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NEGLECTED TROPICAL DISEASES POST TREATMENT MONITORING SURVEY IN 3 REGIONS OF CAMEROON: NORTH- WEST, SOUTH- WEST AND WEST

DRAFT REPORT

Submitted to

Sightsavers
YAOUNDÉ - CAMEROON

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Acronyms and sigles

HA :	Health Area
CD :	Community Distributor
C-P:	Cumulative Percentage
HD :	Health District
FFOM :	Forces, Faiblesses, Opportunités, Menaces
NTD	Non Transmitted Diseases
P. Size :	Population Size
PNLO :	Programme National de Lutte contre l'Onchocercose
PTS :	Post Treatment Survey
TIDC :	Traitement à l'Ivermectine Sous Directive Communautaire

CONTEXT AND JUSTIFICATION

I. GENERAL BACKGROUND OF THE STUDY

The 2015 NTDs campaign was implemented through the mass drug administration with mectizan, Albendazole for community based MDA and mebendazole and Praziquantel for school based MDA. The objective of the 2015 campaign was to treat at least 80% of the total population in order to contribute to the elimination of onchocerciasis, lymphatic filariasis, Helminthiasis and chistosomiasis in the 3 Regions (West, Northwest, and Southwest) supported by Sightsavers

MDA was implemented at the community level through a 'household-by-household' approach. Mectizan and Albendazole are given to everyone over 5 years old according to the height (except pregnant women, very sick person). Mebendazole and praziquantel are given to school aged children from to 15 years old. The dosage and quantity of drugs distributed are recorded in the data collection tools given by the programs.

According to the census done in 2015, the total population recorded is 4,925,991 inhabitants living in 5 209 endemic villages. The program recorded a therapeutic coverage of 82, 30% in the Southwest Region, 80% in the Northwest Region and 82, 9% in the West Region. The therapeutic coverage for school based MDA is over 80% of the total population of school aged children.

The 2015 results have indicated more people and children treated compare to 2014. A total of 4,044,486 people were treated with Mectizan and Albendazole and 1,456,773 children treated with Mebendazole and 341,941 children with Praziquentel compared to respectively 3.819545 people, 1.399,783 children for Mebendazole and 323,401 for Praziquantel.

It is therefore recommended that post treatment surveys are implemented in order to validate the coverage reported in the data collection tools.

II. OBJECTIVES OF THE SURVEY

- **General objective**

To ascertain the quality of treatment during the 2015 campaign through geographic and therapeutic coverage and level of community involvement of the Mass Distribution campaigns in the Northwest, Southwest and West Regions and to make recommendations to improve future campaigns.

- **Specific objectives**
  - Certify the geographic coverage of the 2015 Mass distribution campaign;
  - Certify the therapeutic coverage of the 2015 Mass distribution campaign with Mectizan and Albendazole;
  - Ascertain level of community involvement (through the CSM, CDD motivation, CDD adequacy ratio);
  - To determine the consistency of the data from the Community to the Health District;
  - Identify weaknesses and threats and make recommendations to address these.

III. EXPECTED OUTCOMES

- A document presenting the research methodology on data collection and analysis in each Region, including the tools and the chronogram of activities ;
- A document presenting data collected at the Health District and Health Areas levels;
- A complete report of the Post Treatment Survey in the three research Regions.

CHAPTER I

RESEARCH METHODOLOGY

1.1. Survey implementation

1.1.1. Timing of survey

Technical preparation, data collection / analysis and report writing were carried out from December 10th 2015 to January 31th, 2016) according to the chronogram.

1.1.2. Study area

The 3 Regions have 53 Health Districts undergoing treatment coupled Mectizan/ Albendazole; 57 HDs distributing Mebendazole and 11 HDs doing mass drug administration of Praziquantel.

This field activity covered eighteen Health Districts (6 per Region) with a purposive sampling of the Health Districts taking into account the co-administration of Mectizan and Albendazole, and 1 HD/Region distributing Praziquantel.

1.2. Survey Methodology

1.2.1. Selecting the clusters

A population based survey was conducted in order to determine the proportion of individuals reported taking the drug during the most recent round of MDA.

The survey followed a combine methodology of sampling. The primary clusters (the health district) were purposely selected taking in to account the therapeutic coverage. The second and the third cluster (community and the household) were determined following calculation of sample size through the probability proportional to size method.

Purpose and procedure of the survey were explained to household members in order to obtain their consent. A questionnaire was administered to people of 15 years old and above or to the representative of the household.

1.3. Sampling procedures

1.3.1. Survey frame

The survey frame used consists of a comprehensive list of areas and villages distributed by Health Districts.

1.3.2. Sample size

As in all population surveys, the following factors determine the sample size:

i) the estimated prevalence of the variable being studied;

ii) the targeted level of confidence;

iii) the acceptable error margin.

For a survey model based on a simple random sample, the required sample size by applying the following formula.

Formula:

$$n = \frac{(t)^2 \times p(1-p)}{(e)^2}$$

Where,

i) n = required sample size

ii) t = level pf confidence at 95% (typical value is 1.96);

iii) p =prevalence of the variable being studied;

iv) e = error margin at 5% (typical value is 0.05)

In the case of this study, the sample size was calculated using the following formula:

$$n = \frac{(t)^2 \times p(1-p)}{(e)^2}$$

Where

n is the size of the expected sample;

t is the level of confidence deducted from the level of confidence here set at ***95%,*** that is, ***1.96*** (standard normal distribution);

p is the estimated proportion of the population having the characteristic of interest in the study and in the case of a household survey like this one where more specific objectives have to be achieved.

In this study, we consider that ***p = 0.25****;*

e which represents the error margin is set at ***5%****.*

Thus, $n = \frac{(1{,}96)^2 \times (0{,}20(0{,}80))}{(0{,}05)^2} \approx 246$ households.

Considering that the non-response rate and poor record can be up to 10% and that there can be a cluster effect of 4, the approximate sample size of the study is:

288*4*1.1= 1080 households.

1.3.3. Household sample selection

In each Region concerned, the survey/investigation was carried out in six (06) Health Districts. The Health Districts shall be selected at random in proportion to their size. The numbers of household of the survey were proportionally divided between the three Regions and Health Districts, taking into consideration the size of each Region. In each sampled village, 25 households were surveyed. Thus, a total by 43 villages were covered in the three Regions concerned with the survey that is 14 villages in the West, 14 in the Northwest and 15 in the Southwest. The numbers of households surveyed per Region are presented as follow:

Table 1: Distribution of households and villages by Region

Regions	Number of households	Number of sampled households	Number of sampled villages
Northwest	295 177	359	14
Southwest	306 399	372	15
West	287 157	349	14
Total	**888 733**	**1 080**	**43**

Source : BUCREP, Travaux cartographiques du 3ème RGPH, 2003 and our calculation

At the level of each Region, the division of villages surveyed per health district is equally done in relation to the size of each health district. The selection of the sample villages was made from a list of the villages in each Region. The different populations of the villages are brought together as the survey continues. The enquiry/survey corresponds to the population surveyed divided by the number of the sample village. From the first selection done at random through stage by stage enquiry/survey, we progress step by step till we obtain the number of villages necessary. The list of Health Districts “health post” and sample villages are presented as follows:

Table 2: List of research sites in each administrative Region

REGION	HEALTH DISTRICTS	HEALTH AREAS	VILLAGES
NORTHWEST	**Ndop**	Bangolan	Kwaliang
		Babungo	Mboukang
		Bombalang	Mbashow
	Kumbo East	Tatum	Kishong
		Jakiri IHC	Sabongari
		Mbokam	Nchingong
	Bamenda	Atuakom	Atuakom
		Mulang	Ngomgham
	Batibo	Befang	Ebendi
		Njengei	Njengei
	Oku	Mboh	Mboh
		Jikijem	Ngham
	Njikwa	Oshie	Bereje
SOUTH —WEST	**Bangem**	Nkack	Elum 1
		Ekanjoh-bajoh	Muedimel
	Kumba	Bigbekondo	Mukete Camp
		Fiango	Kosala III
		Kumba Town	Nkangumudikum I
	Muyuka	Bafia	Lykoko native
		Muyuka	Makanga II
	Tombel	Tombel	Mile 20
		Edibenjock	Cocoa Camp
	Mamfé	Hrolha area	Bachouo
		Mamfé	Mile one
	Ekondo Titi	Kendem	Mbeme I
		Ekondo Titi	Balondotown
		Bamusso CMA	Mukeratanda
WEST	**Bafang**	Baboaté	Dackvi
		Manila	Toussa
		Bafang-chefferie	Quartier administrative
	Banganté	Bamena	Tah
		Ndipta III	Ndiop ka ndepla
		Bangoua	Depnou
	Dschang	Doumbouo	Melong
		Fometa	Keleng 1
		Latchouet	Yaguem
	Galim	Bagam	Tsoguet
	Kouoptamo	Kouoptamo	Kouoptamo
	Mifi	Famla	Djeleng 5
		Kongso	Loumgouo
		Wouong	Wouong 3

As far as the selection of households is concerned, in each of the selected villages, a sample of 25 households was selected at random. From the initial/first household chosen at random in the village, we made an in-depth coverage of that village. Neighboring homes

were visited with a step survey in relation to the number of the necessary households reported concerning the number of estimated households in that village.

1.4. DATA COLLECTION PROCEDURE

A total of 43 villages and 1080 households were surveyed. The survey/enquiry took place in 18 Health Districts, which is 6 per Region concerned. Data collection exercise last for 15 days. To survey 1080 households, six teams of 18 survey agents led by 3 controllers was constituted.

1.5. TRAINING

Data enumerators were trained in Yaoundé and in each Region. The training was necessary to get the field data collectors familiar with the methodology, filling in the questionnaire, quality control of the survey and ethics and guidelines of conducting a survey in the community.

1.6. DATA ANALYSIS AND WRITTEN OF THE REPORT

The data collected were entered in CSPRO. These data where then transferred in SPSS for exploitation and interpretation. To this effect, a supplementary typing control program was written and executed in order to eliminate errors which might have escaped during the typing process.

The cluster sampling method was chosen and the same enquiry/survey plan from one health district to another Region will ensure the comparability of the data from a statistical viewpoint/point of view between the different similar entities. Thus the results would therefore be aggregated and differentiated according to the desired geographical area. The following comparative analyses of these entities will follow with the aim of highlighting the appreciable disparities between the indicators, which shall be retained.

From the prevalent rates for each Region, a comparison was carried out between the different Regions, taking into consideration the variables of the people/persons surveyed: their sex, age, religion, level of education, living standards (level of income), their possible areas of residence. Thus, we can understand why and where diseases are still prevalent and highest in some areas.

1.7. RESEARCH TEAM COMPOSITION AND ROLES

The study was conducted by the Centre for Applied Social Sciences Research and Training (CASSRT), an independent institution, working in collaboration with the University of Yaoundé I. The 18 members of the research team (6/Region) were led by **Team leaders** and a coordinator of the survey. **Community guides** were used to introduce the members of the research team in the communities. **Supervision** of the survey was done by Sightsavers staff and the Regional coordination teams. **Coordination** of the entire survey was made by Mr. Antoine SOCPA Antoine, an Associate Professor and social scientist based at University of Yaoundé I and also CASS-RT coordinator.

1.8. DISSEMINATION AND APPLICATION OF RESULTS

The results of the survey should be fed back to all relevant stakeholders, not just at the national but also at the district or community level. Providing feedback to the CDDs and/or health facility staff involved in the MDA campaign will help them to improve their performances in future, provide opportunities for the community to address issues identified during the campaign and also provide motivation for those involved as it shows that their work was valued and being followed up.

CHAPTER II

PRESENTATION AND ANALYSIS OF HOUSEHOLD DATA ON 2015 CAMPAIGN DISTRIBUTION OF MECTIZAN AND ALBENDAZOLE IN THREE REGIONS OF CAMEROON: North-West, South-West and West

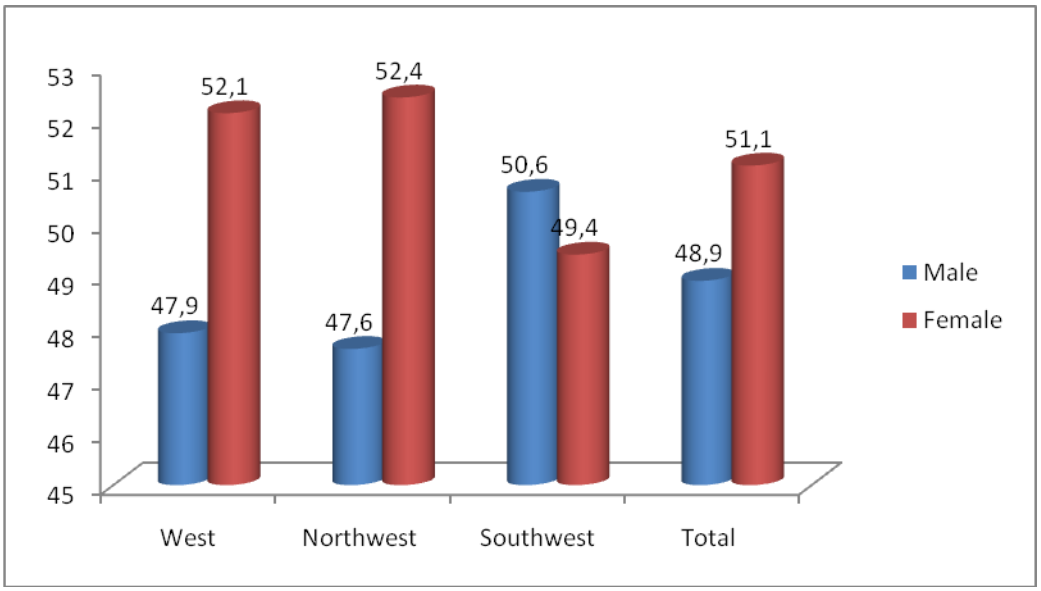
2.1. SOCIODEMOGRAPHIC CHARACTERISTICS OF THE SAMPLE POPULATION

2.1.1. Gender distribution of sampled population

Overall, the survey shows that women (51.1%) are relatively more represented in the sample than men (48.9%).

At the Regional level, this trend is observed in the West and Northwest. In both Regions, 52.1% and 52.4% of women were surveyed against 47.9% and 47.6% of men, respectively. But in the Southwest Region, the proportion of men surveyed is relatively higher (50.6%) than that of women 49.4%.

Figure 1: Gender distribution of sampled population per Region



At the level of the Health District, the results presented in Table 3 show that more women than men were investigated in Health Districts in Dschang (50.3% versus 49.7%), Galim (54 1% versus 45.9%), Kouaptamo (55.8% versus 44.2%), MiFi (59.3% versus 40.7%), Ndop (56.3% versus 43.8%), Kumbo East (52.5% versus 47.5%), Bamenda (54.6% versus 45.4%), Wum (55.1% versus 44.9%), Tombel (51.9 % versus 48.1%). Apart from the Muyuka Health District where 50% of women and 50% men were surveyed, Health Districtsthe proportion of women interviewed is higher than that of men in all other Health Districts.

Table 3 : Gender distribution of informants by Health District

Regions	Health Districts	Male		Female		Total	
		P. size	Percentage	P. size	Percentage	P. size	C-P
West	Bafang	209	52.6	188	47.4	397	100
	Banganté	158	52.7	142	47.3	300	100
	Dschang	261	49.7	264	50.3	525	100
	Galim	68	45.9	80	54.1	148	100
	Kouoptamo	69	44.2	87	55.8	156	100
	Mifi	198	40.7	288	59.3	486	100
Northwest	Ndop	161	43.8	207	56.3	368	100
	Kumbo East	142	47.5	157	52.5	299	100
	Bamenda	93	45.4	112	54.6	205	100
	Wum	62	44.9	76	55.1	138	100
	Oku	143	52.8	128	47.2	271	100
	Njikwa	72	54.5	60	45.5	132	100
Southwest	Bangem	157	54.5	131	45.5	288	100
	Kumba	241	55.4	194	44.6	435	100
	Muyuka	192	50.0	192	50.0	384	100
	Tombel	136	48.1	147	51.9	283	100
	Mamfé	239	51.6	224	48.4	463	100
	Ekondo Titi	114	41.0	164	59.0	278	100
Total		**2715**	**48,9**	**2841**	**51.1**	**5556**	**100**

The trend observed in Health Districts is also observed in the Health Areas. Indeed, in some Health Districts, more women than men were investigated while in others the reverse is observed. However, the proportion of women surveyed seems higher in the Health Areas areas of Famla (63.8%), Kongso (62%) and Ekondo Titi (61.9%). Yet, in the Health Areas Bafang-Chefferie (40.4%) and Bambalang (33.3%), the proportion of women interviewed is low.

