMITTED IN ABUJA WHICH IS JUSTIFIED BY THE FOLLOWING
• Deficient funding of health sector plans and programs at different levels. • Deficient capacity for internal control and audit of the management of resources allocated to health. • Lack of mechanisms for monitoring the economic use of resources allocated to health sector. • Lack of mechanisms to protect the population against financial health risks. • Deficient quality of INSESO's services, as it is both an insurer and manager and provider of health care services.

2.4.2.6. Health information and health research management

According to the results of the evaluation carried out by MOHSW in 2014, through the WHO's Health Metrics Network (HMN), the National Health Information System (NHIS) is deficient in ensuring quality management of health program information and data.

The synthesis of these results indicates a NHIS characterized by a notorious deficiency of reliable information on the health situation, with a routine information system that is practically inefficient, fragmented and non-integrated. This does not allow for instantaneous information on the level of utilization and quality of services or on the level of user satisfaction, to which must be added the difficulties in the management of medicines and health products, due to the lack of consumption data.

Graph Nº 2: Results of the evaluation of the HMN components of the HIS



Source: NHIS National Assessment Report, Equatorial Guinea 2014

EIn the absence of periodic publications of health statistics yearbooks and epidemiological bulletins, the NHIS lacks reference instruments to measure its effectiveness in terms of the collection, processing, analysis, dissemination and conservation of the information produced at the different levels of the health pyramid.

The current situation of the Epidemiological Surveillance service evidences the lack of resources (human, material, logistic and equipment) both in quantity and quality for the adequate management of health information, which has led to deficient personnel training and little supervision, according to the Integrated Disease Surveillance and Response Guidelines (IDSR); there is also no map that provides information on the epidemiological profile of the country. This situation is a

consequence of the low importance given to the management of health information and statistical data and to epidemiological surveillance activities.

In the last fifteen years, the country has carried out few studies and surveys at the national level, such as: (a) National CAP/2010 - 2011 survey on 4 essential family practices, (b) National survey on nutritional status of children under 5 years, 2012, (c) EGDHS - I/2011, (d) Survey on the prevalence of onchocerciasis in Bioko Island, 2013 (e) Neonatal tetanus survey, 2016 and (f) External evaluation of EPI, 2016.

Despite the efforts deployed by MOHSW, with the support of Development Partners, the NHIS faces the following challenges:

***Table 7:** RSummary of the problems of the National Health Information System (SNIS)*

SHORTCOMINGS IN THE NATIONAL HEALTH INFORMATION SYSTEM (NHIS) AT ALL LEVELS AND JUSTIFIED BY THE FOLLOWING
• Insufficient resources (human, material and financial) allocated to the NHIS, including Epidemiological Surveillance. • Absence of a national list of indicators defined and adopted by level of health service delivery. • Very limited source data of poor quality at all levels of the health pyramid. • Deficient dissemination and utilization of NHIS data integrating Epidemiological Surveillance (ES). • Deficient institutional and organizational framework of the NHIS that integrates epidemiological surveillance.

2.4.2.7. Provision of Health Services

LThe lack of data on the availability, utilization and quality of services in health facilities makes it impossible to assess the operational capacity of health structures at the different levels of the public and private sectors. In the absence of a SARA (Service Availability and Readiness Assessment) survey in the country, the NHDP team has based its efforts on the few routine data available from the few surveys conducted in the last 10 years.

Regarding Primary Health Care (PHC), there is still a deficient implementation of the strategy, according to WHO standards and the real needs of the country; whose first level services (prevention and promotion) are carried out in 225 health posts out of 384 existing ones (58.5%) and 47 health centers, considered operational, out of 109 existing ones (43.11%), offering poor quality services due to the deficient availability of human resources (in quantity and quality) (20).

The 11 district hospitals, as the first level reference unit, and the 5 provincial hospitals, which correspond to the second level of health care, offer almost the same package of deficient services, due to the low quality of equipment, frequent stock-outs of medicines and supplies, as well as the deficient quantity and quality of personnel.

The third level of service provision corresponds to the 2 regional hospitals of Malabo and Bata; the Bata hospital is the university hospital due to its role in the training of human resources and health research. This level benefits from the presence of para-public and private

care structures with more extensive and higher quality services, due to the technical equipment and the presence of qualified staff that integrates specialists in medical sciences to deal with complicated cases.

Regarding vaccination, this service is offered at the different levels of care with a total of 62 posts, among which 57 (91.9%) are operational with trained personnel. The procurement of vaccines and supplies is spearheaded by Government and managed by UNICEF, which has prevented stock-outs of vaccines and other supplies since 2016; and has guaranteed the cold chain with 9 chambers, 70 refrigerators and 5 freezers, with the objective of ensuring a vaccination coverage of at least 90%, nationwide. Despite the favorable conditions created, the deficient community participation, the insufficient human resources in the EPI, the irregularity of the advanced vaccination strategy, are among other major weaknesses to be corrected in order to improve such vaccination coverage.

Family Planning (FP) was regulated in 1996 through the Law that authorizes the use of modern contraceptive methods to avoid unwanted pregnancies and to space births without any restriction. The procurement of modern contraceptives and FP supplies is provided by the Government and managed by the United Nations Population Fund (UNFPA). Coverage of FP services remains limited in only 23 health centers out of 47 functional ones in 2018 (48.9%) and 6 public hospitals out of 18 existing ones (33.3%). The 2011 EGDHS - I estimated the unmet need for FP at 34% and the potential demand for FP in the country at 46%.

With regard to prenatal care, 100% of public sector hospitals and 47 functional health centers (HC) perform pregnancy monitoring, in compliance with established standards and procedures, with a staff composed of general practitioners, obstetrician-gynecologists, university graduates in nursing (DUE), midwives, gynecology-obstetrics health technicians (ATS-G) and auxiliary nurses. The same activity is also in place in para-public and private facilities offering maternal and neonatal health services. However, the lack of training supervision and periodic monitoring weakens the quality of services provided in all facilities.

Referring to child nutrition, the practice of breastfeeding is only 7%, which exposes the largest number of children to nutritional problems, leading to malnutrition, with 2,565 cases reported in 2016 (19). The program does not have sufficient trained personnel or a nutritional follow-up plan for children under 5 years of age or pregnant women in the community.

In relation to adolescent and youth reproductive health, the responsiveness of health structures to the needs of adolescents and youth is very low as very little training is provided to health personnel and young people themselves on sexual and reproductive health. This situation is evidence of the limited availability and use of male and female condoms and other modern contraceptive methods among adolescents and young people of both sexes. Another major limitation is the lack of promotion of sexual and reproductive rights among youth due to the poor integration of sexual education in the school curriculum and the lack of multifunctional sexual and reproductive health centers in the community.

For the integration of Traditional Medicine in the provision of services, there is a deficient

promotion of this branch of medicine as a therapeutic alternative, despite the wide environmental offer rich in plants, as an important potential to treat several pathologies. The lack of organization of healers, according to their professional profile, as well as the lack of control of prescriptions and medicinal plants used, hinders the practice of Traditional Medicine in the country.

With the start of the malaria control project, through the National Program financed by the Government and supported by the private sector on Bioko Island and by the Global Fund in the continental region in 2004, the epidemiological situation of the country improved. However, since the withdrawal of the Global Fund in 2011, this improvement was affected due to the availability and utilization of malaria control services only on Bioko Island to the detriment of the mainland and Annobón Island, thus creating a large disparity between the two regions of the country.

In terms of prevention, only 38% of households had at least one insecticide-impregnated net (ITN) and 36% had a long-lasting insecticide-impregnated net (LLIN) in 2011 (23), at the national level. Approximately six out of ten pregnant women (61%) have taken preventive antimalarials during their last pregnancy, but only 28% received at least two doses of SP/Fansidar during a prenatal visit, as recommended under intermittent preventive treatment (IPT) (23).

In terms of treatment, 32% of children under five years of age with fever in the two weeks prior to the 2011 EGDHS were treated with antimalarials, but only 15% were treated with Artemisinin-based combination therapy (ACT). Nearly five out of ten children (48%), aged 6-59 months, had a positive rapid diagnostic test (RDT) for malaria.

The proportion of positive results on Bioko Island was substantially lower (13%) than the proportion recorded on the mainland (59%). This situation may be explained by the discontinuation of malaria control services since the closure of the Global Fund project covering the mainland region.

Despite the efforts deployed, malaria prevalence in children under 5 years of age has been 55.1% in the mainland region, 17.4% in Annobón Island (2017) and 6.6% in Bioko (2018). In the general population, the prevalence is 46.2% in the mainland region (2013) and 10.9% on Bioko Island (2018).

According to WHO, the Republic of Equatorial Guinea is one of the countries most affected by tuberculosis in the CEMAC sub-region. Between 2006 - 2018, the number of diagnosed cases of tuberculosis, of all forms, increased from 420 to 1,366 in a total population of 1,225,367 inhabitants, with a growth in incidence estimated by WHO of 191 per 100,000 inhabitants.

Since 2016, MDR-TB cases have been reported in a proportion of 10% of new TB cases and 30% and 60% in retreatment cases. The detection rate of sensitive TB is 58% and of resistant TB is approximately 18%. Cases of extensively drug-resistant TB (XDR) have been reported since 2016 (7).

Diagnostic coverage with Bacilloscopy (1st line) reaches, in 2019, 66% of the districts and with Xpert is available only in the two regional hospitals for 11% of new patients and 51% of treated patients in the country. To date, the country has no 2nd line resistance

diagnostics, despite the fact that the regimen of choice for multidrug resistance (MDR) is short-course ("Bangladesh") (7).

Despite an HIV/TB co-infection rate of 36% (2018), TB control activities among PLWHA are insufficient. For example, Isoniazid preventive treatment (IPT) is not offered (7).

The overall HIV prevalence in the population has doubled in the last 10 years reaching 6.2% (8.3% in women and 3.7% in men), in ages 15 - 59 years, with 1.2% in young people aged 15 - 19 years and 3.1% in young people aged 15 - 24 years. This worrying situation puts the youth layer at risk in the absence of effective prevention measures. According to data estimated by UNAIDS (2018), the number of people living with HIV (PLWHA) is 62,300 of which only 21,686 (35%) are under treatment.

Services to combat HIV/AIDS and other Sexually Transmitted Infections (STIs) are completely free of charge in the Republic of Equatorial Guinea, financed by the Government's own funds. Awareness-raising, prevention and multi-sectoral HIV/AIDS and STI control activities are the main services provided to the population and are mainly based on educational messages through the media, educational talks in schools and communities, and the distribution of leaflets, posters and banners. Prevention activities are strengthened by the free distribution of condoms to the population. The involvement of other social sectors is one of the achievements being made in the multi-sectoral fight against HIV/AIDS, with greater involvement of the Military Corps and other sectoral departments at the national level.

On the other hand, prevention of vertical transmission of HIV is the strategy applied to cut the chain of transmission of the virus from the infected mother to the child, at different stages. In Equatorial Guinea, the strategy has been initiated since 2003 with monotherapy, which was subsequently changed to tri-therapy, through the updating of treatment protocols, training of personnel, acquisition and distribution of ARVs and other supplies.

The implementation process follows the new WHO therapeutic guidelines for HIV of June 2013, which recommend: (i) early initiation of treatment, (ii) treating all children and young people living with HIV, pregnant and lactating women and (iii) integrating HIV-linked services with other health services to maintain synergy of action and enhance management effectiveness. The vertical transmission elimination strategy is being implemented, covering 100% of public hospitals and 65% of health centers, without recording a stock-out in the last five years.

At the level of clinical service provision, only 27.7% of public hospitals offer complete services to patients with HIV/AIDS (medical consultation/counseling, distribution of ARV drugs and others, biological follow-up, routine data reporting), of which 60% have the category of provincial treatment centers (PTC) and 40% are called infectious disease referral units (IDRU). The latter two are located in the two regional hospitals of Malabo and Bata (7). In the last five years, the basic treatment package has also been extended in some public and para-public health facilities, including Social Security hospitals (7).

Although the Government assumes 100% of the costs of HIV/AIDS management, with treatment coverage for adults, which has increased from 39% in 2008 to 75% in 2012, there are still many weaknesses in

prevention which is the only way to reverse the trend.

Regarding the Fight against HIV/AIDS and other STIs, the program has free services and financed by the Government with State funds; being awareness, prevention and multi-sectoral fight, the main services provided to the population. In terms of coverage, only 5 of the 18 public hospitals (27.7%) offer complete services to HIV/AIDS patients; of which 3 (60%) have the status of provincial treatment centers (PTC) and 2 (40%) are infectious disease referral units (IDRU), which are located in the regional hospitals of Malabo and Bata.

Prevention of mother-to-child transmission (PMTCT) services are provided in the 18 hospitals and 47 functional health centers nationwide through the implementation of treatment protocols, staff training, procurement and distribution of anti-retroviral (ARVs) and other supplies. However, the lack of follow-up mechanisms for children born to mothers with HIV makes it impossible to monitor the efficacy of the intervention at 2 months of age through the laboratory technique of polymerase chain reaction (PCR) analysis.

Despite the efforts made by the Government, the difficulties that undermine the operation of the Program to Fight HIV/AIDS are mainly centered on the following: (i) deficient awareness and social mobilization in the fight against HIV/AIDS, (ii) lack of a social marketing program for the promotion of condom use, (iii) low coverage of ARV treatment services at the national level in relation to demand, (iv) deficient staff training, (v) lack of operational research on HIV/AIDS, (vi) deficient HIV/AIDS data management, and (vii) deficient equipment for the diagnosis and biological follow-up of patients.

Person-centered health care is very limited in relation to chronic non-communicable diseases, due to poor mechanisms for recruitment, follow-up and monitoring of new cases, poor functioning of district mobile teams, limited access of many low-income patients to public health facilities, prolonged stock-outs of essential drugs in many health care facilities, and poor quality of health care.

The management of neglected tropical diseases is based on several programs (human African Trypanosomiasis, Onchocerciasis, Schistosomiasis, Geohelminthiasis, Lymphatic filariasis, Loasis and W. Bancrofti) whose services are free of charge.

The Epidemiological Surveillance system is characterized by a deficient capacity for early detection, alert, notification and response, especially the insufficient application of the Surveillance Guide, the scarcity of qualified human resources, the low motivation and exclusive dedication of personnel to surveillance activities, the scarce means of communication (technical and logistic), the frequent stock out of materials, reagents, pharmaceutical products and other inputs, as well as the lack of formative supervision of the focal points for Epidemiological Surveillance in the health districts.

Regarding health promotion and social marketing, there are a number of weaknesses that hinder the implementation of these components to generate demand for health services at different levels, due to the lack of: (a) a strategic communication plan that includes information and sensitization, (b) adopted operational plans, (c) structures and resources capable of implementing the plans, (d) use of communication channels,

and (e) low participation of community authorities in sensitizing the population.

In view of the constraints described above, the Government and development partners have deployed efforts and resources to reverse the situation; and despite these efforts, health service delivery at all levels faces the problems shown below.

Table 8: Summary of health service delivery problems

DEFICIENT COVERAGE AND UTILIZATION OF CARE SERVICES AT THE DIFFERENT LEVELS WITH A VIEW TO THE GOAL OF HEALTH FOR ALL BY 2020, WHICH IS JUSTIFIED BY THE FOLLOWING
• Limited supply of quality health services at the different levels of the health pyramid.
• Deficient utilization of maternal, neonatal, child, adolescent and male health services.
• Deficient demand for quality health services at all levels of the health pyramid.
• Deficient availability and utilization of communicable disease control services.
• Deficient control of non-communicable and neglected tropical diseases.
• Deficient operational capacity of available biomedical and blood transfusion laboratory services.
• Deficient national response capacity in Epidemiological Surveillance (ES).
• Deficient management of cancer patients, traffic accidents and emergency/disaster situations.
• Deficient consideration of the role of Nursing in the promotion of universal health coverage.

CHAPTER III: PROGRAMMATIC FRAMEWORK OF THE NHDP

3.1. Linkage of the NHDP with development plans and programs

3.1.1. Sustainable Development Goals (SDGs) at Horizon 2030

The indicators of the goals set by the National Health Policy at the 2030 horizon that guide the results of the NHDP are perfectly reflected in SDG No. 3 on health, which is to "Ensure healthy lives and promote well-being for all at all ages". On the other hand, the need for the multisectoral approach to the main health determinants in the implementation of the NHDP imposes a broad approach taking into consideration the other binding SDGs such as: (i) end hunger, achieve food security and improved nutrition and promote sustainable agriculture (SDG No. 2), (ii) ensure inclusive, equitable and quality education and promote lifelong learning opportunities for all (SDG No. 3), (iii) ensure inclusive, equitable and quality education and promote lifelong learning opportunities for all (SDG 4), (iii) achieve gender equality and empower all women and girls (SDG 5) and (iv) ensure availability and sustainable management of water and sanitation for all (SDG 6).

The NHDP is linked to the Sustainable Development Goals and Agenda 2063 of the African Union and aligned with the programs of the Coordinating Organization for the fight against endemics in Central Africa

Table 3: Relationship between NHDP strategic Pillars and SDG 3 targets

N°	NHDP STRATEGIC PILLARS	SDG GOALS N° 3
1	The promotion of equitable access to quality health services that guarantee universal health coverage (UHC)	3.8.1
2	Increased use of quality health services for the entire population	3.1.1, 3.1.2, 3.2.1. 3.2.2, 3.7.1, 3.8.1, 3.a.1, 3.b.1
3	The promotion of a favorable environment for the health of the population	3.5.1, 3.5.2, 3.9.2, 3.b.3, 3.a.1
4	Strengthening health safety and the management of health emergencies	3.3.1, 3.3.2, 3.3.3, 3.3.4, 3.3.5, 3.d.1
5	Strengthening health governance and leadership	3.8.1, 3.8.2

3.1.2. African Union (AU) Agenda 2063

The NHDP strategies are part of the African Union's (AU) Agenda 2063 dream of an Africa whose prosperity is based on inclusive growth and sustainable development, with a population in good health and benefiting from quality food and nutrition accessible to all. With this NHDP, Equatorial Guinea intends to align itself with the strategic orientations of the AU in order to develop and manage, in a sustainable manner, its health system and establish programs and projects in the appropriate institutions to achieve the development objectives in the area of health.

3.1.3. Organization for the Coordination of the Fight against Endemic Diseases in Central Africa (OCEAC)

The NHDP's actions to combat the diseases are clearly defined in the programmatic guidelines of the Organization for the Coordination of the Fight against Endemic Diseases in Central Africa (OCEAC), as the implementing agency of CEMAC's health policy. In this perspective, Equatorial Guinea, through MOHSW, is fully involved in the process of elaborating the Regional Strategic Plan for the fight against HIV/AIDS, tuberculosis and hepatitis for the period 2019 - 2023, among other ongoing actions within the framework of regional integration in health.

3.1.4. National Economic and Social Development Plan to Horizon 2020

The National Economic and Social Development Plan to Horizon 2020, adopted in 2007 during its II Conference, which envisages significant changes in income distribution, economic diversification and the development of a social sector capable of improving the well-being of the entire population, has also been a reference tool for the preparation of this NHDP.

3.1.5. National Health Policy for the 2035 horizon

The vision, mission, principles, values and objectives of the strategic actions of the National Health Policy, set at the 2035 horizon, have also guided the programmatic framework of the National Health Development Plan.

3.1.6. Equatorial Guinea Agenda for the 2035 horizon

The long-term objectives and strategic orientations in health and well-being, adopted during the 3rd National Economic Conference of 2019, have been largely taken into account in the formulation of the NHDP's priority programs, subprograms, outcomes and indicators.

3.2. Programmatic framework of the National Health Development Plan (2021 - 2025)

3.2.1. Vision

The vision of the NHDP is the one set by the Government in the National Health Policy for the 2035 horizon, which envisages that "All girls and boys, adolescents and young people, women and men enjoy good health, through equitable access to quality services".

This vision links to the Astana Declaration of the International Conference on Primary Health Care (PHC), October 2018, assuring the country of the following:

- A strong health system that prioritizes the promotion and protection of people's health and well-being, both at the community and individual levels.

