# CAMEROON, NORTH WEST REGION CASE STUDY: MASS ITN DISTRIBUTION CAMPAIGN IN THE CONTEXT OF INSECURITY AND THE COVID-19 PANDEMIC

**Key enabling factors for continuing the mass campaign during the COVID-19 pandemic while in a complex operating environment (COE) context:**

- **High political commitment** from the Ministry of Health, Governor of North West Region, national level partners, district medical officers and Global Fund.
- **Role of the Regional Coordinating Committee** in facilitating communication and coordination of the campaign, including resolution of unforeseen problems.
- **Organization of advocacy meetings** with new stakeholders at community level (district and health area) to encourage contributions to the planning and engagement in the implementation of activities.
- **High knowledge among the target population about the severity of malaria** and need for ITNs as prevention, along with their interest in assisting with distribution when needed to ensure that they would receive their ITNs.
- **Presence of trusted non-governmental organizations (NGOs)** carrying out humanitarian activities in the region to contribute to the evaluation of the feasibility of implementing the campaign in the current context. NGOs were contacted and the receptiveness of the non-state armed groups (NSAGs) to community interventions was monitored. The contingency plan was developed through a consultative process that involved the district medical officers, administrative authorities and the report of the WHO health cluster for humanitarian activities.
- **Active community health worker (CHW) networks** in many of the targeted areas that have the confidence and trust of community members. This facilitated access during the ITN distribution.
- **Community's ability to organize themselves** for all aspects of the ITN distribution through established dialogue structures (between health staff and community members)**,** as many health centres were closed.
- **Commitment of the campaign actors** and acceptance of the ITN distribution by the population. Campaign personnel were willing to work extra days, including Christmas holidays, as well as in ghost towns where much of the population had moved due to insecurity. Payment of ransoms demanded by the NSAGs in some communities took place without any help from the donors. District medical officers supported access negotiations to ensure that campaign materials reached their destination in areas where contracted transporters were unable to deliver.
- **Flexibility to adjust planned distribution strategy** – whether door-to-door or hit and run (see below) – based on the realities once in the field.
- **Strategic execution of the distribution** by health area staff, including commencing the distribution of ITNs with the NSAGs to ensure their support.

- **Participatory approach in all communities**, including incorporating members of the NSAGs as actors in the campaign in most areas. This contributed to the buy-in of groups that otherwise may have created problems for the campaign itself, as well as for campaign workers.
- **Adapting recruitment criteria for campaign workers to the context,** including the use of more women than men in the field as they had a lower probability of being abducted by the NSAGs or harassed by the state forces out of suspicion.
- **Avoidance of mass communication**, such as public launching of the campaign, and cautious use of megaphones. Interpersonal communication and use of churches were the main communication channels used, as well as use of community radios where available. All communication related to the campaign was in English or local languages (no French was used).
- **Remote and on-site supervision at all levels**
- **Stringent monitoring and evaluation**

**Achievements**

- The distribution of 1,026,101 ITNs out of the 1,162,050 ITNs received, covering 1,797,112 people in all 243 health areas – of which 104,130 people were internally displaced and/or living with families in more secure areas.
- Engagement of leaders and advocates in close to 300 communities who identified alternative transport routes not blocked by NSAGs and who transported ITNs at low cost to hard-to-reach villages.
- In some villages and due to NSAGs and presence of the military, the engagement of women to transport ITNs in a situation where men were being targeted for kidnapping and/or arrest by the military.
- Advocacy with communities, including NSAGs, enabled movement of teams, ITNs and provided access to all targeted communities in the 243 health areas.
- Local procurement and sourcing of approximately one million masks and a quantity of hand sanitizers for campaign actors by PLAN International, in order to implement the campaign in line with WHO COVID-19 prevention measures.
- With valuable support from the incident management system for COVID-19 in the region, convincing NSAGs that COVID-19 was a threat to the population and negotiating the return of seized personal protective equipment (PPE) for use in the ITN campaign and in hospitals.
- Ensuring establishment of mobile money accounts for most actors who in many cases lack phones due to limited mobile telecommunication networks. Around 40 per cent of the population is not covered by mobile phone communication networks.

