Cameroon: a primary health care case study in the context of the COVID-19 pandemic

Pierre Ongolo-Zogo
Cameroon: a primary health care case study in the context of the COVID-19 pandemic

Pierre Ongolo-Zogo
Cameroon: a primary health care case study in the context of the COVID-19 pandemic/
Pierre Ongolo-Zogo

ISBN 978-92-4-006134-7 (electronic version)
ISBN 978-92-4-006135-4 (print version)

© World Health Organization 2023

(acting as the host organization for, and secretariat of, the Alliance for Health Policy and Systems Research)

Some rights reserved. This work is available under the Creative Commons Attribution-NonCommercial-ShareAlike 3.0 IGO licence (CC BY-NC-SA 3.0 IGO; https://creativecommons.org/licenses/by-nc-sa/3.0/igo).

Under the terms of this licence, you may copy, redistribute and adapt the work for non-commercial purposes, provided the work is appropriately cited, as indicated below. In any use of this work, there should be no suggestion that WHO endorses any specific organization, products or services. The use of the WHO logo is not permitted. If you adapt the work, then you must license your work under the same or equivalent Creative Commons licence. If you create a translation of this work, you should add the following disclaimer along with the suggested citation: "This translation was not created by the World Health Organization (WHO). WHO is not responsible for the content or accuracy of this translation. The original English edition shall be the binding and authentic edition".

Any mediation relating to disputes arising under the licence shall be conducted in accordance with the mediation rules of the World Intellectual Property Organization (http://www.wipo.int/amc/en/mediation/rules/).


Cataloguing-in-Publication (CIP) data. CIP data are available at http://apps.who.int/iris.

Sales, rights and licensing. To purchase WHO publications, see http://apps.who.int/bookorders. To submit requests for commercial use and queries on rights and licensing, see http://www.who.int/copyright.

Third-party materials. If you wish to reuse material from this work that is attributed to a third party, such as tables, figures or images, it is your responsibility to determine whether permission is needed for that reuse and to obtain permission from the copyright holder. The risk of claims resulting from infringement of any third-party-owned component in the work rests solely with the user.

General disclaimers. The designations employed and the presentation of the material in this publication do not imply the expression of any opinion whatsoever on the part of WHO concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. Dotted and dashed lines on maps represent approximate border lines for which there may not yet be full agreement.

The mention of specific companies or of certain manufacturers’ products does not imply that they are endorsed or recommended by WHO in preference to others of a similar nature that are not mentioned. Errors and omissions excepted, the names of proprietary products are distinguished by initial capital letters.

All reasonable precautions have been taken by WHO to verify the information contained in this publication. However, the published material is being distributed without warranty of any kind, either expressed or implied. The responsibility for the interpretation and use of the material lies with the reader. In no event shall WHO be liable for damages arising from its use.

The named author alone is responsible for the views expressed in this publication.
# Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acknowledgements</td>
<td>iv</td>
</tr>
<tr>
<td>Executive summary</td>
<td>v</td>
</tr>
<tr>
<td>Introduction and national context</td>
<td>1</td>
</tr>
<tr>
<td>Methods</td>
<td>3</td>
</tr>
<tr>
<td>How primary care and essential public health functions are responding to COVID-19</td>
<td>3</td>
</tr>
<tr>
<td>- Scaling up and managing critical emergency services</td>
<td>3</td>
</tr>
<tr>
<td>- Continuing essential services</td>
<td>5</td>
</tr>
<tr>
<td>- Managing referral systems to ensure appropriate distribution of service load</td>
<td>6</td>
</tr>
<tr>
<td>How multisectoral policy and action are responding to COVID-19</td>
<td>7</td>
</tr>
<tr>
<td>- Addressing broader health determinants and working multisectorally</td>
<td>7</td>
</tr>
<tr>
<td>How communities are responding to COVID-19</td>
<td>8</td>
</tr>
<tr>
<td>- Engaging and communicating with communities effectively and leveraging community resources</td>
<td>8</td>
</tr>
<tr>
<td>Conclusion and lessons learned</td>
<td>10</td>
</tr>
<tr>
<td>References</td>
<td>11</td>
</tr>
</tbody>
</table>
Acknowledgements

