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Original Research Article

The Approach of Community-Directed Treatment with Ivermectin in the Participation of Communities in the Fight against Onchocerciasis: The Resignation of Community Distributors

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Abstract: ***Objective:*** The aim of this article is to analyze the factors behind the resignation of Community Distributors. ***Methodology***: The qualitative method was used to collect data through individual interviews and focus groups in the health districts of Kouoptamo, Foumbot and Massangam in the West region of Cameroon. Between 2020 and 2022, these interviews were conducted with Beneficiaries, Community Distributors, managers of district health services and health facilities, and also town hall managers. The data collected was analyzed using the content analysis technique and interpreted using Michel Crozier's Systemic Analysis. ***Results***: The methodological procedures used led to a number of results, including the low or non-existent coverage of CDs, the choice of CDs, the lack of community ownership, the discrepancy between actual and official data, and the diversion and sale of medicines, the main consequence of which is the misuse of Mectizan. Furthermore, faced with a lack of support, community distributors are showing a lack of interest in distributing this product and are resigning. To alleviate this problem, health professionals are trying to replace them with health auxiliaries, nurses and trainees, who unfortunately have no knowledge of their area of activity. ***Conclusion***: As the Community Distributor is the key to Ivermectin Treatment under the Community Directive, it is important to review its status on the scale of actors and to consider strategies for its funding in order to revitalize the CDTI strategy for the elimination of onchocerciasis.

Keywords: CDTI; Community distributor; Resignation; Participation, empowerment.

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INTRODUCTION

Since 1998, Community-Directed Treatment with Ivermectin (CDTI) has been implemented as part of the fight against onchocerciasis, and is considered to be a better approach given the results it has achieved. Cameroon's current Health Sector Strategy (2016-2027) reveals that, since 2014, it is thanks to this approach that the therapeutic coverage rate has reached 79.84% and the geographical coverage rate 98.98%. This approach owes its success to the Community Distributors (CDs).

In 1998, onchocerciasis was recognised as a priority health problem by the Ministry of Public Health. This led to the creation of a National Onchocerciasis Control Program. But long before this program was set up, control strategies and activities had already begun in endemic areas of the country. In 1987, the Minister of

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Public Health launched mass treatment in the North, particularly in the Vina valley, as part of phase 4 studies on ivermectin by ORSTOM research teams; between 1988 and 1993, the pilot project for the distribution of Mectizan in the South-West at Koumba by the team from the Institute of Medical Plant Research (IMPM); The project to distribute Mectizan in Ndja and Lobo between 1991 and 1992 by the NGO International Eye Foundation (IEF); The pilot project to distribute Mectizan in Monatélé, in the central region, by Helen Keller International (HKI) in 1994; The community-based treatment strategy campaigns in 1995 with the support of Sight First and development NGOs.

In addition to these mass distribution strategies applied in the field by NGOs to ensure mass distribution coverage, the Cameroon government has signed several agreements enabling it to control or envisage the elimination of the disease throughout the country. The most significant of these were: the signing in 1995 of the agreement between Cameroon's Ministry of Health and the Lions Club International Foundation (LCIF); in September 1996, a memorandum of understanding was signed with the African Program for Onchocerciasis Control (APOC); in 2006, through the Yaoundé Declaration on Onchocerciasis Control in Africa, Cameroon, together with other countries, partners and NGOs, undertook to step up the fight to eliminate onchocerciasis as a public health problem. This latest agreement with APOC in 1996 will enable Cameroon to benefit from the CDTI strategy, launched in 1998 by APOC with the support of its partners. This strategy is now the main onchocerciasis control strategy used in Cameroon. (Plan stratégique APOC 2013-2017).

In 1987, drug manufacturers Merck and Co. pledged to provide an unlimited supply of Ivermectin free of charge to all people at risk of contracting onchocerciasis for as long as necessary. With supplies of the drug assured, the challenge for onchocerciasis control program was to find a way of bringing the treatment to those who needed it, and to ensure that the treatment was maintained for a sufficiently long period to achieve total control of the disease. This led to the introduction of the CDTI approach, whereby the people in the affected communities would undertake and manage their own treatment. This approach gave rise to the concept of the Community Distributor. The latter will therefore be a member of the community who has a certain number of moral and intellectual characteristics that enable him or her to assess and distribute Ivermectin to his or her peers in compliance with precise treatment instructions (height, weight, age and state of health, etc.). For the Ivermectin distribution system to work well, a few basic conditions had to be met: the system had to be cheap; the system had to be usable in some of the most difficult, remote, war-torn regions of Africa, many of which were far from urban health centers; the system had to be sustainable to interrupt parasite transmission; Ivermectin had to be administered once a year for 16-18 years to all eligible populations.