*Kick-off of the campaign in Bamenda Health District. Central level supervisor with two distribution teams and proximity supervisor (door-to-door teams) in Nkwen Baptist Health Area*
*© National Malaria Control Programme, Cameroon*

**Country context**

Cameroon, considered for the high burden to high impact approach (HBHI) as defined by WHO[1], has three per cent of the malaria cases in the 11 highest burden countries. The current ITN campaign in Cameroon, co-financed by the Global Fund and the Government of Cameroon, aims for the free distribution of 14,867,748 ITNs in all 10 regions of the country. The Cameroon National Malaria Control Programme (NMCP) initially planned a three-phased campaign beginning in June 2019 and concluding in 2020. The campaign was later implemented in more phases than planned and two regions (South West and Central) will not receive ITNs until 2021 due to delays in procurement of the required ITNs. The North West Region (NWR) was allocated 1,162,050 ITNs to cover the estimated population, with the campaign originally scheduled to take place in December 2019. Delays in implementing the campaign until 2020 were largely related to the socio-political crisis.

The NWR is one of two English-speaking regions of Cameroon, with a total population of 2,213,984 occupying an area of 17,500 square kilometres. The health system in the region is organized into 19 health districts with a total of 243 health areas and 416 health facilities. Nine of the 19 health districts are implementing community-led interventions with a total of 597 Global Fund-sponsored community health workers trained and providing an integrated package of services to the population including but not limited to diagnosis and treatment of malaria and social and behaviour change communication (SBC) about the disease. However, there are a total of over 1,000 CHW working under different organizations and especially the performance-based financing project in all the other health districts.

[1] https://apps.who.int/iris/bitstream/handle/10665/275868/WHO-CDS-GMP-2018.25-eng.pdf

For the NWR, malaria is one of the leading causes of morbidity and mortality and the malaria situation has been exacerbated by the socio-political context. Hospitalizations due to malaria increased by 85 per cent between 2014 and 2018, almost doubling; meanwhile, morbidity (both simple and severe) has increased by 26 per cent. In the same time period, mortality decreased by 35 per cent due to improved case management. Children under the age of five years remain the most affected (hospital mortality 20.8 per cent). The Government of Cameroon and its technical and financial partners are sparing no effort or resources to fight malaria in the region. COVID-19 has increased the collaboration in NWR among all partners, but combined with the insecurity, technical assistance for the campaign could be provided by the Alliance for Malaria Prevention only at a distance, which was not the case in the past.

In the NWR, by mid-July 2020, 610 positive cases of COVID-19 were recorded (97 cases among health care workers) and 61 deaths reported (three cases among health care workers) (DRSP, NO). Thirteen districts out of nineteen reported at least one case of COVID-19. The health districts of Bamenda, Fundong, Kumbe East, Bafut, Santa and Tubah were the most affected. To contain the spread of COVID-19, the Government of Cameroon took decisions to implement the measures recommended by WHO including physical distancing, mass detection of suspected cases, the confinement of confirmed cases, etc.

The armed conflict between NSAGs and the state army since 2017 has resulted in 670,000 internally displaced persons and 58,000 refugees in Nigeria[2]. Though many families have fled and deserted some health areas, there are still some people present in all health districts. According to the North West Regional Delegate of Public Health, about 25 of the 416 health facilities have been destroyed and health workers have deserted many more. Most of these areas are supported by community health workers as well as humanitarian NGOs, which provide some basic services to people.

## STRATEGY FOR THE NORTH WEST REGION ITN DISTRIBUTION

### Macroplanning

Two strategies were identified for the ITN distribution in the NWR prior to the onset of the COVID-19 pandemic – fixed post "hit and run" and door-to-door – in line with the security context of the area. The strategy adopted for each health area was chosen during health area advocacy meetings based on pre-defined criteria.

The fixed post hit and run strategy involves households being registered and then immediately (within one day) going to fixed distribution points[3] to collect their ITNs. This strategy was adopted in areas where settlements were not very concentrated and people lived very far away from each other, as well as where insecurity was reported to be very high during health area advocacy meetings. The strategy limited the number of people to 50 per day at a fixed distribution point which ensured that they were served immediately.

The door-to-door strategy involves the simultaneous registration and distribution of ITNs during a single household visit. The strategy minimizes exposure of household recipients and teams to COVID-19.