The primary health care (PHC) case studies were commissioned and overseen by the Alliance for Health Policy and Systems Research, a hosted partnership based at WHO headquarters. This case study was authored by Pierre Ongolo-Zogo, Centre pour le Développement des Bonnes Pratiques en Santé (CDBPS-H, Center for the Development of Good Practice in Health), University of Yaoundé; and Public Health Emergencies Scientific Council, Cameroon Ministry of Public Health. The WHO Country Office for Cameroon and a team of independent experts provided critical review and input. Special thanks go to Rene Loewenson and Phyllida Travis for their helpful reviews, and Robert Marten, Jeffrey Knezovich, Sonam Yangchen, Alexandra Edelman, Yasmine Yahoum, Joanna Fottrell and David Lloyd for their support in the development of this publication.
Executive summary

The COVID-19 pandemic has had implications for almost every aspect of Cameroon's economic and social policies and development strategies since March 2020. This case study examines primary health care (PHC) in Cameroon in the context of the COVID-19 pandemic between March 2020 and August 2021. Cameroon experienced profound changes in its health governance and stewardship in recent decades. Within a mixed health system, multisectoral action for health has gained precedence in public policies with the establishment of a multilevel incident management policy aligned with the health system pyramid.

In response to the COVID-19 pandemic, risk communication and community engagement gained the highest political importance supported by the head of state and leaders from top government officials as well as local community leaders. In addition, financial resource mobilization went beyond the traditional funders of the health sector: a COVID-19 response National Solidarity Fund ensured all sectors of the national economy were taking action.

Hospital-based care was reinforced nationwide through the creation or upgrading of critical care units (with, for example, respirators and oxygen supplies) in almost all district, regional and tertiary hospitals. Activities for infection prevention and control were revamped, new laboratory facilities were created for polymerase chain reaction (PCR) testing, and in-service training on the management of severe cases of COVID-19 was introduced. Isolation wards were built within or outside hospitals to maintain and safeguard the routine operations of public health programmes.

Cameroon's PHC strategy, inspired by the Alma-Ata Declaration, was overlooked in the early months of the pandemic response. Following reductions from April 2020 of partial movement restrictions, however, enabled the health system to operate almost as usual except in regions facing social unrest and terrorism.

Two national bodies were established – the Public Health Emergencies Operations Centre (PHEOC) and the Public Health Emergencies Scientific Council (PHESC). These advised and supported urgent readjustments towards decentralized incident management that aligned with the country's existing health system pyramid. This pyramid values community health, as seen in the health district framework, to guarantee contextualized surveillance and response, as well as effective referral systems.

The engagement of all political leaders, traditional rulers, religious leaders and both municipal and administrative authorities paved the way for relatively low COVID-19 morbidity and mortality rates. The COVID-19 pandemic has revealed the critical value of solidarity and cooperation as well as the negative consequences of public distrust fueled by conspiracy theories and fake news propagated on social media.
Cameroon’s own pharmaceutical, chemistry and textile industries gained a new impetus given the restrictions on international trade. Most importantly, health issues have gained unprecedented attention from political leadership at the highest levels. The pandemic also contributed to recognition among policymakers of the importance of traditional religious and cultural perspectives to reinforce preventive measures to curb the spread of COVID-19.
Introduction and national context

Socioeconomic context

This case study aims to examine PHC in Cameroon in the context of the COVID-19 pandemic between March 2020 and August 2021. The case study draws from the Astana PHC framework, which includes primary care, community engagement and multisectoral collaboration as key components.

Cameroon is a lower-middle-income country with a population of over 25 million in 2018. More than half (50.6%) of its population is female, while 54% is aged below 20 years including 42.5% aged under 15 years. Only 3.6% of the population is older than 65 years. In 2018, life expectancy at birth was 58 years, and under-five child mortality was estimated at 79 per 1000 live births. The maternal mortality ratio is 406 deaths for every 100 000 live births and the fertility rate is an average of 4.8 (1).

Disease specific mortality rates are as follows: 25 per 100 000 for tuberculosis (TB), 112 per 100 000 for HIV/AIDS and 13 per 100 000 for malaria. Approximately 95 new cases of TB per 100 000 people are registered yearly, HIV prevalence is estimated at 2.7%, and malaria prevalence in children under five years of age is 24%. Hepatitis B prevalence is 8.3% among those aged 15 to 64 years (1).

Chronic child malnutrition remains a major challenge with an estimated rate of 28.9% in 2018. Child overweight is another problem, with an estimated rate of 11% in 2018. Estimates from 2011 on obesity suggest a prevalence of 10.7% and an overweight prevalence among women of 21.5%. However, Cameroon’s breastfeeding rate is estimated at 92.5% and its exclusive breastfeeding rate is 39.7% (1).