Table 4: Gender distribution of informants by Health Area

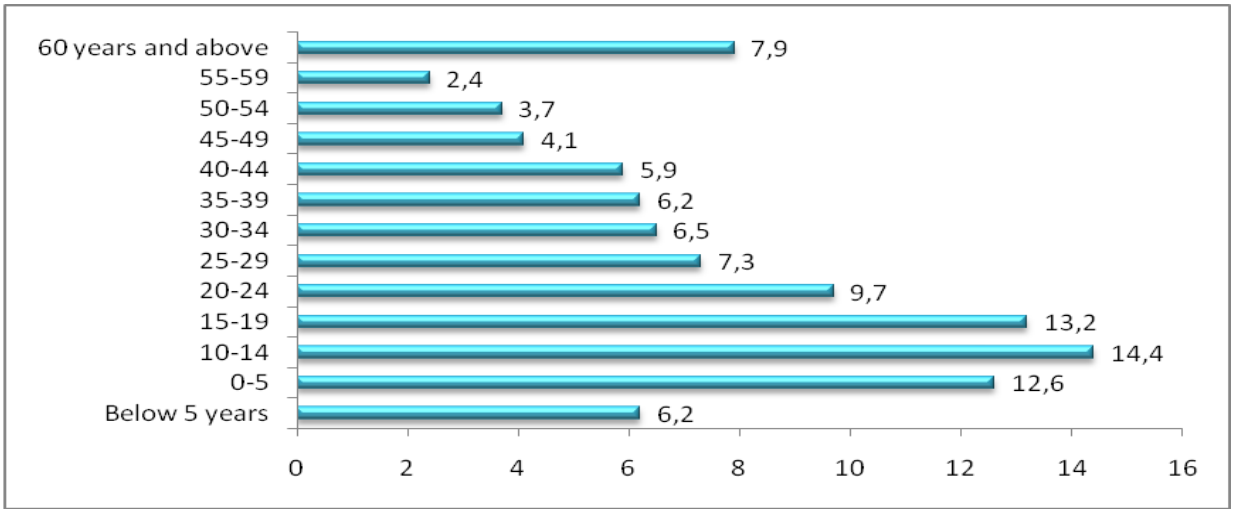
Regions	Health Districts	Male		Female		Total	
		P. size	Percentage	P. size	Percentage	P. size	Percentage
West	Baboaté	78	47.9	85	52.1	163	100
	Manila	62	52.5	56	47.5	118	100
	Bafang-Chefferie	68	59.6	46	40.4	114	100
	Bamena	57	51.4	54	48.6	111	100
	Ndipta III	56	54.9	46	45.1	102	100
	Bangoua	45	51.7	42	48.3	87	100
	Doumbouo	102	47.9	111	52.1	213	100
	Fometa	71	53.0	63	47.0	134	100
	Latchouet	88	49.4	90	50.6	178	100
	Bagam	68	45.9	80	54.1	148	100
	Kouoptamo	69	44.2	87	55.8	156	100
	Famla	57	36.8	98	63.2	155	100
	Kongso	60	38.0	98	62.0	158	100
	Wouong	82	46.9	93	53.1	175	100
Northwest	Bangolan	117	43.0	155	57.0	272	100
	Babungo	41	44.6	51	55.4	92	100
	Bambalang	4	66.7	2	33.3	6	100
	Tatum	59	49.6	60	50.4	119	100
	Jakiri IHC	45	46.9	51	53.1	96	100
	Mbokam	38	45.2	46	54.8	84	100
	Atuakom	51	43.6	66	56.4	117	100
	Mulang	41	48.8	43	51.2	84	100
	Wum Urb	30	46.9	34	53.1	64	100
	Furu-Awa	32	43.2	42	56.8	74	100
	Mboh	60	51.3	57	48.7	117	100
	Jikijem	83	53.9	71	46.1	154	100

	Konda	71	54.6	59	45.4	130	100
Southwest	Nkack	73	54.9	60	45.1	133	100
	Ekanjoh-Bajoh	84	54.2	71	45.8	155	100
	Big Bekondo	241	55.4	194	44.6	435	100
	Bafia	81	51.3	77	48.7	158	100
	Muyuka	112	48.7	118	51.3	230	100
	Tombel	67	44.7	83	55.3	150	100
	Edibenjock	69	51.9	64	48.1	133	100
	Kajifu	90	56.6	69	43.4	159	100
	Mamfe	67	48.2	72	51.8	139	100
	Kendem	82	49.7	83	50.3	165	100
	Ekondo Titi	56	38.1	91	61.9	147	100
	Bamusso CMA	58	44.3	73	55.7	131	100
Total		**2715**	**48.9**	**2841**	**51.1**	**5556**	**100**

2.1.2. Distribution of research participants by age group

Overall, the majority of respondents are young. Indeed, nearly 70% of respondents are under 35 years. The proportions of respondents aged 5-9 years, 10-14 years and 15-19 years are high. These represent respectively 12.6%, 14.4% and 13.2%. Those aged under 5 years represent 6.2% and those aged 60 or older represent 7.9%.

Figure 2: Distribution of research participants by age group



Disparities are observed between Regions, Health Districts and Health Areas. Such differences could be explained in some cases by the approximate accuracy of the ages declared. Indeed, in some Health Districts and Health Areas for example, we observe that the proportion of children under 5 years is zero, very high or low.

Table5: Distribution of informants by age group

	Below 5 years	**5-9**	**10-14**	**15-19**	**20-24**	**25-29**	**30-34**	**35-39**	**40-44**	**45-49**	**50-54**	**55-59**	**60 years and above**	**Total**	**P. size**
West	4.2	14.5	16.5	15.5	8.5	4.9	5.0	5.3	5.3	3.8	3.9	3.1	9.6	100	2012
Northwest	8.5	14.1	12.7	11.4	9.0	7.5	5.7	5.6	7.1	3.8	3.7	2.1	8.8	100	1413
South- West	6.6	9.8	13.6	12.2	11.2	9.6	8.3	7.3	5.7	4.6	3.5	1.9	5.6	100	2131
Total	**6.2**	**12.6**	**14.4**	**13.2**	**9.7**	**7.3**	**6.5**	**6.2**	**5.9**	**4.1**	**3.7**	**2.4**	**7.9**	**100**	**5556**

Table 6: Distribution of informants by age group in Health Districts

Region	**Health District**	**Below 5 years**	**5-9**	**10-14**	**15-19**	**20-24**	**25-29**	**30-34**	**35-39**	**40-44**	**45-49**	**50-54**	**55-59**	**60 years and above**	**Total**	**P. size**
West	Bafang	5.0	14.4	15.6	14.1	8.8	4.0	3.0	5.8	5.8	3.8	4.3	3.8	11.6	100	397
	Banganté		14.3	15.7	11.0	9.3	8.3	8.7	8.7	9.0	3.7	3.7	2.0	5.7	100	300
	Dschang	7.6	12.8	15.2	17.5	11.0	3.6	4.0	3.2	4.6	2.7	3.8	3.8	10.1	100	525
	Galim	11.5	17.6	16.2	15.5	6.8	5.4	4.1	6.8	4.7	4.1	1.4	2.0	4.1	100	148
	Kouoptamo	1.9	12.2	12.2	16.0	9.6	8.3	12.8	7.1	5.1	4.5	3.2	1.9	5.1	100	156
	Mifi	.8	16.3	20.4	16.9	5.1	3.5	3.3	4.1	3.7	4.7	4.7	3.3	13.2	100	486
Nortd-	Ndop	6.8	14.4	13.6	11.4	7.6	4.6	7.1	5.4	7.6	4.3	5.2	1.6	10.3	100	368
	Kumbo East	8.0	13.4	15.7	10.4	6.0	5.0	4.0	5.0	6.7	4.0	6.0	4.0	11.7	100	299

Region	Health District	Below 5 years	5-9	10-14	15-19	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60 years and above	Total	P. size
West	Bamenda	9.3	17.6	10.7	12.2	10.7	14.6	6.3	4.4	6.3	2.0	2.0	1.5	2.4	100	205
	Wum	7.2	8.7	8.0	10.1	18.8	10.1	8.0	8.7	10.9	2.9	1.4	2.2	2.9	100	138
	Oku	9.6	14.4	13.3	13.3	7.4	7.4	5.5	7.4	4.8	4.1	2.6	1.1	9.2	100	271
	Njikwa	12.1	14.4	10.6	9.8	9.8	7.6	3.0	2.3	9.1	4.5	1.5	1.5	13.6	100	132
Southwest	Bangem	6.6	8.7	8.7	15.3	7.3	9.7	10.4	7.3	5.6	6.3	5.2	1.7	7.3	100	288
	Kumba	1.8	8.3	17.0	16.1	17.0	10.1	7.4	2.8	3.7	2.1	4.4	2.3	7.1	100	435
	Muyuka	7.6	10.9	14.6	9.4	12.0	12.0	7.3	10.2	4.4	4.2	1.6	3.1	2.9	100	384
	Tombel	10.2	13.8	14.1	12.4	9.9	7.1	8.1	5.7	5.3	3.9	4.2	2.5	2.8	100	283
	Mamfé	5.8	6.5	11.7	9.1	9.9	9.5	9.9	9.3	8.6	7.6	3.9	0.6	7.6	100	463
	Ekondo Titi	10.1	13.3	14.7	12.2	8.6	7.9	6.5	9.0	6.1	3.6	1.8	1.4	4,7	100	278
Total		**6,2**	**12.6**	**14.4**	**13.2**	**9.7**	**7.3**	**6.5**	**6.2**	**5.9**	**4.1**	**3.7**	**2.4**	**7.9**	**100**	**5556**

Table7: Distribution of informants by age group in Health Areas

Region	Health Areas	Below 5 years	5-9	10-14	15-19	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60 years & above	Total	Psize
West	Baboaté	6.7	20.9	16.0	11.7	6.1	3.7	3.1	6.1	4.3	2.5	3.1	4.3	11.7	100	163
	Manila	1.7	11.0	17.8	19.5	6.8	1.7	1.7	5.1	5.9	5.1	5.1	5.1	13.6	100	118
	Bafang-Chefferie	6.1	8.8	13.2	12.3	14.0	7.0	4.4	6.1	7.0	4.4	5.3	1.8	9.6	100	114
	Bamena	0.0	16.2	16.2	14.4	8.1	9.9	8.1	9.9	8.1	1.8	1.8	2.7	2.7	100	111
	Ndipta III	0.0	13.7	17.6	9.8	9.8	7.8	7.8	6.9	8.8	4.9	2.9	2.0	7.8	100	102
	Bangoua	0.0	12.6	12.6	8.0	10.3	6.9	10.3	9.2	10.3	4.6	6.9	1.1	6.9	100	87
	Doumbouo	6.1	8.0	18.3	19.2	9.9	2.8	4.7	4.2	3.3	2.8	4.7	4.2	11.7	100	213
	Fometa	6.0	15.7	11.2	13.4	17.9	9.0	6.0	3.0	6.0	.7	4.5	0.0	6.7	100	134
	Latchouet	10.7	16.3	14.6	18.5	7.3	.6	1.7	2.2	5.1	3.9	2.2	6.2	10.7	100	178
	Bagam	11.5	17.6	16.2	15.5	6.8	5.4	4.1	6.8	4.7	4.1	1.4	2.0	4.1	100	148
	Kouoptamo	1.9	12.2	12.2	16.0	9.6	8.3	12.8	7.1	5.1	4.5	3.2	1.9	5.1	100	156
	Famla	0.6	13.5	16.1	21.3	9.7	3.9	7.1	5.8	3.9	3.9	5.2	1.9	7.1	100	155
	Kongso	1.3	19.6	24.7	10.1	1.9	4.4	1.3	2.5	4.4	5.1	5.1	4.4	15.2	100	158
	Wouong	.6	15.4	20.0	18.9	4.6	2.3	1.7	4.0	3.4	5.1	4.0	3.4	16.6	100	175
Northwest	Bangolan	5.5	14.7	13.6	11.4	8.1	4.8	7.7	4.8	8.1	2.9	5.9	1.5	11.0	100	272
	Babungo	8.7	14.1	12.0	12.0	6.5	4.3	5.4	7.6	5.4	9.8	2.2	2.2	9.8	100	92

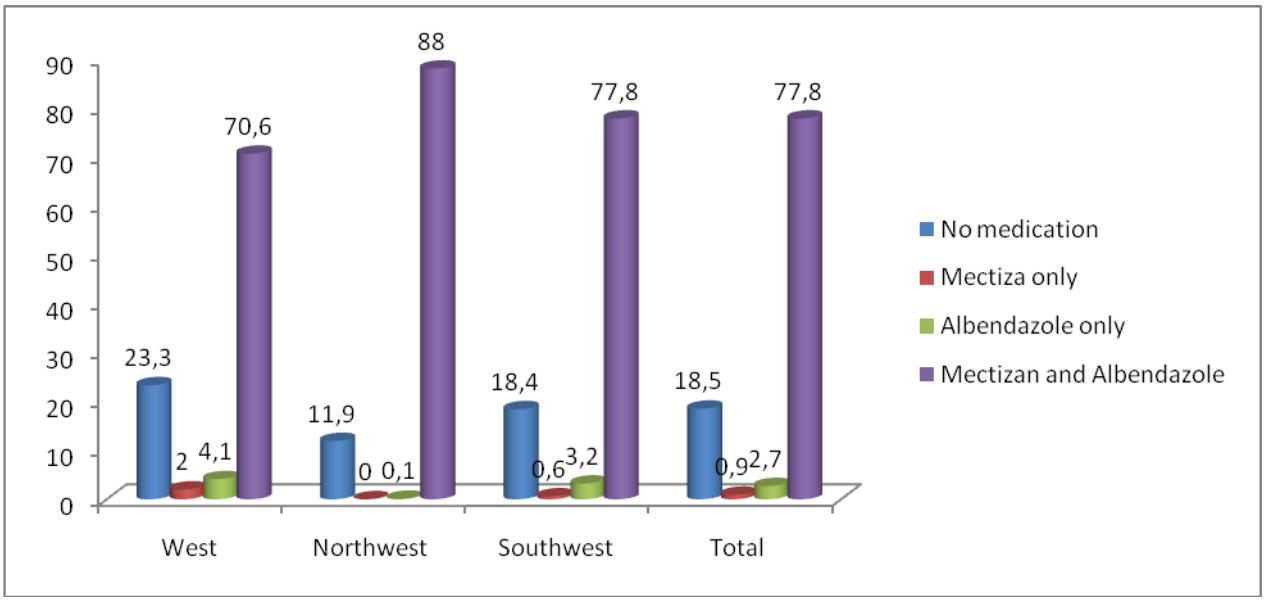
Region	Health Areas	Below 5 years	5-9	10-14	15-19	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60 years & above	Total	Psize
	Bambalang	33.3	0.0	33.3	0.0	0.0	0.0	0.0	0.0	16.7	0.0	16.7	0.0	0.0	100	6
	Tatum	8.4	15.1	16.0	10.1	6.7	7.6	1.7	5.9	5.9	5.9	4.2	1.7	10.9	100	119
	Jakiri IHC	9.4	9.4	14.6	7.3	7.3	3.1	6.3	4.2	7.3	3.1	7.3	6.3	14.6	100	96
	Mbokam	6.0	15.5	16.7	14.3	3.6	3.6	4.8	4.8	7.1	2.4	7.1	4.8	9.5	100	84
	Atuakom	7.7	14.5	16.2	12.0	8.5	17.9	8.5	3.4	6.8	1.7	1.7	0.9	0.0	100	117
	Mulang	10.7	22.6	3.6	13.1	13.1	10.7	3.6	6.0	6.0	2.4	1.2	1.2	6.0	100	84
	Wum Urb	9.4	6.3	4.7	3.1	26.6	9.4	12.5	12.5	7.8	3.1	1.6	0.0	3.1	100	64
	Furu-Awa	5.4	10.8	10.8	16.2	12.2	10.8	4.1	5.4	13.5	2.7	1.4	4.1	2.7	100	74
	Mboh	11.1	13.7	14.5	16.2	5.1	6.0	3.4	8.5	6.8	5.1	2.6	0.0	6.8	100	117
	Jikijem	8.4	14.9	12.3	11.0	9.1	8.4	7.1	6.5	3.2	3.2	2.6	1.9	11.0	100	154
	Oshié	12.3	14.6	10.8	10.0	10.0	7.7	3.1	2.3	9.2	3.8	1.5	1.5	13.1	100	130
Southwest	Nkack	3.8	10.5	9.8	15.0	6.8	6.8	10.5	6.0	6.0	6.8	5.3	3.0	9.8	100	133
	Ekanjoh-Bajoh	9.0	7.1	7.7	15.5	7.7	12.3	10.3	8.4	5.2	5.8	5.2	0.6	5,2	100	155
	Big Bekondo	1.8	8.3	17.0	16.1	17.0	10.1	7.4	2.8	3.7	2.1	4.4	2.3	7,1	100	435
	Bafia	3.2	8.2	12.7	8.9	12.0	12.0	8.9	16.5	6.3	5.7	1.9	2.5	1,3	100	158
	Muyuka	10.9	12.6	15.7	9.6	12.2	11.7	6.1	5.7	3.0	3.0	1.7	3.9	3,9	100	230
	Tombel	10.0	12.7	14.0	10.7	12.0	8.0	9.3	4.0	3.3	2.7	5.3	3.3	4,7	100	150

Region	Health Areas	Below 5 years	5-9	10-14	15-19	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60 years & above	Total	Psize
	Edibenjock	10.5	15.0	14.3	14.3	7.5	6.0	6.8	7.5	7.5	5.3	3.0	1.5	0,8	100	133
	Kajifu	8.8	7.5	10.7	10.7	10.1	6.3	8.2	5.7	8.8	8.2	3.8	1.3	10,1	100	159
	Mamfe	7.2	9.4	15.1	8.6	7.9	12.2	10.8	12.2	7.2	2.9	2.9	0.0	3,6	100	139
	Kendem	1.8	3.0	9.7	7.9	11.5	10.3	10.9	10.3	9.7	10.9	4.8	0.6	8,5	100	165
	Ekondo Titi	9.5	16.3	14.3	9.5	10.2	8.8	8.2	5.4	5.4	2.7	2.0	0.7	6,8	100	147
	Balondo Town	10.7	9.9	15.3	15.3	6.9	6.9	4.6	13.0	6.9	4.6	1.5	2.3	2,3	100	131
Total		**6,2**	**12.6**	**14.4**	**13.2**	**9.7**	**7.3**	**6.5**	**6.2**	**5.9**	**4.1**	**3.7**	**2.4**	**7.9**	**100**	**5556**

2.2. GEOGRAPHICAL COVERAGE OF MECTIZAN AND ALBENDAZOLE

Regarding the distribution of drugs, the results of Figure 3 show that overall, more than three-quarter of respondents (77.8%) reported having received bothdrugs namely Mectizan and Albendazole. The proportion of those reporting to have received only Mectizan or Albendazole is 0.9% and 2.7% respectively. Those who reported they received neither medication distributed during the campaign represent 18.5%. The main reasons given to justify the fact of not receiving the drugs are among others the absence of the respondent during the distribution campaign, shortage of drugs stock, professional occupations, distance from the distribution site, fear of side effects, etc.

Figure 3 : Distribution of participants per Region according to drugs received



Depending on the Region, it appears that the proportion of respondents who reported having received bothdrugs is higher in the Northwest (88%) and Southwest (77.8%). These represent 70.6% in the West Region. In this Region, about a quarter of respondents (23.3%) said they received neither medication. In areas of the Northwest and Southwest, respondents who reported they had received neither medication during the campaign represent 11.9% and 18.4%, respectively.

High discrepancies are observed from one Health District to the next. The proportion of respondents who reported having received both drugs is higher in some Health Districts especially in Health Districts of Bafang (90.9%), Ndop (99.7%) and Kumba (93, 1%). Clearly, in these three Health Districts, nine out of ten respondents reported having received both drugs. However,in Health Districts of Galim (36.5%), Kouoptamo (52.1%) and Ekondo Titi (57.9%), less than 60% of respondents reported having received both drugs. The proportions of those who received no medication are high in Health Districts of Dschang (30%), Galim (48.6%), Kouoptamo (45.9%), Njikwa (25.8%), Mamfe (27%) and Ekondo Titi (37.8%). In Health Districts of East Kumbo, Bamenda, of Wum, Oku and Njikwa, respondents either systematically received both drugs or have not received any.

