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

TO TACKLE NEGLECTED TROPICAL DISEASES

MODULE 1

MAM PROCESS AND ROLES AND RESPONSIBILITIES FOR PARTICIPATORY PLANNING IN MAM

COUNTDOWN

Calling time on Neglected Tropical Diseases

MODULE 1

INTRODUCTION TO PARTICIPATORY PLANNING FOR INCREASED COMMUNITY ENGAGEMENT AND EQUITY IN MASS ADMINISTRATIONS OF MEDICINES

AIM OF GUIDE

This participatory guide for planning (PGP) equitable mass administration of medicines (MAM) has been developed with and for NTD implementers and other NTD actors (donors, NGOs, implementing partners, researchers, and other cross-sectoral partners). The primary goal of the PGP is to help implementers take a more context specific, bottom up, inclusive approach to increasing equity within MAM. The tools presented here aim to:

- Enhance community engagement and ownership of MAM using tools and techniques to identify where and when people are located during MAM campaigns.
- Improve equity in treatment coverage by better connecting with people who are continuously missed by MAM campaigns - these marginalised populations have been identified through research.
- Ensure MAM campaigns are planned to respond to context differences rather than one size fits all approach.
- Maximise stakeholder participation in planning, especially at the community and Local Government Area (LGA) level.
- Aid and encourage easy access to supportive resources including facilities, equipment, funding and human resources.
- Enhance collaboration across the health system and across multiple sectors to maximise support for MAM.
- Encourage systematic and timely planning of all MAM activities by NTD implementers.
- Stimulate solution-focused review of MAM campaigns.
- Move NTD programmes towards universal health coverage.

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.

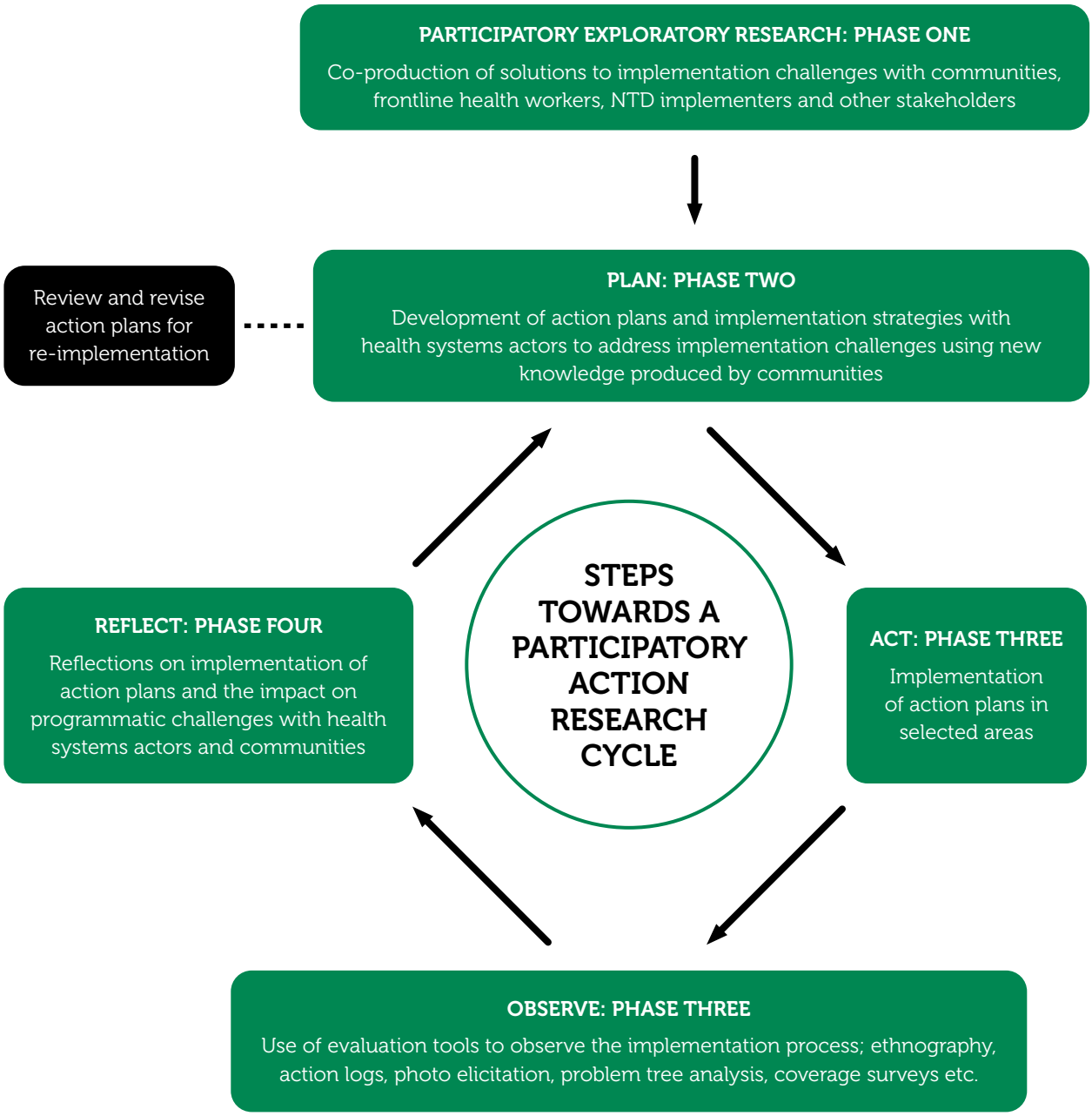


Figure 1. PAR approach to improving equity in MAM (Ozano et al., 2020)

HOW TO USE THE GUIDE

This participatory guide for planning (PGP) will help you develop action plans at both the micro and macro level for planning MAM for Onchocerciasis (Oncho) and Lymphatic Filarisis (LF). Suggested actions are presented throughout the modules however the specific context of your communities should be considered, and actions should be selected and modified as appropriate.

This participatory guide for planning is an interactive way to plan MAM for State coordinators, NTD local government coordinators and others. It provides knowledge and planning mechanisms for MAM including the need to plan based on context (rural/urban) as specific LGA plans may, and should, differ. It also provides an opportunity for building partnerships and collaborations with various stakeholders in determining who to involve, organising the meetings and crafting the agenda and financial responsibility for effective planning.

MAM can be thought of as a process (Figure 2). This guide will take you through the phases of MAM and help guide your planning process. There are four modules which cover how to plan, implement and review the MAM process. Throughout this guide we will present examples of implementation from these two States and highlight context specific actions from urban and rural LGAs. Alternative strategies, methods and techniques will also be discussed.

The actions and recommendations presented here should be considered alongside potential feasibility and sustainability considering timeline, budget and resources available to the programme. This is a working document and can be revised and adapted as health systems change over time.

Alongside this PGP, other tools have been developed to support NTD implementers to increase equitable coverage and uptake for NTD programmes. These additional tools include:

- Learning packs that presents findings for improving community engagement and IEC materials.
- A costing tool kit which can be used by implementers to develop budgets and lobby for funds.
- A training video which visually demonstrates how to use this guide.

OVERVIEW OF MODULES

MODULE 1

MODULE 1: MAM PROCESS AND ROLES AND RESPONSIBILITIES FOR PARTICIPATORY PLANNING IN MAM will introduce you to the process of MAM and the PGP, and what over-arching steps are needed to make achievable and context specific actions. We will also discuss the roles and responsibilities of the various stakeholders of MAM.

By the end of this module you will:

- **Have an understanding of MAM and why it is important.**
- **Understand how to use this guide, its background and how the evidence has been produced.**
- **Understand how the guide can be used to aid equitable planning and implementation of MAM.**
- **Gain an understanding of roles and responsibilities of the workforce and different stakeholders needed to implement MAM activities.**

MODULE 2

MODULE 2: INCLUSIVE BOTTOM-UP PLANNING FOR MAM has two sections 2A and 2B. Module 2A will explore the importance of community engagement in planning for MAM as well as the different methods that can be used to help understand and address community priorities. Module 2B describes the different planning meetings that can take place; how to identify who to involve in these meetings; and how to structure these meetings to achieve a more equitable MAM programme.

MODULE 2A

MODULE 2B

MODULE 2A: ENHANCING COMMUNITY ENGAGEMENT FOR PARTICIPATORY PLANNING details key activities that you can undertake to better understand how to engage communities in MAM and the community stakeholders that can support you. By the end of this section of Module 2 you will:

- **Understand how to engage a wide range of community members so you how, where and with whom they want MAM to take place.**
- **Have key tools and techniques to help you elicit community reflections and identify who is currently missed out in MAM and why.**
- **Be able to employ community engagement activities to understand how to address programme challenges in reaching certain groups.**

MODULE 2B: PARTICIPATORY PLANNING TO INCREASE EQUITY IN MAM describes the different planning meetings that could take place to increase equity and mobilise resources. This module will support you with the following:

- **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.**
- **How to identify who to involve in these meetings.**
- **How to structure these meetings to achieve intended outcomes.**
- **Have developed a draft agenda for your planning meetings.**
- **How to mobilise resources to support implementation.**

MODULE 3

MODULE 3: INCLUSIVE ACTION PLANNING FOR EQUITY IN MAM

In this module you will be guided on how to develop an action plan for MAM implementation in your LGA. This module is divided into the phases of MAM which need to be considered for local planning. In each section we give examples from evidence of what worked well and what are some challenges to consider when planning for equitable MAM. Consideration of context is very important when planning for MAM and we will give some examples from both urban and rural LGAs. Local action planning has been shown to have an impact on acceptability, accessibility, availability and coverage of MAM.

Using the examples provided, by the end of the module you will have a completed action plan which is specific to your LGA, which can be used to guide equitable MAM. You will be able to:

- **Develop an action plan which is specific to your LGA, which can be used to guide equitable MAM.**
- **Identify key people, structures, content and timing for all phases.**
- **Identify what resources are needed throughout the stages.**
- **Consider potential challenges which may be faced throughout this process and identify how they can be mitigated.**
- **Gain an understanding of different methods, tools and communication strategies which can be used in different contexts.**

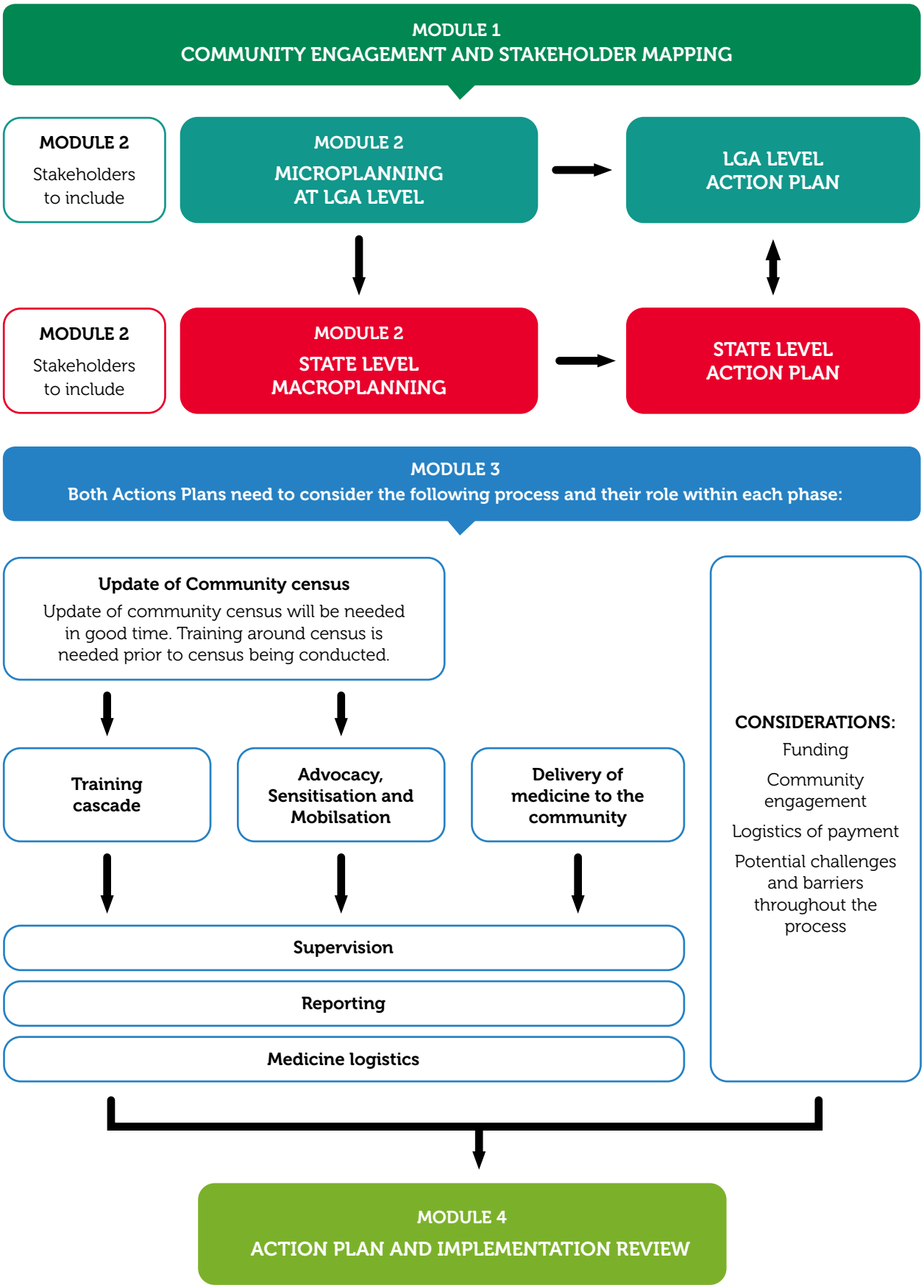
MODULE 4

MODULE 4: REVIEWING MAM IMPLEMENTATION FOR ONGOING IMPROVEMENT will focus on how to ensure that the action plan you developed in Module 2 and 3 is implemented effectively. It will guide you through following the action plan, how to capture and use learning during implementation and tools to aid review and reflections. By the end of this module you should have a clear plan of:

- **How you will capture learnings throughout this year's MAM implementation cycle.**
- **How you will draw stakeholders together to bring everyone's learnings at the end of the process.**
- **How you will use these learnings to shape future planning activities.**

PROCESS OF MAM

Figure 2



ROLES AND RESPONSIBILITIES OF VARIOUS STAKEHOLDERS

The health system that is responsible for the implementation and governance of NTD programmes includes the federal, State, LGA and community levels. This follows the government political structure in the country and their roles and responsibilities are listed below. These actors are referred to throughout the tool and various icons are used to depict the key parts of the process with which they are normally engaged.

ROLE OF STATE NTD (SNTD)

- Request adequate number of medicines from FMoH.
- Inform the Local Government NTD coordinators (LNTDs) when the MAM programme will commence for the year.
- Invite LNTDs for State planning meetings.
- Provide training and refresher training to LNTD coordinators on MAM procedures, documentation and effective monitoring and supervision of MAM activities for the year.
- Allocate the required number of medicines to each LGA.
- Coordinate the movement of medicine from the State to the LGAs.
- Ensure adequate number of materials e.g. Information, Education and Communication (IEC) materials and dose poles get to all endemic LGAs.
- Supervise the MAM activities in the State.
- Complete the State summary form level 4.
- Send MAM report/data to FMoH via zonal coordinators.
- Conduct advocacy visits, mobilisation and sensitisation at the State level to media houses, overall traditional leader in the State, house of assembly and commissioner of health.
- Return of reverse logistics: collecting the remaining medicines from local government to State.
- Facilitate integration of NTD activities into existing health facilities in the communities.
- Support LGAs and communities in the implementation of the annual operational plan.
- Where there are funding gaps, constitute a sub-team to mobilise and source for funds and sponsorship from philanthropists, associations and organisations.

ROLES AND RESPONSIBILITIES OF DIRECTORS OF PRIMARY HEALTH (DPH) AND MEDICAL OFFICERS OF HEALTH (MOH)

- Coordinate relevant staff of the primary health care (PHC) for planning, implementation and evaluation of MAM.
- Supervise MAM activities using supervision checklist.
- Ensure LNTDs, frontline health facilities (FLHFs), Ward Focal Persons and Community Directed Distributors (CDDs) all perform their roles in MAM effectively.
- Support the LNTD with logistics to collect required number of medicines and materials required for MAM.
- Lead advocacy to stakeholders in the LGA to support the NTD programme.
- Lead resource mobilisation and management efforts for MAM in the LGA.
- Supervise training at all levels in the LGA to ensure quality (See NTD training SOP).
- Attend to incidents of adverse events for MAM in the LGAs.
- Support LNTD to organise microplanning for MAM at LGA level.
- Lead monitoring team for MAM in the LGA.

ROLE OF LNTD COORDINATOR

- Lead the implementation of programme activities in the LGA.
- Ensure the collection of implementation materials and medicine from the State.
- Follow the action plan at the local level to ensure it is implemented and that all tasks are followed and adhered to by stakeholders.
- Alter actions in the plan if changes occur for any reason.
- Ensure each health facility in the LGA get the required amount of medicine needed.
- Supervision in the LGA and use of monitoring checklist.
- Ensure reverse logistics of medicines to the State after completion of MAM.
- Collect treatment data from the health facility.
- Request the list of CDDs from the FLHF.
- Complete LGA summary form level 3.
- Send reports/data to the State.
- Ensure sensitisation of key community structures.
- State NTD staff will assist the LNTD during the FLHFs training and throughout the implementation process.
- Request for report of incidents of adverse events in the LGA.
- Identify people with IDM cases (Infectious disease management) in NTDs and submit the list to the State.

ROLES AND RESPONSIBILITIES OF ASSISTANT LNTD

- Assist the LNTD to invite participants for microplanning at the LGA level.
- Support the LNTD to plan and deliver training at the LGA.
- Take part in data collection and validation.
- Monitor MAM exercise and be part of supervision and reporting.
- Assist the LNTD to ensure CDDs, FLHF and ward focal persons perform their roles effectively.
- Check that logistics are adequately provided for all MAM related activities.
- Assist the LNTD in terms of record-keeping for each cycle of MAM or as may be assigned.
- Support the LNTD in taking inventory for medicines and assist to coordinate the process of data submission from CDDs to FLHF etc.

ROLES AND RESPONSIBILITIES OF HEALTH EDUCATORS/ SOCIAL MOBILISATION OFFICERS

- Liaise with the LNTD to conduct sensitisation and advocacy activities in the LGA to stakeholders such as NURTW, ACOMORAN, AMORAN, artisans, market leaders, Ward Development Committees (WDC) / Community Development Committees (CDC), different ethnic groups, religious leaders, LGEA, ZEO, etc).
- Take part in community mobilisation.
- Facilitate community dialogue in the event of medicine apathy.
- Take part in developing IEC materials to ensure language versions are correct.
- Assist the LNTD in sending notification letters for meetings and other activities.
- Facilitate trainings of town announcers and mobilisers using key messages and frequently asked questions on MAM.

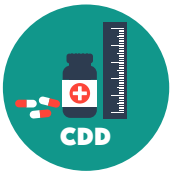
ROLES AND RESPONSIBILITIES OF WARD FOCAL PERSONS/FLHFs

- Train CDDs on MAM implementation.
- Conduct sensitisation meeting with village heads for them to select CDDs.
- Provide CDDs with supportive supervision throughout MAM.
- Guarantee that data tools, namely community-based treatment register, are filled promptly and correctly without errors.
- Support the CDDs to conduct a census.
- Update treatment registers prior to medicines allocation to their communities.
- Handle adverse events associated with MAM.
- Assist the CDDs to complete the village summary form level 1.
- Complete summary form level 2.
- Collection of medicines from the LGA medical store to their facilities.
- Reverse logistics from the FLHF to the LGA store.
- Support supervision of CDDs.

ROLE OF COMMUNITY LEADERS

- Facilitate sensitisation of the community about the MAM programme.
- Contact CDDs from previous years and ask if they will remain as CDDs.
- Conduct community meetings to select and recruit new CDDs where necessary.
- Discuss with community members about any voluntary incentives that may be used to support CDDs to do their work.
- Send letters to other community leaders about the commencement of the MAM.
- Monitor the distribution of medicines i.e. community self-monitoring.
- Liaise with leaders of other ethnic groups e.g. non-indigenous or migrant to sensitise and nominate persons from their communities to attend training and distribute medicines.

ROLE OF COMMUNITY DIRECTED DISTRIBUTORS



- Ensure holistic and timely community sensitisation and mobilisation using IEC materials.
- Attend training for MAM.
- Conduct census for Onchocerciasis and LF treatment only.
- Distribute medicines in the community at the most appropriate time and place to reach as many community members as possible.
- Update and maintain the community-based treatment register.
- Complete the village summary form level 1.
- Return registers to FLHFs.
- Provide feedback on distribution process including any problems and side effects.
- Return remaining medicines to the FLHF.
- Conduct census for onchocerciasis and LF treatment.
- Distribute medicines using a dose pole in the community.
- CDDs should be able to read and write in order to assist the FLHFs in filling treatment registers.

ROLE OF PARTNERS

- Transportation of medicines from central medical store to the States.
- Reverse logistics.
- Fund management.

ROLES AND RESPONSIBILITIES OF FMOH REPRESENTATIVE

- Policy formulation on NTDs.
- Approve and supervise the release of medicines logistics to States for MAM.
- Conduct trainings to implementers at the State and other relevant levels for onward cascading to other levels.
- Supervision of MAM implementation in States and across other levels.
- Take part in advocacy and resource mobilisation for MAM at the State, LGA and community levels.
- Liaising with partners and donors for NTD programme.

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

ACKNOWLEDGEMENTS

COUNTDOWN
Calling time on Neglected Tropical Diseases

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).

RESEARCH ASSISTANTS IN BOTH STATES:

Azeez Abolaji
Sadiq Abubakar
Joshua Adams
David Adekunle
Awayi Namo Angela
Mathew Ayegboyin
Akintunde Albert Ayodeji
McRae Ayuba
Adedoyin Ademola Bernard
Adewumi Taiye Christiana
Filimon Musa David
Sogbuyi Imisioluwa Elijah
Bello Elizabeth
Chigaiti Faith
Hannah Ojone Hussaini
Damina Ibrahim
Adeniran Adebola Ismail
Shiabu James
Emmanuel Kachiro
Adebanji Adedayo Mathew
Oluwasewa Ogunkoya
Busola Ogunlana
Bukola Olagunju
Adeniran Gideon Olusanjo
Foluke Oluyemi
Olasupo Esther Opeyemi
Ozigi Emmanuel Samuel
Ide Siddi
Sodimu Samuel Sunday
Jimoh Nimot Temitope
Stella Udu
Dupe Yahemba

RESEARCHERS FROM SIGHTSAVERS:

Tosin Adekeye
Samson Ayuba
Ruth Dixon
Noela Gwani
Sunday Isiyaku
Gideon Kevin
Luret Lar
Damian Lawong
Akinola Oluwole
Bolanle Surakat
James Yashiyi

RESEARCHERS FROM LSTM:

Efundem Agboraw
Pamela Bongkiyung
Laura Dean
Julie Irving
Kim Ozano
Helen Piotrowski
Kelly Smyth
Sally Theobald
Rachael Thomson
Eve Worrall

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:

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).

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

TO TACKLE NEGLECTED TROPICAL DISEASES

MODULE 2A

ENHANCING COMMUNITY ENGAGEMENT FOR PARTICIPATORY PLANNING

COUNTDOWN

Calling time on Neglected Tropical Diseases

MODULE 2A

ENHANCING COMMUNITY ENGAGEMENT FOR PARTICIPATORY PLANNING

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

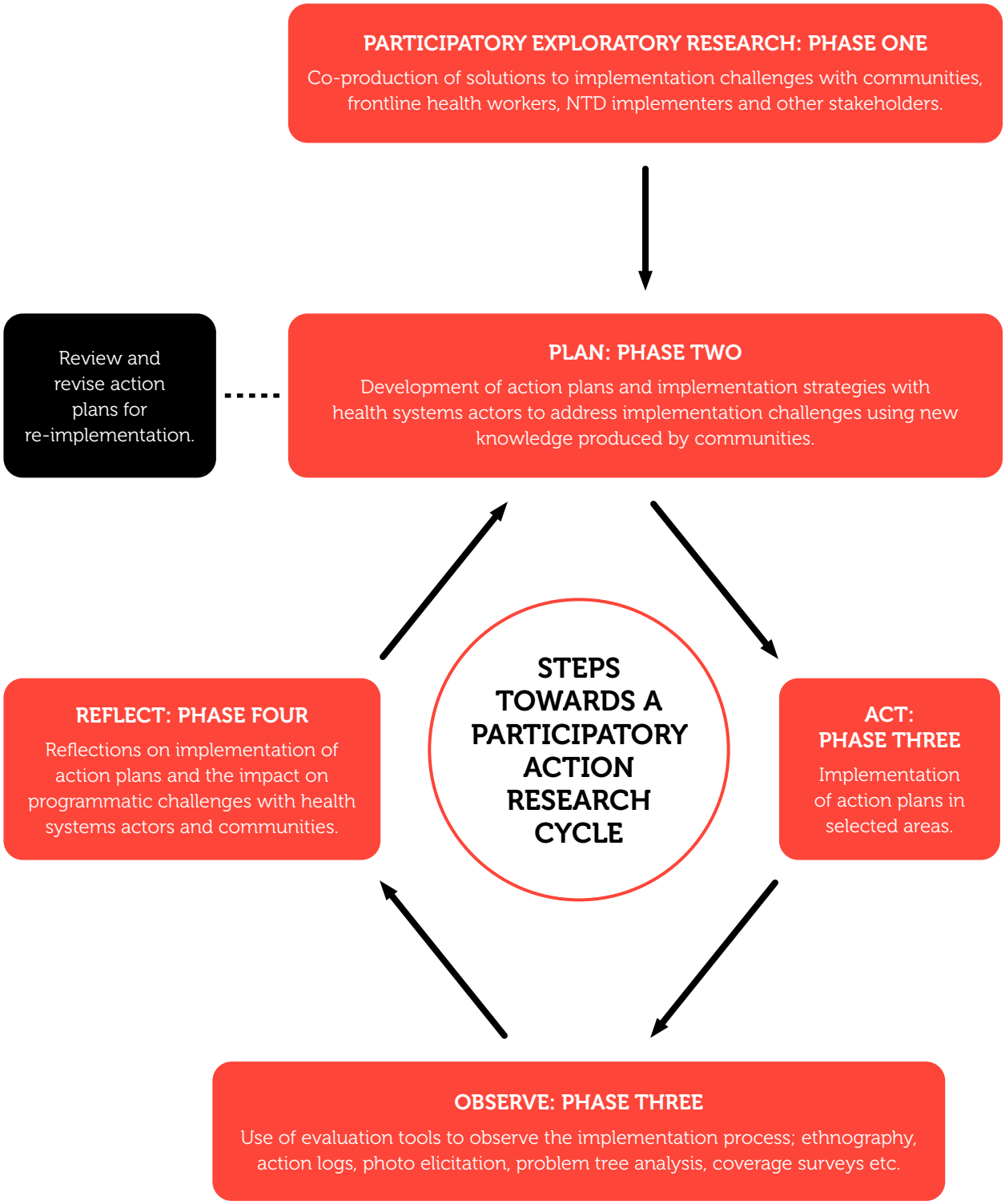


Figure 1. PAR approach to improving equity in MAM (Ozano et al., 2020)

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 2A

ENHANCING COMMUNITY ENGAGEMENT FOR PARTICIPATORY PLANNING

This module details key activities that you can undertake to better understand how to engage communities in MAM and the community stakeholders that can support you.

OBJECTIVES OF THE MODULE:

By the end of this section of Module 2 you will:

- **Understand how to engage a wide range of community members so you know how, where and with whom they want MAM to take place.**
- **Have key tools and techniques to help you elicit community reflections and identify who is currently missed out in MAM and why.**
- **Be able to employ community engagement activities to understand how to address programme challenges in reaching certain groups.**

Some faces have been blurred in photographs to protect confidentiality.

COMMUNITY ENGAGEMENT

Community engagement has always been at the centre of NTD programme delivery, specifically for MAM. Engaging communities effectively is likely to increase acceptance, support and funding for programmes in meeting coverage targets.

Community engagement methods can also be used to review challenges of MAM which can be discussed in review meetings, enabling future MAM to address these gaps identified. See Module 4 for more detail.

WHAT IS COMMUNITY ENGAGEMENT?

'Community engagement' in this context is the meaningful, respectful, and fit-for-purpose involvement of community members in one or more aspects of planning for NTD programme(s) and may include; involvement during the planning process, defining the MAM delivery structure and implementation and suggesting improvements.

(Definition adapted from Glandon et al 2017 https://academic.oup.com/heapol/article/32/10/1457/4582360).

BENEFITS OF EFFECTIVE COMMUNITY ENGAGEMENT:

Many community members of different ages suggested that if the village heads, community leaders, religious leaders or the chairperson of the community development association were involved in planning for MAM, it will increase acceptability and accessibility by reaching all members within that community.

Many reasons are given for why CDDs who are known by the community would be more acceptable, especially in sensitisation and mobilisation, compared to those that are not known by the community. Some community members reported that there is some distrust with Government initiatives or lack of knowledge about purpose of the medication, and therefore community members would be more likely to trust CDDs who they know because of this. They also report CDDs known by the community would be more efficient in their work as they know where to reach people, and appropriate timing to distribute medication.

Other members of the community highlighted the desire for trained health workers to distribute medications. Many suggested paired working between known CDDs and health workers would increase acceptability.

Both women and men need to be engaged in the process of planning and implementation of MAM. Through reflecting with community members on acceptability, accessibility and availability of MAM, many highlighted the need for female and male CDDs to be utilised, as in specific households only women could access women and men access men.

Key: **Evidence informed**

WHAT TECHNIQUES CAN WE USE TO ELICIT COMMUNITY REFLECTIONS?

The following section provides guidance on the different methods and techniques that can be used to engage with different groups of community members.

At the end of this module you will find detailed guides for each method so you can apply them in your setting. They can be revised to suit the context where you work and adapted for the people you will be engaging. A list of stakeholders is presented and all of the techniques can be applied with the groups. It is good to think about power and the effect this may have on group dynamics and communication. For example, some groups should be separated to encourage open communication, for example women and men, older and younger. Also think about the environment where they take place to ensure confidentiality of your participants.

TRANSECT WALKS

APPLICATION OF THE TECHNIQUE

This includes a walk through the community with stakeholders, for example community leaders, religious leaders, youth leaders, and women leaders to better understand locations and popular routes in the community that could be used for different MAM stages such as sensitisation and medicine administration within the community.

On the transect walk, questions you can ask may include:

- **What are key areas where sensitisation and mobilisation can take place?**
- **What group of people can/do use these places?**
- **Where are key locations to distribute medications?**
- **Who will be able to come to these locations?**
- **When is the best time to reach people here?**

WHAT ARE THE KEY CHALLENGES THIS METHOD CAN ADDRESS?

Through the transect walk across the community with different leaders or community members, they may be able to suggest important spaces where CDDs can interact with members of the community who are often invisible and may otherwise be missed in mobilisation or medicines delivery.

This may include:

- **Women**
- **People With Disabilities (PWDs) such as people who are immobile, have lost their sight or are deaf.**
- **Migrant communities, for example, the Fulanis, Ohori and Eegun community.**

Some faces have been blurred in photographs to protect confidentiality.