Only 15.4% of family planning needs were met in 2018, while the antenatal coverage rate was 65% and skilled birth attendance rate was 69%. Penta 3 vaccine coverage rate was 72% and coverage of antiretrovirals for the treatment of HIV/AIDS was 54% (1).

Located on the Atlantic Ocean, Cameroon shares its borders with six countries. The country is predominantly Francophone, with eight out of ten administrative regions speaking French and the other two English. Cameroon has an array of natural resources, including oil and gas, mineral ores, and high-value species of timber. It also has a strong agricultural base growing coffee, cotton, cocoa, maize and cassava (2).

Cameroon has more than 270 political parties, but the ruling party – the Cameroon People’s Democratic Movement (CPDM) – has long dominated the country’s political landscape. The CPDM confirmed its political dominance in the municipal and legislative elections held in February 2020, retaining its parliamentary majority and winning seats in most of the country’s communes.
Although Cameroon has been relatively secure for many years, there has been recent instability in the Far North region with terrorist attacks. In the two Anglophone regions, there is also a move to secede. As of 2021, the UN High Commissioner for Refugees (UNHCR) estimates that there are just under 1 million internally displaced persons (3). They also indicate that in 2021, Cameroon was hosting around 450,000 refugees, predominantly from the Central African Republic and Nigeria (3).

Poverty affects nearly 40% of the country’s population (8.1 million people) and is concentrated in the northern regions, where a majority of the poor live (2). Cameroon’s economic growth, poverty reduction, and reform priorities are set out in its long-term development agenda, Vision 2035, which is operationalized by the National Development Strategy 2020-2030 (4) aiming to support policy action for the localization of the Sustainable Development Goals (SDGs). The health system is aligned with the health district framework and is organized as a pyramid: a central level sets the policies and provides guidance, and 10 regional delegations for public health provide technical support and supervise the 190 health districts (comprising 1836 local health areas). Vertical public health programmes operate nationwide. Access to curative hospital care is conditioned by user’s fees and less than 5% of the population has health insurance (5).

The COVID-19 pandemic occurred at a time when the 2016–2027 health sector strategy was prioritizing community health (5). A state decentralization process was pursued in December 2019 by the General Code for Decentralized Territorial Collectivities, which devolves new powers and competencies to regional and municipal councils as key primary health care actors.

The first two cases of COVID-19 were reported to WHO on 6 March 2020 (6). The number of cases increased rapidly after first being imported from Western Europe, and community transmission was confirmed in late April 2020 (2). In February 2020, the Ministry of Public Health drew up a preparedness and response plan for COVID-19 to quickly detect possible cases of importation of the disease and limit its spread. The incident-management system was activated, and the PHEOC was formally established in the capital, Yaoundé, on 12 May 2020 by decree of the Prime Minister (7).

As of 26 August 2021, Cameroon had experienced two waves of COVID-19. According to figures reported to WHO, there had been 84,210 confirmed cases and 1,357 deaths (6). The weekly situation report from the PHEOC also indicated 81,526 recoveries (96.8%), 90,203 people fully immunized (0.6% of the target population); 2841 health care workers infected and 53 deaths; and 438 pregnant women infected, including 6 deaths (8). During the last week of August 2021, there were 1,357 active cases, including 61 hospitalized patients. The overall case fatality estimate was 1.6%.

At the beginning of the pandemic, Cameroon had not experienced an outbreak of Ebola but had developed containment plans for pandemics following the previous alerts related to SARS-CoV-1 and H5N1 influenza.
Methods

A documentary review of administrative data, epidemiological and situational reports and policy information from websites (Africa Centres for Disease Control and Prevention [CDC], the Prime Minister’s Office, the Ministry of Public Health) was conducted. Lessons learned were also informed by published multidisciplinary research on how Cameroon faced the first year of the COVID-19 pandemic (9, 10).

The case study identifies lessons learned, with an emphasis on highlighting PHC system strengths in the pandemic context. Future studies might seek to examine key underlying health system challenges in greater depth, including power struggles at the district level between administrative and political elites and health professionals, specific aspects pertaining to equity that are traditionally under-reported, and restricted access to administrative reports on governance and financial challenges at the operational level.