Table 8 : Disrtibution of participants per Health District according to drugs received

Region	Health District	No medication	Mectiza only	Albendazole only	Mectizan and Albendazole	C-P	P.size
West	Bafang	5,7	0,8	2,5	90,9	100	353
	Banganté	9,0	0,0	17,0	74,0	100	300
	Dschang	30,0	1,2	0,8	68,1	100	520
	Galim	48,6	6,1	8,8	36,5	100	148
	Kouoptamo	45,9	2,1	0,0	52,1	100	146
	Miffi	23,4	3,8	0,2	72,5	100	418
North-West	Ndop	0,0	0,0	0,3	99,7	100	304
	Kumbo East	16,7	0,0	0,0	83,3	100	299
	Bamenda	14,1	0,0	0,0	85,9	100	205
	Wum	11,7	0,0	0,0	88,3	100	137
	Oku	11,8	0,0	0,0	88,2	100	271
	Njikwa	25,8	0,0	0,0	74,2	100	132
South-West	Bangem	8,4	0,0	5,2	86,4	100	287
	Kumba	1,9	1,7	3,3	93,1	100	360
	Muyuka	16,2	0,3	0,3	83,3	100	383
	Tombel	19,1	0,4	6,0	74,6	100	283
	Mamfé	27,0	0,2	2,6	70,2	100	463
	Ekondo Titi	37,8	1,1	3,2	57,9	100	278
Total		**18,5%**	**0,9**	**2,7**	**77,8**	**100**	**5287**

Depending on Health Areas, we see that less than 50% of respondents reported having received both drugs in Health Area of Bamena (45.9%), Fometa (48.1%) and Bagam (36.5%). In Health Areas of Babungo and Bambalang, all respondents said they always received both drugs at once. In addition to these two Health Areas, all respondents in the Health Areas of Baboaté and Bangolan reported having received at least one of the two drugs. However, the proportion of respondents who said they had received no medication is high in the Health Areas of Fometa (50.4%), Latchouet (38.5%), Bagam (48.6%), Kouoptamo (45.9%), Famla (40.2%), Kajifu (39.6%), EkondoTiti (46.3%). The Bamena Health Area is the only Health Area where a high proportion of respondents said they had received only one particular drug, Albendazole (45.9%).

Table 9 : Distribution of informants by Health areas according to medications received

Region	Health area	No medication	Mectiza only	Albendazole only	Mectizan and Albendazole	C-P	P.size
West	Baboaté	0,0	0,0	2,8	97,2	100	141
	Manila	15,3	2,5	3,4	78,8	100	118
	Bafang-Chefferie	1,1	0,0	0,0	98,9	100	92
	Bamena	8,1	0,0	45,9	45,9	100	111
	Ndipta III	6,9	0,0	0,0	93,1	100	102
	Bangoua	12,6	0,0	0,0	87,4	100	87
	Doumbouo	10,3	0,0	0,0	89,7	100	213
	Fometa	50,4	0,0	1,5	48,1	100	133
	Latchouet	38,5	3,4	1,1	56,9	100	174
	Bagam	48,6	6,1	8,8	36,5	100	148
	Kouoptamo	45,9	2,1	0,0	52,1	100	146
	Famla	40,2	0,0	2,3	57,5	100	87
	Kongso	15,2	3,2	0,0	81,6	100	158
	Wouong	22,9	6,3	0,0	70,9	100	175
North-West	Bangolan	0,0	0,0	0,5	99,5	100	220
	Babungo	0,0	0,0	0,0	100	100	80
	Bambalang	0,0	0,0	0,0	100	100	6
	Tatum	10,9	0,0	0,0	89,1	100	119
	Jakiri IHC	27,1	0,0	0,0	72,9	100	96
	Mbokam	13,1	0,0	0,0	86,9	100	84
	Atuakom	11,1	0,0	0,0	88,9	100	117
	Mulang	17,9	0,0	0,0	82,1	100	84
	Wum Urb	12,7	0,0	0,0	87,3	100	63
	Furu-Awa	10,8	0,0	0,0	89,2	100	74
	Mboh	10,3	0,0	0,0	89,7	100	117
	Jikijem	13,0	0,0	0,0	87,0	100	154

Region	Health area	No medication	Mectiza only	Albendazole only	Mectizan and Albendazole	C-P	P.size
	Konda	26,2	0,0	0,0	73,8	100	130
South-West	Nkack	1,5	0,0	6,1	92,4	100	132
	Ekanjoh-Bajoh	14,2	0,0	4,5	81,3	100	155
	Big Bekondo	1,9	1,7	3,3	93,1	100	360
	Bafia	16,6	0,6	0,6	82,2	100	157
	Muyuka	16,1	0,0	0,0	83,9	100	230
	Tombel	14,7	0,7	4,7	80,0	100	150
	Edibenjock	24,1	0,0	7,5	68,4	100	133
	Kajifu	39,6	0,0	,6	59,7	100	159
	Mamfe	27,3	0,7	6,5	65,5	100	139
	Kendem	14,5	0,0	1,2	84,2	100	165
	Ekondo titi	46,3	2,0	0,7	51,0	100	147
	Bamusso CMA	28,2	0,0	6,1	65,6	100	131
Total		**18,5%**	**0,9**	**2,7**	**77,8**	**100**	**5287**

Going by sex, we find that the proportion of men who received the drugs is relatively higher than that of women (78.4% versusversus 77.3%). The proportion of men who received both drugs, Albendazole and Mectizan represent respectively 78.4%, 2.9% and 0.9% (versus (77.3%, 2.6% and 0.9%) . 17.7% and 19.2% of men and women said they had received no respectively of both drugs when distributing campaign.

In the western and Northwest regions, the proportion of men who reported having received both drugs is higher than women (respectively 72.3% and 88.7% versus 68.9% and 87.4%). However, in the Southwest Region, the proportion of women who reported having received both drugs is higher than that of men (78.3% of women versus 77.4% of men).

In the Health District of Bafang, Galim, Ndop, Oku, Bangem, Kumba, Muyuka, Tombel, Mamfe, the proportion of women surveyed who reported having received bothdrugs is higher than men. However, in all other Health Districts, the proportion of male respondents who reported having received both drugs is higher than that of women. Regarding those who said they had received neither medication, the proportion of women who reported they had received neither medication is lower than that of men in the Health Districts of Oku (11.7 % versus 11.9%), Bangem (6.9% versus 9.7%), Kumba (1.3% versus 2.5%), Muyuka (15.2% versus 17.2%), and Mamfe (25% versus 28.9%).

Depending on Health Areas, we found that the proportion of women surveyed who reported having received both drugs is higher than that of women in the Health Areas of Baboaté (97.4% versus 96.9%), Manila (82.1% versus 75.8%), Ndipta III (93.3% versus 92.9%), Bagam (41.3% versus 30.9%), Wouong (71% versus 70 , 7%), Bangolan (100% versus 99%), Jakiri IHC (74.5% versus 71.1%) Atuakom (89.4% versus 88.2%), Wum Urb (88.2% versus 86.2%), Jikijem (88.7% versus 85.5%), Nkack (95% versus 91.5%), Big Bekondo (94.4% versus 92.5%), Bafia (85.5% versus 80%), Tombel (83.1% versus 76.1%), Edibenjock (72.1% versus 65.2%), Mamfe (66.2% versus 65. 7%), and Kendem (88% versus 80.5%). In all otherHealth Areas, the proportion of male respondents who reported having received both drugs is higher than that of women.

Table 10 : Gender distribution of respondents by region according to the received medication

	Men						Women					
	No drugs	**Mectizan only**	**Albendazole only**	**Mectizan and Albendazole**	**P-C**	**P size**	**No drugs**	**Mectizan only**	**Albendazole only**	**Mectizan and Albendazole**	**P-C**	**P size**
West	21,9	2,0	3,7	72,3	100	907	24,6	1,9	4,5	68,9	100	978
North-West	11,2	0,0	0,2	88,7	100	644	12,6	0,0	0,0	87,4	100	704
South-West	18,1	0,6	3,9	77,4	100	1037	18,6	0,6	2,6	78,3	100	1017
Total	**17,7**	**0,9**	**2,9**	**78,4**	**100**	**2588**	**19,2**	**0,9**	**2,6**	**77,3**	**100**	**2699**

Table 11 : Gender distribution of respondents by Health District according to the received medication

Region	**Health District**	**Men**						**Women**					
		No drugs	**Mectizan only**	**Albendazole only**	**Mectizan and Albendazole**	**P-C**	**P size**	**No drugs**	**Mectizan only**	**Albendazole only**	**Mectizan and Albendazole**	**P-C**	**P size**
West	Bafang	5,3	1,6	2,7	90,4	100	187	6,0	0,0	2,4	91,6	100	166
	Banganté	7,6	0,0	12,7	79,7	100	158	10,6	0,0	21,8	67,6	100	142
	Dschang	28,9	0,8	0,4	69,9	100	256	31,1	1,5	1,1	66,3	100	264
	Galim	51,5	7,4	10,3	30,9	100	68	46,3	5,0	7,5	41,3	100	80
	Kouoptamo	49,2	3,2	0,0	47,6	100	63	43,4	1,2	0,0	55,4	100	83
	Mifi	21,1	3,4	0,6	74,9	100	175	25,1	4,1	0,0	70,8	100	243
North-	Ndop	0,0	0,0	0,8	99,2	100	133	0,0	0,0	0,0	100,0	100	171

West	Kumbo East	16,2	0,0	0,0	83,8	100	142	17,2	0,0	0,0	82,8	100	157
	Bamenda	10,8	0,0	0,0	89,2	100	93	17,0	0,0	0,0	83,0	100	112
	Wum	8,2	0,0	0,0	91,8	100	61	14,5	0,0	0,0	85,5	100	76
	Oku	11,9	0,0	0,0	88,1	100	143	11,7	0,0	0,0	88,3	100	128
	Njikwa	23,6	0,0	0,0	76,4	100	72	28,3	0,0	0,0	71,7	100	60
South-West	Bangem	9,6	0,0	7,7	82,7	100	156	6,9	0,0	2,3	90,8	100	131
	Kumba	2,5	2,0	3,5	92,0	100	200	1,3	1,3	3,1	94,4	100	160
	Muyuka	17,2	0,5	0,5	81,8	100	192	15,2	0,0	0,0	84,8	100	191
	Tombel	19,9	0,7	8,8	70,6	100	136	18,4	0,0	3,4	78,2	100	147
	Mamfé	28,9	0,0	1,3	69,9	100	239	25,0	0,4	4,0	70,5	100	224
	Ekondo Titi	34,2	0,0	4,4	61,4	100	114	40,2	1,8	2,4	55,5	100	164
Total		**17,7**	**0,9**	**2,9**	**78,4**	**100**	**2588**	**19,2**	**0,9**	**2,6**	**77,3**	**100**	**2699**

Table 12: Gender distribution of respondents by Health Area according to the received medication

Region	Health areas	Men						Women					
		No drugs	Mectizan only	Albendazole only	Mectizan and Albendazole	P-C	P size	No drugs	Mectizan only	Albendazole only	Mectizan and Albendazole	P-C	P size
West	Baboaté	0,0	0,0	3,1	96,9	100	65	0,0	0,0	2,6	97,4	100	76
	Manila	16,1	4,8	3,2	75,8	100	62	14,3	0,0	3,6	82,1	100	56
	Bafang-Chefferie	0,0	0,0	0,0	100	100	59	3,0	0,0	0,0	97,0	100	33
	Bamena	7,0	0,0	35,1	57,9	100	57	9,3	0,0	57,4	33,3	100	54
	Ndipta III	7,1	0,0	0,0	92,9	100	56	6,5	0,0	0,0	93,5	100	46
	Bangoua	8,9	0,0	0,0	91,1	100	45	16,7	0,0	0,0	83,3	100	42
	Doumbouo	7,8	0,0	0,0	92,2	100	102	12,6	0,0	0,0	87,4	100	111
	Fometa	48,6	0,0	0,0	51,4	100	70	52,4	0,0	3,2	44,4	100	63
	Latchouet	38,1	2,4	1,2	58,3	100	84	38,9	4,4	1,1	55,6	100	90
	Bagam	51,5	7,4	10,3	30,9	100	68	46,3	5,0	7,5	41,3	100	80
	Kouoptamo	49,2	3,2	0,0	47,6	100	63	43,4	1,2	0,0	55,4	100	83
	Famla	26,5	0,0	5,9	67,6	100	34	49,1	0,0	0,0	50,9	100	53
	Kongso	16,7	0,0	0,0	83,3	100	60	14,3	5,1	0,0	80,6	100	98
	Wouong	22,0	7,3	0,0	70,7	100	82	23,7	5,4	0,0	71,0	100	93
North-	Bangolan	0,0	0,0	1,0	99,0	100	96	0,0	0,0	0,0	100	100	124

West	Babungo	0,0	0,0	0,0	100	100	34	0,0	0,0	0,0	100	100	46
	Bambalang	0,0	0,0	0,0	100	100	4	0,0	0,0	0,0	100	100	2
	Tatum	11,9	0,0	0,0	88,1	100	59	10,0	0,0	0,0	90,0	100	60
	Jakiri IHC	28,9	0,0	0,0	71,1	100	45	25,5	0,0	0,0	74,5	100	51
	Mbokam	7,9	0,0	0,0	92,1	100	38	17,4	0,0	0,0	82,6	100	46
	Atuakom	11,8	0,0	0,0	88,2	100	51	10,6	0,0	0,0	89,4	100	66
	Mulang	9,8	0,0	0,0	90,2	100	41	25,6	0,0	0,0	74,4	100	43
	Wum Urb	13,8	0,0	0,0	86,2	100	29	11,8	0,0	0,0	88,2	100	34
	Furu-Awa	3,1	0,0	0,0	96,9	100	32	16,7	0,0	0,0	83,3	100	42
	Mboh	8,3	0,0	0,0	91,7	100	60	12,3	0,0	0,0	87,7	100	57
	Jikijem	14,5	0,0	0,0	85,5	100	83	11,3	0,0	0,0	88,7	100	71
	Konda	23,9	0,0	0,0	76,1	100	71	28,8	0,0	0,0	71,2	100	59
South-West	Nkack	1,4	0,0	8,3	90,3	100	72	1,7	0,0	3,3	95,0	100	60
	Ekanjoh-Bajoh	16,7	0,0	7,1	76,2	100	84	11,3	0,0	1,4	87,3	100	71
	Big Bekondo	2,5	2,0	3,5	92,0	100	200	1,3	1,3	3,1	94,4	100	160
	Bafia	18,5	1,2	1,2	79,0	100	81	14,5	0,0	0,0	85,5	100	76
	Muyuka	16,1	0,0	0,0	83,9	100	112	16,1	0,0	0,0	83,9	100	118
	Tombel	14,9	1,5	7,5	76,1	100	67	14,5	0,0	2,4	83,1	100	83

	Edibenjock	24,6	0,0	10,1	65,2	100	69	23,4	0,0	4,7	71,9	100	64
	Kajifu	36,7	0,0	0,0	63,3	100	90	43,5	0,0	1,4	55,1	100	69
	Mamfe	32,8	0,0	1,5	65,7	100	67	22,2	1,4	11,1	65,3	100	72
	Kendem	17,1	0,0	2,4	80,5	100	82	12,0	0,0	0,0	88,0	100	83
	Ekondo titi	42,9	0,0	1,8	55,4	100	56	48,4	3,3	0,0	48,4	100	91
	Bamusso CMA	25,9	0,0	6,9	67,2	100	58	30,1	0,0	5,5	64,4	100	73
Total		**17,7**	**0,9**	**2,9**	**78,4**	**100**	**2588**	**19,2**	**0,9**	**2,6**	**77,3**	**100**	**2699**

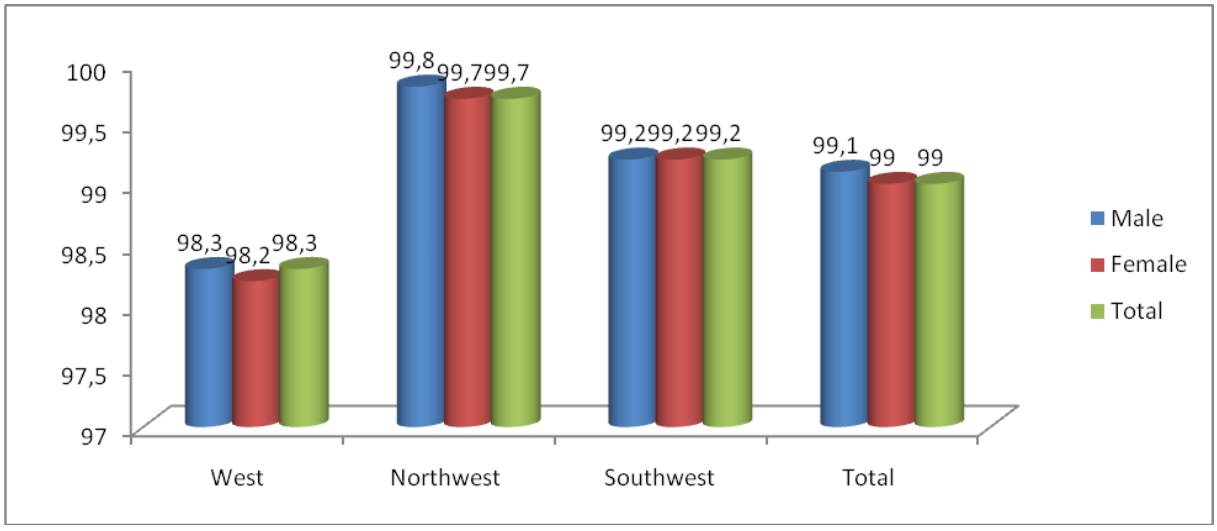
2.3. THERAPEUTIC COVERAGE OF DRUGS RECEIVED

In this context, therapeutic coverage refers to the consumption of medication received by the persons surveyed. Therapeutic coverage does not mean the number of people cured after consumption of the drugs. More specifically, we are talking about the number of people treated with Mectizan and Albendazole. When asked whether the drugs received were swallowed, almost all (99%) of the respondents (all sexes) reported having swallowed it. Despite this improvement, reserves may be raised because this "taking the drugs" was not made under the control of Communittee Distributor (DC) and in addition, some informants themselves said the Mectizan was used to kill lice or also for cosmetic purposes.

2.3.1. Therapeutic coverage by Region

At the Regional level, the balance between the gender of respondents and drugs consumption is broadly observed. However, the level of use of drugs received appears to be relatively higher in the Northwest and Southwest (99.7% and 99.2% respectively) than in the West Region (98, 3%).

Figure 4: Proportion of informants who declared having swallowed the drugs by Region and by gender



2.3.2. Therapeutic coverage by Health District

At the Health district level, the results in Table 13 show that all the respondents who received the drugs said to have swallowed them in Bangante Health Districts, East Kumbo, Bamenda, Wum and Tombel. In the Health Districts of Oku, Njikwa, Muyuka and Mamfe, all men surveyed reported having swallowed the drugs received, which is not the case with women. Yet, in some Health Districts such as Galim, Kouoptamo, Ndop, Bangem and Kumba, more women than men swallowed drugs received were.