SOCIAL MAPPING

APPLICATION OF THE TECHNIQUE

Social mapping includes engaging with community members to map out places in the community where people interact and the different structures or groups that exist within the community. The map will show the boundaries, key landmarks and meeting points for different types of people within the community, e.g. women, men, youth, children, elders etc.

Questions asked could include:

- **How could the places identified in the map increase the reach for medicines distribution?**
- **How can existing places/structures/organisations be engaged in MAM, either in sensitisation, mobilisation, advocacy or medicine management and distribution?**

WHAT ARE THE KEY CHALLENGES THIS METHOD CAN ADDRESS?

Social mapping can be particularly useful in trying to understand how to make sensitisation and mobilisation and medicines delivery more accessible to community members. E.g. where would the best distribution points be? Who would you reach at these areas?

Through social mapping, community members could suggest alternative structures to the existing ones in the community map which could be used to administer medicines.

These could include the football field to reach more youths, the market place for more women and the social centres for more accessibility to the men.

To see examples of what was learned when NTD implementers conducted transect walks and social mapping in different contexts, see our **learning packs** from Ogun and Kaduna which can be found in this toolbox or online here:

https://countdown.lstmed.ac.uk/publications-resources/tools-and-booklets

IN-DEPTH INTERVIEWS (IDIs)

APPLICATION OF THE TECHNIQUE

IDIs entail having discussions with selected community members on how to improve on MAM. Participants could include:

- **Marginalised groups within the community e.g. someone with a disability or someone from a migrant community for example.**
- **People who previously refused medicines but later accepted or people who were previously absent during MAM but are now present.**

WHAT ARE THE KEY CHALLENGES THIS METHOD CAN ADDRESS?

Through IDIs, people who are often missed in MAM can be identified and accessed. For example, PWDs may be able to recommend better ways to access medicines and to access information about MAM.

Secondly, selected individuals may advise on what could be done to encourage people to accept medications.

Confidentiality of individuals interviewed must always be maintained.

APPLICATION OF THE TECHNIQUE

FGDs are a good way to understand from community members their experiences around awareness, availability, accessibility, acceptability and areas for improvement for MAM implementation.

This could include having separate discussions with older and younger women, older and younger men.

WHAT ARE THE KEY CHALLENGES THIS METHOD CAN ADDRESS?

Through focus group discussions, community members may be able to suggest appropriate timing/season of distribution of medicines where people will be available and not missed during treatment.

Secondly, community members may be able to suggest preferable ways for awareness of MAM to increase acceptability of medicines.

Confidentiality of individuals interviewed must always be maintained.

Some faces have been blurred in photographs to protect confidentiality.

WHO CAN THESE METHODS BE USED WITH?

Each of these methods can be used with anyone within the community or individuals familiar with the community to understand their views and preferences. The box below shows the type of people you may want to engage using these methods and to understand views from to shape the MAM planning process. These groups can also be useful in shaping other activities e.g. social mobilisation and sensitisation. *(See Module 3).*

- Religious leaders
- Community leaders
- Older men and older women
- Ward health committees
- Community Based Organisations (CBOs)
- Commercial Operators of Motorcycles and Riders of Nigeria (ACOMORON) and Marwa (tricycle riders)
- State NTD (SNTD)
- National Union of Road Transport Workers (NURTW)
- Local Government NTD (LNTD)
- Jama'atul Nasir Islam (JNI)
- Community Development Committees (CDCs) as one of the important gateways through which community sensitisation can be carried out
- Health teachers' forum (AOPSHON) (association of primary school health teachers of Nigeria)
- Persons with Disabilities (PWD)
- Fulani leaders (Ardos) and other migrant communities
- Market women leaders
- Faith Based Organisations (FBOs)
- Christian Association of Nigeria (CAN)
- Trade associations (Hair dressers association leaders, tailors association leaders and fashion designers)
- Youth associations
- Federation of Muslim Women Association in Nigeria (FOMWAN)
- Traditional Birth Attendants (TBAs)
- Frontline Health Facility Staff (FLHFs)
- Community Drug Distributors (CDDs)
- Community Engagement Officer
- Community Development Committee
- Artisan groups
- Disabled peoples associations (DPOs)

'It was through the help and guidance of the PGP that this sensitisation of fashion designers was carried out, similar to the sensitisation of Association of Bricklayers and the Iyaloja and Babaloja in the LGA.'

(LGA implementer)

COUNTDOWN

Calling time on Neglected Tropical Diseases

ANNEX

TRANSECT WALK GUIDE
(FOR USE WITH INFLUENTIAL COMMUNITY MEMBERS)

PURPOSE OF THIS WALK

To understand the communities in which you are working better. You are particularly interested in different areas/where different groups are located and interact. Remember that following the walk you will need to be able to understand how the community use the different spaces available to them as well as identify specific people you might want to engage in future data collection activities.

RESOURCES NEEDED

- **Flipchart paper**
- **Pens**

THE TRANSECT WALK

It is important to ensure that everyone who will be involved in the activity is clear on the purpose of the walk. Below is some text that will help you to explain this:

> ***I would like for us to take a walk by the most prominent route in your community to learn more about the location and distribution of resources within your community and how they are used or could be used to deliver health programmes within your community. I would also like to learn how people in your community interact with the local environment. I would like you to indicate during the walk meeting points for different types of people within your community, e.g. women, men, youth, children, elders etc., important community features, such as where people collect water, firewood, school, sports etc. as well as who the people of influence within the community are and where they are based (e.g. teachers, community leaders etc.)***

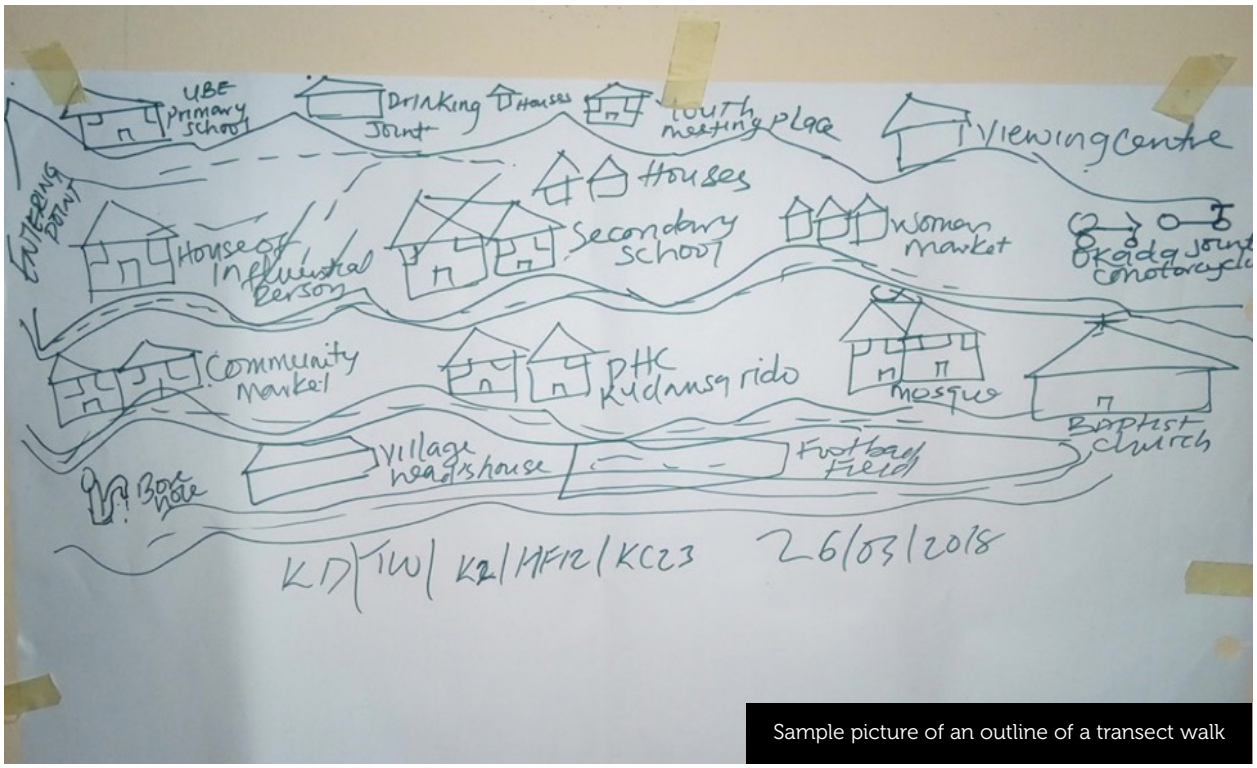
Once you have explained this, make sure you leave time for any questions and then walk the transect. Observe, ask, discuss and listen BUT DON'T LECTURE.

NB: You may want to also define what you mean by community structures, for example: it can be a group, an organisation or an individual. It can include influential community members, education groups, schools, religious institutions, art and drama groups, disability support groups, informal and formal community structures etc.

As you walk identify the main things you might want to include in the different sections of the community. Below are some questions that might help you instigate these observations and discussions:

- **What is located here?**
- **Who meets there?**
- **How frequently do people meet there?**
- **How long has this been there?**
- **Where do people collect water?**
- **Where do people collect firewood?**
- **Where do people pray?**
- **What times of day/year do people meet at specific places/complete specific activities?**
- **Where are the points and people of influence within the community located?**

Once you have walked the transect, sit down somewhere with all your participants and draw the outline of the walk you have taken at the top of a piece of paper.



Sample picture of an outline of a transect walk

Then draw a grid beneath the transect that explores different areas of the transect and discuss some of your observations, an example of the type of the grid follows. It's your job as the facilitator to make sure that you encourage the participants to reflect on these different areas with you so that you get a sense of how the community functions. The observations in each box don't need to be overly detailed.

TYPE OF STRUCTURE	House				
WHO INTERACTS THERE (MEN, WOMEN, CHILDREN ETC.)	Family members (including mother, father, children)				
TIMES OF DAY	Morning and Evening				
TIMES OF YEAR	All year				
CURRENT USE FOR HEALTH PROMOTION OR DELIVERY OF MAM[1]	Distribution of medicines				
OPPORTUNITIES FOR HEALTH PROMOTION OR DELIVERY OF MAM[1]	Repeat visits for mop up. Provision of information booklets				
CHALLENGES TO HEALTH PROMOTION OR DELIVERY OF MAM[1]	Husband controls access to the household				

SOCIAL MAPPING GUIDE

PURPOSE OF THIS ACTIVITY

- To understand the communities in which you are working better. You are particularly interested in different areas/where different groups are located and interact as well as different community structures.
- The knowledge that you gained from the transect walk can be used to probe for information based on some of the things you have seen in the community.

KEY CONSIDERATIONS

- It is important to ensure that everyone who will be involved in the activity is clear on its purpose.
- You may want to also define what you mean by community structures, for example: it can be a group, an organisation or an individual. It can include influential community members, education groups, schools, religious institutions, art and drama groups, disability support groups, informal and formal community structures etc.
- Remember that you need to pass over control to the participants to draw the map for themselves, you are there to guide them and support them to add detail.
- Sometimes people will dominate in the group so do your best as the facilitator to encourage all participants to interact with the exercise.
- Some people may feel comfortable drawing with pen and paper, whereas others may prefer to draw in the ground using a stick, so take time at the beginning to understand how participants would like to do the drawing.
- Gain consent prior to any activity.

RESOURCES NEEDED

- **Flipchart paper**
- **Pens**
- **Consent forms**
- **For discussion section: An appropriate environment which is safe, has enough space and has limited or no distractions will need needed**

SOCIAL MAPPING ACTIVITY

Below is some text that will help you to explain what is detailed above:

I would like to learn more about structures in your community and how they are utilised or could be utilised within the delivery of health programmes, particularly when the stick medicine is being distributed. I would also like to learn how people in your community interact with the local environment and the different structures or groups that you tell me about. I would like you to firstly draw a map of your community that shows the boundaries, key landmarks and meeting points for different types of people within your community, e.g. women, men, youth, children, elders etc. It would be great if you could also mark on important community features, such as where people collect water, firewood, school etc. as well as who people of influence within the community are and where they are based (e.g. teachers, community leaders etc.)

As the participants begin to draw, you could begin to ask them questions about what they are drawing to gather more information, below are some questions that may help you do this:

- **What is located here?**
- **How frequently do people meet there?**
- **Who meets there?**
- **How long has this been there?**
- **Where do people collect water?**
- **Where do people collect firewood?**
- **Where do people pray?**
- **What social activities do people do? E.g. sporting, drinking etc.**
- **What times of day/year do people meet at specific places/complete specific activities?**
- **Where are the points and people of influence within the community located?**

Once the community map has been made, you need to review the map with the participants to understand current use and potential future use of different community structures in health intervention and MAM delivery. When thinking about this remember to encourage participants to think about:

(1) the sensitisation process

(2) mobilisation process

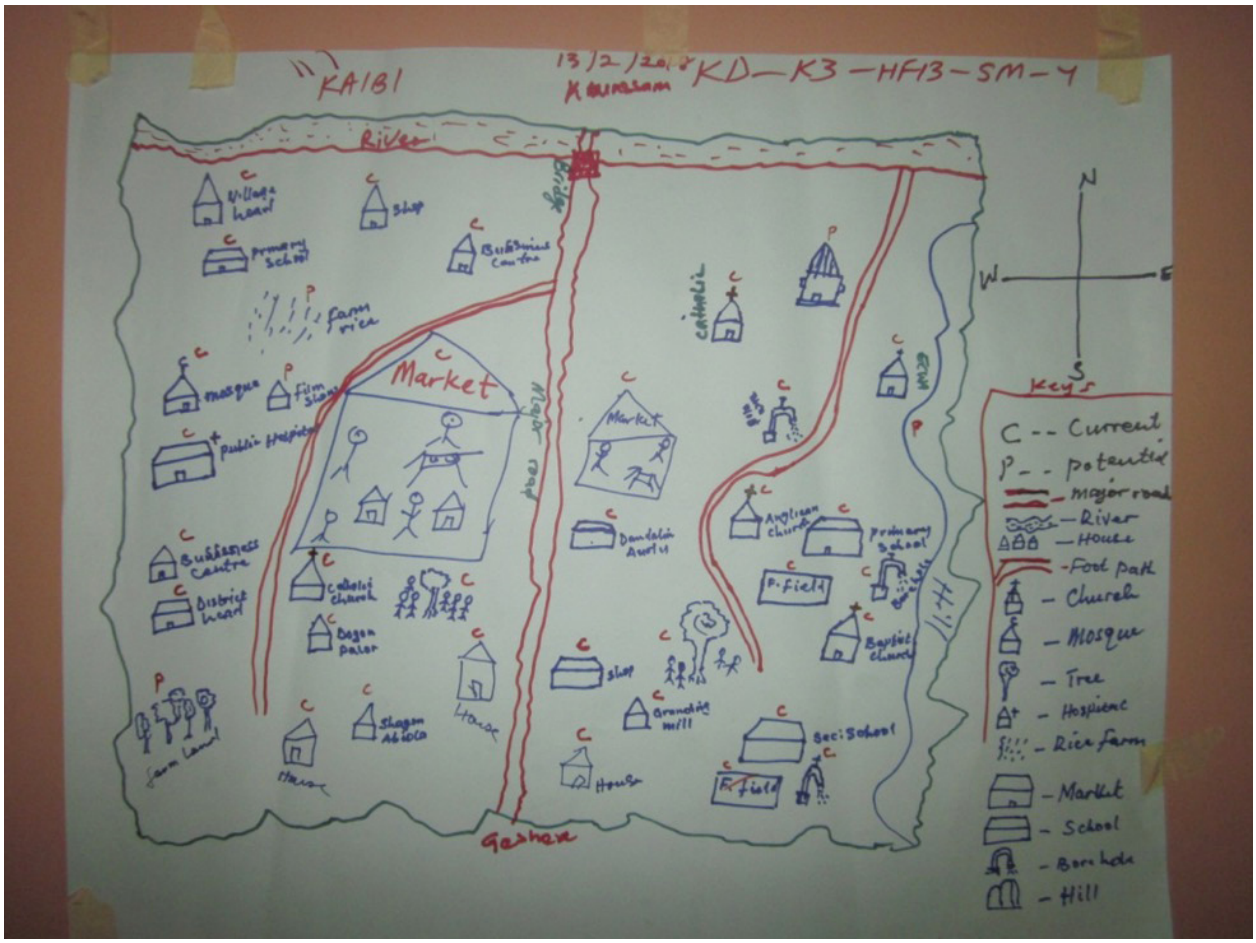
(3) communication processes

(4) identification of community members for MAM

(5) mechanisms to administer medicines.

Below are some questions that may help you do that, but try to encourage participants to label areas on the map, circle things in different colours etc. to identify how things could/should be used.

- **How are the community structures you have identified currently used in the distribution of Mectizan/ Albendazole?**
  - How do you find out about the distribution of the medicines?
    Which groups are involved?
    What activities do they carry out?
  - How were existing community drug distributors selected?
  - Which of the influential individuals you have identified were involved in this?
  - How were other community members involved?
  - What could have been done better?
- **Of the structures identified in your community map, which could be used as alternative structures to deliver the medicines?**
- **What would be better about these structures?**
- **What would be not so good about these structures?**
- **How could these structures increase the reach medicines during MAM?**



Once you have completed the map with your group, remember to explain to the participants that you would like to bring them together with other members of the community who have also drawn maps to compare them and understand how different people see the community differently. Below is some text to help you with this:

> ***If you are happy to, we would like to compare your community map with other groups who have also taken part in the social mapping in this community. We would then like to bring you all together to review the similarities and differences between your maps and to develop these discussions further.***

(NB: If any participant does not want to be involved in this process then they do not have to be. They will be excluded from the combined group discussions).

Once participants are brought together, ask one member of each group to go through their map with other community members. Once all groups have presented, ask them to discuss observations/differences between each of the maps and why these might exist. As the facilitator, be sure to look for differences between the different maps and ask questions about why they might be different etc. The idea is to get the community to think critically about how the programme might need to use different structures to reach all sections/groups within a community and to encourage them to identify what these structures may be.

FOCUS GROUP DISCUSSIONS (FGDs)

PURPOSE OF THIS ACTIVITY

To understand from community members their experience of the most recent MAM intervention and how this compares to previous MAM cycles to identify what worked, what did not work and how it can be improved next time.

KEY CONSIDERATIONS

It is important to ensure that everyone who will be involved in the activity is clear on the purpose of the activity before you start, and that consent is gained.

It is important to consider power dynamics and relationships of participants. When making selections around group participants, it is important to also navigate power dynamics, some top tips are:

- Try to make groups as similar as possible. i.e. groups should be divided by age, gender, or any other category.
- Typically, in group activities you don't want more than 10 participants.
- Confidentiality must be maintained.

RESOURCES NEEDED

- **Consent forms**
- **Audio recorder (if applicable and consented to)**
- **Note taker**
- **Interviewer**
- **Appropriate environment which is safe, has enough space and has limited or no distractions**
- **Refreshments (if appropriate)**

THE FOLLOWING INTRODUCTIONS COULD BE USED

Thank you for agreeing to take part in this discussion. The objective of this discussion is to understand your experiences when the people came to give out stick medicine in your community. We are particularly interested in your understandings of the programme and how you feel about the way it is implemented in your community. As this is a group discussion we ask that you respect the opinions and confidentiality of others within the group.

ICE BREAKER

Begin by trying to make the group feel at ease. To do this, get them to introduce their experience of the most recent treatment round. You could do this by saying the following:

I would like each of you to introduce yourself and tell me briefly about your experience during the most recent time that the people came to give out the stick medicine.

Once all the participants have shared their brief story with you, then tell the participants that we are going to explore the process of giving out stick medicine in a little more detail.

TOPIC GUIDANCE

The topics and questions below can be used to help guide your discussion. The questions have been divided into areas of Awareness, Availability, and Accessibility of the program, as well as what could be improved.

AWARENESS OF THE PROGRAMME

Can you tell me what you know about the purpose of Mectizan/Albendazole?

- What did you know in advance of the distribution of medicines?
- What were you told?
- Who told you these things? E.g. Family, traditional healer, friends.
- How were you told? E.g. using leaflet, verbally, poster etc. (What IEC materials or methods were used?)
- Where were you told? E.g. at clinic, town chiefs house etc. (What structures were used to share awareness messages?)
- How did this differ from previous times they have distributed the medicines in relation to awareness?
  - What did you like about this time in relation to awareness during MAM? What did you dislike about this time in relation to awareness during MAM?

AVAILABILITY OF THE PROGRAMME

Can you tell me what you think about the time of day/year that the distribution of Mectizan/Albendazole took place?

- What do you like about the timing for MAM? What do you dislike about the timing for MAM?
- Can you tell me about any parts of the community or people within the community who were not reached because of the time of year distribution took place?

Can you tell me about any other time the distribution of Mectizan/Albendazole took place?

- What did you think about that timing? What did you like/dislike about it?
- Can you tell me about any parts of the community or people within the community who were not reached because distribution took place at this time of year?

During the most recent medicine distribution, was there enough medicines available to reach everyone who wanted them in the community?

- If yes, how would you compare this to other times the medicine has been distributed?
- If no, who was not able to access the medicine because of this? What did people do to try to get these people the medicines?
- Were there any delays in the medicines getting to the community? Why?/Why not?

ACCESSIBILITY OF THE PROGRAMME

Can you tell us about the ways that the medicines were distributed during the most recent MAM?

- What structures were used in the community during the distribution?
  - How were they used? (Probe for: giving out medicines, follow up etc).
- Is this the same or different to before?
- What times of day could you access the medicines?
- What did you like about time? What did you dislike about the time?
- What time would you like it to be done next MAM?
- Were there people in your community who couldn't access the medicines because of the way it was distributed? Who were these people? Why could they not access the medicines?
- If people were absent from the community during the distribution, how were they followed up? Who followed them up?

How much does it cost the community/individuals to be able to access the medicines?

- Do you pay to get the medicines?
- How much does it cost to get to where the medicines are being distributed?
- What time do you have to take away from your routine activities to be able to access the medicines?

ACCEPTABILITY OF THE PROGRAMME

Can you tell us about how the people who distributed the medicines during this round of MAM were selected?

- Who selected them? Where were they selected from?
- Was this the same or different to previous years of MAM?
- Can certain people access certain parts of the community? Can men enter all the households? Can women enter all the households? Etc.

What do you think about the people who were selected to distribute medicine?

- How knowledgeable/skilful are they?
- What activities do they or have they carried out to tell the community about the programme?

Can you tell us any stories about people in your community who refuse to take the medicines during MAM?

- Who are the types of people who refuse to take the medicine? Why do they refuse to take it? (Probe for: side effects, cost of the medicines, perception of need/traditional beliefs etc.)
- What could be done to encourage these people to take the medicines?

What do you think are the benefits of taking the medicines?

- Can you describe the positive impacts you have seen because of people taking the medicines?
- Can you describe the negative impacts you have seen because of people taking the medicines?

AREAS FOR IMPROVEMENT

What could be done better in the next MAM?

- What other ways do you think the distribution of medicines could have been done?
- How could you or your community be better involved or prefer to be involved in this in the future?
- How have the medicines or the programme made a difference to you, your family or your community?

CLOSING THE FGD

Remember to thank the participants when drawing the meeting to a close.

Thank you very much for taking the time to answer my questions, do you have any questions for me?

IN-DEPTH INTERVIEWS (IDIs)

PURPOSE OF THIS ACTIVITY

To understand from purposively selected individuals their experience of the most recent MAM intervention and how this compares to previous MAM cycles.

KEY CONSIDERATIONS

- Participants should be selected to be representative of the communities and include: marginalised groups within their community (e.g. someone living with a disability, or someone from a migrant community); previously refused MAM and have now accepted or were previously absent and are now present.
- Make sure you allow participants time to gain answers to any questions they have and reassure them that confidentiality will be maintained.
- Gain consent prior to conducting the interviews.
- Interviews should be conducted on a one to one basis in a suitable environment.
- Confidentiality must be maintained.

INTRODUCTION TO INTERVIEW

Below is some text that will help you to explain the purpose of the interview:

> ***Thank you for agreeing to take part in this research study. The objective of this discussion is to understand your experiences during MAM in your community. We are particularly interested in your understandings of the programme and how you feel about the way it is implemented in your community.***

ICE BREAKER

Remember to familiarise yourself with the participant and make them feel comfortable in your presence.

RESOURCES NEEDED

- **Consent form**
- **Audio recorder (if applicable and consented to)**
- **Note taker**
- **Interviewer**
- **Appropriate environment which is safe, has enough space and has limited or no distractions**
- **Refreshments (if appropriate)**

TOPIC GUIDANCE

AWARENESS OF THE PROGRAMME

Can you tell me what you know about the purpose of Mectizan/Albendazole?

- What did you know prior to the distribution?
- What were you told?
- Who told you these things? E.g. Family, traditional leader, friends.
- How were you told? E.g. using leaflet, verbally, poster etc. (What IEC materials or methods were used?)
- Where were you told? E.g. at clinic, town chiefs house etc. (What structures were used to share awareness messages?)
- How did this differ from previous times they have brought the stick medicine?
  - What did you like about it this time? What didn't you like about it this time?

How easy is it for you to access and understand information about the medicines?

- (Probe here for ability to read/understand/access awareness information, engaged with by CDD/health workers)

What would enable you to access information more easily?

- What ways help you understand?
- Where and how should the information be provided to you?

AVAILABILITY OF THE PROGRAMME

Can you tell me what you think about the time of day/year that Mass administration of medicines for Mectizan/Albendazole took place?

- What do you like about the timing? What do you dislike about the timing?
- How did the timing of the distribution help/hinder you in taking the medicines?

Can you tell me about any other time the distribution took place that is different from the recent?

- What did you think about that timing? What did you like/dislike about it?
- How did the timing of that distribution help/hinder you to take the medicines?

During the most recent Mass administration of medicines, were there enough medicines available to reach you?

- If yes, how did this compare to other times it has been distributed?
- If no, how did you access the medicines? What did people do to try to get you the medicines?
- Were there any delays in the medicines getting to you? Why?/Why not?
- Was there anyone in the community that the medicines did not reach? Why did it not reach them?

ACCESSIBILITY OF THE PROGRAMME

Can you tell us about the ways that the medicines were distributed during Mass Administration of Medicines?

- What structures were used in the community during the distribution?
  - How were they used? (Probe for: giving out medicines, follow up etc.)
- What times of day could you access the medicines?
- What did you like about it? What did you dislike about it?

How much did it cost you to be able to access the medicines?

- Did it cost you to get the medicine?
- How much did it cost to get to where the medicines are being distributed?
- What time did you have to take away from your routine activities to be able to access the medicines?
- Did anyone in your household have to accompany you to where the medicine was being distributed?
  - If Yes, how much did it cost them to accompany you? (Probe for: direct costs e.g. transport etc. as well as time away from the farm/livelihoods etc.)

What would make it easier for you to be able to access the medicines?

Were there people in your community/household who couldn't access the medicines because of the way it was distributed?

- Who were these people? Why could they not access the medicines?

If people were absent from the community during the distribution, how were they followed up? Who followed them up?

If the participant was not able to access medicines during the last MAM, what was different about the way the medicine was distributed during the most recent distribution that allowed you to access the medicines?

How did you feel about being able to access the medicines this time?

ACCEPTABILITY OF THE PROGRAMME

Can you tell us about how the people who gave out the medicines during this round of MAM were selected?

- Who selected them? Where were they selected from?
- Is it the same way they have been selected before or different?
- Can certain people from the community offer you medicines more easily than others? Can men give you the medicines? Why/Why not? Can women give you the medicines? Why/Why not?
- Who offered you the medicines?

What do you think about the people who were selected to give out the stick medicine?

- How knowledgeable/skilful were they?
- What activities did they carry out to tell you about the programme?
- In future, who would you most like to receive medicines from? Why?

Why or why did you not take the medicines during this distribution?

- (If participant didn't take, probe for side effects, cost of medicines, perception of need/traditional beliefs, absent from the community etc.)
- (If participant did take the medicine, probe for medicine benefits, feeling of wellness, who instructed them to take the medicines etc.)

Why did you take/or not take the medicine during the last round of distribution?

- (If the participant didn't take the medicines in the last round, but took them in this round): What was different about this medicine distribution that meant you accepted the medicines?

Can you tell us any stories about people in your community/household who refuse to take the stick medicine?

- Who are the types of people who refuse to take the medicine? Why do they refuse to take it? (Probe for: side effects, cost of the medicines, perception of need/traditional beliefs etc.)
- What could be done to encourage these people to take the medicines?

What do you think the benefits are of taking the medicines?

- Can you describe the positive impacts you have seen because of taking the medicines?

AREAS FOR IMPROVEMENT

How could the distribution of the medicines have been done differently? How would these changes help you to take the medicines?

CLOSING THE INTERVIEW

Remember to thank the participant when drawing the interview to a close.

Thank you very much for taking the time to answer my questions, do you have any questions for me?

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'.

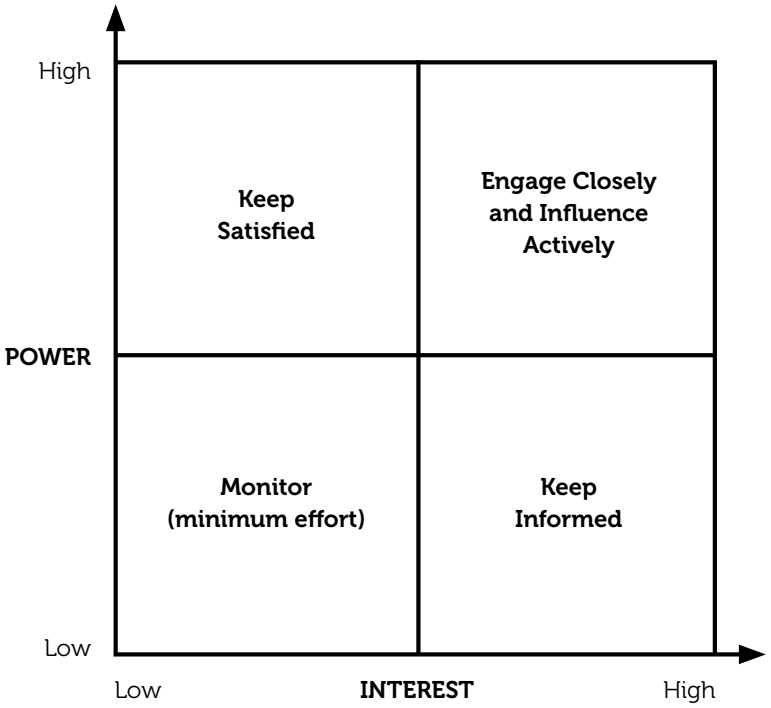


Figure 2: Influence Map

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*

SEASONAL CALENDARS

PURPOSE OF THIS ACTIVITY

Seasonal calendars can be drawn by community members to show the seasons they experience annually and reflect their movements and activities during these times. For example, they can be used to map the movements of Fulani People during the wet and dry season, or to understand what different livelihood activities take place for static communities during different periods, such as religious festivals etc. Completing these activities would support the NTD Programme to understand **when best** to deliver medicines to increase access for as many people as possible.