To ensure that all these conditions were met, the solution was Community-Directed Treatment with Ivermectin (CDTI), in which communities living in affected areas are encouraged to undertake and manage their own treatment. This strategy has taken community involvement in public health to a level that no other program has done before. The following table shows chronologically the sequence of events relating to the implementation of CDTI (WHO 2018).

Table: History of Community-Directed Treatment with Ivermectin (CDTI)

Years	Actions
1988	The OCP uses mobile teams of health workers to distribute ivermectin. There is very little community involvement, and costs to the health system are high.
1995	Experts from WHO, the World Bank and the UNICEF/UNDP/World Bank/WHO Special Program for Research and Training in Tropical Diseases (TDR) are recruiting a team of African scientists to find a more viable and cost-effective method of treating Ivermectin.
1996	The results of a multi-country study show that Community-Directed Treatment with Ivermectin (CDIT) is a feasible, effective and viable approach.
1997	APOC officially adopts the CDTI strategy, which proves to be a huge success.
1998	Launch of CDTI in Cameroon with the support of APOC and partners

Source: Taken from WHO (2018) and DLM/MSP (2012-2016), synthesisze by the authors

In its application, this strategy emphasizes the contribution of the community through the mobilization of so-called DC community players to contribute to the health of their peers. Thanks to these community players, mass drug treatment campaigns have reached the most inaccessible geographical areas. These actors have made it possible to achieve the highest percentages of therapeutic coverage in the history of chemotherapy campaigns for the prevention and elimination of onchocerciasis. However, according to sources and empirical observations, in recent years we have increasingly seen the resignation of these key players in Community-Directed Ivermectin Treatment. This abandonment by CDs is giving rise to factors which are now becoming obstacles to achieving the objective of eliminating onchocerciasis as set out in the CDTI strategy. The aim of this article is therefore to analyze the factors that explain the resignation of CDs and its impact on the achievement of the objective of eliminating onchocerciasis.

METHODOLOGY

This article falls within the field of Medical Anthropology and the qualitative method was used to collect primary data through individual interview techniques and focus groups carried out in the Department of Noun in West Cameroon. Between 2020 and 2022, these interviews were conducted with beneficiaries, community distributors, district health service and health facility managers, members of dialogue structures (COSA, COSADI) and also managers of the Decentralized Territorial Collectivities (DTC). Secondary data were collected through documentary research. The data for this article were collected mainly as part of a research project entitled "Persistence of Neglected Tropical Diseases and Cultural Diseases in Cameroon: the case of onchocerciasis among the Bamoun, West Cameroon Region", conducted as part of a PhD in Medical Anthropology at the University of Yaoundé 1 in Cameroon. Participation in several other research activities on the same issue led to the triangulation of data on the resignation of community distributors from the strategy of Ivermectin Treatment under Community Directives, with the immediate consequence of the persistence of Onchocerciasis in these endemic areas. The data collected was analyzed by using the content analysis technique. The interpretation was based on Michel Crozier's Systemic Analysis (1977). This theory accurately reflects the situation of the CDs and shows how their strategies, in pursuit of satisfaction, can undermine the operation of the CDTI. The discredit caused by the CDs' actions in solving individual problems thus becomes an obstacle to the elimination of onchocerciasis, which is the objective of the system and the approach implemented.

RESULTS

Support for Community Distributors

The assumption of responsibility by the Community Distributor is the factor behind their resignation and the lapse of the CDIT. It is also leading to a slowdown or stagnation in the elimination of onchocerciasis and related diseases. These key players in the strategy are resigning for lack of support. As they themselves put it, *"I left the distribution because, even though it's a voluntary activity, we still had to be aware that there are people who go out of their way to do this distribution, and with this outlay comes the risk. There's the fact that you're leaving your family to go and do voluntary work, which shouldn't mean that it's free. When you're volunteering somewhere, you have to have the minimum. That's what discouraged us from saying no. Because sometimes we're called upon to do something for free. Because sometimes we have to walk long distances, talking to people to get them to take the Mectizan. It's not a discussion that often takes place on a head table. It's a discussion where you have to convince someone. So, you put your heart and soul into it, but in the end, you're told that the people who have distributed the money will have to wait 6 months. In the end, the money stops coming. They say so-and-so ate it. So, we found it better to throw in the towel*". (Interview conducted on 15 May 2022 with a former CD at Fosset).

Management is also at the root of several other factors associated with the poor implementation of the onchocerciasis elimination strategy. These include the sale and misuse of ivermectin, the gap between official and actual data, and community commitment to the fight against onchocerciasis. One community leader underlined this state of affairs. He said, "Before, the distribution agents used to come here. I don't know what happened. Others even said they were given Mectizan. They didn't distribute. They preferred to sell. Others blocked medicines in their homes. People asked if they could take the box, if they could sell it, maybe to solve their problems, we don't know, but we need the medicine. (Interview conducted on 17 May 2022 with the village chief in Fosset DS of Foumbot). The management of CDDs leads to behaviors that are obstacles not only to the elimination of Onchocerciasis, but also to other program to combat Neglected Tropical Diseases (NTDs) that use these actors. If we look at the history of this problem of management over time, we can divide it into several periods.