How primary care and essential public health functions are responding to COVID-19

Scaling up and managing critical emergency services

To respond to the pandemic, a multilevel incident management mechanism was established through a decree by the Prime Minister (7). The Prime Minister also chaired an Inter-Ministerial Committee tasked with evaluating the implementation of the government’s response plan. At the central level, the PHEOC comprises a National Incident Management Team that combines political and technical staff, including staff from the World Health Organization (WHO). In the country’s 10 administrative regions, regional incident managers were governors seconded by regional delegates for public health. At the subregional level (administrative divisions and subdivisions), incident managers were senior divisional officers or divisional officers seconded by health district chief medical officers.

This pyramid structure created conditions for integrated planning and implementation of a national response (11). The regions and districts accessed cascade training for emergency preparedness and management to equip them to implement the priority strategies and actions. Financial resource allocation followed the same cascade system, depending on the spread of the disease. As of 31 May 2021, more than 2000 hospital beds were available nationwide (with a bed occupation rate of 3.8%), and 307 physicians and 735 nurses were posted in dedicated COVID-19 units (12).

Strategies for risk communication and community engagement were implemented and contextualized in all administrative regions and health districts in collaboration with municipal authorities, religious and traditional leaders, and community-based associations that provide community health workers (CHWs).
How primary care and essential public health functions are responding to COVID-19

To boost the water, sanitation and hygiene (WASH) strategy, the head of state provided resources to purchase and distribute hand-washing commodities and facemasks using the administrative and municipal authorities to relay these supplies to every village and community. In the regions affected by social unrest and insecurity, the army, gendarmerie and police were engaged to ensure distribution of WASH commodities and facemasks. The maintenance of hand-washing kits has, however, declined over time.

There were several innovations related to the governance and stewardship of health activities, such as weekly national online coordination meetings to bring together national stakeholders including the Minister of Public Health, the National Incident Management Team and the regional delegates for public health and the regional delegates and district management teams in each region.

The PHEOC was established to advise on decision-making and to build trust and general public adherence to public health measures. The chair and vice-chairs of the PHEOC were invited to several TV and radio broadcasts to explain the strategy and communicate the risk, and some of their advice was disseminated through social media. The rising penetration of mobile phone technology was exploited to convey preventive messages with the four mobile phone companies creating waiting messages and short text messages (SMS) on COVID-19 prevention. Facilities for e-meetings were used to ensure coordination meetings within and across different levels of the health pyramid. Surveillance data and health management information systems were integrated to enable weekly publication of an e-situation report that captured key elements of pandemic response. Since the introduction of COVID-19 vaccines on 12 April 2021, a weekly e-situation report captured vaccine deployment.

Laboratory facilities were scaled up, building on the existing lab platforms for TB at the district and regional levels to perform polymerase chain reaction (PCR) testing during the initial phase and before the availability of rapid antigen tests. Several rapid antigen and serological tests were also evaluated to speed up COVID-19 diagnosis with the National Public Health Laboratory leading the process.

A toll-free phone line was established at the national and regional levels to facilitate communication between the public and care givers to provide accurate information, combat fake news, and signpost those seeking care towards testing and remote management, as well as mental health support if needed (13, 14). The operations of the national call centre were structured to filter and channel information requests. Care seekers were directed to their nearest facility based on their health needs, including mobile testing units equipped for household testing and ambulatory treatment, as well as WASH to decontaminate compounds. As of 25 August 2021, a total of 1 026 230 calls had been received including 3498 (0.3%) alerting the service to potential cases, 97 678 information calls (9.5%), 303 calls from international travelers (0.03%) and the remaining 924 751 calls unrelated to COVID-19 (90.1%) (8).
A district-based survey and needs assessment of critical care units was initiated in March and April 2020 to inform the investment plans to strengthen the capacities of the critical care units, both in terms of human resources and health technology (respirators, oxygen supply, surveillance monitors, pulse oximeters). Based on the epidemiological profile and the spread of COVID-19, 179 dedicated management units were functional as of 25 August 2021; these centres offered 3774 beds and operated with 513 physicians, including 13 specialists in intensive care and 1423 nurses. In addition, 377 oxygen concentrators and 73 respirators were available nationwide (8, 11).

Continuing essential services

There was marked disruption in the early stages of the pandemic of international supply chains, health workforce, health infrastructure, service provision and patient access. The negative effects were transient, however, with mitigation measures leading to a bounce back (9–17). Moreover, the financing of essential health services and the country’s domestic supply chains were not affected.