RESOURCES NEEDED

- **Consent forms**
- **Facilitator**
- **Appropriate environment which is safe, has enough space and has limited or no distractions**
- **Refreshments (if appropriate)**

KEY CONSIDERATIONS

Season calendars can be used as a participatory tool within focus group discussions.

It is important to ensure that everyone who will be involved in the activity is clear on the purpose of the activity before you start, and that consent is gained.

It is important to consider power dynamics and relationships of participants. When making selections around group participants, it is important to also navigate power dynamics, some top tips are:

- Try to make groups as similar as possible i.e. groups should be divided by age, gender, or any other category.
- Typically, in group activities you don't want more than 10 participants.

When asking participants to draw their seasonal calendar, you can ask them questions such as:

- When is the best time for MAM?
- When are people away from the communities for farming/work/school/travel?
- When are festivals held within the community?

Here is an example of what a seasonal calendar might look like:

Further examples can be found at: Loewenson, R., Laurell, A. C., Hogstedt, C., D'Ambruoso, L., & Shroff, Z. (2014). Participatory action research in health systems: a methods reader. Harare: TARSC, AHPSR, WHO, IDRC Canada, Equinet.

Source: *COUNTDOWN Research on Seasonal Calendars in Ghana in partnership with Dodowa Health Research Centre Ghana. Courtesy of Irene Honam Tsey.* ***https://countdown.lstmed.ac.uk/sites/default/files/centre/Seasonal%20Calendars%20in%20Ghana.pdf***

ACKNOWLEDGEMENTS

COUNTDOWN
Calling time on Neglected Tropical Diseases

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).

RESEARCH ASSISTANTS IN BOTH STATES:

Azeez Abolaji
Sadiq Abubakar
Joshua Adams
David Adekunle
Awayi Namo Angela
Mathew Ayegboyin
Akintunde Albert Ayodeji
McRae Ayuba
Adedoyin Ademola Bernard
Adewumi Taiye Christiana
Filimon Musa David
Sogbuyi Imisioluwa Elijah
Bello Elizabeth
Chigaiti Faith
Hannah Ojone Hussaini
Damina Ibrahim
Adeniran Adebola Ismail
Shiabu James
Emmanuel Kachiro
Adebanji Adedayo Mathew
Oluwasewa Ogunkoya
Busola Ogunlana
Bukola Olagunju
Adeniran Gideon Olusanjo
Foluke Oluyemi
Olasupo Esther Opeyemi
Ozigi Emmanuel Samuel
Ide Siddi
Sodimu Samuel Sunday
Jimoh Nimot Temitope
Stella Udu
Dupe Yahemba

RESEARCHERS FROM SIGHTSAVERS:

Tosin Adekeye
Samson Ayuba
Ruth Dixon
Noela Gwani
Sunday Isiyaku
Gideon Kevin
Luret Lar
Damian Lawong
Akinola Oluwole
Bolanle Surakat
James Yashiyi

RESEARCHERS FROM LSTM:

Efundem Agboraw
Pamela Bongkiyung
Laura Dean
Julie Irving
Kim Ozano
Helen Piotrowski
Kelly Smyth
Sally Theobald
Rachael Thomson
Eve Worrall

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:

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).

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

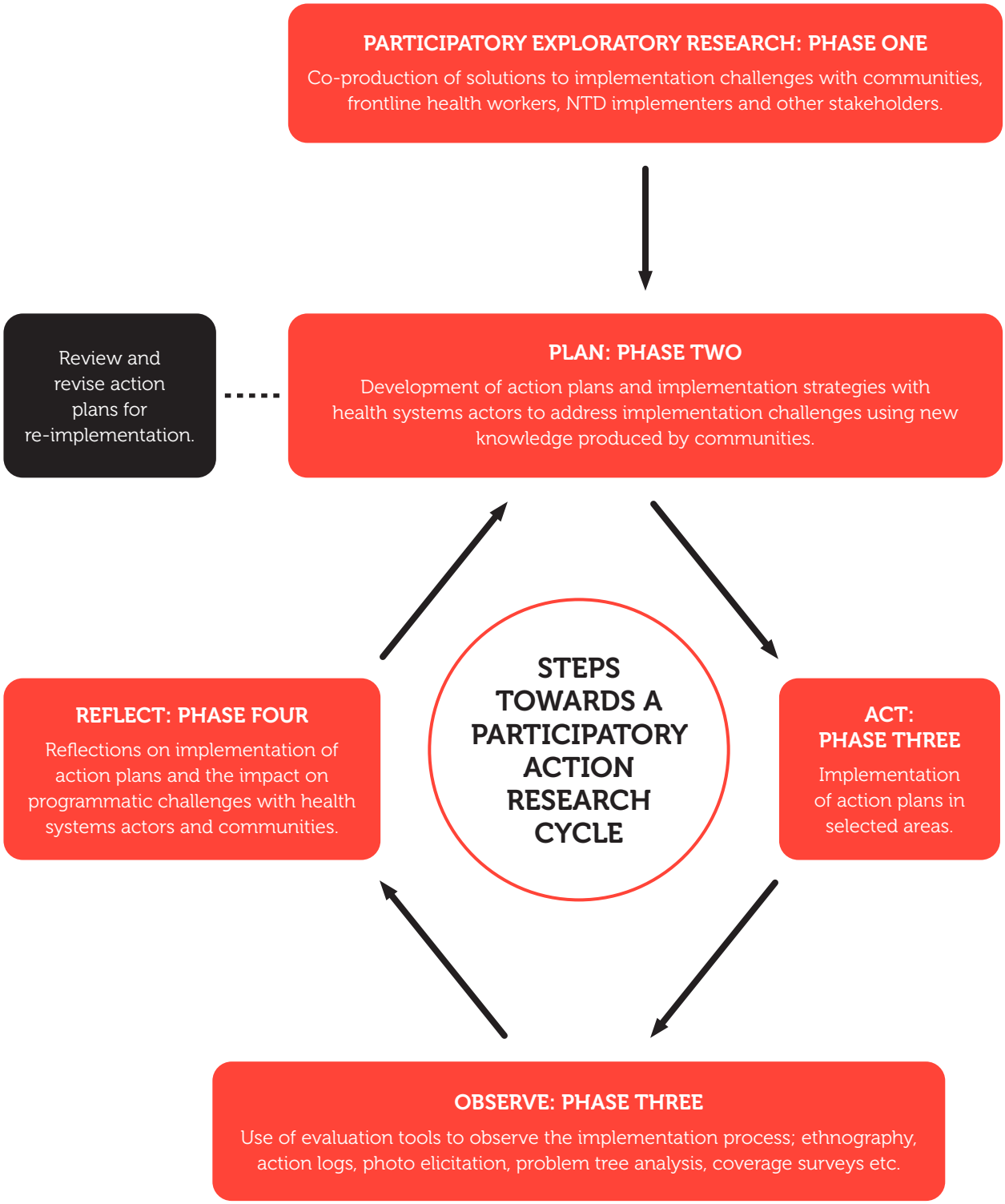


Figure 1. PAR approach to improving equity in MAM (Ozano et al., 2020)

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

COUNTDOWN

Calling time on Neglected Tropical Diseases

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'.

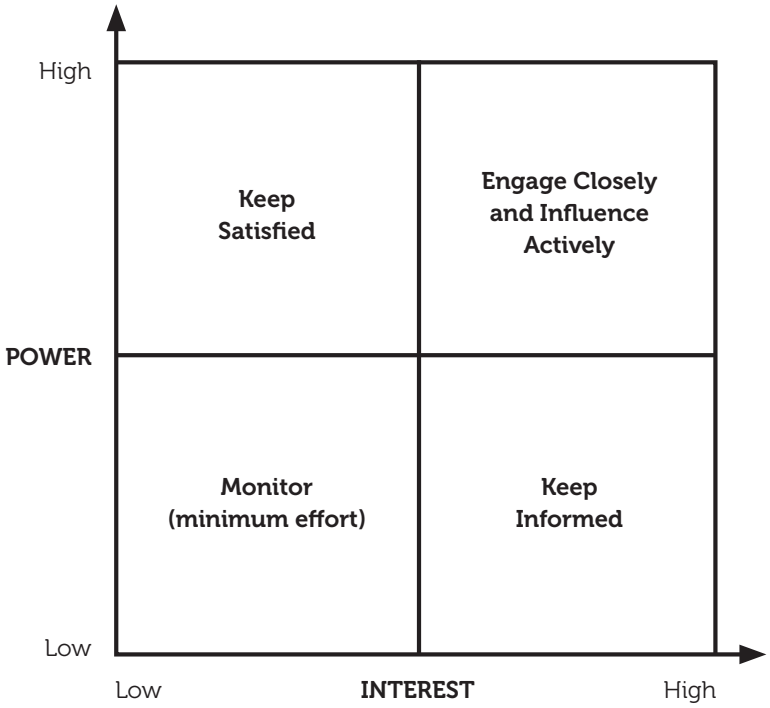


Figure 2: Influence Map

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

COUNTDOWN
Calling time on Neglected Tropical Diseases

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).

RESEARCH ASSISTANTS IN BOTH STATES:

Azeez Abolaji
Sadiq Abubakar
Joshua Adams
David Adekunle
Awayi Namo Angela
Mathew Ayegboyin
Akintunde Albert Ayodeji
McRae Ayuba
Adedoyin Ademola Bernard
Adewumi Taiye Christiana
Filimon Musa David
Sogbuyi Imisioluwa Elijah
Bello Elizabeth
Chigaiti Faith
Hannah Ojone Hussaini
Damina Ibrahim
Adeniran Adebola Ismail
Shiabu James
Emmanuel Kachiro
Adebanji Adedayo Mathew
Oluwasewa Ogunkoya
Busola Ogunlana
Bukola Olagunju
Adeniran Gideon Olusanjo
Foluke Oluyemi
Olasupo Esther Opeyemi
Ozigi Emmanuel Samuel
Ide Siddi
Sodimu Samuel Sunday
Jimoh Nimot Temitope
Stella Udu
Dupe Yahemba

RESEARCHERS FROM SIGHTSAVERS:

Tosin Adekeye
Samson Ayuba
Ruth Dixon
Noela Gwani
Sunday Isiyaku
Gideon Kevin
Luret Lar
Damian Lawong
Akinola Oluwole
Bolanle Surakat
James Yashiyi

RESEARCHERS FROM LSTM:

Efundem Agboraw
Pamela Bongkiyung
Laura Dean
Julie Irving
Kim Ozano
Helen Piotrowski
Kelly Smyth
Sally Theobald
Rachael Thomson
Eve Worrall

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).

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

TO TACKLE NEGLECTED TROPICAL DISEASES

MODULE 3

INCLUSIVE ACTION PLANNING FOR EQUITY IN MASS ADMINISTRATION OF MEDICINES (MAM)

COUNTDOWN

Calling time on Neglected Tropical Diseases

MODULE 3

INCLUSIVE ACTION PLANNING FOR EQUITY IN MASS ADMINISTRATION OF MEDICINES (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.

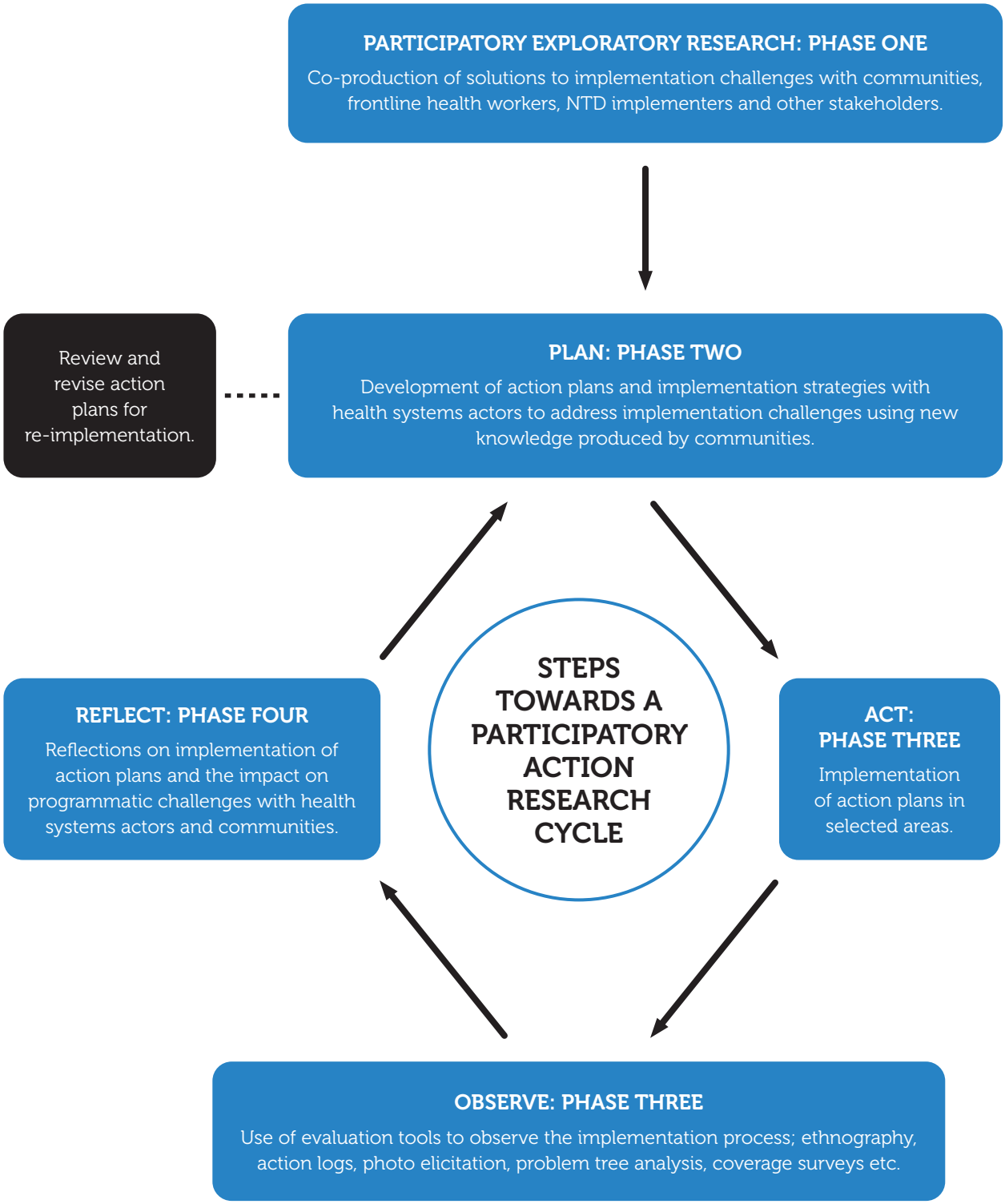


Figure 1. PAR approach to improving equity in MAM (Ozano et al., 2020)

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

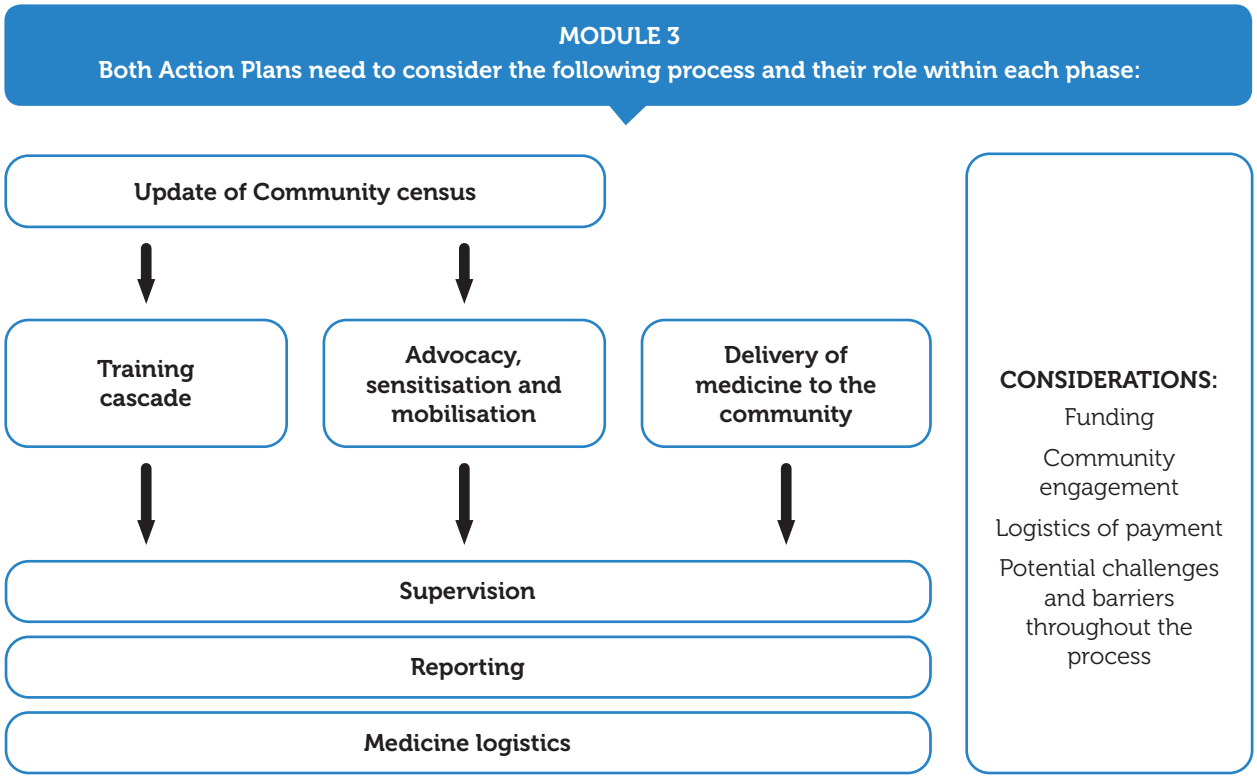
ACOMORON	Association of Commercial Operators of Motorcycles and Riders of Nigeria
ALB	Albendazole
AOPSHON	Association of primary school health teachers of Nigeria
AZT	Azithromycin
CAN	Christian Association of Nigeria
CDA	Community Development Association
CDCs	Community Development Committees
CDD	Community 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 3

INCLUSIVE ACTION PLANNING FOR EQUITY IN MASS ADMINISTRATION OF MEDICINES (MAM)

When developing your action plans (State level Macroplanning and Microplanning at the LGA level) it is important to consider the whole MAM process and plan for each stage.



We are going to explore each phase of the process, giving examples from implementation from two States (two urban settings and two rural settings). Important issues which relate to **Rural** or **Urban** contexts will be highlighted. Example of actions will be given. These are optional, and consideration of local needs and resources must be assessed when developing your action plans.

MAM with people with disabilities

MAM at business areas

OBJECTIVES OF THE MODULE:

By the end of this module you should have:

- **Established clear actions that will help you achieve the outcomes you desire in relation to the core areas of MAM delivery, including:**
  - **Training of LNTD, FLHFs and CDDs**
  - **Advocacy, sensitisation and mobilisation**
  - **Medicine Distribution**
  - **Supervision throughout the stages**
  - **Reporting**
  - **Medicine Logistics, which includes census update/population update based on national population commission's projected population, acquisition, storage and reverse logistics.**
- **Allocated dates to when each of these activities or actions will take place.**
- **Allocated or estimated budget necessary to complete each action.**
- **Identification of who will be responsible for completing specific actions and who will monitor or supervise this activity.**

Faces have been blurred in photographs to protect confidentiality.

BLANK TEMPLATE FOR ACTION PLANNING AT LGA LEVEL

This action plan template has been modified to support planning for MAM at the LGA level. You should consider what activities and actions are needed for each phase of the MAM process. This module will guide you through each phase and give examples of activities and actions which may be useful for your context. At the end of each phase (e.g. training, medicine logistics etc.), you will find an example of a prepopulated action plan for urban and rural context (where appropriate).

For each activity and action, consider if this is appropriate for your context. Do you need to adapt it to fit your LGA? Remember that equity in coverage is at the heart of planning for MAM and therefore actions should be considered on how to reach people who are missed. This may be whole communities (see bottom of template), or it may be individuals such as people with disabilities or migrant groups. You should consider who from the NTD team will be responsible to ensure this takes place. You may also wish to add a predicted date for this activity. Remember to select activities which your budget can accommodate. Ideally at microplanning you should list resources required and a budget when known. For further information on how to cost activities, please see the Costing toolkit, 2021.

S/N	Activity	No. of days	Start date	End date	Actions	Person responsible *(insert name and role)*	Resources required / Budget
TRAINING CASCADE AND CDD SELECTION							
1							
2							
ADVOCACY, SENSITISATION, AND MOBILISATION							
3							
4							
MEDICINE DELIVERY TO COMMUNITIES							
5							
6							
REPORTING							
7							
8							
SUPERVISION							
9							
10							
MEDICINE LOGISTICS							
11							
12							

HARD TO REACH COMMUNITIES IN THE LGA:

S/N	Name of community	FLHF in charge	Reason the community is hard to reach	Eligible population	Cost of transportation	Suggestion for treating effectively in the community
1						
2						
3						

3.1 HOW TO DEVELOP ACTION PLANS FOR TRAINING

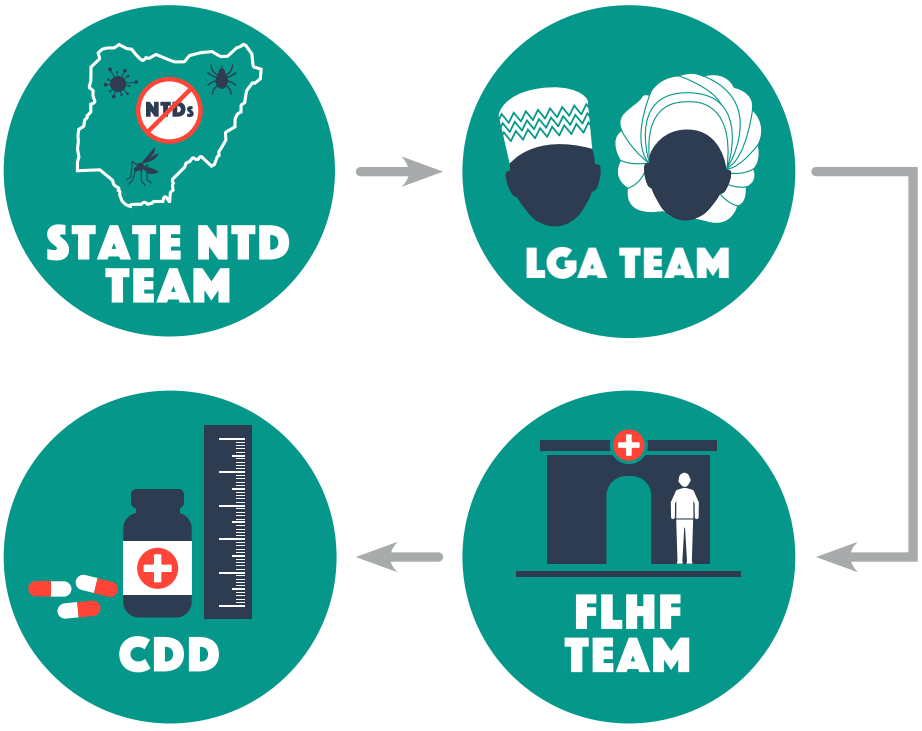
OBJECTIVES OF SECTION:

At the end of this section, you should be able to:

- **Identify responsibilities of stakeholders involved in training at the macro and micro planning stages.**
- **Set and apply an agenda for training of FLHF and CDDs. (See FMOH training tools for further guidance).**
- **Identify key people, training structure, content and timing.**
- **Gain an understanding of different methods of communication which can be used to sensitise and mobilise the NTD workforce.**
- **Identify what resources are needed during training.**
- **Consider potential challenges which may be faced throughout this process and identify how they can be mitigated.**
- **Learn facilitation skills which may support training.**

Traditionally training of the MAM workforce has been from State level downwards. An alternative training structure that was trialled in one Urban LGA is also presented as an option, it is important that you consider all options and select the best one for your area.

TRADITIONAL TRAINING CASCADE



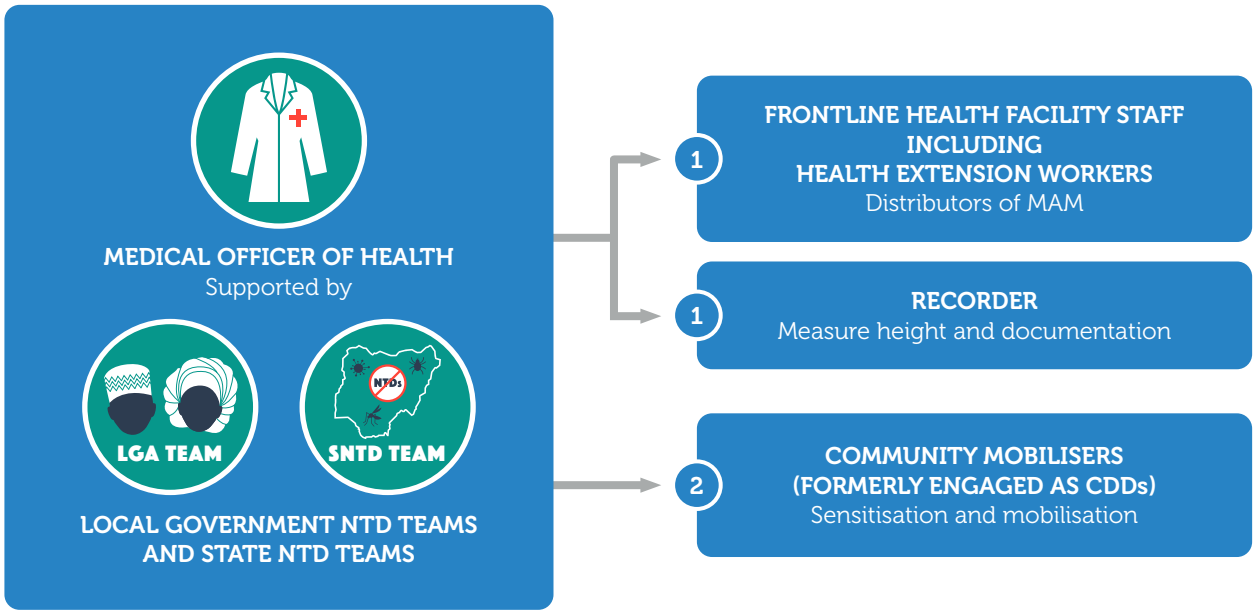
**FLHF representatives may consist of the Officer In-Charge and/or the NTD Focal Person at facility level. Either or both traditionally attend training.*

ALTERNATIVE TRAINING STRUCTURE

EXAMPLE OF ALTERNATIVE TRAINING FLOW - URBAN LGA IN OGUN STATE

At the microplanning level, it was decided that the roles of the MAM workforce would change to meet the needs of the urban context.

The Health Worker Ivermectin Administration (HWIA) Strategy was developed by the LGA. This meant a fundamental change in the role for Health extension workers in frontline health facilities, which changed from a previously supervisory role to distributing medicines to the community. Those members who were previously CDDs also had a change in role, and instead acted as Community Mobilisers. To maintain quality of training, FLHFs, Health workers and recorders were trained at the same time. Training was conducted by the Medical Officer of Health (MOH) with support of the LNTD and SNTD teams. Community Mobilisers were trained separately to the above. Training for Community Mobilisers was conducted at the LGA and not ward level; this ensured that the same contents were passed across to all mobilisers in the LGA.



PLANNING LGA TEAM TRAINING

The example actions in each table are not all relevant for all contexts and LGAs, you, as implementers should consider each action alongside your given context, budget restrictions and human resource management structures and only choose actions which will best respond to your LGA needs. Some actions work better in urban areas and others in rural and so you should consider the feasibility of using that action within your area and not choose all.

Where you see [X] this indicates that you should insert a number or choice that suits your population.

PURPOSE OF ACTION	EXAMPLE ACTIONS ARE OPTIONS, PLEASE CONSIDER WHICH ARE RELEVANT FOR YOUR CONTEXT	EXAMPLE OUTCOMES FROM EVIDENCE
Selection of conducive environments for training.	Environments should be selected that have: • an area with suitable capacity for numbers to LNTD to be trained. • a quiet location with no distraction *(NB: this may involve consideration of other ongoing programmes or activities at your chosen venue).*	! **URBAN**: The training venue at the State capital was too choked, and the chairs were not enough for all participants, leading to some not concentrating.  ✓ Training was conducted in clusters to reduce overcrowding.
Timing and duration of training should be chosen carefully to ensure maximum attendance.	• Training will take place on [X] and [X] date for two days for a minimum of 3 hours per day.	✓ The two days training gives room for better understanding as there was opportunity to ask questions and get clarity on any aspect of the MAM programme.
Early communication about training period. This is necessary because most of the LNTDs are involved in other health intervention programme at the LGAs and also need to seek permission from their superior.	• Information about training will be communicated on [X] date to allow for proper planning of participants.	! LNTDs complained that notice for NTD activities are sometimes impromptu and do clash with other programmes they are engaged in.
Using visual learning aids like a projector during training and printed training materials will aid better understanding for participants than when such aid is not used.	• [X] visual learning materials will be produced by [X] date. • A projector will be made available on [X] date and supplied by [X] .	✓ LNTDs said the training was interesting and they were able to flow along with the trainer because a projector was used during the training. ✓ Use of local language, role plays and pictorial training materials during training increased understanding.
The training should be conducted by someone that has full understanding of the programme who will be able to answer critical questions about the programme from participants.	• Training will be conducted by [X] staff of the NTD unit (this could be someone from the NTD unit at the Federal Ministry of Health or State Ministry of Health).	✓ The presence of a FMoH at the training help in the response to questions. ✓ At an LGA training in one State, a FMoH staff was present at the training who was able to educate participants on how to treat people with disabilities, a gap in understanding that was identified by research with CDDs.

Key: ✓ **Example of success** ! **Example of challenge/caution needed**

PLANNING WARD FOCAL/FRONTLINE HEALTH FACILITY TRAINING

PURPOSE OF ACTION	EXAMPLE ACTIONS ARE OPTIONS, PLEASE CONSIDER WHICH ARE RELEVANT FOR YOUR CONTEXT	EXAMPLE OUTCOMES FROM EVIDENCE
Selection of appropriate environments for training.	Environments should be selected that have: • an area with suitable capacity for numbers to be trained. • a quiet space where no one will disturb. *(NB: this may involve consideration of other ongoing programmes or activities at your chosen venue).*	✓ **RURAL**: FLHFs' training was conducted in a big hall at the Primary Healthcare department. The hall was conducive for the training because it was not overcrowded.  ! **RURAL**: Training delivered at a Health Centre where other activities were taking place, this led to some distractions to training which may hinder learning. 
Ensure appropriate mix of gender, age and skill set of FLHFs (including Nurses, Community Health Extension Workers, other primary health care workers and sometimes ward focal persons) trained to maximise quality of training to CDDs.	Appropriate mix of FLHFs should include: • [X] numbers of FLHFs with previous experience of MAM. • [X] numbers of both men and women to be included in training. • FLHFs trained should have appropriate language skills to effectively communicate with CDDs. • A focal person should be picked from each facility to be known as NTD focal person who will be dedicated and committed to NTD activities.	! **URBAN**: Training took place for 28 health workers, most were new with only 2 having been to the training previously. This was because new health facilities had been commissioned which meant a lot of staff transfers. This had an impact on the quality of training delivered to the CDDs and the LNTD had to be involved training CDDs.  ✓ **URBAN**: Out of 15 FLHFs, 6 were men and 9 were women. As FLHFs also helped with distribution of medicine and supervision of CDDs in the community, it was important to have a balance of genders to ensure appropriate access to community households. 