The factors that made these strategies applicable in the context of the insecurity were similar to the factors to be addressed with the onset of the COVID-19 pandemic (e.g. limiting groups of people and

[2] OCHA, August 2020.

[3] "Fixed" post distribution points were able to move rapidly from one quarter to another depending on the security situation.

ensuring physical distancing, reducing contacts with households, ensuring that ITNs were in households as quickly as possible to increase access to effective malaria prevention), but in fact the overall strategy for the region had to be adapted in line with WHO recommendations and guidance for continuity of malaria services in the context of the pandemic.

The two strategies were explained at the macroplanning phase, but their application in the field was not well understood, particularly the workload and resupply of teams, as door-to-door was a new strategy for the region. During implementation, modifications were needed due to the vast distances in the region, including health areas changing from hit and run to door-to-door and vice versa as they identified solutions to problems during implementation.

The main difficulty for the macroplanning phase was estimating the percentage of the population still in their villages and the percentage that was displaced, as the quality of the data from the administrative authorities was poor. Given the unpredictable nature of the ongoing insecurity, the decision was made to maintain the populations as they would have been before the conflict and plan for population shifts during the campaign. As it was difficult to know exactly how many ITNs were needed and in an effort to avoid problems of oversupply of ITNs, each health area was allocated a proportion of the ITNs available to it based on estimates of the amount of population that had been displaced. This proportion varied from one health area to another and the retained ITNs were stored at the district level (at the District Health Service) to be deployed as needed to health areas.

**Coordination and implementation arrangements**

The many challenges in the field required strong coordination in all areas of the ITN campaign. Coordinating the national campaign remains the responsibility of the National Coordination Committee (NCC) chaired by the Minister of Public Health. Coordination meetings were held with the National Committee for the Management of the COVID-19 Pandemic Response before making decisions and determining the safest and best-suited campaign modalities.

A Regional Coordination Committee (RCC) was established to allow for engagement of regional actors and involvement of religious, municipal and administrative authorities in the decisions taken around the campaign strategy, as well as for follow-up during implementation. The RCC was established early, chaired by the Governor of the North West Region and joined by all seven administrative heads of the region, technical personnel, military personnel, traditional and religious authorities, in addition to implementing partners (World Food Programme [WFP], NGOs, etc.) and those in related sectors (education, communication, etc.) that are engaged in the communities. Advocacy meetings were organized at the regional level to ensure high participation of key stakeholders in the region. These meetings were more frequent than in regions without security issues targeted for ITNs in the country.

The campaign was led by the North-West Regional Delegation of Public Health. The main partner to the campaign was the WFP, responsible for the storage and transport of the ITNs up to the health area level. With the onset of the COVID-19 pandemic, WFP was also responsible for the storage and transport of the PPE procured for the campaign up to the health area level. WFP used existing contractors in the region to implement the transport operations.

Advocacy meetings were held at district level and health area levels at the beginning of the campaign planning to ensure buy-in of all stakeholders, including NSAGs, as well as their support. Cameroon's Ministry of Health uses "dialogue structures" to ensure community participation (platforms for collaboration between health staff and community representatives). Since the beginning of the crisis in

the NWR, these dialogue structures have been disrupted and so the advocacy meetings organized at each crucial stage of the campaign were critical for dialogue between health staff and communities and also served as coordination mechanisms as they brought together leaders and influencers at district and community level.

WhatsApp groups were established to enhance coordination during implementation, but some areas have insufficient network coverage for information to be received in real-time.

**Microplanning**

The armed conflict in the NWR is very dynamic and has caused population movement out of villages. However, the COVID-19 pandemic has had the opposite effect as populations returned to their villages given the high prevalence of COVID-19 in larger cities. Under normal circumstances, microplanning brings together the district medical officer, chief of health bureau and the chairperson of the district health committee (dialogue structure at district level). Owing to the humanitarian emergency, microplanning workshops were planned to bring the health area actors to the regional headquarters to ensure an objective microplan that accounted for the profound modifications in various communities because of the crisis.

