PARTICIPATORY GUIDE FOR PLANNING EQUITABLE MASS ADMINISTRATION OF MEDICINES (PGP)

TO TACKLE NEGLECTED TROPICAL DISEASES

MODULE 2B

PARTICIPATORY PLANNING TO INCREASE EQUITY IN MAM

COUNTDOWN

Calling time on Neglected Tropical Diseases

MODULE 2B

PARTICIPATORY PLANNING TO INCREASE EQUITY IN MAM

BACKGROUND TO DEVELOPING THIS TOOL

All the evidence presented has been co-produced by the Federal Ministry of Health (FMoH), Ogun and Kaduna State Ministry of Health, the LGA teams, community members and multidisciplinary researchers from the Liverpool School of Tropical Medicine and Sightsavers Nigeria as part of the COUNTDOWN consortium funded by FCDO. A Participatory Action Research (PAR) approach was applied in response to a situational analysis conducted in 2016 which identified community engagement as a bottleneck to achieving equitable coverage of MAM within the different and emerging contexts (border, migrant, rural and urban) of Nigeria, related to programmatic, social, political and environmental changes over time (Oluwole et al., 2019, Dean et al., 2019, Adekeye et al., 2020, Ozano et al., 2020). PAR (Figure 1) was chosen to promote a new bottom-up approach to planning that would ensure voices from the community were captured and represented and that local level implementers were able to add context specific changes to MAM implementation (Figure 1). Using participatory research methods NTD implementers and communities identified challenges and solutions to implementation and highlighted new social structures and distribution strategies for women, youth, men, migrant populations and people with disabilities. This guide presents evidence from that research (2016 to 2021), which includes challenges and facilitators for equitable MAM, highlighting the importance of wider community and stakeholder engagement.

COUNTDOWN
Calling time on Neglected Tropical Diseases

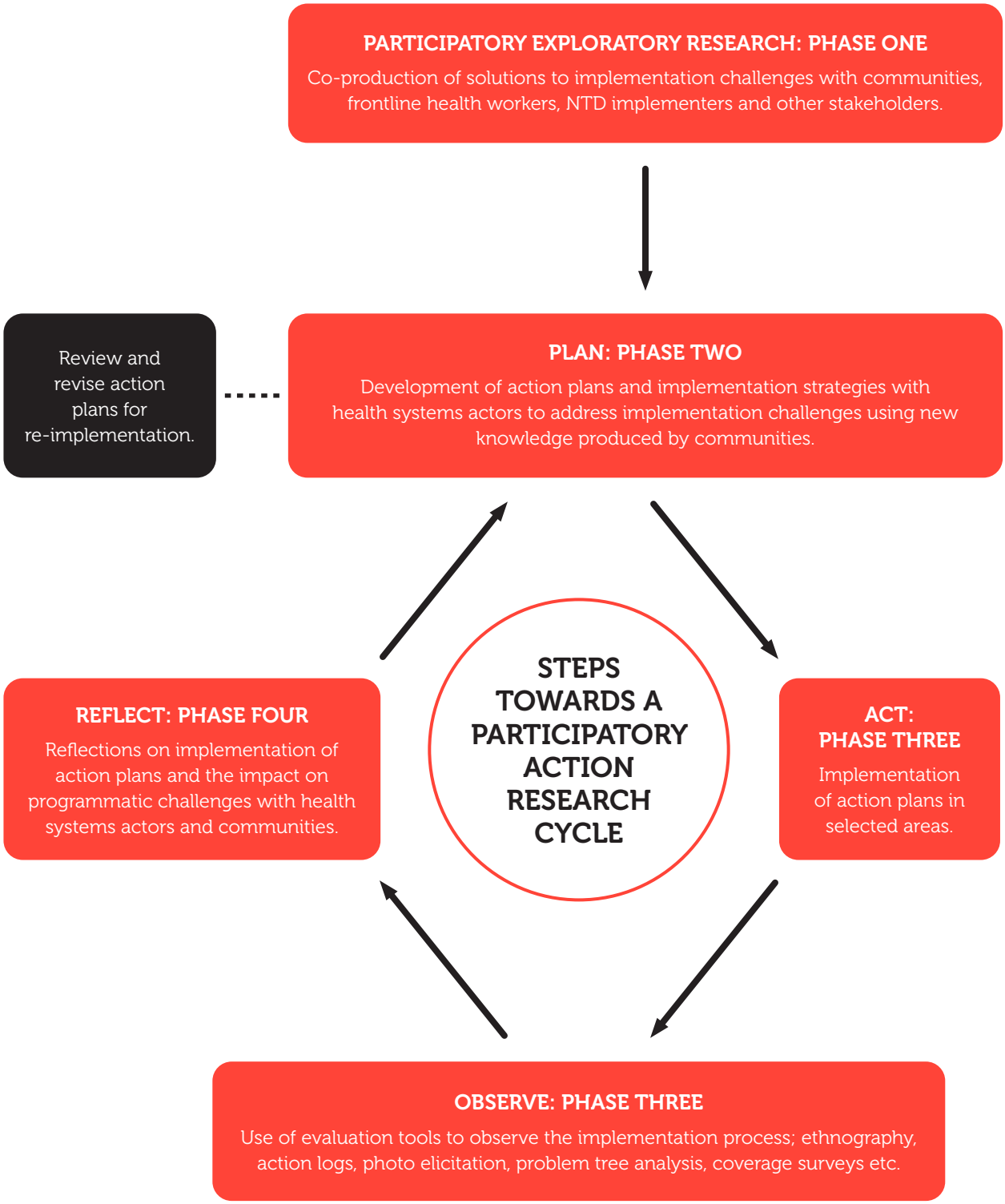

Figure 1. PAR approach to improving equity in MAM (Ozano et al., 2020)