- A health system that prioritizes Primary Health Care (PHC) and higher quality, safe, comprehensive, integrated, accessible, accessible, available and affordable services for all and everywhere.
- A health system that prioritizes health services delivered with compassion, respect and dignity by competent, motivated and committed professionals.
- Health governance in an enabling and supportive environment, in which individuals and the community are empowered and collaborate for the consolidation and improvement of health and well-being.
- Health governance together with development partners involved and participating in the development of health sector policies, strategies and operational plans.

3.2.2. Mission

The mission of the NHDP is to provide Equatorial Guinea with a powerful, resilient health system capable of ensuring universal access to quality health services and optimal health status, in order to sustain the durability of economic growth and sustainable social development.

3.2.3. Principles

The principles of the NHDP are those of the National Health Policy vision, in line with the Universal Health Coverage (UHC) goal of SDG #3 and the 2018 Astana Declaration on PHC, namely:

1) Promotion of good governance in health, through high-level political support for the promotion and protection of the population's health, with the involvement of the President of Equatorial Guinea as the highest authority of the State.

The mission of the NHDP is to equip Equatorial Guinea with a powerful, resilient and efficient health system to ensure universal access to quality services and optimal health status.

2) Political decision making for health in all sectors, reaffirming the primary role and responsibility of the Government at all levels and in the promotion and protection of the right of all people to the enjoyment of the highest attainable standard of health.

3) Participation in health policy dialogue in order to maximize the mobilization and use of resources, the harmonization of interventions, and the follow-up and monitoring of intervention plans.

4) Decentralization of resource management and decision-making at different levels of the health system, through the operationalization of the health district.

5) Development of a common programmatic and management framework for all parties with greater involvement of the population in the development of health policies and programs.

6) Development of a human resources plan in health that emphasizes training, distribution and motivation of personnel to improve the quality of services at different levels.

7) Promotion of a sustainable Primary Health Care with investments and

improved infrastructures that prioritizes disease prevention and enhances services for promotion, prevention, cure, rehabilitation and palliative care, accessible to all.

8) Promotion of Universal Health Coverage (UHC) in collaboration with all stakeholders and community empowerment to increase the use of quality health services equitably accessible to the population.

9) Taking into consideration economic, socio-cultural and environmental determinants of health, to reduce risk factors in health and to ensure their incorporation in all already binding sectoral policies.

10) Involvement of all parties in achieving health for all, in order to leave no one behind, promoting transparency and a participatory approach.

11) Development of coherent and inclusive approaches to scale up PHC as a pillar of UHC in emergencies, ensuring continuity of care and delivery of essential services, in line with humanitarian principles.

3.2.4. Values

The NHDP respects the values of equity, social justice, national solidarity, sustainability, ethics, rigor, transparency and democracy at all stages of planning and implementation.

3.2.5. Goals and objectives

3.2.5.1. Goal

To raise the health status of the population of Equatorial Guinea to the highest and most equitable level in accordance with the resources available for the fulfillment of health commitments.

3.2.5.2. Objectives

a) General objectives

- Combat poverty and promote the sustained improvement of the health status of the Equatoguinean population.
- Promote strategies that enable the population to achieve a healthy longevity.
- Promote a culture of accountability in the governance of the National Health System (NHS).

b) Specific objectives

The strategic objectives that were approved in the National Economic and Social Development Plan ''Equatorial Guinea to Horizon 2020'' are still relevant to be reinforced and redirected in the present NHDP, namely:

- Boosting quality governance of the health system for greater service delivery and promotion of the culture of accountability.
- Strengthen the organization and coordination and management mechanisms of the National Health System.
- Improve the supply, informed demand, access and quality of health services for mothers and women, children, adolescents and men.
- Strengthen the fight against endemic diseases (malaria, tuberculosis, HIV/AIDS, hepatitis and other neglected diseases).
- Strengthen the control of chronic communicable and non-communicable diseases.
- Strengthen the health surveillance and response system for emerging and re-emerging endemic diseases and other public health events.

- Substantially increase the quantity and quality of human resources in the health sector, giving priority to the national supply, including those in the diaspora.

- Develop a financing model that involves the participation of the private sector and other partners in health development.

c) Objectives towards the SDG 3 targets by 2030.

Ensure universal access to integrated, continuous, equitable, equitable and people-centered quality healthcare for the following purpose:

1) Reduce maternal mortality from 290 to 140 deaths per 100,000 live births.

2) Reduce neonatal mortality from 33 to 16.5 per 1,000 live births.

3) Reduce infant and child mortality from 113 to 56.5 per 1,000 live births.

4) Reduce mortality related to communicable diseases by 50%.

5) Reduce by 50% the prevalence of risk factors associated with non-communicable diseases.

6) Reduce by 50% the prevalence of risky behaviors among adolescents and young men and women.

7) Reduce by 50% the level of vulnerability of the population to epidemics, emergencies and other health events.

8) To improve leadership in the coordination and overall management of the National Health System.

3.2.6. Strategic orientations of the National Health Policy

a) Improving equitable access of the population to quality health services in order to guarantee Universal Health Coverage (UHC)

Access to services is the basis for the implementation of UHC to ensure that everyone, regardless of their place of residence or socioeconomic status, has access to quality health services that are both integrated, continuous and comprehensive, through a health insurance mechanism. The aim is to improve the population's financial and equitable access to health services by progressively reducing out-of-pocket payments and financial health risks through the strengthening of existing maternal, child, adolescent and youth health programs, and the creation of a health care program for the disabled and the elderly.

To this end, the following actions will be carried out: (a) the elaboration and implementation of a health map that allows for a better distribution of health infrastructures, technical equipment, trained human resources, medicines and other supplies; (b) the strengthening of Primary Health Care (PHC) with the offer of essential quality services accessible to the entire population and (c) the elaboration and implementation of a hospital policy that establishes the standards and tools for curative care at the different levels of reference.

b) Increasing the use of quality health services for the entire population

The realization of this strategy involves the following: (a) increasing the availability of quality health services with a complete package, (b) implementing mechanisms for the application of free care services, established by the Government, (c) expanding national health insurance coverage, and (e) developing and

implementing a communication plan for health behavior change.

c) Promoting better health of the population

The aim is to promote a favorable environment for the prevention and treatment of communicable, non-communicable and neglected tropical diseases through multisectoral and inter-institutional health actions. This requires the availability of sufficient and well-distributed competent human resources, updated guidelines and standards and/or protocols and the necessary inputs to improve care, the promotion of multisectoral collaboration for the improvement of hygiene and quality sanitation conditions, the improvement of safe drinking water supply to the population, the promotion of physical activity through sports and physical education, as well as healthy eating practices.

d) Strengthening health safety and health emergency management

This strategic pillar includes the following actions: (a) the training of human resources and the acquisition of technical and logistical equipment for preparedness and response to epidemics and adverse health events, in accordance with the International Health Regulations (IHR), (b) the improvement of the availability of essential health surveillance services in all border areas and health centers for surveillance of diseases and public health events, (c) improved laboratory diagnostic capacity including operationalization of the Baney Reference Laboratory for rapid confirmation of epidemics, (d) development and implementation of a communication plan on emergencies/emergencies and public health events, and (e) improved availability and quality of statistical information on notifiable diseases and public health events.

e) Strengthening governance and leadership in the health sector

The actions to be carried out are the following: (a) improvement of legal and legal provisions in health, (b) improvement of the programmatic and resource management framework in the health sector, (c) coordination of interventions of development partners and private initiative in health, (d) decentralization of health resource management to the region, (e) strengthening of the health information system, (f) development of a culture of accountability at the different levels of management of economic resources allocated to the health sector, and (g) strengthening of human resources management.

3.2.7. NHDP results logical framework

The medium and long-term results, target indicators, means of verification and implementation risks are shown on Table 4.

Table 4: National Health Development Plan Results Logical Framework (2021- 2025)

HIERARCHY OF RESULTS AND INDICATORS	GOALS		VERIFICATION MEANS	RISKS
	START-UP 2021	HORIZON 2025		
A. Morbidity and mortality				
1) Overall mortality				
General mortality rate	5,2‰	3‰	Annual Report and EGDHS	Insufficient financial resources
% malaria deaths in general population	37%	20%	Annual Report and EGDHS	Insufficient financial resources
% malaria deaths in children under 5 years of age	28%	14%	Annual Report and EGDHS	Insufficient economic resources
2) Maternal mortality				
Maternal mortality rate (290/100 000 live births)	290	145	EGDHS	Insufficient financial resources
3) Neonatal mortality				
Neonatal mortality rate (less than 28 days)	33‰	16,5‰	EGDHS	Insufficient financial resources
4) Infant mortality				
Infant mortality rate	65‰	30‰	EGDHS	Insufficient financial resources
Infant and child mortality rate	113‰	56,5‰	EGDHS	Insufficient financial resources
5) Morbidity-mortality due to communicable diseases (CD)	ND	50%	EGDHS	Insufficient economic resources
MALARIA				
Percentage of users of insecticide-treated bed nets	ND	60%	Annual Report and EGDHS	Insufficient financial resources
Percentage of pregnant women with at least 3 doses of IPTs	ND	90%	Annual Report and EGDHS	Insufficient financial resources
Percentage of individuals with knowledge, attitudes, and practices (KAP) to prevent malaria	ND	70%	CAP Survey and EGDHS	Non-application of NMCP monitoring plan
Percentage of patients with rapid malaria screening test and with adequate treatment	ND	90%	Annual Report and EGDHS	Insufficient financial resources
Malaria vaccine availability	ND	In process	WHO Certification	Deficient implementation of the research plan
Prevalence of malaria on Bioko Island	10,9%	5%	Annual Report and EGDHS	Insufficient financial resources
Malaria prevalence in the Mainland Region	46.2%	23%	Annual Report and EGDHS	Insufficient financial resources
Parasitemia % on Annobón Island	24%	10%	Annual Report and EGDHS	Insufficient financial resources

HIERARCHY OF RESULTS AND INDICATORS	GOALS		VERIFICATION MEANS	RISKS
	START-UP 2021	HORIZON 2025		
TUBERCULOSIS				
Percentage of detection of sensitive TB in adults	58%	75%	Periodic studies and EGDHS	Insufficient financial resources
Percentage of adults with TB treated	78%	90%	Periodic studies and EGDHS	Insufficient financial resources
Percentage of treated TB-MR cases in adults	86%	93%	Periodic studies and EGDHS	Insufficient financial resources
Percentage of patients with co-infection on ART	73%	93%	Periodic studies and EGDHS	Insufficient financial resources
HIV/AIDS				
Percentage of people receiving ART (PNLS data)	40%	90%	Periodic studies and EGDHS	Insufficient financial resources
Percentage of complaints about HIV/AIDS documented and resolved by the Human Rights Ombudsman's Office	ND	50%	Periodic studies and EGDHSI	Insufficient financial resources
HIV prevalence reduced by half (EGDHS/2011)	6,2%	4%	Periodic studies and EGDHS	Insufficient economic resources
A. Prevalence of non-communicable disease (NCD) risk factors reduced by 50%.				
Prevalence of behavioral risk factors (smoking, alcohol, diet, physical activity)	ND	50%	Periodic studies and EGDHS	Insufficient financial resources
Prevalence of biological risk factors (arterial hypertension, obesity, diabetes and hypercholesterolemia)	ND	50%	Periodic studies and EGDHSI	Insufficient economic resources
B. Prevalence of risk behaviors in adolescents and young men and women reduced by 50%.				
National communication strategy for the prevention of adolescent pregnancy and STIs available	ND	Existe	Periodic reports	Implementation of NHDP operating plan
Existence of a national school and university health policy and program	ND	Existe	Periodic reports	Insufficient financial resources
% of in-school and out-of-school adolescents with knowledge on prevention of pregnancy, STIs and other risks	ND	60%	Periodic studies and EGDHS	Insufficient economic resources
% of adolescents in and out of school who use condoms during unsafe sex	ND	60%	Periodic studies and EGDHS	Insufficient economic resources

HIERARCHY OF RESULTS AND INDICATORS	GOALS		VERIFICATION MEANS	RISKS
	START-UP 2021	HORIZON 2025		
C. Vulnerability of the population to epidemics, health emergencies and other health events reduced by 50%.				
Existence of a surveillance, alert and response plan for health emergencies	ND	Available	Periodic reports	Insufficient financial resources
Existence of a national epidemic prevention and control policy and plan	ND	Available	Periodic reports	Insufficient financial resources
Existence of updated and enforced international health regulations	ND	Available	Periodic reports	Insufficient financial resources
% of health districts notifying ODEs in a timely manner (daily, weekly and monthly)	ND	Available	Periodic reports	Insufficient financial resources
% of EV structures applying the IHR	ND	Available	Periodic reports	Insufficient financial resources
% of suspected cases of diseases subject to surveillance investigated and confirmed	ND	Available	Informes de rutina y estudios epidemiológicos	Insufficient financial resources
Existence of a national cancer control service	ND	Available	Periodic reports	Insufficient financial resources
D. Strengthened coordination leadership and resource management at all levels of the health system.				
No. of health professionals trained in legal matters	ND	60%	Periodic studies and EGDHS	Insufficient economic resources
% of State budget allocated to the health sector	ND	20%	Periodic studies	Economic crisis
Existence of mechanisms to monitor economic resources allocated to the health sector	ND	Available	Periodic studies	Lack of implementation of the NHDP Follow-up Plan
% increase in disease coverage in the population	7%	50%	Periodic studies and EGDHS	Insufficient financial resources
Existence of National Health Accounts (NHA)	ND	Available	Periodic studies	Lack of implementation of NHDP operational plan
NHIS operational at all levels	ND	Available	Periodic reports and EGDHS	Insufficient economic resources
Existence of a coordination committee of health sector development partners	ND	Available	Periodic reports	Lack of implementation of the NHDP Follow-up Plan

3.2.8. NHDP Priority Programs

The NHDP has four priority programs broken down into 13 subprograms, 51 expected results and 248 process indicators, which are described in the table 5.

THE PNDS HAS FOUR PRIORITY PROGRAMS BROKEN DOWN INTO

13 SUBPROGRAMS
52 EXPECTED RESULTS
248 PROCESS INDICATORS

N°	PRIORITY PROGRAMS	SUBPROGRAMS	EXPECTED RESULTS	INDICATORS
1	Equitable access of the population to quality health services	1. Improvement of the supply and demand of quality health services.	4	15
		2. Improving maternal, women's and children's health services.	4	40
		3. Improving sexual and reproductive health services for adolescents and young people.	2	10
Subtotal 1		3	10	64
2	Health security, emergency and disaster situations and health resilience	1. Epidemic management according to the provisions of the International Health Regulations (IHR) 2.	2	8
		2.Disaster management in accordance with the provisions of the International Health Regulations (IHR).	1	3
Subtotal 2		2	3	11
3	Health promotion	3. Control of Communicable Diseases (CD).	14	80
		4. Control of Non-Communicable Diseases (NCDs) .	2	12
		5. Control of Neglected Tropical Diseases (NTDs) .	4	9
		6. Improving the population's environment and/or way of life.	1	5
Subtotal 3		4	21	106
4	Strengthening leadership and governance in the health sector	1. Strengthening leadership and accountability in the health sector.	7	25
		6. Improving financial management in the health sector.	4	16
		3. Strengthening health information management.	4	16
		4. Health research.	3	10
Subtotal 4		4	18	67
Total General	4	13	51	248

3.2.9. NHDP Strategic Outcomes

Based on the results logical framework in the table above, the expected strategic results of the successful implementation of NHDP, by the end of 2025, are as follows:

1) Reduction of overall mortality from 5.2 to 3%, reduction of maternal mortality from 290 to 145 per 100 000 live births, reduction of neonatal mortality from 33% to 16.5%, of infant mortality from 65 to 30% and of child mortality from 113% to 56.5%. At the malaria level, the reduction of the percentage of malaria deaths from 37% to 20%, in the general population, and from 28% to 14% in children under 5 years of age is sought.

2) Reduction of the risks of early pregnancies, clandestine abortions and maternal deaths in adolescent girls through appropriate communication strategies and prevention measures available in and out of school.

3) Reduction of HIV prevalence from 6.2% to 4%, increase in the number of patients under ARV treatment and condom use, and implementation of mechanisms for documented complaints about discrimination and stigmatization of people living with HIV and resolved by a human rights ombudsperson's office.

4) Reduction of malaria prevalence from 10.9% to less than 5% on Bioko Island, from 46.2% to 23% on the mainland and from 24% to 10% on Annobón Island; use of insecticide-treated mosquito nets by 60% of the population and treatment of intermittent malaria (IPT) reaching at least 90% in all pregnant women.

5) Consolidation of the elimination of neonatal tetanus and poliomyelitis, through the reinforcement of vaccination coverage, reaching at least 90% for all antigens. Also the elimination of onchocerciasis in Bioko Island and the organization of campaigns for the elimination of Lymphatic filariasis, Schistosomiasis and Geohelminthiasis.

6) Significant reduction of the population's vulnerability to epidemics, health emergencies and other health events and control of chronic non-communicable diseases that constitute real public health problems in the country.

7) A health system with sufficient and competent human resources distributed equitably, with a financing mechanism involving the public, para-public and private sectors and a strong governance system that ensures coordination and management of human, material and financial resources with a culture of accountability.

3.2.10. Development of NHDP Priority Programs

The four priority programs of the NHDP are developed in this document, respecting the vertical logic and the horizontal logic of results-based planning for the period 2021 - 2025.

PROGRAM 1:

EQUITABLE ACCESS OF THE POPULATION TO QUALITY HEALTH SERVICES

3.3. Location and programmatic framework

Program 1, which is developed in the following pages, constitutes the cornerstone of Universal Health Coverage (UHC) and is composed of three subprograms, as follows:

- **Subprogram 1:** Improving the supply of and demand for quality health services.
- **Subprogram 2:** Improvement of health services for mothers, women and children.
- **Subprogram 3:** Improvement of adolescent and youth sexual and reproductive health.

The logical framework on the following page establishes the 10 expected results, 59 indicators and their corresponding targets to be achieved during the five years covered by the NHDP. It should be noted that the lack of baseline indicators in several expected results has made projections of the desired level of progress difficult, in the period (2021 - 2025), the results of the EGDHS and other studies and surveys to be conducted in year 1 of NHDP implementation will be awaited.

THE FIRST PRIORITY PROGRAM OF THE NDP AIMS TO ACHIEVE EQUITABLE ACCESS TO QUALITY HEALTH SERVICES FOR THE POPULATION.