PURPOSE OF ACTION	EXAMPLE ACTIONS ARE OPTIONS, PLEASE CONSIDER WHICH ARE RELEVANT FOR YOUR CONTEXT	EXAMPLE OUTCOMES FROM EVIDENCE
Timing and duration of training should be chosen carefully to ensure maximum attendance. The dates chosen for training of FLHFs needs to consider: • To ensure it is appropriate for attendance. • There is enough time afterwards to train CDDs. • There is enough time for CDDs to sensitise and mobilise the communities.	• Training will take place on [X] and [X] date for two days for a minimum of 3 hours per day. • The trainer should arrive at least 30 minutes before session to ensure a prompt start. • Training should be conducted on [X] date after discussions with implementers. • FLHF training will be for two days; one day for theory and one day for practical.	! **URBAN**: The action plan had suggested two 3-hour sessions on two days. However, training was carried out in one day as that was the provision in the budget line. This full day of training was reported to compromise the concentration for the participants which could hinder retaining information. ! The specific day of the week when the training took place impacted attendance e.g. Friday was observed to create a lot of distraction as most participants wanted to leave as Fridays are perceived as half days. ✓ **RURAL**: FLHFs training was a two-day training. This gives room for quality time to spend on data reporting tools which has been one of the challenges in the past MAM cycle. The training was facilitated by the SNTD and supported by LNTD which worked well.
Appropriate communication methods need to be put in place to allow for any changes, especially change of dates. • The training date of FLHFs should be communicated to in-charges at least 2 weeks prior to the scheduled date. • Appropriate local systems of communication should be in place such as text message, WhatsApp or verbal correspondence to allow any changes in schedule to be communicated ahead of time.	• The training date of FLHFs should be communicated to in-charges on [X] date [X] weeks prior to the scheduled MAM date. • Information about training will be communicated on [X] date via [X] communication system, to allow for proper planning of participants.	! **RURAL**: Training notification messages were not sent to the in-charges via WhatsApp but the LNTD organised a meeting with the In-charges 2 weeks prior to the FLHF training to notify them of the upcoming training and MAM. Using WhatsApp messages did not work probably due to poor network connectivity in some parts of the LGA. ! **RURAL**: Due to a change in arrival date for the medicines, the training date was changed. This led to some dissatisfaction amongst workers due unnecessary transport costs.

Key: ✓ **Example of success** ! **Example of challenge/caution needed**

PURPOSE OF ACTION	EXAMPLE ACTIONS ARE OPTIONS, PLEASE CONSIDER WHICH ARE RELEVANT FOR YOUR CONTEXT	EXAMPLE OUTCOMES FROM EVIDENCE
		✓ A WhatsApp group was created and numbers of FLHFs were collected so that the LNTD did not only call them, but brief them about the forthcoming local microplanning meeting and information expected from them. All these helped to facilitate exchange of information with the FLHFs.
Training contents should include all that is necessary to make the FLHFs and CDDs have confidence to do the job.	• Training content to include knowledge about the disease symptoms, mode of transmission, how to determine dosage, how to handle side effects and determine medicine dosage for people living with disabilities to increase confidence in medicine administration and supervision of CDDs. • [X] visual learning materials will be produced by [X] date. • Use of role play will include [X] and [X] and take [X] minutes.	*See Training Agenda below, and FMoH Training Guide in the Nigeria MAM Documentation for further information.* ! Some CDDs reported that their training was too basic, mainly covering how to calculate the dosage of medicines. Many wanted a more comprehensive understanding of NTDs, the symptoms and manifestations and how to sensitise the community. As one CDD said "We were only informed on dosage and how to measure on the dose pole, we need a structured and effective training". ! CDDs reported being unsure how to treat people with physical disabilities and other complex conditions. The messages during the training were inconsistent, and there was no clear treatment guidance. As a result, many CDDs could not determine the treatment dosage, and patients with physical disabilities or complex needs were left out of MAM. ! FLHF staff reported minimal training and knowledge on NTD programme implementation and a lack of knowledge on how to handle adverse conditions and stressed that not enough health facility staff are trained to support the NTD programme which could affect their ability to provide adequate training to CDDs.

KEY CONSIDERATION:

- ✓ Different parts of your action plan will link together in different ways, changes in timing of one activity will impact changes to timing of others. You need to consider this, and you may even want to add an action that gives someone the responsibility of managing timing shifts across the whole plan.
- ✓ All the above actions are suggestions. Please consider which options are most appropriate for your LGAs.

PLANNING CDD TRAINING

PURPOSE OF ACTION	EXAMPLE ACTIONS ARE OPTIONS, PLEASE CONSIDER WHICH ARE RELEVANT FOR YOUR CONTEXT	EXAMPLE OUTCOMES FROM EVIDENCE
Timing and duration of training should be chosen to maximise attendance and give enough time to sensitise and mobilise the community prior to MAM.	• Training should be [X] weeks prior to MAM and last for 3 hours. • CDDs should be given [X] amount of notice to attend training. • Training should take place at [X] time of day. • Trainers should arrive at least 30 minutes to the time. • Preferred training time should be from 10am to 1pm each day. • Training days should be Tuesdays and Wednesdays or Wednesdays and Thursdays but not Friday.	! The training was done in the mornings and though the CDDs attended, some went out to attend to their shops and came back thus disrupting the learning. ! CDDs and facilitators complain that trainers do arrive at the venue of the training late which is a discouragement and wasting of their time. ! Facilitators complain that the notice for training are too short hence affect some persons from attending or coming late to the training. ! Friday is not a good day for training because it is seen as half day as many may want to travel to their home and also Muslims go for prayer by between 1pm and 2pm.
Selection of appropriate environments for training.	Environments should be selected that have: • an area with suitable capacity for numbers to be trained. • a quiet space where no one will disturb. *(NB: this may involve consideration of other ongoing programmes or activities at your chosen venue).*	! Training of CDDs if conducted outside may limit attention and learning. This is because there is no provision for seating or shade from weather, and CDDs may be distracted from people passing by. A suitable venue will support learning and motivate CDDs.
Ensure all CDDs can easily access training to increase attendance.	• Select locations which are accessible for CDDs.	✓ **URBAN**: The health facilities in the communities were used and this was a walkable distance which worked well for CDDs. 

Key: ✓ **Example of success** ! **Example of challenge/caution needed**

PURPOSE OF ACTION	EXAMPLE ACTIONS ARE OPTIONS, PLEASE CONSIDER WHICH ARE RELEVANT FOR YOUR CONTEXT	EXAMPLE OUTCOMES FROM EVIDENCE
Training contents should include all that is necessary to make the CDDs have confidence to do the job.	• Training content to include knowledge about the disease symptoms, mode of transmission, how to determine dosage, how to handle side effects and determine medicine dosage for people living with disabilities to increase confidence in medicine administration.	✓ **RURAL**: CDDs were able to convince community members who refused the medicine initially about the benefit of the medicine and this increased acceptability. ✓ **RURAL**: CDDs want to know how to handle side effects and determine medicine dosage for people living with disabilities. This would increase their confidence in administration of medicines. ✓ **URBAN AND RURAL**: Practical sessions to support CDDs to practice completing registers will ensure that national documentation is completed accurately.
Make sure contact details are collected and kept up to date and only trained CDDs are allocated medicines to distribute.	• Develop a template to collect CDD contact information on that is stored at the health facility. • Cross check names of CDDs trained to those who are allocated medicines to distribute.	! **RURAL**: Only names of CDDs were handed over to the FLHF without contacts so there was no way he could inform them about the meeting and change of date. ! **RURAL**: Some CDDs who weren't trained were allocated medicines to distribute and this caused challenges, such as wrong dosages, using weight/age instead of height for those who did not attend the training.
Language used for training. • Training of CDDs should be conducted in the local language so that they can easily understand and be carried along.	• Training of CDDs should be conducted in [X] language.	✓ **RURAL**: CDDs want training to be conducted in the local language to increase understanding.

PURPOSE OF ACTION	EXAMPLE ACTIONS ARE OPTIONS, PLEASE CONSIDER WHICH ARE RELEVANT FOR YOUR CONTEXT	EXAMPLE OUTCOMES FROM EVIDENCE
Training style should include use of training materials and hand on practical session. • Training should include role plays and use of pictorial IEC materials.	• [X] visual learning materials will be produced by [X] date. • Use of role play throughout training on all subject areas.	✓ **RURAL**: Use of role play and pictorial training materials during training for better understanding.  ✓ CDDs mentioned that the pictures on the IEC materials helps their understanding. They also mentioned that role plays help drive home the point on how they are to administer the medicine. ✓ State implementers mentioned that the role plays help them to assess if the FLHF and teachers understand what to do especially with the reporting forms. ✓ Role plays and demonstrations were included in some training sessions and most participants felt that gave them better understanding of the training. ✓ Training Guides were seen as useful by trainers of community Implementers on NTDs control and elimination. ✓ Photocopies of treatment registers and summary forms were useful for practical session.
Provision of meals should be provided during training of CDDs to motivate them to concentrate while the training is on-going.	• Allocate [X] to the budget for food provisions for [X] amount of CDDs.	✓ CDDs want meals to be provided during training as this will motivate them to concentrate on the training.

RESOURCES TO BE SUPPLIED TO CDDs BEFORE DISTRIBUTION

CDDs need to be provided with appropriate resources and required mobility to distribute medications. These include the following and should be accounted for in expenditure:

- **IEC MATERIALS:** Whilst sensitisation should be done prior to MAM distribution, community members have expressed the need for further enlightenment prior to taking MAM. Visual aids such as handbills and posters were recommended. A review of IEC materials by the implementers was conducted and the findings can be found in the learning pack see the link below:

  https://countdown.lstmed.ac.uk/publications-resources/tools-and-booklets

- **DOSE POLE:** Community members had a good awareness about the importance of receiving the correct dose. Being measured prior to having medication was seen to confirm that CDDs were appropriately trained.

Example of IEC material

- **MEDICATION:** Adequate supplies must be provided. This means an accurate census should be conducted in enough time for acquiring sufficient quantities of medication.
- **TRANSPORTATION:** Community members believe it is the role of MAM organisers/the Government to provide appropriate transport to CDDs to allow them to conduct house to house distribution. Motorbikes were often recommended for remote travel.
- **CLEAN WATER FOR COMMUNITY MEMBERS:** This has been shown to increase acceptance and prevent out of pocket spending for CDDs. Community leaders may take the responsibility of providing clean water for community members to take medicines when it is fixed points distribution.
- **IDENTIFICATION TAGS/CARDS:** It is believed that this gives the CDDs credibility in the eyes of the community members and increases acceptance.
- **MEDICINE CONTAINERS AND GLOVES** were requested by CDDs to make sure medicines are stored and protected.
- **EXERCISE BOOKS, PENS AND REGISTERS** will help ensure CDDs are able to adequately record numbers and make notes for return households.
- **BAGS, BOOTS AND WATERPROOF COATS** are needed in the rainy season to ensure items for distribution are dry and CDDs are able to reach households safely.
- **ACCESS TO PHONES AND PHONE CREDIT** will support communication and supervision during distribution.

TIPS TO IMPROVE FACILITATION OF NTD TRAINING

The following are tips to support you to make your training session run smoothly and be more engaging:

TIP ONE: SETTING GROUND RULES

Establishing initial rapport with training participants can be really helpful in shaping how interactive your session becomes. One way to support people to feel comfortable is through having a collaborative discussion about setting ground rules. To do this, you could use a flip chart at the front of the room and ask participants to share things with you that they think would be important to allow participation from everyone. For example:

- Keep things that are shared about others within the training to ourselves.
- Listen to and respect each other's ideas, there are no wrong or right answers.

TIP TWO: USING ENERGISERS

Sometimes training can be long and drag on for participants. After group activities or breaks, it can sometimes be useful to bring participants back together as a whole with the use of energisers. Some example energisers that might be useful to you are as follows: A short dance, singing a well-known song, a little exercise like standing up and stretching, asking funny questions etc.

TIP THREE: THINK ABOUT YOUR GROUP SIZE AND TAKING BREAKS

Always think about your group size. When you are in small buzz groups, groups of 4 normally increases participation and can decrease feedback time from group activities.

Taking regular breaks is also important, even if these are only mini-breaks. Try to take at least a five minute break every 60-90 minutes.

TIP FOUR: CREATING A PARTICIPATORY ENVIRONMENT

Learning is unlikely to happen solely based on lectures or PowerPoint slides. We need to create a space where individuals can go on their own personal learning journey. This requires the use of a variety of methods including more participatory techniques such as role play, discussion and other interactive activities. There are examples of these in your facilitation guides but try to think about the use of:

- **Role Play:** This type of activities allows you to demonstrate different situations to the group, and to reflect on further learning.
- **Scenario:** This activity can be helpful in helping you to assess how much people have learned or understood from specific aspects of the training.
- **Skills Practice:** This type of activity is useful to ensure learning is taken on by participants.

Try to also think about what resource materials you might need to make your sessions interactive, and to facilitate the exercise types described above, some examples are provided in your training toolkits. But try to think about making sure you have:

- Something on which you can write or draw big enough for the group to read.
- Papers for participants to write on.
- Something to allow the group to choose sides (e.g. tape to divide the room or green and red cards).

TIP FIVE: MANAGING YOUR RESPONSES

Remember when facilitating training sessions and participatory activities it's important to think about shaping the session to make sure that you:

- Do not judge what is right or wrong, discuss points that come up.
- Write and talk (local language preferred) so that all participants feel included.
- Try to use a speaking volume, as if you were talking to one or two other people. This might involve projecting your voice a little to make sure those at the back can hear you. But try your best not to shout.

One thing that might be good to do as a facilitator before a session is think about what might trigger you to respond negatively or lose patience. These can be thought of as your red flags - note them down on a piece of paper. If these issues come up in your training session try to actively think about responding in a positive and non-confrontational way.

TIP SIX: THINK ABOUT POWER DYNAMICS

Power (when someone has influence or control over someone else) can exist for many different reasons e.g. a person's gender, age, level of experience in a job. Different power relationships are likely to exist in your training session. You need to think about these carefully.

Power Relation One: Your power 'over' your participants

- It is common in a teacher-pupil relationship that people will see you as powerful and the person who knows best.
- It is important to recognise that this isn't always the case and there is much you can learn from your group participants. Try to be aware of this in how you facilitate.
- The skills above will help you with this (e.g. the tone of your voice, how you engage with questions and answers in a non-judgemental way).
- Power dynamics can also be influenced by other things such as you age and gender. For example, it might not be considered appropriate for a young female trainee to challenge the opinion of you as an older male facilitator or vice versa.
- Try to be honest and open about this when setting ground rules. Encourage participants to recognise that norms and customs that may exist outside the training venue do not apply here. They should feel free to engage in debate and discussion and learn from each other.

Power Relation Two: Between your participants

- In training sessions where people come from a range of backgrounds and genders, it may be apparent that some people have more say in certain situations than others. For example, health workers may attend training in pairs and one may supervise another; one health worker might have more experience than another and so expect that their opinion should be more counted; you may notice the majority of female participants are not talking freely around their male colleagues.
- Try to think about or recognise why different power dynamics might exist amongst your group of trainees. You can support to manage these dynamics by thinking about how you divide people for group activities e.g. put all women in one group and all men in another; try to mix participants up so they are from separate health facilities or work teams.
- You can also have an open discussion about how power might exist and why it should not matter in this training session. Below is an exercise to help you think about this.

POWER EXERCISE

- **Step One:** Provide participants with 5-10 pieces of paper.
- **Step Two:** Ask participants to write on the paper any title they are known by- e.g. mum, dad, boss, Dr, Mr, Mrs etc.
- **Step Three:** Place a rubbish bin in the middle of the room.
- **Step Four:** Ask participants to gather around the rubbish bin.
- **Step Five:** One by one ask participants to read out their different titles, telling you what they mean to them. (NB things about status or power will likely come up, particularly in relation to titles such as Dr etc.).
- **Step Six:** Ask participants to scrunch up their titles and throw them into the waste paper basket.
- **Step Seven:** Make the point that we have tried to remove hierarchy and titles for this training session and that everyone should feel able to participate equally.

FACILITATION STYLES

FACILITATION STYLE	DESCRIPTION
Directive	Facilitators provide instructions and information to participants
Exploratory	Facilitators asks questions to explore experience and ideas of participants.
Delegation	There are occasions that facilitators assign tasks, roles, and functions to group members such as during roles play, discussion in groups on the issue of trust and how to handle them.
Participative	Facilitator taking part in discussion and sharing personal experiences. For example, facilitator takes part in a role play to demonstrate how to ask open-ended questions and also asked other participants to do likewise.
Interpretive	Facilitator helps participants to clarify their thoughts by use of other words to help them find the right words to express them.

POSITIVE TRAITS THAT AID FACILITATION:

- Good listener
- Flexible
- Non-judgemental
- Deeply respectful

NEGATIVE TRAITS THAT HINDER FACILITATION:

- Not listening to others
- Not respecting others
- Rigidity

EXAMPLE FROM EVIDENCE:

The facilitation at trainings was participatory; the facilitators asked a lot of open-ended questions. Practical and demonstration sessions were also used to teach the participants how to correctly fill the treatment register and summary forms. IEC materials like posters, dose poles, Albendazole and Mectizan containers were used during the training for demonstrations.

For further information of participatory training and facilitation skills, please see other COUNTDOWN tools.

TRAINING CHECKLIST FOR FLHFs AND CDD TRAINING

☐ **Do you have a local Training guide available? If not please see the Nigeria MAM Documentation booklet.**

☐ **Your Agenda should be comprehensive and include the following as a minimum:**

1. Signs and symptoms of disease and specific PC-MAM diseases endemic within community/LGA.
2. Inclusion and exclusion criteria for treatment.
3. How to deliver medicines including how to determine medicine dosage for people living with disabilities.
4. Side effects and how they should be managed.
5. Importance of documentation to keep accurate records.

In some LGAs the medicines were supplied to CDDs during the training, if this is something your LGA will do, ensure this is included in the agenda. CDDs reported that often training was short, rushed and in some cases CDDs were only informed on dosage and how to measure on the dose pole not what is expected in their role.

Rumour crisis mitigation plan should be included at all levels of training so that everyone taking part in MAM will have the same message about side effects of the medicines. This is important so that different persons on the implementation pathway will not pass conflicting messages on side effects and scare persons from accepting the medicines.

☐ **Local Language** should be used to facilitate interaction, this should include local terminology for the NTDs and descriptions of how they are contacted.

☐ **Use of participatory methods for teaching such as role plays and pictorial training materials.**

Use of participatory methods for teaching such as role plays can help facilitate learning and improve understanding by participants and opportunities for identifying any potential issues so participants can collectively solve them. Also, the use of pictorial training materials during training increases understanding and memory.

In one LGA, a new m-health program was launched which involved re-training participants on community sensitisation. Instead of the usual presentation style it was decided that role plays would be a better medium of training which was received well by the participants.

☐ **Observations from Supervision of training quality.**

Limits of the cascade approach to training have been observed. In one LGA, it was observed that the quality of the training diminished from the State training to the FLHF training and finally to the CDD training. Hence, some training areas were missed out and resulting mistakes were made during medicine administration. It was also noted that CDD training did not include how to reach marginalised groups, including people living with disability.

Be aware of any FLHFs new to the facility as too many new staff in one LGA meant the cascade training to CDDs was of lower quality and there was more pressure on the LNTD.

Key consideration: Supervision at all levels of training is important to minimise omissions and improve quality.

☐ **Ensure there are adequate provisions during training and funding to provide stipend.**

CDDs wanted to have refreshments provided during training, this had been monetised previously also incentives for CDDs were slow in being paid and led to a lot of data submission issues.

In one LGA, provision of community register and writing materials prevented CDDs from spending personal money to buy anything for MAM.

☐ Appropriate **IEC material** should be used, refer to the Learning Pack to identify what communities think about current IEC materials and adapt according to your area.
https://countdown.lstmed.ac.uk/publications-resources/tools-and-booklets

☐ **Pre and post testing** can be used to evaluate learning from training sessions so it may be improved. An example of possible questions you could use are located in the Nigeria MAM Documentation booklet.

EXAMPLE FROM RURAL LGA: ACTIONS FOR TRAINING CASCADE

**Please note that the budget in this example is not a current figure. For further information on costing for activities please see the Costing Toolkit, 2021.*

S/N	Activity	No. of days	Start date	End date	Actions	Person responsible *(insert name and role)*	Resources required / Budget*
1	**Training of FLHF**	2	30/08/2018	31/08/2018	• The training would be conducted at the PHC in Imeko Afon LGA. • 15 FLHF staff would be invited for a two-day training at the same venue. • The FLHF will be contacted through phone calls and text messages and WhatsApp chat to notify them for the training a week and 3 days before training. • They will be trained with the relevant IEC materials. • They will also be trained on how to determine medicine dosage using dose pole, treatment registers level 0, 1 and 2, summary forms and management of side effect. • There will be role play to ensure they understand all that were being taught. • Role play will be used throughout the training day to cover all aspects of training. • The State NTD will support during training. • They will be given medicine for all communities under their health facility. • Before the training of CDDs, FLHFs in charge will allocate medicines to communities based on their population.	Role: LNTD Name: Tosin	6,000 for stationeries 20,000 for training manual, transport allowance 3,000 per person = 60,000, refreshment 500 per person per day = 20,000, T-shirt = 1,500 each = 30,000 Venue = appropriate for 15 people
2	**Training of CDDs**	1	05/09/2018	05/09/2018	• 201 CDDs will be divided and allocated to the 15 Health facility in Imeko Afon based on the population of the communities under these health facilities. • The CDDs will be trained by the 15 FLHF that were trained at the LGA level. • The CDDs will be trained at the health facilities where their communities received health services. • Training will take place on the same day in all the health facilities. • Training should not be more than 3 hours and all CDDs should be given medicine at training venue. • Training would last from 10am - 1pm. • Trainers should arrive at least 30 minutes prior to the time. • Training content to include knowledge about the disease symptoms, mode of transmission, how to determine dosage, how to handle side effects and determine medicine dosage for people living with disabilities to increase confidence in medicine administration. • Develop a template to collect CDD contact information on that is stored at the health facility. • Role play will be used throughout the training day to cover all aspects of training.	Role: FLHF, supervised by LNTD and LGA team Names: Noela and Tosin	Venue = appropriate for 216 people Include: - Refreshment - Stationaries

EXAMPLE FROM URBAN LGA: ACTIONS FOR TRAINING CASCADE

**Please note that the budget in this example is not a current figure. For further information on costing for activities please see the Costing Toolkit, 2021.*

S/N	Activity	No. of days	Start date	End date	Actions	Person responsible *(insert name and role)*	Resources required / Budget*
1	**FLHF Training**	2	03/07/2018	04/07/2018	• 16 FLHF will be invited for training two weeks before (24/06/18). The training by the LNTD, who will also inform them and follow up with an SMS. • Training will be done at Sidi Yero Memorial clinic. A total of 16 FLHF staff will be trained by LNTD and supported by SNTD. • Training will be done for three hours per day for 2 days. - Day one will cover theory (as described below) - Day two will be role play on the topics below • FLHFs will be trained on: 1. different diseases, 2. how to fill the summary forms, 3. how to explain the relevant IEC materials to the CDDs, 4. how to explain dosage, measurement and adverse drug reaction, 5. how to supervise CDDs, how to fill the ledger at the facility level for the drugs issued to the CDDs. • The store officer will train FLHF staff on inventory of medicines, allocation of receipts and storage.	Roles: LNTD, Assistant LNTD, Store officer, SNTD Names: James, Noela, Akinola, Tosin	N20,000 for writing materials and stationaries. Venue and refreshments = for 16-20 people for 2 days
2	**CDD Training**	2	09/07/2018	10/07/2018	• The community leaders will invite the CDDs who live in the community for the training a week before. • A total of 1115 will be trained based on population. • Training will be done in three districts. • Training will take place in suitable venues with enough room, with no distractions. • Training will be done for six hours per day for 2 days. - Day one will cover theory (as described below) - Day two will be role play on the topics below • Distribution of medicines by the store officer to the FLHF will take place after the training • Training would last from 9am – 12pm each day. • Trainers should arrive at least 30 minutes to the time. • Training content to include: 1. knowledge about the disease symptoms, 2. mode of transmission, 3. how to determine dosage, 4. how to handle side effects and determine medicine dosage for people living with disabilities to increase confidence in medicine administration, how when to carry our 'mop up activities'. Providing the community with Information as to where there will be fixed points for mop up. That it is a one-time treatment only for those who don't reside in the community but only came in to do business.	Roles: FLHF staff, community leaders Names: Musa, Mohammed	N25,000 for stationaries and writing materials Venue = 3 venues for 400 people each

3.2 HOW TO DEVELOP ACTION PLANS FOR COMMUNITY ADVOCACY, SENSITISATION AND MOBILISATION

OBJECTIVES OF THE SECTION:

By the end of this section, you will gain an understanding of key considerations for action planning to improve advocacy, sensitisation and mobilisation within your communities for MAM.

- Identify appropriate stakeholders for implementing sensitisation and mobilisation.
- Identify key people in your communities to sensitise and mobilise.
- Gain an understanding of different methods of communication which can be used for advocacy, sensitise and mobilise.
- Identify what resources are needed for advocacy, and to sensitise and mobilise the community.
- Consider potential challenges which may be faced throughout this process and identify how they can be mitigated.

COMMUNITY ADVOCACY

Community advocacy involves visiting community and religious leaders and or decision makers in a community to create awareness and involvement in the NTD program. Key messages at advocacy involve disease transmission, medicines and doses, eligibility criteria and role in selecting CDDs.

OUTCOME OF ADVOCACY:

Increase in acceptance of NTD program by community leaders and identification of good locations (and ideas) for sensitisation and medicine distribution.

Advocacy was done with 19 community leaders including two Fulani community leaders. This had a positive effect as the Fulani leaders said they would select CDDs from their communities which would help increase uptake.

COMMUNITY SENSITISATION

Community sensitisation involves creating awareness to community members. Method of sensitisation could be in form of a walk around a community using public address system and posters on NTD awareness.

Remember you can use Transect walks and social mapping to help you identify key stakeholders and structures - for further information see Module 2A.

OUTCOME OF ADVOCACY:

The method used for sensitisation was a procession within a major street in a community using a public address system which was clear and loud for people to hear the information being passed, this drew the attention of the community members as many came out of their houses and shops while others on transit on motorbikes and cars stopped to listen to the information being passed. IEC posters were also distributed at different locations to individuals and groups. The presence of community leaders during sensitisation added more value to the sensitisation.

COMMUNITY MOBILISATION

Community mobilisation involves encouraging the community to be available and take part in MAM. This activity should commence a week or two to MAM to inform people about treatment dates and time. Community mobilisation is not a campaign that is undertaken only once, it can be conducted before community-based treatment and school-based treatment or before any community intervention.

- Community advocacy, sensitisation and mobilisation requires proper planning.
- Good community sensitisation and mobilisation will enable community members to make an informed decision about taking part. It will also improve and promote equity and equality in coverage of MAM in the community.
- There are many stakeholders who should be involved in planning for, and implementation of, sensitisation and mobilisation. This will ensure that the correct information is passed across to a wider population; enabling all community members to have the opportunity to take medicines to treat preventable NTDs.
- Whilst the main target audience of community sensitisation and mobilisation is community members themselves, there are key stakeholders and structures in the community which will enable effective sensitisation and mobilisation to take place.
- Including the appropriate stakeholders in planning and implementation has been shown to have positive outcomes on increasing accessibility and acceptability MAM, thus increasing coverage. The stakeholders will change depending on the context, culture, geography and hierarchies within the community.
- LNTDs should be aware of key stakeholders within their own communities and involve them throughout the process.
- An understanding of gender roles and norms within your communities, and what challenges this may bring to accessing men and women is important when considering what stakeholders to sensitise.

Potential side effects of medications should be intelligently and carefully communicated to communities so as to avoid scaring people. It should be worded along the lines of "*there are different responses of the body to different medicines.*" Communication around side effects could include the time frame after taking the medications when side effects may occur, and instructions on what actions they should take if they experience side effects.

Key: **Evidence informed**

IMPORTANCE OF INCREASING AWARENESS ABOUT MEDICATION

Whilst some community members will accept MAM based on trust with the mobilisers and distributors alone, or on order of family members, it is important that adequate sensitisation is done for the following reasons:

TO DISPEL MYTHS AND REDUCE FEAR:

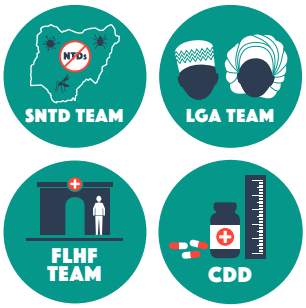
- Some communities believe that the medicines are used for family planning which has been suggested to cause fear and refusal of medicines.
- A few community members believe that the medication will cause harm from side effects and even cause death.
- Some community members distrust the medication as they fear it originates from a foreign country, has expired, or it is of no use to them because they do not have signs of disease.

TO INCREASE KNOWLEDGE ON THE PURPOSE AND HEALTH BENEFITS OF THE MEDICATION:

- Some people refuse the medicines because they do not know the purpose of the medicines.
- Some people collect the medicines without swallowing as they are not sure of the importance of the medicines.
- Some older men advised that focus group discussions could be carried out with community members or adequate sensitisation on the purpose of the medicines.
- A main motivator for accepting medication was reportedly due to perceived health benefits of the medication. Some community members had seen improvement in their own vision, reduction in itching and passing of worms. This encouraged them to take medicines in subsequent rounds and increased their likelihood to encourage other community members to take the medications.

WHO HAS RESPONSIBILITY FOR SENSITISATION AND MOBILISATION AND WHO SHOULD BE INCLUDED?

It is expected that implementers at the three main levels; State, LGA and FLHF are aware of their responsibilities for sensitisation and mobilisation and who should be included.



Remember you can use different ways outlined in Module 2 and the accompanying Learning Packs to help identify key stakeholders.

Flag off of distribution was introduced in an LGA. The executive chairman and the Chief Imam being prominent political and religious figures conducted the flag off. They both encouraged people to lend support for the programme by accepting to take the medicines because they have been certified safe by renowned healthcare authorities like the WHO and the FMoH. A representative of the zonal office of the FMoH, the SNTD, traditional leaders etc. were all in attendance. This flag off took place in one of the health facilities in the LGA headquarters and at the Central mosque respectively. It was covered by electronic media thereby increasing awareness and support for the programme in the LGA.

MAM Flag off by a religious leader

THE RESPONSIBILITIES OF THE ADVOCACY, SENSITISATION AND MOBILISATION TEAM:

STATE TEAM RESPONSIBILITIES

- Organise and fund macroplanning meeting to identify effective sensitisation and mobilisation strategies for the State.
- Make provision for pre-recorded jingles for MAM across all LGAs in the State.
- Fund and print IEC materials and share them with LGAs.
- Fund supervision of sensitisation activities at the LGAs.
- Development of crisis prevention plan.
- Set up an advocacy, sensitisation and mobilisation team consisting of: National Orientation Agency representative, Director PHC, Director Disease Control, Social Mobilisation Officers and all other relevant stakeholders.