Dynamics of the takeover of Community Distributors

The management of CDD can be situated in a chronological dynamic. It has therefore evolved along a decreasing curve over time. According to the people we met in the various localities, care for CDDs has deteriorated over time and continues to do so. Today, the only thing they talk about is motivation. "At present, remuneration is not what it used to be. Now it's just an incentive. Because before, the CDDs collected a hundred francs, they had a lot of money back then. Let's just say that every medal has its downside. The big problem at the time was that parents didn't pay for their children". (Interview conducted on 17/04/20 at Fosset DS on Foumbot).

According to this informant, CDD management strategies led community members to contribute financially to the purchase of Mectizan. This participation not only motivates the commitment of distributors but also ensures good therapeutic coverage. Then the strategy changed and it was the program that paid for the CDD. A certain percentage was set per person treated, depending on the year. DCs therefore had to wait for their remuneration once the reports had been evaluated and the funds were available. Later, this remuneration was cancelled altogether. The account of a health facility manager retraces the history of how the payment system evolved until it was cancelled altogether.

We pay the CDDs, perhaps at 15%, 15f or 20f per person treated after the census, that's what was said. Things used to work very well. But at a certain point, we felt that the money wasn't coming in as soon, sometimes

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we say it comes in boxes, and managing the boxes isn't always easy. Now an English-speaking organization X has taken over this community distribution. They said they couldn't bring Mectizan to people in need in a community and pay people to distribute it. Maybe they'll take care of transport to the communities, train the CDDs and give it to them. His policy was to multiply the number of CDDs in the community to the point where there was one CDD per family. That's what we've started to do, and it's not at all easy because recruiting CDDs in such large numbers, when they want to be trained a lot there, it's not everyone who comes to work. They come for training, we give them the money and they leave. As soon as the medicines arrive, you have to beg them. Others even take it and keep it at home" (Interview conducted on 16/04/20 in Fosset, Western Region).

We can understand from this account that the management of boxes dedicated to taking charge of distributors has always encountered difficulties until they were completely cancelled today. The strategy for cancelling payment for CDDs is to multiply the number of CDDs at community and family level. This strategy has also encountered difficulties and even seems to have exacerbated the problem of controlling stocks of tablets and their presence on the market and in communities. This has encouraged the misuse of Mectizan in communities. The lack of uptake is therefore linked to the performance of distributors and their ability to cover all the geographical and demographic areas within their sphere of coverage.

Free Ivermectin policy and support for Community Distributors

The problem of covering the costs of community distributors is a real bottleneck to achieving the objectives of eliminating onchocerciasis. According to informants at institutional level, there is no support or bonus for distributors. There is currently no budget line for the implementation of the free Ivermectin policy. Apart from the allowances received during training activities, which only cover transport costs, nothing has been set aside for the CD. According to those in charge of the program, the CDs are paid for under the CDTI. This implies that they are working for their community and therefore do not need to be supported or paid. *"There is no bonus! Distributors work within the framework of CDTI, which implies that it's community work. So, there's nothing for the distributor. The only thing they get is transport, which is often given to them during training. There's no official amount. The amount of these transport allowances often depends on the number of distributors and the fee we get for managing the distributors for the whole Region. And then we divide it up according to the budget allocated to us by the partner to train the distributors. Since the distributor is trained in his community to work in his community, where does he go next?* » (Interview conducted on 07/06/20 in Bafoussam with a program manager).

It is easy to see that there is a gap between the reality on the ground and the official information on what needs to be done on the ground. It can also be said in the light of the empirical data that there is a mismatch between the information given by the institutional players and the reality on the ground as regards the places where CDs are trained and their community of origin. What attracts attention is the undefined nature of the amount received or to be received for the CDs' training expenses. This amount of training allowances may vary. But it does not take into account the realities experienced by the distributors. In the community of Massangam, for example, CDs travel to training sessions at double or even triple the amount they are paid for transport.

The policy of providing Ivermectin free of charge is thus opposed to that of free distribution. Indeed, when the pharmaceutical group Merck and Co. Inc. undertook in 1987 to provide free Ivermectin, which is effective against the microfilariae of onchocerciasis, the African Program for Onchocerciasis Control (APOC), in its policy of eliminating the disease, set up the strategy of Treatment with Ivermectin under Community Directive, with the main players being members of the community known as Community Distributors. As we saw when presenting the chronology of this strategy, these Distributors were given a kind of motivation which has diminished over time to the point where it is now non-existent. Faced with free distribution, these distributors are giving up day by day, and the fight against the disease is stagnating. In addition, the members of the beneficiary communities are called upon to participate, both by adhering to the taking of medicines, and by taking charge of the CDD.

