



# IMPLEMENTATION OF THE «HIGH BURDEN HIGH IMPACT» APPROACH IN CAMEROON

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# PLAN OF PRESENTATION

1. Context
2. Planning uptake of the HBHI
3. Convening the launching meeting
4. Implementation plan
5. Follow up activities
6. Best practices
7. Challenges

# 1. CONTEXT

- Population: 24 863 337 inhabitants in 2018 and growth rate of 2,45 %.
- Women of child bearing age (15-49 ans): 24,9 %
- Children under five: 15,6 %
- Pregnant women: 3,7%
- Life expectancy at birth: M: 57 years F: 60 years
- Malaria is endemic in all regions, part of GMP's 11 high burden countries
- HIV prevalence 3,4 % (CAMPHIA 2018)
- Maternal mortality ratio 782/100 000 lb
- Infant mortality ratio 103‰
- 1,07 health personnel/1000 inhabitants
- (Projections démographiques, 2016).

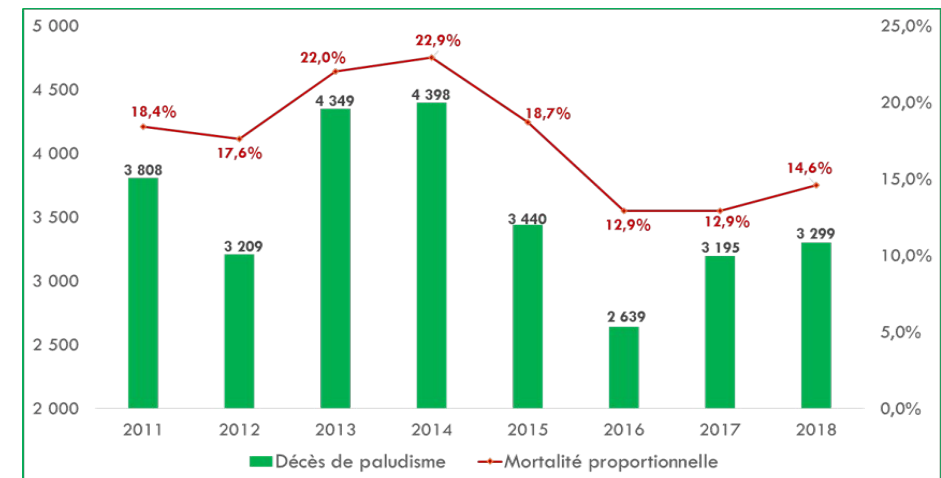
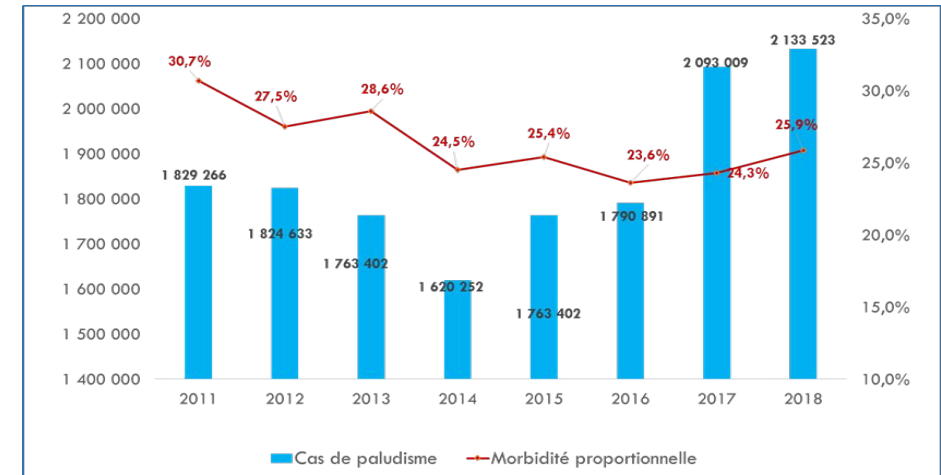