ICON KEY

EVIDENCE INFORMED

EXAMPLE OF CHALLENGE / CAUTION NEEDED

WEBSITE LINK

RESOURCES / TRAINING MATERIALS NEEDED

KEY POINTS

POSITIVE INFORMATION

URBAN AREA

RURAL AREA

URBAN AND RURAL AREAS

WHATSAPP OR OTHER INSTANT MESSAGING SERVICE

EMAIL ADDRESS

PRINTED VERSIONS OF THE ACTION PLAN

LIST OF ACRONYMS AND ABBREVIATIONS

ACOMORON	Association of Commercial Operators of Motorcycles and Riders of Nigeria
ALB	Albendazole
AOPSHON	Association of primary school health teachers of Nigeria
AZT	Azithromycin
CAN	Christian Association of Nigeria
CDA	Community Development Association
CDCs	Community Development Committees
CDD	Community Drug Distributors
CDI	Community Directed Intervention
CDTi	Community-Directed Treatment with ivermectin
CHAN	Christian Health Association of Nigeria
CHEW	Community Health Extension Workers
CI	Community Implementers
CMS	Central Medical Store
CSO	Civil society organisations
DPHC	Directors of Primary Health Care
DPOs	Disabled People's Organisation
DOT	Directly Observed Therapy
DSNO	Disease Surveillance and Notification Officer
FBO	Faith-Based Organisations
FCMS	Federal Central Medical Store
FCT	Federal Capital Territory
FGD	Focus Group Discussions
FLHFs	Frontline Health Facility Staff
FMoH	Federal Ministry of Health
FOMWAN	Federation of Muslim Women's Association of Nigeria
HE	Health Educators
HWIA	Health Worker Ivermectin Administration
ICT	Immunochromatographic Test
IDIs	In-Depth Interviews
IDM	Infectious Disease Management
IEC	Information, Education, Communication
IVM	Ivermectin
JRSM	Joint Request for Selected PCT Medicines
KAP	Knowledge Attitude and Practice
LF	Lymphatic Filariasis
LGAs	Local Government Areas
LGEA	Local Government Education Authority
LLINS	Long Lasting Insecticide Treated Nets
LNTD	Local Government NTD Coordinator
M&E	Monitoring and Evaluation
MAM	Mass Administration of Medicines
MDA	Mass Drug Administration
MDV	Mad Dog Vaccination

MEB	Mebendazole
MOH	Medical Officer of Health
NAFDAC	National Agency for Food and Drugs Administration Control
NARTO	National Road Transport Operators
NC	National Coordinator
NOA	National Orientation Agency
NPC	National Population Census
NPower	Need for power
NUJ	National Union of Journalists
NURTW	National Union of Road Transport Workers
NTD	Neglected Tropical Diseases
Oncho	Onchocerciasis
PAR	Participatory Action Research
PAS	Public Address System
PC-NTDs	Preventive Chemotherapy Neglected Tropical Diseases
PENGASSAN	Petroleum and Natural Gas Senior Staff Association of Nigeria
PGP	Participatory Guide for Planning Mass Administration of Medicines
PHC	Primary Health Care
PWDs	Persons With Disability
POD	Proof of Delivery
POS	Paediatric Oral Suspension
PSAC	Pre School Age Children
PSM	Procurement and Supply Management Unit
PZQ	Praziquantel
RUWASA	Rural Water and Sanitation Agency
SAEs	Severe Adverse Events
Schisto	Schistosomiasis
SCM	Supply Chain Management
SCMS	State Central Medical Store
SMC	Social Mobilisation Committee
SMO	Social Mobilisation Officer
SoH	Stock on Hand
SOP	Standard Operating Procedure
TBA	Traditional Birth Attendant
TEO	Tetracycline Eye Ointment
TV	Television
UNICEF	United Nations International Children's Emergency Fund
VCM	Volunteer Community Mobilisers
VDC	Village Development Committees
WASH	Water and Sanitation Hygiene
WCBA	Women of Child-Bearing Age
WDC	Ward Development Committees
WFP	Ward Focal Person
WHO	World Health Organisation
ZEO	Zonal Education Office

MODULE 2B

PARTICIPATORY PLANNING TO INCREASE EQUITY IN MAM

This module describes the different planning meetings that could take place to increase equity and mobilise resources.

OBJECTIVES OF THE MODULE:

By the end of this module you should:

- Know what participatory planning meetings you will hold in preparing for MAM.
- Have an idea of who you will invite to the participatory planning meetings at each stage.
- Know how to identify who to involve in these meetings.
- Know how to structure these meetings to achieve intended outcomes.
- Have developed a draft agenda for your planning meetings.
- Know how to mobilise resources to support implementation.

Some faces have been blurred in photographs to protect confidentiality.

PARTICIPATORY PLANNING

Engaging the right stakeholders in participatory planning activities enables individuals, policymakers and communities at different levels to be involved in decision-making, planning and implementation of MAM. Working in partnership will allow better relationships and trust to develop between implementers and community members. Sustainable change can happen if communities are involved from the start, that is, from the planning stage. For example in Kaduna State, representatives of people with disability were invited for planning meetings to provide strategies for reaching marginalised people in communities. In Ogun State, engagement of stakeholders at the LGA level like the transport association, village heads and chiefs during planning meetings for MAM resulted in support from them. E.g. one of the chiefs donated measuring sticks, the transport association agreed to transport medicines to hard to reach areas for free. You can use your findings from the community engagement activities in Module 2A described above to inform the participatory planning phase.