LGA TEAM RESPONSIBILITIES

- Organise a microplanning meeting to identify effective and context specific sensitisation and mobilisation strategy for the LGA.
- Fund airing of jingles on the radio.
- Distribute of IEC materials e.g. posters, leaflets to different FLHFs.
- Train community mobilisers.
- Supervise sensitisation at the FLHF.
- Identify personalities, groups and associations to sensitise and mobilise in the LGA.
- Fund sensitisation and mobilisation meetings with identified groups e.g. Stakeholders Mobilisation Meetings etc.
- Development of crisis prevention plan.
- Set up advocacy, sensitisation and mobilsation team consisting of: National Orientation Agency representative, Director PHC, Director Disease Control, Social Mobilisation Officers, Health Educators and all other relevant stakeholders.

FLHF TEAM RESPONSIBILITIES

- Liaise with communities to come up with sensitisation and mobilisation committees with individuals to be responsible for identified roles.
- Identify and compile the list of mobilisers from each community under the facility.
- Share IEC materials for the communities under it.
- Supervise sensitisation activities in each community.
- Provide a megaphone for community announcement.
- It is one of their responsibilities to report any crisis or unforeseen events to the LGA team for them to take action.

For SNTD, LNTD and FLHF focal people to fill their responsibilities in sensitisation and mobilisation, they must consider engaging other stakeholders.

Key: ✓ **Example of success** ! **Example of challenge/caution needed**

The State Director of primary health advised the LNTD *"When going into an LGA for advocacy, is the LGA aware, is the Zone aware? By going through the Director of Primary Care, he will take you to the chairman and you will have your advocacy, you return back to his office and you strategise together."*

Advocacy and sensitisation to the LGA chairman and community leaders plays an important role, formerly, it was more senior people that pay advocacy visits, the LNTD team were not involved. The State usually visits the first class chief only but in the last MAM, the health department and LNTD team all went to the chairman and also visited three chiefdoms. The communities all appreciated this new approach.

Health educators have proven to be an integral part of the advocacy and sensitisation aspects of MAM. They are usually associated with health services in the mind of members of the community and as such are more welcome and readily accepted because they have been established to be authorities in health related matters. In line with their duties, they also have structures and contacts in place for effective cascading of information at all levels, from the traditional rulers, to religious leaders, market leaders amongst others.

CSOs were recognised as stakeholders whose roles and responsibilities is to advocate at all levels, but particularly at the community level for NTDs. This enhanced partnership for implementation of NTD activities like supporting collection and delivery of medicines, sensitizing and providing health education in communities, assisting in training distributors selected by the community, facilitation of reverse logistics, supervision of treatments at community level, provision of local resources for distribution of medicines and commodities, supporting community self-monitoring of NTD programme implementation, providing financial and technical support, facilitating networks for leveraging resources, providing necessary support for operational research and aligning programme objectives with national objectives for NTDs.

The advocacy teams were encouraged to follow the due protocol when going for advocacy in communities within the LGAs by letting the zone, and the LGA authority know. They were also encouraged to see the Director for Public health who would introduce the advocacy team to the chairman of the LGA council.

ACTIONS RELATED TO ADVOCACY, SENSITISATION AND MOBILISATION TO BE CONSIDERED FOR INCLUSION IN YOUR ACTION PLAN

The example actions in each table are not all relevant for all contexts and LGAs, you, as implementers should consider each action alongside your given context, budget restrictions and human resource management structures and only choose actions which will best respond to your LGA needs. Some actions work better in urban areas and others in rural and so you should consider the feasibility of using that action within your area and not choose all.

Where you see [X] this indicates that you should insert a number or choice that suits your population.

PURPOSE OF ACTION	EXAMPLE ACTIONS	EXAMPLE OUTCOMES FROM EVIDENCE
ACTION PLAN FOR DIFFERENT STAKEHOLDERS TO INVOLVE IN SENSITISATION AND MOBILISATION		
All these bodies have structures from the national through the State and to the LGAs. Through these structures, they are able to cascade information. Example structures include: • State Chapter of National Union of Journalists (NUJ) • State Chapter of National Orientation Agency (NOA) • National Union of Road Transport Workers (NURTW) • National Road Transport Operators (NARTO) • Voluntary community mobilisers • Christian Association of Nigeria (CAN) • Community Development Committees (CDC) Ensure messages are in the local language so they are understood by all.	• Letters will be sent to (insert names) at (insert date) and will include prevalence of the NTDs, availability and safety of medicines to treat NTDs. • Emails will be sent to (insert names) by (insert dates) and will include prevalence of the NTDs, availability and safety of medicines to treat NTDs. • Visits to explain prevalence of the NTDs, availability and safety of medicines to treat NTDs will be conducted to (insert names) by (insert dates). • Printed and electronic messages to NOA and NUJ will be sent by (insert dates). • Provide NURTW and NARTO with printed and verbal messages by (insert dates) so they can pass the message via transportation associations at the motor parks where they operate daily and interact with passengers on daily basis.	✓ An advocacy visit was carried out to the manager of a State media corporation and this allowed for radio jingles to be aired in Hausa with a phone in programme where the public was educated on the NTD programme in the State and anyone who had questions could call in. TV adverts were also placed informing people of the upcoming MAM and why it was necessary to take the medicines. **URBAN:** Town announcers were to be engaged for mobilisation of the community. Also, open air vehicles were proposed during market days and in strategic places, this was to be facilitated by the National Orientation Agency and the media cooperation to help air the jingles. ✓ In one State, the NOA at the LGA level were involved in sensitisation and enlightenment of the communities using their existing structures. ✓ In one LGA, the LNTD coordinator, assistant LNTD, Social Mobilisation Officer, ward Focal Persons and Christian religious leaders were involved in sensitisation. The LNTD stated that letters were sent to churches to create awareness of MAM and to encourage them to participate. A reminder for training was sent via the Health Workers WhatsApp platform to ensure that everyone was aware of the scheduled training.

'A well-documented letter that was delivered to HOLGA really helped the mobilisation process, similarly was the involvement of the MOH and Head of PHC during the sensitisation visit to the HOLGA. Phone calls with FLHF and personal visits facilitated exchange of information. Essentially, the use of NTD posters and the corporation of the NTD team made the difference. Similarly, artisans were visited at their monthly meetings and sensitised which is new.'

The LNT therefore reflected that the PGP recommends collaboration because the LNTD cannot do it all alone. (LNTD)

PURPOSE OF ACTION	EXAMPLE ACTIONS	EXAMPLE OUTCOMES FROM EVIDENCE
ACTION PLAN FOR DIFFERENT STAKEHOLDERS TO INVOLVE IN SENSITISATION AND MOBILISATION		
To ensure that the management of the LGAs are aware of the programme and are invited to lend support for its success.	• Conduct an advocacy visit to LGA management of local council development areas where the campaign is taking place, so they are aware of the medicines and when they will be distributed.	✓ **URBAN:** The MOH, LNTD, Health Educators (HE) and apex nurse undertook a sensitisation visit to the executive chairperson of the LGA and they were assured of support for the programme. ✓ **RURAL:** There was an advocacy visit to the management of the two local council development areas and they were adequately informed about the programme as planned. ✓ **RURAL:** The Social Mobilisation Officer (SMO) led an advocacy visit to the LGA chairperson who is a political leader requesting financial and moral support for the NTD program. The LGA chairperson gave the assurance of support for the programme in the LGA. ! **RURAL:** Older men suggest some people refused the medicines because they are afraid that the medicines might kill their children, others refuse to swallow the medicines because they believe it might make them infertile and they are not yet done giving birth. Older men observed that the presence of Government officials during treatment encouraged the people to accept medicines and they appreciated the efforts of the Government in providing medicines to prevent Oncho/LF. They advised that Government officials can be used for sensitisation and that collaboration with the Government hospital during MAM will encourage acceptability. ✓ SNTD stated that joint collaboration in planning for the community mobilisation and sensitisation together with community leaders worked well.

Key: ✓ **Example of success** ! **Example of challenge/caution needed**

PURPOSE OF ACTION	EXAMPLE ACTIONS	EXAMPLE OUTCOMES FROM EVIDENCE
ACTION PLAN FOR DIFFERENT STAKEHOLDERS TO INVOLVE IN SENSITISATION AND MOBILISATION		
To ensure health facilities are able to promote health awareness among their clients is critical to community engagement practices. Health Facilities include: • Primary health care centres. • Service Delivery points. • Private health care facilities/ services. • Pharmaceutical and medicine dispensing stores. • Traditional Health service providers including traditional birth attendants.	The FHLF focal person can do the following: • Ensure adequate and valid information is communicated to community members [X] weeks before medicine distribution. • Provide training to CDDs [X] weeks prior to distribution. • Provide support and advise throughout the implementation process.	**RURAL:** Some community members mentioned that they refused medicines because the CDDs are not health workers and have no knowledge of what the medicines are meant for. They advised that the remedy is to get health workers from the hospital to enlighten them on the purpose of the medicines. More awareness about the importance of the medicines among older women changed their previous belief that the medicines destroy female ovaries, however some older women report that there is still fear in the community. Older women reported that although they were initially sceptical about the medicines, government staff explained the purpose of the medication and encouraged them to take it, therefore working with health workers from government hospitals may increase acceptability of medicines for older women.

PURPOSE OF ACTION	EXAMPLE ACTIONS	EXAMPLE OUTCOMES FROM EVIDENCE
ACTION PLAN FOR DIFFERENT STAKEHOLDERS TO INVOLVE IN SENSITISATION AND MOBILISATION		
To identify existing community structures, committees and groups who can be used to support sensitisation processes and to understand how and when they can be used.	• Identify what CDCs, SMOs, groups, institutions, key community members are important in your communities *using social mapping tools described in Module 2A.* • Identify key dates and locations when activities such as market days, sanitation days are taking place. • Conduct sensitisation activities using dates and locations identified in your target communities. • Provide [X] numbers of appropriate IEC material to conduct sensitisation on [X] dates. • Sensitisation will take [X] hours at each location. • Ensure that all sensitisation materials are translated into local languages.	✓ Key community leaders, structures, committees and groups have great influence in the way that information can be passed across to their members. These associations and networks make up the community of peoples in various town and villages. When we engage these associations and networks with our prevention's interventions, we create a wide interface among community members with a common message. Working with these existing structures is fundamental to promoting community acceptance and awareness raising to increase access to MAM. These networks are well spread in urban and rural areas and they often meet at regular times for social and economic development discussions. ✓ **URBAN:** In one LGA the advocacy visit was taken to the LGA chairman and his cabinet. CDCs, department of sanitation, market leaders amongst others were also visited.

Key: ✓ **Example of success** ! **Example of challenge/caution needed**

PURPOSE OF ACTION	EXAMPLE ACTIONS	EXAMPLE OUTCOMES FROM EVIDENCE
ACTION PLAN FOR DIFFERENT STAKEHOLDERS TO INVOLVE IN SENSITISATION AND MOBILISATION		
Community members being sensitised and encouraged to sensitise other community members. Family structures and dynamics may change depending on context, which may include religion. Depending on your communities there may be members who are unavailable or unseen. These may include people who work away from home, women, children of school age, people living with disabilities, people living in geographically hard to reach communities, migrant populations who may travel.	• Encourage community members to share messages with friends, colleagues and family. • Provide community members handbills and posters to show to other members of their community. • Sensitise pregnant women and nursing mothers to encourage them to create awareness among their family members and ensure they serve as knowledge champions for MAM in their household and communities.	Community member across States in both rural and urban contexts mentioned that those who took the medicines and derived its benefits can share their stories with those who don't take the medicines. This highlight the importance of 'word of mouth' and its potential effect on acceptability. **URBAN:** Male youths in a community reported hearing about MAM treatment at their places of work. Besides, there was much awareness created on the effectiveness of the medicines by mobilisers who went round with the message in the community. Also, sight of people queuing to take the medicines made some residents to decide to participate. To older males, the effectiveness of the medicines from previous distribution and reports from those who took it earlier during this year's cycle were things that encouraged/ sensitised them. Youth males mentioned that many people that accepted the medicine did so because of the testimony of people that have used it before. They could confirm the benefit to others who took interest also.

In one urban LGA, a woman who would not take MAM stated that following rumours of fainting by people after taking the medicines in the previous cycle, she was advised by her husband not to take MAM.

In some instances, husbands decided if the wives and children take the medicines or not. Others added that the decision for them to use the medicines was taken by their relations e.g. brother. Knowing that the brother will not mislead them, they took the medicines even without having complete knowledge/information about the medicines.

Please consider gender roles and norms within communities, and what challenges this may bring in autonomy to accept medication, especially for women and children.

PURPOSE OF ACTION	EXAMPLE ACTIONS	EXAMPLE OUTCOMES FROM EVIDENCE
INCLUDE PROVISION OF RESOURCES IN YOUR ACTION PLAN		
Use appropriate language for communication and where possible obtain IEC material changed into appropriate languages.	• Provide a variety of IEC materials which is appropriate to the stakeholders above. • Provide IEC material in the local language. • Ensure adequate quantities of IEC material is available. • Print [X] number of posters, [X] number of leaflets by [X] date ***Please refer to the Learning Pack for more advice on how to involve your community in reviewing materials used for communication, and potential unseen barriers which means the IEC material is not communicating what it proposes to communicate.***	✓ In one urban LGA, the LNTD used the IEC materials for sensitisation at the district heads meeting and also gave the materials to leaders present at the meeting. This was used in creating awareness for community members and helped the acceptance of MAM. Also where CDDs took IEC materials along during distribution, it helped to increase acceptance by community members as they were able to ask questions and clarify issues they had. 
Conduct advocacy visits to community leaders and religious leaders before sensitisation.	• Identify key leaders for advocacy visit by [X] date • Visit community leaders on [X] date	✓ LNTDs affirm that due to advocacy with community leaders in the LGA, community leaders choose the community square and market as structures to be used during sensitisation and mobilisation.

Key: ✓ **Example of success** ! **Example of challenge/caution needed**

PURPOSE OF ACTION	EXAMPLE ACTIONS	EXAMPLE OUTCOMES FROM EVIDENCE
	LOCATIONS	
Sensitisation and mobilisation should take place in multiple locations within the community.	• Identify key structures within the community where sensitisation and mobilisation should take place, *use Module 2 to guide.* • Organise visits to all Faith centres. • Visit (insert name) festival at (insert name) location on [X] date. • Visit (insert number) (insert venue / structure) at (insert name) location on [X] date.	✓ Alternative spaces such as festivals could be considered. One popular cultural festival which is well attended was identified in the planning stages for one LGA. The festival was identified as one of the channels to be used to communicate MAM to residents of the LGA and people who will be attending the festival from different places. It is usually held immediately after the annual Muslim festival of Laiya. However, this was not carried out despite holding within the period MAM was about to take place in the LGA. The LNTD is of the opinion that if that opportunity was utilised, a lot of awareness would have been created easily because of the crowd that normally attend the festival. The MAM message therefore may have been widely spread if it was taken there. ✓ There was the first Global NTD Day celebration on 31st January which was marked by a road walk along major parts of the LGA to create awareness and sensitise the population about the presence of the diseases in the LGA. This worked well and is an opportunity to engage communities and raise awareness. Often NTD implementers will fund such activities. Consider this as an advocacy visit in your planning.

PURPOSE OF ACTION	EXAMPLE ACTIONS	EXAMPLE OUTCOMES FROM EVIDENCE
TIMING IS ESSENTIAL TO INCLUDE IN YOUR ACTION PLAN		
Sensitisation and mobilisation must be carried out in adequate time to allow communities to be aware of MAM.	• Inform Community leaders 2 weeks before sensitisation and mobilisation. • Sensitisation and mobilisation should be conducted [X] weeks prior to MAM distribution. • Sensitisation and mobilisation (insert method) [ ] should take place for [X] hours for [X] number of days.	Community members across 4 LGAs suggest that Community members, and especially Community Leaders, should be informed between 1 and 4 weeks prior to MAM. Many community members who had been absent during MAM 2018 reported that if they had known about the importance of MAM and when and where it will take place, then they would have changed their activities to be available, this was especially relevant for males who work away from the villages. **RURAL:** Mobilisation was carried out twice in a week (Saturdays and Sundays), in the evening and lasted for two weeks before implementation. An older woman suggested that sensitisation by town announcers could be done a day before MAM. Therefore, different routes and methods of communication may need to be done at different times for maximum acceptability and accessibility. Town announcers for example began sensitisation a week before MAM. **URBAN AND RURAL:** In one case the time scheduled for MAM collided with the time for religious services, prompt knowledge of MAM timing will help them to reschedule some church programmes if they observe it will collide. The MOH explained how the State ministry of health handed down the timeline, nevertheless, it was condemned severally. And a notice **of a month** was suggested so that every stakeholder will do proper sensitisation. Otherwise, this will lead to conflicting messages that will hinder the success of the programmes.

Key: ✓ **Example of success** ! **Example of challenge/caution needed**

PURPOSE OF ACTION	EXAMPLE ACTIONS	EXAMPLE OUTCOMES FROM EVIDENCE
MONITORING AND SUPERVISION OF SENSITISATION AND MOBILISATION		
Monitoring and supervision during MAM.	• SNTD (insert name) _____ and (insert names and roles) _____ from the programme coordination unit should be directly supervising. • LNTD (insert name) and Health educator (HE) (insert name) will coordinate the sensitisation activity which should be supervised by representative of the State e.g. the SNTD or representative (insert name). • Allocate how to supervise and on [X] dates. • Allocate [X] budget and provision for [X] transport to supervise.	Who to supervise and monitor supervision depends on the level where the sensitisation and mobilisation activity is being carried. Monitoring and supervision at all levels will ensure that the target groups and the action are completed as identified in the plan. ✓ **URBAN:** Regular feedback was provided during supervision and this helped to correct things as the process went along.  ✓ **RURAL AND URBAN:** Supervision at the LGA helped to tackle issues with shortages of medicines as supervisors provided medicines to CDDs with shortages of medicines, treatment registers and dose poles. SNTD stated that the ability of the team to resolve issues encountered by the CDDs and to improvise where necessary made the supervision of great benefit to MAM.
CONSIDERATION OF BUDGET EARLY IN ACTION PLANNING		
Consider early what your budget is for sensitisation and mobilisation.	• Plan budget [X] months prior to MAM. • Consider additional funding and approach alternative sources. • Set realistic plans which are within budget. • For each action a budget should be specified.	! In some LGAs, multiple methods and means of sensitisation and mobilisation which were in the action plan could not be implemented due to lack of funding. Consider early on what your budget is for sensitisation and mobilisation. Increased funding and alternative/additional sourcing can be considered e.g. from Rotary Club, Save the Children, hospitality industry and public-spirited individuals etc. could make the difference. This requires early planning, and Action plans should be realistic and achievable for your LGAs.

STRUCTURES AND KEY STAKEHOLDERS

COMMUNITY DEVELOPMENT COMMITTEES (CDCs) AS A KEY GATEWAY THROUGH WHICH COMMUNITY SENSITISATION CAN BE CARRIED OUT

EXAMPLE OUTCOME:

They are known to oversee community associations and committees and they have a better understanding of cultural individualities of communities and have a greater influence on issues related to fixing market days, sanitation days etc.

URBAN: Posters and handbills can be handed to them at their monthly meeting for onward sensitisation of associations and other groups under their umbrella about MAM.

COMMUNITY-BASED NETWORKS AND ASSOCIATIONS / SOCIAL MOBILISATION COMMITTEES

EXAMPLE OUTCOME:

URBAN: Representatives of the Christian Association of Nigeria (CAN), Association of Commercial Operators of Motorcycles and Riders of Nigeria (ACOMORON) etc that constitute the Social Mobilisation Committee were addressed by the Medical Officer of Health (MOH) and other members of the implementing team at the LGA. The representative of the State NTDs coordinator explained to participants the need for everyone in the LGA that is eligible to be treated. At the end of the meeting, the representative of the paramount ruler and majority requested to be treated instantly and that eventually became the flag off ceremony of distribution of medicine for the year in the LGA because virtually all the 46 persons in attendance swallowed the medicines at the meeting to signify their acceptance.

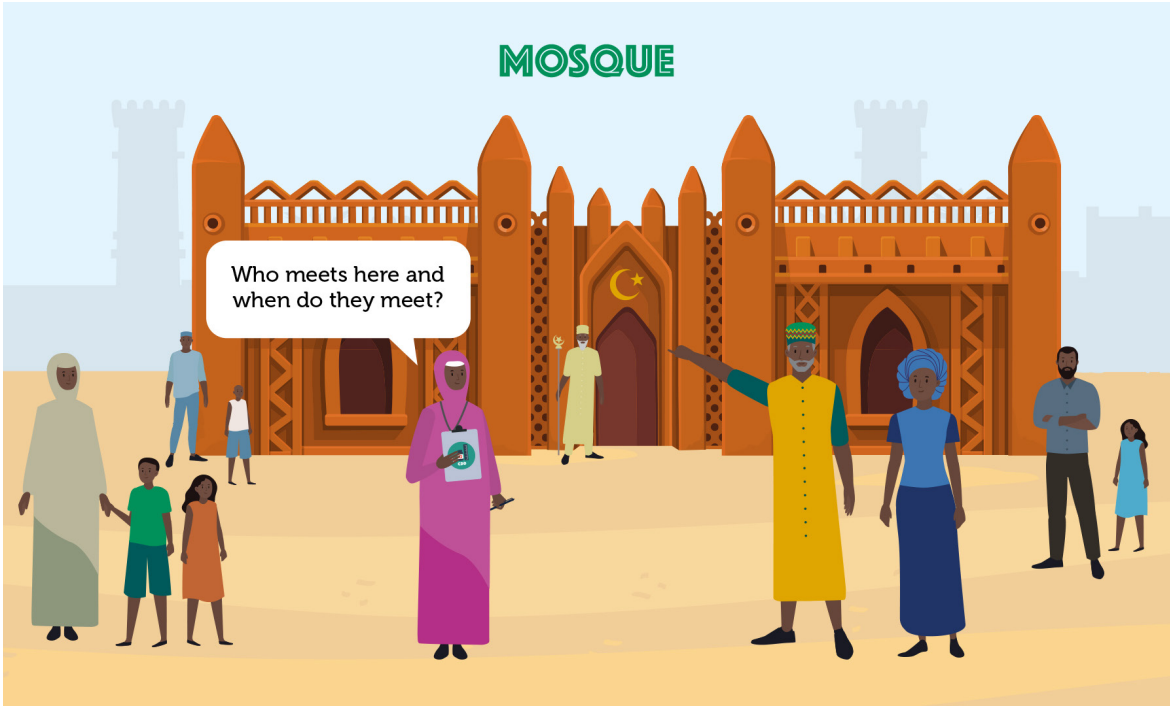
The following were engaged for sensitisation, it was a one-day activity and had the community leaders (including; district heads, men, women, youth leaders), religious groups, ward heads and shop owners who were told about the programme using IEC materials and were given IEC materials to sensitise other members of the community.

Other examples include:

- Barbers' Association
- Association of Women Hairdressers
- Motor Mechanic Association
- Market Women Association
- Artisan groups like electricians, welders etc.
- Nigeria Union of Teachers (NUT)
- Police officers' mess
- Baale Agbe (Head of the Farmers)
- Iya Loja - market women leader
- Baba Loja - market men leader
- Association of bricklayers
- Fashion designers association
- NURTW

At a stakeholders' meeting at the LGA, some stakeholders e.g. the woman leader recommended the involvement of the Baale Agbe (Head of the Farmers) because the majority of the farmers would easily listen to him when he speaks. To her, Baale Agbe controls the farmers very well and since the LGA is an agrarian community the support of such office would make a remarkable difference it is imperative for him to attend a meeting like this.

COMMUNITY BASED ORGANISATIONS, NON-GOVERNMENTAL ORGANISATIONS (NGOs), RELIGIOUS/FAITH-BASED ORGANISATIONS, SOCIAL INSTITUTIONS



EXAMPLE OUTCOME:

The members of these organisations are drawn from the communities where health facilities are based or located. It is possible to work through these groups in relation to information sharing and awareness raising. Working with and through them is indirectly working with the community leadership since most members in these associations tend to be people in the community.

Urban youth leader's e.g. Olori odo, Rotary club etc. were identified as potential structures for MAM sensitisation in urban centres.

Other examples include:

- Artisan groups
- The Lion's Club
- Aged Group Associations
- Ward Development Committees (WDC)
- Village Development Committees (VDC) for mobilisation and sensitisation
- Voluntary Community Mobilisers

At the church the CDD and the FLHF drew the attention of the ushers standing at the entrance of the main auditorium. The Head of Ushering Unit attended to them and he was told about the distribution of mectizan and Albendazole intended for all community members and in this case for the church members. The Head of Ushering Unit attended to them and was briefed about their assignment i.e. distribution of mectizan and Albendazole to the community and in this case, his church members. The leader (a Bishop) immediately set aside space to accommodate the children in the church. He had had prior knowledge about MAM so it was not new at all. He even went back to the main auditorium to announce the distribution of medicines and mobilised the congregation in small batches to receive the medicine.

COMMUNITY MOBILISATION OFFICERS WITHIN THE COMMUNITY

EXAMPLE OUTCOME:

CDDs often are the ones going house to house to sensitise and mobilise communities.

Community mobilisers have also been used. In one urban setting, people who had previously been involved in medicine distribution were instead utilised as mobilisers. They were known by the community, and often paired with a Health Extension Worker to mobilise.

URBAN: Mobilisers went through important community structures like Junctions, markets, drinking joints, places where women fetch water and braid hair to sensitise.

Mobilisers in the community went around with megaphone to make an announcement about the distribution. These announcements were made in churches, mosques, streets etc. They talked about the benefits of the medicines and that encouraged people to take the medicines. Older men observed that former CDDs who now functioned as mobilisers were effective in passing the message across.

WOMEN GROUPS AND ASSOCIATIONS

EXAMPLE OUTCOME:

To utilise forum to speak to women group about MAM to increase gender equity and maximise cost effectiveness through wide dissemination of NTD message.

RURAL: Younger women suggested that women can be gathered by the community leader, using a woman to sensitise them on the benefits of the medicines and those eligible and ineligible to swallow the medicines. Younger women suggested sensitisation by writing letters to villages on the day of treatment so that they can avail themselves as it is done in other programmes like family planning.

URBAN: State Director of Public Health, the MOH of the LGA, the LNTD and the HE passed information on the forthcoming MAM to a group of women - food vendors for public primary schools in the LGA. They mentioned the causes of oncho and LF as bites from black flies and mosquitoes respectively, wearing protective clothing and sleeping under protective nets, taking preventive chemotherapy like the one about to be distributed in the LGA are all ways that one could prevent himself/herself from the diseases. Most importantly, they were told that the medicines are safe to be used and are given for free etc.

URBAN: Older women in a community were sensitised about the NTD programme during an opening ceremony of a new health facility.

VISIT TO COMMUNITY AND RELIGIOUS LEADERS FOR ADVOCACY AND SENSITISATION

EXAMPLE OUTCOME:

Examples include:

- District head
- Imams
- Olorithuns
- Baale
- Pastors
- Village heads
- Kings

Targeting them as champions to work with in promoting awareness on MAM. Because of their influence in their communities, and the fact that they are opinion leaders, they can easily gather their members together for any community gathering or meeting.

RURAL: 5 different kings were sensitised on the scheduled commencement of MAM for the year and the need for the community to give incentives to the CDD. A very influential king said, "*If he was not first informed before the distribution of the medicine, he would not have allowed his people to take the medicine*".

Elsewhere in another rural LGA, older females suggest informing religious leaders will help announce the programme at their various religious centres and it is an avenue through which people can hear about it. A woman mentioned that the medicine distributor involved the village head of her community during awareness creation about MAM.

RURAL: Village heads were sensitised through the information they got about MAM. They were encouraged to summon their community members to participate fully. And they gave their assurance of full participation. A man living with disability in a community advised that community leaders could be engaged by communicating the time and date of distribution so as to facilitate the implementation. He recalled that was done in the Polio campaign.

Engaging religious leaders led to better sharing of information in the community. The Pastors and Imams who are religious leaders were the influential people engaged for the sensitisation. In one rural LGA for instance, engaging religious leaders led to better sharing of information in the community.

URBAN: The LGA implementation team headed by the MOH visited a council of community leaders during one of their security meetings which held in the house of a leading member and sensitised them for onward sensitisation of their different communities.

Community leaders usually supported community services by offering their compounds with chairs for people to sit down and distribute medicines. Usually, the community leader (Oloritun) sent people to the community to ring a bell and invite people to come over, in this case, to collect medicines for free. In addition to the Oloritun, other community members mentioned influential individuals like market and religious leader's involvement and the health facilities too.

Religious Leaders were sensitised and went on to sensitise their congregation towards MAM.

The LNTD took advantage of the regular meetings held by all leaders in the district to sensitise them at the gathering. This helped to facilitate the creation of awareness about the program as leaders went back to sensitise their people on the advantages of the program.

Representatives of the Ohori, Fulani and Eegun people are needed because they respect their leaders and they would only listen to them in matters such as MAM. A researcher reflected that the leader of Ohori people who lives in the town said his people have been expecting the medicine because more people have known the value of the medicine.

METHODS OF COMMUNICATION

There are many different methods which can be used for sensitisation and mobilisation; multiple methods is the best way to reach the needs of diverse communities. The following are some examples from implementation of different methods of communication. *For further information please see Learning Pack.*

See also: https://countdown.lstmed.ac.uk/news-events/news/research-to-practice-countdown-findings-lead-to-improved-community-awareness-for

MEDIA (RADIOS AND TV)

- **To pass the message across a wide space that mobilisers may not effectively cover**

Discussants after a radio programme on NTDs in a local radio station

EXAMPLE OUTCOMES:

RURAL: Some community members suggested that announcements on MAM be made prior to distribution so they can avail themselves to increase acceptability. One community member said the reason why he was absent is because he was at his place of work. He added that they have never heard MAM announced via radio or another means but if they have ever heard that medicines will be distributed at the LGA or any place, they would have suspended other activities to wait and take the medicines.

URBAN: A few people who were persistently absent during previous MAM also said there is need to announce the distribution on radio clearly stating what the medicine treats. Once it is announced on the radio everybody can hear about.

JINGLES

To increase awareness about NTDs in the community through airing of jingles

EXAMPLE OUTCOMES:

URBAN: An advocacy visit was carried out to the manager of the State media cooperation and this allowed for radio jingles to be aired in Hausa where the people were educated about the NTD program in the State and anyone who had questions could call in. TV adverts were also placed informing people about the upcoming MAM and why it was necessary to take the medicines.

URBAN: In another LGA, edutainment (Public Address System and Jingles) and sensitisation through local radio were not carried out even though in the plan due to lack of funding. These communication methods may have increased community sensitisation.

HOUSE TO HOUSE

EXAMPLE OUTCOMES:

RURAL: CDDs went house to house to sensitise people. Many community members reported this was done verbally. IEC materials could have been used to increase ways to communicate about MAM.