The COVID-19 response National Solidarity Fund was created on 31 March 2020, and the state budget for the 2020 fiscal year was revised. Contributions were mobilized beyond the traditional funders of the health sector. Private corporations and individuals were invited to contribute in addition to the XAF 180 billion (US$ 305 million) from the state budget. Loans were negotiated from the International Monetary Fund (IMF) and the World Bank to support policy action to mitigate the impact of the pandemic – particularly its economic impact on the private and public sectors – by strengthening public debt management, improving public procurement processes, and aiming for transparency in the use of COVID-19 response funds (9, 11, 18).

In the health sector, resources were allocated to ensure the continuity of essential services. Specifically, dedicated COVID-19 screening and treatment units and isolation wards were built and equipped to ensure two separate clinical pathways for non-COVID-19 patients and patients with suspected COVID-19 attending health facilities. Mobile screening units were created during the initial phase for on-call home testing (7, 11).

Communication campaigns were organized to reassure potential users that health facilities were still operating normally, and efforts were made to maintain and continue quality essential services. Hundreds of recently graduated nurses and physicians were recruited to staff the newly created screening units, COVID-19 community centres and wards, as well as rapid intervention mobile units. CHWs were recruited and trained to scale up sensitization and WASH activities in the community (7, 13).
Cameroon’s integrated multilevel incident management system, comprising the administrative and municipal authorities and the district health management teams, made it easy to contextualize the strategies and actions included in the national response to each district’s epidemiological situation. Rapid intervention units comprising a physician, a nurse, a driver, a hygienist and an epidemiologist were established and equipped to cover dedicated geographical areas upon call through the toll-free phone number after interview by a counsellor to assess the individual risk (10–14).

Mobile clinical teams were created in some districts where there was a high burden of disease for the home management of mild cases. These teams had the resources for home testing and treatment, for referral to isolation wards and referral to specialized treatment centres (13, 14).

Most training activities were organized using the cascade implementation strategy, with the training of trainers occurring at the central level – then at the regional and the district level. As the pandemic worsened, regional delegates for public health and district chief medical officers were instructed to survey the technical capacities of private clinics and to sign collaboration agreement with those that were equipped to provide critical care in their respective catchment areas.

Most hospitals and districts experienced service disruptions for at least one month, but the magnitude and duration of the disruptions varied. Although decreases in service volume were most common in April and May 2020, there were still significant disruptions in July 2020. Outpatient consultations and child vaccinations were the most commonly affected services, falling by the largest margins as a result of fear and restrictions on mobility. Decreases in maternal health service utilization, however, were less generalized (15–19).

Clinical activities were disrupted in 2020 in both referral and district hospitals. Rumours spread on the risks of contamination in hospitals treating COVID-19 patients, impacting service use patterns. Significant declines in institutional deliveries, antenatal care and postnatal care were reported (15).

Managing referral systems to ensure appropriate distribution of service load

Multilevel incident management mechanisms facilitated the handling of referral systems. These mechanisms aimed to adapt and contextualize messages based on religious and cultural diversity, with district-level coordination mechanisms encompassing situational analysis and needs assessment of health facilities.

National guidelines were validated and disseminated for the management of suspected cases. In the cities of Yaoundé and Douala, which had had the highest rates of infection, dedicated centres were created for mild cases and a registry of critical care units were established in state-owned hospitals and private
clinics. A regional coordinator of care was appointed to ensure the appropriate distribution of critical care service load (11–17).

Local health facilities – particularly dispensaries and integrated health centres – were invited to convey preventive messages on, for example, WASH activities, and staff were trained to recognize signs and symptoms related to COVID-19. Subsequently, triage nurses and physicians in emergency rooms were encouraged to act according to the management guidelines. In the event of a suspected case, nurses and physicians had the following options: dial the toll-free number to request a mobile screening unit; redirect the patient to the closest screening centre; or refer the patient to the nearest dedicated COVID-19 critical care centre. In addition, several means were used to sensitize Cameroon’s population to recognize signs of infection and encourage them to dial the toll-free number to be referred to the appropriate care pathway (13, 20).

How multisectoral policy and action are responding to COVID-19

Addressing broader health determinants and working multisectorally

High-level political engagement led to a government response to COVID-19 that embodied a holistic perspective. The cabinet’s response involved several dedicated task forces in charge of evidence synthesis, monitoring the burden of disease and consequences and anticipating mitigation strategies. The weekly meetings of the inter-ministerial committee in charge of monitoring, evaluating and learning from the COVID-19 response enhanced its responsiveness and timeliness.