Table 13: Gender distribution of respondents who declared having swallowed (Mectizan and Albendazole) per Health District

Region	Health District	Men	Women	Total
West	Bafang	97.2	96.2	96.7
	Banganté	100	100	100
	Dschang	99.5	98.9	99.2
	Galim	97.0	100	98.7
	Kouoptamo	90.9	100	96.3
	Mifi	98.6	97.3	97.8
North - West	Ndop	99.2	100	99.7
	Kumbo East	100	100	100
	Bamenda	100	100	100
	Wum	100	100	100
	Oku	100	99.1	99.6
	Njikwa	100	97.7	99.0
Southwest	Bangem	98.6	100	99.2
	Kumba	98.5	100	99.2
	Muyuka	100	99.4	99.7
	Tombel	100	100	100
	Mamfé	100	99.4	99.7
	Ekondo Titi	97.4	94.9	96.0
Total		**99,1**	**99.0**	**99.0**

2.3.3. Therapeutic coverage by Health Area

According to information collected in the Health Areas, all respondents who received the drugs said they had swallowed them. This was especially the case in the Health Areas of ManilaHealth Area, Bamena, Ndipta III, Bangoua, Doumbouo, Wouong, Bambalang, Tatum, Jakiri IHC, Mbokam, Atuakom, Mulang, Wum Urb, Furu-Awa, MBOH, Ekanjoh-Bajoh, Bafia, Tombel, Edibenjock, Mamfe, and Kendem. In Health Areas of Fometa, Kongso, Jikijem, Konda, Muyuka, Kajifu and Ekondo Titi, it is noted that among those surveyed, men, unlike women, reported having swallowed the drugs received. In the Health Areas of Bagam, Kouoptamo, Bangolan, Nkack, and Big Bekondo, all women reported having swallowed the drugs received.

Table 14: Gender distribution of respondents who declared that they swallowed the Mectizan and Albendazole by Health Area.

Region	Health Areas	Men	Women	P Size
West	Baboaté	100	96.1	97.9
	Manila	100	100	100
	Bafang-Chefferie	93.2	90.6	92.3
	Bamena	100	100	100
	Ndipta III	100	100	100
	Bangoua	100	100	100
	Doumbouo	100	100	100
	Fometa	100	96.7	98.5
	Latchouet	98.1	98.2	98.1
	Bagam	97.0	100	98.7
	Kouoptamo	90.9	100	96.3
	Famla	88.0	96.3	92.3
	Kongso	100	95.2	97.0
	Wouong	100	100	100
Northwest	Bangolan	99.0	100	99.5
	Babungo	100	100	100
	Bambalang	100	100	100
	Tatum	100	100	100
	Jakiri IHC	100	100	100
	Mbokam	100	100	100
	Atuakom	100	100	100
	Mulang	100	100	100
	Wum Urb	100	100	100
	Furu-Awa	100	100	100
	Mboh	100	100	100
	Jikijem	100	98.4	99,3
	Oshié	100	97.7	99,0

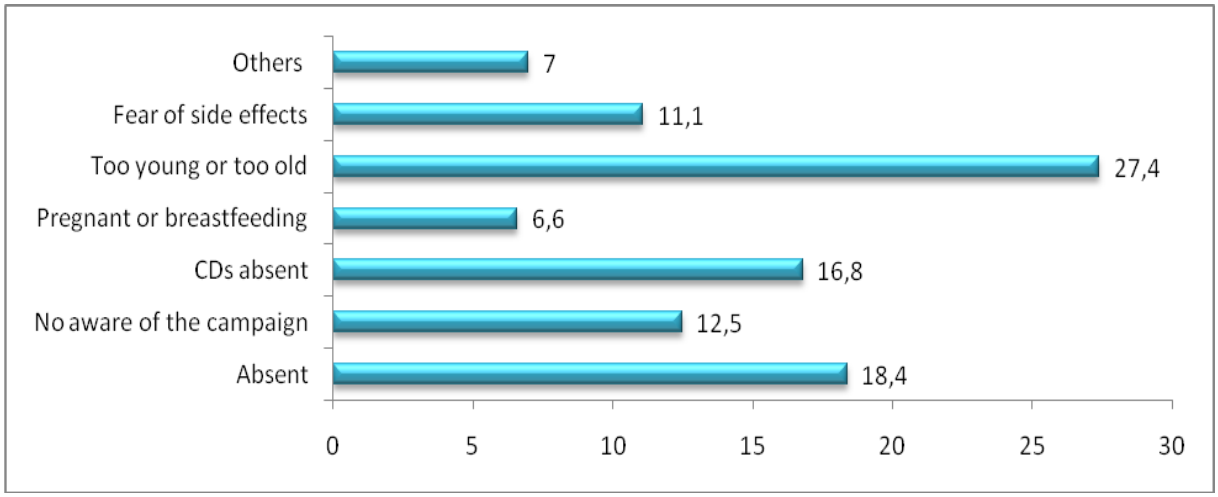
	Nkack	97.2	100	98,5
	Ekanjoh-Bajoh	100	100	100
	Big Bekondo	98.5	100	99,2
	Bafia	100	100	100
	Muyuka	100	99.0	99,5
	Tombel	100	100	100
Southwest	Edibenjock	100	100	100
	Kajifu	100	97.4	99,0
	Mamfe	100	100	100
	Kendem	100	100	100
	Ekondo Titi	100	95.7	97,5
	Bamusso CMA	95.5	94.1	94,7
Total		**99,1**	**99.0**	**99.0**

2.4. REASONS FOR THE NON CONSUMPTION OF MECTIZAN AND ALBENDAZOLE

Broadly speaking, the reasons for not taking medicines that this study set out to examine are as follows: Absence of beneficiaries when drug distributors visited the village, no information on the campaign, absence of drugs distributors in the village, pregnan, breastfeeding women, the beneficiary is a minor or is too old, fear of side effects, healthy person, treatment that "does not work", tired of taking tablets and other (s).

On this point, some respondents who received the drugs said they did not consume them for a number of reasons: being a minor or too old (27.4%), absence of beneficiaries in the village (18.4%), absence of the drugs distributors (16.8%), population not aware of the campaign (12.5%), fear of side effects (11.1%), pregnancy or breastfeeding (6.6%).

Figure 5: Reasons for non consumption of Mectizan and Albendazole)

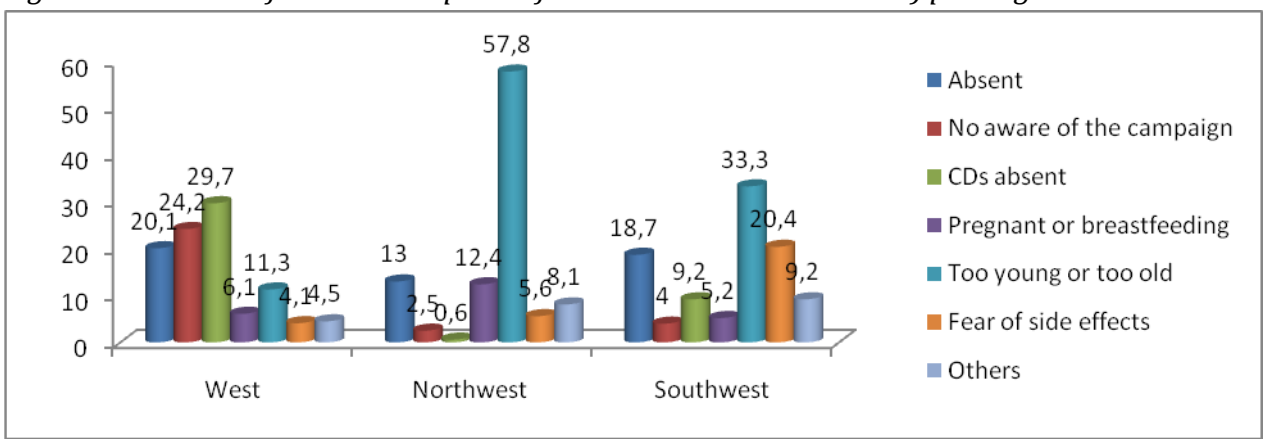


2.4.1. Reasons for non consumption at the Regional level

At the Regional level, the results show that the reasons for non-use of drugs received vary.

- ✓ In the WWest Region, the main reasons are the absence of household members during the last mass distribution campaign (20.1%), lack of information on the campaign (24.2%), nonarrival of drug distrutors ((29.7%).
- ✓ In the Northwest Region, the main reasons are the absence of household members during the last mass distribution campaign (13%), pregnancy or breastfeeding (12%), and respondents being minors or too old (57.8%).
- ✓ In the Southwest, the main reasons are the absence of household members during the last mass distribution campaign (18.7%), respondents being minor or too old (57.8%) and fear of side effects (20.4%).

Figure 6 : Reasons of non consumption of Mectizan and Albendazole) per Region



As it is already the case at the Regional level, reasons for not taking the drugs received also vary by districts and Health Areas.

2.4.2. Consumption of drugs at the Health District level

At the Health Districts level, we observe that in Bangangte and the Mifi, the majority of respondents (respectively 53.8% and 36.9%) justified failure to take medications by their absence during the distribution campaign.However, In Health Districts of Galim (60.3%) and Kouoptamo (47%), the majority of respondents did not receive the drugs because of the non-arrival of drug distributors. In other Health DistrictsDistricts, the main reason for not taking drugs was blamed on the age of the respondents (minor or too old).

Table 15: Reasons for failure of Mectizan and Albendazole consumption per Health district

Region	Health District	Absent	No aware of the campaign	CDs absent	Pregnant or breastfeeding	Too young or too old	Fear of side effects	Others	Total	P. Size
West	Bafang	0.0	27.3	24.2	0.0	6.1	12.1	30.3	100	33
	Banganté	53.8	0.0	0.0	23.1	0.0	19.2	3.8	100	26
	Dschang	15.5	31.7	18.0	3.1	24.8	5.0	1.9	100	161
	Galim	4.1	23.3	60.3	2.7	9.6	0.0	0.0	100	73
	Kouoptamo	19.7	12.1	47.0	12.1	3.0	1.5	4.5	100	66
	Miffi	36.9	26.2	24.3	6.8	1.0	1.0	3.9	100	103
Northwest	Ndop	0.0	0.0	0.0	0.0	0.0	0.0	100	100	1
	Kumbo East	16.0	2.0	0.0	8.0	58.0	4.0	12.0	100	50
	Bamenda	0.0	7.4	0.0	7.4	63.0	18.5	3.7	100	27
	Wum	5.9	0.0	0.0	29.4	52.9	0.0	11.8	100	17

	Oku	9.1	0.0	0.0	21.2	66.7	0.0	3.0	100	33
	Njikwa	27.3	3.0	3.0	6.1	48.5	6.1	6.1	100	33
Southwest	Bangem	21.4	0.0	0.0	0.0	53.6	17.9	7.1	100	28
	Kumba	15.8	0.0	5.3	0.0	26.3	52.6	0.0	100	19
	Muyuka	22.7	0.0	7.6	9.1	45.5	3.0	12.1	100	66
	Tombel	25.0	0.0	0.0	3.9	39.5	22.4	9.2	100	76
	Mamfé	9.5	5.1	24.8	6.6	24.8	19.7	9.5	100	137
	Ekondo Titi	22.7	9.2	0.8	4.2	28.6	25.2	9.2	100	119
Total		**18.4**	**12.5**	**16.8**	**6.6**	**27.4**	**11.1**	**7.0**	**100**	**1068**

2.4.3. Consumption of Mectizan and Albendazole at Health Area level

At the level Health Areas , one finds that in Bamena (62.5%), Ndipta III (85.7%) and Kongso (72%), the majority of respondents justified the non taking of drugs by their absence in the village during the distribution campaign. In the Health Areas of Bagam (60.3%), Kouoptamo (47%) and Famla (47.5%), the majority of respondents did not received the drugs because the distributor did not do his duty. Moreover, in the Health Areas of Manila (50%), Fometa (30.4%), Latchouet (42.9%) and Wouong (47%), the main reason for not taking drugs is the lack information about the organization of the distribution campaign. In the other Health Areas , the main reason for not taking drugs is related to the age of the respondents (minor and too old).

Table 16: Reasons for the non-consumption of Mectizan and Albendazole per Health Area

Region	Health Area	Absent	No aware of the campaign	CDs absent	Pregnant or breastfeeding	Too young or too old	Fear of side effects	Others	Total	P. Size
West	Baboaté	0.0	0.0	0.0	0.0	40.0	0.0	60.0	100	5
	Manila	0.0	50.0	44.4	0.0	0.0	5.6	0.0	100	18
	Bafang-Chefferie	0.0	0.0	0.0	0.0	0.0	25.0	75.0	100	8
	Bamena	62.5	0.0	0.0	37.5	0.0	0.0	0.0	100	8
	Ndipta III	85.7	0.0	0.0	14.3	0.0	0.0	0.0	100	7
	Bangoua	27.3	0.0	0.0	18.2	0.0	45.5	9.1	100	11
	Doumbouo	9.1	0.0	0.0	4.5	63.6	18.2	4.5	100	22
	Fometa	21.7	30.4	27.5	4.3	10.1	5.8	0.0	100	69
	Latchouet	11.4	42.9	14.3	1.4	27.1	0.0	2.9	100	70
	Bagam	4.1	23.3	60.3	2.7	9.6	0.0	0.0	100	73
	Kouoptamo	19.7	12.1	47.0	12.1	3.0	1.5	4.5	100	66
	Famla	25.0	15.0	47.5	5.0	0.0	2.5	5.0	100	40
	Kongso	72.0	8.0		16.0	0.0	0.0	4.0	100	25
	Wouong	25.0	47.5	15.0	2.5	2.5	2.5	5.0	100	40
Northwest	Bangolan	0.0	0.0	0.0	0.0	0.0	0.0	100	100	1

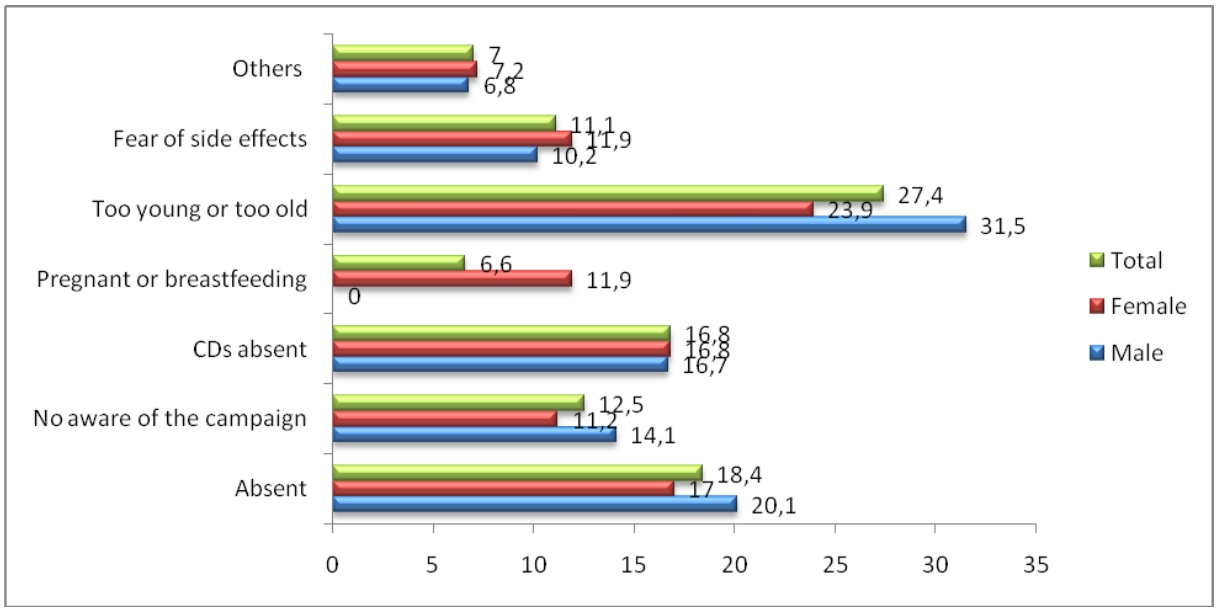
	Tatum	15.4	0.0	0.0	7.7	69.2	0.0	7.7	100	13
	Jakiri IHC	23.1	3.8	0.0	11.5	46.2	3.8	11.5	100	26
	Mbokam	0.0	0.0	0.0	0.0	72.7	9.1	18.2	100	11
	Atuakom	0.0	16.7	0.0	0.0	66.7	8.3	8.3	100	12
	Mulang	0.0	0.0	0.0	14.3	57.1	28.6	0.0	100	14
	Wum Urb	0.0	0.0	0.0	33.3	55.6	0.0	11.1	100	9
	Furu-Awa	12.5	0.0	0.0	25.0	50.0	0.0	12.5	100	8
	Mboh	0.0	0.0	0.0	25.0	75.0	0.0	0.0	100	12
	Jikijem	14.3	0.0	0.0	19.0	61.9	0.0	4.8	100	21
	Konda	27.3	3.0	3.0	6.1	48.5	6.1	6.1	100	33
Southwest	Nkack	0.0	0.0	0.0	0.0	77.8	22.2	0.0	100	9
	Ekanjoh-Bajoh	31.6	0.0	0.0	0.0	42.1	15.8	10.5	100	19
	Big Bekondo	15.8	0.0	5.3	0.0	26.3	52.6	0.0	100	19
	Bafia	28.6	0.0	17.9	7.1	17.9	3.6	25.0	100	28
	Muyuka	17.9	0.0	0.0	10.3	66.7	2.6	2.6	100	39
	Tombel	16.7	0.0	0.0	0.0	53.3	26.7	3.3	100	30
	Edibenjock	30.4	0.0	0.0	6.5	30.4	19.6	13.0	100	46
	Kajifu	14.1	6.3	25.0	7.8	25.0	17.2	4.7	100	64

	Mamfe	2.1	4.3	23.4	4.3	27.7	23.4	14.9	100	47
	Kendem	11.5	3.8	26.9	7.7	19.2	19.2	11.5	100	26
	Ekondo Titi	25.7	14.9	0.0	2.7	25.7	24.3	6.8	100	74
	Balondo Town	17.8	0.0	2.2	6.7	33.3	26.7	13.3	100	45
Total		**18.4**	**12.5**	**16.8**	**6.6**	**27.4**	**11.1**	**7.0**	**100**	**1068**

2.5. REASONS FOR THE NON-CONSUMPTION OF DRUGS PER SEX

The study reveals that a proportion of 20.1% of men surveyed were absent the day of the distribution of drugs, 14.1% were not aware of the campaign is, while 31.5% were disqualified for age (minor child / too old) .These proportions are higher for men compared to those observed for women that are 17%, 11.2% and 23.9%, respectively.