THROUGH 3 SUBPROGRAMS:

Improving the supply of and demand for quality health services

Improving health services for mothers, women and children

Improving sexual and reproductive health for adolescents and young people

Table 6: Logical framework of program 1: equitable access to quality health services for the population

SUBPROGRAMS	EXPECTED RESULTS	INDICATORS	DATA BASE	TARGETS TO HORIZON 2025				
				2021	2022	2023	2024	2025
SUBPROGRAM 1 : Improving the supply of and demand for quality health services	**R1: National coverage of health services is increased.**	1) % of operational health posts offering essential services to the base.	ND	50%	70%	75%	80%	85%
		2) % of operational health centers offering the essential package of first level services.	43,11%	65%	70%	75%	80%	85%
		3) % of hospitals with the necessary equipment, personnel and supplies to provide quality care.	20%	30%	45%	50%	55%	80%
		4) % density of health personnel per 1,000 population (WHO standard is 4.45%).	1,68%	2,50%	3,25%	3,50%	4,45%	4,45%
	R2: Technical competencies and motivation of health personnel at all levels of the health pyramid are improved.	5) Existence of plans for initial and continuous training, distribution and motivation of health personnel.	ND	X	X	X	X	X
		6) % decrease in wound, post-injury and other traumatic injuries infections.	ND	20%	6%	4%	3%	1%
		7) % decrease in postoperative, postpartum, and post-abortion infections in facilities.	ND	20%	6%	4%	3%	1%
		8) % decrease in occupational risk of contamination of health personnel.	ND	20%	6%	4%	3%	1%
	R3: The level of health information, awareness and education of the population is improved.	9) Existence of an operational communication and health promotion program.	ND	1				1
		10) No. of communication plans implemented at the district level.	ND	1	1	1	1	1
		11) Results of surveys on the level of knowledge, attitudes and practices of the population.	ND	1		1		1
	R4: Private initiative in health is promoted through the opening and operation of the Oyala Fertility Center.	12) No. of women treated for infertility and sterility problems at the Oyala Fertility Center.	ND					
		13) Number of children born through assisted reproduction techniques at the Oyala Fertility Center.	ND					
		14) No. of national professionals trained in gynecology and assisted reproduction through the Oyala Fertility Center.	ND					
		15) % of people informed about assisted reproduction in order to have children in Equatorial Guinea.	ND	40%	60%	80%	85%	90%

SUBPROGRAMS	EXPECTED RESULTS	INDICATORS	DATA BASE	TARGETS TO HORIZON 2025				
				2021	2022	2023	2024	2025
SUBPROGRAM 2 : Improving maternal, women's and children's health services	**R5: Availability and utilization of quality integrated NPC services, including elimination of HIV transmission, is increased.**	16) % of health facilities offering quality NPC services (routine data 2018).	51,18%	65%	75%	85%	90%	95%
		17) % of pregnant women with 1 integrated NPC of quality services.	ND	50%	70%	85%	90%	95%
		18) % of pregnant women with HIV testing.	ND	50%	70%	85%	90%	95%
		19) % of pregnant women with confirmed HIV (+).	ND	50%	70%	85%	90%	95%
		20) % of pregnant women with 8 service-integrated NPCs + HIV whose last one is at 9th month.	ND	50%	70%	85%	90%	95%
		21) % of pregnant women with HIV (+) on ARVs.	ND	50%	70%	85%	90%	95%
		22) % of pregnant women with 3 doses of IPT to prevent malaria during pregnancy.	28%	350%	45%	55%	65%	80%
	R6: Increased availability and utilization of quality Emergency Obstetric Care (EmOC) services, including elimination of HIV transmission.	23) No. of EmOC facilities per 500,000 people, with 1 of comprehensive EmOC (cesarean section + blood transfusion).	4,90	5	6	7	7	7
		24) % of deliveries attended by skilled attendants (evaluation/EmOC/2016).	34,24%	50	65	75	90	95%
		25) % deliveries attended by skilled attendants including pregnant women with HIV.	%	50	65	75	90	95%
		26) % of parturient with postpartum follow-up.	44%	50	65	75	90	95%
		27) % EmOC needs met (obstetric complications treated) (Eva/2016).	14,65%	40	60	70	85	95%
		28) % of caesarean sections in EmOC facilities.	3,31%	3,75%	4%	5	5	5
		29) Direct obstetric case fatality rate.	2,98%	2,50%	2%	1,75%	1,20%	1%
		30) % intra-natal and very early neonatal (24 hours) mortality (evaluation/ EmOC/2016).	2,58%	%	%	%	%	1%
		31) % of maternal deaths due to indirect causes (evaluation/AOU/2016).	12,5%	10 %	8%	5%	2,50%	1%
		32) Maternal mortality rate (per 100 000 live births).	290					140

SUBPROGRAMS	EXPECTED RESULTS	INDICATORS	DATA BASE	TARGETS TO HORIZON 2025				
				2021	2022	2023	2024	2025
SUBPROGRAM 2 : Improving maternal, women's and children's health services	**R7: The availability and utilization of quality integrated child health services in health facilities is increased.**	33) % of integrated health facilities with IMCI services.	ND	20%	30%	45%	60%	70%
		34) % of children with low birth weight (EGDHS/11).	12%	10%	8%	6%	5%	35%
		35) % of children exclusively breastfed up to 6 months of age (EGDHS/11).	7%	12%	20%	25%	30%	35%
		36) % of vaccination posts functional (2018).	86%	90%	100%	100%	100%	100%
		37) % of children fully vaccinated (BCG, Hep B at birth, VPO3, Penta3, VPI, VAA, VAS, and VitA) (routine data/018).	45%	55%	65%	75%	85%	90%
		38) % of pregnant women vaccinated against diphtheria and tetanus (DT) (routine data/018).	41%	51%	61%	71%	81%	90%
		39) % of children vaccinated (Penta3) (routine data/018).	45%	55%	65%	75%	85%	90%
		40) % of children incompletely vaccinated (Penta1 - Penta3) (routine data/018).	16%	14%	12%	10%	10%	10%
		41) Annualized rate of non-Polio AFP (2/100 000 under 15 years) (active surveillance - 018/ 7.3/100 000).	7,3	7,3	7,3	7,3	7,3	7,3
		42) % of adequate samples (14 days from onset of paralysis) (018).	97%	97%	97%	97%	97%	97%
		43) % of children under 5 sleeping under insecticide-treated mosquito nets (018).	35%	40%	450%	55%	65%	75%
		44) % of children under 5 years of age benefiting from nutritional monitoring and deworming (018).	ND	40%	55%	65%	70%	85%
		45) Infant mortality rate (EGDHS/2011).	65‰	60‰	50‰	40‰	350‰	32.5‰
		46) Infant and child mortality rate (EGDHS/2011).	113‰	103‰	88‰	73‰	58‰	50‰
	R8: The availability and utilization of quality family planning (FP) services is increased.	47) % Facilities offering Family Planning (FP) services (routine data/018).	37%	45%	65%	75%	80%	85%
		48) % women of women and men of childbearing age informed about FP and its advantages.	DN	45%	65%	75%	80%	85%
		49) Contraceptive prevalence among married women or couples aged 15-49 years (EGDHS - 2011).	14%	15%	17%	19%	22%	24%
		50) % unmet demand for FP (EGDHS-2011).	34%	30%	25%	20%	10%	5%

SUBPROGRAMS	EXPECTED RESULTS	INDICATORS	DATA BASE	TARGETS TO HORIZON 2025				
				2021	2022	2023	2024	2025
	R9: : The availability and use of services for early diagnosis, prevention and treatment of precancerous and cancerous cervical cancer (CCU) is increased.	51) No. of CCU diagnostic centers in operation.	9	9	9	9	9	9
		52) % of women and men informed about cervical cancer prevention and treatment measures.	ND	50%	60%	70%	80%	85%
		53) % of women who underwent VIA screening for early detection of cervical cancer.	ND	50%	60%	70%	80%	85%
		54) % of women with positive VIA.	3%	3%	2,5%	2%	2%	1,5%
		55) % of women with VIA (+) treated with Cold Coagulation.	88%	90%	95%	95%	95%	95%
		56) No. of adolescents aged 9 to 12 years vaccinated against cervical cancer virus.	ND	10.000	20.000	50.000	70.000	100.000
		57) No. of women with cervical cancer successfully operated on.	5	40%	55%	65%	70%	85%
SUBPROGRAMA 3 : Mejora de la salud sexual y reproductiva de los adolescentes y Jóvenes	R10: The exercise of sexual and reproductive rights of adolescents and young people of both sexes is enhanced.	58) National Communication Strategy for the prevention of adolescent pregnancy and STIs available.	ND	1	1	1	1	1
		59) % of health facilities that offer differentiated care in sexual and reproductive health (prevention of STIs, pregnancies and other risk behaviors).	ND	15%	35%	45%	60%	80%
		60) % of primary and secondary schools that offer services for the prevention of STIs, pregnancies and other risk behaviors).	ND	15%	35%	45%	60%	80%
		61) No. of youth structures offering sexual and reproductive health care (prevention of STIs, pregnancies and other risk behaviors).	ND	10%	20%	40%	60%	65%
		62) % of in-school and out-of-school adolescents with accurate knowledge on prevention of pregnancy, STIs and other risk behaviors.	ND	15%	35%	55%	65%	80%
		63) % of in-school and out-of-school adolescents using condoms in risky sexual relations.	ND	15%	25%	35%	45%	65%
	R11: Strengthening school and university health services at the national level.	64) Existence of a National School and University Health Policy and Program.	ND	1	1	1	1	1
		65) Existence of norms and tools on school and university health.	ND	1	1	1	1	1
		66) % of educational centers with operational health posts.	ND	15%	25%	35%	45%	75%

3.4. Description of Program 1

SUBPROGRAM 1:

IMPROVEMENT OF THE SUPPLY AND DEMAND FOR QUALITY HEALTH SERVICES

The improvement of the supply of services requires the development of the following strategic actions: (a) the development and implementation of a strategic plan for Primary Health Care (PHC), (b) the improvement of hospital management, (c) the improvement of logistics management for easy access to medicines and other health products, (d) the strengthening of the operational capacities of laboratory services and the blood bank, (e) the development of a national plan for human resources in health, for the improvement of competencies and personnel management, (f) the increase in demand for health services, and (g) the development of capacities for the supply of assisted reproduction services.

a) The development and implementation of a strategic plan for Primary Health Care (PHC)

Achieving sustainable Universal Health Coverage (UHC) in Equatorial Guinea requires health services that are based on integrated health care with an essential package of services per level of delivery and that are embedded in the recommendations of the October 2018 Astana Conference on PHC to achieve UHC by 2030 at the latest.

The aim is to establish Primary Health Care that is sustainable and strengthens the health system through the following actions: (i) strengthening the technical capacity of the structure in charge of health infrastructure through trainings of technicians to ensure the planning, implementation, control and maintenance of biomedical buildings and facilities, (ii) completion of works in progress (rehabilitation/construction of hospitals and district health centers) for the operationalization of district, provincial and regional hospitals, (iii) empowerment of community participation for the operation of health posts, (iv) strengthening disease prevention and health promotion measures through promotion, prevention, cure and rehabilitation services, with primary care focused on vaccination, control and treatment of communicable and non-communicable diseases, and services that promote, maintain and improve maternal, newborn, child and adolescent health; mental health, and sexual and reproductive health, (v) provision of primary health care that is geographically accessible, equitable, safe, of high quality, comprehensive, efficient, acceptable, affordable, available, and providing integrated and continuous, person-centered, and gender-sensitive services, and (vi) provision of sustainable primary health care that improves the resilience of the health system to prevent, detect, and respond to infectious diseases and outbreaks.

b) Improving hospital management

The availability of a hospital policy forms the basis of hospital reform to improve accessibility to quality health services for the entire population and also to increase, both individually and collectively, the rates of improvement in the quality of life and satisfaction of the patient, their families, the community and the service delivery personnel. To this end, 3 main actions will be carried out:

1) Adoption of a hospital policy for the improvement of patients' health status, striving for effective, safe and efficient care with attention focused on strict respect for their personal dignity.

2) AUpdating and implementation of the normative and methodological documents for the organization and operation of a hospital network, namely:

- The general hospital regulations.
- The internal functional regulations for each hospital category.
- The established rules on working hours and working hours in force.
- Internal disciplinary regulations.
- The regulations for applying the principle of suitability for each position and the code of medical ethics.
- The organization and procedure manuals, protocols used as a tool for hospital management.
- The technical and administrative procedures of the hospitals related to planning, organization, information system and control.

3) Implementation of the hospital network through the following activities: (i) reinforcement of the processes of organization, management and training of human resources, (ii) improvement of the capacity and quality of infrastructures with rehabilitations and new constructions according to the standards established in the health map to be developed, (iii) application of the advances of Science and Technology in the improvement of technical equipment for prevention, (iv) implementation and standardization of the organization of the care process of an emergency and outpatient unit in all hospitals of the public network, (v) establishment and control of the application of methodological regulations for the development of quality programs in the hospital network, (v) strengthening and implementation of hospital management centers and hospital network quality circles, (vi) organization of audits of hospital network health care processes, (vii) evaluation of the productivity and effectiveness of hospital network care processes, (viii) implementation of a quality management system for the hospital network, (viii) implementation of a quality management system for the hospital network, (viii) implementation of a quality management system for the hospital network, (viii) implementation of a quality management system for the hospital network, (viii) implementation of mechanisms that guarantee patient safety and allow adequate supervision of the private health sector, (ix) improvement of the hospital health information system and analysis of indicator results, and (x) use of hospital indicators to periodically evaluate compliance with hospital policy and revise it when necessary.

c) Improving access to medicines and other health products.

To ensure easy access to medicines for the entire population, the following actions will be carried out:

1) RStrengthening the supply and stock management system by: (i) adoption and implementation of procurement rules and procedures, (ii) definition and clarification of the organizational and functional relationships between CENTRAMED as the National Procurement Center and the General Directorate of Pharmacy, Procurement and Traditional Medicine, for the supply of medicines to public and private health facilities, (iii) definition and implementation of procedures for unblocking funds allocated to the purchase of essential medicines, and (iv) adoption of the National Pharmacy Policy with its corresponding strategic implementation plan.

2) Strengthening of mechanisms for financial accessibility of the population to medicines and other health products by: (i) strengthening the quality of service delivery of the INSESO insurer to expand access and coverage of the population to medicines, (ii) expansion of the health insurance system to include easy access to medicines and (iii) reactivation of the Bamako initiative in health centers and posts and hospitals to facilitate access to essential medicines.

3) Implementation of a quality control system for medicines and other health products through: (i) adoption and implementation of quality control tools for medicines and other health products and food, (ii) adoption of an initial training plan for pharmacists, biologists and other technicians to meet the needs of the area, (iii) maintenance of the cold chain at reception and storage of temperature sensitive products in the country and (iv) creation of a database of drug suppliers in collaboration with WHO to facilitate the selection of companies that meet all the requirements.

4) Control and elimination of the illicit sale and circulation of medicines of dubious origin through: (i) improvement of CENTRAMED's logistics management to cover the needs of the different levels of the health system, (ii) adoption and application of standards and procedures for controlling the entry and exit of medicines in the country, (iii) activation of the functioning of the National Corps of Pharmacy Inspectors of MOHSW, (iv) monitoring of the correct application of the laws that regulate the practice of Pharmacy in the country and in the CEMAC zone.

5) Promotion of the use of Natural and Traditional Medicine as a therapeutic alternative through: (i) integration of Traditional and Natural Medicine in the health system, (ii) promotion of research in Traditional Pharmacopeia for the easy identification, classification and use of medicinal plants for therapeutic purposes, (iii) training of specialists and authorized persons in the use of Traditional and Natural Medicine and (iv) elaboration and dissemination of good practices in Traditional and Natural Medicine.

d) Strengthening the operational capacities of the laboratory services and the blood bank.

Improving the supply of health services also involves strengthening laboratory services to ensure the analysis and confirmation of samples through the following actions: (i) Involvement of the laboratory service in needs assessment, design of plans for construction of buildings for laboratories, as well as technical equipment, (ii) development and implementation of a strategic plan for laboratory services, (iii) creation of the laboratory network by a specialist in Microbiology and training of staff in Biosafety, sample collection and transport, microbiological diagnostic techniques and quality control, (iv) strengthening of regional laboratory equipment, (iv) strengthening the equipment of regional, provincial and district laboratories that do not meet the standards established by level of service provision, (v) improving the system for supplying reagents and consumables to all laboratories and the system for sending laboratory data, (vi) providing laboratories with the quantity and quality of personnel (physicians, pharmacists, biologists, hematologists and other technicians), (vii) putting into operation the National Public Health Laboratory in Baney and Ebola in Sipopo, and (viii) signing a maintenance contract for the laboratory network with a specialized company.

On the other hand, the availability of quality blood is a recognized right of every

patient and, to this end, the following activities will be carried out to improve the supply of quality health services: (i) adoption and implementation of a strategy to attract voluntary and altruistic blood donors, (ii) supplying the transfusion center through replenishment donations, (iii) completion, equipping and commissioning of the construction works of transfusion centers and posts underway by the Health/ AfDB - II Project at the different levels, (iv) connection of the Regional Blood Transfusion Center of Malabo and Bata to ensure the exchange of information and measures to operate 24 hours out of 24, 7 days out of 7, according to established standards to meet medical and obstetric and neonatal emergencies, (v) implementation of an effective coordination of the transfusion centers between MOHSW and the management company AGEM recruited by the Government and (vi) updating and implementation of the National Blood Transfusion Policy.

e) The development of a plan to improve staff skills and management.

The realization of this strategy involves the following: (i) development and implementation of a continuous staff training plan, (ii) training of medical specialists, (iii) creation of continuous training units in regional and provincial hospitals, (iv) creation of an intersectoral coordination structure for the initial training of health technicians in the private sector, (v) development and implementation of guidelines for supervision and evaluation of personnel, (vi) periodic supervision and evaluation of personnel performance, (vii) updating and implementation of the MOHSW management organization chart at the different levels (central, regional, provincial and district), and (viii) creation of an intersectoral coordination structure for human resources in health.

f) Strengthening the demand for health services for the population.

The demand for services will be based on the needs expressed through data from studies and surveys to be conducted in 2021, at the level of the population requesting services, with emphasis on the main health determinants. The promotion of demand should also include the promotion of patients' and families' rights, mechanisms and modalities of access to services, the guarantee of confidentiality and respect for human rights. The texts of laws on the rights to health, adopted and promulgated by the State of Equatorial Guinea, will be widely disseminated.

It should be noted that interpersonal communication - through educational talks in the community, health posts and centers and hospitals, counseling in medical consultation rooms and mass communication through public animations, using groups of artists and singers to disseminate educational messages, conferences and health forums - will be carried out to inform, sensitize and educate the population in order to achieve the desired health behavior in rural and urban areas.

g) Development of capacities for the supply of assisted reproduction services

The implementation of this strategy involves the following actions: (i) provision of clinical gynecological and assisted reproduction services through the implementation of staff training and research activities, (ii) acquisition and installation of more complete and demanding state-of-the-art equipment and other devices and also of maximum and total safety and (iii) the organization of a special national, regional and international multimedia campaign on the Oyala Fertility Center.

SUBPROGRAM 2:

IMPROVEMENT OF QUALITY MATERNAL, WOMEN'S AND CHILD HEALTH SERVICES

Four strategic actions will be undertaken to achieve the expected results in this Subprogram No. 2: (a) increased availability and utilization of integrated Pre Natal Control (PNC) services including elimination of vertical transmission of HIV, (b) increased availability and utilization of quality Emergency Obstetric Care (EmOC) services, (c) increased availability and utilization of family planning (FP) services, (d) increased services for early diagnosis, prevention and treatment of cervical cancer and precancerous lesions (CCP), and (e) increased availability and utilization of child health services integrated into IMCI.

a) Increasing the availability and utilization of integrated PNC services that include elimination of vertical transmission of HIV.

Recently in 2018, MOHSW approved an updated manual of standards that establishes the eight PNCs as a right of every pregnant woman to meet quality criteria. To this end, the following actions will be carried out: (i) integration of PNC services according to the new standards in all health centers and hospitals to ensure equity in service delivery (outpatient consultation and treatment of patients, neonatal tetanus prevention, malaria, syphilis, HIV, hepatitis B and C, prevention of Infections, IEC/BCC, essential drug management and routine SIS data); (ii) reproduction and distribution of log books and other service delivery management tools and (iii) implementation of formative supervision and monitoring of daily service delivery activities.

b) Increasing the availability and use of quality Emergency Obstetric Care (EmOC) and integrated vertical elimination of HIV.

With the objective of preventing maternal and neonatal deaths and maternal disability of obstetric origin in health facilities, a package of activities has been defined and classified into three hierarchical levels:

1) At a strategic and programmatic level in maternal and neonatal health: (i) Development of the Maternal and Neonatal Health Gratuity Plan that was approved by the Government in 2019 in application of Decree No. 41/2015, as an operational project that will include the Roadmap for reducing maternal and neonatal mortality adopted and funded in 2008, taking as reference the essential functions and the United Nations EmOC Process Indicators,, (ii) organization of a round table of donors in maternal health to enhance the mobilization of resources with the aim of achieving the elimination of vertical transmission of HIV, (iii) organization of the second National Reproductive Health Symposium on universal access to maternal and newborn health services and the promotion of adolescent and youth sexual and reproductive health, and (iv) organization of sensitization sessions for the Government, Parliament and development partners on universal access to maternal and newborn health.