Ideally, this plan would have required several training sessions due to the COVID-19 pandemic and the need to restrict the number of people that could be in one place at a time. Due to time constraints, the previous microplanning approach (e.g. the district teams only) had to be implemented. This created challenges as the district health staff are limited in terms of the granularity of their knowledge of communities in their districts. To bridge the gaps in knowledge at the district level, a questionnaire was sent to the health areas and essential information about their communities, including access and security, was filled in by health staff and community stakeholders during advocacy meetings. This information was put at the disposal of the district teams to ensure that microplanning was as close as possible to reality. All information collected during the microplanning and advocacy meetings was compiled and then shared with WFP for organizing the transport of materials to the different health areas.

The microplanning had to account for the different distribution strategies, identify secure transport routes and storage locations and particularly identify the final pre-positioning sites for the ITNs.

During the review and finalization of the microplans, the number of people per fixed site distribution team was reduced to two instead of three due to budgetary constraints. Given the hit and run strategy, this did not have an effect on distribution point management as crowds were controlled through the registration and immediate redemption approach.

Based on the lessons learned from the phase 2 distribution in Littoral region and due to the COVID-19 context, the final microplans included an increased number of actors (an additional three per cent) in case those identified for participation tested positive for COVID-19 and had to be replaced. Within the framework of the national response plan against COVID-19, mass testing of the population is included. The ITN campaign used this existing channel to test campaign actors at all levels. Results are yet to be compiled from all the health areas.


*Kumbo East health district: Householder receiving nets in strict respect of barrier measures against COVID-19 at a distribution point*
*© National malaria control programme, Cameroon*

**Procurement**
The procurement of ITNs and other materials was undertaken through the Global Fund pooled procurement mechanism (PPM) and in advance of the COVID-19 pandemic. PLAN International procured approximately one million locally sourced masks, as well as hand sanitizer and handwashing stations to ensure protection of household recipients and campaign workers.

**Logistics**
Logistics was complicated both by the complex operating environment caused by the insecurity and by the COVID-19 pandemic as well as the strategy adaptations at the field level. The ITN campaign in NWR involved huge logistics planning with the transportation of 1,162,050 ITNs to 19 districts and 243 health areas in the NWR. The logistics operation was contracted to the WFP and then sub-contracted to its NGO partners CARITAS, SHUMAS and COMINSUD. The delivery included the transport of non-food items including ITNs, PPE and didactic and SBC materials from the WFP warehouses. Given the lack of presence of WFP in many of the districts prior to the campaign, as well as the remoteness of some communities, in a number of cases communities organized local transportation for themselves and received payment for the transport from WFP.

After delivery by WFP to the health area warehouses, ITNs were subsequently redeployed to previously identified village level stores (village chiefs' homes), which, for the period of the distribution, served as fixed distribution points for the hit and run strategy and resupply sites for the door-to-door strategy. For the hit and run strategy, household recipients registered the previous day came to the distribution point to collect their ITNs. For the door-to-door strategy, a delivery agent with a means of transport (such as a motorcycle) was used to bring ITNs to distribution teams from the resupply site. In some areas, the strategy was changed to hit and run particularly in hilly areas where the cattle grazers settle very sparsely.

*Batibo health district: A community member from Olorunti (a woman) carrying a bale to cross a hanging bridge to Olorunti (important community participation)*
*© National Malaria Control Programme, Cameroon*

In districts where security was assessed as a moderate or low risk, ITNs were positioned closer to households to support the door-to-door strategy (with allocation of ITNs per household or according to the number of people per household depending on the strategy adopted). In districts with high security risks, the hit and run strategy was utilized with a fixed site distribution and ITN supply based on the head count done the day before.

**Training**

Trainings were adapted for both the context of insecurity and COVID-19. Training for regional and district health management team members took place over two days at the regional headquarters. The training for health area supervisors took place in one day at the district headquarters. Training for head count/distribution teams and their proximity (front line community) supervisors took place in half-day sessions of four hours each with a maximum of 14 participants and one facilitator in order to adhere to physical distancing and group size limitations put in place by the government as part of COVID-19 infection prevention. For the areas with more than 14 participants, two or more sessions took place over more days to accommodate the additional sessions needed. Due to issues of insecurity, the training in pools of small health areas combined together at district level was not possible and all actors were trained in the health area or community where they would work. This led to the need for many more sessions to train actors. The budget had to be increased since the trainings were held in each health area rather than grouping people at the district level.