Figure 7: Reasons for the non-consumption of Mectizan and Albendazole by sex



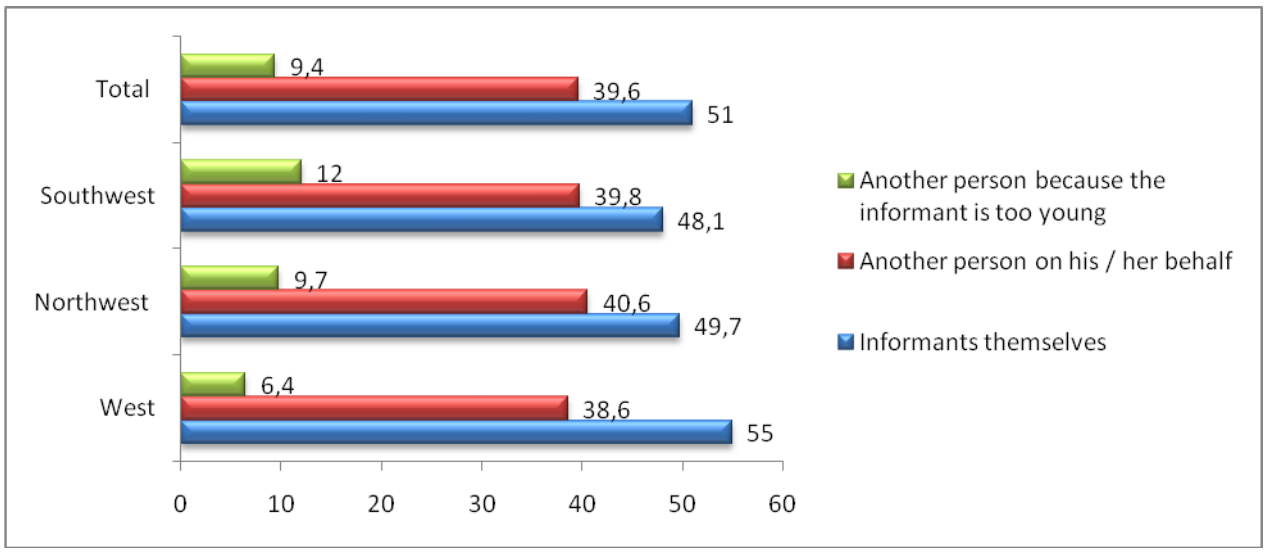
2.6. INFORMATION SOURCES

Overall, more than half of respondents (51%) answered to the various questions themselves. Persons absent during the survey represent 39.6% while minors and those who were unable to answer questions despite their presence are estimated at 9.4%.

2.6.1. Information source by Region

Depending on the Region, the results in Figure 8 show that the proportion of respondents who answered themselves the various questions is higher in the West Region (55%) compared to the Northwest Region (49.7%) and Southwest Region (48.1%) where less than half of respondents have actually provided the information themselves. The proportion of those for whom someone else responded because they were young is higher in the Southwest Region (12% versus 6.4% in the West and 9.7% in the Southwest). Yet, those whose for whom relatives responded because they were absent represent 38.6% in the West, 40.6% in the Northwest and 48.1% in the Southwest.

Figure 8: Status of informants who were interviewed per Region



2.6.2. Sources of information at Health District level

From oneHealth District to the next, disparities are observed depending on the source of information. Indeed, in some districts, less than half of the respondents provided their own information. These are Dschang Health Districts (35.2%), Galim (42.6%), Kumbo East (40.6%), Bamenda (47.3%), Oku (42 , 4%), Bangem (36.1%) Tombel (38.9%) Mamfé (49.2%) and Ekondo Titi (32.4%). However, in the Health Districts of Bafang (67.3), Bangangte (77%), Wum (72.5%) and Kumba (69%), at least six out of ten respondents responded themselves.

Table17: Status of study participants per Health District

Region	Health District	**Informants themselves**	**Another person on his / her behalf**	**Another person because the informant is too young**	**Percentage**
West	Bafang	67.3	27.5	5.3	100
	Banganté	77.0	17.7	5.3	100
	Dschang	35.2	58.5	6.3	100
	Galim	42.6	44.6	12.8	100
	Kouoptamo	58.3	37.2	4.5	100
	Miffi	55.3	37.7	7.0	100
Northwest	Ndop	53.0	34.5	12.5	100
	Kumbo East	40.5	49.2	10.4	100
	Bamenda	47.3	48.3	4.4	100
	Wum	72.5	27.5	0.0	100
	Oku	42.4	48.0	9.6	100
	Njikwa	56.1	25.0	18.9	100
Southwest	Bangem	36.1	52.8	11.1	100
	Kumba	69.0	24.8	6.2	100
	Muyuka	50.5	35.2	14.3	100
	Tombel	38.9	39.2	21.9	100
	Mamfé	49.2	41.3	9.5	100
	Ekondo Titi	32.4	54.7	12.9	100
Total		**51,0**	**39.6**	**9.4**	**100**

2.6.3. Sources of informations in the Health Areas

In Health Areas, the proportion of respondents who provided information themselves is high in Baboaté (70.6%), Bafang-Chefferie (70.2%), Bamena (84.7%), Bangoua (81.6%), Wouong (66.9%), Wum Urb (85.9%), Furu-Awa (60.8%) and Big Bekondo (69 %).

In contrast, in the Health Areas of Doumbouya (70%), Fometa (54.5%), Latchouet (66.3%), Bagam (57.4%), Famla (51.6%), Babungo (53.3%), Tatum (59.7%), Jakiri IHC (62.5%), Mbokam (66%), Atuakom (54.7%), Mboh (66, 7%), Jikijem (50.6%), Nkack (55.6%), Ekanjoh-Bajoh (71%), Muyuka (53.5%), Tombel (64%), Edibenjock (57.9%), Mamfé (54.4%), Kendem (51.5%), Ekondo Titi (72.1%) and Balondo Town (62.6%), the information of more than half of those surveyed was provided by others on their behalf.

Table 18: Status of study participants per Health Area

Region	Health District	**Informants themselves**	**Another person on his / her behalf**	**Another person because the informant is too young**	**Cumulative Percentage**
West Region	Baboaté	70.6	23.3	6.1	100
	Manila	59.3	38.1	2.5	100
	Bafang-Chefferie	70.2	22.8	7.0	100
	Bamena	84.7	9.9	5.4	100
	Ndipta III	64.7	31.4	3.9	100
	Bangoua	81.6	11.5	6.9	100
	Doumbouo	30.0	66.2	3.8	100
	Fometa	45.5	50.0	4.5	100
	Latchouet	33.7	55.6	10.7	100
	Bagam	42.6	44.6	12.8	100
	Kouoptamo	58.3	37.2	4.5	100
	Famla	48.4	46.5	5.2	100
	Kongso	50.0	36.7	13.3	100
	Wouong	66.9	30.3	2.9	100
Northwest Region	Bangolan	55.5	34.2	10.3	100
	Babungo	46.7	35.9	17.4	100
	Bambalang	50.0	16.7	33.3	100

	Tatum	40.3	51.3	8.4	100
	Jakiri IHC	37.5	49.0	13.5	100
	Mbokam	44.0	46.4	9.5	100
	Atuakom	45.3	49.6	5.1	100
	Mulang	50.0	46.4	3.6	100
	Wum Urb	85.9	14.1	0.0	100
	Furu-Awa	60.8	39.2	0.0	100
	Mboh	33.3	55.6	11.1	100
	Jikijem	49.4	42.2	8.4	100
	Konda	55.4	25.4	19.2	100
Southwest Region	Nkack	44.4	45.9	9.8	100
	Ekanjoh-Bajoh	29.0	58.7	12.3	100
	Big Bekondo	69.0	24.8	6.2	100
	Bafia	56.3	33.5	10.1	100
	Muyuka	46.5	36.5	17.0	100
	Tombel	36.0	42.7	21.3	100
	Edibenjock	42.1	35.3	22.6	100
	Kajifu	54.1	33.3	12.6	100
	Mamfe	44.6	43.2	12.2	100
	Kendem	48.5	47.3	4.2	100
	Ekondo Titi	27.9	60.5	11.6	100
	Bamusso CMA	37.4	48.1	14.5	100
Total		**51,0**	**39.6**	**9.4**	**100**

CHAPTER III

EVALUATION OF COMMUNITY APPROPRIATION OF THE MASS DISTRIBUTION OF MECTIZAN AND ALBENDAZOLE IN THE WEST, NORTH-WEST AND SOUTH-WEST REGIONS OF CAMEROON

This chapter focuses on the involvement of community members in mass distribution activities of Mectizan and Albendazole during the 2015 campaign.

3.1. INFORMATION ON THE ORGANISATION OF COMMUNITY MEETINGS ON THE MASS DISTRIBUTION OF MECTIZAN ET ALBENDAZOLE

3.1.1. At the Regional level

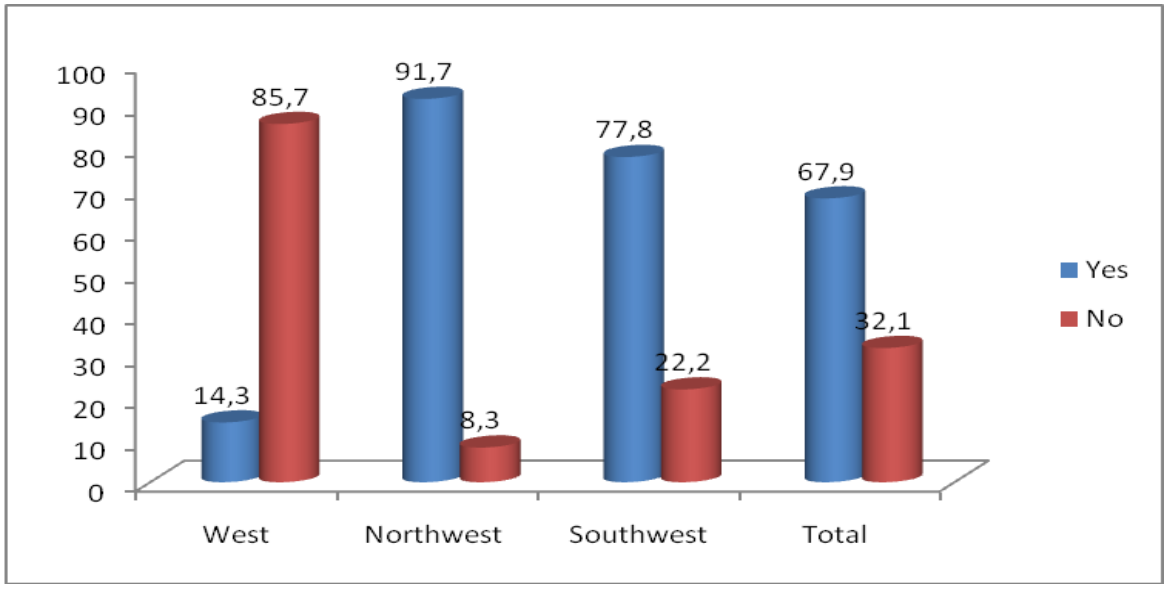
In all Regions, 67.9% of community leaders surveyed reported that community meetings on the distribution of Mectizan and Albendazole were organized within the community.

However, it is noted that the organization of these meetings varies from one Region to another. According to statements by community leaders, community meetings are usually held in the Northwest Region (91.7%) and Southwest (77.8%). Actually in these two Regions, some traditional authorities are truly involved in the program despite the lack of human resources and discouragement of some actors involved in the distribution because of the lack of motivation. The testimonies of community leaders are evocative:

« […] *the Quarter Head does the distribution of the drugs with his wife who is mid wife in the Hospital. This is usually done at 5 AM in the early mornings. Both do the distribution because the other distributors refused to continue the distribution for lack incentives ”*. (Community Leader, Mamfe/Mile One).

In the West Region however, only 14.3% of community leaders said that meetings were organized on the distribution of Mectizan and Albendazole in their community.

Figure 9: Organisation of community meetings on the mass distribution of Mectizan Albendazole and Albendazole per Region



3.1.2. At the Health District level

The results in Table 19 show that in the Health Districts of Ndop, East Kumbo, Oku, Wum, Njikwa, Bangem and Kumba, all leaders surveyed said that community meetings on distribution of Mectizan and AlbendazoleAlbendazole were organized. They represent 50% in Bafang Health District, Ekondo Titi and Nkambé and 75% in Mamfe Health District. Yet, in the Health Districts of Bangangte, the MiFi, Bamenda and Tombel, community meetings on the distribution of Mectizan and Albendazole were not organized. Indeed, in these Health Districts, no community leader said a meeting has been organized before and even after Mectizan and Albendazole mass distribution.

Table 19: Certification of meetings organisation on Mectizan and Albendazole mass distribution per Health District.

Region	Health District	Yes	No	Cumulative Percentage
West	Bafang	50.0	50.0	100
	Banganté	0.0	100	100
	Mifi	0.0	100	100
Northwest	Ndop	100	0.0	100
	Kumbo East	100	0.0	100
	Bamenda	0.0	100	100
	Wum	100	0.0	100
	Oku	100	0.0	100
	Njikwa	100	0.0	100
	Ekondo Titi	50.0	50.0	100
Southwest	Bangem	100	0.0	100
	Kumba	100	0.0	100
	Muyuka	100	0.0	100

	Tombel	0.0	100	100
	Mamfé	100(75.0)	0.0(25.0)	100
	Nkambé	50.0	50.0	100
Total		**67,9**	**32.1**	**100**

3.1.3. At the Health Area level

Regarding Health Areas, we find that community meetings on the distribution of Mectizan and AlbendazoleAlbendazole were not organized in nine (09) Health Areas on the twenty eight (28) relevant Health Areas; this represents 32.14%. These 09 Health Areas include: Manila, Bamena, Ndipta III, Famla, Kongso, Wouong, Mulang, Edibenjock and Kendem.

Table 20: Certification of meetings organisation onMectizan and Albendazole mass distribution per Health area

Region	**Health Area**	**Organisation of community meetings on the mass distribution of Mectizan and Albendazole**
West	Manila	**No**
	Bafang-Chefferie	Yes
	Bamena	**No**
	Ndipta III	**No**
	Famla	**No**
	Kongso	**No**
	Wouong	**No**
North-West	Bangolan	Yes
	Babungo	Yes
	Bambalang	Yes
	Tatum	Yes
	Jakiri IHC	Yes
	Mbokam	Yes
	Mulang	**No**
	Wum Urb	Yes
	Furu-Awa	Yes
	Mboh	Yes
	Jikijem	Yes
Southwest	Oshié	Yes
	Ekanjoh-Bajoh	Yes
	Big Bekondo	Yes
	Kumba Town	Yes
	Bafia	Yes
	Ekondo Titi	Yes
	Muyuka	Yes
	Bekora	Yes
	Edibenjock	**No**
	Kajifu	Yes
	Mamfe	**No**

	Kendem	Yes

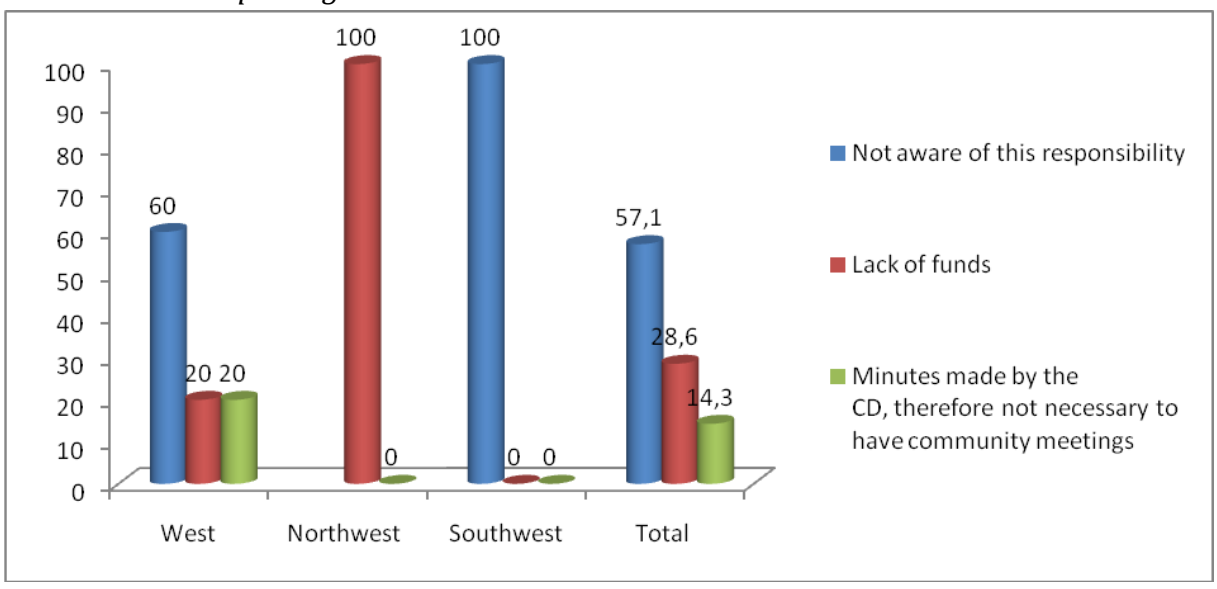
3.2. REASONS FOR THE NON-ORGANISATION OF COMMUNITY MEETINGS ON THE MASS DISTRIBUTION OF MECTIZAN AND ALBENDAZOLE

Failure to organize community meetings can be explained by three main reasons according to community leaders interviewed. These are, in order of importance, ignorance of their responsibility by some community leaders (57.1%), lack of funds (28.6%) and the non-necessity of these meetings due to the fact that the minutes prepared by distributors (14.2%).

3.2.1. At the level of the Region

TRegion-wise, he chart below shows that in the Northwest and the Southwest, the main reasons for not organizing community meetings on the distribution of Mectizan and Albendazole are lack of funds (100%) and non-awareness of the duty to organize meetings (100%). In the West Region, 20% and 60% of respondents share the last two reasons, and 20% also justified the non-organization of meetings saying they were not necessary.

Figure 10: Reasons for non-holding of community meetings on the distribution of Mectizan and Albendazole per Region.



3.2.2. At the Health District level

In Health Districts, several community leaders justified thenon-organization of community meetings on the distribution of Mectizan and Albendazole by the fact that they were not aware of this responsibility and lacked funds (this was the case in Tombel and Bamenda Health Districts). In the Bangante and Mifi Health Districts for example, respectively 50% and 66.7% of community leaders justify thenon-organization of meetings by the fact they were unaware that it was their responsibility to do so. In terms of the lack of funds, 50% of leaders Bangangte agree said they lacked funds. In the Health Districts of the Mifi, the non-necessity of these meetings is emphasized by (33.3%) of community leaders who argue that the reports are usually prepared by distributors.

