GOVERNMENT OF GUINEA-BISSAU

MINISTRY OF PUBLIC HEALTH
DIRECTORATE GENERAL OF PREVENTION AND HEALTH PROMOTION
NATIONAL MALARIA PROGRAMME

GUINEA-BISSAU LONG-LASTING INSECTICIDE-TREATED NET (LLIN) CAMPAIGN 2020

MAIN FACTORS THAT CONTRIBUTED TO CONTINUING THE 2020 LLIN CAMPAIGN IN THE CONTEXT OF THE COVID-19 PANDEMIC

- **Strong support from** the Government of Guinea-Bissau and the Ministry of Health through the National Malaria Control Programme (NMCP) to continue with the implementation of the 2020 LLIN campaign (CMILDA 2020) at a time of restrictions for COVID-19 infection prevention and control, culminating in the state of emergency imposed due to the pandemic in March 2020. The movement of LLIN campaign personnel was only allowed through credentials provided by the Ministry of the Interior.
- **Effective coordination** between international partners (Global Fund, United Nations Development Programme [UNDP], World Health Organization [WHO] and the Alliance for Malaria Prevention [AMP]) and the NMCP and partners in the country. Through video conferences, international and national consultants helped review existing/planned strategies and examine alternatives and different interventions that could be adopted to safely deliver LLINs to targeted households. UNDP developed a response plan and mobilized resources to support the government, including strengthening health systems to respond to COVID-19.
- **Regular communication** between the main campaign funder (Global Fund), the Ministry of Health, UNDP, the management unit of the National Health Development Plan (CG-PNDS), NMCP and the Regional Health Directorates (DRS) for crucial and timely decision-making in order to avoid major delays in the implementation of the different stages of CMILDA 2020.
- **Rapid solutions to problems** by the NMCP/Ministry of Health and partners (e.g. supply of materials, campaign management tools, as well as COVID-19 personal protection equipment (PPE) for the majority of campaign personnel), as well as authorization for local rental of vehicles to address identified gaps. Local leaders were instrumental in contributing to problem resolution during the campaign.
- **Flexibility** in adapting procurement procedures through the revision of tools and timelines to ensure that there were adequate commodities so that delays in campaign implementation were minimized.
- **Use of various tools and channels** for data collection (paper reports, SMS, phone calls, daily review meetings, e-mails, data inserted into Excel tables and DHIS2) which facilitated the transmission of information from the community to the central level and partners during the implementation of CMILDA 2020. Data were collected daily by the regional team phoning team supervisors. Every morning the regional supervisory team and national consultants met (no more than 10 people) to follow-up progress, to analyse the performance of each team and to monitor the logistics situation (e.g. stock of LLINs).

ACHIEVEMENTS

- **At the end of the campaign, 2,293,177 people had access to LLINs for protection from malaria,** through the distribution of 1,287,746 LLINs before the high transmission season. This equated to one LLIN for every 1.8 people (provisional administrative data)

- **Strong engagement of all actors** involved in the campaign at a time when the state of emergency was declared ensured a rapid strategy review and adaptation to align to the context of COVID-19 and the measures for its prevention put in place by the Government of Guinea-Bissau
- The opening training session of Regional Health Team members was chaired by administrative authorities in most health regions to demonstrate **high-level political engagement** for the campaign even during the COVID-19 pandemic
- **Effective coordination of all stakeholders** through video conferences and e-mails during the planning and implementation of CMILDA 2020
- **Rapid adaptation of key strategies and activities** in compliance with the state of emergency and WHO guidelines to prevent COVID-19:
    - The fixed and advanced (outreach) site LLIN distribution approach developed during the microplanning in March 2020, before the COVID-19 pandemic declaration, was reviewed and modified to a single-contact, door-to-door distribution aligned with the COVID-19 context and limiting exposure to and transmission of the disease for both household recipients and campaign personnel
    - The structure of distribution teams for the door-to-door distribution was revised to comprise three people (one community health worker (CHW) as team leader, one mobilizer (activista) and one support staff who ensured the local LLIN door to door transportation), who were in turn supported by two supervisors from the health area, as well as supervisors from the regional health department and monitors from the central level
    - The period for the door-to-door registration and LLIN distribution was adjusted to eight days. The CHWs/mobilizers provided the LLINs to each head of household or representative at the door of the household based on the number of people living in the household (one LLIN for two people)
    - The training manual for members of regional health teams was adapted and training scripts for CHWs were developed
    - The integrated training workshops (technical, logistics and communication) in support of the door-to-door registration and distribution were carried out at three levels:
        1. Regional Health Teams (ERS)
        2. Health area in-charges (RAS)
        3. Community health workers and mobilizers
    - All training sessions had provisions in place for handwashing, physical distancing and wearing masks
    - The use of data from door-to-door teams for programme decision-making during the distribution period to correct and/or strengthen issues related to stock-outs of LLINs or other campaign management tools and materials including PPE
- **Continuous and timely supply** of LLINs to distribution teams was key to meeting daily targets.
- **Strengthened supervision** of distribution teams with two supervisors for each health area in addition to the regional and central level personnel allowed for immediate resolution of problems encountered
- **Strong, multi-pronged communication strategy** that included messages disseminated by the media, the production of posters, leaflets and stickers for malaria, public announcements by political and religious authorities and communication of key messages by CHWs during the door-to-door distribution. Messages included information about the campaign, LLINs and COVID-19
- **Leveraging on the existing network of CHWs** for CMILDA 2020, who disseminated messages on behaviour change and on the distribution of the LLINs including messages on staying safe and healthy in the COVID-19 context by using PPE, handwashing and physical distancing. Local mobilizers (teachers and community students) completed vouchers, tally sheets and summary forms
- **Rapid procurement and delivery of masks** for protection against COVID-19 for the distribution teams that were interacting with the household members