Training materials needed to be translated to English from French locally as there was a delay from the national level. Use of the local dialect and English was mandatory: use of French would have disrupted the training and ultimately the campaign, as the NSAG actors participating in the training would have destroyed the documents. All posters were produced specifically for NWR in English and without official logos.

Due to security issues with NSAGs, there was a long delay of almost one month between the training of district level campaign personnel and the training of health area campaign actors which led to people forgetting what they had learned and reduced the quality of the training at health area level. To mitigate

this weakness, remote support to district medical officers was reinforced by putting in place a call centre to receive their concerns and address them in real time. In addition on-site supervision was conducted in areas with moderate insecurity. This permitted supervisors to correct the errors observed in the field.

**Social and behaviour change communication (SBC)**

Advocacy meetings were organized at all levels and at the health area level served as a mechanism for collecting local level information to inform planning of campaign activities as well as a coordination structure. These sessions were important to ensure that everyone understood the strategies that had been adopted, contributed to detailed planning on how activities would be implemented and understood their roles and responsibilities to ensure a safe and secure campaign in line with COVID-19 infection prevention.

SBC plans were developed for both the door-to-door and hit and run strategies. For the areas of high insecurity, key messages took into account the risks of rejection by communities as outlined in the contingency plan for the NWR campaign. As such, the messages intentionally excluded the name of the Ministry of Public Health to maintain neutrality and a focus on the humanitarian side of the campaign, as well as to facilitate community ownership and access to and use of the ITNs made available to improve malaria prevention in the region.

There was extensive use of community radios instead of state media. Community radio stations disseminated messages in the vernacular dialect rather than in English or French. Town criers were used in the areas without communication networks. Churches also disseminated messages, which the community reported to be an effective medium. Rumours were identified in only one district, but they were political in nature and resolved through advocacy meetings.

*Town criers using megaphones for undertaking social mobilization in a market square in Kumbo West*
*© National Malaria Control Programme, Cameroon*

Head count and distribution teams for both the hit and run and door-to-door strategies were trained on key messages to be communicated to households about hanging and using ITNs during their visits, as well as at distribution points.

**Head count and ITN distribution**

As described above, two strategies were implemented in the NWR: fixed distribution point hit and run and door-to-door. For the Littoral region, which was completed before the NWR campaign started, the door-to-door household registration had already taken place as per the campaign strategy of two separate phases when the COVID-19 pandemic reached Cameroon. The distribution in Littoral had then to be adapted to a door-to-door approach to align with COVID-19 infection prevention measures. For the NWR, the door-to-door strategy for the ITN distribution was seen to be more aligned with COVID-19 infection prevention than with the security situation, which meant that only 80 of 243 health areas were able to use this strategy.

For the hit and run strategy, head count was done in an area and households were told to pick up their ITNs the following day (at fixed temporary distribution points). SBC messages reinforced the importance of attending the fixed distribution point the following day to ensure that the number of people attending the distribution point each day was limited in line with COVID-19 infection prevention and control measures. Households counted were required to go to the distribution site the very next day. The head count and the distribution were each carried out by teams of two people over a five-day period.

Vouchers were not used during the campaign in the NWR to limit contact between campaign personnel and household recipients of ITNs. Household head count was not done on registers as was the case in other phases of the campaign prior to COVID-19. Fixed distribution points were not static but were instead moved closer to the population to be served on each day of the distribution. During the household head count, the household representative was given an identification code to write down and memorize and present at the distribution point along with a personal identification document. Instead of registers, head count/distribution forms were used. These forms were used by the head count team to fill in the head count section and at the end of the day the forms were given to the distribution team via their proximity supervisor. A new form was used each day by head count teams. The distribution point teams used the form given to them from the head count team that worked the previous day to serve the household recipients. This greatly limited the number of persons at the distribution site each day. However, the hit and run strategy required too many actors and this created challenges in terms of recruitment of personnel who met the requirement of having mobile money accounts.