Table 21: Reasons for non-holding community meetings on the Mectizan and Albendazole distribution per Health District.

Region	**Health District**	**Not aware of this responsibility**	**Lack of funds**	**Minutes made by the CD, therefore not necessary to have community meetings**	**Percentage**
West	Banganté	50.0	50.0	0.0	100
	Mifi	66.7	0.0	33.3	100
Northwest	Bamenda	0.0	100	0.0	100
Southwest	Tombel	100	0.0	0.0	100
Total		**57,1**	**28.6**	**14.3**	**100**

3.2.3. At the Health Area level

Regarding Health Areas, lack of funds was quoted in Ndipta III and Mulang. The fact of not being aware of this responsibility was mentioned in the Health Areas of Bamena, Kongso, Wouong and Edibenjock. The non-necessity of community meetingswas mentioned only in the Famla Health Area, the reason advanced being that distributors often do the reporting.

Table 22: Reasons for non holding community meetings on the Mectizan and Albendazole distribution per Health Area.

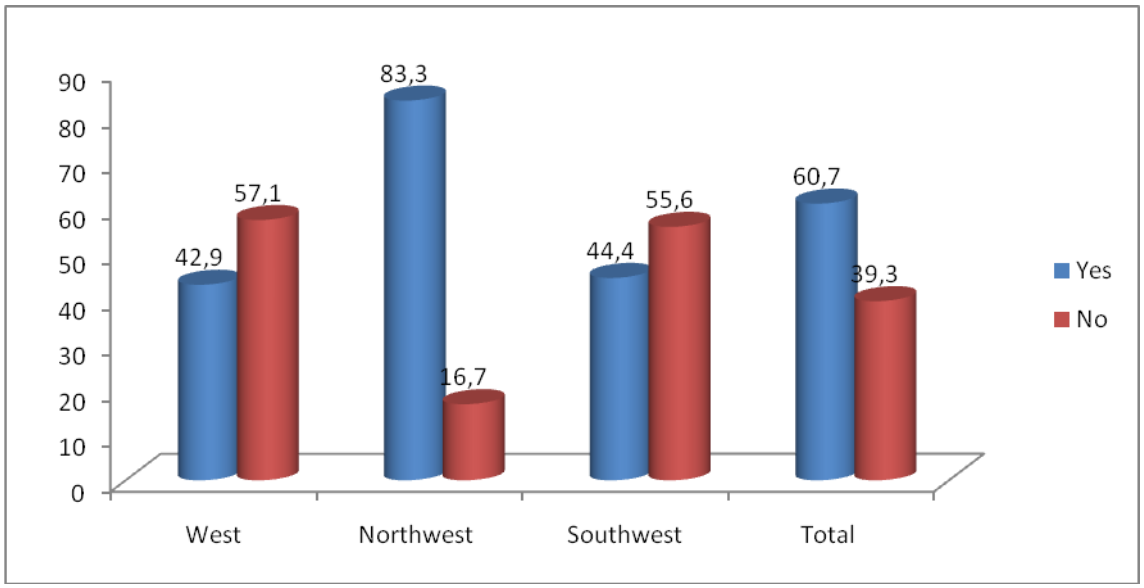
Region	Health Area	***Reasons for non holding community meetings on the Mectizan and Albendazole distribution***
West	Bamena	Not aware of that responsibility
	Ndipta III	Lack of funds
	Famla	reports made by the CD, thefore no necessity to organize community meetings
	Kongso	Not aware of that responsibility
	Wouong	Not aware of that responsibility
Northwest-	Mulang	Lack of funds
Southwest	Edibenjock	Not aware of that responsibility

3.3. INFORMATION ON COMMUNITY DISTRIBUTORS BY THE COMMUNITY MEMBERS

3.3.1. At the regional level

Overall, 60.7% of respondents said their community motivates CDs From information obtained in the Regions, we note that CDs are more motivated by community members in the Northwest (83.3%) than those in the West (42.9%) and Southwest (44.4 %).

Figure 11: Motivation of the CDs by community members per Region enquêtés selon la motivation des DC par la communauté par Région



3.3.2. At the Health distric level

At the Health Districts level, the results in Table 23 show that all community leaders interviewed in Ndop, East Kumbo, Bamenda, Wum and Kumba said their respective communities motivate CDs. In contrast, in Bagangté, Muyuka, Tombel, Bangem and Mamfe, all respondents said their communities do not motivate CDs. The reason for this refusal is highlighted by this informant:

"The community does not motivate CDs because they consider them as civil servants"(Community Leader, Mamfé/Mbémé1) "They did not motivate them because they believe that the distributors should be paid by the health centers " (Community Leader, Bangem/Élum1).

The community does not motivate CDs because they consider them as civil servants "(Community Leader, Mamfe / Mbémé1)" They did not motivate them because they believe that, the distributors should be paid by the health centers "(Community Leader Bangem / Élum1).

Table 23: Motivation of CDs by community members per Health District

Region	Health District	Yes	No	C-P
West	Bafang	50.0	50.0	100
	Banganté	0.0	100	100
	Mifi	66.7	33.3	100
Northwest	Ndop	100	0.0	100
	Kumbo East	100	0.0	100
	Bamenda	100	0.0	100
	Wum	100	0.0	100
	Oku	50.0	50.0	100
	Njikwa	0.0	100	100
Southwest	Bangem	100	0.0	100
	Kumba	100	0.0	100
	Muyuka	0.0	100	100
	Tombel	0.0	100	100
	Mamfé	0.0	100	100
	Nkambé	50.0	50.0	100
Total		**60,7**	**39.3**	**100**

3.3.3. At Health Area level

In Health Areas, we find that CDs are not motivated enough notably in Manila, Bamena, Ndipta III, Wouong, Mboh, Oshie, Bafia, Muyuka, Edibenjock, Kajifu and Kendem. In all other Health Areas, community leaders surveyed said their communities motivate CDs.

Tableau 24: Motivation of CDs by community members per Health Area

Region	Health Area	Motivation of CDs by community members
West	Manila	**No**
	Bafang-Chefferie	Yes
	Bamena	**No**
	Ndipta III	**No**
	Famla	Yes
	Kongso	Yes
	Wouong	**No**
Northwest	Bangolan	Yes
	Babungo	Yes
	Bambalang	Yes
	Tatum	Yes
	Jakiri IHC	Yes
	Mbokam	Yes
	Mulang	Yes
	Wum Urb	Yes
	Furu-Awa	Yes
	Mboh	**No**
	Jikijem	Yes
	Oshié	**No**
Southwest	Ekanjoh-Bajoh	Yes
	Big Bekondo	Yes
	Kumba Town	Yes
	Bafia	**No**
	Muyuka	**No**
	Edibenjock	**No**
	Kajifu	**No**
	Mamfe	Yes
	Kendem	**No**

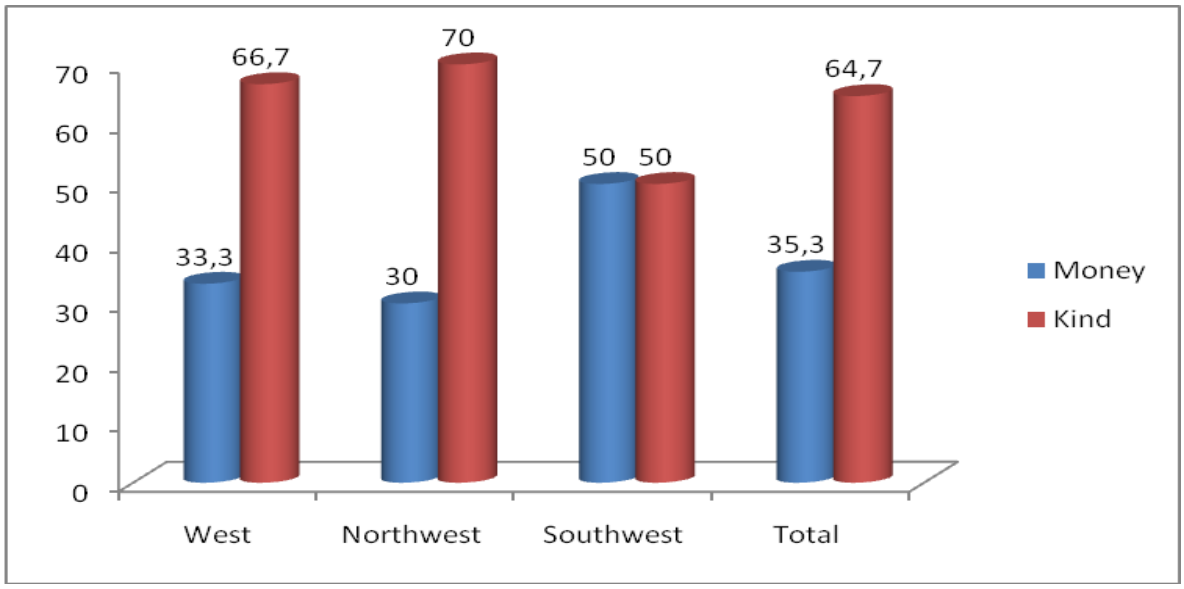
3.4. NATURE OF MOTIVATION OFFERED TO CDs

Motivation is either in cash (money) or in kind. Overall, 64.7% of the surveyed community leaders said their community motivates CDs in kind. Those reporting that CDs are motivated with money represent 35.3%.

3.4.1. At the regional level

At the level of Regions, 66.7%, 70% and 50% of community leaders surveyed said their community motivates CDs in kind in the West, Northwest and Southwest Regions, respectively. The CDs seem more motivated by money in the Southwest Region and in kind in the other two Regions (West and Northwest).

Figure 12: Nature of DCs motivation by the community at the Regional level



3.4.2. At Health Disrtict level

According to information gathered in Health Districts, CDs are motivated solely with money in Bafang, Oku and Nkambé. In contrast, they are motivated with material goods in the Health Districts of the Mifi, Bamenda, Wum and Bangem. In the other Health Districts, community motivates CDs both cash (money) and in kind.

Table 25: Nature of motivation given to DCs by the community at the Health District level

Region	Health District	Money	Kind	C-P
West	Bafang	100	0.0	100
	Mifi	0.0	100	100
Northwest	Ndop	0.0	100	100
	Kumbo East	66.7	33.3	100
	Bamenda	0.0	100	100
	Wum	0.0	100	100
	Oku	100	0.0	100
Southwest	Bangem	0.0	100	100
	Kumba	50.0	50.0	100
	Nkambé	100	0.0	100
Total		**35,3**	**64.7**	**100**

3.4.3. At the Health Area level

As far as Health Areas are concerned, community members motivate CDs with money in Bafang-Chefferie, Tatum, Jakiri IHC, Jikijem, Big BEKONDO and Mamfe. In the Health Areas of Famla , Kongso, Bangolan, Babungo, Bambalang, to Mbokam, Mulang, Wum Urban, Furu-Awa, Ekanjoh-Bajoh and Kumba Town, CDs are motivated in nature.

Table 26: Nature of motivation given to DCs by the community at the Health Area level

Region	Health Area	Type of motivation
West	Bafang-Chefferie	Money
	Famla	Kind
	Kongso	Kind
Northwest	Bangolan	Kind
	Babungo	Kind
	Bambalang	Kind
	Tatum	Money
	Jakiri IHC	Money
	Mbokam	Kind
	Mulang	Kind
	Wum Urb	Kind
	Furu-Awa	Kind
	Jikijem	Money
Southwest	Ekanjoh-Bajoh	Kind
	Big Bekondo	Money
	Kumba Town	Kind
	Mamfe	Money

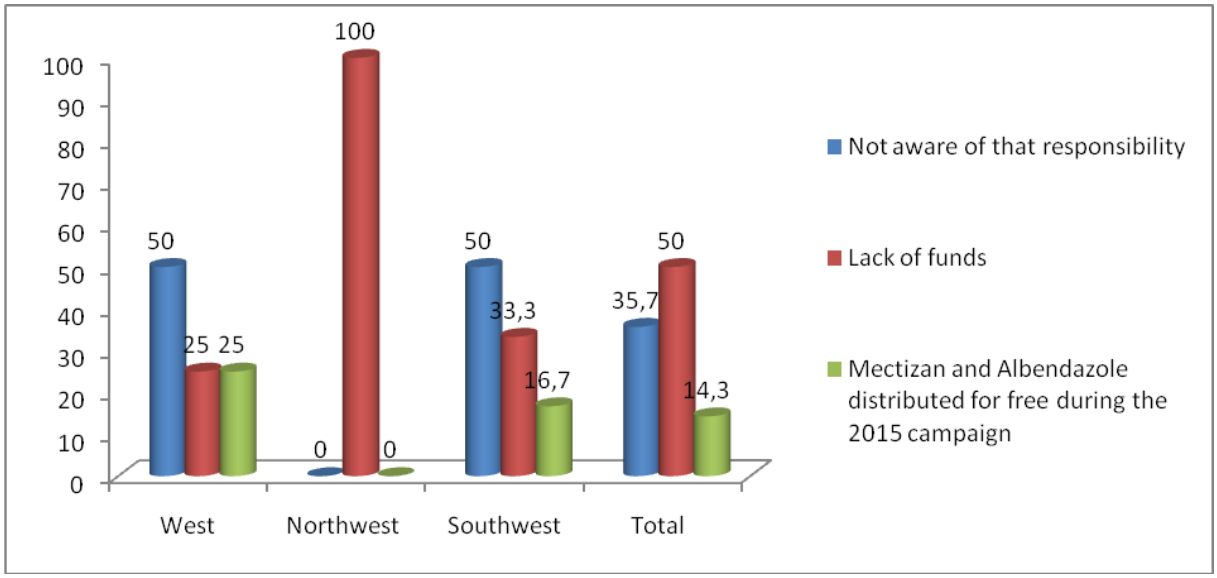
3.5. REASONS FOR NON-MOTIVATION OF CDs

Overall, half of the respondents declared that CDs are not motivated because of lack of funds. Also, they noted that they ignored it was their responsibility given that Mectizan and Albendazole are distributed free of charge.

3.5.1. At the Regional level

Informants from Northwest argue that the non-motivation of the CDs by community members is justified only by the lack of necessary resources (funds). This last reason has been cited in the West and the Southwest Regions by 25% and 33.3% respondents, respectively.

Figure 13: Reasons for non-motivation of CDs by community members at the Regional level



3.5.2. At the Health district level

As far as Health Districts are concerned, it appears that the main reasons for non motivation of CDs by the community are:

- Ignorance of that responsibility by community leaders (Bafang, Kumba, Mamfe and Tombel);
- Lack of financial means (funds) in the Health Districts (Mifi, Ndop, Oku, Njikwa and Muyuka;
- The fact that Mectizan and Albendazole (Nkambé HD) are distributed free of charge.

Table 27: Reasons for the non-motivation of CDs by community members at the Health District level

Region	Health district	Not aware of that responsibility	Lack of funds	Mectizan and Albendazole distributed for free during the 2015 campaign	C-P
West	Bafang	100	0.0	0.0	100
	Banganté	50.0	0.0	50.0	100
	Mifi	0.0	100	0.0	100
Northwest	Ndop	0.0	100	0.0	100
	Oku	0.0	100	0.0	100
	Njikwa	0.0	100	0.0	100
Southwest	Kumba	100	0.0	0.0	100
	Muyuka	0.0	100	0.0	100
	Tombel	100	0.0	0.0	100
	Mamfé	100	0.0	0.0	100
	Nkambé	0.0	0.0	100	100
Total		**35,7**	**50.0**	**14.3**	**100**

3.5.3. At the Health Area level

As far as Health Areas are concerned, the main reasons for the non-motivation of DCs by the community are:

- Ignorance of this responsibility by the local actors (in Manila, Bamena, Kumba Town, Kendem and Edibenjock);
- Lack of financial means (funds) in the Health Areas of Wouong, Bambalang, Mboh, Jikijem, Konda, Bafia and Muyuka;
- The fact that Mectizan and Albendazole are distributed for free in the Health Areas of Ndipta III and Kajifu.

Table 28: Reasons for the non-motivation of CDs by community members at the Health Area level

Region	**Health Area**	**Reasons for non motivation of CDs by community members**
West	Manila	Not aware of that responsibility
	Bamena	Not aware of that responsibility
	Ndipta III	*Mectizan and Albendazole are free*
	Wouong	Lack of funds
Northwest	Bambalang	Lack of funds
	Mboh	Lack of funds
	Jikijem	Lack of funds
	Oshié	Lack of funds
Sud-Ouest	Kumba Town	Not aware of that responsibility
	Bafia	Lack of funds
	Muyuka	Lack of funds
	Edibenjock	Not aware of that responsibility
	Kajifu	*Mectizan and Albendazole are free*
	Kendem	Not aware of that responsibility

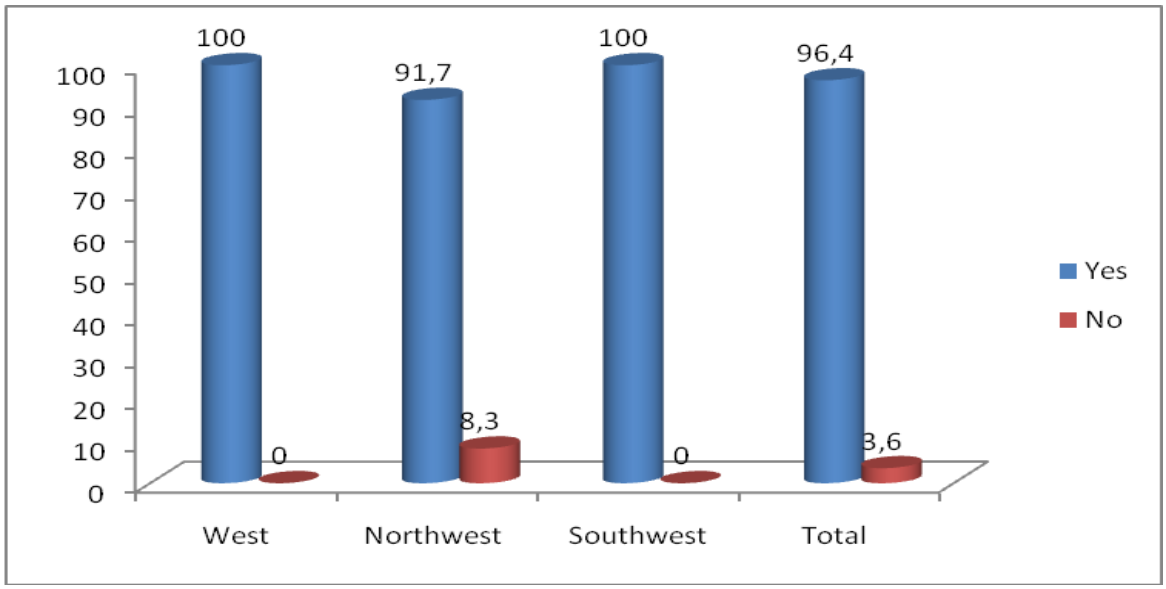
3.6. OPINIONS ON CDs MOTIVATION

The survey results show that communities give importance to the motivation of CDs. Indeed, overall, 96.4% of the surveyed community leaders said their respective community attaches importance to the motivation of DC.