IMPLEMENTING THE PARTICIPATORY PLANNING PROCESS

There are two key levels of planning for MAM that should be organised:

LEVEL ONE
MICROPLANNING AT THE LGA LEVEL

LEVEL TWO
MACROPLANNING AT THE STATE LEVEL

Traditionally State level meetings have been held first before LGA planning. In this guide we suggest that LGAs develop their microplans first that then feed into the State macro level plan as this allows for context specific variations between LGAs and innovation at the local level. Research suggests that context specific planning can; mobilise human and financial resources, maximise community ownership and participation, share workload and promote equity within MAM.

TO ENSURE EFFECTIVENESS OF THE PARTICIPATORY PLANNING PROCESS ENGAGING THE RIGHT STAKEHOLDERS IS ESSENTIAL.

A key first step in planning State and LGA meetings is therefore completing a stakeholder mapping activity to identify who should be present. A stakeholder analysis guide is presented at the end of this booklet for you to use.

KEY POINTS FOR STAKEHOLDER ENGAGEMENT

- Support stakeholders to plan their own engagement activities as they know best how to work with their communities.
- Be inclusive - don't forget Persons With Disabilities (PWD), youths, gender balance and migrant communities.
- Don't forget to feedback to your stakeholders as soon as possible/in a timely manner so they remain motivated and supportive throughout MAM and for the future.
- Ensure your communications can be easily understood by your stakeholders - use of simple language or local language.
- Every engagement process needs to be planned effectively; this includes making sure adequate funds are in place.

Ideally, holding your microplanning meeting first would support with ensuring ideas of those at local levels of the health system are shared and feed into State level planning activities. We have structured the below section to allow for this, indicating the key steps in relation to each meeting. Meeting 1 is the local level microplanning meeting and meeting 2 is the State planning meeting.

MEETING ONE: MICROPLANNING MEETING AT THE LGA LEVEL

This is a crucial step in ensuring MAM meets the needs of the LGA. The key objective of the meeting is to understand how LGA level implementers want the MAM process to operate for that cycle. Specific actions and their associated timing should be detailed as well as who is responsible for each action.

STEP ONE: ESTABLISH A CLEAR MEETING AGENDA AND AGREE A LOCATION

Identifying a clear agenda and sticking to it will be essential to ensure people remain engaged and know what to expect/come prepared to the meeting. The agenda (at the end of this booklet) is an example of things to include in this meeting, but it should be adapted for your specific LGA needs.

CONTENT: Participants should be issued with an Action plan template to fill in as they discuss each stage of the MAM process. This template will form the basis of the annual MAM Action Plan to be discussed at the State meeting (See Module 3). Participants should be given time to think about each stage in the MAM process and what activities they need to complete under each phase (See Module 3). Participants should also be asked to assign dates and budget to key activities. They should also use the opportunity to update the list of existing communities under their health facilities and specify which communities are hard to reach in order to plan adequately how best to reach such areas. Meetings should be participatory and engage all stakeholders. Too many presentations have been seen to be directive and not enable space for discussion. For advice on facilitation skills please see Module 3.

DURATION: From our experience of microplanning activities, the initial planning session should take approximately one day and last between 5-6 hours. If this is too long for your stakeholders, you could consider spreading the meeting over two days.

LOCATION: When picking a location for your meeting try to think about a meeting hall that is comfortable for the number of participants you want to accommodate as well as being away from other general office distraction.

Official permission for participants: Considering the administrative expectation of formal application for permission before government employees can be away from the office, it is advised that letters requesting the release of participating personnel in the LGA should be sent by the MOH through the LNTD early to their immediate superiors to secure their release to attend the planning meeting.

Census update of communities: The expected population of communities where MAM will be carried out needs to be handy before the microplanning. This will ensure that planning is tied to verifiable statistics and population. Where necessary, information may be sought from frontline health facilities overseeing those communities or from recent credible figures used by a health programme in the LGA e.g. from malaria programme. However, these figures should be ascertained by the health team at the LGA and State to be reliable.

DRAFT AGENDA FOR LGA MICROPLANNING MEETING		
AGENDA	**TIME**	**FACILITATOR**
Arrival and Registration	8:00 - 8:30am	
Opening prayer	8:30 - 8:35am	
Welcome address and self-introduction	8:35 - 8:40am	
Meeting objectives/expected outcomes	8:40 - 8:45am	
Overview of Oncho/LF achievements and challenges	8:45 - 9:00am	
Action planning for Advocacy, Sensitisation and medicine distribution	9:00 - 10:00am	Group work all participants
Tea break	10:00 - 10:30am	
Action planning for Supervision and reporting, financial and non-financial incentives	10:30 - 11:30am	Group work all participants
Presentations of summaries from action planning on Advocacy, Sensitisation and medicine distribution*	11:30 - 11:45am	LGAs
Presentations of summaries from action planning on Supervision and reporting, financial and non-financial incentives	11:45am - 12:00noon	LGAs
Action planning for community structures and mechanism to administer medicines	12:00 - 1:00pm	Group work all participants
Lunch	1:00 - 1:30pm	All
Presentations of summaries from Action planning on community structures and mechanism to administer medicines*	1:30 - 2:30pm	Group work all participants
Action planning to improve IEC materials%	2:30 - 3:30pm	Group work all participants
Bring each activity sheet together into main document of action planning	3:30 - 4:30pm	All
Discuss actions for local level planning session	4:30 - 5:00pm	All
Closing remarks and prayer	5pm	NTD team

**You may consider ice breakers and energisers to maximise attention of all participants. See Module 3.*

STEP TWO: WHO SHOULD BE PRESENT?