The door-to-door strategy involved teams of two people carrying 25 ITNs each in bags provided for the campaign. The head count (household registration) and distribution of ITNs were done at the same time and the household was therefore only contacted once during the campaign. The door-to-door teams were resupplied with ITNs by a delivery agent when they required additional ITNs. One delivery agent served three teams in rural areas and five teams in urban areas during the distribution days using an appropriate means of transport. Door-to-door teams had a workload of 50 households per day in rural areas and 60 households in urban areas over a six-day period.

Each strategy adopted was aligned with the COVID-19 infection prevention measures (avoiding large gatherings, physical distancing, utilization of PPE, etc.). In addition, washing hands with soap and water or using hand sanitizer after visiting five households was mandated for door-to-door teams. The number

of days allocated for the campaign (five days for the hit and run strategy and six days for the door-to-door strategy) was reportedly insufficient. There was no time to undertake revisits to households, so SBC messages were communicated through interpersonal communication and town criers to households that were missed to go to the health facility to be served.

It was noted that in the Bamenda health district (regional headquarters of the NWR and relatively safest health district) there was a shortage of ITNs with several households not receiving their nets. In one *quartier*, the NSAGs, due to the shooting of one of their members one day earlier, prevented the distribution of ITNs in spite of the head count having been completed. In the second health area it was due to the short duration of the campaign, while in the third health area, it was largely due to the underestimation of the population. The shortage of ITNs was not foreseen since there was no head count prior to the distribution to establish actual ITN needs for the population to be served. A mop-up campaign was organized for three days to complete the distribution and ITNs were taken from another health district to complete the needs of the Bamenda health district.

**Data collection**

Data collection was one of the biggest challenges. Late submission of reports was linked to the complexity of the current socio-political context of the NWR and the inability of supervisors to reach or leave some areas. The problem of network coverage in many districts created challenges with the use of the DHIS2 platform, leading to incomplete data on a daily basis.

A decision was made to minimize and simplify the number of tools required at the field level and make them generic to both strategies to ensure that the training was clear and there was limited confusion during implementation. In addition to the head count and distribution forms described above for the hit and run strategy, head count forms were also used for the door-to-door strategy. Tally sheets were used for both strategies and were a critical tool for ITN accountability as registration as an activity phase and use of vouchers were discontinued.

**Payments**

The MTN mobile money platform was used for payment of campaign workers. The district medical officers took a strong lead when campaign workers did not have mobile money accounts by taking their information and registering them so they could be paid. This is one clear example of the leadership of the regional and district health personnel to ensure the success of the campaign. Despite difficulties with the functionality of the mobile money system in the NWR, the acceptance of the mobile telephony among campaign actors is high because people are sure to receive their compensation.

The main challenge in payment included the absence of identification papers by some NSAG members who were actors in the campaign. Authorizations were obtained from the donor to apply more flexible procedures that permitted actors to be paid at community level.

**Supervision and monitoring**

Due to the conflict and reality in the field in terms of security of health workers, more women supervisors were deployed than men as they are safer in the field. Deployment of male supervisors in some regions runs a risk of kidnapping by the NSAGs or arrest or detainment by the military. The campaign capitalized on the frontline community supervisors (proximity supervisors) who had good access in the communities. Provisions were made for distance supervision by phone, using simplified forms, as the large distances limited the practical coverage of regional supervisors in all health areas. There was less supervision from central level than from the region, as most supervisors from the central

level are French-speaking and their accent, even if they speak English, will expose them to security risks. The NSAGs were not ready to tolerate any French speaker in the region.

*Bambili health area in Tubah health district: The permanent secretary of the NMCP (Dr Achu in the red dress) in the field supervising a distribution point to ensure respect of COVID-19 barrier measures*
*© National Malaria Control Programme, Cameroon*

**Security**

To avoid the risk of the campaign being linked with the Government, WFP and all actors and stakeholders decided to remove all the Ministry of Public Health logos or other government identification from bales, forms and training materials. Intensive advocacy was undertaken with NSAGs to facilitate passage of campaign materials (including ITNs and PPE), as well as campaign personnel. Regular security updates were provided during the implementation of activities and, as needed, activities were suspended pending a normalization of the security context. Advocacy was carried out among both the NSAG and the military battalions for a wide acceptance of the activity and collaboration although there were still cases of harassment of campaign actors and even destruction of ITNs and campaign material.