CHALLENGES

- **Communication materials** (posters, pamphlets, stickers and labels) were produced, but delivered late such that some health regions did not receive them in time
- **Insufficient time allocated for the training** of campaign personnel. For example, for regional and health area campaign personnel, only two days were planned for an integrated training across campaign areas. Lack of adequate training of door-to-door teams and supervisors on the household registration process led to the number of people in households being falsely inflated by heads of households during the door-to-door distribution. This, in turn, led to insufficient LLINs available in the Biombo, Cacheu, Oio and SAB health regions. A second phase distribution of LLINs was organized in these regions to improve household access to LLINs, which incurred additional costs.
- **Delays in the positioning of LLINs** in the distribution warehouses of Bafatá, Gabú and Farim due to insufficient fleet capacity, weak coordination and lack of knowledge of the regions by those contracted for transport resulted in delays in beginning the distribution of LLINs in these health regions. Additional challenges included that the contracted transport company did not have appropriate vehicles to access the distribution warehouses once the roads were negatively affected by the rains.
- **Lack of communication (phone) credit during** the cascade training and the distribution of LLINs.
- **Delays in procurement of sufficient quantities of personal protective equipment (PPE)** such as masks. PPE waste management should be considered as part of the strategic adaptations to the COVID-19 context.
- Adapting to new **work from home/virtual meetings was difficult**. During the preparation of CMILDA 2020 in the context of COVID-19, measures to stay safe and healthy were respected, especially telecommuting. This was a challenge for the NMCP staff who were not used to working at home and meeting virtually, and thus tended to perceive that that UNDP decision-makers and technicians were not as present in meetings as in previous campaigns with face-to-face discussions.
- The **number of supervisors was insufficient** based on the number of teams required for door-to-door distribution.

LESSONS LEARNED

- **Careful planning** for door-to-door distribution is critical.
- **Adapting the training modules** to the context of COVID-19, organizing the regional trainings by axis and having the NMCP teams from the central level as trainers reduces the potential loss of information from one level of the training cascade to the next.
- Detailed quantification is needed to ensure that sufficient means of transport are available. Setting up strong logistics teams in areas known to be challenging, such as Bissau and Bafatá, contributes to the timely delivery of supplies of LLINs and other materials.
- **Time for training for campaign personnel should be reviewed** and increased for all levels of the cascade to ensure all topics can be sufficiently covered.
- **Signing of contracts with the national consultants** must take place at the beginning of the preparation of CMILDA 2020 so that they can participate from the beginning of macroplanning.
- **Human resource capacity strengthening** is necessary to ensure adequate coordination and implementation by the NMCP in the COVID-19 context.

CONTEXT

In 2020, Guinea-Bissau, with the support of its partners, carried out a national campaign to distribute LLINs to the entire population in line with the WHO recommendation of a three-year campaign cycle. This time, due to the coronavirus pandemic, strategy adaptations were required, following the recommendations of WHO, the Global Fund and AMP for the COVID-19 context. The distribution of LLINs to each household was carried out door-to-door (instead of at fixed and outreach distribution points) through 4,414 CHWs and

4,414 mobilizers (and the same number of support staff tasked with transporting the LLINs using local means, such as wheelbarrows).
Preparations for the CMILDA 2020 began in November – December 2019, prior to the onset of COVID-19 in Guinea-Bissau, with macroplanning supported by two international AMP consultants.
After the regional microplanning workshops in 09–13 March 2020, the 117 microplans (from 11 health regions and their respective districts) were submitted to the national consultants and consolidated into a single national microplan.
The household registration in preparation for the LLIN distribution had been planned the week of 16—20 March 2020, but due to the declaration of the COVID- 19 state of emergency, it was not implemented and the entire campaign was only completed in May 2020.
The team of national consultants put in place before the COVID-19 pandemic was strengthened by hiring four additional national consultants to support the regions in the CMILDA 2020 process.