From your stakeholder analysis try to ensure you invite relevant attendees. Most people like to be invited by letter at least 2 weeks in advance of the meeting. Ensure as many of the stakeholders are present during the planning stages as possible and that they understand their role in the planning and implementation process. You may want to make time for understanding roles and responsibilities in the meeting agenda. If there are key stakeholders who are unable to attend it is a good idea to follow up with these individuals following the meeting. Remember to send a reminder two or three days before the meeting to confirm attendance.

Some examples of the stakeholders that will enhance microplanning include:

- State NTD coordinator
- Federal Ministry of Health
- Local Government NTD team including head of disease control
- LGA NTD coordinators
- Assistant LGA NTD coordinators
- Store officers ward focal persons
- Chief pharmacist
- Medical officer of health
- Director of primary health care
- State NTD team
- Key influential community members*
- Social mobilisation officers
- Monitoring & evaluation officers (M&E officer)
- Implementing partners
- Civil society
- Apex nurse and health education officer
- NURTW
- Ministry of Budget and Planning
- State Primary Health Care Development Agency
- Ministry for Local Government
- Representatives of PWDs, migrant communities and women groups
- National Agency for Food and Drugs Administration Contol (NAFDAC)
- Rural Water and Sanitation Agency (RUWASA)
- The media

**E.g. Youth leaders (Olori odo), head of non-indigenous communities (e.g. Sarkin Hausawa, Ardon Fulani, Eze Igbo etc.) head of community security and vigilante group etc. We may also consider inviting a desk officer of any of the health programmes in the LGA e.g. desk officer for malaria or tuberculosis. They could share ideas from their programme that will benefit MAM planning.*

'The involvement of the Health Educator in advocacy in the 2019 MAM was recommended in the PGP. This made my work easier... It was the first time we engaged the HE for MAM and also the first time we paid advocacy to most of the Baales (traditional leaders) in the LGA, CAN, Chief Imam, representatives of CDCs, NURTW etc. Module 2 of the PGP on community engagement was useful.'

(An LNTD)

'An advantage of the PGP in the 2019 MAM was the decision to hold a joint meeting with all the traditional leaders in the LGA e.g. leaders of the Fulani, Ketous, Ohoris etc... It made this set of stakeholders to own the programme and it was the first time it was engaging widely like this, hence, different from previous years.'

(An LNTD)

STEP THREE: WHAT WE LEARNED FROM MICROPLANNING MEETINGS

It is best practice to think about what went well and what went less well during the microplanning process. If this is the first time of doing this, we have shared some of our learnings below. If you have done this before, you could think about what went well last time and what you may like to change. Make sure your learnings are reflected in your agenda.

WHAT WORKED WELL?

- By extending participation to wider networks of stakeholders, additional resources were secured. For example, the secretary of the Council of Oloritun promised to support MAM with twenty dose poles, the Community Development Committee (CDC) Chairman promised to support with customised T-shirts while the COPHOONS Chairman pledged provision of potable water for pupils to take the medicines in their schools.
- The implementing partner M&E officer made a presentation on the purpose of the microplanning meeting at the beginning of the session. They described a clear purpose to integrate plans for the States and LGAs to provide high quality intervention at the community and LGA.
- The LGAs provided venues for the microplanning meetings.
- Microplanning was held for all the endemic Local Government Areas (LGAs) simultaneously, the LGAs were split into groups and given a planning template to fill for each LGA. Each team comprised of local government NTD (LNTD) coordinators, health educators and in some cases FLHFS, social mobilisation Officers (SMO) and disease control officers.
- Involving participants from other sectors such as WASH also improved collaboration at the LGA level.
- Microplanning supported in identifying hard-to-reach areas and those with low treatment coverage in the previous year and proffered practical solutions to increase coverage in such areas in the current year.
- New stakeholders were involved in microplanning compared to previous years, the new stakeholders included Social Mobilisation Officers, Disease Control Directors, representatives from Civil Society Organisations, Persons with Disabilities, National Agency for Food and Drugs Administration Contol, Rural Water and Sanitation Agency and the media. The involvement of these new stakeholders had a positive impact on MAM.
- The involvement of personnel from the primary health care unit like the MOH, apex nurse, Chief pharmacist, LNTD and the seventeen focal persons in the LGA kept everyone involved in the microplanning. It encouraged the sharing of ideas leading to innovative creation of a medicine distributing strategy to suit the peculiarity of their LGA.
- The use of an agenda to guide discussions during the microplanning made the session organised and less time consuming.
- Scheduling the meeting in the morning hours ensured that participants paid maximum attention than other times of the day when there is likely to be other activities competing for their attention.
- Microplanning was used as a space to formulate advocacy teams and decide what structures and stakeholders should be engaged for advocacy and sensitisation.
- Women representatives or groups invited for planning meetings to enable gender balance.

Key: **Evidence informed**

WHAT DID NOT WORK WELL?

- Microplanning was rushed, and not enough time was allocated to this activity in some LGAs, this meant that some LGAs could not finalise their plans.
- Some LGAs were absent at the meeting because they did not receive information on the date and venue at an appropriate time or because of security issues.
- There is a need to ensure that there is early and detailed communication regarding the meeting. This will aid attendance at the meeting.
- There was some reluctance from specific LGA teams about formalised planning as they concluded that the State would provide harmonised plans. Encouraging the State to engage with these meetings and encourage planning that is guided by the LGAs supported innovation to overcome these challenges.
- Decision to co-opt microplanning during a departmental technical meeting of the LGA primary health department limited time for detailed discussion and planning. This is because shorter time is allotted for different activities including the microplanning.
- Not inviting representatives of the Community Development Committees (CDCs) or other relevant groups and associations in the LGA excluded perspectives from important stakeholders that may be important to consider for effective planning.