The NWR campaign has been completed in all 243 health areas. The last health area that supplied figures constituted a great challenge given that it is highly enclaved and the headquarters for several NSAGs. In addition, the area is not served by mobile telephone networks and roadblocks were established during the crisis. The first attempts to transport ITNs to the area took place during a period of political elections and led to the destruction of 12 bales of ITNs. Given the problems with accessing the area, intense advocacy took place and the transportation of ITNs was permitted. The poor communication network did not permit daily follow-up and the security situation only permitted supervision at a distance.

**Post-distribution activities**

The NWR has a network of close to 1,000 community health workers from different organizations that will be used to raise awareness on the use of the ITNs during their home visits (community monitoring). Media communication through community radios is also planned. A documentary has also been realized to stress the importance of using the ITNs effectively.

*ITNs spread out under the shade to air as prescribed by the programme and relayed by the town criers*
*© National malaria control programme, Cameroon*

**Challenges**

- Significant delays were incurred in the campaign implementation, which led to challenges with retention of personnel identified for the implementation of activities and a need to identify and train new campaign personnel immediately prior to the implementation period. The changing of personnel between listing of their information and implementation also created bottlenecks for timely payments to be implemented.
- Budgetary constraints for the campaign were huge because the strategies for the campaign were resource intensive and led to rationing of some budget lines, including the duration of the campaign.
- Insecurity in the NWR, in addition to the belief by some NSAGs and actors that COVID-19 was not a serious problem, created a need for ongoing advocacy with stakeholders at different levels. This also led to delays when, for example, the NSAGs seized masks and hand sanitizer and districts were required to use existing stocks for the campaign pending recuperation of the materials through advocacy.
- Coordination was a challenge for the logistics operation given the need for WFP to operate according to their humanitarian mandate. Initially WFP, due to their humanitarian principles of impartiality and neutrality, restricted their communication with the local health system, which led to little visibility of their activities and led to difficulties in the coordination and movement of the ITNs and other materials to and in the field. In addition, the need to implement the campaign in two phases due to the delayed supply of ITNs and training and implementation materials by WFP and its partners required budget adaptations. The unpredictable nature of the activities of the WFP made coordination difficult.
- Establishing population figures for the number of people and households to be reached, as well as the number of ITNs needed, was a challenge during microplanning given the movement of the population related to the security context. During implementation, delays were created due to restricted movement in some areas at some times and roadblocks, in addition to the insecurity. Understanding the population movement due to the conflict and determining the best strategy to reach the internally displaced was a challenge given the changing security context. The unpredictable movement of people led to shortages of ITNs in Bamenda and increased costs to resolve the problem through later distribution of additional ITNs.

- Procedures for selecting service providers in the context of the crisis were cumbersome, as many businesses lacked liquidity to tender, thereby limiting the offers for services and increasing costs.
- The use of electronic money transfer through MTN mobile money is highly welcome to campaign actors because they are sure to receive their money, but also represents a challenge in that to establish a mobile money account identification cards are required, which were not available to many people working on the campaign (due to carelessness, displacement, homes destroyed or the NSAGs seizing and destroying them). Charges for money withdrawal in those areas are disproportionately high.
- Justification of expenses created a challenge due to the disruption of fiscal services in most parts of the NWR and many people lacking official documents. In some areas it was a challenge to even find a service provider for some of the activities of the campaign.
- NSAGs assumed that the ITNs were government-sponsored and linked to the regional elections. This confusion led to 12 bales being burned on their way to the health area in one district (Ntong health area in Nwa health district) and a need for increased advocacy to ensure safe access to enclaved populations.
- Lack of telephone network coverage in many parts of the region caused delays in uploading data to DHIS2 for final reporting.
- Training materials were numerous and they were transported directly to the health areas, which led to a lot of confusion by the health area supervisors who mistook many forms for different activities. This was quickly realized on the first day and corrected.
- Campaign personnel felt that the distribution period of six days was too short, especially with the door-to-door strategy, given the long distances and combining household registration with the distribution. The time frame for the hit and run was also a challenge as population movement was unpredictable and caused many shortages, but especially in Bamenda where ITNs had to be sourced from other villages.
- Many more actors were needed but unfortunately and partly due to the crisis many of them never had official documents to establish mobile money accounts and resorted to using proxies (using the accounts of their relatives or friends).
- Late payments, particularly for campaign personnel at the implementation level, caused some problems. The slowness of the payments is due to the district medical officers being greatly overwhelmed by other MOH programme demands and difficulties in transferring paper justifications to the regional level for processing (conflicts of calendar of activities of the MOH especially in December).