2) At the operational level of the provision of maternal and neonatal health services: (i) Development of a plan to reinforce the competencies of the personnel who provide maternal and neonatal health services to improve the quality of the supply of EmOC and other linked services, (ii) Strengthening the availability of quality EmOC services in accordance with the standards established by the EmOC guidelines, the objectives of the national health

policy and Subprogram No. 2 of the NHDP for Strengthening quality health services for Mother, Woman and Child health, (iii) Strengthening the supply of essential medicines for EmOC, (iv) Institutionalization of monitoring and evaluation of EmOC services in the different establishments of the health pyramid, (iv) Development of an information, education and communication strategy for behavior change (IEC / SBCC) in maternal and neonatal health integrated HIV, Hepatitis. Tuberculosis, Malaria, etc; (v) Development of a communication and transport network to improve the management of obstetric and neonatal emergencies through the acquisition of logistical means and necessary equipment, (vi) Organization of periodic training supervisions of health establishments using guides and files based on the essential functions of EmOC, (vii) Improvement of the quality of the follow-up of the parturient in the immediate and late postpartum, (viii) Promotion of FP in the postpartum for the improvement of the health of the mother and the child, (ix) Organization of periodic monitoring of the EmOC Process Indicators and the preparation of the annual report of routine EmOC data, (x) Conducting studies and research on maternal and neonatal health and audits of maternal deaths, and (xi) Documentation and dissemination of good practices in maternal and neonatal health in Equatorial Guinea. 3) At the intersectoral level in maternal and neonatal health: (i) improved collaboration with the Ministry of Social Affairs and Gender Equality and other sectors (Justice, Security, Press and Radio Television) and civil society organizations for greater attention to women victims of gender-based violence in order to reduce the consequences on the mother during pregnancy and the neonate, (ii) strengthened collaboration with the private sector with the signing of memorandum of agreement for better management of the obstetric and neonatal emergency referral chain, (iii) organization of sensitization and advocacy sessions for greater involvement of private cell phone companies, for example, in the financing of maternal and neonatal mortality reduction projects and programs, and (iv) creation and implementation of a multisectoral committee for coordination, monitoring and evaluation of maternal and neonatal health activities.

c) Increasing the availability and utilization of quality family planning (FP) services

To meet the unmet demand for FP, the following actions will be carried out: (i) extension of FP service coverage in all public, para-public and private health facilities, (ii) organization of a national FP week every year, (iii) expansion of information and awareness raising on the advantages of FP in the community through markets, educational centers, Churches and other places of worship; (iii) integration of FP into the National Condom Social Marketing Program as one of the key activities of the NHDP, to include contraceptives, (iv) involvement of civil society organizations in promoting the distribution of FP integrated essential health services, (v) promotion of education on family life, FP and other sexual and reproductive rights, through the involvement of community health post agents and local NGOs, and (vi) conduct of socio-cultural studies and surveys on FP.

d) Increasing services for early diagnosis, prevention and treatment of precancerous lesions and cervical cancer (CC).

In the fight against cervical cancer, the aim is to implement early detection, diagnosis and treatment measures to reduce the prevalence and improve the health situation of women affected by the disease, using the "see and treat" strategy, by means of visual inspection with acetic acid (VIA) and cold coagulation, cytological diagnosis and free treatment of confirmed cases. In this regard, a large project is being implemented at the national level, benefiting from private oil sector funding, whose very positive results have motivated its extension at the national level. The main actions to be carried out with a view to consolidating the achievements of the project are as follows:

- Reinforce the detection and treatment of precancerous lesions by: (i) carrying out cytology and HPV-DNA tests in the regional hospitals of Bata and Malabo, (ii) signing contracts for the provision of cytology (Bata and Malabo hospitals) and biopsy services (INSESO in Malabo and Bata), (iii) procurement of cytology and cytopathology laboratory supplies for Malabo and Bata regional hospitals, (iv) training of laboratory technicians in cytology and HPV-DNA testing in the two regional hospitals (Malabo and Bata), (v) development of quality control mechanisms in the two regional laboratories in Malabo and Bata and (vi) provision of cone biopsy services and LEEP procedure in the regional hospitals.

- Strengthen diagnosis and treatment of early stages of UCC by: (i) conducting confirmatory diagnosis of UCC, (ii) comprehensive surgery, radiotherapy and chemotherapy in the two regional hospitals (Malabo and Bata), (iii) implementation of palliative care for terminally ill patients and (iv) implementation of a system and protocol for follow-up of patients with UCC.

- Enhance the implementation of the HPV vaccine, with the implementation of a safe and effective vaccine against human papillomavirus (HPV) for adolescent girls/boys, before initiating sexual relations, with a two-dose vaccination schedule for girls between 9 and 13 years of age. To this end, the following actions will be carried out: (i) adoption of the consultancy report conducted by MOHSW and MCDI, in 2018, on the feasibility of the HPV vaccine in Equatorial Guinea, (ii) conduct of an epidemiological study on the types of HPV found in the country for greater appropriateness of vaccine procurement, (iii) census and vaccination of 10,000 girls and boys each year, and (iv) adoption and implementation of a post-vaccination anti - HPV follow-up plan.

e) Increasing the availability and utilization of child health services integrated into IMCI services.

- • To guarantee the survival and development of the child during all its stages, based on their fundamental rights and health strategies as we have contemplated in the National Child Health Policy adopted by the MOHSW in 2019, ensuring an essential package of services and interventions that allow the harmonious development and growth of the child through the following actions: Improvement of neonatal and infant care through: (i) implementation of immediate care measures for healthy and critically at-risk newborns through qualified personnel, (ii) vaccination within the first 24 hours of birth according to the vaccination schedule in force, (iii) implementation of the strategy for elimination of mother-to-child HIV transmission and treatment of the exposed child, (iii) logistical availability of material resources and equipment for the adequate care of

healthy and critically at-risk newborns, (iv) increased knowledge of mothers on the importance of breastfeeding, immediately at birth and exclusively until six months of age, nutrition of mother and child, vaccination, sanitary hygiene measures to be maintained with the newborn, prevention of AIDs, ARI, intestinal parasitism, prevention of malaria, HIV and warning signs, among others, and (v) detection of warning signs by qualified personnel, ensuring timely referral.

- Implementation of the Comprehensive Multi-Year Immunization Plan (CMP), 2019 - 2023, through the following:

  - In terms of service delivery: (i) increasing national and district vaccination coverage for all antigens, (ii) realization of dispensing of children < 15 years of age, (iii) reduction of the national dropout rate and (iv) introduction of new vaccines in line with the country's health needs.

  - In surveillance: (i) improvement of the rate of non-polio AFP to at least 3/100,000, the rate of AFP with adequate specimens and the rate of districts reporting at least one suspected measles case with specimen taken, (ii) implementation of a MAPI management system, (iii) implementation of sentinel surveillance for hemophilus influenzae type b meningitis and yellow fever and environmental surveillance for polio in the country.

  - In logistics management: (i) adequate availability of transportation and vaccines at all levels, (ii) regular preventive and corrective maintenance of cold chambers and refrigerators, (iii) improved staff competency in vaccine and cold chain management and handling, and (iv) adequate destruction of vaccination waste in all 18 districts of the country.

  - In the area of communication: (i) development of social communication actions aimed at promoting routine vaccination, (ii) strengthening inter-sectoral and civil society participation in the promotion of routine vaccination and (iii) increasing the level of knowledge of parents about vaccines and the vaccination schedule.

  - In terms of EPI management: (i) implementation of the mechanism for financing activities and implementation of a regulatory mechanism for the EPI, (ii) improvement of data and information management and mechanisms for monitoring and control of the EPI, (iii) creation and expansion of partnerships to achieve EPI goals, and (iv) strengthening of the quantity and quality of human resources for the EPI at all levels.

- Promotion of exclusive breastfeeding up to 6 months of age and artificial breastfeeding of children of HIV-positive mothers through: (i) organizing educational talks, in health facilities and in the community, on the importance and advantages of early and exclusive breastfeeding up to six months of age and complementary feeding, (ii) enhancing artificial breastfeeding of children of mothers with HIV, ensuring the availability of milk and (iii) training mothers on the "kangaroo method" for low birth weight newborns (preterm or premature) and exclusive breastfeeding.

- Promotion of activities to combat food insecurity and malnutrition in children and pregnant women through: (i) advocacy for the strengthening of national capacities in the production, conservation and marketing of food

and management of food and nutrition programs, (ii) promotion of prevention and awareness raising in the fight against child malnutrition, (iii) advocacy for the implementation of actions to combat malnutrition in a cross-cutting and multi-sectoral manner, (iv) promotion of the consumption of essential vitamins and minerals (iron, folic acid, vitamin A, zinc, iodized salt), (v) promotion of the feeding of children born to HIV+ mothers to reduce the incidence of HIV transmission through breastfeeding, (vi) promotion of the use of local foods, healthy eating habits and community awareness of the need for growth monitoring of children under 5 years of age (weight/height/age ratio) and (vii) promotion of research on nutrition and feeding.

- Comprehensive management of children under five years of age with prevalent diseases through: (i) promotion of the correct application of essential family practices through IEC/SBCC, training of health personnel in comprehensive child management procedures and follow-up, as well as collection, analysis of data on prevalent diseases; (ii) availability of essential drugs and management materials and other supplies, at the level of each service delivery center, (iii) support for operational research on prevalent childhood diseases, (iv) training of community personnel and families on basic notions of IMCI and (v) organization of periodic formative supervisions.

- Availability of an essential package of services and interventions that enable the harmonious development and growth of the child through: (i) availability of resources (human, financial, material) that have an impact on the growth and development of the child, (ii) reinforcement of the follow-up of the child and those born to HIV positive mothers, according to the Protocol for HIV Exposed and Infected Children, (iii) support for operational research on determinants that have an impact on the growth and development of children, (iv) implementation of a monitoring and assessment plan for preschool and school-age children and at the community level, (v) creation and operation of rehabilitation centers for children with special education needs (visual, hearing, motor and intellectual, physical and motor disabilities, psychomotor development deficits or neurodevelopmental disorders), and (vi) dissemination and application of children's health rights.

- Promotion of school health to improve children's health indexes and intellectual performance through: (i) elaboration, adoption and implementation of a school health program in collaboration with the Ministry of Education and Science, (ii) organization of regular health consultations in schools, (iii) promotion of essential family practices (EFP) as a pedagogical activity in primary education and (iv) promotion of family education, responsible parenthood and gender education at the family and school levels.

- P• Promotion of behavioral change to improve child and maternal health status and advocacy by: (i) strengthening the capacity of the structures in charge of implementing IEC/BCC activities on child and maternal health, (ii) creation and implementation of an intersectoral IEC operational structure at the national level, (iii) increasing IEC interventions implemented at the community level, (iii) strengthening or creation of IEC structures to ensure actions aimed at improving individual, family and community behavioral change for child and maternal health, and (iv) organization of advocacy sessions for decision-making in favor of

child and maternal health through the use of statistical data on these two target populations.

SUBPROGRAM 3:

IMPROVING THE HEALTH OF ADOLESCENTS AND YOUNG PEOPLE

Within the framework of this subprogram, four major actions will be developed: (i) the improvement of the supply of sexual and reproductive health services for adolescents and young people at health facilities and in the community, (ii) the implementation of measures to prevent early and unwanted pregnancies, clandestine abortions, STIs and HIV/AIDS, (iii) the strengthening of measures to prevent risky behaviors, and (iv) the implementation of quality school and university health services, at the national level.

a) Improving the supply and quality of school and university health services at the national level.

The development and implementation of a national school and university health policy and program, standards and tools to regulate school and university health services, accessible to all educational centers through the opening and operation of health posts, staff and essential medicines distributed free of charge according to the demand of pupils, students, teachers and professors, the systematization of medical consultations as a rule in the first enrollments in preschool and primary school, for the early detection and orientation of special education needs, and the regular supervision of health posts opened in educational centers.

The realization of this strategic action will go through the implementation of the following activities: (i) adoption and implementation of a national school and university health policy and program, (ii) adoption and implementation of school and university health standards and tools, (iii) implementation of health posts with minimum staffing in all educational centers with the highest concentration of students, and (iv) regular supervision of Educational centers with the respective operational health posts.

b) Improving the supply of sexual and reproductive health services for adolescents and young people.

The main activities to be carried out are: (i) construction and implementation of 5 multiservice centers, at the level of provincial capitals for youth and adolescents that enable a supply of specific sexual and reproductive health services, (ii) improvement of the response capacity of health structures, to the needs of adolescents and young people with the training of health personnel and adolescents and young people themselves on sexual and reproductive health, (iii) implementation of a social marketing program for condoms accessible to all adolescents and young people of both sexes, (iv) review, updating and introduction of sexual and reproductive health modules in teaching curricula as a subject, and (v) adoption and dissemination of the Draft Bill on sexual and reproductive rights, prepared in 2019 by MOHSW.

c) Implementation of measures to prevent early and unwanted pregnancies, clandestine abortions, STIs and HIV/AIDS.

The promotion of adolescent and youth health needs: (i) improved access to and use of accessible family planning services in and out of school, (ii) creation of spaces for differentiated sexual and reproductive education in health facilities for early diagnosis, treatment and prevention of STIs, (iii) increased use of condoms for adolescents

and youth and intensified information and awareness for greater use of available sexual and reproductive services.

d) Strengthening preventive measures against risky behaviors.

The realization of this strategic action will go through the implementation of the Three-Year Plan to Combat Alcoholism, Tobacco and Other Drugs that was approved in 2018 with the following activities: (i) training of health professionals and professionals from other related social institutions on the problems associated with the abusive consumption of alcohol, tobacco and other drugs, (ii) implementation of information and awareness activities on the abusive consumption of alcohol, tobacco and other drugs, (iii) development of protocols for the management of effects associated with the abusive consumption of alcohol, tobacco and other drugs and (iv) strengthening of the management capacities of the National Program to Combat Alcoholism, Tobacco and other Drugs.

PROGRAM 2:

HEALTH SAFETY AND MANAGEMENT OF EMERGENCY AND DISASTER SITUATIONS

3.5. Location and programmatic framework of Program No. 2

Program No. 2, which is developed in the following pages, is the cornerstone of the National Health System to consolidate and expand strategies to combat health emergencies and manage disasters and other health events, in order to ensure universal health coverage (UHC) and enhance health resilience at the national and sub-regional level by 2025. Program No. 2 is composed of two subprograms, namely:

- **Subprogram 1:** Management of epidemics, according to the provisions of the International Health Regulations (IHR).

- **Subprogram 2:** Disaster management, in accordance with the provisions of the International Health Regulations (IHR).

The logical framework on the following page sets out the expected results, indicators and corresponding targets to be achieved in the two subprograms belonging to Program No. 2 during the 5-year period covered by this National Health Development Plan (NHDP). It should be noted that the lack of baseline indicators, in several of the expected results in the table on the following page, has hindered projections of the desired level of progress between 2021-2025, while awaiting the results of surveys and studies to be conducted in the first year of NHDP implementation.

THE SECOND PRIORITY PROGRAM OF THE NHDP CONSOLIDATES AND EXPANDS HEALTH EMERGENCY AND DISASTER MANAGEMENT STRATEGIES TO ENSURE UNIVERSAL HEALTH COVERAGE AND ENHANCE HEALTH RESILIENCE AT THE NATIONAL AND SUBREGIONAL LEVELS.

THROUGH 2 SUBPROGRAMS:

Management of epidemics according to the provisions of the International Health Regulations

Management of disasters in accordance with the provisions of the International Health Regulations

Table 7: Logical framework of Program No. 2 "Health security, management of health emergencies and disasters" (2021-2025)

SUBPROGRAMS	EXPECTED RESULTS	INDICATORS	BASELINE DATA	GOALS TO THE HORIZON 2025				
				2021	2022	2023	2024	2025
SUBPROGRAM 1 : Epidemic Management under the provisions of the International Health Regulations (IHR)	**R1: National capacities for early warning and response to epidemics strengthened.**	1) Existence of a surveillance, alert and response plan for health emergencies.	ND	1	1	1	1	1
		2) % of health districts reporting Notifiable diseases in a timely manner (daily, weekly, and monthly).	ND	50%	60%	70%	80%	100%
		3) Proportion of epidemics detected in time (cholera, Ebola, measles, poliomyelitis, yellow fever).	ND	40%	60%	70%	80%	100%
		4) Proportion of people affected by epidemics (cholera, Ebola, measles, poliomyelitis, yellow fever).	ND	100%	80%	60%	40%	20%
		5) Proportion of epidemics (cholera, Ebola, measles, poliomyelitis, yellow fever) eliminated.	ND	30%	45%	60%	70%	100%
	R2: Means of intervention for enhanced response at the national level.	6) % of sanitary structures applying the International Health Regulations (IHR).	ND	30%	45%	60%	70%	100%
		7) % of border posts operational for surveillance of diseases under surveillance.	ND	50%	65%	70%	80%	100%
		8) % of suspected cases of diseases under surveillance investigated and confirmed.	ND	50%	75%	85%	95%	100%
SUBPROGRAM 2 : Disaster and Event Management under the provisions of the IHR	**R3: National disaster and other health risk management capacities are strengthened.**	9) % of health districts with health risk map developed.	ND	50%	65%	70%	80%	100%
		10) No. of simulations of rapid response to different types of disasters (erosion, flooding, explosions).	ND	1	1	1	1	1
		11) Ratio of deaths (missing and disaster victims) per 100,000 populations.	ND	-50%	-40%	-30%	-10%	-5%

3.6. Description of the subprograms of Program No. 2

SUBPROGRAM 1:

EPIDEMIC MANAGEMENT ACCORDING TO THE PROVISIONS OF THE INTERNATIONAL HEALTH REGULATIONS (IHR)

The strategic actions to be carried out to achieve the expected results in this Subprogram are focused on the implementation of the International Health Regulations (IHR) and the Technical Guide for Integrated Surveillance and Response, through the following strategic actions: (i) the development and implementation of a plan for surveillance, alert and response to health emergencies, (ii) the improvement of the capacities of health districts in the notification of notifiable diseases (NODs) in accordance with the established standards (daily, weekly and monthly), (iii) improvement of capacities for early detection of epidemics (cholera, Ebola, measles, polio, yellow fever) and (iv) development of capacities for elimination of epidemics (cholera, Ebola, measles, polio, yellow fever and others) in the country.

a) The development and implementation of a plan for surveillance, alert and response to health emergencies.

The activities to be carried out under this strategy are as follows: (i) elaboration and implementation of a list of epidemiological indicators, (ii) elaboration and implementation of a Plan for Strengthening the National System for Integrated Disease Surveillance and Response to Epidemic Risks and Outbreaks, (iii) elaboration of a Multisectoral Contingency Plan in Situations of Health Emergencies, (iv) strengthening of the organizational framework of the national epidemiological surveillance and alert system, (v) updating of the Technical Guide for Integrated Surveillance and Response, and (vi) implementation of the IHR and the Technical Guide for Integrated Disease Surveillance and Response.

b) Improvement of the capacities of the health districts in the notification of notifiable diseases (NOD) according to the established standards (daily, weekly and monthly).

Under this strategy, the following activities will be carried out: (i) training of physicians, epidemiologists, health technicians in hygiene and epidemiology and other related specialties, (iii) improvement of the quality of epidemiological data management, and (iv) expansion of the epidemiological data dissemination system (epidemiological bulletins and yearbooks).

c) Improving the capacity for early detection of epidemics (cholera, Ebola, measles, polio and yellow fever).

The following activities will be carried out under this strategy: (i) constitution and training of immediate response teams in health emergencies with provision of basic inputs and material resources, (ii) re-energization of the National Committee and district health emergency committees, (iii) creation of regional and provincial health emergency committees, (iv) training of Focal points for Epidemiological Surveillance (ES), Port Health and others involved in response under the IHR and the IDSR Technical Guide, (v) creation of an operational center within the Ministry of Health for health emergencies, (vi) strengthening of the technical capacity of laboratories for epidemiological surveillance with qualified human resources, (vii) regular supply of reagents and laboratory supplies, and (viii) improvement of the quality of epidemiological data management.

d) The development of capacities for the elimination of epidemics in the country (cholera, Ebola, measles, polio and yellow fever).

The activities to be carried out are as follows: (i) periodic monitoring of the multisectoral contingency plan for health emergencies, (ii) supervision of the immediate response teams in health emergencies, (iii) supervision of the National Committee and district health emergency committees, (iv) supervision of the regional and provincial health emergency committees and of the ES and Port health focal points, and (v) preparation and dissemination of Epidemiological Surveillance data.

SUBPROGRAM 2:

MANAGEMENT OF DISASTERS AND OTHER EVENTS, ACCORDING TO THE PROVISIONS OF THE INTERNATIONAL HEALTH REGULATIONS (IHNR)

The following strategic actions will be carried out to achieve the expected results in this Subprogram No. 2, through prevention and response measures against disasters and other health events, by means of the following: (i) development of epidemiological multi-risk and health disaster mapping, (ii) development and implementation of response simulation plans, and (iii) advocacy for resource mobilization for the funding of the Emergency and Disaster Plan.