Community participation in the management of Community Distributors

In the community participation strategy, local people are called upon to support the activities by helping to take charge of or motivate the CDDs. In reality, they are asked to motivate the distributors when the latter come to distribute to households. The empirical data show the opposite to be true. In Fosset, Kouoptamo and Massangam, people seem to be unaware of their role. The distributors questioned on this subject maintain that they receive nothing from the population. A health worker in the Kouoptamo health area explained that he was not aware of any CDD support from the community. *"I know that when the money goes out it's to the health center. I don't know if there's anything coming from elsewhere. I'm sure it was planned. They're aware of it but they don't do it, because often they're the ones we call first, we work with them before working with the DCs. But since then, I don't know if they're taking part, I can't guess".* (Interview conducted on 21/04/20 in Kouoptamo).

According to this health worker, people are aware that they have to motivate the distributors when they visit. However, they do not do so and the reasons

are linked to poverty, but much more to the perception of the distributors' work and above all to the fact that these people think and maintain that the Mectizan distributed is a gift from the government that should be given free of charge. In fact, as the CDDs state with regard to the community's contribution, during community meetings people agree to help pay for the distributors. However, they do not do so when the distributors turn up to administer the treatments in the households. *"They often say that at the end of the distribution we're going to pay, but when we finish, they don't give us anything. Once they came to hold a meeting at the chiefdom, and they asked the local people to say what they could give to satisfy the distributors so that they wouldn't think they were working for nothing. They talked like that and the people agreed. But they didn't respect that. They didn't do anything. So, we're distributing for nothing, just like that. Since we're not doctors or nurses, we're just people from the village who we've taken on and trained to distribute just like that".* (FGD conducted on 17/04/20 in Fosset*).* The distributors therefore complain about distributing without receiving anything from the population as motivation. Reading these comments, we understand a lack of consideration for the CDD by his community. They seem to be neglecting their role because they are *"just local people"* with no real training, recruited by the health center just for distribution. Other community members went so far as to say that the CDDs, when recruited by the health center, should be taken on by the center to carry out the distribution task.

Sources of funding for the Community Distributor

For community members, health staff and auxiliaries are agents of the State. Consequently, they are the responsibility of the state or the health facilities that employ them. In fact, this last argument came up several times during the interviews in the various study sites, if we are to go by these statements: *"Do we have the means? The hospital sends them to give us the medicine and they say it's free. It already pays them because the government owns the hospital, so it pays everyone who works there. So, I don't know what else I'm going to give the distributor because he works at the hospital*." (Interview conducted on 05/04/20 in Massangam). These comments illustrate the realities of the profile of distributors. Faced with the massive resignation of distributors, distribution is carried out either by health workers or by people attached to the health facility. They are no longer people from the community, as prescribed by the CDTI strategy. As a result, local people feel that they do not have the means to contribute to the cost of these distributors, who, for them, are paid for by their employer, the state.

Local people feel that it is not their responsibility to motivate distributors. Given that health facilities belong to the State, these distributors work in collaboration with health professionals and should also be supported by these employers. As a result, the public do not feel that they are being motivated by the distributors. This is why no action is taken by the community. A head of a health center said that the communities do not have the mentality to support health initiatives, even though they benefit them. He said, *"In my opinion, they don't do anything to support the CDDs. They think that CDDs are paid to do this work. Nothing can take them away from that. But what I've seen in this Bamoun community, elsewhere you could do it but they don't. There's no one willing to do it. There's no one who wants to take the lead, people are busy in the fields".* (Interview conducted on 17/04/20 in Fosset).

Motivating CDDs and implementing mass distribution campaigns

Motivating CDDs remains a crucial problem in the implementation of distribution campaigns. Given the unavailability of human resources, members of the beneficiary communities are involved. But as we can see, they do not really contribute to the care of the CDDs. Apart from a few socio-cultural privileges linked to the position of health auxiliary that health facilities can offer to encourage them. Incidentally, the question of motivation has grown since the early years, until it has been completely negated, as one former distributor pointed out. *"The care is no longer good. Before, when I went out with Mr X, we benefited from transport costs and the perdiem; because before, a community distributor received 25 francs cfa per person counted taking Mectizan. From 98-2000 it was 30 francs; from 2000-2004 it was 30 francs; from 2004 to 2010 it was down to 25 francs; it was around the beginning of 2011 that distribution became free. You work, you work and, in the end, you get nothing; they tell you there's no money yet, just wait and see, and in the end, it never arrives".* (Interview conducted on 05/04/20 in Massangam). It is important to understand that the CDDs were responsible for the distribution of medicines. They were paid in proportion to the number of people treated. Over the years, distribution has become totally free of charge for DCs, and sometimes, when they are able to collect a penny, the funds made available do not always reach them. This has an impact on the implementation of mass distribution activities.