**Lessons learned and recommendations**

- An armed conflict in the NWR between the state army and non-state armed groups since 2017 has resulted in internally displaced populations (IDPs) and thus required adapting the distribution strategy by risk area.
- Advocacy meetings held at all levels helped to ensure community participation, dispel rumours and secure the support of all stakeholders.
- There were challenges that were subsequently resolved with WFP through enhanced coordination.
- Distribution of tools for training and implementation should be handled by the district medical officer who may take some time to brief the chiefs of health areas and verify the documents with them before they take them to their health areas. This will reduce the confusion observed

in the field. The transportation and distribution of campaign tools should follow the health system structure.

- Collaboration between WFP and the health system in place facilitated the transportation of ITNs, although WFP and NGO partners had limited access to many areas where communities needed to be engaged for the final distribution.
- The cost of transport was significantly higher in some areas where transporters were few in number; this should be anticipated during microplanning. Payment to local transporters and flexibility in distribution timelines is required.
- In the future, if required due to insecurity, the microplanning will need to take into account the shortened work hours of the actors to ensure their safety to and from the ITN campaign activities, especially when considering the number of households that can be reached per day. Strategies were significantly adapted to the ongoing response to COVID-19. However, the number of days allotted for the door-to-door strategy was insufficient, making the workload heavy for actors due to the vast distances that needed to be covered.
- Duration of training for such new strategies was short (one day) and did not permit adequate assimilation particularly on the filling of data collection tools. However proximity (front line community) supervision was helpful.
- The early determination of campaign actors along with their mobile money accounts makes payment faster.
- Campaign coordination was facilitated through the use of WhatsApp groups and daily virtual meetings: the creation of a situation room, where key partners meet on a daily basis to identify and resolve issues arising health area by health area, is mandatory in such a context.
- There was a need to understand the settlement patterns of displaced populations: they did not settle in camps but moved in with family members in other areas but within the same region, thus creating multiple heads of household. Ideally, the maximum number of nets in the household would have been increased from four to seven, which was not possible at the last minute during the implementation of activities. The definition of a household should be reviewed for future campaigns to allow for all households to receive a sufficient number of ITNs for their members.
- Lessons learned from the recent measles and rubella campaigns showed it was possible to implement the ITN campaign in one phase and not two phases as earlier proposed, although ultimately, access issues mandated distribution in two phases.
- The use of the WFP did not show any added value in the transportation of the ITNs in the context, but community participation proved very helpful in the negotiation of access and transportation of ITNs.
- Monitoring and evaluation (M&E) in the field was very challenging due to access and availability of staff, particularly due to conflicts with other health campaigns undertaken in December.
- There can be no linkages between the government and the ITN distribution and all logos must be taken off all materials – including materials used for training and for distributing the ITNs.
- Based on the Littoral 2 distribution, the following lessons were learned:
    - An effort was made to reinforce the bags used by door-to-door teams to handle the weight of the ITNs distributed.
    - An extra three per cent of people should be trained and placed on a waiting list in the event that the hired actors test positive for COVID-19.

**BUDGET**

It is worth noting that the introduction of the door-to-door campaign and adjustments to the campaign due to the insecurity context led to a significant projected increase of at least 50 per cent over the initial budget. However after appropriate macroplanning was done, the campaign remained within five per cent of the original. During implementation, savings were made on some procurements. For example, raincoats originally budgeted for were not procured. Instead of purchasing raincoats, funds were reallocated to offset adding extra days to the campaign. This was also the case for transportation. WFP was responsible for the transportation of ITNs, training and implementation materials, as well as the PPE. Due to WFPs unexpected lack of access, the extra funds allowed the campaign to launch local bids for transportation of training and implementation materials including PPE in 14 out of the 19 districts.