PROGRAM 3:

HEALTH PROMOTION

3.7. Location and Programmatic Framework of Program No. 3

The health promotion program aims to strengthen the prevention and care of communicable diseases (CD), non-communicable diseases (NCD) and neglected tropical diseases (NTD), as well as to create - through multisectoral actions - the promotion of behaviors favorable to the health of the community. With regard to disease prevention and management, the objective is to ensure that, at all levels of the health system, there are sufficient qualified human resources, updated guidelines and/or protocols and the necessary inputs to improve the effectiveness of interventions that contribute to improving the health and well-being of the population.

Program No. 3 is composed of four priority subprograms, as follows:

- **Subprogram 1:** Fight against communicable diseases (CD).
- **Subprogram 2:** Fight against non-communicable diseases (NCDs).
- **Subprogram 3:** Control of neglected tropical diseases (NTDs).
- **Subprogram 4:** Improvement of the population's environment and/or way of life.

It should be noted that, within the framework of the implementation of the National Health Policy (NHP), the National Primary Health Care Strategy provides that the first, second and third level services of the district level of the National Health System should offer control and follow-up of patients with chronic communicable and non-communicable diseases, accompanied by extensive information and awareness-raising on good health practices. Proof of this is that, currently, district hospitals and health centers have mobile PHC teams equipped with motorcycles and vehicles to offer these services to people in their homes.

The logical framework of Program No. 3 establishes 21 expected results, 108 indicators with their corresponding targets to be achieved by the four subprograms, during the 5 years covered by the National Health Development Plan (NHDP). It should be noted that the lack of baseline indicators has not made it possible to set projections as to the desired level of progress between 2021-2025.

THE THIRD PRIORITY PROGRAM OF THE NHDP AIMS TO STRENGTHEN PREVENTION AND CARE OF COMMUNICABLE, NONCOMMUNICABLE AND NEGLECTED TROPICAL DISEASES.

THROUGH 4 SUBPROGRAMS:

1. Fight against communicable diseases.
2. Fight against non-communicable diseases.
3. Fight against neglected tropical diseases.
4. Improvement of the environment and the population's way of life.

Table 8: Logical framework of results of Program 3 "Health promotion" (2021- 2025)

SUB-PROGRAMS	EXPECTED RESULTS	INDICATORS	BASELINE DATA	GOALS TO HORIZON 2025				
				2021	2022	2023	2024	2025
SUBPROGRAM 1 : Control of Communicable Diseases (CT)	**PALUDISMO**							
	R1: Malaria prevention measures strengthened.	1) % of houses sprayed on Bioko Island.	ND					
		2) % of beneficiaries of insecticide-treated mosquito nets on Bioko Island.	DN	40%	60%	80%	85%	95%
		3) % beneficiaries of insecticide-impregnated bed nets in the mainland region.						
		4) % users of insecticide-treated mosquito nets on Bioko Island.						
		5) % users of insecticide-treated nets in mainland region.	DN	40%	60%	80%	85%	95%
		6) % of pregnant women with 3 doses of IPT (island).	DN	40%	60%	80%	85%	95%
		7) % of pregnant women with 3 doses of ITNs (mainland).						
		8) % of individuals with knowledge, attitudes and practices (KAP) to prevent malaria (island).	60%	70%	75%	80%	85%	90%
	R2: Malaria case management is enhanced.	9) % of patients with rapid malaria screening test on Bioko Island.		40%	60%	80%	85%	95%
		10) % of patients with rapid malaria screening test in mainland region.						
		11) % of patients with malaria treatment (island).	ND	40%	60%	80%	85%	95%
		12) % patients with malaria treatment (mainland).						
	R3: Research and epidemiological surveillance on malaria are strengthened.	13) No. of studies conducted on malaria.		2	2	2	2	2
		14) No. of surveys conducted on malaria vaccination in Equatorial Guinea.	3	2	2	2	2	2
		15) No. of publications conducted on malaria.	2	2	2	2	2	2
	R4: Monitoring and evaluation of malaria control is strengthened.	16) No. of monitoring meetings on malaria.	DN	2	2	2	2	2
		17) No. of evaluations conducted on malaria.	1	1	1	1	1	1

SUB-PROGRAMS	EXPECTED RESULTS	INDICATORS	BASELINE DATA	GOALS TO HORIZON 2025				
				2021	2022	2023	2024	2025
SUBPROGRAM 1 : Control of Communicable Diseases (CT)	**HIV/AIDS AND STIS**							
	R5: STI and HIV prevention measures are strengthened.	18) % of patients with STIs in health facilities who have received treatment and counseling.	ND	40%	60%	80%	85%	95%
		19) % of adolescents/young people aged 15-24 years who identify methods to prevent sexual transmission of HIV and misconceptions about HIV transmission.	ND	40%	60%	80%	85%	95%
		20) % of adolescents/young people aged 15-24 years who report using a condom during sexual intercourse with a non-regular partner.	ND	20%	30%	35%	40%	50%
		21) % of pregnant women with HIV who have received adequate ARV preventive treatment to reduce the risk of vertical transmission of HIV.	ND	40%	60%	80%	85%	95%
		22) % of children born to mothers with HIV, receiving treatment with known sero status at 18 months of age.	ND	40%	60%	80%	85%	95%
		23) % of children born to HIV-positive mothers with (+) HIV test results at 2, 6, 9, 12 and 18 months of age.	ND	40%	60%	80%	85%	95%
		24) Existence of a national social marketing program for condoms.	ND	1	1	1	1	1
	R6: Management of patients with HIV/AIDS is strengthened.	25) % of people living with HIV and AIDS receiving antiretroviral therapy.	ND	40%	60%	80%	85%	90%
		26) % of health personnel caring for patients with HIV/AIDS trained and applying care protocols.	ND	40%	60%	80%	85%	90%
		27) No. of groups organized to support the Program for the care and counseling of PLWHA.	ND	3	10	15	20	25
		28) % of patients with HIV/AIDS abandoning ART.	ND					
		29) Incidence rate of HIV/AIDS.	ND					
	R7: Civil society participation in support of PLWHA is enhanced.	30) Number of active organized groups for the prevention, care and support of PLWHA.	ND	3	10	15	20	25
		31) Number of trainings organized with vulnerable groups for the prevention and care of HIV/AIDS.	ND	3	3	3	3	3
		32) No. of non-formal groups or associations of male and female workers benefiting from support for STI and HIV prevention and social reintegration.	ND	3	3	3	3	3
		33) Number of structures and institutions that support organized groups of people living with HIV/AIDS.	ND	3	10	15	20	25

SUB-PROGRAMS	EXPECTED RESULTS	INDICATORS	BASELINE DATA	GOALS TO HORIZON 2025				
				2021	2022	2023	2024	2025
SUBPROGRAM 1 : Control of Communicable Diseases (CT)	**R8: Respect for the human rights of people living with HIV is promoted.**	34) Existence of a training program on co-responsibility for the most vulnerable groups with regard to HIV.	ND	1	1	1	1	
		35) % of trained professionals in health services that provide comprehensive care free of stigmatization.	ND	30%	40%	60%	75%	85%
		36) Existence of a National Human Rights Observatory on HIV/AIDS.	ND	1	1	1	1	1
		37) % of complaints documented by the National Observatory of Human Rights on HIV/ AIDS.	ND	5%	10%	15%	20%	25%
		38) % of complaints on HIV/AIDS documented and solved by the Human Rights Ombudsman's Office.	ND	5%	10%	15%	20%	25%
	R9: Research, ES, monitoring and evaluation on HIV / AIDS are reinforced.	39) No. of surveys conducted on HIV/AIDS in Equatorial Guinea.	ND	1	1	1	1	1
		40) No. of publications on HIV/AIDS conducted.	ND	1	1	1	1	1
		41) No. of monitoring meetings conducted on HIV/AIDS.	ND	2	2	2	2	2
		42) No. of evaluations conducted on HIV/AIDS.	ND	1	1	1	1	1
	TUBERCULOSIS							
	R10: Increased detection of all forms of TB.	43) % of children with TB detected.	ND	50%	65%	75%	80%	90%
		44) % detection of sensitive TB in adults (58% /2018).	58%	60%	65%	75%	80%	90%
		45) % detection of TB - MR in adults (63% in 2018).	63%	85%	90%	95%	95%	95%
	R11: TB therapeutic success increased.	46) % of children with TB detected and treated.	ND					
		47) % of adults with TB treated (78% in 2018).	78%	90%	91%	92%	93%	93%
		48) % of treated TB - MR cases in adults (86%/2018).	86%	89%	90%	91%	91%	93%
	R12: All TB patients are tested for HIV.	49) % of children with TB detected who perform HIV test.	ND	40%	60%	75%	80%	90%
		50) % of TB patients with HIV on ARVs.	89%	95%	97%	100%	100%	100%

SUB-PROGRAMS	EXPECTED RESULTS	INDICATORS	BASELINE DATA	GOALS TO HORIZON 2025				
				2021	2022	2023	2024	2025
SUBPROGRAM 1 : Control of Communicable Diseases (CT)	**R13: ARV treatment coverage is increased in TB co-infected patients.**	51) % of co-infected children on ARV treatment.	ND	30 %	40%	60%	70%	90%
		52) % of co-infected patients on ART treatment (73% in 2018).	73%	80%	85%	90%	95%	100%
	R14: Research and epidemiological surveillance on TB is strengthened.	53) No. of studies conducted on TB.	ND	1		1		1
		54) No. of publications conducted on TB in Equatorial Guinea.	ND	1		1		1
SUBPROGRAM 2 : Combating Non-Communicable Diseases (NCDs)	**R15: The prevalence of risk behavior factors (tobacco, alcohol, unbalanced diet, physical inactivity) is reduced.**	55) % daily smokers in the last 12 months.	ND	25%	20%	15%	10%	5%
		56) % of low alcohol consumption (less than 40g of alcohol per day in men or 20 g of alcohol in women) during the past 30 days.	ND	50%	40%	30%	30%	25%
		57) % binge drinking (6 glasses/units of alcohol or more on 1 single occasion) in the past 30 days.	ND	30%	25%	20%	15%	10%
		58) % of abusive alcohol consumption (between 40g and 59.9g of alcohol on average per day in men or between 20g or 39.9g in women) during the last 30 days.	ND	30%	25%	20%	15%	10%
		59) % of harmful alcohol consumption (more than 60g of alcohol per day in men or 40g in women) in the last 30 days.	ND	15%	12%	10%	8%	5%
	R16: The prevalence of biological risk factors (hypertension, obesity, diabetes and hypercholesterolemia) is reduced.	60) % of insufficient consumption of fruits and vegetables (less than 5 portions of fruits and vegetables per day).	ND	30%	35%	40%	45%	50%
		61) % of physical activity practice (not less than 150 minutes of activity or equivalent per week).	ND	10%	15%	20%	25%	30%
		62) % of overweight (BMI ≥ 25 kg/m2).	ND	30%	26%	22%	20%	18%
		63) % of obesity (weight/(height)^2) (BMI ≥ 25 kg/m2).	ND	30%	26%	22%	20%	18%
		64) % of elevated blood pressure (BP) ((SBP ≥ 140 and/or DBP ≥ 90 mmHg) or currently under elevated BP.	ND	30%	26%	22%	20%	18%
		65) % of patients with elevated fasting blood glucose or under medical treatment for elevated blood glucose.	ND	30%	26%	22%	20%	18%
		66) % of patients with elevated blood cholesterol (≥ 240 mg/dL) or currently under treatment for elevated blood cholesterol level.	ND	30%	26%	22%	20%	18%

SUB-PROGRAMS	EXPECTED RESULTS	INDICATORS	BASELINE DATA	GOALS TO HORIZON 2025				
				2021	2022	2023	2024	2025
SUBPROGRAM 3 : **Control of Neglected Tropical Diseases (NTDs)**	**R17: The framework for assessing the disease burden of NTDs is improved.**	67) % of people affected and exposed to NTDs (by sex and age range).	ND	40%	30%	20%	10%	5%
		68) % of people in need of interventions to combat and prevent NTDs.	ND	40%	30%	20%	10%	5%
	R18: There is an integrated approach to multisectoral disease control interventions.	69) Existence of an integrated national program of multisectoral actions to combat NTDs.	ND	1	1	1	1	1
		70) No. of sectoral action plans to combat NTDs developed, financed, implemented and evaluated.	ND	1	1	1	1	1
	R19: The health care system and the development of management capacities are strengthened.	71) % of people covered by mass distribution of preventive and anti-transmission chemotherapy drugs.	ND	50%	60%	70%	75%	85%
		72) Surveys conducted on prevalence and incidence of the most common NTDs in Central Africa.	ND	2		2		2
		73) Amount of financial resources mobilized for the control and elimination of NTDs.	ND	20%	20%	20%	20%	20%
	R20: Integrated vector management and capacity building for control of NTDs are strengthened.	74) Existence of a national integrated, adopted and implemented vector management policy.	ND	1	1	1	1	1
		75) No. of evaluation reports on the national integrated vector management policy available.	ND	1	1	1	1	1
SUBPROGRAM 4 : **Improving the environment and/or way of life of the population**	**R21: Promoting healthier lifestyles and mitigating the health effects of social and environmental hazards.**	76) % of the population with access to sufficient and balanced food.	ND	30%	40%	40%	50%	60%
		77) % of population applying at least 4 essential family practices (EFP) for health.	ND	30%	40%	40%	50%	60%
		78) % of population with knowledge, attitudes and adopting appropriate practices for health.	ND	30%	40%	40%	50%	60%
		79) % of population with access to safe drinking water and basic sanitation.	ND					
		80) % of population practicing a regular physical activity or sport (150 minutes or equivalent/week).	ND	5%	10%	15%	25%	30%

3.8. Description of the main subprograms of Program No.3

SUBPROGRAM 1:

CONTROL OF COMMUNICABLE DISEASES (CD)

a) Malaria

The National Malaria Control Program is the national structure responsible for implementing activities to control and, if possible, eliminate malaria in Equatorial Guinea. Although activities are spread throughout the country, it has been implemented mainly on Bioko Island by components and through funding from the Government and oil companies, as follows: (i) vector control through Indoor Residual spraying (IRS) and distribution of mosquito nets and application of larvicides, (ii) case management through laboratory diagnosis, antimalarial treatment and prevention during pregnancy with intermittent preventive treatment (IPT), (iii) epidemiological surveillance, monitoring, follow-up and evaluation, (iv) entomology through mosquito surveys, (v) operational research through malaria vaccine trials and Insecticide resistance studies, and (vi) community sensitization and mobilization.

The mainland region and Annobón Island - where more than 70% of the population is concentrated are almost devoid of malaria control activities due to lack of funding, since the withdrawal in September 2011 of the Global Fund to Fight HIV, Malaria and TB and with the closure of the Malaria Control Project in this part of the country.

The operational units of the National Malaria Control Program (NMCP) are health posts, health centers and district, provincial and regional hospitals. It is important to note the progressive integration of private sector health facilities in the fight against malaria by applying the procedures and tools established by the NMCP.

In the framework of the implementation of universal health coverage (UHC) through equitable access to malaria control services, the Government of Equatorial Guinea, with the support of private oil sector partners, is taking the necessary steps to ensure coverage of the mainland region and the island of Annobón in malaria control services accessible to the entire population and respecting the same norms and standards as those of Bioko Island.

b) Tuberculosis

To achieve the expected 2025 targets for TB control, the following actions will be developed: (i) reinforcement of the detection of sensitive TB (in adults and children) and MDR, by extending coverage and active case finding through awareness raising and using new diagnostic technologies, (ii) improvement of therapeutic success through the implementation of DOT, decentralization of activities, as well as community involvement in order to decrease lost to follow up and non-assessed, (iii) strengthening collaboration between TB and HIV/AIDS programs, (iv) developing the ONE STOP strategy with focused and integrated care for the co-infected patient, (v) promotion of public-private partnership in multisectoral fight, mobilization of domestic resources and promotion of community involvement and (vi) strengthening the functional structure of the NTBP, ensuring funding, leadership and good governance of the program.

c) HIV/AIDS and other Sexually Transmitted Infections (STIs)

In the fight against HIV/AIDS, it should be assumed that the epidemic is still

concentrated in Equatorial Guinea and that efforts should be made to keep it in this category with major action that make this purpose feasible. In this regard, there is a national response program, the NHAP, with a strategic plan framed according to the Global Strategy of 90, 90, 90, which means: (i) 90% of people diagnosed, (ii) 90% of people diagnosed receive antiretroviral treatment and (iii) 90% of people under antiretroviral treatment benefit from adequate follow-up.

In the face of deficient prevention measures, in the absence of a national condom social marketing program, poor implementation of the sections of the law on protection of the rights of people living with HIV/AIDS and their families, persistent discrimination and stigmatization, poor integration and management of STIs at all levels of health care., low effectiveness of the strategy for elimination of vertical transmission of HIV and control of exposed children, low effectiveness of the multisectoral response; Program No. 3 Health Promotion of the present NHDP aims to: (i) develop programs to prevent the transmission of STIs, HIV and AIDS in the population, prioritizing the most vulnerable groups, (ii) develop comprehensive STI-HIV/AIDS care programs with a multisectoral and gender approach, (iii) control the spread of the pandemic and reduce the negative impact of the pandemic, both for the people affected and for their social environment, (iv) promote the defense of human rights in the population covered by the creation of a national observatory that contributes to the elimination of discrimination and stigmatization, (v) develop a communication program to eradicate discrimination and stigmatization of workers and the promotion of preventive activities in the workplace, (vi) promote joint and coordinated actions between the Government, the private sector and civil society organizations to strengthen the national response, (vii) develop an epidemiological surveillance system to measure and monitor the impact of HIV/AIDS and develop lines of research, and (viii) mobilize the human and financial resources necessary to address the epidemic efficiently and effectively.

a) In the area of primary prevention: (i) promotion of all scientifically proven STI and HIV/AIDS prevention practices (abstinence, fidelity, condom use), (ii) coordination and implementation of prevention actions in the formal economic sector, (iii) development and implementation of an information, education and communication plan with a focus on behavioral change for the prevention of STI and HIV/AIDS transmission, (iv) expansion of the coverage of the Prevention of mother-to-child transmission of HIV, (v) implementation of universal biosafety standards in health care services, (vi) promotion of access to voluntary counseling and testing services for HIV with pre- and post-test counseling, and (vii) implementation of syndromic management of STIs.

b) In the area of comprehensive care or secondary prevention: Development of programs with comprehensive STI/HIV/AIDS care with a multidisciplinary, intersectoral, multicultural and gender approach, framed within the framework of respect for human rights through the following actions: (i) geographic and administrative decentralization of comprehensive care services aimed at improving the patients' environment, (ii) training of human resources for decentralized care, (iii) availability of essential drugs, ARVs and laboratory supplies, and (iv) quality management of routine HIV data.

c) In terms of guaranteeing human rights: the NHAP will ensure respect for human

rights in relation to people living with HIV and AIDS, both at the care, family and work environment levels, through the following actions: (i) promotion of the defense of human rights in the population in general and particularly in the work environment, contributing to the elimination of discrimination and stigmatization of infected and affected persons, (ii) strengthening of communication mechanisms and standards to guarantee the human rights of the population, (iii) promotion of training in co-responsibility for the most vulnerable groups (PLWHA, SW, MSM) in HIV prevention and care, and (iv) training of health personnel to provide comprehensive care free of stigma and discrimination, as well as in the work environment.

d) Information, education and communication (IEC): the aim is to develop this theme with a multidisciplinary, multisectoral, multiethnic and gender approach, based on an analysis of the national context of STIs and HIV/AIDS and through an IEC program for STIs and HIV/AIDS, (ii) development of operational IEC plans for STIs and HIV/AIDS at the local level, (ii) development of operational IEC plans for STIs and HIV/AIDS at the local level, in accordance with the needs for promotion and prevention at the workplace, family and community levels to reduce risk factors, and (iii) promotion of the development of surveys (KAP) to periodically measure efforts to change behavior towards STIs and HIV/AIDS.

e) In the area of coordination between the State, civil society and the private sector: (i) improvement of intra and inter-institutional communication capacity to enhance efforts in relation to the HIV/AIDS epidemic and to avoid duplication of interventions and use of resources, (ii) coordination of intervention measures through the NHAP, (iii) implementation of preventive and educational actions in companies through the participation of civil society to prevent discrimination of PLWHA in the workplace, and (iv) strengthening the protection of workers who are at occupational risk of acquiring opportunistic infections.

f) In the area of epidemiological surveillance and research: (i) development of a case registry system on the incidence, prevalence and mortality related to HIV/AIDS, maintaining a standard of data quality and that are comparable at the national and international level, (ii) development of an Epidemiological Surveillance system for the purpose of sizing, monitoring the impact of the epidemic and promoting research, (iii) elaboration and implementation of a National Strategic Plan for Epidemiological Surveillance, and (iv) development of research on the population at risk, specific studies on sexuality, incidence and impact of STIs, HIV and AIDS on social and economic development.

g) Eg) Concerning human and financial resources: (i) development of a plan of human resources and in-service training needs, (ii) provision of the human and financial resources necessary to ensure supplies and services to support universal access to comprehensive HIV/AIDS care, and (iii) development of a record of annual expenditures on HIV/AIDS activities for cost management.