In short, there is no real support for community distributors in the communities of Kouoptamo, Fosset and Massangam. The only time they really receive an allowance is during training. The idea of motivation or taking charge is a distant one, and the CDDs only talk about it in terms of memories. *"Even when we started this distribution, we only got paid once. For the rest we only give the money for the training day, 2000 fcfa."* (FGD conducted on 20/04/20 in Kouoptamo). Apart from the training allowances received, the motivations for distribution are often unfulfilled promises. For the distributors, the only motivation they are given is to encourage them to do the work, which then fails to materialize. This lack of motivation not only has an

impact on their performance in the distribution field, but is also a factor in their resignation.

Performance of Community Distributors in carrying out their activities

Taking charge of community distributors has an impact on performance and on the quality of distribution work in the field. It has an impact at every level, from drug management to data management. The quality of coverage reports, and even their reliability, depends on how well distributors take charge of their work. Motivation, as the people we met used to call the CDD gain after the distribution activity, fails to motivate distributors to render reports efficiently and in accordance with reality. The way in which the CDDs are looked after therefore has an impact on their performance and their assiduity with regard to distribution, which is the culmination of the fight against onchocerciasis or the persistence of onchocerciasis. *"The CDD don't mark as well as they used to. It's rare. They prefer to share like this. They go to the distribution centers. But it's not easy to see a marking of the year as they used to mark PNLO2018. They find it wastes their time"*. (Interview conducted on 16/04/20 in Fosset).

Without motivation, marking activities, which are favorable for assessing the quality of geographical and therapeutic coverage, are no longer applied. This certainly raises the problem of the verifiability and reliability of the coverage data transmitted by these distributors at the end of the campaign. We get the impression that the geographical and even therapeutic coverage data for the Fosset Kouoptamo and Massangam localities do not reflect reality. It seems that these data are just put together to satisfy the program, but the reality shows the opposite. According to informants, the minimum motivation provided for the DCs to encourage them generally does not reach their destination. Faced with this other reality, which affects the motivation of Ivermectin distributors, the health center managers are proposing a different approach to remuneration. *"Now the CDDs would like, and I share this idea with them, to be given the minimum provided by Orange Money (means of payment via mobile phones), because when it takes an administrative circuit, it doesn't come as it should. Since we started paying by Orange Money, they've been satisfied. They would now like us to use Orange Money for all types of activity"*. (Interview conducted on 20/04/20 in Kouoptamo).

For better performance and more assiduity in the geographical and even therapeutic coverage activity, the CDDs propose to receive their motivation by mobile payment; in other words, they receive their motivation directly in their mobile phones from the program or organization in charge of managing the coverage campaigns. This is because of their experience of the hassles observed when payments for this incentive have to pass through several departments and generally end up not arriving because of embezzlement and background distraction.

Financial malpractice surrounding the management of Community distributors

The misappropriation of funds earmarked for distributors was mentioned several times by informants and in all the study sites. In fact, it is to get round this misappropriation that some Community Health Workers (CHWs), who now often work as CDDs, request payment by mobile payment for the distribution of Mectizan, as is the case with other programmes with which they are associated. One CDD told us that he had signed discharges for much more than he had received. In one story after another, several distributors pointed out irregularities in their payments. In the community of Massangam, for example, control activities are more intense because of the existence of sources of contamination. According to the CDDs, financial malpractice in the management of CDDs is a real obstacle to the elimination of onchocerciasis. In other words, this could be considered to be one of the main factors explaining the persistence of onchocerciasis in endemic areas. This situation is described in the following life story:

"In 2013, I had some problems here. The Head of the Health Office (CBS) and the head of the health center in one of the study localities had collected money from the Community Distributors and they shared it out without giving it to the beneficiaries. I'm still on duty. Doctor X asked me if I had received my perdiem, amounting to 13,650 francs cfa (thirteen thousand six hundred and fifty), which I had been receiving for a fortnight. I said no. The CBS called me into his office, not about the oncho, but about the EPI vaccination report, as I'm the hospital's EPI manager. Inadvertently, I saw some registers with the words 'justifs oncho' on them. I kept my cool and took advantage of a minute's absence because he'd been called by the doctor to leaf through the register. I saw my name with the money already signed, even though I hadn't had any. Someone had already signed in my place and the number on the identity card wasn't the number of the new card I'd used for the campaign. They went and found the old Mectizan registers and transferred the names of the CDDs with the old identity card numbers. So, when I'd finished with him, I went to complain to the doctor that I'd actually seen my name on the list of justifications, even though someone had already signed for me to collect my thirteen thousand six hundred and fifty francs. And I saw a signature that wasn't mine with an identity card number that wasn't my card number; and I can see the date was very recent. He said, "Is that true?" He said, "OK, where's the register? I said, as soon as you come in, the register is on the table on the left-hand side, with Mectizan's register on top. He said OK, and after work he called the CBS and the Area Manager of locality X. He said, 'Bring me the juices. He said, 'Bring me the oncho documents that you've signed. I'm going to