Public–private consultations were organized to address the multidimensional consequences of restriction measures. The National Solidarity Fund to fight against COVID-19 enabled concerted resource allocation to different sectors as well as the introduction of innovative resource mobilization from the IMF, World Bank, bilateral development agencies, United Nations (UN) agencies and the private sector (7, 9, 21).

The loans were intended to improve equity and efficiency in the allocation and use of health resources, and to scale up social protection. The programme of reforms was expected to have positive effects on poverty through cash transfers to vulnerable groups who lost income as a result of the crisis and restriction measures.

The UN agencies developed a common framework to support Cameroon’s fight against the pandemic (22). Similarly, several bilateral development agencies provided technical, financial and material support, including Agence Française de Développement (AFD), the United States Agency for International
How communities are responding to COVID-19

Engaging and communicating with communities effectively and leveraging community resources

A cabinet crisis meeting was organized after the outbreak of COVID-19 and the government issued 13 restriction measures on 17 March 2020 (18). Subsequent meetings were convened by the Prime Minister, inviting political elites, religious leaders, traditional rulers, and administrative and municipal authorities as well as the media and civil society organizations to unite in the response. The institutionalization of the multilevel incident management mechanism nationwide offered the opportunity to engage almost all actors in society and to communicate the risk with contextualized messages.

Almost all members of the political elite contributed to the provision of hand-washing commodities for public places and facemasks for their communities. Several traditional leaders met with local leaders to change the rules and regulations for the organization of funerals and cultural gatherings, with most of them enforcing a ban on gatherings.

Social media and radio broadcasters showcased the benefits of herbal medicines, with a rise in the numbers of vendors of herbal medicines noted in most food markets. In urban areas, there was a boom in the number of informal units producing facemasks with local fabric and thousands of street vendors were selling facemasks.
Nationwide, women's associations were engaged in efforts to sensitize people on COVID-19 and to produce facemasks, hand-sanitizers, soaps and kits for hand hygiene. Following meetings with the administrative authorities, religious leaders incorporated preventive messages on social distancing and hand hygiene in most places of worship. However, some churches opposed governmental measures relating to the wearing of facemasks (27).

Cameroon's revised financial law creates room for decentralized budgeting and the effective transfer of resources to the regional and municipal levels. Several health districts recorded mobilization of local resources for WASH activities (28) and for food and nutrition support to those affected by the restriction measures. The existing regulatory provisions that endow municipal executives as chairs of health district and district hospital management boards made it easier for municipal executives to understand and engage in crisis management and work towards local solutions in addition to the guidance and resources provided by the central level. Several charities and nongovernmental organizations offered medical equipment to hospitals as well food to affected populations.
Conclusions and lessons learned

This report provides insights into profound changes in health governance, stewardship and financing in the COVID-19 context. These changes relate to: political leadership; health emergencies management; evidence-informed policy-making; coordination of governmental action; strengthening municipal and local community engagement for health promotion and prevention (in such areas as WASH, food and nutrition); boosting local industries (pharmaceutical, chemical and textile); and the use of mobile health technologies.

The pandemic generated an unprecedented national mobilization for health and the rapid implementation of initiatives to build or reinforce community resilience. The pandemic presented an opportunity to strengthen the health system, including to improve governance, stewardship and financing, upgrade intensive care units and optimize infection prevention and control in hospitals.

In addition, the pandemic led to improvements in the country’s national epidemiological surveillance systems and in hospital care, particularly in intensive care. The pandemic also encouraged multisectoral action including action across the agropastoral, transport, mobile technology, commercial and industrial sectors.

There is an opportunity to evaluate the role and performance of the PHEOC and PHESC to identify opportunities for improvement. Case study findings suggest that the PHESC fostered evidence-informed decision-making, which could be leveraged during future health crises.
References


Cameroon: a primary health care case study in the context of the COVID-19 pandemic


This case study was developed by the Alliance for Health Policy and Systems Research, an international partnership hosted by the World Health Organization. In 2015, the Alliance commissioned the Primary Health Care Systems (PRIMASYS) case studies in twenty low- and middle-income countries (LMICs) across WHO regions. This case study builds on and expands these previous studies in the context of the COVID-19 pandemic, applying the Astana PHC framework considering integrated health services, multisectoral policy and action and people and communities. This case study aims to advance the science and lay a groundwork for improved policy efforts to advance primary health care in LMICs.