URBAN: Youth males reported that there was house-to-house sensitisation in the community. The mobilisers were telling people how the medicines were coming from the federal government and are beneficial. This ensured that the message of what was to take place in the community still reached people who could not leave their homes, for reasons such as age, immobility or health conditions. Some also sent messages to the distributors from the mobile fixed posts to take the medicines to them at home.

POSTERS AND HANDBILLS

- **To provide residents with a visual message of MAM to compliment the audio announcements**
- **This is to sensitise different segments of the community**

EXAMPLE OUTCOMES:

Posters were placed at strategic locations in the community, places like the village heads' house, chemist, health facility and entrance of the community. CDDs used IEC materials on awareness and prevention for onchocerciasis to sensitise people house to house. Printed IEC materials were among the items allocated to one urban LGA by the State medical store. These were used for awareness creation in the community.

URBAN: By having young males bring the medicines to the health centres, they were encouraged to take the medicine. Seeing posters that were brought to the communities with pictures of people having poor vision, itchy skin etc. also made them to go for the medicines. Older males too observed that posters were used, especially that it was shown to them when they went to the house of the community leader (the Oloritun) where the poster showed different pictures of the signs and symptoms of the diseases including enlarged scrotum of a person etc. They reported that this was different from 2015 when they did not see any posters. The advantage this method provided was that those without ability to read had the opportunity to see the posters and draw some key messages therein.

TOWN ANNOUNCERS

EXAMPLE OUTCOMES:

RURAL: Before the distribution of the medicine in every house, town announcers communicate that on particular dates, such activities will take place.

URBAN: Female youths observed that town announcers went from street to street announcing the forthcoming MAM. This was later followed by the health workers. This helped spread the message in the community especially among those who did not have the opportunity of seeing the posters or are not literate enough to read written messages. It also served those who do not have radio or could not go to churches/mosques where the message was announced. The town announcer sensitised the community in Hausa and Yoruba languages (which is their local language). He went through important community structures like Junctions, markets, drinking joints, places where women fetch water and braid hair.

MEGAPHONES AND PUBLIC ADDRESS SYSTEMS

EXAMPLE OUTCOMES:

RURAL: Women advised that awareness could be created using the town announcer and churches by making announcements. The use of market campaign was a good strategy because a wider audience will be reached at once, many of which lived in hard to reach areas. The LNTD recommend use of vehicles to move about with the mega phone in subsequent market campaign provision of funds.

URBAN: Younger women in a community were sensitised on the benefits of taking the medicines which includes treatment for itchy body and eyes, stomach aches etc. These messages were passed across before the distribution started and megaphones were used to announce at different times of the day, such as morning, afternoon and evening so that those that missed the previous announcements got the subsequent ones.

EXAMPLE FROM RURAL LGA: ACTIONS FOR ADVOCACY, SENSITISATION, AND MOBILISATION

**Please note that the budget in this example is not a current figure. For further information on costing for activities please see the Costing Toolkit, 2021.*

S/N	Activity	No. of days	Start date	End date	Actions	Person responsible *(insert name and role)*	Resources required / Budget*
1	**Sensitisation to LGA Management**	1	30/07/2018	30/07/2018	LNTD will meet with all Head of local government administration (HOLGA) of all councils in the LGA prior to the meeting to ask for slot to talk to the management about Oncho/LF control programme. Advocacy message will include: • signs and symptoms of the disease using the poster • the medicine available for the control of the diseases • the people eligible and those that are not eligible to take the medicine • how long the medicine needs to be taken to control/eliminate the disease in the LGA • the need for financial support for the programme for those that will distribute the drugs.	Role: LNTD Name: AB	Cost of transportation #10,000 to cover the two LCDA that make up Imeko Afon LGA (For LNTD), #15,000 DSA for SNTD, #7,500 as cost of producing 20 copies of posters and 20 copies of advocacy kits.
2	**Sensitisation to traditional leaders**				• Three months before implementation LNTD will meet with each of the traditional rulers individually to sensitise them and find out about the meeting date for community leaders under them. • Sensitisation will take 20 to 30 minutes at each location. • Advocacy message will include: ✓ A brief information about the disease and its mode of transmission. ✓ The medicine of choice for each disease. ✓ Those that are eligible to take the medicine and those that are not eligible. ✓ The dosage for administration of the medicine. ✓ When the 2018 MAM cycle will take place and the role of the leaders in organising a meeting to select the CDDs. ✓ The need for the community to incentivise their CDD.	Role: LNTD Name: AB	#30,000 for transportation to visit and sensitise all the traditional rulers.
3	**Sensitisation of community leaders**	4	03/08/2018	07/08/2018	• LNTD and FLHF will attend the community leaders meeting to sensitize them about the MAM and discuss their role in the implementation of MAM. They will be requested to hold community meeting with their people and select their CDDs as well as desire how to enumerate the CDDs. • Sensitisation will take 20 to 30 minutes at each location. • Advocacy message will include: ✓ A brief information about the disease and its mode of transmission ✓ The medicine of choice for each disease ✓ Those that are eligible to take the medicine and those that are not eligible ✓ The dosage for administration of the medicine ✓ When the 2018 MAM cycle will take place and the role of the leaders in organising a meeting to select the CDDs.	Role: LNTD and FLHF Name: AB and BC	30,000 naira transportation to the various community leaders meeting.

EXAMPLE FROM RURAL LGA: ACTIONS FOR ADVOCACY, SENSITISATION, AND MOBILISATION

**Please note that the budget in this example is not a current figure. For further information on costing for activities please see the Costing Toolkit, 2021.*

S/N	Activity	No. of days	Start date	End date	Actions	Person responsible *(insert name and role)*	Resources required / Budget*
4	**Sensitisation of Artisans and Okada riders**	1	08/08/2018	08/08/2018	LNTD and FLHF to attend meetings of artisans and Okada riders and sensitise them about the MAM.	Role: LNTD and FLHF Name: AB and BC	30,000 naira transportation to the meeting of Artisans and Okada riders.
5	**Sensitisation of SMCs and associations**	1	12/08/2018	12/08/2018	• LNTD to identify what CDCs, SMOs, groups, institutions, key community members are important in your communities using social mapping tools. • Identify key dates and locations when activities such as market days, sanitation days are taking place. • Conduct sensitisation activities using dates and locations identified in your target communities. • Sensitisation will take 20 to 30 minutes at each location. • Invite Named social mobilisation committees, which include village heads, representative from CAN, representative from the Muslim, the Artisan, chiefs and other association will be invited to attend a meeting. • The people will be sensitised about Onchocerciasis and Lymphatic Filariasis disease, the importance of taking the medicine • The role of each of the members in the upcoming MAM will be discussed, including; sensitisation and mobilisation of their community members, about selection of CDDs provision of incentives, the date for training of CDDs, the duration for the medicine administration for CDDs.	Role: LNTD, to be supported by SNTD Name: AB supported by CD	1,000 for transportation, 500 for feeding for 30 people = 45,000
6	**Sensitisation to religious leaders**	2	14/08/2018	15/08/2018	LNTD and FLHF will meet with all the clergies like pastors, Imam in communities where they provide health services. LNTD/FLHF staff will visit these people one on one to sensitise them at their home or respective offices.	Role: LNTD and FLHF Name: AB and BC	5000 naira for transportation
7	**Sensitisation of Market women and motor park leaders**	1	16/08/2018	16/08/2018	LNTD/FLHF will meet with market women and motor park leaders at their respective offices (market and motor park).	Role: LNTD and FLHF Name: AB and BC	5000 naira for transportation

EXAMPLE FROM URBAN LGA: ACTIONS FOR ADVOCACY, SENSITISATION, AND MOBILISATION

**Please note that the budget in this example is not a current figure. For further information on costing for activities please see the Costing Toolkit, 2021.*

S/N	Activity	No. of days	Start date	End date	Actions	Person responsible *(insert name and role)*	Resources required / Budget*
1	**Provision of sensitisation material and dissemination methods**	5	11/05/2018	15/05/2018	Provide open air vehicles in the market in collaboration with the National Orientation Agency and town announcers over 4 days across the three districts in the LGA.	Sight savers** *(**Example of implementation partner), LNTD*	Transportation #5,000 to cover the three districts that make up Kaduna North LGA (For LNTD), Sightsavers to provide 500 posters each for the diseases. Transportation to the different districts N2,000. Transportation for SNTD & LNTD N2,000.
					Provide sensitisation material using relevant IEC materials which will be disseminated in worship centers, football viewing centers, food joints, bus stops from 12th to 15th July 2018. • LNTD to distribute IEC materials to the CDDs. • Assistant LNTD to assist in distributing IEC materials to other parts of the LGA. • FLHFs to monitor placement of IEC materials CDD. • CDDs to place IEC materials in places identified such as worship centers, provision stores, markets.	LNTD, Assistant, LNTD, FLHFs, CDDs	
					State coordinator to involve the State Technical Advisory Committee to carry out a high-level advocacy to the three districts in Kaduna North which will help advocacy.	State NTD coordinator to plan, invite and facilitate meeting	
2	**Community mobilisation**	4	12/07/2018	15/07/2018	• FLHFs will sensitise community members under their clinics, use of bill boards. A total of 3 bill boards one per district. • FLHF will monitor the placing of IECs and use by CDDs in the different areas. • LNTD team to Collaborate with social mobilisation officer in the LGA to provide a list of all worship centers and worship leaders, viewing centers, and food joints in the LGA. This will make for easy planning for the LNTD team so that they know where to go and who to meet. • LNTD to Conduct sensitisation and provide the IEC materials. • CDDs to paste IECs at strategic areas in the community at all churches, mosques, football viewing centers, schools and markets over 3 days. • Sensitisation will take 4 hours at each district • The mobilisation of community leaders will be carried out by the LNTD and will take place at the district heads' offices in three districts. - The program will take advantage of the regular weekly security meeting in each district. - Sensitisation will take 4 hours at each district.	LNTD, SMO, FLHF & CDD	Transport for 4 officers working in the LGA @ N2,000 as they usually split the LGA among themselves.

EXAMPLE FROM URBAN LGA: ACTIONS FOR ADVOCACY, SENSITISATION, AND MOBILISATION

**Please note that the budget in this example is not a current figure. For further information on costing for activities please see the Costing Toolkit, 2021.*

S/N	Activity	No. of days	Start date	End date	Actions	Person responsible *(insert name and role)*	Resources required / Budget*
3	**Sensitisation of leaders**	4	18/06/2018	29/06/2018	• SNTD will write the letters & LNTD will distribute them to the chairman, councillor on health and head of health in the LGA. • Letters to be sent out to the LGA informing them of the commencement of MAM on 18/06/19. • A week later (25.06.18), SNTD and LNTD to meet the community leaders through all the three districts in the State to arrange for advocacy for the various leaders who will gather at a central place for mobilisation.	SNTD, LNTD	Writing letters, photocopy, printing and transportation to the LGA.
4	**Advocacy visit for community leaders**	1	11/07/2018	11/07/2018	LNTD to pay initial visit to community leaders and plan advocacy visit obtaining convenient date and time for this to happen.	LNTD	Transport for SNTD & LNTD at N5,000 per person. Transport for community leaders at N2,000 per participant.

3.3 HOW TO DEVELOP ACTION PLANS FOR DELIVERY OF MEDICINES TO COMMUNITY MEMBERS

OBJECTIVES OF SECTION:

By the end of this section you will gain an understanding of key considerations for action planning to deliver medications to the community.

- **Consider appropriate timing of distribution to the community.**
- **Who should be considered for the distribution teams.**
- **In line with your local context, what methods you will use to deliver medicines to the community.**
- **What resources you will need to provide.**

Examples of actions will be demonstrated which have an effect on acceptability, accessibility and availability of MAM.

The example actions in each table are not all relevant for all contexts and LGAs, you, as implementers should consider each action alongside your given context, budget restrictions and human resource management structures and only choose actions which will best respond to your LGA needs. Some actions work better in urban areas and others in rural and so you should consider the feasibility of using that action within your area and not choose all.

Where you see [X] this indicates that you should insert a number or choice that suits your population.

PURPOSE OF ACTION:

Decide when to distribute. For many community members, especially farming communities in rural areas, the time/season of medicine distribution is a factor that influences accessibility. Many community members who missed MAM reported that they either did not hear about MAM happening or were away at work during distribution. Since MAM is a seasonal activity, the availability of people and the method of distribution needs to be carefully considered.

EXAMPLE ACTIONS ARE OPTIONS, PLEASE CONSIDER WHICH ARE RELEVANT FOR YOUR CONTEXT:

- Distribution will take place between (insert dates). Peak farming season or religious fasting times should be avoided where possible.
- Medicines will be distributed in the morning before communities go to work and after communities return home in the evening.
- Children who are away for school will be accessed during (insert dates) period when they are back from school.

EXAMPLE OUTCOMES FROM EVIDENCE:

Many men who were either absent during MAM 2018 (or previous rounds), reported that if they were aware of the importance of the medication and when it will be provided they would organise their time to meet distributors. This again highlights the importance of adequate sensitisation and mobilisation.

There are recognised benefits of delivery medicines both in the dry season and in the wet season, however some community members in both urban and rural LGAs, felt that more people would be at home during the dry season as they would not be away from their homes for long periods of time. In wet season it is more difficult for CDDs to travel and you should consider supplies needed to support this like rain boots and a coat.

Continued on next page

Seasonal Calendars could be used in the planning process of MAM, to elicit the most appropriate timing for distribution to maximise coverage. See Module 2A for further guidance on this.

In urban and rural areas, young people who are away for school were reportedly missed.

In urban areas, people felt that MAM should not fall during Islamic or Christian festivals.

In both rural and urban areas, it was suggested that mornings and evenings were the best time to deliver medications as more people would be at home.

Many suggested that there should be two distributions each day, as some would prefer medications in the morning before leaving for work or school, and others in the evening, when they have returned. Many community members also suggested that weekends would be appropriate times to distribute medications.

PURPOSE OF ACTION:

Decide how long distribution will be to maximise availability of medicines to all community members.

EXAMPLE ACTIONS ARE OPTIONS, PLEASE CONSIDER WHICH ARE RELEVANT FOR YOUR CONTEXT:

- Distribution will take place over [X] number of days.

EXAMPLE OUTCOMES FROM EVIDENCE:

Most MAM distributions are usually scheduled for 7 days. Some community members suggested that MAM period should be as long as 2 weeks to 2 months, which would include a period where CDDs re-visited locations to ensure that no one is left behind.

PURPOSE OF ACTION:

Decide how many distributors will be required. Ensure CDD teams are enough in number and have an adequate balance of gender and experience.

EXAMPLE ACTIONS ARE OPTIONS, PLEASE CONSIDER WHICH ARE RELEVANT FOR YOUR CONTEXT:

- [X] CDDs will be used to distribute medicines.
- If CDDs are insufficient the alternative plan of (insert plan) will be used to increase distribution.
- CDDs will work in pairs to distribute.
- Ensure CDD teams have a balance of men and women.
- Each team will consist of [X] number of CDDs.
- CDDs will be provided with (insert amount) for travel costs.
- CDDs will have access to a motorbike for distribution, this will be provided by (insert name).

EXAMPLE OUTCOMES FROM EVIDENCE:

To maximise coverage adequate numbers of CDDs need to be utilised as evidence suggests insufficient planning and funding of this has led to community members who wanted to access medications being unable to. For some communities and households, community members advised that the CDD teams should be made up of both male and female distributors. This is because in some households, especially where women are in Purdah, only female CDDs would be allowed to enter. For others, community members preferred female and male CDDs present as they perceived either work-ethic or characteristics to be more amenable to their preference, which would have an impact on the trust community members have with CDDs.

In some LGAs, three people made up distribution teams. Each person within this team was allocated a role such as mobilising families, measuring height, recording details and administering medicine.

URBAN: Medicines were distributed by Health Extension Workers and supported by CDDs who mobilised communities to fixed points chosen by the community. This was well accepted by the community and increased coverage and acceptability of medicines.

RURAL: In some rural areas, community members would only receive medications from health workers, and preferred distribution teams to be made up of health workers as well as CDDs known by the community.

PURPOSE OF ACTION:

Ensure there are enough medicines for the community and decide on a back-up plan if medicines run short.

EXAMPLE ACTIONS ARE OPTIONS, PLEASE CONSIDER WHICH ARE RELEVANT FOR YOUR CONTEXT:

- If medicines are not enough (named person) will be approached for additional supplies.

EXAMPLE OUTCOMES FROM EVIDENCE:

To maximise coverage sufficient supplies of medications, need to be available as evidence suggests insufficient planning and funding of this has led to community members who wanted to access medications but were unable.

PURPOSE OF ACTION:

Ensure all CDDs understand how to determine dosage and the inclusion and exclusion criteria so that there is consistency amongst distribution teams.

EXAMPLE ACTIONS ARE OPTIONS, PLEASE CONSIDER WHICH ARE RELEVANT FOR YOUR CONTEXT:

- Before medications are given, height is measured and age is checked.
- Identify clear exclusion criteria and ensure that CDDs are fully aware.
- Community members who have received medicines will be marked with (insert method).
- Mop-up will take place between (insert dates).

EXAMPLE OUTCOMES FROM EVIDENCE:

Many community members felt reassured that the actions above were taken and saw it as indicative that the CDDs were knowledgeable in what they are doing. This is likely to increase acceptance of medicines from CDDs and free up health extension workers.

Height, age and name were recorded by the medicine distributors and in one LGA, a marking was administered to the recipients' thumb to indicate that they had taken the medication.

MAM is usually observed 'on the spot'. This ensures that the correct dose of medications are swallowed and not wasted. It also ensures that there are accurate records of people who have taken the medication. This is Directly Observed Therapy (DOT).

However, arguments are given by some community members both for and against this, with some advocating that medicines could be left with Health Facilities or family members, for those who are away during distribution. The safety rational for directly observed treatment should be adequately explained to community members.

Please see 'Mop-up' for an alternative to leaving medicines for people who are absent.

PURPOSE OF ACTION:

Identify in the action plan who will be contacted in the event of side effects, this should be communicated to CDDs so they feel reassured that a process is in place that can be communicated to community members.

EXAMPLE ACTIONS ARE OPTIONS, PLEASE CONSIDER WHICH ARE RELEVANT FOR YOUR CONTEXT:

- In the event of side effects (named FLHF) will be contacted on this number.
- Side effects communicated to CDDs will be recorded in the reporting forms

EXAMPLE OUTCOMES FROM EVIDENCE:

URBAN: Use of pharmacovigilance guidelines supported FLHFs to manage side effects.

METHODS OF DISTRIBUTION OF MAM

There are different ways to distribute medications within the communities. Some methods are more appropriate in rural or urban settings and therefore careful consideration of the method of distribution should be considered in the planning stage. See Module 2 for ways to engage the community and stakeholders in understanding which methods are most appropriate for your communities. Multiple methods should be utilised to maximise coverage, these can include the following:

HOUSE TO HOUSE

DESCRIPTION:

- CDDs go from one house to another to administer medicine to people in the community.
- The number of persons in a household determines the length of time the CDD will spend in a particular house.

House to house medicine distribution

BENEFITS:

- House to house distribution is highly appreciated by many in the community, it helps increase accessibility for people with disabilities or other health conditions who are immobile and would not be able to travel outside of their homes.
- House to house method also enables people to access the medicine at no cost as they do not have to spend money or time on travelling to locations such as fixed points.
- Many community members appreciated that MAM cost them nothing and were often willing to give small donations to CDDs to enable them to continue with house to house distribution.

House to house medicine distribution

CHALLENGES:

House to house method is time consuming hence energy demanding and there were reports that houses in remote locations may not be visited. Be aware of this and identify alternative ways to reach these houses.

It requires transportation cost to reach some remote communities. Recommendations were made by community members that CDDs should be provided with or have temporary access to motorbikes to enable them to access these communities, and that numbers of CDDs should be increased.

Only people who are at home at the time of distribution will be available to collect MAM. In some households, family dynamics and cultures may mean that the head of household should be present to allow other members of the household to take MAM. Consider this when making house to house plans, gender balance may be needed here.

In considering distribution method, autonomy of decision making for individuals within your communities need to be considered. *(See case study on page 58).*

Strategies also need to be considered of how people who are not at home will be able to access medications, particularly those that are away for work.

Appropriate timing of house to house visits also needs to be planned. Clear communication to the community of when people can expect house visits is important and may mean people will change plans to be at home during that time. *(See case study on page 58).*

Costs to CDDs also need to be considered here.

Please consider in your budget transport costs for CDDs to reach geographically hard-to reach communities, as well renumeration for the impact on the CDD's usual economic activities.

Faces have been blurred in photographs to protect confidentiality.

At the health facility (Fixed post)

Remember structures and spaces can be identified through community engagement methods. Please refer back to Module 2 for further guidance.

DESCRIPTION:

- Fixed post is the use of a health facility or another known structure as distribution points.
- Temporary distribution post is using a well-known area/structure in the community selected as temporary distribution points e.g. house of community leader.
- Community structures and spaces should be identified to allow community members to access medications.

BENEFITS:

- The use of a health fixed point or a well-known area/structure for medicine distribution provides opportunity for many community members who may not be at home during house to house distribution to be able to access the medicine. An example would be the use of the LGA secretariat, home of the community leader or health facility as a fixed post.
- Members recommended that community leaders' houses should be used to distribute medications. It allows the community to access the medicine at any time of the day during the distribution period. It has been suggested that this will increase acceptability and accessibility as leaders are trusted within their community, locations are familiar and community leaders will ensure many people are aware that distribution is taking place. Early involvement in the planning stages of MAM is critical if leaders are to be utilised.

At a religious place - Church (Temporary mobile post)

FIXED POINT AND TEMPORARY DISTRIBUTION POINTS

- **URBAN:** Teams of four administered the medicines from temporary mobile fixed posts while the ward focal persons remained at the fixed posts i.e. the health facilities to administer went around the communities to supervise the teams. Abattoir, motor garage, markets, churches and mosques were some of the spots used as fixed mobile posts to administer the medicines.
- This method ensured that people in the community did not spend in terms of money and time to be treated as those locations were selected within the communities. In an urban LGA people also went to health centres and were treated. In one community health centre, the pharmacist and the ward focal person attended to those that visited the centre for NTD medicines. The pharmacist took measurements and made entries in the register while the WFC administered the medicines. This process was speedy as they returned to attend to other issues while waiting for the next person to walk in with the request.
- Other recommendations from LGAs include: Health centres, faith centres, market places, schools, and community halls.
- Many people across the LGAs liked a combination of house to house distribution and fixed-point collection, this was to make sure the medication was available to all within the community.

At the abattoir (Temporary mobile post)

At the health facility (Fixed post)

At a religious place - Mosque (Temporary mobile post)

At the health facility (Fixed post)

CHALLENGES:

Accessibility of locations need to be assessed. Techniques in Module 2 can help with this.

Distribution points should be local to community members, so people do not have to pay for unreasonable transport costs to reach the venue.

URBAN: Microplanning for action plans were made to reach PWD. During MAM, the LGA team went to the spots in the LGA where people with disability mostly sit to beg for alms to refer them to the health facilities closest to them, especially those on wheel chairs and those with mobility challenges. However, preference was made to be treated 'on the spot'.

For fixed point distribution there needs to be adequate sensitisation and mobilisation to alert people where and when they can collect medications. Consideration of people who may not be able to attend venues such as people living in remote locations, those with mobility issues, those who cannot afford to travel outside of home etc. need to be planned for and additional strategies implemented.

Faces have been blurred in photographs to protect confidentiality.

SWEEP METHOD

DESCRIPTION:

This involves medicine distribution to people wherever you meet them. These include shops, hair dressing saloons at major junction as the CDDs went along for house to house distribution. This is to ensure that no one is missed.

BENEFITS:

URBAN: There was a good increase in treatment coverage using this technique.

CHALLENGES:

- There needs to be accurate record keeping and training on the dangers of double treating. Marking individuals may be key here.
- CDDs must ensure that people they treat, have not taken MAM via a different method during that cycle of MAM.

Sweep method

MOP UP

DESCRIPTION:

- This is the process of re-visiting the houses or an area in order to treat people that were initially absent during the first visit.
- The aim is to ensure that no one is left behind

RURAL: During the distribution of medicines, there were people who were absent; the majority of people absent were older men, younger men and women who were engaged in farm work, and some students in higher institutions. The CDDs mentioned that they would go back for a mop up after visiting their houses for the first time and found them absent.

URBAN: The treatment data of communities treated for 2018 MAM was compared with that of 2017 to check the coverage. The communities with low coverage were identified from the treatment data. Communities that have low treatment coverage will be selected for mop up. A plan was then made to follow up in communities with low treatment coverage for mop up.

BENEFITS:

- Community members suggested re-visiting communities three weeks after initial MAM would ensure that those that were absent can collect MAM.

CHALLENGES:

- Mop up is only possible when there is enough time for distribution and the medicine are available.
- Some members of the community are keen to accept medications for other family members, however there are many challenges associated with this including (but not limited to): medication given inappropriately to those who should not take it, being given incorrect doses, people misplacing medications and inaccurate records. Mop up allows those that have not been able to take initially to do so and planning for mop up, means that CDDs can explain this to households, allowing them time for absent members of the household to be mobilised.

KEY LEARNINGS

ACCEPTANCE: Adequate and appropriate sensitisation of the purpose of medication, relationship and trust in the CDDs, and involvement of community leaders were the most important factors which contributed to accepting MAM.

AWARENESS: Community members will be more likely to be able to access MAM if they are informed in reasonable time before distribution of the time and location of MAM. They report community leader's involvement in this will ensure that the message is spread in good time.

ACCESSIBILITY: A variety of distribution methods should be utilised to reach everyone in the community, including the children, young adults, elders, men and women of different religions, PWD, people living in remote locations and migrant populations. Effective planning of the timing of MAM will ensure wider coverage.

AVAILABILITY: Adequate provision of medication, resources, CDDs and enablers such as transport facilitates for CDDs and water for community members will ensure that availability is optimised.

RELATIONSHIP OF CDD WITH COMMUNITY AND FAMILY DYNAMICS

This is an abstract from an ethnographic observation. Please read to identify key learnings. What are the factors which may enable increased acceptance, access and availability?

The CDD wore a red T-shirt and a blue pair of jean trousers to enable for easy distribution of medicines. The village head accompanied him. The village head wore his native attire. The distribution started in the afternoon, at around 12:35p.m. The CDD decided to start the distribution around the lesser populated community. He and the village head mounted the same motorbike to the community. The route to the community was very narrow and bushy. On getting to the first household in the community, the CDD asked for the household head, he introduced the programme to him, he told them he has brought medicine to them for their use. He also showed the posters showing the pictures of the medicines, effect of the medicines and disease the medicine prevents. He further requested for the ***presence of every member of the household.***

This should be checked against the register.

In this example the head of house hold was male, but this may change depending on context.

During the distribution of medicines, the CDD always insisted to meet the oldest in the household first. They tried to administer the medications based on the set instructions. He also brought out the community register where he fills the details of every recipient of the medicines. Whenever he was to distribute medications for a particular ***household,*** *he asked for the head of the household. He then* ***writes the detail*** *of the man, followed by the oldest wife, followed by the children of the oldest wife, followed by the details of the second wife and her children, arranged by their age if such man has more than one wife.*

Document and record: See section 3.4

Local knowledge and understanding of different cultures may help increase acceptability of MAM.

In administering the medicines, for him to decide the number of medicines a recipient receives, the CDD measured the height of the recipient with the measuring pole. The ***measuring pole*** *has been calibrated, it has been marked at different points to indicate the height limit for whom to take one dose, two doses, three doses and four doses of Mectizan. Irrespective of the number of Mectizan received, he gives out only one tablet of albendazole for everyone.*

Posters and a discussion about how the CDD will support any side effects is important, the CDD should show the recipient that he has a number for the health facility who can help with side effects immediately and explain how the medicines work and the benefits they will have for the whole family.

It may be necessary to recruit CDDs that are from the tribe to increase acceptability.

The CDD claimed he went back to those households who missed the medicine and those who required the permission of their husbands. On the following morning, the CDD had gone to revisit the households that were missed and to those houses whose husbands were not around the previous day. He continues his distribution at the main area where the majority of the villagers live. He distributed the medications to them. The CDD was welcomed, he is very ***familiar among his people,*** *some did not even ask him what the medicine was meant for before they collected it from him. They were all shouting his name in acceptance of the medicine. Although, some people rejected the medications they claimed they won't be able to bear the discomfort of the* ***side effect.***

The CDD went to the next ***Fulani community;*** *he met the men saying their afternoon prayer around 2pm. He waited for them until they finished their prayers. He gave everyone the medicine except few who declined. When the CDD asked why they refused to take the medicine, one of them just kept mute while the other gently walked away. The CDD packed his load and decided to leave the community back to his house.*

Timing of MAM is key to uptake.

At this point, the CDD was tired.

The workload of CDDs is important to consider to ensure they do not become exhausted.

ALTERNATIVE DISTRIBUTION STRATEGY FOR AN URBAN LGA

THIS PROCESS TAKES PLACE OVER 6 DAYS

EXAMPLE FROM RURAL LGA: ACTIONS FOR MEDICINE DELIVERY TO COMMUNITIES

**Please note that the budget in this example is not a current figure. For further information on costing for activities please see the Costing Toolkit, 2021.*

S/N	Activity	No. of days	Start date	End date	Actions	Person responsible *(insert name and role)*	Resources required / Budget*
1	**House to House distribution**	7	07/09/2018	13/09/2018	• Distribution to take place for 7 days which should avoid during peak farming season or religious fasting times, and is preferable for the LGA. • Medicines will be distributed in the morning before communities go to work and after communities return home in the evening. • Children who are away for school will be accessed during evening period when they are back from school. • 650 CDDs will be used to distribute medicines for population of 650,000. • If CDDs are insufficient the alternative plan temporary distribution post (e.g. village head's house) will be used to increase distribution. • Ensure CDD teams have a balance of men and women. • CDDs will work in pairs to distribute or a group of three. • Payment should be made within 5 days after MAM has been completed.	Role: CDDs Supervised by: FLHF	N130,000 for dose poles N91,000 community register apron.
2	**Alternative Mechanism of medicines administration (Churches)**	1	14/09/2018	14/09/2018	• CDDs will discuss with pastors of churches within their community 3 or 4 days before the church service day and organise for the CDDs to come to administer the medicine at the church on Sundays during the distribution period. • Pastors will inform CDD the time to come and distribute medicine at the church and announce to their congregation when the CDD will be around at an agreed time to administer medicine to only those who has not received the medicine. • CDDs will arrange that Pastors will arrange water for the congregation who will take the medicine at church.	Roles: LNTD, FLHF, CDDs and clergies at the church	Enough medicines, data tools, dose poles apron for CDDs will be provided by Saturday before Sunday service.
3	**Alternative Mechanism of drug administration (Mosque)**	1	11/09/2018	11/09/2018	• CDDs will discuss with Imams of mosques within their community 3 or 4 days before the Jumaat service on Friday for the CDDs to come to administer the medicine at the mosque on Friday during distribution period. • Imams will inform CDD the time to come and distribute the medicine and will also announce to their congregation that CDDs will be around at the time he has asked the CDD to come to administer medicine to only those who has not received the medicine. • CDDs will arrange that Imam will arrange water for the people that will take the medicine at mosque service on Fridays.	LNTD, FLHF, CDDs	Enough medicines, data tools, dose poles apron for CDDs will be provided by Friday during Jumat service.