Bafoussam in the morning with them'. He said to them, 'I'm going to Bafoussam tomorrow, Bafoussam is calling me, you haven't done it or you have?' They said it wasn't finished yet, Doctor, 'Bring me what you've already finished. They left and when they went to his office, he didn't know that the doctor was following them. They went into the CBS's office, they wanted to move the register but the doctor was already behind them, 'give me the register there, the third register there, give me that, is that the register or what? the CBS wanted to say no and said 'give me that, give me that Mr Y, give me that'. As soon as he takes it, he starts leafing through it and says 'here are the justifications noon, we've already signed everything, there are the signatures with the CNI numbers, come on! They went out to the office, and he saw how I was crossing the courtyard to get back, so he said, 'Call me Z here. N went out to tell me that the doctor wanted me. I went in and he said, 'Z, have you got your Mectizan money yet? I said I hadn't got it. He said, 'Didn't you sign here? I said no, Doctor, I haven't had five francs of Mectizan since it was distributed. You haven't got any, have you?' I said no, I haven't got any, Doctor! I went to the doctor and he said, "Isn't that your signature there?" I said, "That's not my signature, Doctor, and that's not my ID number, and I took out my computerized card. I say here's my number with my photo. He says yes, young man, you've seen this number or 'no, boss, we'll manage, we'll manage with Z. He said 'you told me that there are the receipts, but you stayed in the office to do the receipts without the CDDs, so go and think about it, because I'm going to give this to Z and he's going to lodge the complaint with the public prosecutor's office, but what's the matter with you, you're spoiling my work. there was a representative of the administration who worked with me, B, they had signed and they divided the nine hundred thousand between three of them, I was even responsible for the oncho, when the white people came or we left or Doctor X sent me and since then even the first district chief Mr Y and I had started with Doctor X himself, the doctor said 'ha! you're doing all this with Z? you find out about someone you want to embezzle? when he went to Makouopsap there you were witnesses noon? we went to find him in Makouopsap with the whites to go to Mankare to find him noon? but when that happens at least give him a bit! how much is his money?' he said thirteen thousand six hundred and fifty, 'multiply by ten! and you deposit that. If you don't, I'll send you to the prosecutor's office with him' I also mentioned C's name, he's my maternal uncle, he hadn't got anything and he asked me if Mectizan's perdiem hadn't come through, even though he's also a former distributor and as I see his name in seventh place there, he hasn't got anything and he's even at six thousand and dust. There are a lot of them, even the Cs I see here, these are the old signatures in the archives, do you understand where he's going? So, he can only list three CDDs and you won't get away with it, that's use of forgery, theft and use of forgery, you've embezzled money from them, that's embezzlement and you've also forged their signatures and false identification. The doctor multiplied that by ten and he said you're going to pay right away! He said I'm giving you the last deadline, which is tomorrow at 3pm if that money isn't available, I'll send you to the public prosecutor's office on Friday and I'll have you heard by the commander. I go out and he finds me on the way to the bar, kil calls me, weeh Membouot how do you want to sell us like that? I say you're the nasty one, how am I going to sell you? We're working, B tu sais les rapports de Mectizan avec moi nous sommes dans le même bureau, voilà ta chaise voici la mien, vous me détournez parce que je suis ignorant et vous êtes les trois là, ça ne va pas marcher comme ça, on va s'chauffer ! je vais même dire au commandant de brigade ce soir. They begged and I said come tomorrow and deposit the money, pay my brother Moussa and C. Suddenly we were talking and the doctor came into the bar and asked me to come and not talk to the thieves, I told him they were begging. He said no, there's nothing to be done, they'll be heard by the brigade commander and we'll go to the public prosecutor. I'm the boss here, I went to Bafoussam and I came back with money and I gave them everything without taking a penny and I even let them see the copy of the discharge that I was made to sign at the region and they put their wisdom in it! Ask them if they even offered me a bottle of wine? so they're the only ones who know about the money! So that's what's causing the confusion about how to deal with the DC, and that's the big problem." (Interview conducted on 05/04/20 in Massangam).

This informant, more than others who have often expressed their suspicions about a possible misappropriation of the funds earmarked for them, recounts his experience of a situation of misappropriation of funds of which he and some of his colleagues in the beneficiary communities were victims. This account reflects the real situation of several distributors who not only end up getting tired of waiting, but also decide not to respond to future invitations for other distribution campaigns. These are just some of the reasons for the current resignation of distributors. Better still, the more cunning CDDs stay and try to satisfy themselves or their personal needs by diverting medicines from time to time. These medicines are then diverted and end up on the market, rather than being sold directly to the public at a price that may vary according to the applicant or the mood of the distributor.