# 1. CONTEXT

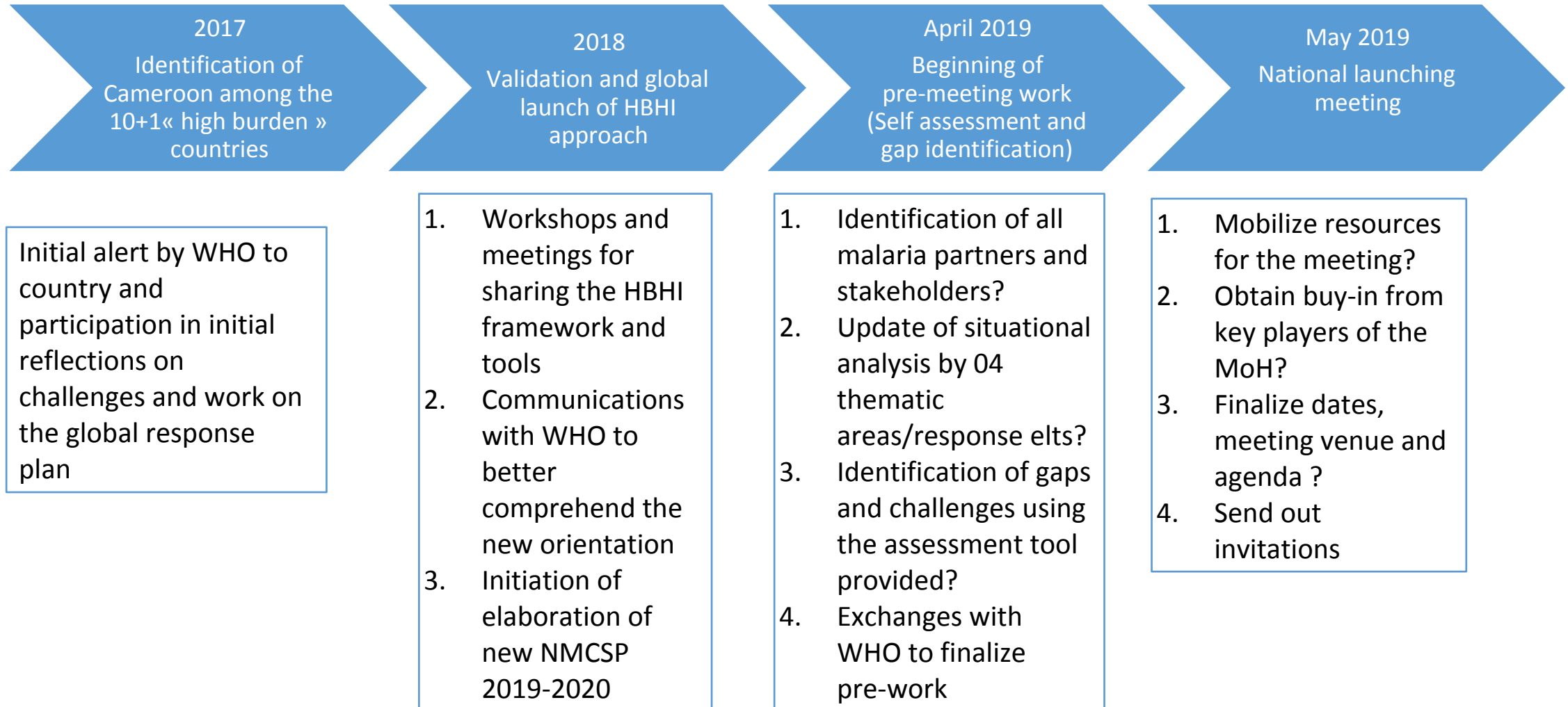
Malaria is one of the 03 leading public health problems in Cameroon in the general population and first cause of mortality in children under five years (*2016, Analytic health profile*)

- > 2 millions reported cases (*≈ 7 millions, 2018 WMR*) ;
- 3263 deaths in health facilities in 2018, (*≈ 10 000, 2018 WMR*)
- 61% of cases occur in children under five
- Parasite prevalence rate reduced from 33,3% (*MIS 2011*) to 24% (*DHS, 2018*);
- Hospital morbidity rate 25,9% *in 2018 compared to 24 % in 2017*;
- Mortality rate increased from 12,8% *en 2017 to 14,6% in 2018* ;

Tab 1 : Evolution du nombre des cas et décès 2011-2018




## 2. PLANNING UPTAKE OF THE HBHI APPROACH



# 3. LAUNCHING MEETING

The main objective of this meeting was to facilitate the rapid implementation of the HBHI approach through targeted tangible interventions based on evidence for rapid impact on the malaria burden in Cameroun