Key: **Evidence informed**

MEETING TWO: STATE PLANNING MEETING

STEP ONE: ESTABLISH A CLEAR MEETING AGENDA AND AGREE A LOCATION

Identifying a clear agenda and sticking to it will be essential to ensure people remain engaged and know what to expect/come prepared to the meeting. The agenda overleaf is an example of things to include in this meeting, but it should be adapted for your specific State needs.

CONTENT: During this meeting, LGAs should be asked to present their action plans which were developed during microplanning meetings. The State NTD team should then sit with each of the LGA coordinators in groups to support them in filling in any gaps in their plans, reviewing resource allocations and considering what they could learn from other LGA presentations. It should be the job of the State NTD co-ordinator to consolidate all specific LGA plans into a larger State level action plan. Where possible activities across LGAs could be harmonised, however flexibility in activities and timings should be maintained where possible. At State planning the need for more CDDs and for the workforce to be diverse should be advocated for, this includes CDDs living with disabilities, and women. Meetings should be participatory and engage all stakeholders. Too many presentations have been seen to be directive and not enable space for discussion. For advice on facilitation skills please see Module 3.

DURATION: From our experience of State meeting activities, the State meeting should take approximately two days and last between 5-6 hours each day. If this is too long for your stakeholders, you could consider shortening each day. Good time keeping is important to cover the agenda and allow the meeting to finish on time as some stakeholders may travel long distances.

LOCATION: When picking a location for your meeting try to think about a meeting hall that is comfortable for the number of participants you want to accommodate as well as being away from other general office distraction.

Official permission for participants: Considering the administrative expectation of formal application for permission before government employees can be away from the office, it is advised that letters requesting the release of participating personnel from the State and LGAs should be sent by the SNTD early to their immediate superiors to secure their release to attend planning meetings.

Template invite letters to State planning meetings:

Date: 03/01/2018

Dear Sir / Ma,

INVITATION TO STATE PLANNING MEETING FOR MASS ADMINISTRATION OF MEDICINES (MAM) IN KADUNA STATE

As a major stakeholder in the NTD Programme we request your attendance to a one day State Planning meeting for 2018 MAM cycle.

Following the LGA microplanning meeting, micro plans will be presented at this meeting to afford the opportunity for key Stakeholders to appraise the micro plans and chart the course for MAM implementation.

Below are the details of the meeting:

Date: .....

Venue: .....

Time: .....

Your presence at this meeting is highly valuable.

Yours Sincerely,

.....

NTD Unit, Federal Ministry of Health, Nigeria.

Review of previous plan: Documents of previous plans should be reviewed at the beginning of the meeting and thereafter commence a new plan having in mind the lessons, gaps and challenges encountered in the previous cycle.

Share copy of the plan to all stakeholders: All stakeholders in the programme especially those in the State are expected to monitor the implementation process. The sure way to do that is to share copies of the plan with everyone as a way to inform/remind/and ensure everyone meets their responsibilities in the implementation cycle.

DRAFT AGENDA FOR ONCHO/LF STAKEHOLDERS MACROPLANNING MEETING AT THE STATE

S/NO	AGENDA	TIME	FACILITATOR
1	Arrival and registration of participants	9:00 - 9:15am	SNTD team
2	Opening prayer	9:15 - 9:20am	Volunteer
3	Self-introduction	9:20 - 9:30am	All
4	Welcome address	9:30 - 9:40am	SNTD
5	Brief remarks	9:40 - 9:50am	DPH
6	Review of agenda	9:50 - 10:00am	All
7	Stating objective of meeting/expected outcomes	10:00 - 10:10am	SNTD
8	Tea break	10:10 - 10:30am	All
9	Overview of Oncho/LF activities and outcome of the previous MAM in the State.*	10:30 - 11: 30am	SNTD
10	Overview of previous MAM cycle in three randomly selected LGAs; at least one from each zone of the State.	11:30am - 12:15pm	LNTDs of the selected LGAs
11	Grouping of SNTD team; LNTDs, partners to review LGAs micro plans. Areas to review include: • Number of communities to be treated per health facility • LGA planned activities • Number of days assigned for each activity • Funding for activities • Expected outcome • Areas needing support/gaps identified.	12:15 - 1:00pm	All
12	Lunch break/prayer	1:00 - 2:00pm	All
13	Collective developing of a State-wide work plan for Oncho/LF to include*: • Planning for integrated supportive supervision and coming up with a checklist as guide • Budget/funding • Allocation and transportation of medicines • Coverage assessment etc.	2:00 - 4:00pm	All
14	Discussions on the plan details	4:00 - 4:45pm	All
15	Closing remarks	4:45 - 4:55pm	DPH
16	Closing prayer	4:55 - 5:00pm	Volunteer

**You may consider ice breakers and energisers to maximise attention of all participants. See Module 3.*

Key: **Evidence informed**

STEP TWO: WHO SHOULD BE PRESENT?

From your stakeholder analysis (See Module 2A) try to ensure you invite relevant attendees. Most people like to be invited by letter at least 2 weeks in advance of the meeting. Ensure as many of the stakeholders are present during the planning stages as possible and that they understand their role in the planning and implementation process. You may want to make time for understanding roles and responsibilities in the meeting agenda. If there are key stakeholders who are unable to attend it is a good idea to follow up with these individuals following the meeting.