Community Distributors support, therapeutic coverage and coverage data

Community Distributors support also has an impact on the actual coverage and quality of the reports produced. Reports on which the program bases its decisions. In the communities, the training allowances are lower than the travel expenses used by the distributors to attend the training. Here the communities are far from the health district service, the CDD's training point. These community agents travel long distances to attend the training of distributors for the launch of distribution campaigns. The failure to take

these factors into account is at the root of the resignation of many distributors and, consequently, the factor that explains the persistence of onchocerciasis: *"Even now, sometimes we call people and they don't come. Even simple training, someone can leave Makouopsap and pay one thousand francs (1000f) for transport, two thousand each way to come here, and you give them five hundred for transport? You travel 32 km on which road? You waste your day without going about your business. When you leave, you don't even get a coffee break or a lunch break; they tell you five hundred for transport! When it's too much, it's a thousand francs (1000f). Mectizan is always there, and the area manager chases after the CDDs to no avail. Then they come back to make false reports. That's what's behind the maintenance of the CDs and that's even the cause of fraudulent distribution. You're going to say that they take the Mectizan and sell them, but have you maintained them"* (Interview conducted on 05/04/20 in Massangam).

These are all factors that explain the resignation of distributors. To fill the gap, health area managers often use trainees to distribute in the communities. It should be noted that trainees are students in training schools, either in nursing or in any other health speciality. They arrive from different towns or regions for refresher or impregnation courses. This means that they are not members of the communities for which they are required to distribute Ivermectin. In view of the procedure for introducing these trainees into the community for distribution, even the CDDs are indignant about the quality and delivery of their reports. Several factors were mentioned: knowledge of the community, acceptability of the trainees by the local population, and lack of training in distribution.

Here's a batch of trainees, they can arrive here one morning and we say two on this side two here for Mectizan and the briefing is on site, will they respect the instructions? Do they even know the community? When the community sees someone going out with a box of Mectizan in his hand without a measuring tape, you can imagine the sizes. You come to my house and you find my measuring cup, made at least ten years ago. Even a center manager who doesn't know the criteria for a Community Distributor and doesn't even know who to give to and who not to give to. The center manager is asked to train, but he comes here and doesn't train because there's no money, because now everyone wants money. So, the distributor does voluntary work. Doctor X but he used to flirt with us to get us to be a CDD. Sometimes, he would dip into the funds of the hospital, the Centre Médical d'Arrondissement (CMA), which was still the Centre Médical d'Arrondissement, to boost the resources of the CDDs. And if you give him a programme that I'm going to go to such and such a community to do the distribution tomorrow, you're going to stay there and he's going to come with the motorbike to see if you're doing the work. You're doing the work, you see he comes either with a juice, a loaf of bread loaded with sardines, he encourages you and when he leaves, he can even put his hand in, he even gives you a two thousand, he tells you that it's not in your per diem, but courage. But now it's a money hunt (Interview conducted on 05/04/20 in Massangam).

This former distributor, through his experience in CDD work, raises many realities that impact on the performance of trainees but also on the fact that health area managers no longer carry out training as prescribed. With both CDDs and trainees enrolled for the job, there is just one briefing. This also raises the problem of the supervision of activities in the field during coverage campaigns. The presence of nurses in the communities was also mentioned. *"Nurses come to distribute Mectizan for filaria; they also give medicines for children aged 0 to 5".* (FGD conducted on 05/04/20 in Massangam).

Picture of Trainee Nurses taken for Community Distribution
Source: Moustapha Mohamed Nsangou (2020)

Reliability of coverage data from Community Distributors

In the process of monitoring and evaluating the CDDs' work in the field, the people in charge of this evaluation adopt approaches that do not always enable the distributor to give a faithful account of the reality on the ground. CDDs are faced with evaluators who refuse to accept CDD reports, to the point of casting doubt on their ability and the quality of their work in the field. Faced with this pressure, CDDs provide answers tailored to what the assessor wants to hear. In reality, as this informant explains, when the CDD brings in a distribution report in which he mentions cases of reluctance or refusal of the drug by certain beneficiaries, he is very quickly considered not to be working hard enough or simply refuses to do the work that falls to him as a CDD. This puts pressure on the distributor, who receives no remuneration for the work they do. They are sometimes threatened with suspension from other community health activities in which they are involved and which seem to be more profitable than distributing Mectizan. The pressure on CDDs encourages the fictitious filling in of data that is transferred. This data does not reflect the reality on the ground. And the words of this informant seem to reflect this state of affairs. *"So that's how we evolved, and experience had also shown us that there was a lot of reluctance in the community and that the CDD was afraid to show, i.e., to make a report, to say that there was reluctance, it was seen more as if they were refusing to work".* (Interview conducted on 04/04/20 in Massangam).