SUBPROGRAM 2:

CONTROL OF NONCOMMUNICABLE DISEASES (NCDS)

Despite international efforts, the global burden of non-communicable diseases (NCDs) continues to increase, causing 36 million deaths in 2008, representing 63% of all deaths worldwide, with 80% (29 million) occurring in low- and middle-income countries. It should be noted that mortality due to NCDs is expected to increase by 17% over the next ten years if nothing is done. Due to lack of data, it is not possible to reflect the situation of this major public health problem in Equatorial Guinea.

Reduce the prevalence of behavioral risk factors (tobacco, alcohol, unbalanced diet, physical inactivity), the prevalence of biological risk factors (hypertension, obesity, diabetes and hypercholesterolemia). Expanding the associations' knowledge of behavioral and biological risk factors of NCDs and monitoring the evolution of their prevalence are the main objectives of this subprogram, which consists of 2 outcomes and 6 indicators.

In view of the worrying situation of NCDs in Equatorial Guinea, based on a simple everyday observation in health facilities and in the community, the main actions to be taken within the framework of this Subprogram are the following: (i) greater consideration of NCDs as a national priority and which may lead to a declaration of a national day for the fight against NCDs, (ii) placing the prevention and control of NCDs under the leadership of the President of the Country, Head of State and Government, (ii) conducting a study on NCDs, (iii) promotion of a multi-sectoral approach in the fight against NCDs, (iv) development and implementation of a strategic plan for the fight against NCDs and an implementation roadmap, (v) strengthening community involvement in the fight against NCDs, (v) conducting specific research on certain NCDs such as diabetes and Arterial Hypertension (AHT), for example, in order to better delimit their evolution, (vii) mobilizing the necessary resources for the integration, management and surveillance of NCDs and risk factors, and (viii) adopting and disseminating the integrated disease surveillance and response guide in health facilities and in the community.

Specifically, the fight against diabetes, AHT and other cardiovascular diseases will require a greater focus on broad public information and awareness of the risk factors for these diseases, strengthening prevention and treatment capacities by training specialists, and acquiring equipment and affordable drugs for all patients (oral antidiabetics, insulin and antihypertensive drugs), the promotion of sports in schools and in the community, the dissemination of good hygiene, dietary and lifestyle practices, and the adoption and promotion of early detection of diabetes and hypertension in the general population and systematization, particularly in pregnant women, through the advanced strategies of the mobile teams of the health districts.

With regard to the fight against cancer, the need to reinforce the fight against smoking and alcoholism, which are the major risk factors, the vaccination of adolescents against HPV, the strengthening of strategies for early detection and treatment of cervical cancer, the implementation of two cancer services in the two regional hospitals of Malabo and Bata for the early detection of precancerous lesions through continuous training of staff in the management of these cases, access to anticancer drugs, and the implementation of a program for the prevention of cervical cancer, the implementation of two cancer services in the two regional hospitals of Malabo and

Bata for the early detection of precancerous lesions through continuous training of staff in the management of these cases, access to anticancer drugs and radiotherapy, psychosocial support for patients with advanced and terminal cancer, as well as the development and implementation of a registry book of cancer patients.

The fight against sickle cell disease is part of the Government's priorities by conducting a comprehensive study on the prevalence of the disease underway with the involvement of civil society and in order to develop a response intervention program, access to treatment of pre-crisis symptoms, the creation of a link between the Oyala Fertility Center project of the National Institute of Health, under implementation, and the research project on sickle cell disease to ensure assisted reproduction without sickle cell disease.

Mental illnesses, like other NCDs, have become one of the Government's priorities according to international recommendations and the associated disability burden, but also because of the evidence that there are efficient interventions with a great impact on the mental health of individuals, communities and the economic and social development of each person. To this end, the following activities will be carried out under this NHDP: (i) elaboration, adoption and implementation of a national policy and strategic plan for mental health, (ii) elaboration, adoption and implementation of a law regulating mental health activity, (iii) elaboration, adoption and implementation of a strategy for social reintegration of recovered mental health patients, (iv) promotion of operational research in mental health and (v) documentation and dissemination of Equatorial Guinea's good practices in mental health through the Sampaka Psychiatric Hospital in Malabo.

Regarding traffic accidents and their consequences which constitute one of the most relevant problems affecting economic and social development, with individual and family consequences due to the disabilities due to the states of partial or total disability that are recorded, the loss of employment and property, as well as human lives; the following activities will be carried out to improve this situation: (i) elaboration of a collaboration framework between the Ministry of Interior and Local Corporations as the entity responsible for road safety or road, Health and Social Welfare assuming the management of the consequences and Labor and Social Security assuming the protection of the insured, (ii) reinforcement of road traffic regulation, (iii) reinforcement of the technical control of vehicles (iv) continuous training of the road safety police force, promotion of awareness and education of the population on the proper use of traffic for the protection of people's lives, maintenance of roads, as well as reinforcement of signs and traffic lights and (v) implementation of two trauma services in the regional hospitals of Malabo and Bata and improvement of the technical and logistical capacity of provincial and district hospitals to ensure the management of medical emergencies related to traffic accidents and their consequences.

The World Health Organization (WHO) considers neglected tropical diseases (NTDs) a group of diseases that affect nearly 1.5 billion people worldwide. Many of these diseases cause disability, disfigurement, social exclusion and death. In response to this social injustice, the continental framework for the control and elimination of neglected tropical diseases (NTDs) by 2020 is "The Elimination of Neglected Tropical Diseases in Africa is Possible" March 2013; and focused on the theme: "The Impact of Non-Communicable Diseases (NTDs) and Neglected Tropical Diseases on Africa's Development". The 6th African Union Minister of Health Conference of April 2013

in Addis Ababa was the main instrument from which we drew inspiration for the formulation of this NTD Sub-Program.

Faced with this global situation of NTDs and their consequences, the objective of this Subprogram is to reduce morbidity and disabilities due to these diseases, reinforcing the prospects of achieving SDG No. 3: "Ensure healthy lives and promote well-being for all at all ages", by improving the health and socio-economic status of the entire population of the Republic of Equatorial Guinea. This implies the implementation of a solid program of integrated control at all levels of the epidemiological chain: infected persons, vectors, parasite reservoirs and environment, using the most suitable approaches for the elimination of these diseases.

The following strategic orientations with impact activities have been retained to respond to the expected results of the subprogram, namely:

a) Strengthening national ownership, advocacy, coordination and partnership by (i) enhancing the capacities and coordination mechanisms of the National Control Program for NTDS, at the national level, (ii) strengthening and promoting partnership for the control, elimination and eradication of NTDs, at the national level, and (iii) strengthening the visibility and traceability of NTDs control, elimination and eradication interventions at all levels.

b) Strengthening results-oriented planning, resource mobilization and sustainability of interventions to combat NTDs through: (i) development and implementation of a resource mobilization plan with the contribution of all development partners to cover interventions to combat NTDs , (ii) strengthening the integration of the activities of the NTDs Control Program into national plans and health reforms of the Ministry of Health and Social Welfare, (iii) increased funding for NTDs in the Government's PIP budget, (iv) development and implementation of policies, guidelines and other tools to improve the management of the National Program to Combat NTDs, and (v) integration of the gender concept in planning for the control and elimination of NTDs.

c) Expanding access to interventions, treatment and strengthening the service delivery capacities of the National NTDs Control Program through: (i) integration of essential NTDs control activities by health system level, (ii) introduction of vector control for the control and elimination of NTDs, (iii) strengthening of response capacities at all levels of the National Health System (including the community level) for management and coordination of NTDs control.

d) Control and evaluation of NTDs by: (i) strengthening the supervision, monitoring and evaluation of activities to combat NTDs, (ii) strengthening the surveillance system for NTDs at the different levels of the health system, and (iii) promoting research on NTDs.

It is important to mention that these measures should be implemented based on the six strategies recommended by the World Health Organization (WHO) to prevent and combat NTDs namely: (i) chemoprophylaxis or prevention, (ii) intensified case management, (iii) vector control, (iv) availability of safe water and good sanitation and hygiene, (v) implementation of veterinary public health measures, and (vi) strengthening capacity to control NTDs.

In order to ensure the sustainability of the achievements made, any intervention

related to NTDs, whether by the State's own funding or by international aid from the WHO and other development partners, must be accompanied by measures that directly influence the determinants of health, such as access to drinking water, improved living conditions, food security, proper sanitation or the strengthening of the National Health System itself.

SUBPROGRAM 3:

IMPROVEMENT OF THE POPULATION'S ENVIRONMENT AND/OR WAY OF LIFE

This subprogram refers to actions to promote practices, behaviors and attitudes that are favorable to the health of the population. It involves implementing the interventions of a multisectoral communication plan to reduce the impact of risk factors such as tobacco use, alcohol consumption, consumption of psychotropic substances, non-observance of traffic rules on public roads, sedentary lifestyles, lack of sports and prenuptial examinations among young people.

The subprogram is directly linked to health promotion, which is a process that allows people to increase control over their health in order to improve it and constitutes an essential element for achieving healthy lifestyles and behaviors. It encompasses not only actions aimed directly at increasing people's skills and capabilities at the individual level, but also those aimed at modifying the social, environmental and economic conditions that have an impact on health determinants at the collective level.

The Subprogram is an essential factor for the improvement of health in Equatorial Guinea since the population faces the same health and development problems and, as such, health promotion strategies must be carried out with a comprehensive social, community and political approach that allows equitable access to effective health responses. To this end, the following activities will be carried out: (i) dissemination of the main diseases in the population and essential family practices (EFPs) to be adopted at the individual and community level, (ii) enhancement of social communication for behavioral change with broad community involvement, (iii) reactivation of multisectoral structures to fight epidemics, (iv) strengthening and expanding the awareness and prevention capacities of civil society organizations in health promotion, (v) integration of health promotion activities in the operational plans of all ministries for their internalization, and (vi) promotion of regular individual and collective physical activity, healthy eating and the use of drinking water.

PROGRAM 4:

STRENGTHENING HEALTH SYSTEM LEADERSHIP AND GOVERNANCE

3.9.Location and programmatic framework

The program for strengthening leadership and governance in the health sector includes 4 sub-programs which are:

1) **Subprogram 1:** Strengthening leadership and accountability in the health sector.

2) **Subprogram 2:** Improving financial management in the health sector.

3) **Subprogram 3:** Strengthening health information management.

4) **Subprogram 4:** Health Research.

The logical framework of Program No. 4 establishes 14 expected results, 64 indicators with their corresponding targets to be achieved in the 4 Subprograms during the 5 years covered by the National Health Development Plan (NHDP). It should be noted that the lack of baseline indicators has not made it possible to set projections as to the desired level of progress between 2021-2025, while the results of the studies and surveys to be carried out during year 1 of NHDP implementation are still awaited.

THE FOURTH PRIORITY PROGRAM OF THE NHDP AIMS TO STRENGTHEN THE LEADERSHIP AND GOVERNANCE OF THE HEALTH SYSTEM THROUGH 4 SUBPROGRAMS

THROUGH 4 SUBPROGRAMS:

Strengthening leadership and accountability in the health sector

Improving financial management in the health sector

Strengthening health information management

Health research

Table 9: Logical results framework for Program 4 "Strengthening leadership and governance of the health system (2021-2025)

SUBPROGRAMS	EXPECTED RESULTS	INDICATORS	BASELINE DATA	GOALS TO HORIZON 2025				
				2021	2022	2023	2024	2025
SUBPROGRAM 1 : Strengthening health sector leadership and accountability	**R1: The legal and juridical framework in the health sector is improved.**	1) % of health professionals trained in legal issues related to health.	ND	5%	10%	15%	20%	25%
		2) % of professionals informed and sensitized on the texts of existing health laws.	ND	25%	35%	45%	55%	65%
		3) Existence of a program for operational dissemination of existing health laws.	ND	1	1	1	1	1
	R2: The programmatic and coordination framework in the health sector is improved.	4) % of professionals trained in the logical framework for health planning.	ND	30%	40%	45%	50%	60%
		5) No. of NHDP sub-programs adopted, financed, and implemented.	ND	13	13	13	13	13
		6) Existence of a monitoring and evaluation plan for the subprograms with established indicators.	ND	1	1	1	1	1
	R3: Coordination of interventions by development partners and the private health initiative is improved.	7) Existence of a Coordination Committee of health sector development partners.	ND	1	1	1	1	1
		8) Existence of national guidelines on partnership in the health sector.	ND	1	1	1	1	1
		9) Existence of a coordination unit for private for-profit and not-for-profit health care.	ND	1	1	1	1	1
	R4: Decentralization is expanded and community participation is strengthened.	10) No. of district health plans developed and implemented with community participation.	ND	18	18	18	18	18
		11) % of district health committees operating with the participation of other sectors.	ND	18	18	18	18	18
		12) No. of studies conducted on community participation in health.	ND	1				1
	R5: Health sector reforms are effectively implemented.	13) Existence of a strategic plan for training human resources in health (UNGE/ MOHSW/other).	ND		1			
		14) Existence of a database of existing private health facilities.	ND	1				
		15) Number of control reports and inspections of private health facilities available.	ND	1	1	1	1	1
		16) Existence of a social marketing program for condoms to prevent HIV and other STIs.	ND	1				
		17) Existence of a system for the supply of medicines and other health input.	ND	1	1	1	1	1

SUBPROGRAMS	EXPECTED RESULTS	INDICATORS	BASELINE DATA	GOALS TO HORIZON 2025				
				2021	2022	2023	2024	2025
SUBPROGRAM 1 : Strengthening health sector leadership and accountability	**R6: Accountability and management control of health resources are implemented.**	18) Existence of a document of standards and procedures for resource management control in health care.	ND	1				
		19) Number of professionals trained in resource management control and health auditing.	ND	30	40	45	50	60
		20) Existence of a personnel evaluation plan applied in service delivery positions.	ND	1				
		21) No. of internal control reports available and used.	ND	1	1	1	1	1
		22) No. of program and project audit reports available and used.	ND	1	1	1	1	1
	R7: Health policy dialogue with all stakeholders is promoted.	23) Existence of structures for promoting policy dialogue in health (public, civil society, joint).	ND	2	2	2	2	2
		24) No. of national participants in international health meetings, forums, and conferences.	ND	30	40	45	50	60
		25) Number of international partners providing technical and/or financial support to the health sector.	ND	6	10	12	12	12
SUBPROGRAM 2 : Improving Financial Management in the Health Sector	**R8: A mechanism for monitoring the use of economic resources allocated to the sector is implemented.**	26) Existence of a plan to monitor the economic resources allocated to the health sector.	ND	1				
		27) Existence of national health accounts (NHA) that estimate and monitor health expenditures.	ND		1			
		28) Existence of a manual for administrative and financial management of resources allocated to the health sector.	ND	1				
		29) No. of internal control and performance audits conducted on the quality of program and project management.	ND	2	2	2	2	2
		30) No. of evaluations carried out to measure the effectiveness and efficiency of health program and project management.	ND	1	1	1	1	1
	R9: Health sector funding is increased to more than 15% of the General State Budget.	31) % of health sector budget allocated to the health sector.	ND	15%	20%	20%	20%	20%
		32) % of health expenditure per inhabitant.	ND					
		33) No. of MOHSW professionals trained in the preparation of the General State Budget.		10	10	10	10	10
		34) % of private sector participation in health sector financing.	ND	10%	15%	15%	15%	15%
		35) Existence of a resource mobilization plan to finance the health of the population.	ND	1	1	1	1	1

SUBPROGRAMS	EXPECTED RESULTS	INDICATORS	BASELINE DATA	GOALS TO HORIZON 2025				
				2021	2022	2023	2024	2025
	R10: Universal health coverage (UHC) is increased for the entire population.	36) % of the population with health coverage by a third party payer.	6.8%	20%	30%	40%	50%	60%
		37) % of population bearing the direct payment of health services benefits.	45%	35%	25%	20%	20%	20%
		38) Existence of a universal health insurance mechanism accessible to the population.	ND		1			
	R11: Measures are recommended to improve the quality of INSESO's services, avoiding the duality of functions.	39) Evaluation report on the quality of services provided by INSESO insurance company available.	ND	1 1	1	1	1	1
		40) Report of a study on drug costs and available benefits.	ND					1
		41) % of public hospitals that are subcontractors of INSESO and/or health insurer.	ND	10%	15%	25%	35%	38%
		42) Existence of a roadmap for the extension of INSESO's health coverage to other population groups.	ND		1			
SUBPROGRAM 3 : Strengthening of the National Health Information System (NHIS)	R12: The availability and quality of resources (human, material and financial) allocated to the NHIS, including epidemiological surveillance, are increased.	43) % of professionals by sex trained in SIS in public health facilities.	ND	25%	45%	55%	65%	85%
		44) No. of professionals trained in statistics, epidemiology, planning, demography and informatics.	ND	5	5	5	5	5
		45) % of health facilities with logistical equipment, means of communication and NIS infrastructure.	ND	40%	70%	80%	90%	100%
		46) % of resources allocated to the NHIS in the State's Public Investment Program (PIP).	ND	5%	5%	5%	5%	5%
		47) Existence of a resource mobilization plan to support the NHIS with donors and health programs and projects.	ND	1	1	1	1	1
	R13: There is a national list of indicators defined and adopted by level of health service delivery.	48) % of health facilities using indicators for health planning and decision making.	ND	40%	50%	50%	50%	50%
		49) % of professionals with knowledge of goals and indicators of NHDP, SDGs and other public health facilities.	ND	40%	50%	70%	80%	90%
		50) Existence of tools (logical framework) for the use of indicators of SDGs and other health programs.	ND	1	1	1	1	1
		51) Existence of metadata dictionaries (guidelines) for the use of National Health System indicators.	ND	1				
		52) Existence of updated population data for estimates of target groups in programs and projects.	ND	1	1	1	1	1
		53) Existence of routine para-public and private sector data integration procedures in the NHIS.	ND	1				
		54) % of operational Epidemiological Surveillance focal points.	ND	40%	60%	80%	90%	100%

SUBPROGRAMS	EXPECTED RESULTS	INDICATORS	BASELINE DATA	GOALS TO HORIZON 2025				
				2021	2022	2023	2024	2025
	R15: NHIS data dissemination and utilization, including epidemiological surveillance (ES), is improved.	55) No. of awareness-raising sessions for decision makers and civil society on health indicators.	ND	3	3	3	3	3
		56) % of promptness in submitting routine health information according to NHIS standards.	ND	40%	60%	80%	90%	100%
		57) No. of epidemiological bulletins and statistical yearbooks reproduced and distributed per year .	ND	1	1	1	1	1
		58) No. of health professionals and media actors informed and trained on the use of indicators for awareness raising and advocacy.	ND	30	30	30	30	30
		59) % of health facilities making use of NICTs in health information management.	ND	40%	60%	80%	90%	100%
		60) Existence of an operational organizational framework for routine HIS and ES at all levels.	ND	1	1	1	1	1
SUBPROGRAM 4 : Health research	R16: National technical research capacities are strengthened.	61) Existence of an operational structure for coordinating health research.	ND	30	5	5	5	5
		62) Existence of a national team trained in health research.	ND	1	1	1	1	1
		63) Number of research coordination reports available.	ND					
	R17: Operational research in health is implemented.	64) Existence of a national health research plan with a budget allocated by the State's PIP.	ND	1	1	1	1	1
		65) Number of health studies and research carried out with available adopted data.	ND	5	10	15	20	25
		66) EGDHS - III conducted and data available.	ND					1
		67) Number of publications of studies and research on health carried out.	ND	5	10	15	20	25
	R18: Collaboration with the National Institute of Public Health and the National Research Ethics Committee is implemented.	68) Existence of a framework for collaboration with the National Institute of Public Health on research.	ND	1	1	1	1	1
		69) Existence of a National Health Research Committee.	ND	1	1	1	1	1
		70) Existence of a collaboration mechanism with the National Research Ethics Committee.	ND	1	1	1	1	1