EXAMPLE FROM URBAN LGA: ACTIONS FOR MEDICINE DELIVERY TO COMMUNITIES

**Please note that the budget in this example is not a current figure. For further information on costing for activities please see the Costing Toolkit, 2021.*

S/N	Activity	No. of days	Start date	End date	Actions	Person responsible *(insert name and role)*	Resources required / Budget*
1	**House to House distribution**	7	07/09/2018	13/09/2018	• Distribution will take place for 7 days. • Medicines will be distributed in the morning before communities go to work and after communities return home in the evening. • 650 CDDs will be used to distribute medicines for population of 650, 000. • Ensure CDD teams have a balance of men and women. • CDDs will work in pairs to distribute or a group of three. • Payment should be made within 5 days after MAM has been completed.	Role: CDDs Supervised by: FLHF	130,000 for dose poles 91,000 community register apron
2	**Alternative Mechanism of medicines administration (fixed point health facilities)**	7	07/09/2018	13/09/2018	• x Distribution will take place for 7 days. • A total of 53 teams comprising 1 health worker, one recorder and one mobiliser each will distribute medicines in the LGA. At least one health team per ward and where the ward is large, more teams to be allocated. • Daily work plan to be submitted by each team to their Ward Focal Persons or FLHFs. • Mobilisers will be persons who have worked as CDDs in time past, the mobilisers to be youths on the current government youth empowerment programme N-Power and health workers to be deployed from the various health facilities in the LGAs. The health workers to move along with other members of the team in their uniforms. • Use popular spots such as major junctions, public spaces like community schools, houses of prominent personalities in the community, community hall etc. as mobile fixed posts. • Mobilisers to go from house-to-house mobilising persons to go to the nearest mobile fixed post to be treated, recorders to take measurement of eligible persons for treatment and fill the data tools, then the health worker to administer the medicine. • Persons who have been administered the medicines to have their left thumb marked to indicated they have been treated. • Health facilities to serve as fixed posts for persons to receive medicines. • Health team to move round with improvised banners to be hung at every spot to indicate they are using those spots as mobile fixed posts. • Improvised banners to be written in local languages such as Yoruba. It could read "*Aje sara agbalagba*" meaning immunisation for adults. • Persons to be treated in shops, motor parks, mosques, churches, and along the way from one mobile fixed post to another. • Creation of a WhatsApp group for all the teams. • Conveyance of daily review meeting at the end of the day; to be chaired by the MOH and be attended by the FLHFs and Ward Focal Persons. • All team members to have an identity number with the phone number of the MOH written on it for confirmation.	Role: Health teams Supervised by: The LGA team headed by the MOH	53 dose poles 53 community registers 53 markers 53 improvised banners 53 containers of ivermectin and 53 containers of albendazole 53 spoons for counting of medicines 53 megaphones to be used by the mobilisers

EXAMPLE FROM URBAN LGA: ACTIONS FOR MEDICINE DELIVERY TO COMMUNITIES

**Please note that the budget in this example is not a current figure. For further information on costing for activities please see the Costing Toolkit, 2021.*

S/N	Activity	No. of days	Start date	End date	Actions	Person responsible *(insert name and role)*	Resources required / Budget*
3	**Alternative mechanism of sweep method**	7	07/09/2018	13/09/2018	• CDDs to treat community members at their shops or places of work. • Ensure that these people have not been treated at home. • Capture each person's detail in the treatment register.	CDDS supervised by FLHF	Dose poles for CDDs. Medicines and community registers.
4	**Mop up (if required)**	5	14/09/2018	18/08/2018	• LNTD to select communities that have low treatment coverage to be selected for mop up. • The communities with low coverage will be identified from the treatment data by LNTD & SNTD. • The treatment data of communities treated for 2018 MAM will be compared with that of 2017 to check the coverage and if there is treatment shortage in the communities, they will be selected for mop up. • The mop up will be carried out by the CDDs. • Store keeper to issue extra medicines where there is need. • Disease control officer to help with the planning of mop up.	CDDs, FLHFs, LNTD, SNTD, Disease control officer, store keeper	Dose poles and medicines. Community registers.

3.4 HOW TO DEVELOP AN ACTION PLAN FOR REPORTING

OBJECTIVES OF SECTION:

Official data tools should be used to capture the reporting and monitoring of MAM. Reporting is a crucial process of the NTD programme because it is only through reports that the programme can keep track and identify areas of strength and weakness and make efforts to improve delivery.

Reporting should be specific, verifiable, and through the use of purposely designed data collection tools. It should be systematic and without methodical error in order not to mislead. People who engage in reporting need to have practical, effective training on how to use data forms. The reporting forms are referred to as 'Integrated forms' and are the main forms that are used for all PC-NTD programmes. They are the priority forms to be used for all the diseases. Any other form may just be an addition.

By the end of this section you will gain an understanding of key considerations for reporting, which includes:

- **Understanding the reporting structures for MAM.**
- **Be able to develop actions for reporting throughout the MAM process at each level:**

State

LGA

FLHFs

CDDs

The example actions in each table are not all relevant for all contexts and LGAs, you, as implementers should consider each action alongside your given context, budget restrictions and human resource management structures and only choose actions which will best respond to your LGA needs. Some actions work better in urban areas and others in rural and so you should consider the feasibility of using that action within your area and not choose all.

Where you see [X] this indicates that you should insert a number or choice that suits your population.

PURPOSE OF ACTION	EXAMPLE ACTIONS ARE OPTIONS, PLEASE CONSIDER WHICH ARE RELEVANT FOR YOUR CONTEXT	EXAMPLE OUTCOMES FROM EVIDENCE
To report on the training cascade that takes place before MAM.	• Take an attendance record at all training levels. • Report these to key stakeholders at the LGA and State level and to partners within a brief report.	**RURAL:** 40 health facility in-charges were all trained together at the PHC department hall in the LGA secretariat. The training was for 1 day. The LNTD and his assistant conducted the training and were supervised by the State NTD staff. **URBAN:** The training was carried out by people who understood the language, and this facilitated a lot of interaction.

PURPOSE OF ACTION	EXAMPLE ACTIONS ARE OPTIONS, PLEASE CONSIDER WHICH ARE RELEVANT FOR YOUR CONTEXT	EXAMPLE OUTCOMES FROM EVIDENCE
To document the distribution method employed in each LGA which is likely to vary as this guide allows for variability across contexts. This will serve as reference point and provide basis for assessment of how the distribution was carried out.	• Document in the notes section of the action plan a detailed description of whatever distribution method was employed to get the medicines across to the people.	 **URBAN:** The supervisor stated that *"CDDs went from house to house for the distribution. In the previous year, there had been a challenge with distribution as eligible people were not around during distribution. This year however, it was agreed during the CDD training that after the house to house distribution there was also going to be fixed point distribution. New settlements were also captured this year as a result of better census update which meant there were more first time settlements to treat. There was however a challenge with the recording of medicines administered by CDDs in the treatment registers."*
Treatment register - The first source of NTD data is the Community based treatment register. It is very critical and should be taken seriously. Everything depends on this form. It is printed in a booklet form with triplicate copies.	• CDD to fill in the treatment-based booklet with triplicate copies. • One copy to be given to the FLHF. • One copy to the LNTD. • One copy to be kept by the CDD who may choose to keep it safe at the community leaders house.	See Nigeria MAM documentation.
Community summary form - The next form summarises all community data from the CDDs into the community summary form - Level 1. It is printed in a booklet form with quadruple copies. This form is not to be skipped. It must be completed. It will be first form that will be checked during external supervision.	• Summary form - Level 1 to be completed by the CDD in communities (assisted by the FLHF) with quadruple copies. • One copy to be sent to FLHF. • One copy to the LGA. • One copy must reach the State level for electronic data entry. • One copy to be kept by the CDD who may choose to keep it safe at the community leader's house.	See Nigeria MAM documentation.
FLHF Summary form - Level 2 is printed in booklets and in triplicates. It has all information on all communities in the catchment area and must be included in this form whether treatment was carried out or not.	• FLHF Summary form - Level 2 to be completed by a designated FLHF and kept at the health centre. • Mark all urban communities with an asterisk (*). • One copy of the completed form is to be sent to the LGA level. • One copy must reach the State level for electronic data entry.	See Nigeria MAM documentation.

PURPOSE OF ACTION	EXAMPLE ACTIONS ARE OPTIONS, PLEASE CONSIDER WHICH ARE RELEVANT FOR YOUR CONTEXT	EXAMPLE OUTCOMES FROM EVIDENCE
LGA Summary form - Level 3 is in duplicate copies in a booklet form.	• LGA Summary form - Level 3 to be completed by LGA coordinators using submissions from health facilities as above. • Reporting will be done by medicine combinations. • One copy to be submitted to the State. • One copy to be kept at the LGA.	See Nigeria MAM documentation.
State Summary form - Level 4 is to be completed by the State data manager. Data quality assessors will pick one community data from this form and verify the information by going down to that community.	• State Summary form - Level 4 to be completed by the State data manager. • A copy will be submitted to the national office along with electronic version of community and summarised NTD data on [X] date. • All the data from the previous level must aggregate on this form.	See Nigeria MAM documentation.
The register, village and FLHF summary forms require good training sessions especially at the community and FLHF levels and should not be rushed.	• A practical training session will be delivered on [X] date to all levels using the training manual for Onchocerciasis and LF. • Allocate adequate time for better training delivery. • Supportive supervision to ensure that all forms are correctly completed with minor errors corrected will be provided by one or more of the following methods: - Face to face - Telephone - WhatsApp - Email	See training section 3.1 (pages 10-25).

PURPOSE OF ACTION	EXAMPLE ACTIONS ARE OPTIONS, PLEASE CONSIDER WHICH ARE RELEVANT FOR YOUR CONTEXT	EXAMPLE OUTCOMES FROM EVIDENCE
Each level within the MAM process, including FLHF, LNTD and State needs to produce a brief report on activities that happened during MAM as a verification process alongside reporting forms.	• A brief report of MAM activities to be cascaded up the system will be produced on [X] date.	In both States MAM review meetings were held involving all the LNTDs, representatives of the SNTD in each of the LGAs that supervised the process in those LGAs, and the COUNTDOWN researchers who worked in those LGAs i.e. the controlled and the intervention LGAs. Therapeutic and geographic coverages were all reported for each LGA with details on the quantity of medicines allocated, the quantity distributed, challenges encountered etc. These details were taken note of and are built into plans for next year. In one State, the director of public health admitted that the review meeting will: (i) Serve as a feedback mechanism and an avenue for the appraisal of implementers in their roles during the concluded 2018 MAM in the State. (ii) Keep implementers abreast with what we are expected to do during subsequent implementation; in case they have forgotten.

EXAMPLE FROM RURAL/URBAN LGA: ACTIONS FOR REPORTING

**Please note that the budget in this example is not a current figure. For further information on costing for activities please see the Costing Toolkit, 2021.*

S/N	Activity	No. of days	Start date	End date	Actions	Person responsible *(insert name and role)*	Resources required / Budget*
2	**Summary form 1**	2	24/09/2018	25/09/2018	• Data collection will be for two days at the health facility. • Data to be transferred from level zero i.e. community register to summary form 1 by CDD and the FLHF. • Data to be compared to see number of persons treated against number of medicines used or/and returned.	FLHF Staff, CDDs	Community registers, Summary form 1, biros, tables.
1	**Summary form 2**		26/09/2018	27/09/2018	• FLHF to update the health facility level form by transferring details from summary form 1 from each community into one form. • Each form sheet to contain entries from six communities.	FLHF Staff, LNTD	Summary form 1 and 2, table, biros.
2	**Summary form 3**	2	01/10/2018	02/10/2018	• LNTDs to fill and complete LGA summary forms using data from level 2 summary form from all FLHFs. • A duplicate copy will be sent to the State and also kept at the LGA.	FLHFs, LNTDs and assistants	Summary form 2 and 3, table, biros.
3	**Summary form 4**	2	03/10/2018	04/10/2018	• SNTD will compile all summaries from the LGAs into level 4 summary form. • LNTDs and SNTDs will sit with each FLHF to cross check the treatment data and ensure the data tallies with the quantity of medicine received. They will also check the accuracy of therapeutic and geographical coverage.	SNTD, State data officer and LNTDs	Summary form 3 and 4, table, biros
1	**Community treatment registers**	2	20/09/ 2018	21/09/2018	• Data collection will be for two days at the health facility. • FLHF will sit with each CDD to ensure that the treatment summary forms are filled with no errors and ensure the data tallies with the quantity of medicine received.	FLHF Staff, CDDs	Community treatment registers, Balance of medicines, biros, tables.

3.5 HOW TO DEVELOP ACTION PLANS FOR SUPERVISION

OBJECTIVES OF SECTION:

This is commonly described as the act of overseeing a person or activity to ensure that everything is done correctly, safely, etc. It entails sharing, showing and giving support to help another person make progress and feel comfortable in their work.

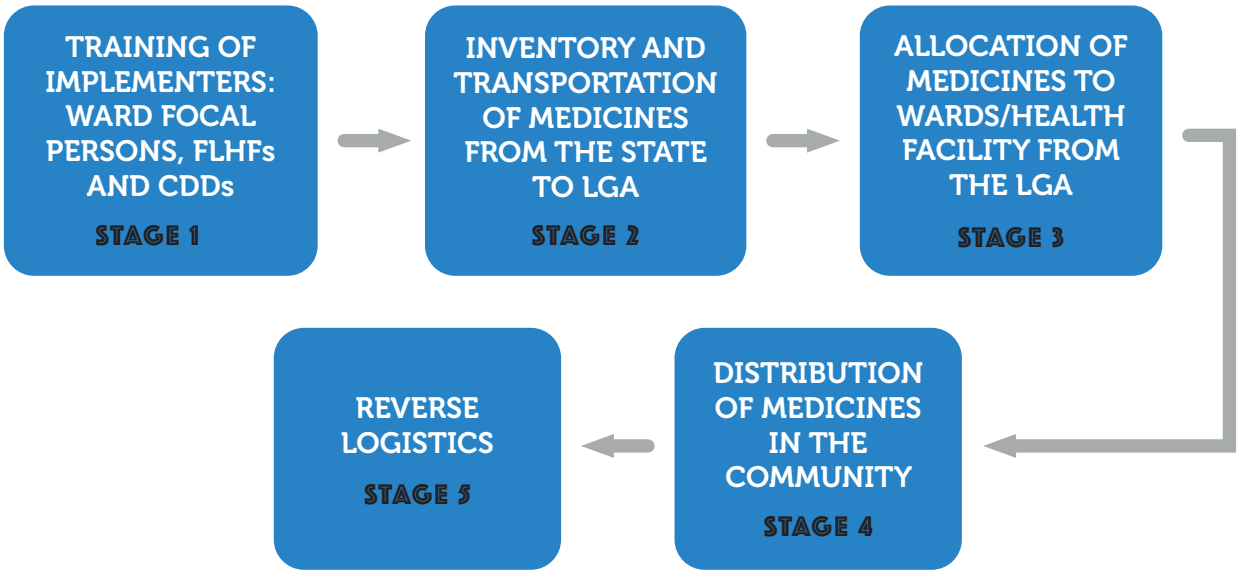
In NTD programme as well as in some other instances, the word supervision is used interchangeably with monitoring and sometimes, they are used jointly i.e. **monitoring and supervision**. Supervision is an important aspect of MAM implementation to ensure that implementers feel appropriately guided, supported and improved in their performance.

By the end of this section you should:

- **Understand why and when supervision is important throughout the MAM process.**
- **Identify what activities will need to be supervised.**
- **Identify what strategies will be used to supervise each activity.**
- **Gain an understanding of tool which can be used to support supervision.**

Official supervision checklists are provided in the Nigeria MAM documentation booklet at the different levels of the health system including: the community, the health facility, the LGA and the State. Supervision should be provided in relation to: reporting or record keeping; training; supply chain and medicine distribution; and surveillance. Checklists state the minimum requirement for the activity being supervised. The essence of supervision is for quality assurance through problem solving; mentorship, logistical support, motivation and ultimately monitoring of progress of the activity towards the target outcome.

ACTIVITIES TO SUPERVISE



As a result of the fact that the State training is conducted by the national representatives, no supervision is necessary at that point.

PURPOSE OF ACTION/ACTIVITY:

Key points during MAM when supervision should take place agreed.

EXAMPLE ACTIONS:

- Supervision to commence one week prior to training activities and continue until the end of MAM.

EVIDENCE:

URBAN: Supervision commenced immediately after CDD training. This ensured that important preparatory activity like census update was carried out and data tools were properly filled during the mass administration of medicines. Supervision also provided an opportunity for challenges to be identified while the programme was ongoing, and the identified challenges were corrected immediately.

Where the supervision team were unable to physically carry out supervision, they did so through other means such as phone calls and WhatsApp.

PURPOSE OF ACTION/ACTIVITY:

Supervision of training activities along the training cascade including: FMOH/State team to LGA team; LGA team to Facility; Facility to CDDs. *(See training section 3.1)*

EXAMPLE ACTIONS:

- Agree who will supervise each level of the training cascade. (e.g. SNTD to supervise LNTD training; LNTD to supervise FLHF).
- Supervisors to familiarise themselves with national guidelines and action plan activities linked to how training should be conducted.
- Review training activities to ensure that all that is needed to conduct a successful training are available/ provided. See box one for suggested things to look out for when observing training activities.
- Supervisors to refer to items in the supervision checklist to ensure key activities are monitored.
- Interact with one or two participants to ascertain they understood what they were taught.
- Give practical example of a scenario the trainees will encounter on the field and ask them how they will handle the situation.
- Do not condemn or interrupt the trainer openly when he makes a mistake/error as this can affect their morale/confidence rather point out the error privately and allow the person to correct it by him/her self or make it like an addition to what has been said.

EVIDENCE:

RURAL: There was supervision during CDD training. SNTD and Local Government team went to different FLHFs to supervise the training which were taking place simultaneously across the various FLHFs. The Medical Officer of Health (MOH) for the LGA and Health Educator (HE) were also part of the supervision team. This made trainers to sit up and manage time allocated for the activity.

During the trainings, checklist of materials were filled and at the end, reports were written by all those who supervised the trainings and filed them with the State NTD programme office.

PURPOSE OF ACTION/ACTIVITY:

Supervision of medicine transportation to ensure medicines are delivered to the LGA from the State on time. *(See related activities in section 3.6)*

EXAMPLE ACTIONS:

- Agree who will form the supervisory team for this activity.
- Supervisors to follow checklists for transportation of medicines to ensure they are adhered too.
- Supervisor to travel to State medical store to ensure appropriate storage of medicines, all relevant documentation is completed including the quantity of medicines arriving in the LGA.
- Supervisors to complete interventions supplies section within the supervision checklist. *(See Nigeria MAM documentation).*

EVIDENCE:

RURAL: A signed voucher was attached to the medicines brought to the LGA indicating that the medicines were counted and verified by the State NTD at the State medical store. The store keeper and LNTD duly signed allocation vouchers for record purposes. The details on the voucher comprises batch number, quantity of medicines, issuer, receiver, expiry date, description of medicines, name of person that approved the medicines collected and the witness.

URBAN: There was supervision of the collection of mectizan and albendazole tablets from State to the LGA store which were counted and received by the store keeper for the LGA and the LNTD also signed the receipt voucher as witness. Note that the collection of medicines from the State and its transfer to the LGA store is an activity in the work plan for the year's MAM activities.

PURPOSE OF ACTION/ACTIVITY:

Supervision of medicine transportation to ensure medicines are delivered to the health facility or ward from the LGA on time. *(See related activities in section 3.6)*

EXAMPLE ACTIONS:

- Agree who will form the supervisory team for this activity. This may include independent observers (e.g. from community representatives as well as NTD programme staff).
- Supervisors to follow SOP for transportation of medicines to ensure they are adhered too.
- Supervisor to travel to LGA medical store to ensure appropriate storage of medicines, all relevant documentation is completed including the quantity of medicines distributed to the facility or ward.
- Supervisors to complete interventions supplies section within the supervision checklist *(See the Annex).*
- Supervision to commence one day prior to medicine movements and support in ensuring medicines are ready for collection by the LGA.

EVIDENCE:

URBAN: The ward focal persons proceeded to the primary health care centre where the LGA medical store is and took delivery of their wards' allocation. That was shortly after the training for FLHF, health workers and recorders which held five days before the commencement of MAM in the LGA. The representative of the SNTD supervised the process and filled/signed allocation forms. Thereafter, those with personal vehicles began to transport their allocations as they travelled back to their wards, while others hired vehicles to convey theirs. There were other focal persons who sent officials from their wards to sign and take delivery on their behalf to the wards. Doing this 5-days before the commencement of MAM made it easier to manage both for the store officers and the ward focal persons who attended the allocation meeting from wards that are far from the LGA metropolis where the store is.

RURAL: The SNTD, Independent monitor and LNTD were involved in issuing the medicines to ensure that each health facility got medicines and a copy of the allocation form was kept in the health facility after the documentation.

PURPOSE OF ACTION/ACTIVITY:

Supervision of community level medicine distribution.

EXAMPLE ACTIONS:

- Agree who will form the supervisory team for this activity.

KEY LEARNINGS

Community involvement within supervision structures should be prioritised. This could be through the engagement of community health committees or community leaders in the delivery of supervision activities.

- **Supervisors to refer to the intervention supplies, logistics/ownership, and surveillance sections of the supervisor checklist.**
- **Supervisors to check medicines are only being delivered by those individuals who have been trained in distribution.**
- **Check CDDs are registered with the health centre.**
- **Supervision should take place throughout the medicine distribution phase. Examples of different supervision strategies can be found in Box Two. Actions should be developed that reflect how different supervision processes could be implemented.**
- **Community members who are supervisors should ensure all four corners of their communities are reached.**
- **Community members who are supervisors should report any fraudulent act of CDDs/health workers (e.g. collecting money before administering the medicine) to LGA health officers immediately.**

EVIDENCE:

RURAL: In a community supervision of MAM started from the point of medicines distribution at the health facility till it got to the CDDs. The representative of the SNTD supervised while assisting with the allocation of medicines, posters and dose poles to communities via the CDDs who signed for what they collected. This meant CDDs felt more supported during distribution.

RURAL: The SNTD representative and an independent monitor went for monitoring and supervision in different communities in the LGA to ensure that medicines have been distributed to the CDDs and treatment had commenced. This outing enabled them to confirm that indeed treatment had commenced and the CDDs were issuing the medicines correctly.

RURAL: Supervision increased the morale of the CDDs and gave opportunity for quick corrections while distribution was still going on. The expansion of the supervisory team at the LGA level gave more strength to supervision in collaboration with the State team and supporting NGOs. Involvement of religious and community leaders gave more credence to the MAM implementation programme as people tend to believe them.

URBAN AND RURAL: Community self-monitoring across all the LGAs by community leaders and traditional leaders helped to reduce the incidence of medicines not be accounted for.

PURPOSE OF ACTION/ACTIVITY:

Supervision of reverse logistics to ensure reduction of localised medicine shortages.

EXAMPLE ACTIONS:

- Agree who will form the supervisory team for this activity.
- Supervisors to follow checklists for supply chain management to ensure they are adhered too.
- Specified supervisor to travel to observe the reverse supply chain to monitor movement of medicines from CDD to Facility; Facility to LGA; and LGA to State.
- Supervisors to ensure appropriate documentation is completed at all levels.
- Supervisors to complete interventions supplies section within the supervision checklist *(See the Nigeria MAM Documentation booklet).*
- Supervision activities should continue until all medicines have been returned.

PURPOSE OF ACTION/ACTIVITY:

Feedback to Community implementers.

EXAMPLE ACTIONS:

- Supervisors, especially superior Health officers, should give feedback of the performance of Community implementers to the person they supervised by first encouraging them before pointing out areas where they need improvement. This will help boost their performance during the next implementation round.

EVIDENCE:

RURAL: Implementers request that supervisors should give them feedback of their performance in the implementation to boost their morale to do better next time.

URBAN AND RURAL: Positive feedback from programme beneficiaries was reported to be a major motivating factor; both teachers and CDDs described feeling happy and fulfilled when they received positive feedback from the community.

URBAN AND RURAL: Community implementers also wanted more feedback from the health sector and to be acknowledged as contributors to population health.

URBAN AND RURAL: CDDs wanted appreciation from their supervisors and/or certificates or preferential treatment at local health centres.

URBAN AND RURAL: Teachers and CDDs wanted appreciation from the parents, the head teacher and the education authorities; a simple thank you or just basic appreciation would be sufficient.

URBAN AND RURAL: CDDs requested a text message from the higher authority.

PURPOSE OF ACTION/ACTIVITY:

Feedback on MAM provided to all levels of the health system.

EXAMPLE ACTIONS:

- Supervisors to summarise observations within supervisory checklists and fill in necessary report forms (level 0 and level 1). *(See Nigeria MAM documentation booklet).*
- Supervisors to share completed forms with next level of the health system.

EVIDENCE:

- In the course of the MAM in the communities, supervisory checklist and forms were filled out which included level 0 and level 1 (summary forms). In the end, a detailed report was submitted at the health facility and a copy to the State.

BOX ONE: KEY THINGS TO CONSIDER ARE INCLUDED IN SUPERVISION CHECKLISTS FOR TRAINING

These should be informed by key training stipulations agreed in the training section of the PGP.

- ☐ **The specified tools are made available e.g. training manual, measuring sticks, writing materials, IEC materials, training agenda etc.**
- ☐ **The specified person i.e. facilitator is present to facilitate the sessions.**
- ☐ **The specified set/number of trainees are those invited/present to take the training.**
- ☐ **The right venue/conducive is ready for the training.**
- ☐ **The specified supervision material/documents are filled at the venue.**
- ☐ **Language used is understood by trainees.**

BOX TWO: SUPERVISION STRATEGIES

DAILY REVIEW MEETING

DESCRIPTION:

- This strategy can work perfectly at the health facility level.
- FLHF organise a daily review meeting with the CDDs.
- The meeting can be done in the morning before the CDDs go to the community or after the day's activity.
- The timing and the venue of the meeting should be jointly agreed by the CDDs and the FLHF.

BENEFIT:

- This will create an opportunity for the CDDs to share daily experiences and learn from each other.
- FLHF can identify errors and correct them.
- CDDs can seek assistance about challenges being encountered.

CHALLENGES:

- It could be impracticable if the communities where the CDDs work are very far from each other.
- Although daily review meetings have proven to be important within supervision, it was observed to be challenging financially and physically. Hence it is suggested that it could be held daily but where distance is an issue, two days interval may be considered. Alternatively, it can be held on the 4th day of MAM or be conducted using platforms like WhatsApp or Zoom.

PAIRING OF COMMUNITY IMPLEMENTERS

DESCRIPTION:

- Pairing of CDDs (a new and an old) is another supervision strategy.

BENEFIT:

- The new one will learn from the experience of the old one thereby building their confidence to carry out the job effectively, unlike if only the new CDD is going about all alone.
- This will enable them to share ideas.

CHALLENGES:

- The more experienced one may start feeling superior and acting like the boss to the new one, leading to intimidation and quarrel. The FLHF can give warning to guide against it.

USE OF WHATSAPP AND EMAIL

DESCRIPTION:

- A WhatsApp group could be created by implementers at the different level of implementation in order to ease their communication regarding implementation of NTD programme. E.g. a WhatsApp group could be created for implementers in a community, health facility or LGA. Email could also be used to support supervision.

BENEFIT:

This approach gives opportunity:

- To ask questions and get immediate response.
- Pass across general information, urgent messages or updated information.
- It is more cost effective.
- It is less time consuming.

CHALLENGES:

- It is challenging to use where there is poor internet network.
- Internet drains the phone battery fast.

PROVISION OF CONTACT NUMBER OF A SUPERIOR HEALTH OFFICER

DESCRIPTION:

- Provision of contact number of LNTD and SNTD to implementers at the community level (CDDs and FLHFs) at every stage of implementation. Please consider if community leaders could also share their contact details.

BENEFIT:

- The community implementers can make calls or send messages to them whenever they need clarification while on the field.
- It allows for direct communication and feedback that may not be easy to share by message.
- It allows for personal communication that one may not want to share on the group WhatsApp.

CHALLENGES:

- It is challenging to use if the CDD is in a no network or bad network area.
- It could be overwhelming for the LNTD or SNTD if the calls are too frequent.

ON SPOT SUPERVISION

DESCRIPTION:

- This is when any of the superior health officers at the LGA, State or Federal level go to the community to supervise medicine distribution.

BENEFIT:

- This on spot supervision approach can boost morale of the community implementer.
- It can earn the implementer respect from the community.
- It can increase acceptability of the programme in such community.
- It gives room for on-site supportive supervision.

CHALLENGES:

- It requires a lot of logistics.
- It could be expensive.
- It is impossible to go to all the communities.

EXAMPLE FROM RURAL/URBAN LGA: ACTIONS FOR SUPERVISION

**Please note that the budget in this example is not a current figure. For further information on costing for activities please see the Costing Toolkit, 2021.*

S/N	Activity	No. of days	Start date	End date	Actions	Person responsible *(insert name and role)*	Resources required / Budget*
1	**Supervision of training cascade**	2	01/08/2018	02/08/2018	• Training at all levels should be supervised by supervision team. • Supervisors to ensure pre and post tests are conducted. • Supervisors to ensure that all training materials are available. • Supervisors will ensure that attendance of participants is taken. • Supervisors will assist in answering difficult questions during training.	SNTD, MoH	Training checklist, Transportation fare.
2	**FLHF supervision of CDDs during medicine distribution**	7	07/09/2018	13/09/2018	• Supervision commences immediately after the CDDs training to the end date of MAM. • One meeting per day (where possible) with CDDs prior to medicine delivery each day. • Supervisors to check registers to confirm that update is properly done and where it is not, they will correct the CDDs. • During medicine distribution, supervisor to ensure proper dosage is followed and the dose poles are utilised. • Supervisors to ensure all registers and summary forms are appropriately filled and where not make corrections. • Supervisors to ensure proper filling of stock medicine cards.	FLHF	Transport and daily rates for FLHF to supervise.
3	**LGA team supervision of FLHF**	24	01/08/2018	13/09/2018	• From the commencement of MAM activities to the end, the persons responsible will go to communities to monitor how the activities are ongoing. • LNTD to identify the communities to be supervised where FLHFs have raised challenges and they will be identified during MAM implementation.	LNTD, SNTD, MOH, community representatives	Transport and daily rates for FLHF to supervise.
3	**Communication to aid supervision**	24	01/08/2018	13/09/2018	• A WhatsApp group will be set up immediately after training.	LNTD and MOH	Internet data.