**Launched by the MPH** in the presence of WHO, UNICEF, USAID **RBM, ALMA**, and other bilateral agencies 

Multi-sectorial participation:

## Methodology:

- 04-days meeting
- Presentations made to present recent data and harmonize understanding of the concept of HBHI
- Group work for development of log frames
- Plenary discussions
- Engagements from partners
- Advocacy meetings with MOH, SESP
- Field visits

- Prime Minister's Office
- Members of parliament
- Representatives from urban councils
- MOH Officials (Minister, SG, Inspectors, NMCP Staff, Departments Disease Control, Family Health, Health Care Organization, NHIS, Health Operational Research...)
- Other Ministries (Agriculture, Environment, Livestock, Economy, Finance, Territorial Administration, Communication, Social affairs, Education, Transport, Defense)
- Decentralized services of the MOH (Regional delegations)
- Academia (Faculties of Medicine, Nursing Schools...)
- National Councils (Medical doctors, Nurses, Medical Lab scientists...)
- Research Institutes
- Private sector (Corporate structures: GICAM, CCA-Santé, Forest Organizations...)
- Civil Society Organizations and associations involved in malaria control

# 3. LAUNCHING MEETING: Outcomes

## Planned outcomes

## Success factors

## Status

1

Focus on **identification of tangible next steps** through **well-guided working sessions**



Detailed situation analysis and identification of relevant gaps

Situational analysis finalized, gaps identified and integrated into the new NMCS 2019 - 2023

2

Foster **collaboration and commitment** among relevant country partners at global, national and sub-national level



Identification and involvement of relevant external and internal stakeholders early on

Shared responsibilities identified in the response log frame involving actors from multisector groups

3

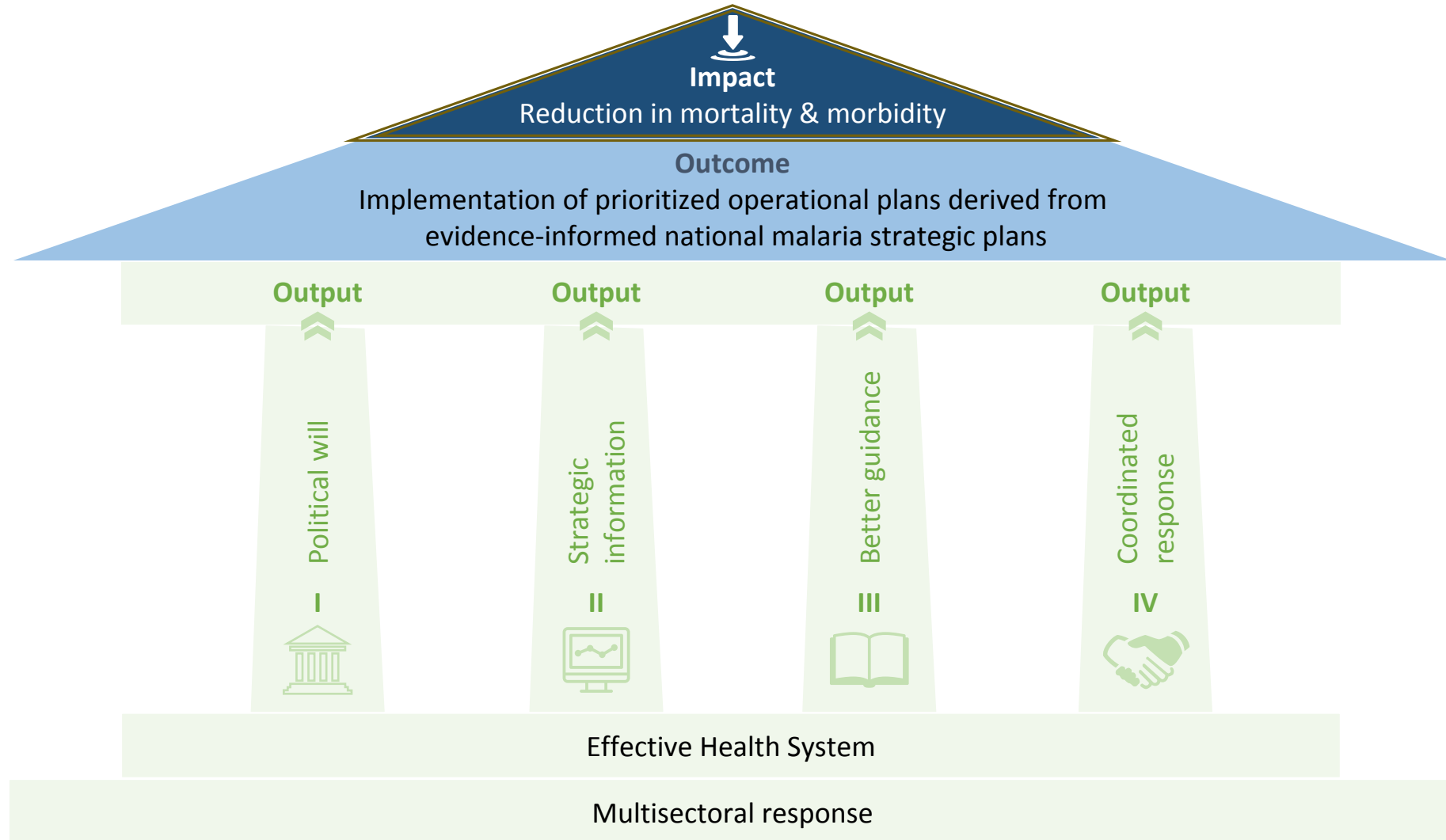
Lead to **agreements on next steps** to be implemented with broad partner support (e.g, increased transparency through data sharing)