REVIEW OF THE STRATEGY

A number of activities had taken place before the COVID-19 pandemic, including the macroplanning and microplanning. Therefore, only the strategies for the remaining activities were reviewed to ensure a safe and secure distribution of LLINs (updating of the training manual, implementation of training, door-to-door registration and LLIN distribution, supervision, monitoring, logistics and social and behaviour change [SBC]).

Development of revised macroplan aligned to COVID-19 context

Using the original macroplanning documents as a base, a brief document was developed and aligned with a revised budget. It described the updated strategy for the LLIN distribution and other COVID-19 adaptations required for appropriate infection prevention and control. The strategy was presented to the national coordinating committee and approved for implementation. The updated budget included the required PPE and other materials to ensure respect for handwashing and disinfection of spaces used (e.g. warehouses, training venues).

Update of manuals and tools

Following WHO recommendations on the rigorous observation of physical distancing in the context of COVID-19, preparations for CMILDA 2020 were resumed. One major priority was updating the training manual for the facilitators of the regional trainings that were planned from region to community level. The training manual update included details about the COVID-19 adapted strategy, including guidance for the CHWs and mobilizers for their activities and how they should be adjusted to limit the potential for COVID-19 exposure and transmission. With the new strategy, the distribution team consisted of three members (as noted above) and the roles and responsibilities of each were defined in the updated manual for the door-to-door distribution.

Training

To maintain quality of training in the context of COVID-19, campaign staff from the different levels were convened in three training/orientation sessions. The facilitators were then assigned to the 11 regions and supported by the 9 national consultants. All trainings held the same content and included PowerPoint slides, exercises in filling out tools and simulations and the demonstration of how to distribute the LLINs in the COVID-19 context.

Training participants at all levels used PPE, including masks. Water and soap for handwashing were available at the training site, installed by the Regional Health Directorates (DRS) in compliance with WHO recommendations.

In order to respect the guidelines on physical distancing, the training took place in three phases:

1. **Training of trainers for regional technicians** at central level– seven technicians from each of the 11 Regional Health Teams – a total of 77 regional health directorate staff – were trained for five days on all aspects of the campaign (logistics, M&E, SBC, data collection and management, finance management, etc.). Practical exercises were reinforced, as was COVID-19 infection prevention during all role-plays for campaign activities.
2. **Training of health area supervisors at regional level** – two health technicians from each health area were trained for two days per session as supervisors (total of 234 health technicians for 117 health areas). In regions with three to six health areas, the training took place in a single session, while in regions with more than six health areas training was organized in groups of six to seven health areas to ensure physical distancing and group limitations for COVID-19 prevention were respected. The training took place over two days and included all aspects of the campaign.
3. **Training of community health workers and mobilizers at health area level-** a total of **8,828** CHWs and mobilizers (4,414 of each cadre) were trained in door-to-door distribution over a period of two days plus one additional day for team supervisors. The third support member of each door-to-door team did not require special training. To respect the physical distancing guidelines, training sessions comprised fewer than 20 people and some groups worked outdoors.

Household registration and distribution of LLINs

The campaign was initially planned for a single period of time throughout the country, but some challenges during implementation linked to the adapted strategy for COVID-19, particularly not having household registration figures in advance of starting the LLIN distribution, led to a second phase being necessary in some regions to complete the distribution to all targeted households.

First phase: *08—15 June 2020*

During the eight days of household registration, the teams collected information from households, such as the names of the heads of the household and the number of members of their family and recorded the information on vouchers. The head of the household was given the correct number of LLINs based on the allocation parameters (one LLIN per two people, rounding up in the case of an uneven number of household members) with no limit on the number of LLINs per household during the same visit. During the registration and distribution of LLINs, team members (with the exception of support personnel) wore masks and were instructed to undertake frequent handwashing with liquid soap that was provided by UNDP for the prevention of COVID-19. During the registration and LLIN distribution, team members passed on key information about the campaign, such as the importance of correctly using and hanging LLINs and how to care for them properly.

Second phase of distribution

A second phase distribution of close to 40,000 LLINs to some households in five health regions (Quinara, Biombo, Cacheu, Oio and SAB) that were missed during the first phase has just been concluded. At this stage LLINs were also delivered to dwellings and special houses in these regions missed due to stock-outs of LLINs.

