# Humanitarian emergencies case study: Cameroon

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This case study is part of the Alliance for Malaria Prevention (AMP) Innovation and Evaluation Working Group (IEWG)/United Nations Foundation (UNF)'s work on Malaria in Humanitarian Emergencies, highlighting challenges and adaptations to malaria campaign operational activities within humanitarian settings to inform future planning and service delivery.

**Cameroon**

As defined by WHO[1], Cameroon is considered a high burden to high impact country (HBHI) for malaria as it has three per cent of the malaria cases in the 11 highest burden countries. The 2019—2020 insecticide-treated net (ITN) campaign in Cameroon, co-financed by the Global Fund and the Government of Cameroon, aimed 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 due to delays in procurement and/or delivery of the required ITNs. The North West Region (NWR) was allocated 1,162,050 ITNs to cover the estimated total 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 in the region.

Location of the Northwest Region within Cameroon

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. 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) 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 remain the most affected (hospital mortality 20.8 per cent).

By mid-July 2020 in the NWR, 610 positive cases of COVID-19 were recorded (97 cases among healthcare workers) and 61 deaths were reported (three cases among healthcare workers)[2]. 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 non-state armed groups (NSAGs) and the state army since 2017 has resulted in 670,000 internally displaced persons (IDPs) and 58,000 refugees residing in Nigeria[3]. Though many families had fled and deserted some health areas, there were still some people present in all health districts. The armed conflict also caused population movement out of villages. However, the COVID-19 pandemic had the opposite effect as populations returned to their villages given the high prevalence of COVID-19 in larger cities. According to the North West Regional Delegate of Public Health, about 25 of the 416 health facilities were destroyed and health

[1] https://apps.who.int/iris/bitstream/handle/10665/275868/WHO-CDS-GMP-2018.25-eng.pdf
[2] Source: DRSP - Regional Delegation for Public Health in the Northwest Region
[3] OCHA, August 2020.

workers deserted many more. Most of these areas are supported by community health workers as well as humanitarian non-governmental organizations (NGOs), which provided some basic services to people.

**Adaptations to ITN distributions during the COVID-19 pandemic in the context of insecurity**

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 factors that made these strategies applicable in the context of the insecurity were similar to the factors addressed with the onset of the COVID-19 pandemic (e.g. limiting groups of people and ensuring physical distancing, reducing contacts with households, ensuring that ITNs were in households as quickly as possible to increase access to effective malaria prevention, ensuring safety of campaign personnel), 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.

Access to some communities in NWR was a challenge due to insecurity. In some villages, due to NSAGs and the presence of the military, a further modification/adaptation was the engagement of women to transport ITNs in a situation where men were being targeted for kidnapping and/or arrest by the military.

**Coordination and implementation arrangements to ensure campaign implementation**

The many challenges in the field implementing a large-scale operation required strong coordination in all areas of the ITN campaign. Coordinating the national campaign remained 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 campaign was led by the North-West Regional Delegation of Public Health. The main partner to the campaign was the World Food Programme (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 personal protective equipment (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 used "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 were disrupted and so the advocacy meetings organized by members 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.

**Modified training prepared campaign workers for ITN distribution during COVID-19**

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 registration/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.

**Supervision and monitoring activities were adapted to address new challenges and ensure effective collaboration across all levels**

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, would expose them to security risks. The NSAGs were not ready to tolerate any French speaker in the region.

**Logistics adaptations due to insecurity and community access issues**

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 WFP and 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 social and behaviour change (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.

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 registration done the day before. The cost of transport was significantly higher in some areas where transporters were few in number. Payment to local transporters and flexibility in distribution timelines was required.

**Adapted communication strategy due to insecurity**

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, access to and use of the ITNs made available to improve malaria prevention in the region.

There was extensive use of community radio 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.

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.

**Challenges due to COVID-19 and insecurity**

- 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.
- 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.
- 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.
- 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 and a need for increased advocacy to ensure safe access to enclaved populations.

**Lessons learned**

There are a number of lessons learned from the ITN distribution in NWR of Cameroon during the COVID-19 pandemic that might be applicable to other country programmes in complex operating environments planning campaigns with known insecurity challenges and community access constraints.

1. The distribution strategy needed to be adapted by risk area given that the armed conflict between the state army and NSAGs since 2017 has resulted in IDPs and regular population movement.

2. Advocacy meetings held at all levels helped to ensure community participation, dispel rumours and secure the support of all stakeholders.
3. 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 last-mile transport.
4. 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.
5. There was a need to understand the settlement patterns of displaced populations as 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. The definition of a household should be reviewed for future campaigns to allow for all households to receive a sufficient number of ITNs for those with multiple heads of households.

Under the context of insecurity and COVID-19, 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 – is to be applauded.