3.10. Description of the main subprograms of Program No. 4

SUBPROGRAM 1:

STRENGTHENING LEADERSHIP AND ACCOUNTABILITY IN THE HEALTH SECTOR

Strengthening leadership and accountability in the health sector requires the development of the following strategic actions: (a) improvement of the legal and legal framework of the health sector, (b) improvement of the programmatic and coordination framework of the health sector, (c) improvement of the coordination of interventions of development partners and private initiative in health, (d) decentralization of decision making, (e) implementation of health sector reforms, (f) implementation of a culture of accountability and management control of health sector resources, and (g) promotion of political dialogue in health, involving all stakeholders.

a) Improvement of the health sector's legal and judicial framework

The following activities will be developed within the framework of this strategy: (i) training of professionals on legal issues related to health, (ii) information and sensitization of professionals on the sections of existing health laws, and (iii) development of a broad program for the dissemination of existing health laws.

b) Improving the programmatic and coordination framework of the health sector

The following activities will be developed under this strategy: (i) training of professionals in the logical framework of health planning, (ii) development, adoption, financing and implementation of operational plans by health system level, and (iii) development and implementation of plans for monitoring and evaluation of health programs using established indicators.

c) Improving the coordination of the interventions of development partners and the private health initiative

The following activities will be developed within the framework of this strategy: (i) creation of a Coordination Committee of Development Partners in the health sector, (ii) elaboration of national guidelines on partnership in the health sector, (iii) creation of a coordination structure for private for-profit and not-for-profit health, and (iv) participation in regional and international health forums, conferences and meetings.

d) Decentralization of decision-making, resource management and strengthening community participation

The following activities will be developed under this strategy: (i) development and implementation of district health plans with full community participation, (ii) operationalization of district health committees with the participation of other sectors of the administration, and (iii) studies on community participation in health.

e) Implementation of health sector reforms

The following activities will be developed under this strategy: (i) elaboration and adoption of a strategic plan for the training of human resources in health with the involvement of the UNGE, MOHSW, MINEDUC and the private health sector, (ii) creation of a database of existing private health facilities, (iii) organization of control missions and inspections of private health

facilities, (iv) development of a social marketing program for condoms to prevent HIV and other STDs, (v) strengthening of the logistics system for the supply of medicines and other health inputs, and (vi) extension of national universal health insurance coverage.

f) Implementation of the culture of accountability and control of health resource management

The following activities will be developed within the framework of this strategy: (i) development and adoption of standards and procedures for health resource management control, (ii) training of professionals in resource management control and health auditing, (iii) development of an evaluation plan for personnel in service delivery positions, (iv) implementation of internal control of health services and programs, and (v) organization of the audit of health programs and projects.

g) Promotion of health policy dialogue involving all stakeholders

The following activities will be developed within the framework of this strategy: (i) creation of health policy dialogue structures (public services and civil society), (ii) participation of professionals in international health meetings, forums and conferences, and (iii) increase in the number of development partners providing technical and/or financial support to the health sector.

SUBPROGRAM 2:

IMPROVING HEALTH SECTOR FINANCIAL MANAGEMENT

The improvement of the supply of services requires the development of the following priority actions: (a) the implementation of mechanisms to monitor the use of economic resources allocated to the sector, (b) the increase of health sector funding in the General State Budget, (c) the extension of universal health coverage (UHC) to the entire population, and (d) the adoption of measures to improve the quality of INSESO's services to avoid the duality of functions.

h) The implementation of mechanisms to monitor the use of the economic resources allocated to the sector

The following activities will be developed within the framework of this strategy: (i) preparation of a plan to monitor the use of resources allocated to the health sector, (ii) preparation of National Health Accounts (NHA) to estimate and monitor health expenditures, (iii) preparation of an Administrative and Financial Management Manual for resources allocated to the health sector, (iv) institutionalization of internal control and performance auditing in the health sector, and (vi) annual and biannual evaluation of the effectiveness and efficiency of health program and project management.

i) Increasing health sector funding in the General State Budget

The following activities will be developed under this strategy: (i) operationalization of the health district to keep accessible quality care available at different levels, (ii) improvement of the delivery capacity of third level hospitals to reduce health evacuations and improve the quality of care for INSESO insured, (iii) implementation of the texts of the laws on free health services to reduce direct payment, and (iv) implementation of a mechanism to monitor universal health coverage (UHC) in the country.

j) Expansion of universal health coverage (UHC) to the entire population

The following activities will be developed under this strategy: (i) operationalization of the health district to keep accessible quality care available at different levels, (ii) improvement of the delivery capacity of tertiary hospitals to reduce health evacuations and improve the quality of care for INSESO insured, (iii) implementation of the sections of the laws on free health services to reduce direct payment, and (iv) implementation of a monitoring mechanism for universal health coverage (UHC) in the country.

k) Adoption of measures to improve the quality of INSESO's services in order to avoid the duality of functions

The following activities will be developed under this strategy: (i) independent evaluation of the quality of INSESO benefits for the insured, (ii) study on the costs of medicines and health benefits in INSESO facilities, (iii) improvement of INSESO reimbursement mechanisms in subcontractor hospitals, and (iv) development of the roadmap with MOHSW, Social Security and other sectors for the extension of INSESO health coverage to other population groups.

SUBPROGRAM 3:

STRENGTHENING OF THE NATIONAL HEALTH INFORMATION SYSTEM (NHIS)

The improvement of the supply of services requires the development of the following strategic actions: (a) increasing the availability and quality of resources (human, material and financial) allocated to the NHIS, which include Epidemiological Surveillance, (b) the availability of a national list of indicators defined and adopted by level of health service delivery, (c) the improvement of diversified and quality NHIS data sources at all levels of the health pyramid, and (d) the dissemination and utilization of NHIS data, which include Epidemiological Surveillance (ES).

a) Increasing the availability and quality of resources (human, material and financial) allocated to the NHIS, including epidemiological surveillance

The following activities will be developed within the framework of this strategy: (i) training of professionals in routine NHIS to cover the needs of public health facilities and specialists in health statistics, Epidemiology, Health Planning, Demography and Informatics, (ii) provision of public health facilities with technical, logistical equipment, means of communication and NHIS infrastructure, and (iii) allocation of sufficient resources to the NHIS in the State's Public Investment Program (PIP) and adoption of a resource mobilization plan to support the NHIS, financed by donors and health programs and projects.

b) The availability of a national list of indicators defined and adopted by level of health service delivery

The following activities will be developed under this strategy: (i) adoption and use of indicators in all public and private health facilities for planning and making appropriate health decisions, (ii) training of health professionals and other sectors on goals and indicators of the NHDP, ODS and other public health programs; (iii) development and use of programmatic tools (logical framework) for the appropriate use of indicators of ODS and other public health programs and (iv) development and

dissemination of a metadata dictionary (guidelines) for the usual definition of indicators of the National Health System.

c) Improvement of diversified and quality HIS data sources at all levels of the health pyramid

The following activities will be developed within the framework of this strategy: (i) adoption and financing of a national health research plan with resources from the PIP and other donors, (ii) implementation of health studies and research that respond to public health needs, (iii) District health census to obtain updated population data, (iv) development of routine NHIS data integration procedures in the para-public and private health sector, (v) training, technical and logistical equipping of ES focal points at the national level, and (vi) provision of sites in public, para-public and private health facilities for the storage of NHIS data.

d) Dissemination and use of HIS data, including Epidemiological Surveillance (ES)

The following activities will be developed under this strategy: (i) organization of sensitization sessions in decision makers and civil society on NHIS indicators, (ii) periodic monitoring of routine data management to require promptness and accuracy in the remission of reports and feedback, according to the standards established by the NHIS, (iii) annual production and dissemination of epidemiological bulletins and statistical yearbooks, (iv) training of health professionals and other media actors on the use of indicators for awareness-raising and advocacy purposes, and (v) strengthening the use of NICT in health information management in public, para-public and private health facilities.

SUBPROGRAM 4:
HEALTH RESEARCH

The promotion of health research requires the development of the following strategic actions: (a) the strengthening of national technical capacities in research, (b) the promotion of operational research in health, and (c) the implementation of collaboration with the National Institute of Public Health and the National Research Ethics Committee.

a) Strengthening of national technical capacities in research

The following activities will be developed under this strategy: (i) creation and implementation of a National Health Research Committee, (ii) constitution and training of a national team of health researchers, and (iii) support for the organization of coordination meetings of the National Health Research Committee.

b) Promotion of operational research in health

The following activities will be developed under this strategy: (i) development of a national health research plan and mobilization of resources needed to finance research activities, (ii) allocation of resources in the government's research program for sustainable financing of health research, (iii) implementation of the EGDHS - III in 2025 and (iv) publication of studies and research conducted.

c) Development of a collaborative framework with the National Institute of Public Health and the National Research Ethics Committee

The following activities will be developed under this strategy: (i) establishment of a collaboration framework with the National Institute of Public Health for the promotion of health research, (ii) creation and implementation of a National Health Research Committee and (iii) establishment of a collaboration mechanism with the National Research Ethics Committee.

CHAPTER IV: MECHANISMS FOR IMPLEMENTING AND COORDINATING THE NHDP

4.1. Structures and bodies for coordinating and executing the NHDP

4.1.1. Coordination structures and bodies

The NHDP is a complex project whose success requires not only strong leadership commitment but also a strong implementation and monitoring mechanism. This implies (i) the creation and implementation of a steering committee as a strategic body of the NHDP that will be multisectoral in nature, including health sector development partners, (ii) the creation and implementation of the NHDP National Technical Committee and (iii) the Coordination Committee of health sector development partners. Chaired by the Minister of Health and Social Welfare, these management structures will have the following functions:

- Support the reinforcement of the institutional set-up of the health system's operational implementation structures.
- Approve annual NHDP implementation work plans and management tools (procedures, indicators, budgets, etc.).
- Institutionalize the monitoring and evaluation of the operational implementation plans to inform and document the members of the NHDP steering committee.
- To formulate relevant recommendations for the improvement of the quality of implementation in an approach to promote accountability.

In total, four priority programs and twelve subprograms will be coordinated by the Ministry of Health and Social Welfare, through the general directorates and their respective national services and programs.

At the national level, the NHDP will be coordinated by (i) the General Directorate of Health Planning and Programming and Public Health and (ii) the General Directorate of Public Health and Health Prevention.

At the regional level, the NHDP activities will be coordinated by the Regional Health Delegation supported by the regional coordinators of health sector programs and projects.

At the provincial level, the NHDP will be coordinated by the provincial delegations supported by the district health teams, which are responsible for the implementation and enforcement of health actions in all districts nationwide.

At the district level, district health teams will be in charge of implementing NHDP activities through district health plans containing the components of priority programs with an approach of integration and harmonization of health needs. The planned activities will be geared towards the operationalization of the health district, which will emphasize the decentralization of services and resource management at the different levels of care.

The technical structure of inter-sectoral coordination of the NHDP will be in charge of the National Technical Committee composed of representatives of all health-related sectors and health development partners. The attributions and mechanisms for the functioning of this Committee will be established as an annex to the normative documents for the execution of the NHDP.

4.1.2. Coordination of implementation of the NHDP

The implementation of the NHDP will be effective for the period 2020-2024, aligned with Equatorial Guinea 2035 Agenda, through the priority programs and annual

operational plans that respond to the logical framework of results of the five-year plan, established for this purpose with their respective expected results, indicators and targets set for 2025.

At the regional level, activities will be carried out at the Regional Health Delegation through the Regional Health Coordination and with the close collaboration of the Faculty of Health Sciences and the Bata University Hospital.

At the provincial level, there will be a reinforced team from the 7 provincial delegations that will allow the development of provincial action plans focused on the decentralization of the planning process and the management of resources and decision making.

At the district level, there will be a management team for the development of the district action plans which will be the real operational instruments of the NHDP with the involvement of the community through the Health Development Committees chaired by the Government delegates. In total, 18 district health plans will be developed, based on the logical framework of results, which will make it possible to meet the needs of the population in the 109 health centers and 387 health posts.

4.2. Role and responsibilities of stakeholders and partners in the development of the NHDP

The Government is responsible for the implementation of the NHDP and will make available the necessary institutional and financial resources to meet the goals set for 2025. Through the Ministry of Health and Social Welfare, the Government will facilitate the effective and coordinated participation of the other sectors involved in the implementation of the operational action plans, the creation and implementation of coordination structures and the provision of the necessary national human resources.

The Ministry of Health and Social Welfare will ensure management and administration and will allocate and release, in a timely manner, the national counterpart funds needed to complement the partners' contribution, through a resource mobilization plan. It will also develop decentralized action plans within the framework of the operationalization of the health districts to ensure universal health coverage, establishing the monitoring and evaluation mechanisms in a participatory manner with the involvement of the following actors:

1) Ministry of Education and Science for the promotion of sexual and reproductive health of young people and adolescents in the school environment and in the associations of parents/guardians of students for the integration of sexual education as a teaching subject in schools.

2) Ministry of Infrastructure and Urban Planning for the development of health infrastructure that respect the established health map to ensure objective planning of infrastructure development.

3) Ministry of Finance, Planning and Budget to ensure the integration of the NHDP budget into the Government Investment Program (PIP).

4) Ministry of Social Affairs and Gender Equality for the integration of gender aspects in the NHDP operational plans

and to ensure greater involvement of women and girls in all stages of implementation, monitoring and evaluation, ensuring the promotion and protection of women's and girls' sexual and reproductive rights, as well as their active participation in improving maternal, newborn and child health.

5) Ministry of Information, Media and Radio-Television, through the IEC/ Advocacy Project, for the development of sustainable awareness and advocacy programs to scale up initiatives to reduce maternal and neonatal mortality, promote the use of contraceptive methods, adolescent and youth sexual and reproductive health, and combat communicable and non-communicable diseases.

6) Ministry of Agriculture, Livestock and Forestry for the implementation of a real Food and Nutrition Program based on the new approach of "Macrobiotic Diet", in application of good food practices in order to ensure a balanced diet in pregnant women and their babies and other vulnerable groups.

7) Ministry of Labor and Social Security for greater involvement in the extension of disease coverage and the strengthening of INSESO services as the main State insurer of the Republic of Equatorial Guinea.

Development partners will be asked to contribute to efforts to mobilize technical, material and financial resources within the framework of public development assistance (PDA), which could mainly focus on technical cooperation for the development of human resources, in order to strengthen national capacity for the management of the NHDP.

Coordination and collaboration will be strengthened to ensure complementarity and synergy of interventions with the agencies of the United Nations System (WHO, UNFPA, UNICEF, UNDP, UNAIDS, FAO) and other cooperation institutions, including religious denominations and civil society. Greater involvement of all partners is expected at all stages of planning, implementation, monitoring and evaluation of strategies at all levels of the health pyramid, as well as in grassroots communities and civil society.

The private sector will also be involved in support of the government's efforts, mainly with the oil and petroleum companies through ongoing projects to combat malaria, improve maternal, neonatal and child health, and strengthen the technical competence of personnel.

4.3. Opportunities for success of the NHDP

The NHDP is the greatest opportunity to provide the country with a powerful, resilient health system capable of guaranteeing universal access to quality health services and sustaining the durability of economic and social growth in an equitable manner. To this end, the Government's will be increasingly visible and marked by commitments that are reflected in the following:

- The importance given by the Government to the social sector with the creation of a Social Fund through its own resources to finance projects of greater investment in health in the State Budget (PIP) that carry important economic resourcess.

- The approach of the First Lady to the health needs of Equatoguinean women in her capacity as the Patron of the National Reproductive Health

Program, with the intense advocacy of her leadership towards the Government and development partners to promote equitable access to quality sexual and reproductive health services.

- The promulgation of Presidential Decree No. 41/2016, dated March 11, adopting "the Action Plan for the implementation of some social measures in the short and medium term to carry out actions of greater social impact such as free maternal and neonatal health care including cesarean section and care for women in difficult situations and elderly people."

- The reduction of maternal and neonatal mortality as a national priority to consolidate the achievements made in 2015 in achieving the MDG target, reaching a maternal mortality rate of 290 per 100,000 live births in 2013 (Final Evaluation Report OMD), through a significant mobilization of Government funds to finance the roadmap for the reduction of maternal and neonatal mortality.

- Progressive involvement of the private sector in maternal health financing to accelerate the reduction of maternal and neonatal mortality as a national priority by mobilizing funds through the oil sector, led by the Ministry of Mines and Hydrocarbons with the following achievements: (i) the financing of the Maternal and Neonatal Mortality Reduction Project in the provinces of Bioko North and Kie-Ntem by Noble Energy and in the amount of USD 6 million, (ii) the financing of the Cervical Cancer Prevention and Treatment Project with about USD 2 million, (iii) the financing of the research project on sickle cell disease in children under 1 year of age, at the national level, (iv) the financing of the fight against malaria by the Government and oil sector partners, which mainly benefits pregnant women and children.

- The existence of a favorable climate for the development of South-South and North-South cooperation in health and the favorable attitude of the population in contributing to the implementation of health programs at the national level.

- The existence of a willingness of development partners to support the government in the implementation of national and international commitments in health, through their involvement in all programmatic processes and implementation of the various national development plans in the health sector.

4.4. Conditions for success and risk management in the implementation of the NHDP

By adopting a National Health Policy for 2035 and an NHDP for 2025, the Republic of Equatorial Guinea commits itself to a new path of change in the global supply of health services, with the aim of achieving universal health coverage in an equitable manner with the involvement of all health development partners. To this end, certain important factors must be taken into consideration:

- A high level political leadership: Through the involvement of the President of the Country, Obiang Nguema Mbasogo, for a successful implementation of the National Health Policy and the NHDP in order to ensure universal access to health services and consolidate the achievements made in the health sector.

- A planned intervention framework: The vision, stages, objectives and expected

results, adequate resources and regular monitoring should guide, on a daily basis, the implementation of the NHDP in an integrated and coherent framework of the four priority programs of the NHDP.

- A management towards measurable results: the NHDP should translate, after the first two years, into significant changes, highlighting Equatorial Guinea as a model country in the management of its health system, through objectively verifiable indicators that measure the impact on the population.

- Competent human resources: Current shortfalls in terms of human capacities will be addressed, not only through optimal management of existing competencies, but also in an approach geared towards a strategic external partnership that will bring distinctive added value. External partners are necessary to make a contribution in terms of skills and experience and to enable the country to benefit from the experience of others.

- A solid institutional implementation framework: The revision, adoption and implementation of the Management Organizational Chart of the Ministry of Health and Social Welfare is essential to ensure quality implementation of the NHDP at all levels of the national health pyramid.

- Strategic communication: Communication on the NHDP will be multifaceted through radio and television, in official speeches, in schools and universities, in sectoral ministries, in civil society organizations and in the community. It will take advantage of the potential of new information and communication technologies to broaden the dissemination of NHDP instruments and results. Adequate and permanent communication will fuel the NHDP vehicle.

- An implementation risk management based on a matrix approach: based on the major weaknesses of the causal analysis of the seven pillars of the health system and the risks that may compromise the successful implementation of the NHDP, intervention measures will be formulated.