Some examples of the stakeholders that will enhance macroplanning include:

- Director of Public Health
- State NTD coordinator
- Zonal NTD coordinator
- State NTD team
- Representative of Federal Ministry of Health
- Representative of FOMWAN
- Representative of CHAN
- Representative of Ummul-Khair foundation
- LNTDs
- Social Mobilisation officers and implementing partner (i.e. Sightsavers)
- State Primary Health Care Development Agency
- Ministry of Budget and Planning
- Ministry for Local Government
- Directors of Primary Health Care
- M+E Officers
- Ruwassa
- Statistics and Monitoring Team
- Respective Local Government Education Authorities (LGEA)
- Deputy Director Programs, National Orientation Agency (NOA)
- A representative from Federation of Muslim Women Association of Nigeria (FOMWAN)
- A representative from Ummulkhair Foundation
- A representative from Kaduna State Media Corporation (KSMC)
- A representative from Federal Radio Corporation of Nigeria (FRCN)
- Chairman, Albino Association
- Chairman, Joint National Association of People With Disabilities (JONAPWDS)
- An Instructor from Quranic Schools Board, representative of National Agency for Food and Drug Administration Control (NAFDAC)

STEP THREE: WHAT WE LEARNED FROM STATE PLANNING MEETINGS

It is best practice to think about what went well and what went less well during the macroplanning process. If this is the first time of doing this, we have shared some of our learnings below. If you have done this before, you could think about what went well last time and what you may like to change. Consider including learnings collected from action logs or other implementation feedback mechanisms in your agenda.

REFLECTIONS FROM STATE PLANNING MEETINGS

- ✓ LNTDs talked about their experiences on MAM, achievements and areas for improvement. For example, one of the LNTDs said more people in the LGA are now accepting medicines because of activities completed during the last MAM. This serves as motivation for other LNTDs. Another LNTD shared how advocacy visits to some members in the community led to donation of items to help the smooth execution of MAM. Also engagement of National Orientation Agency help in creation of more awareness and about the programme.
- ! LNTDs discussed about the timeframe for report which is set by the NTD office, they said that the one week given for reporting is too short and that compromises the quality. This allowed for time to be increased for reporting.
- ! There was no representative of any of the non-governmental and development partners working in the State except researchers from COUNTDOWN. Involving partners allow for sharing of ideas and clear understanding of the terms and areas to partner in. Implementing partners like Sightsavers, Evidence Action, UNICEF etc may all be part of such planning meetings.
- ! LNTDs of the various LGAs seemed unsure of the projected/expected population needing treatment. Therefore, census update in all LGAs should be completed before the planning meeting. That way, each LGA comes to plan with a reliable population target. Alternatively, recent figures used by a health programme in LGAs which has been ascertained to be reliable by the LGA team can be used to support the planning.
- ✓ It was observed that participants at the meeting only stumbled on areas needing details when they arrived at the meeting. It is therefore suggested that a planning template should be shared to all that will be attending ahead of the meeting so that everyone will study and prepare before the meeting.
- ✓ ! LNTD explained that they have high level of attrition because in some communities, they engaged young people as CDDs (mostly those that just completed their secondary school) and they normally will leave once they get admissions. The Social Mobilisation officer suggested the involvement of Volunteer Community Mobilisers (VCMs). It was accepted as a good idea, but the challenge was the fact that they are paid a monthly allowance of 5000 naira by UNICEF which is greater than the renumeration currently provided by the NTD implementation programme.
- ✓ One of the participants at the meeting advised that the activities should be fixed in accordance with when the planning meeting takes place because people may forget if the gap between the meeting and implementation is too long. Dates could be input in a separate meeting so as not to delay planning.
- ! During the planning the LNTDs were not able to fill the budget column and more training should be provided in this area in advance of future planning activities.
- ✓ At macroplanning the need for more CDDs and for the workforce to be diverse was advocated for, this includes CDDs living with disabilities, and women.
- ! At macroplanning, a new urban strategy of fixed post distribution was discussed to mitigate against the challenges of house to house distribution for those not at home during MAM.

Key: **Evidence informed**

REFLECTIONS FROM STATE PLANNING MEETINGS

- Distribution methods were encouraged to be equitable and reach previously missed populations like migrant communities and people with disabilities.
- When people become tired and not interactive at meetings it may be good to introduce ice breakers and energisers.
- During the macroplanning meeting, the programme officer from the implementing partner explained that in the past the Directors of Public Health at the local government level were not involved in the NTD programme, but now they are being carried along. She stated that this is strategic because it will support the work of the Local Government Neglected Tropical Diseases (LNTD) coordinators and help them know what is going on and stay in touch with the processes at the State level.

ADVOCACY FOR RESOURCE AND FUNDS MOBILISATION

A key aspect of the NTD programme is funding without which a lot of expected outcomes may not be achieved. A situational analysis conducted in 2017 by the COUNTDOWN research showed that funding gaps are one among other factors that impact the programme negatively.

See **https://countdown.lstmed.ac.uk/sites/default/files/content/centre_page/attachments/policy_summary_final.pdf**

Therefore, to achieve effective coverage of treatment, there may be need for engagement of different stakeholders to harness opportunities for funding or support through resource mobilisation activities. The current structure of funding for the community-based MAM in many States of Nigeria is through implementation partners, for example Sightsavers and UNICEF. However, relying just on donor funding can be problematic and can limit coverage due to increasing demands in terms of human and material resources. Sourcing for additional funds therefore through resource mobilisation and advocacy becomes a need both at the State and LGA levels. Some activities that may need funding may cut across all MAM activities such as logistics for sensitisation, advocacy, medicines logistics and delivery, financial and non-financial incentives for programme volunteers, venues and human resources.

Where there is such a funding gap which will impact negatively on the outcome of the programme, the SNTD, the LNTD and representatives of communities may consider constituting a resource mobilisation sub-team with a goal of mobilising extra resources through engaging with public and/or private individuals and organisations using the Costing toolkit. (For further details to support this see the Costing tool for equitable Mass Administration of Medicine, 2021).