3.6.1. At the Regional level

In the West and the Southwest Regions, all community leaders surveyed said their community attaches importance to the motivation of DCs., They represent 91.7% in the Northwest Region

Figure 14: Importance given to the motivation of CDs by the community per Region



3.6.2. At Health District level

Considering Health Districts, that of Njikwa is the only where community leaders surveyed said it is not important to motivate CDs. In all other Health Districts involved in this study, all surveyed community leaders felt that the motivation of CDs is of utmost importance.

Table29: Importance given to the motivation of CDs by the community at Health District level

Region	Health district	Yes	No	C-P
West	Bafang	100	0.0	100
	Banganté	100	0.0	100
	Mifi	100	0.0	100
Northwest	Ndop	100	0.0	100
	Kumbo East	100	0.0	100
	Bamenda	100	0.0	100
	Wum	100	0.0	100
	Oku	100	0.0	100
	Njikwa	0.0	100	100
Southwest	Bangem	100	0.0	100
	Kumba	100	0.0	100
	Muyuka	100	0.0	100
	Tombel	100	0.0	100
	Mamfé	100	0.0	100
	Nkambé	100	0.0	100
Total		**96.4**	**3.6**	**100**

3.6.3. At the Health Area level

Of all the Health Areas where community leaders were surveyed, Oshie is the only one where community members have diverging views on the importance of CD motivation. In all other relevant Health Areas, community leaders said it is important to motivate CDs. This is the example of community leaders of Tah (HD of Bangangté), Melong (HD of Dschang) or Ayukaba (HD Mamfe) which respectively state that:

> "It is better (to motivate CDs) because they walk a lot and suffer to help us"; "Cds do a good job. If a CD is motivated, he will work more "..." They should be encouraged because they do a lot of sacrifices. "

Table 30: Importance given to the motivation of CDs by the community per Health Area

Region	Health Area	Importance of CD motivation by the community
West	Manila	Yes
	Bafang-Chefferie	Yes
	Bamena	Yes
	Ndipta III	Yes
	Famla	Yes
	Kongso	Yes
	Wouong	Yes
Northwest	Bangolan	Yes
	Babungo	Yes
	Bambalang	Yes
	Tatum	Yes
	Jakiri IHC	Yes
	Mbokam	Yes
	Mulang	Yes
	Wum Urb	Yes
	Furu-Awa	Yes
	Mboh	Yes
	Jikijem	Yes
	Oshié	No
Southwest	Ekanjoh-Bajoh	Yes
	Big Bekondo	Yes
	Kumba Town	Yes
	Bafia	Yes
	Muyuka	Yes
	Edibenjock	Yes
	Kajifu	Yes
	Mamfe	Yes
	Kendem	Yes

3.7. REASONS FOR THE IMPORTANCE OF MOTIVATING CDS

The reasons given by those surveyed on the need to encourage CDs can be summarized in the words of this informant:

> "The reasons why the CDs are to be motivated are as follows: it is in order to encourage them to continue with the job. The motivation will encourage them (CDs) to better distribute the drugs in the community. In the past, the CDs distributed the drugs but they latter stopped the distribution of the drugs because they were not motivated by the relevant authorities. It is very tedious to distribute the drugs, to inform the people of the community about the drugs and to move from door to door to distribute the drug". (Community Leader, Mamfe/Mile One).

These reasons can be summarized in all spheres of implementation of the distribution program by the following:

- Painful work;
- Support or sacrifice made for the community;
- Highly time-consumming work;
- Abandonment of their own activities for the benefit of community work.

In sum, whether at the regional, Health District or Health Area level, 30.8% of informants felt that CDs do a hard job, 46.2% find they offer their time, while 23% claim that they do charity work on behalf of the community.

Table 31 Importance given to CDs motivation by the community per Region

Region	**Health District**	**Painful job**	Abandonment of their own activities	**Community assistance**	**Time consuming**	**Total**
West	57.1	28.6	14.3	0.0	100	
Southwest	0.0	0.0	50.0	50.0	100	
Ensemble	**30.8**	**15.4**	**30.8**	**23.1**	**100**	

Table 32: Importance given to CDs motivation by the community per Health district

Region	**Health District**	**Painful job**	Abandonment of their own activities	**Community assistance**	Time consuming	**Total**
West	Bafang	50.0	50.0	0.0	0.0	100
	Banganté	50.0	50.0	0.0	0.0	100
	Mifi	66.7	0.0	33.3	0.0	100
Southwest	Muyuka	0.0	0.0	50.0	50.0	100
	Tombel	0.0	0.0	100	0.0	100
	Mamfé	0.0	0.0	0.0	100	100
	Nkambé	0.0	0.0	50.0	50.0	100
Total		**30.8**	**15.4**	**30.8**	**23.1**	**100**

Table 33: Reasons for the importance given to the motivation of CDs by the community per Health Area

Region	**Health Area**	**Reasons for the importance given to CDs motivation by the community**
West	Manila	Abandonment of their own activities
	Bafang-Chefferie	Painful job
	Bamena	Painful job
	Ndipta III	Abandonment of their own activities
	Famla	Painful job
	Kongso	Painful job
	Wouong	Assistance to the community
Southwest	Bafia	Time consuming
	Muyuka	Assistance to the community
	Edibenjock	Assistance to the community
	Kajifu	Time consuming
	Mamfe	Assistance to the community
	Kendem	Time consuming

CHAPITRE IV

MAJOR FINDINGS FROM QUALITATIVE RESEARCH COMPONENT

4.1. ANALYSIS OF THE PERCEPTION OF MOTIVATION OF CDs THEMSELVES

Regarding the motivation of CDs, the study shows that CDs themselves have different opinions on the financial amount of motivation they expect for work done. Moreover age appears as an important factor because mature CDs (aged average 40 years and over) are less interested in motivation.

> *"People do not motivate us, and we have no problem with that because it's a job we accepted to do." (CD, Wouong 3, 12/25/15)*

However, younger CDs (aged 20 and above or less) pay special attention to the motivation to receive for the work done. This category of CDs tends to denounce the treatment they are subject to and often refuses to do the work according the standards set by the program.

> *"Lately for the second round of distribution, young people were not interested because of the motivation. Young people no longer want to participate. [...] "(Kouoptamo on 12/26/15).*

This may partially explain the shortcomings observed in the coverage of Mectizan and Albendazole distribution campaign of 2015.

4.2. COMMUNITY INITIATIVES FOR CDs MOTIVATION

Population initiatives for CDs motivation differ by Region. In Northwest and the Southwest Regions, the amounts were previously fixed in the community meetings. These amounts ranged from 50 CFA francs to 200 CFA francs and should not be bargained. However, in some communities of these Regions, this community measure turned into an obligation without which we had no access Mectizan and Albendazole to the point where some CDs abandonned the work if people refused to submit to this measure.

> "All those who used to distribute the drugs in the past stopped the distribution because, not all the members of the community gave the motivation. Some of the members of the community deliberately refused to pay the FRS200 FRS meant for Community distributors. "(Head Quarter / Mamfe / One Mile)

In contrast, in the West Region, support to the initiative or motivation of DCs was individual and voluntary.

> "Yes we sometimes motivated people. When we entered in their houses when the table was set or when food was ready, they shared it with us "(DC Kouoptamo)

4.3. APPRECIATION OF COMMUNITY DISTRIBUTORS WORK BY THE BENEFICIARIES

Empirical evidence reveals a differential assessment of nominated CDs for work. This assessment, positive or negative is determined by the age variable. Indeed, in the communities where the CD is of a mature age (Loumgouo; Wouong3), people are happy with the work of CDs.

> "I appreciate the CD to have raised awareness and visited into each compound to distribute mectizans" (Wouong 3, 12/25/15)

However, in the communities where the CDs were young, people were not really satisfied by with their work.

> "I think that CDs did not do their job because I am working in the health sector and this enables me to take medication for myself and the kids. I would not have received the mectizan if I was well informed " (Djeleng 5, 12/24/15)

Overall, misunderstanding about the amount of the DC motivation influences the perception of their work by people in some communities. For some individuals, the DC are merely traders because some of them ask for money before they give you drugs. Hence the frustration of the informant:

> "The CDs must stop ask asking 100F. Na them work that They choosam "(Farmer, Balondo Town / DC EkondoTiti, 12.30.2015).

4.4. MISUSE OF MECTIZAN

In the Kouoptamo DS, several respondents said the Mectizan is a powerful disinfectant for hair. Indeed, Mectizan serve to eliminate hair fleas. This is what an informant underlines:

"It is the remedy for lice. There are people who take but do not consume, they prefer to use it to kill lice "(Kouoptamo, 12/26/15)

This misuse is often maintained by the DC. Thus, a nurse from the village reported that:

"There are even distributors who fill the register and keep the Mectizans which they sale for us as remedies to kill lice "(Kouoptamo, 12/26/15)

In the same vein another informant believes that:

"Mectizan is great for the community; however, distributors should do distribution properly. Some prefer to sell it to women who use to kill lice on the head "(the Kouoptamo 12/26/15).

At the Ekondo Titi DS, particularly in the Balondo Town and Bekora Z10 communities, Mectizan is an ingredient of cosmetic products. In these Regions, Mectizan is used in body lotions to lightening filaria-attacked skins. In fact, they believe that swallowed Mectizan attacks filaria from inside and pushes the rest of it out of the body. They also believe that the filaria on the skin can be cleaned away following the application of a skin lotion containing Mectizan. A perfect testimony of a female informant goes:

"When I received it, I drink When you drink Mectizan, it treats the disease inside the body and as aresults, some filarias come out of the body, on your skin. Then you have to to wipe it with a mixture of Mectizan and body lotion. " (Balondo Town, 12/29/2015).

4.5. PROBLEMS LINKED TO THE DISTRIBUTION OF MECTIZAN AND ALBENDAZOLE

Several factors influenced the proper course of these drugs distribution campaign. These factors are among other agricultural activities, religious beliefs, conflicts between beneficiaries and CDs, conflicts between CDs and decision makers, fear of side effects and physical accessibility of villages.

- **Agro-economic actitivies and geographical distribution coverage of the drugs**

The daily activities of the people have often constituted an obstacle to the success of some programs. The Mestizan and Albendazole distribution campaign was no exception to this reality. In different Health Areas, the absence of people when CDs visited is often due to farm work in rural communities.
To solve this problem, some informants has suggested to make announcements in public services, markets and churches to inform people about the passage of drug distribution teams.

- **Religious pratices and consumption of drugs**

In some communities the drug distribution campaign coincided with the period of intense religious activity. Indeed in the Kouoptamo HD (Muslim community), the

Mectizan and Albendazole distribution campaign took place while people were in the Ramadan fasting period. That is why the controlled consumption strategy that was embedded in the programme could not be applied rigorously. This is highlighted by a CD who worked in this locality:

> "It was during the Ramadan fasting and that is why people used to take it for consumption at a later time. So it is not very sure that everyone effectively consumed it "(Kouoptamo, 12/26/15)

- **Conflict between Community distributors and local populations**

Some people who did not receive Mectizan believe that CD had deliberately excluded their households. CDs are also suspected of distributing by affinity "because they they choose the houses of their families" (Kouoptamo, 12/26/15)

> "We were aware of the Mectizan distribution campaign but the distributors did not come to our compound, exactly as they did beforeWe still wonder why we are excluded even during free distribution campaigns "(Djeleng 5, 12/24/15)

This situation has led some people to think that

"They should either train more new distributors since current one serve the households of their relatives,leave the drugs at the King's Palace where everyone can go and be served." (Kouoptamo, 12/26/15)

One of the points of conflict between the beneficiaries and CDs concerns the motivation of latter. In fact, some people believe that CDs are paid by the State and therefore should not receive motivation from the community.

For instance, in Bachuo Ntai, the villagers believe that distributors are paid by the Ministry of Public Health and because of that they have completely refused to give the 200 FRSFrs which is meant to motivate the distributors. Also, some of the villagers of Bachuo Ntai say, Mectizan and Albendazole are to be given free of charge, they say they used to receive drugs free of charge and can't understand why they now need to pay 200 Frs CFA per household.

- **Conflict between CDs and decision makers**

Many CDs believe that the distribution of Mectizan and Albendazole is similar to exploitation or discrimination orchestrated by the local decision-making actors. For the latter, the choice of CDs depends on the amount of money received for each program.

> "These people, when there is a paid campaign such as the distribution of mosquito nets, they choose their relatives to do the work because there is money. But when it's for free labor, they come and see us "(Kouoptamo, 12/26/15)

CDs also accused of bad faith those who supervise and manage the funds made available by the State of Cameroon for the purpose of the campaign:

"They say that the State gives nothing for us, yet we know that the State gives them money which they share" (Kouoptamo 12/26/15)

Broken promises:

"The person who recruited me assured me that I will be paid for the work done; I sought no holiday job based on that promise. Eventually, I received no payment; it is not encouraging at all. "(Kouoptamo on 12/26/15)

- **Geographical inaccessibility to concessions**

The geographical location of some villages hindered the mobility of CDs and limited access to some localities for the distribution of Mectizan. This is the case of Wouong3 in the West Region.

"Distributors have not come up to us here because we are at the nook of the village; we need Mectizan, too." (Wouong 3, 12/25/15)

- **Fear of side effects from Mectizan**

Fear of side effects on populations is also another bottleneck to the coverage of Mectizan distribution campaign. Through their experiences and representations, the opinions of populations diverge on whether or not to take Mectizan.

"When I had filaria I had huge pimples all over the body; that was the first time. Subsequently, I had no such pimples when I had filaria "(5 Djeleng the 24/12/15-West)

"I lost four of my family members as a result of taking Mectizan. For me, none of my relatives will ever take Mectizan in it when I am still alive. "

Some of the members of the community of Mile One (Mamfe) said: "Whenever the drugs are distributed to them, they collect the drugs from the distributors and do not drink because they fear their side effects."

- **Managing side effects**

Populations adopt several approaches for managing the side effects when they appear. Among these approaches, three have caught our attention:

Those who do not take any measures and prefer to be resigned themselves to doing nothing:

"I did nothing to manage it; it cured itself" (Djeleng 5, 24/12/15-West)

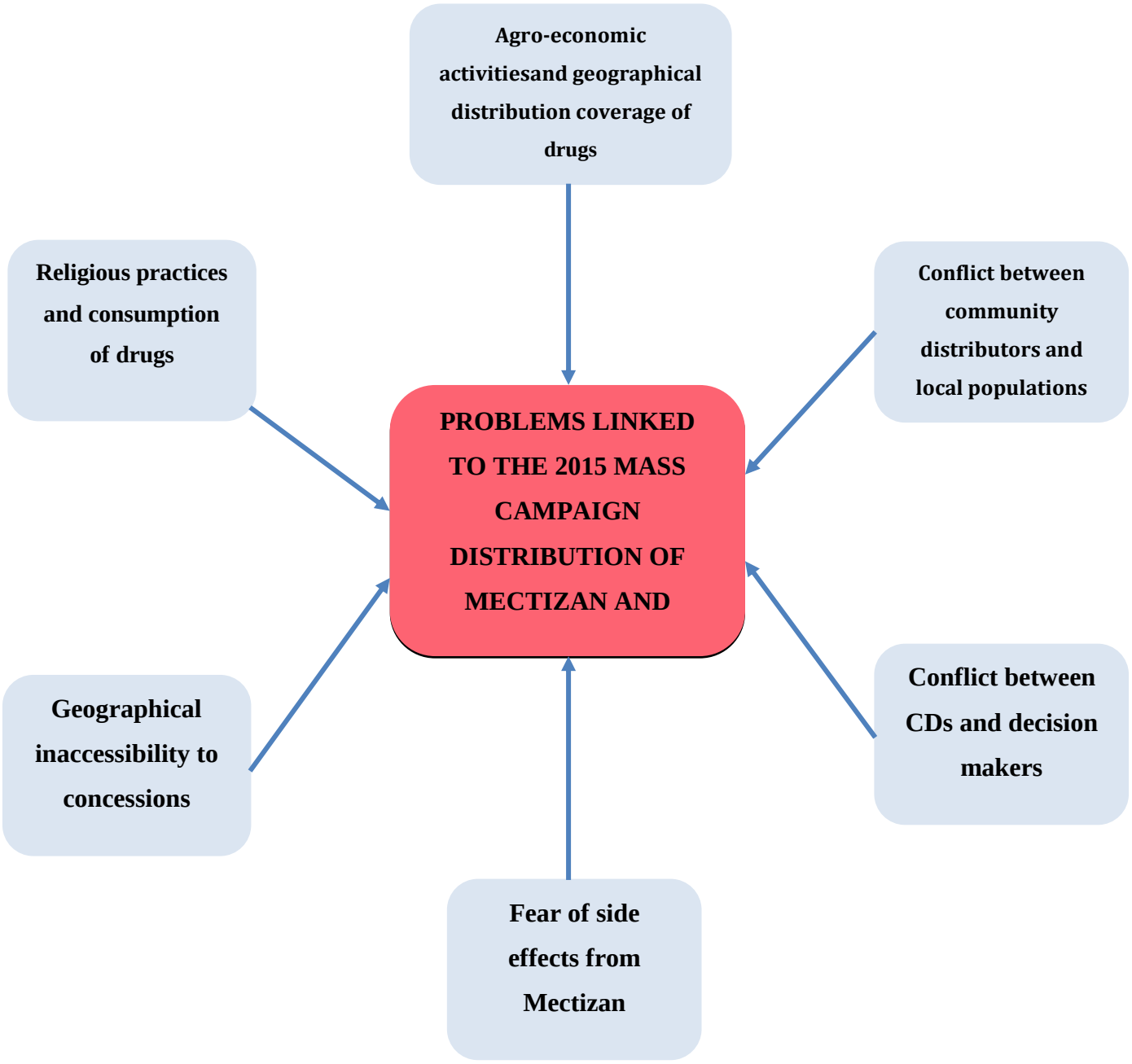
Those who return to the hospital:

I had a lot of pimples after taking the drugs. I went to the hospital paid for a treatment "(Wouong 3, 25/12/15-West)

Those who resort to traditional medicine:

> "When I take it, it gives me stomach ache. I often use traditional medicines to manage that side effect. I use them as painkillers "(Wouong 3, 25/12/15-West).