Ensure **broad participation** including sub-national stakeholders

Consensus on Next steps  
Involvement of 03/10 RDPH;  
04/10 regional Mal Coord;  
02 regional urban councils  
**(Need for more sub-national stakeholder engagement)**

# The implementation plan





# 4. IMPLEMENTATION PLAN (OBJECTIVES)

<b>1. Increase political will</b>	<ul style="list-style-type: none"><li>• Reposition malaria control at the <b>top of the political agenda</b> of the government</li><li>• <b>Increase visibility</b> of malaria control achievements and needs (involving the PRC)</li><li>• Strengthen <b>leadership capacity</b> of key actors of the Health system (Malaria focal points at all levels including communities and related sectors)</li><li>• Develop an <b>advocacy plan</b> based in an investment case for resource mobilization at all levels</li></ul>
<b>2. Strategic information</b>	<ul style="list-style-type: none"><li>• Collect data from all levels for stratification and determination of intervention mixes (<b>data repository</b>)</li><li>• Strengthen capacity of <b>ME focal points</b> on data management (including community and private sector) based on DHIS2, on surveillance methods, monitoring and evaluation in malaria programs</li><li>• Carry out <b>MIS to establish baseline data</b> and carry out targeted interventions</li></ul>

## 4. IMPLEMENTATION PLAN (OBJECTIVES)

<b>3. Better ploicy guidance</b>	<ul style="list-style-type: none"><li>• Update the various <b>guidelines</b> (CM, iCCM, IVM, IRM, Chemoprevention...)</li><li>• <b>Develop SOPs</b> for Case management in HF and communities, Vector Control, drug supply...)</li><li>• Strengthen capacity of health personnel to <b>respect guidelines</b> (case management, supply chain management...)</li></ul>
<b>4. Coordinated response</b>	<ul style="list-style-type: none"><li>• Put in place <b>multisectorial steering</b> and follow-up committees to advocacy for resource mobilization and effective engagement of actors of related sectors of the NRBMC</li><li>• Improve commitment of the government, <b>decentralized services (councils) and the media including the private profit-making sector;</b></li><li>• <b>Revise the ToR of the NRBMC</b> and render functional the regional braches and improve meeting agenda with emphasis on strategic monitoring and accountability</li></ul>

# 5. FOLLOW-UP OF NEXT STEPS

No.	Action	Responsable(s)	Délai	STATUS
1	Mener la campagne MILDA. Renforcer la communication intégrée lors de la campagne	PNLP	Juin 2019	On-going
2	Analyse des gaps financiers du PSNLP 2019-2023 pour la mise en œuvre des interventions	OMS/RBM	Juin 2019	Executed
3	Organiser la prochaine réunion du CNRBM pour présenter les recommandations, activités et élaborer un plan d'action	PNLP	Juillet 2019	Planned for Sept
4	Rendre fonctionnel des groupes de travail thématiques du PNL	PNLP/Universités	Juin 2019	On-going
5	Finaliser le PSNLP en s'inspirant de tous les actions et recommandations de l'atelier HBHI	PNLP	Sept 2019	On-going
6	Accélérer la mise en place de l'entrepôt des données sur la mise en place du paludisme	OMS/PMI-Measure Evaluation	Sept 2019	On-going
7	Création d'un Task Force pour le pilier 1 volonté politique	OMS/PMI-USAID/CDC/MMV/Malaria No More	Juillet 2019	TBD
8	Développer un « investment case » et plan de plaidoyer	OMS/USAID/CDC/MMV/Malaria No More/ALMA/RBM/FM	Juillet 2019	TBD