THINGS TO CONSIDER BEFORE SETTING OUT FOR RESOURCE MOBILISATION

All MAM activities are crucial, hence must be accounted for. Similarly, resources mobilised for every activity will need to be accounted for and audited. Therefore, sub-teams with the responsibility of mobilising additional resources will need to put together a budget that aligns with an action plan (either microplanning or macroplanning) to clearly identify the gap and the resources required.

WHO SHOULD BE INVOLVED?

Decisions in the NTD programme are better taken collaboratively. Therefore, who should be involved depends on the level where the resources are needed, and the resource mobilisation conducted.

Example of stakeholders to engage at the LGA level include:

- LNTD
- MoH
- DPHC
- Apex nurse
- Health educator / SMO
- Representatives of CDCs, CDAs
- Religious bodies e.g. CAN and JNI
- Representatives of the SNTD coordinator
- Representative of zonal FMOH
- Representative of civil society
- Representative of Artisans
- Representative of transport association e.g. NURTW

At the State level, the team can include:

- DPH
- The SNTD coordinator
- Logistics and data officer
- Representative of donor partners for community MAM in the State
- Representatives of civil rights groups
- Representatives of PWDs etc.

WHAT WE LEARNED FROM RESOURCE MOBILISATION

WHY ADDITIONAL FINANCIAL AND NON-FINANCIAL RESOURCES WERE NEEDED:
An alternative distribution strategy called the Health Worker Ivermectin Administration (HWIA) was co-created in the south western State, Nigeria (see Module 3). Extra resources were needed to support additional activities such as financial incentives for health workers, recorders and mobilisers that were engaged and the purchasing of markers for marking of thumbs of persons who have been administered the medicines etc. These were additional activities that needed to be funded. They approached the LG Chairman and other stakeholders like religious bodies for financial support and they were given which was used to augment the financial gaps.

In the State, microplanning was not usually funded despite being an important aspect of MAM. The SNTD team sought funding for this activity through presenting a predicted budget and rationale for the importance of the activity to the COUNTDOWN research consortium. This request was backed by genuine need hence, the consortium sponsored the activity in all the LGAs that conducted community treatment for onchocerciasis and LF in the State.

At the LGA level, the NTD team paid advocacy visits to stakeholders including:

- CDCs,
- WASH,
- community department and
- the executive chairman of the LGA.

In response, there were donations of aprons, dose poles etc for MAM.

POTENTIAL SOURCES FOR RESOURCE MOBILISATION

Different organisations and individuals can be approached for the purpose of resource mobilisation. These may include:

- Politicians
- Philanthropists
- Companies e.g. Breweries and beverages companies like Cadbury and Guinness
- Multinational companies like MTN, Shell, Globacom etc.

EXAMPLES OF ACTIVITIES FOR RESOURCE MOBILISATION

- The secretary to the Council promised to support MAM with twenty dose poles, the Community Development Committee (CDC) Chairman promised to support with customised T-shirts while the COPHOONS Chairman pledged provision of potable water for pupils to take the medicines in their schools.
- The LNTD liked the idea of forming a health advocacy team as recommended by the PGP. This will enable the NTD team in the LGA to reach more stakeholders for MAM. Meanwhile, the HOLGA and WASH department were reached for the first time for MAM this year due to PGP recommendation.
- The Director of the Department of Sanitation Services, the Deputy Director, the officer in charge of emergency relief were all paid advocacy to gain their support.
- There was a personal visit to the Head of Local Government Administration (HOLGA) of the LGA. The team also met with the traditional ruler of Ayetoro to secure a venue for the local microplanning meeting and sensitised him in the process about MAM.
- The LGA team led by the MOH paid an advocacy visit to the LGA chairman and other social and non-governmental associations like Rotary Club to mobilise additional resources to support the new MAM strategy in the LGA. Resources mobilised in the process were used to increase incentives given to the MAM teams and for the purchase of markers to mark the thumbs of persons administered the medicine.

CHECKLIST

DO YOU HAVE:

- [ ] A plan of how to engage community views
- [ ] A plan for holding a microplanning including an agenda, a list of stakeholders to engage and invite letters
- [ ] A plan for holding a macroplanning including an agenda, a list of stakeholders to engage and invite letters
- [ ] An advocacy plan for addressing any resource gaps

NOTES

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ANNEX

STAKEHOLDER ANALYSIS

PURPOSE OF THIS ACTIVITY

To understand the needs and concerns of different stakeholders as they are likely to shape the outcome of programme and policy implementation.

RESOURCES NEEDED

- **Stakeholder grid (See below as an example)**

KEY CONSIDERATIONS

- Every engagement process needs to be planned effectively; this includes making sure adequate funds are in place.
- Give stakeholders the opportunity to help plan their own engagement.
- Be inclusive - don't forget Persons With Disability (PWD), youths and gender balance.
- Don't forget to feedback to your stakeholders as soon as possible/in a timely manner.
- Ensure your communications can be easily understood by your stakeholders – use of simple language or local language.

THE PROCESS

The first step is to identify all the stakeholders or interest groups associated with the delivery of MAM who should be engaged in planning processes. Groups should consist of 6-8 people who have a varied perspective on MAM. This is considered enough to create a good brainstorming session. Stakeholders can be organisations, groups, departments, structures, networks or individuals, but the list needs to be pretty exhaustive to ensure nobody is left out. The following grid may help organise the brainstorm or provide a structure for feedback to plenary if you are working in breakout groups.