This form of evaluation and control of the work of the CDDs, based on the absolute negation of any response that does not go in the desired direction or does not give answers that attest to the expected results, leads distributors to provide false reports. They resort to fabricating data to satisfy demand, but above all to satisfy themselves, to the detriment of achieving the objectives of eliminating onchocerciasis. Add to this the remuneration formula, which is not always satisfactory. When we also know that the distributor's remuneration depends on the number of people treated, it is understandable that the distributor is tempted to inflate the figures on his reports to increase his profits. As one healthcare manager put it «*When they're out in the field, they register people. When it's time to give the treatment, some of the people registered don't want to take the treatment. However, the CDD fills in the distribution register without mentioning these people, as this will be a loss of income for him. He will simply declare that everyone has taken the treatment when this is not really the case. We find this out when, during other activities, people claim not to have received anything even though the register for their village shows that coverage is complete". (Interview conducted on 04/04/20 in Massangam).* The fabrication of data and the distraction of medicines are at the heart of these declarations. The data thus distorted makes it impossible to control the real level of therapeutic and even geographical coverage. This makes it impossible to take objective decisions about eliminating the disease. In addition, distracted or diverted medicines take directions that pave the way for misuse or abuse of Ivermectin.

The lack of motivation gives the health area managers or any other health authority responsible for monitoring and checking the effectiveness of distribution no autonomy to sanction or reproach a CDD who has done a poor job. Without remuneration, the CDD seems to be completely free to do with the medicinal product as he sees fit. Of course, today, distribution work is entirely voluntary. But it should be noted, as some CDDs themselves have pointed out, that motivation or even the payment of a "salary" at the end of a task gives decision-makers the autonomy to question, check and evaluate the work done on the basis of the salary paid. "*You have to motivate! It's better to motivate because sometimes we motivate in relation to the workload, we give the person; we'd be able to demand and say that you've done badly. You didn't give, you didn't distribute. We have to support them financially, so that they do a job that you yourself can control. Because if you don't motivate them, you won't have the courage to control their actions on the ground".* (Interview conducted on 20/04/20 in Kouoptamo). The lack of support relieves the CDD of any constraints and supervision loses autonomy over the CDD. No objective sanction can be imposed on them as long as they receive nothing for doing their work.

DISCUSSION

The fight against onchocerciasis falls within the scope of community health, and support for those involved is central to achieving health objectives at community level. According to the 2021-2025 National Community Health Plan for Cameroon, expenditure on human resources is covered by the technical and financial partners who support program as part of the implementation of community health interventions. This presupposes the existence of a budget line to support community health workers, who form part of the human resources at the service of community health. However, they are considered to be volunteers and are called upon to contribute free of charge to the health of their communities.

It is also important to understand that the practice of volunteering is defined by very specific criteria. As a reminder, a volunteer is anyone who voluntarily undertakes to carry out activities free of charge and outside their working and family time. Volunteers have no salary requirements and receive no remuneration. However, they may be compensated for expenses incurred, such as food, travel, purchase of work equipment, health costs, etc. It is precisely because these costs are not taken into account that these volunteers in the fight against Onchocerciasis and other Neglected Tropical Diseases are resigning.

According to empirical sources, the financial resources available are only used by decision-makers and those working for community development. This observation extends to the case of the Mectizan Community Distributors. They work without remuneration or support under the slogan "working to save your community from disease". However, it turns out that institutional players, decision-makers and even officials from so-called development partner humanitarian organizations tend to redirect the funds allocated to Distributors who ask very little to save the lives of their population.

CONCLUSION

The motivation, remuneration and support of Community Distributors influence the success of Mectizan mass distribution campaigns in communities. The low or lack of support for CDs, the choice of CDs and the lack of community ownership are the factors that explain the resignation of Community Distributors. Furthermore, the lack of support for these actors leads to irregularities between actual and official data, and to the diversion and sale of Mectizan, the main consequence of which is the misuse of Mectizan. This situation is undermining community activities to combat Onchocerciasis and is an obstacle to the elimination of this disease and other Neglected Tropical Diseases that use the CDTI strategy. As the Community distributor is the key to treatment with Ivermectin under the Community Directive, it would be advisable to review its status on the scale of the players and consider strategies for financing them or supporting their commitment in order to revitalize the CDTI strategy for the elimination of onchocerciasis. In other words, it would be desirable to put the support or motivation of distributors back on the agenda. Some distributors have suggested this and feel that it would be the only way to reawaken their commitment to volunteer their time for the health of their community and continue on the road to eliminating onchocerciasis.

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