Supervision and follow-up

On a daily basis, supervisors at the regional and central level, as well as national consultants, met in person (no more than 10 people) to analyse team data and progress and, if necessary, address and strengthen problem areas. The main findings identified and discussed were related to stock-outs of LLIN vouchers and incorrect distribution in polygamous households. Monitoring of COVID-19 infection prevention measures was part of the national response and implemented through a team of well-trained staff and thus was not specific to the LLIN distribution. The door-to-door campaign was an opportunity to integrate communication and sensitization on staying safe and healthy during the pandemic

Logistics

For CMILDA 2020, UNDP procured 1,341,000 LLINs with Global Fund financing. All the LLINs arrived the country before the COVID 19 pandemic and were stored in two central warehouses: 641,000 LLINs in the CECOME Central Bissau warehouse and 700,000 LLINs in the World Food Programme (WFP) warehouse in Bafatá. This required careful planning, including LLIN specification decisions, quantification and a macro storage and transport plan at national level.

Due to the COVID-19 pandemic, the logistics process was different from previous campaigns. In compliance with the recommendations of WHO and the Government of Guinea-Bissau, the physical distancing and avoiding crowding regulations were taken into account. To avoid delays and to reduce the number of person to person contacts given the COVID 19 context, household registration (identification of beneficiaries) was coupled with distribution and it was therefore not possible to adjust the LLIN needs based on the household registration results. The LLINs were transported from the central warehouse (CEMOME and Bafata) directly to the distribution points of the health areas according to the microplans completed in March. Since the microplans were not adjusted based on registration data, some localities did not receive enough LLINs while others received too many. Many redeployments were made during distribution by supervisors, but this effort did not correct the gap in all households. This is one of the main reasons why a second phase of distribution was planned in order to ensure access to households that were missed due to stock out in some localities during the first phase.

WFP Warehouse in Bafatá

Social and behaviour communication (SBC)

The CMILDA 2020 SBC plan included three strategies: (i) advocacy (ii) social mobilization and (iii) social and behaviour change communication.

Political, administrative and religious representatives, NGOs and associations, civil society organizations, media leaders, etc. were involved in all three strategies. Following the declaration of the COVID-19 pandemic and during the review of the tools and materials for the new door-to-door strategy, messages and communication materials were reviewed and approved for CMILDA 2020 and COVID-19 (posters, stickers, etc.) based on the new WHO guidelines. The strategy included measures to be taken for COVID-19 infection prevention such as physical distancing, handwashing and the use of masks. Messages were disseminated through different channels: CHWs/mobilizers, community radios, television, mobile phones, and community-based organizations (CBOs). All health areas have megaphones provided to CHWs by UNICEF, which were used for community sensitization activities. The CHWs/mobilizers used megaphones to pass messages to communities as a method of limiting the number of contacts with households and community members.

Advocacy meetings were held with the regional committees (including journalists) set up for this purpose from the beginning of the microplanning process. Only media announcements based on prepared radio announcements were made by journalists in order to avoid crowds of people. These announcements were made by the political-administrative authorities, religious and community leaders on all public, private and community radio. The main announcements addressed LLINs and COVID-19 prevention.
Given the COVID-19 restrictions in place, the campaign launch could not be implemented as planned. On the first day of the campaign an announcement about the start-up of the campaign was made by the Minister of Health at the national level, while in the regions the announcement was made by the political-administrative authorities and traditional leaders.

During the distribution of LLINs to the heads of households, CHWs/mobilizers communicated messages about malaria and the advantages of sleeping under LLINs, as well as the need to use masks and perform regular handwashing for the prevention of COVID-19. Mobile phone messages at no charge by Orange and MTN were also used to spread messages about the dates of the campaign and the importance of using the LLINs.

The strong communication campaign at all levels allowed for greater involvement of the community and household members in the campaign, avoiding adverse rumours about the campaign, and allowing good final coverage of households with LLINs.

Figure 1 - Communication media for CMILDA 2020

BUDGET IMPLICATIONS

The budget changes were made quickly in line with the new door-to-door strategy, taking into account the country's specific geographic and logistical context, and the human resources available. Given the urgency of the situation and the remaining funds in the country's grant, the Global Fund was able to quickly approve the amendments. Important changes included (i) the increased number of days needed for community mobilization, (ii) the production of communication materials on the prevention of COVID-19, (iii) the increased number of days for cascade training, organized by axis and avoiding too many people in rooms at the same time, (iv) the increase in human resources through the addition of more national consultants to support NMCP, and (v) the purchase of protective materials against COVID-19 for campaign staff.

The total duration of the campaign, taking in training, mobilization and distribution was initially planned for 11 days. This was increased to 14 days with the new strategy, thus contributing to an increase in the budget. The finance team will in due course present a final budget for the campaign that will allow for a clear comparison of the original and the modified budget.