POLICY MAKERS/ IMPLEMENTERS	PUBLIC SECTOR STAKEHOLDERS	CIVIL SOCIETY	COMMUNITY MEMBERS
• State NTD coordinator • Federal Ministry of Health • State NTD team • Local Government • NTD team • Monitoring & evaluation • Social mobilisation officers • LGA NTD coordinators • Medical Officer of Health	• Chief pharmacist • Apex nurse and health education officer	• Implementing partners officers • Representative of CHAN • Representative of FOMWAN • Representative of National Orientation Agency	• Community leaders • Men • Women • People living with disability • Migrant populations • Youths • Elders

Figure 1: Stakeholder Analysis

Then, using the grid in Figure 2, which has been taken from the ODI (ref below), organise the stakeholders in different matrices according to their interest and power. 'Interest' measures to what degree they are likely to be affected by the MAM planning processes and changes to it, and what degree of interest or concern they have in or about it. 'Power' measures the influence they have over MAM delivery, and to what degree they can help achieve, or block, the desired change. Stakeholders with high power, and interests aligned with the project, are the people or organisations it is important to fully engage and bring on board through invitation to planning meetings. At the very top of the 'power' list will be the 'decision-makers', usually members of the government. Beneath these are people whose opinion matters – the 'opinion leaders'.

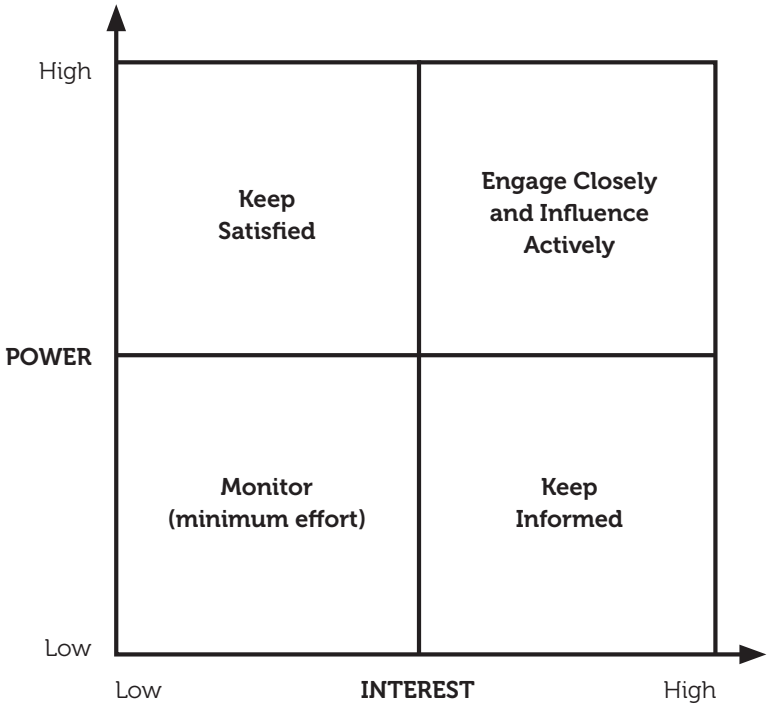

Figure 2: Influence Map

Keep stakeholders with high interest and low power informed as they may form the basis of an interest group or coalition which can lobby for change. Those with high power but low interest should be kept satisfied and ideally brought around as are important to the programme and policy change.

The final step is to develop a strategy for how best to engage different stakeholders in the MAM programme, how to 'frame' or present the message or information so it is useful to them, and how to maintain a relationship with them. Identify who will make each contact and how, what message they will communicate and how they will follow-up.

Adapted from: *Overseas Development Institute Successful Communication: Planning Tools (online)* ***https://www.odi.org/sites/odi.org.uk/files/odi-assets/publications-opinion-files/6459.pdf*** *(accessed) 11.06.2019*

ACKNOWLEDGEMENTS

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COUNTDOWN acknowledges the under listed for their various contributions to the research and its outcome:

- The research ethics committee, Federal Ministry of Health, Nigeria, headed by Prof. Zubairu Iliyasu.
- The research ethics committee, Liverpool School of Tropical Medicine.
- The National Coordinator of NTD programme at the Federal Ministry of Health, Dr. Chukwuma Anyaike.
- Directors of Public Health in Kaduna and Ogun States Ministries of Health, Drs. Ado Zakari and Festus Olukayode Soyinka.
- State Coordinators of NTD Programme in Kaduna and Ogun, Mallam Mohammed Bukar and Dr Islamiat Soneye.
- Staff of Federal and State Ministries of Health on the project: Mr. Gideon Uduak, Hauwa Mohammed, Mohammed Danjuma, Adebisi Faneye and Mrs Kafil Emiola.
- Local Government staff and coordinators of NTD programme in the various research intervention LGAs: Hauwa Mohammed, John Adamu (Kaduna State), Ganiyat Sodipo and Babarinde Oyegbule (Ogun State).

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ORGANISATIONS / INSTITUTIONS:

Federal Ministry of Health, Nigeria
Kaduna State Ministry of Health
Liverpool School of Tropical Medicine
Ogun State Ministry of Health
Sightsavers
Welton Media Ltd

Thank you to all heads of communities and members across both States for their support and contribution to the study.

Names listed alphabetically.

Version 2 | March 2021

In partnership with:

FEDERAL MINISTRY OF HEALTH
OGUN STATE NIGERIA
Sightsavers
LSTM LIVERPOOL SCHOOL OF TROPICAL MEDICINE
UKaid from the British people

The research is funded by the COUNTDOWN programme (Grant ID - PO 6407) which is a multi-disciplinary research consortium dedicated to investigating cost-effective, scaled-up and sustainable solutions, necessary to control and eliminate the seven most common NTDs. COUNTDOWN was formed in 2014 and is funded by UKAID, part of the Foreign, Commonwealth and Development Office (FCDO).