Table 10: Risk analysis Matrix to the NHDP implementation

HEALTH SYSTEM AREAS	POTENTIAL RISKS	ACTIONS TO BE TAKEN
I. LEADERSHIP AND GOVERNANCE IN HEALTH SYSTEM MANAGEMENT.	1. Weak application of legal and juridical provisions in health.	• Implement a training plan for personnel on legal issues in the health sector.
	2. Deficient application of the programmatic and management framework of the health sector.	• Develop a program to disseminate existing laws in the health sector.
	3. Lack of coordination of partner interventionss.	• Create and implement a structure for coordinating health development partners.
II. DEVELOPMENT OF HUMAN RESOURCES IN HEALTH	4. Lack of production planning of health personnel.	• Provide health planning professionals with a greater focus on the logical framework of results.
	5. Poor management of health personnel at all levels.	• Establish a mechanism for coordination and control of activities and resources.
	6. Deficient functioning of the management organization chart.	• Update and implement the MOHSW management organization chart at all levels.
III. HEALTH INFRASTRUCTURES AND QUALITY MEDICAL EQUIPMENTD	7. Receipt of poor quality health infrastructure.	• Establish a coordination mechanism between MOHSW, the Ministry of Public Works and Urban Planning and EG-Projects for the development of sanitation infrastructure.
	8. Acquisition of equipment that does not comply with the standards.	• Adopt and implement a policy for the procurement and management of biomedical equipment.
IV. SUPPLY OF ELECTRICITY AND POTABLE WATER	9. Poor quality of health care at different levels.	• Advocacy for the connection of Health infrastructure to the public drinking water network.
	10. Deficient referral and counter-referral system.	• Develop an efficient communication system in health structures and facilities (telephones, internet, radio frequency).

HEALTH SYSTEM AREAS	POTENTIAL RISKS	ACTIONS TO BE TAKEN
V. LOGISTICS MANAGEMENT SYSTEM FOR MEDICINES AND OTHER PRODUCTS	11. Frequent stock-outs of medicines and other products.	• Implement a consumption-based procurement system for drugs and other health products.
	12. Use of medicines of poor quality.	• Acquire and apply quality control tools for medicines and other health products and strengthen the inspection of pharmacies.
	13. Inadequate use of Natural and Traditional Medicine.	• Promote the integration of Traditional and Natural Medicine into the health system.
	14. Inadequate health financing.	• Develop and implement a health financing strategy.
	15. Lack of protection against financial health risks.	• Reactivate Primary Health Care (PHC) and develop a comprehensive health insurance system.
	16. Lack of defined and adopted indicators.	• Ensure the operationalization of the health district.
VI. UNIVERSAL HEALTH COVERAGE (UHC))	17. Limited supply of quality health services.	• Ensure the implementation of an effective logistics management system for essential drugs and intermediate equipment.
	18. Poor utilization of services.	• Involve MOHSW in the management of infrastructure maintenance contracts.
	19. Deficient demand for health services.	• Adopt and implement a national health communication strategy and conduct specific studies on the population's knowledge and behavior.

CHAPTER V: BUDGET AND FINANCING MODEL OF THE NHDP

(the budgetary part can be found in an annexed document)

CHAPTER VI: MECHANISMS FOR MONITORING, EVALUATION AND CONTROL OF THE NHDP

6.1. Selection and Validation of NHDP Indicators

The availability of a national list of indicators defined and adopted by level of health service delivery is one of the components of the Strategic Plan for Strengthening the National Health Information System adopted by MOHSW, which aims to ensure the availability, quality and use of reliable, integrated, harmonized and accessible health statistical information for all partners and actors in the National Health System.

The purpose of using the indicators is to improve the allocation of resources, the development of health strategies, the effective implementation of work plans and the processes of monitoring and evaluation of activities, according to the annual programs and plans, obtaining as a purpose the improvement in decision making at the different levels of intervention of the health system of Equatorial Guinea.

To this end, during 2019, the Ministry of Health and Social Welfare developed a National Manual of Health Indicators, which were identified and selected by those responsible for health services, programs and projects and with the participation of development partners in the health sector.

The National Indicators Manual developed has been the reference tool for classifying the indicators of the National Health Development Plan (NHDP) into three groups, namely: (i) demographic and socioeconomic indicators, (ii) environmental indicators and (iii) health indicators. These are distributed according to the NHDP priority program guidelines into: (a) input indicators, (b) process indicators, (c) outcome indicators and (e) impact indicators, as reflected in the following table.

In total, there are 111 indicators that have been selected, in October 2020, by the NHDP national budgeting team during the meeting in Bata and were distributed in the table on the following page and whose details are provided in the annex to this document.

N°	INDICATOR CONCEPTS	TOTAL
1	Input indicators	8
2	Process indicators	31
3	Outcome indicators	55
4	Impact indicators	18
Total		**112**

Comments:

I. Input indicators measure the resources used in the program such as: personnel, health facilities, equipment, supplies and funds to implement the program. They are human and financial resources, physical facilities, equipment and operational policies that allow implementing program activities.

II. Process Indicators are those that show the status of activities and are intended to measure some specific and observable characteristics that show the changes and progress being made in a period of no more than twelve months. They include both what is being done and how well it is being done (quality of the intervention). An example of such indicators is the emergency obstetric care (EmOC) indicators that track efforts to reduce maternal and neonatal mortality.

III. Outcome indicators provide quantitative evidence of the results obtained with respect to the actions implemented, so that progress over a year or more can be evaluated. They monitor the progress of the implementation of the strategic plans and contribute to the achievement of the related objectives, particularly service coverage. For example, contraceptive prevalence and the percentage of hospital deliveries, both of which contribute to the reduction of maternal mortality.

IV. The impact indicators reflect the changes achieved in the target population (level of coverage in the long term), as well as the situations expressed qualitatively (satisfaction, health, well-being) in a period that is desirably between 3 and 5 years.

6.2. Monitoring and evaluation plan

On the basis of the indicators established in the logical framework of results of the NHDP programs, a monitoring and evaluation plan will establish a mechanism to ensure joint supervisions and periodic monitoring of activities in the field, with greater involvement of the Bata Regional Delegation, the provincial health delegations and the district health teams. Based on the established annual NHDP work plans, the periodicity of meetings of the NHDP piloting and technical structures will be specified.

Monitoring will be carried out monthly by the district health teams, quarterly by the provincial teams and biannually by the joint central and regional Bata team. A NHDP monitoring and evaluation manual will be the subject of a specific document that will establish the rules for supervision by level of delivery and monitoring, respecting the operationalization framework of the health district.

An annual evaluation of the level of implementation of the annual work plans will be carried out on the basis of the indicators defined in the logical results framework matrix of the NHDP five-year plan, which will also be the subject of another annexed document. A mid-term evaluation is foreseen in the third year of implementation and a final evaluation, through an external consultancy, during the last year of implementation of the NHDP five-year plan. The annual evaluation reports will be periodically submitted to the National Technical Committee for technical validation and forwarding to the Steering Committee for discussion and analysis in plenary session for the purpose of making appropriate decisions to improve the quality of the management of the activities and of the resources mobilized and made available.

6.3. Auditing and management control of the NHDP

Con el objetivo de garantizar la adecuada aplicación de los procedimientos de gestión del PNDS, se implementará un sistema de control interno mediante la implementación de un manual de procedimiento administrativo y financiero y la organización de auditorías anuales de cuentas, cuyos informes serán periódicamente sometidos al Comité Técnico Nacional para su validación técnica y remisión al comité de pilotaje del PNDS.

6.4. Approach to data collection

The NHDP monitoring, evaluation and control data collection will use the following approaches:

6.4.1. Manual routine data collection at health facilities

The physical collection of routine data will be systematic and mandatory in all health facilities in the country through the implementation of the routine data management tools established in the Strategic Plan for Strengthening the Health Information System, which is currently being implemented and includes several training and capacity building activities and the reproduction and distribution of management materials. The formation of a team of 37 statistical technicians is an opportunity to ensure the implementation of this procedure.

6.4.2. Data collection using an electronic data platform

This is a system that allows the integration of the different information subsystems through the use of new information and communication technologies. It is a free and open software, designed by the University of Oslo, to manage health information systems and made available to countries in support of their health systems. It operates in a network and requires the permanent use of the Internet; it allows easy access to decentralized level data (health centers, hospital, province and region) depending on the basic configuration level.

At the level of this platform, access to data by users is based on the level of decision-making responsibility of the individual; a confidential access code to the database is available for this purpose. The system offers, for example, the possibility of programmed follow-up of pregnant women to remind them of upcoming prenatal appointments via cell phones; synthesis of vaccination data, follow-up of patients on ARVs, among others.

This new system also offers the possibility of interconnection with data platforms in other countries where the model works successfully. The human resources department of MOHSW, for example, can perfectly benefit from this modern management system for a regular update of the management of health personnel at the different levels of the health pyramid, without the need to travel to the field.

The NHIS National Directorate is institutionally responsible for coordinating the implementation of the data platform and is supported by specialized international technical assistance. The implementation of the tool requires the following requirements: (i) leadership of the NHIS Directorate in the whole process of implementation of the data platform.(ii) availability of qualified human resources in the NHIS and distributed at all levels, (iii) availability of harmonized data collection tools in the field, (iv) availability of computer equipment with permanent supply of electric current in all health facilities of data collection and (v) availability of permanent internet connection, in all health facilities, directorates and services interconnected to the data platform network.

DISTRIBUTION FRAMEWORK OF INDICATORS OF THE NATIONAL HEALTH DEVELOPMENT PLAN (NHDP)

N°	INPUT INDICATORS	N°	PROCESS INDICATORS	N°	OUTCOME INDICATORS (OUTPUT)	N°	IMPACT INDICATORS
1	Number of inhabitants.	1	% of women screened for cervical cancer and with VIA testing.	1	% of satisfied demand for family planning (FP) with modern methods.	1	Crude mortality rate.
2	% of population by age group.	2	% cases diagnosed with cervical cancer by clinical stage.	2	% of positive results based on tests performed in the laboratory service.	2	Mortality rate by cause.
3	Number of live births.	3	% of hospital admissions by cause.	3	% of positive results according to examinations performed in the Imaging service.	3	Crude mortality rate by age.
4	Number of women of childbearing age.	4	% of cases treated for neglected tropical diseases.	4	% of patients rehabilitated in the psychiatry department.	4	Proportional mortality by cause.
5	Number of wholesale suppliers of medicines and other health products.	5	% of tests performed in the laboratory service.	5	% of discharges according to classification in the psychiatry department.	5	Mortality rate in children under 5 years old.
6	Number of private pharmacies established in the country.	6	Average number of examinations performed in the Imaging Service.	6	% of children under 5 years of age fully vaccinated.	6	Infant mortality rate (< 1 year).
7	Number of specialists trained in health statistics, epidemiology, planning, demography and informatics.	7	% of surgical activities performed by specialty.	7	% of pregnant women who received 3 doses of tetanus vaccine during pregnancy.	7	Perinatal mortality rate.
8	Number of health facilities making use of new information and communication technologies (NICT) in health information management.	8	% of surgical activities performed by type of surgery (major elective, minor elective, major urgent and minor urgent).	8	% of live births in health facilities.	8	Fetal mortality rate.
		9	% of surgeries performed by cause.	9	% of houses sprayed according to location or region.	9	Maternal mortality rate.
		10	% of anesthetic techniques applied according to classification (general, neuroaxial, spinal).	10	% beneficiaries of insecticide-impregnated bed nets.	10	% of maternal deaths by direct cause.

N°	INPUT INDICATORS	N°	PROCESS INDICATORS	N°	OUTCOME INDICATORS (OUTPUT)	N°	IMPACT INDICATORS
		11	(general, neuroaxial, spinal, regional, local, multimodal, combined, among others).	11	% of users of insecticide-impregnated bed nets.	11	of maternal deaths due to indirect causes.
		12	% of children under 5 years of age with clinically diagnosed suspected pneumonia.	12	% of pregnant women attended in the last trimester of pregnancy with at least 3 doses of Intermittent Malaria Treatment (IPT).	12	Case fatality rate.
		13	% of children up to 5 years (0 6-59 months) dewormed in the last 6 months.	13	% reported cases of congenital syphilis.	13	In-hospital mortality rate, gross and net.
		14	% of children aged 6-59 months who received two doses of vitamin A supplements.	14	Net rate of children completing primary education.	14	Disease incidence rate.
		15	% of children under 5 with diarrhea receiving oral rehydration solution (ORS) and zinc supplementation.	15	HIV/AIDS incidence rate per 1,000 inhabitants.	15	Percentage of patients under psychiatric treatment for addiction, reintegrated into the community.
		16	% vaccination coverage for all antigens.	16	HIV prevalence rate per 100 inhabitants.	16	Suicide rate per 1,000 population.
		17	Parasite prevalence of malaria.	17	% of people living with HIV (PLWHA) receiving antiretroviral treatment.	17	Prevalence of tobacco use among persons 15 years of age and over.
		18	% of children of women living with HIV adequately followed up.	18	Incidence of tuberculosis per 1,000 inhabitants.	18	Adolescent fertility rate (per 1,000 girls aged 10-14 years and 15-19 years).
		19	% of people living with HIV/AIDS with follow-up consultations.	19	% detection of susceptible TB in adults.	19	Exclusive breastfeeding rate (up to 6 months).
		20	% of pregnant women seen in the 1st pregnancy consultation with HIV, syphilis and viral hepatitis tests that have received their results.	20	% of water samples suitable for consumption.		
		21	% of pregnant women with HIV under ARV treatment.	21	% of population with access to drinking water through home connection.		

N°	INPUT INDICATORS	N°	PROCESS INDICATORS	N°	OUTCOME INDICATORS (OUTPUT)	N°	IMPACT INDICATORS
		22	% of pregnant women with positive syphilis and viral hepatitis tests undergoing treatment.	22	% of population with access to sanitary means of excreta disposal.		
		23	% of population using at least 4 essential family practices (EFP) for health.	23	% of population with health insurance by third-party payer.		
		24	% of population practicing regular physical activity or sport (150 minutes or equivalent/week).	24	% of direct payment for health care borne by the population.		
		25	% of births attended by skilled health personnel.	25	% of children detected with TB.		
		26	Direct obstetric case fatality rate in AOU facilities.	26	% of children co-infected (TB and HIV).		
		27	Antenatal care coverage with at least 8 antenatal care visits (ANC) at the end of pregnancy.	27	% of co-infected children on ARV treatment.		
		28	Average number of integrated prenatal consultations.	28	% of adults co-infected (TB and HIV).		
		29	% discharges for births attended by skilled attendants.	29	% of new TB cases in HIV-positive persons who received treatment for both TB and HIV.		
		30	% of cesarean sections performed in comprehensive AOU facilities.	30	% of people co-infected with HIV and HBV receiving combination therapy.		
		31	Early neonatal (0-6 days), late neonatal (7-27 days) and post-neonatal (28 days-11 months and 29 days) mortality rates.	31	% of women aged 25-49 years living with HIV screened for cervical cancer by VIA.		
				32	% screening for multidrug-resistant tuberculosis (MDR-TB) in adults.		
				33	% cases of multidrug-resistant tuberculosis (MDR-TB) treated in adults .		

N°	INPUT INDICATORS	N°	PROCESS INDICATORS	N°	OUTCOME INDICATORS (OUTPUT)	N°	IMPACT INDICATORS
				34	% of health professionals with knowledge of NHDP, SDG and other health plan targets and indicators.		
				35	% of patients with mental disorders rehabilitated in health institutions.		
				36	% of people covered by health insurance (public or private).		
				37	% availability of contraceptive methods.		
				38	Low birth weight index (< 2,500g).		
				39	Prevalence of anemia in children 6-59 months old.		
				40	Prevalence of stunting among children under 5 years of age.		
				41	Prevalence of malnutrition among children under 5 years of age.		
				42	Prevalence of anemia in women aged 15-49 years, by age and pregnancy status.		
				43	% of pregnant women smokers.		
				44	% of pregnant women with excessive consumption of alcoholic beverages.		
				45	Prevalence of pregnant women by nutritional status classification.		
				46	% of adolescents (15-19 years) who are already mothers or are pregnant.		

N°	INPUT INDICATORS	N°	PROCESS INDICATORS	N°	OUTCOME INDICATORS (OUTPUT)	N°	IMPACT INDICATORS
				47	% of women and girls 11 years of age and older who have suffered physical, sexual or psychological violence from a current or former partner in the last 12 months.		
				48	% of men and boys 11 years of age and older who have suffered domestic and sexual violence in the past 12 months.		
				49	% of pregnant women classified with preconception risk.		
				50	% counseling on sexual and reproductive health and other components.		
				51	Postpartum care coverage.		
				52	% of direct obstetric complications that were treated in basic and comprehensive EmOC.		
				53	% of individuals with knowledge, attitudes, and practices (KAP) to combat malaria.		
				54	Incidence rate of sexually transmitted infections (STIs).		
				55	% of patients treated in health facilities for drug use.		

BIBLIOGRAPHY

1. *Equatorial Guinea, Ministry of Health and Social Welfare: Strategic approach of the health sector to the 2020 and 2035 horizon; report submitted to the International Monetary Fund (IMF), Malabo, September 2019.*
2. *Equatorial Guinea/WHO, Instituto de Salud Carlos III, Global Health Program, MCDI (2019): Guía Terapéutica de tratamiento del Paludismo.*
3. *Equatorial Guinea, Ministry of Finance, Planning and Economy/UNFPA: International Conference on Population and Development (ICPD) + 2014 Assessment Report, May 2018.*
4. *Equatorial Guinea, Ministry of Health and Social Welfare (2018): National Child Health Policy Document.*
5. *WHO and UNICEF: Declaration of the Astana Conference on Primary Health Care (PHC) targeting universal health coverage (UHC); October 2018.*
6. *Equatorial Guinea, Ministry of Health and Social Welfare: 2018 NHIS routine data reports.*
7. *Equatorial Guinea, Ministry of Health and Social Welfare (2018): Consolidated report of situation analysis data on Health Services, Programs and Projects in the framework of the evaluation of the seven Pillars of the National Health System.*
8. *Equatorial Guinea, Ministry of Health and Social Welfare/MCDI (2018): Annual Evaluation Report of Phase No. 2 of the Early Diagnosis, Prevention and Treatment of Cervical Cancer Project.*
9. *Equatorial Guinea, Ministry of Health and Social Welfare/Ministry of Health and Social Welfare (2018): National health information system (NHIS) routine data report.*
10. *Equatorial Guinea, Ministry of Health and Social Welfare, WHO, MCBI, RBM, UNICEF (2017): Need for urgent support in the fight against malaria in the Mainland and Annobon region; Malabo, Equatorial Guinea.*
11. *Equatorial Guinea, Ministry of Health and Social Welfare (2017): National health information system (NHIS) routine data report.*
12. *UNAIDS (2017): HIV estimates in Equatorial Guinea (1990-2016).*
13. *Equatorial Guinea, Ministry of Education of Equatorial Guinea (2017): Statistical Yearbook of Early Childhood and Preschool, Primary, Secondary, Technical and Vocational Education. School Year 2015-2016.*
14. *Equatorial Guinea - UN (2011): Common Country Assessment (CCA) November 2017.*
15. *Equatorial Guinea, Ministry of Health and Social Welfare (2016): National health information system (NHIS) routine data report.*
16. *Equatorial Guinea, Ministry of Health and Social Welfare/UNICEF (2016): independent assessment report on vaccination coverage.*
17. *Ministry of Health and Social Welfare: Report of the study on Alternatives for financing health services in Equatorial Guinea, July 2016.*
18. *Equatorial Guinea, National Institute of Statistics of Equatorial Guinea (INEGE) (2016): Equatorial Guinea in figures 2016.*
19. *Equatorial Guinea UNICEF - Equatorial Guinea (2016): Analysis of the situation of children in Equatorial Guinea.*
20. *Equatorial Guinea, Ministry of Health and Social Welfare/UNPA (2016): Technical Evaluation Report on the Availability, Utilization and Quality of Emergency Obstetric Care.*
21. *United Nations (UN): General Assembly (2015) Draft outcome document of the United Nations Summit for the adoption of the Post-2015 Development Agenda. Transforming our world: the 2030 Agenda for Sustainable Development.*
22. *Equatorial Guinea, Ministry of Finance, Planning and Economy (2015): General Population and Housing Census (CGPV).*
23. *Equatorial Guinea, Ministry of Health and Social Welfare and Ministry of Economy, Planning and Public Investment (2011): 2011 Demographic and Health Survey (EGDHS-I), Equatorial Guinea.*
24. *Equatorial Guinea, Ministry of Education and Science: National University of Distance Education (UNED), Geography and History of Equatorial Guinea 1982.*

Ministerio de Sanidad y Bienestar Social
República de Guinea Ecuatorial

Guinea
Ecuatorial
Salud