Problems associated to the 2015 mass distribution campaign of Mectizan and Albendazole



SUGGESTIONS FOR BARRIERS RELATED TO THE 2015 DISTRIBUTION CAMPAIGN AND MECTIZAN AND ALBENDAZOLE

In relation to many difficulties encountered by both the beneficiary populations that Community Distributors, some suggestions were made by them.

❖ Suggestions from Community Distributors

- ✓ Concerning the non-support of the population

"We must get tough on peopleas the subdivisionnal officer was for yellow fever vaccination campaign. People refused to be vaccinated and to have their children vaccinated. The subdivisionnal officer then said when classes resume, all children with no have the vaccination card would not be admitted in any school. If your child has no vaccination card, he won't be accepted in any school "(Loumgouo, 12/23/15)

- ✓ Concerning the motivation of CD

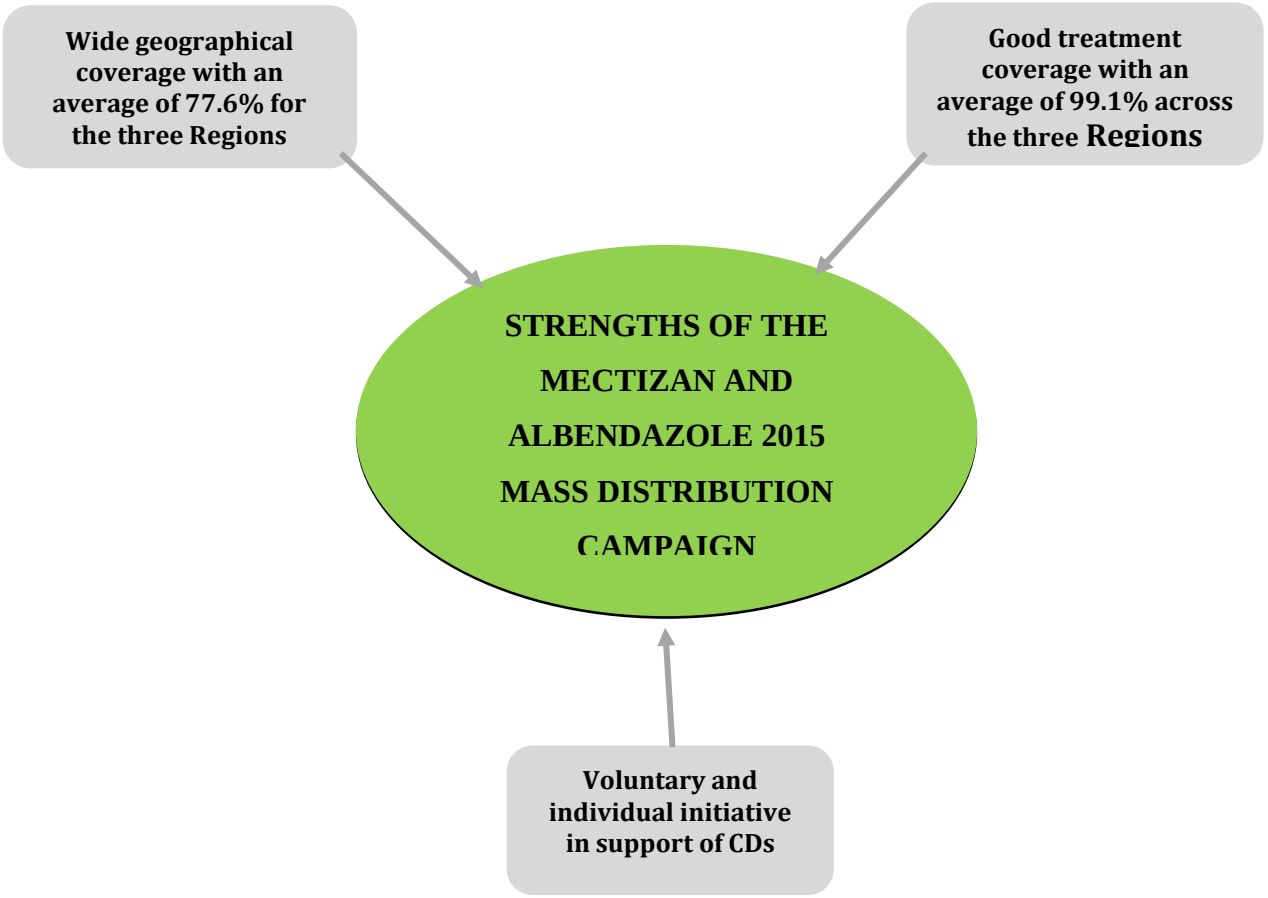
"For transport fairs, CDs can be given even 5,000 CFA francs per person Promises must be kept and, above all, must not be made when there is no certainty they will be kept. We came safe in the idea that there will be some sort of payment; in the end, we received nothing; quite disheartening "(Kouoptamo, 26/12/15-West)

❖ Suggestions from the populations (beneficiaries)

- ✓ Raise awareness and inform people about the days of visit for distribution;
- ✓ Set up a CDs control field mission during the distribution campaign;
- ✓ Give more responsibility to traditional authorities in the distribution of Mectizan and Albendazole;
- ✓ Increase the number of CDs in large Heath Districts;
- ✓ Institute the motivation of CDs by the population so the latter can support the campaign;
- ✓ Empower CDs with adequate action instruments to facilitate distribution;
- ✓ Increase communication / awareness about the possible side effects and their management;
- ✓ Provide information on prevention of different diseases targeted by the campaign;
- ✓ Strengthen the capacity of medical personnel with respect to the management of side effects that may arise from taking Mectizan and Albendazole.

STRENGTHS AND WEAKNESSES OF THE MECTIZAN AND ALBENDAZOLE 2015 MASS DISTRIBUTION CAMPAIGN

STRENGTHS



Overall, the survey notes a kin interest of populations in Mectizan and Albendazole endemic areas at risk. This is characterized by:

- ✓ Wide geographical coverage with an average of 77.6% for the three Regions, although it is regrettable that CDs do not use the appropriate protocol in distribution campaigns.
- ✓ Good treatment coverage with an average of 99.1% across the three Regions.
- ✓ Voluntary and individual initiative in support of CDs especially in the West Region. This motivation is generally in the form of kind donations which CDs appreciate, hence their strengthened dynamism on the field.

WEAKNESSES

- ✓ **Population awareness deficit**

Another weakness was the deficit in distribution-related awareness raising (non-consumption of the distributed products), many surveyed did not know what they took or even why they were taking. Such ignorance influenced the consumption of the product and also caused reluctance toward product-related investigations;

- ✓ **Communication deficit on the therapeutic use of Mectizan**

The survey showed that the Mectizan was used as a remedy against hair lice (pediculus hominis) in combination with cosmetic products to remove dead skin on the one hand, and then specifically to remove dark spots left on the skin after recovery from fileria

- ✓ **Lack / insufficiency of CDs in some areas**

The distribution has not been very effective because of the lack of distributors in some localities (case of Mamfe, Bafang, Manila).

- ✓ **Inadequate motivation of CDs**

The distribution of premiums provided by the program is considered insignificant by the DCs compared to the workload. Difficult physical accessibility of some villages coupled with the lack of means of transportation (bicycle, motorcycle) constitute an obstacle to the mobility of CDs.

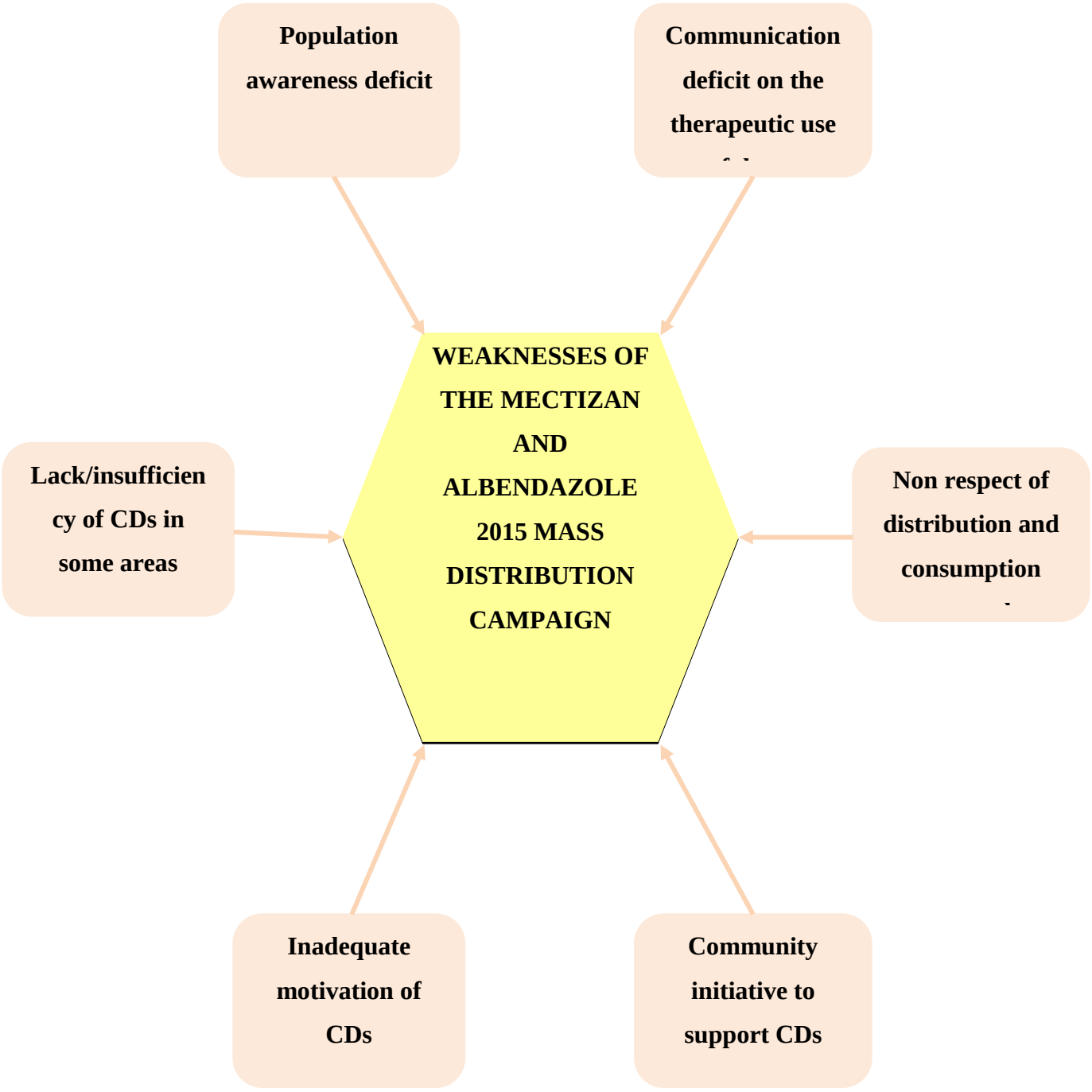
- ✓ **Community Initiative to support CDs**

Community support to the CDs initiative was a weakness in parts of the Northwest and the Southwest Regions since its misinterpretation on the part of both CDs and beneficiaries was a real handicap for the coverage of the distribution campaign. Thus, the beneficiaries are reluctant to motivate CDs because they think they are sufficiently paid by the government (Ministry of Public Health).

- ✓ **Non respect du protocole de distribution et de consommation**

Distribution was a failure at the level of ensuring whether or not they took the drugs immediately. People receive the drugs, but do not necessary swallow it in the presence of the CD. In addition, household members were not registered in the distribution register. In many cases and in all the tree Regions, drugs were distributed in the markets, road sites, schools (especially for children) and during public and cultural events.

Weaknesses of the Mectizan and Albendazole 2015 mass distribution campaign



CONCLUSION
IDENTIFIED PROBLEMS, CAUSES AND SUGGESTIONS

Problem n° 1	Causes	Regions	Suggestions
No coding of households in the villages visited / no visibility of code marks	Instructions from the formation of DC asking them not to write the numbers on the door of the concession visited.	West	Undertake a codification of all households that received the drugs for a better monitoring.
	Superposition of the numbers on the doors of concessions that benefited other health campaigns (polio, yellow fever ...).	South West	Ask CDs to codify all households that received the drugs and report the number in the registry book for an easy follow up. Use a permanent marker for marking and writing the household number at an appropriate place in consultation with the head of household. Notify the beneficiaries not to wipe or erase the code of their household for the monitoring of their health needs.

Problem n° 2	Causes	Regions	Suggestions
Not systematization of the households registration in the registers provided for this purpose	Non-compliance with the Distribution Protocol either by negligence or due to demotivation[1]	North-west, South-west and West	Training of CDs on techniques and standard of beneficiaries' registration Strengthening the motivation of CDs

Problem n° 3	Causes	Regions	Suggestions
Insufficient motivation of the CD	Workload is not proportional to the received financial motivation[2]	North-West South-West West	Propose a substantial motivation or apply the policy of cost

[1] *For example, a CD from West Region said: "If you arrive at a crossroads and found interested people, you also gave them the drugs". Another CD added that " they ask us to give the drugs to everybody that we meet since it is a matter of health"*

2 *Many community Distributors (CDDs) have resigned from distributing Mectizan and Albendazole because, they are not motivated by members of the community and by the Health Centers. Example: in the past in Bachuo Ntai there were 09 community Distributors (CDDs) but now there are just 4 CDDs. They have all resigned because they were not motivated by the Health Centers.*

Problem n° 4	Causes	Regions	Suggestions
Absence of people in their households during CDs visits.	Awareness deficit, low enthusiasm for membership campaigns, professional occupations in town and farm work in rural areas	North-West South-West West	Awareness campaigns for populations on the benefits of drugs on their health; Distribution of drugs can be program on public holidays and on Sundays.

Problem n° 5	Causes	Regions	Suggestions
Non-compliance of protocol distribution of Mectizan: *Drugs not swallowed in the presence of CD;* *Members of the community complained of the fact that: people's ages and heights are not taken into consideration before the drugs are being given to them.* -	Negligence of CD : Lack of monitoring of CDs during the exercise of their duties	North-West South-West West	Training of CDs Establish a monitoring system / field supervision of CDs during distribution campaigns

Problem 6	Causes	Regions	Suggestions
Misuse of Mectizan by beneficiaries	Mectizan is prized in the fight against lice[3]	West and particularly in the Noun	Raise awareness of the population on the specificity of this medicine and on the side effects after usage if not not indicated. Public awareness on the proper use of medicines
	Mectizan is used as a cosmetic product on the skin to clean the stains (blackspots) left by wired	South west	

Problem 7	Causes	Regions	Suggestions
Non exhaustive geographical coverage of the population with the drugs	lack of information on the distribution campaigns	North-West South-West West	Use outreach strategy based on community volunteers through the door to door, the media (community radio, TV, NTIC), megaphones, criers and public ceremonies (funerals, weddings, funerals, markets, churches and mosques)
	Physical difficulties of access to concessions[4]	Remote villages of the three regions	Equipping DCs with appropriate outreaching means (motorcycles, bicycles)

[3] *"There were some distributors who filled the registers and kept the Mectizan for sale like a remedy to kill lies"*

[4] "DCs do not come here because we are at the end of the village background, we also need Mectizan" (Wouong 3)

Problem n° 8	Causes	Regions	Suggestions
Resistance from the population on the distribution of drugs	Sociocultural perceptions on drugs and in particular because they are giving for free	North-West South-West West	Awareness campaigns for populations on the benefits of the drugs and the reasons for free

Problem n°9	Causes	Regions	Suggestions
Reluctance of people to join the program against Filarial and intestinal worms	Lack of information on potential side effects of drugs	North-West South-West West	Education of people on the side effects and on how to manage them.

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ANNEXES

DATA COLLECTION TOOLS

1. MDA post coverage survey questionnaire
2. Village information (CDI Ownership)
3. Interview guide for community members
4. Interview guide for community distributors

REPUBLIC OF CAMEROON

******MINISTRY OF PUBLIC HEALTH******

MDA POST COVERAGE SURVEY QUESTIONNAIRE

District name:		District ID n°:		Village name:		Village ID n°:	
Name of household Head:		Household n°:		Interviewer name:		Date of interview:	
ID n°	Name	Age (years)	Sex 1=M 2=F	Received the drugs in recent MDA round (show tablets)? 1= Mectizan 2= Albendazole 3= None	Swallowed the drugs ? 1= Yes 2= No	Reason if not taken*	Person responding? 1= Themselves 2=Someone on their behalf as absent 3= Someone on their behalf as under age
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							

Reason for not taken drug: 1= Absent, 2=Did not hear about campaign, 3= Drug distributor did not come, 4=Pregnant, 5= Breastfeeding, 6= Underage or too old, 7= Fear of side effects, 8= Person healthy, 9= Medicine does not work, 10= Tired of taking drugs , 11= Other (specify)

NB.: Please note down any other relevant information or comments from the respondents.

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Village information (CDI Ownership)

I- GENERAL INFORMATION

Health District :_____ Health Area :_____
Village :_____Population of village :_____
Name of village leader :_____ Phone number……..

II- CDI ownership

1	Have you organize a community meeting on the Mectizan and Albendazole distribution?	|_|	1 = Yes 2 = No
2	If No why ?	|_|	1 = Not aware of the responsability 2 = No funds 3= other (pleasespecify) _____ _____
3	Did your community motivate the CDDs?	|_|	1 = Yes 2 = No
4	If Yes, How	|_|	1= Money 2= Kind
	If No, Why	|_|	1 = Not aware of the responsability 2 = No funds 3= other (pleasespecify) _____ _____
5	Do you think that it is important to encourage the CDD?	|_|	1 = Yes 2 = No

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INTERVIEW GUIDE FOR COMMUNITY MEMBERS

Health District: _____
Village: _____
Informant name (not compulsory)_____ _____
Occupation: _____ _____

- During distribution campaign, are drugs given to you free of charge or not?
    - If Yes, indicate the price of Mectizan?
    - If Yes, indicate the price of Abendazole
- Who sold the drug(s) to you?
- What are your perceptions on free distribution of Mectizan and Abendazole?
- What are your suggestions for a better coverage of Mectizan and Abendazole mass distribution campaign?

INTERVIEW GUIDE FOR COMMUNITY DISTRIBUTORS

Health District: _____
Village: _____
Informant name (not compulsory)_____ _____
Occupation: _____ _____

- Why do you become a community distributor?
- What are the problems faced during mass distribution of drugs?
- What do you suggest for a better coverage of Mectizan and Abendazole mass distribution campaign?