## 6. BEST PRACTICES

- **Political will:**

- i. Mobilization of domestic funding for procurement of LLINs in one region and procurement of commodities for health facilities and for iCCM
- ii. Engagement of some local councils
- iii. On-going development of a UHC strategy

- **Policy guidance and implementation**

- i. On-going LLIN campaign in 2019: (86% distribution coverage in 4 regions);
- ii. Increased offer of IPTp through outreach FANC and integrated health campaigns improving coverage in IPTp3 ( 33% in 2016 to 42% in 2018);
- iii. Successful implementation of SMC campaigns: coverages of above 95%;
- iv. Revision of treatment guidelines based on evidence
- v. iCCM in 84 out of 189 health districts

## 6. BEST PRACTICES

- **Strategic information**

- i. A data management system in place with possibility of monitoring key malaria indicators in over 90% of formal health facilities
- ii. Revised entomological profile with regular update from entomological surveillance
- iii. Monitoring of antimalarial drug efficacy (ACT, SPAQ)

- **Coordination and intersectorial collaboration**

- i. Participation in several coordination platforms (CCM, NRBMC, IVM, Campaign coordination committees...)
- ii. Existence of collaborative relations with research institutions, education sector,
- iii. Participation of the NMCP in several integrated taskforces (iCCM, Health financing, UHC, PSM...)

## 6. BEST PRACTICES (iCCM)

- i. Existing national policy and guidelines on iCCM;
- ii. Updated training modules and job aids for CHW;
- iii. Guidelines for dialogue structures to regulate community participation;
- iv. Validated integrated package of activities targeting priority health problems (referral of PW and sick newborns);
- v. 16 health services offered (malaria, diarrhea, pneumonia, HIV, TB, MCH...);
- vi. Free treatment of uncomplicated malaria in children U5;
- vii. Regular stakeholders coordination meetings at central, regional, and community levels;
- viii. Pool of trained master trainers to harmonize training standards at all levels;
- ix. Network of CSOs supporting supervision and remuneration of CHW.

# 7. Challenges

## Political will

1. Political will still to be raised from a higher level and translated in resource/Funding mobilization
2. Insufficient mobilization of funds (LLIN for Center region);
3. Weak intersectorial collaboration;
4. Low community engagement and ownership

## Strategic information

5. Insufficient data to permit adequate stratification of disease burden and risk factors;
6. Low buy-in by health facilities into data management using DHIS2;
7. Insufficient **data quality** to permit decision making based on evidence

# 7. Challenges

## Policy guidance

1. Low utilization of LLINs by the population;
2. Absence of implementation of an insecticide resistance management ;
3. Insufficient resources to implement IRS;
4. Low respect of treatment guidelines;
5. Insufficient quality control of diagnostics;
6. No harmonized strategy to engage the private sector.

## Coordination

7. Inadequate representation of key stakeholders in coordination platforms
8. Insufficient leveraging of funding, technical resources by other related sectors for malaria control



## 7. Challenges (iCCM)

1. No strategic plan or investment case to guide scaling up of interventions or geographical coverage
2. iCCM is not institutionalized to encourage retention of CHW
3. Non-optimal implementation of certain services (pneumonia, referral of loss-to-followup...)
4. Long stock-outs of iCCM commodities reducing expected outcomes of reduction in the disease burden
5. Implementing the cost recovery policy at community level
6. Insufficient supervision of CHW by Health staff
7. Insufficiently organized and unsupported referral system
8. Incomplete integration of iCCM data into the NHIS ie DHIS2
9. Engaging communities with weak community systems
10. Lack of action research to understand contextual enablers that can permit adjustment of strategies

# ACKNOWLEDGEMENTS



HOPE  
FOUNDATION



BTC