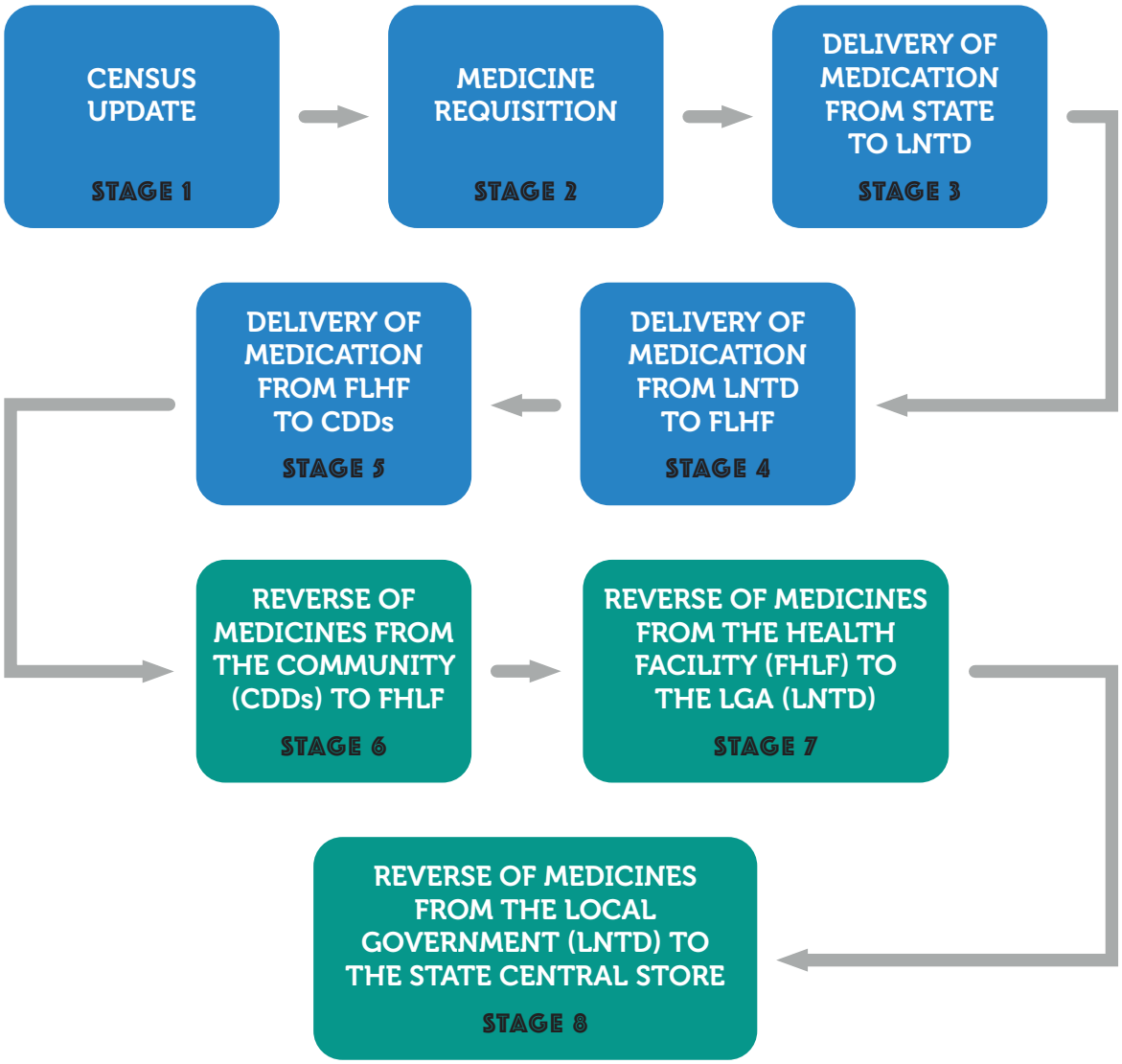
3.6 HOW TO DEVELOP ACTION PLANS FOR LOGISTICS OF MEDICINES

OBJECTIVES OF SECTION:

By the end of this section you should be able to develop actions for stages 1 to 8 on the medicine logistics pathway. This includes:

- **Ensuring adequate supplies are requested.**
- **Ensuring medications are received safely along the delivery pathway.**
- **Ensuring medications are accounted and used medications are reversed appropriately.**

Before medications can be distributed to the community, an adequate number of medications need to be requested, received and transported along the pathway below.



ACTION PLANNING FOR STAGE 1

Census update is done only for the onchocerciasis programme, other disease programmes use the national population census (NPC) updates as population figures for medicine projections. The Onchocerciasis programme should also use yearly projected population from last census as its census update and updates of new settlements should be done.

Occasionally recent credible figures are 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. It is important to understand if there are any new communities, or population changes within the LGA otherwise medicine allocation may be insufficient for the population. Remember, methods such as Transect Walk in Module 2A are useful tools here and should be considered in good time before MAM implementation.

CENSUS UPDATE

PURPOSE OF ACTIVITY?

Medicines are allocated to FLHFs based on the census update.

HOW TO DO ACTIVITY?

Census update entails the going from house to house to check for the following:

- Are there new members in the household, such as wife, husband, children older than 5 years, relatives?
- Are there new households based on migration?
- Are there any new communities etc.

If yes then the name must be entered on the register. This will allow accurate allocation of medication for the population.

WHO TO CONDUCT ACTIVITY?

It is the responsibility of the FLHF to ensure that CDDs conduct a census update to make sure the treatment registers are up to date before medicines will be allocated to their communities. By doing this activity they can update the current population of people in their community. Training needs to be given on how to do this accurately.

POTENTIAL CHALLENGES TO ACTIVITY

Weather, lack of funding and poor planning may mean that this essential activity does not take place. We observed examples of this happening across States in specific communities resulting in insufficient supply of medication for those communities.

POSITIVE EXAMPLE FROM IMPLEMENTATION

In one community, a CDD did a census update and also used the opportunity to sensitise community members before the distribution of medicines began.

In one LGA, projected national population growth of 2.8% was used to determine the eligible population in the LGA. This was used probably because census update was not conducted in the LGA before microplanning. In another, it was observed that CDDs were updating household records while carrying out treatment.

Please consider renumeration for CDDs. Research showed that this may effect participation in subsequent MAM.

'Despite the fact that CDDs were promised payment during census update which lasted for 5 days, they were shocked that only N1,300 was given them after treatment. Sadly, a number of them are yet to be paid. She fears this may affect MAM 2019'.

(NTD Implementer, 2019).

ACTION PLANNING FOR STAGE 2

MEDICINE REQUISITION

PURPOSE OF ACTIVITY?

To ensure medicines get to the State in preparation for distribution in the community.

HOW TO DO THE ACTIVITY?

STATE LEVEL:

States request for medicines using recommended templates and based on:

a. LGA endemicity and co-endemicity
b. Treatment plans
c. Historical records of number of rounds
d. Historical records of therapeutic coverage
e. Geographic coverage
f. Medicine balance
g. New amount of medicine requested
h. Micro plan document

Completed request are sent by the States to zonal coordinators for review and approval.

ZONAL LEVEL:

Zones review on State by State basis requests in line with national priority and direction for the zone. Once it is finalised with States and accepted, request documents are sent to the National medicine SCM focal point.

WHO TO CONDUCT ACTIVITY?

NATIONAL LEVEL:

1. National NTDs Supply Chain Management (SCM) Units calls for bi-monthly or periodic meeting of the SCM approving body which comprises of:
   - National coordinator - Chairman
   - National medicine SCM focal Person - Vice Chairman
   - National programme Managers - Members
   - National programme data managers - Members
   - UNICEF - Member
   - WHO - Member
2. Committee critically reviews all requests from States through zones.
3. Committee utilises the current national situation analysis and its discretion to make recommendations for approval according to FMoH guidelines.
4. Approval document containing number requested, number approved, and cost of total tablets approved is signed by committee and forwarded to National coordinator (NC) for final approval.
5. NC reverts and authorises national central medical store focal point to transmit same to States and zones.
6. Approved letter is sent to national store, State and zones by facsimile within 48 hours of approval by the NC.

HOW MUCH TIME WILL IT TAKE?

Depended on various factors including timing of previous treatment cycle; availability of medicines etc.

POTENTIAL CHALLENGES TO ACTIVITY

- Time of arrival of the medicines into the country.
- Logistic challenges from States without funding partners.
- Late submission of reports of previous cycle.

ACTION PLANNING FOR STAGES 3 TO 8

The example actions in each table are not all relevant for all contexts and LGAs, you, as implementers should consider each action alongside your given context, budget restrictions and human resource management structures and only choose actions which will best respond to your LGA needs. Some actions work better in urban areas and others in rural and so you should consider the feasibility of using that action within your area and not choose all.

Where you see [X] this indicates that you should insert a number or choice that suits your population.

PURPOSE OF ACTION	EXAMPLE ACTION
Medicine delivery from the State to the LGA.	• Meeting with SNTD and LNTD to take place on (insert date), this meeting will consider and agree: date/time, who and how the medicines and materials will be transported to the LGA. • State to organise registered/recognised transportation company (insert name) to transport the medicines (insert date). • LNTD to organise storage of medicine at (insert location). • SNTD and LNTD to ensure process and documentation in place to document the use of stock allocation issue and received **voucher**. ***The details on the voucher comprises of the batch number, quantity of medicines, issuer, receiver, expiry date, description of medicines, name of person that approved the medicines collected and a witness.*** • Ensure other officers like the store officer (insert name), MOH (insert name) or representative (insert name) are available to supervise the process of delivery on [X] date. *(Find stock allocation form in Nigeria MAM documentation booklet).*
Medicine delivery to the FLHF from the LGA based on census update.	• LNTD and FLHF to decide and communicate via (insert communication method) that medicines should be brought to the facility (insert name) on (insert date). • LNTD and FHLF to allocate store space [X] weeks before planned arrival date. • The chosen space for medications must have enough space for [X] amount of medicines and be sanitised [X] days before arrival. • Document stock of the medicines and materials via [X] resource e.g. stock allocation issue and received voucher. The process will be complete when store officers and witnesses are available at the point of delivery. *(Find stock allocation form in the Nigeria MAM documentation).*
Medicine delivery from the FLHF to CDDs.	• FLHF and CDDs will distribute medication on (insert date) during training. • FLHF to ensure that the [X] amount of (specify type) containers are used for the distribution of the medicines.

PURPOSE OF ACTION	EXAMPLE ACTION
Reverse of medicines from the community (CDDs) to FHLF. This ensures that medicines which are remaining after the completion of treatment in the community are returned to the health facility. Consider the following for accuracy and quality of data: • FLHF to check the quantity of medicines against the community register which contains details of households treated; number of medicines administered. • Independent observers e.g. traditional council, youth or groups and association and committees should be involved in the activity. • FLHF to ask questions on what led to the wastage of medicines as reported by each CDD. • FLHF to aggregate number of administered medicines against the number allocated and those damaged/wasted during the MAM. ! These steps will bring about accountability regarding the medicines and give less room for mismanagement or abuse.	• FLHF and CDDs will meet on (insert date) at (insert location) to hand over the remaining medicines and materials. • FLHF and CDDs to refer to the forms which were filled when the medicines and materials were handed to the CDDs; each of both to provide their copies on (insert date) e.g. stock allocation issue and received voucher. • FLHF to fill portion on the reporting form for each CDD on the spot and remark on the status of the medicines including; whether expired, damaged, quantity re-usable etc. • FLHF to confirm receipt of returned medicines from all communities where MAM took place under the health facility and fill a checklist on (insert date) to be kept in the facility. • Send report form on (insert date) to the LGA. • LNTD to take physical custody of medicines on (insert date) and materials from all CDDs. • It is at this point that the FLHF should explore how MAM went for CDDs and to document their experience so it may be shared and addressed by the review team ready for the following year. • Provide feedback to CDDs in relation to their performance and if possible a certificate or token of appreciation. • Document any issues that have been faced and explore potential solutions ready for feedback at the review meeting.
Reverse of medicines from the health facility (FHLF) to the LGA (LNTD). Consider: • LNTD and FLHFs/focal persons/ in-charges to refer to the stock allocation issue and received voucher/form to see quantity and details of medicines supplied.	• LNTD to fill portion on the allocation form on (insert date) for each health facility and remark on the status of the medicines i.e. the quantity expired, damaged, re-usable etc. *(Find in the Nigeria MAM documentation booklet: Medicines return and transfer form).* • LNTD to take physical custody of medicines and materials from all FLHF/focal persons/in-charges on (insert date). • LNTD and FLHF to plan transportation of medicines and materials retrieved to the LGA central medical store under the supervision of the LNTD on (insert date). • Document any issues that have been faced and explore potential solutions ready for feedback at the review meeting.
Reverse of medicines from the local government (LNTD) to the State central store. Consider: • SNTD and LNTD to agree when - date/time/how to transport the medicines to the State central medical store. • Both to ensure physical taking and handing over of the medicines. This may involve the store office.	• SNTD to check quantity of medicines allocated and handed to each LGA from the allocation form on (insert date). • SNTD/store officer to aggregate quantity of medicines allocated to each LGA against the quantity that have been reversed; and those damaged/wasted during the MAM. • SNTD to fill portion on the form for each LGA and remark on the status of the medicines on (insert date) i.e. the quantity expired, damaged, re-usable etc. • SNTD to organise only registered driver/company (insert name) transports the medicine from one level to another on (insert date). • Document any issues that have been faced and explore potential solutions ready for feedback at the review meeting.

CASE STUDY: URBAN

The LNTD arrived at the State central medical store with the LGA's allocation form and submitted same to the store officers and waited for her turn to be handed her allocation. After a while, she was called upon to take delivery and sign relevant portions on the form to confirm she was supplied the allocated quantity. A total of 165, 725 albendazole was the expected quantity and 464, 029 Mectizan. However, the number supplied to the LNTD were; 156,000 tablets of albendazole with 450,000 Mectizan. Other items supplied were 5 pack of biros, Level 0, level 1 and level 2 registers, 70 dose polls, a dozen of IEC materials i.e flyers and posters, 17 pieces of higher education exercise books and 17 files. Thereafter, these items were transported via an ambulance to the central medical store located by the primary health care centre.

CASE STUDY: RURAL

LNTD with the support of the SNTD allocated medications so each health facility would have adequate medicines for their populations. These were then given to the 15 FLHFs on the second day of their training. They were issued medicines allocation receipt duly signed by the issuer and receiver. All the FLHFs signed the medicines allocation receipt as they collected the medicines. In one LGA, there was a plan to give each FLHFs 500 naira to transport medicine to their facility. FLHFs were asked to transport their medicine to their health facility with their money first and get reimbursement later. The allocation of medicines to communities based on their population was done during the CDD training and not before. The SNTD helped in allocation of medicines. The FLHFs gave the CDDs amount of medicines that they think will be enough for their target populations. In another LGA, the plan was also to give the CDDs the medications on the day of training, however the FLHFs In-charge couldn't distribute medicines to the CDDs on the scheduled day because there was a directive from the State NTD team asking the LNTD not to allocate medicines to the health facilities because the SNTD wanted to be present during the allocation. The CDDs had waited for long hours to collect the medicines but were disappointed and told to go back the next day, because of the delay some female CDDs couldn't go back to collect their medicines but asked others to help collect for their communities. The FLHFs confirmed the recipient, documented the exact quantity of medicines and got another CDD to witness prior to the one who collected it signing.

DOCUMENTATION REQUIREMENT FOR MEDICINE DELIVERY

For proper documentation medicines delivery, the stock allocation issue and received voucher needs to be filled by designated officials e.g. SNTD, LNTD, FLHF Store officers etc. It is the document filled whenever the movement of NTDs medicines is from higher to lower level.

The below job aid will guide you through the process of completing the form for allocation/issue and receipt voucher. It is usually completed in quadruplicate (4 copies). Forms are provided by the Standard Operating Procedures Manual for NTDs Supply Chain Management, 2016. (See Nigeria MAM documentation booklet for further information). On completion of the forms, the copies are distributed as follows:

1. **White copy** goes to receiving.
2. **Yellow copy** goes to issuing facility (Proof of Delivery).
3. **Green copy** goes to the transporter.
4. **Blue copy** This remains at the issuing facility (tickler copy).

STOCK ALLOCATION ISSUE AND RECEIVED VOUCHER

STEP	ACTIONS	NOTES/EXAMPLE
	ISSUING FACILITY (FCMS, CMS, LG STORE OR FLHF)	
1	**State:** Write the name of the State.	E.g. Kaduna
2	**LGA:** Write name of the LGA that is returning the medicines.	E.g. Kauru
3	**Issuing facility:** Write the name of the facility that is issuing the medicines.	E.g. KSMC, Kauru LGA medical store or Ungwan Sauri PHC.
4	**Receiving facility:** Write the name of the facility that would receive the medicines.	E.g. PHC Damakasuwa.
5	**Date:** Write date of issuing medicines.	E.g. 7/08/2017
6	**Item description, strength and dosage form:** Write the description, strength and dosage form of the medicines.	E.g. Albendazole tablet 250mg.
7	**Unit:** Write the smallest unit of measure for the medicines.	Unit of medicine is the smallest unit of measure that can be dispensed to a patient e.g. tablet cap, bottle, tube.
8	**Quantity allocated:** Write the quantity of the medicines allocated to the facility.	E.g. 600
9	**Batch no:** Write the batch number of the medicines to be issued.	E.g. 1330hyt
10	**Expiry date:** Write the expiry date of the medicine being issued.	E.g. 12/2017
11	**Quantity issued:** Write the quantity of medicines being issued to the facility.	E.g. 600
12	**Remarks:** Add any comments regarding the quantity issued.	For clarity, write the quantity issued in packs of cartons or tins.
13	Detach the first three (3) copies and send with the medicines to the receiving facility.	The signed yellow copy will be returned to the issuing facility as proof of delivery (POD).
14	**Quantity received:** Write the quantity of NTDs medicines being received.	E.g. 600
15	**Remarks:** Add any comments regarding the quantity received.	Complete, 50 damaged, short of 50 etc.
16	**Signatures**	
17	**Approved by:** Write the name, designation, signature, date and mobile number.	This is filled in by the store manager, store pharmacist, LNTD, or officers in-charge at the issuing facility or their designation.
18	**Issued by:** Write the name, designation, signature, date and mobile number.	This is filled in by the store pharmacist, store officer at the issuing store.
	Delivered by: Write the name, designation, signature, date and mobile number.	This is filled in by the person responsible for transporting the medicines.
	Received by: Write the name, designation, signature, date and mobile number.	This is filled in by the person designated to do so at the receiving facility.
	Witnessed by: Write the name, designation, signature, date and mobile number.	This is filled in by the person designated to do so at the receiving facility. The designate include: The SNTD, the LNTD, ward head and village head or their representative.

Taken from Standard Operating Procedures Manual for NTDs Supply Chain Management, October 2016.

THE COMPLETION OF THIS TASK IS WHEN:

a. The description, unit, expiry date and batch number of each NTD medicine has been filled in the form.

b. The quantity allocated and issued has been entered on the form for each item.

c. The quantity received has been entered on the form for each.

d. Names, designations, signatures, dates and phone numbers, have been completed by the relevant personnel.

e. The yellow copy (POD) of the form with the quantity received filled and signed has been received from the transporter and filed by the issuing store for its records.

DOCUMENTATION REQUIREMENT DURING MEDICINE REVERSING

For proper documentation during reverse logistics the medicines return and transfer form is to be filled. It is the document filled whenever the movement of NTDs medicines is from lower to higher level as well as when the transfer is between facilities at the same level. It is often completed in quadruplicate (4 copies) and after the completion, the copies are distributed as follows:

1. **White copy** goes to receiving facility.
2. **Yellow copy** goes to the transporter.
3. **Blue copy** returns to the issuing facility (as Proof of Delivery).
4. **Pink copy** to the transfer/returning facility.

MEDICINES RETURN AND TRANSFER FORM

STEP	ACTIONS	NOTES/EXAMPLE
1	**State:** Write the name of the State.	E.g. Ogun
2	**LGA:** Write returning/transferring the medicines.	E.g. Ijebu Ode
3	**Receiving facility: The FLHF/LGA/State (SCMS)** Write where the medicines are being taken to.	E.g. Oke Agbede PHC/Imeko Afon/Ogun
4	**Medicines returning/transferring facility: The PHC/LGA/State** Write where the medicine is leaving from.	E.g. Ita Osu/Ijebu ode/Ogun
	FOR EACH MEDICINE BEING RETURNED/TRANSFERRED	
5	**Item description, strength & dosage form:** Write the name and description of the medicine.	E.g. Ivermectin tablet 400mg
6	**Unit:** Write the smallest unit of measure for the medicines.	E.g. Tablet, cap, bottle, tube etc.
7	**Batch no:** Write the batch number of the medicines being returned/transferred.	E.g. EPA22221
8	**Expiry date:** Write the expiry date of the medicines being returned/transferred.	E.g. December 2014 or 12/2014
9	**Quantity returned/transferred:** Write the quantity of medicines being returned/transferred.	E.g. 600 tabs., cap, tubes or bottles.
10	**Reason for return/transfer:** Write the reason for which the product is being returned.	E.g. Damaged, expired, unused, redistribution etc.
11	**Items returned/transfer officer:** Write the name of the person returning/transferring the medicine, his/her signature, mobile number and date.	E.g. James Bosco, JY, 080362477.. 25/12/2014*
12	**Items returned/transfer Approving Officer:** The name of the person who approved the return/transfer, signature, mobile number and the date.	E.g. Ifeoluwa Adepoju, IA, 080362477.*
13	**Transporter:** The name of the driver transporting the medicines; his/name, signature, mobile number, date and vehicle registration number.	E.g. Akanbi Sojuade, AS, 080353187.. 25/12/2014 BDG 002 XY.*
14	**Receiving facility:** Name of the person who receives the returned/transferred medicines, signature, mobile number, and the date.	E.g. Folarin Baoku, FB, 08078965... 25/12/2014*
15	**Receiving witness:** Name of the person who witnesses the receipt of the medicines, his/her signature, mobile number and the date.	E.g. Laolu Odunayo LO, 070954218... 25/12/2014*
16	**Remarks:** This is written by the receiving officer to acknowledge the quantity and the condition of the returned medicines.	E.g. Complete, incomplete, unlabelled, improperly packaged etc.

Taken from Standard Operating Procedures Manual for NTDs Supply Chain Management, October 2016.

**These are pseudonyms used only as examples.*

An ideal situation will be for the medicines to be delivered to the local governments by the State and to the facilities by the LGAs.

THE COMPLETION OF THIS TASK IS WHEN:

a. The names of the State, LGA, facility to which the medicines were sent and the facility returning/transferring the medicines have been completed.

b. The returned/transferred medicines are fully described by batch number, expiry date, the quantity returned/transferred recorded and the reason(s) for the transaction stated.

c. When the person returning/transferring the medicines signs the form.

d. When the transporter signs the form.

e. When the approving officer signs the form.

f. When the witness to the transaction signs the form. When the receiving officer signs the form.

g. When a signed copy of the form is sent back to the facility that returned/transferred the medicines.

TRANSPORTATION REQUIREMENT DURING MEDICINES REVERSING

Having satisfied the first condition of record keeping and documentation, the next crucial requirement is transportation. To meet that, it is expected that the State will ensure that movement across all the levels are guided by the NTDs transportation guidelines, which include that:

- **Medicines are moved in containerised vehicle or van.**
- **Driver of the vehicle must have valid driving license.**
- **Current and vehicle documents must be valid and complete.**
- **Goods in transit are insured.**
- **Vehicle certification of road worthiness must be current.**

EXAMPLE FROM RURAL/URBAN LGA: ACTIONS FOR MEDICINE LOGISTICS

**Please note that the budget in this example is not a current figure. For further information on costing for activities please see the Costing Toolkit, 2021.*

S/N	Activity	No. of days	Start date	End date	Actions	Person responsible *(insert name and role)*	Resources required / Budget*
1	**Census Update**	TBC	TBC	TBC	• The CDDs selected will conduct a census update of their community. • FLHF will train and supervise the CDDs on how to conduct the census update. • CDDs to be renumerated for census.	CDDs	TBC
2	**Collection of medicines**	1	13/08/2018	13/08/2018	• LNTD or with the assistant to submit eligible population for treatment to the State for allocation of medicines. • The LNTD and/or assistant to travel to the State medical store to collect the allocated medicines and materials ahead of the distribution. • At the LGA, the LNTD and/ or assistant to allocate the medicines to the FLHFs ahead of MAM.	The FLHF, Assistant LNTD, FLHF	N7,000 (Seven thousand naira only) to cover the cost of travel to Abeokuta the location of the State medicine store and to convey the medicine and materials. Or The sum of N6,000 to fuel vehicle assigned by the LGA for the transportation to the State medicine store and conveyance of medicines and materials to the LGA. *Note: This may need to be calculated by mileage.*
3	**Reverse logistics**	2	08/10/2018	09/10/2018	For reverse logistics, the FLHF to collect medicine balance from CDDs and document it properly for onward return to the LNTD. In the case of reverse logistics: • The FLHF to submit the balance of medicines collected from the CDDs and the data tools they filled.	LNTD, SNTD / logistics officer	N7,000 (Seven thousand naira only) to cover the cost of travel to Abeokuta the location of the State medicine store and to convey the medicines remaining after the treatment cycle. Or The sum of N6,000 to fuel vehicle assigned by the LGA for the transportation to the State medicine store to return the medicines and materials. *Note: This may need to be calculated by mileage.*

NOTES

ACKNOWLEDGEMENTS

COUNTDOWN
Calling time on Neglected Tropical Diseases

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).

RESEARCH ASSISTANTS IN BOTH STATES:

Azeez Abolaji
Sadiq Abubakar
Joshua Adams
David Adekunle
Awayi Namo Angela
Mathew Ayegboyin
Akintunde Albert Ayodeji
McRae Ayuba
Adedoyin Ademola Bernard
Adewumi Taiye Christiana
Filimon Musa David
Sogbuyi Imisioluwa Elijah
Bello Elizabeth
Chigaiti Faith
Hannah Ojone Hussaini
Damina Ibrahim
Adeniran Adebola Ismail
Shiabu James
Emmanuel Kachiro
Adebanji Adedayo Mathew
Oluwasewa Ogunkoya
Busola Ogunlana
Bukola Olagunju
Adeniran Gideon Olusanjo
Foluke Oluyemi
Olasupo Esther Opeyemi
Ozigi Emmanuel Samuel
Ide Siddi
Sodimu Samuel Sunday
Jimoh Nimot Temitope
Stella Udu
Dupe Yahemba

RESEARCHERS FROM SIGHTSAVERS:

Tosin Adekeye
Samson Ayuba
Ruth Dixon
Noela Gwani
Sunday Isiyaku
Gideon Kevin
Luret Lar
Damian Lawong
Akinola Oluwole
Bolanle Surakat
James Yashiyi

RESEARCHERS FROM LSTM:

Efundem Agboraw
Pamela Bongkiyung
Laura Dean
Julie Irving
Kim Ozano
Helen Piotrowski
Kelly Smyth
Sally Theobald
Rachael Thomson
Eve Worrall

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).

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

TO TACKLE NEGLECTED TROPICAL DISEASES

MODULE 4

REVIEWING MAM IMPLEMENTATION FOR ONGOING IMPROVEMENT

COUNTDOWN

Calling time on Neglected Tropical Diseases

MODULE 4

REVIEWING MAM IMPLEMENTATION FOR ONGOING IMPROVEMENT

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.

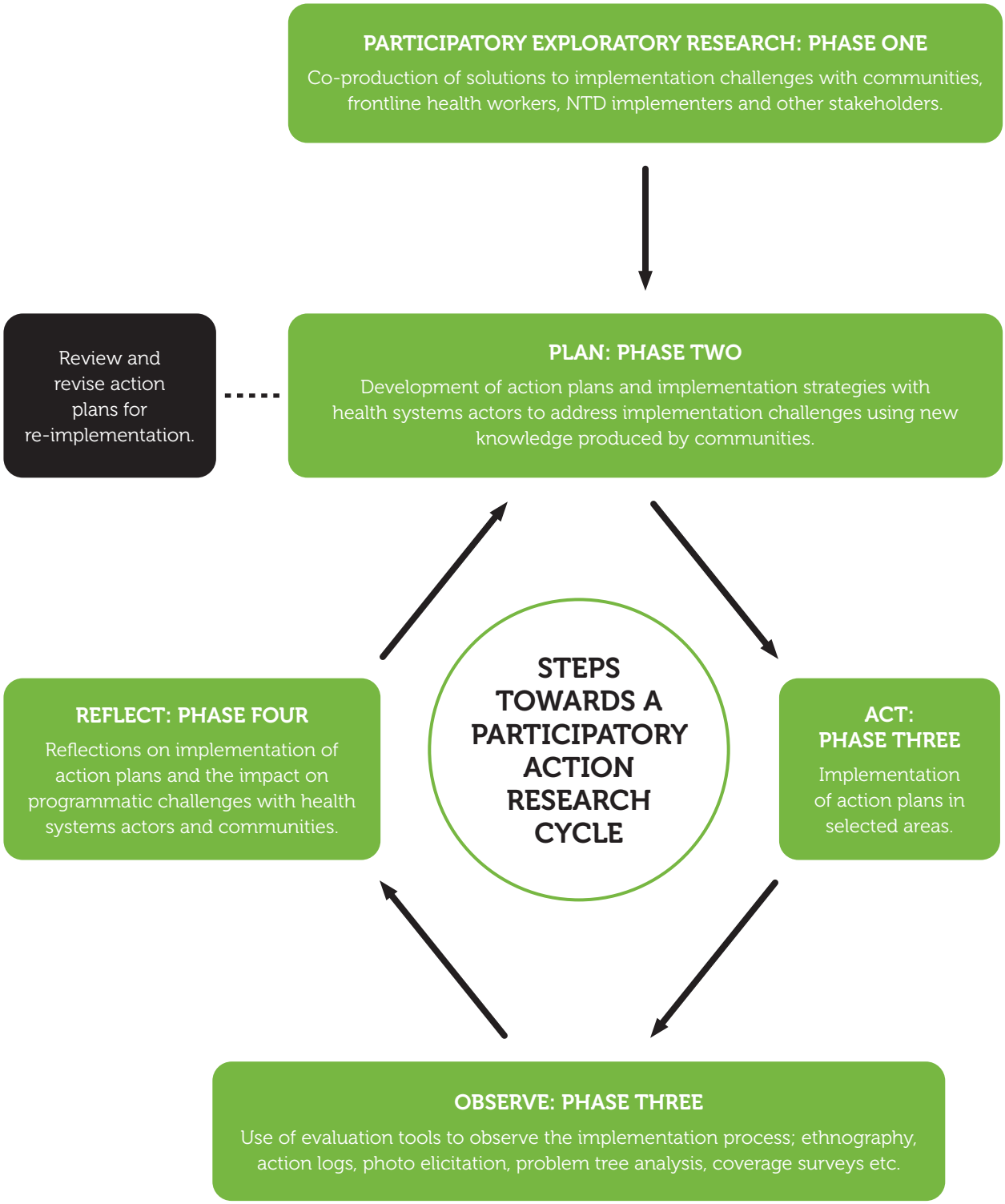


Figure 1. PAR approach to improving equity in MAM (Ozano et al., 2020)

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 4

REVIEWING MAM IMPLEMENTATION FOR ONGOING IMPROVEMENT

LNTD training

This module will focus on how to ensure that the action plan you developed in modules 2 and 3 is implemented effectively. This will be done under the three following headings:

1. **FOLLOWING THE ACTION PLAN**
2. **CAPTURING AND USING LEARNING DURING IMPLEMENTATION**
3. **REVIEW AND REFLECTIONS**

OBJECTIVES OF THE MODULE:

By the end of this module you should have a clear plan of:

- **How you will capture learnings throughout this year's MAM implementation cycle**
- **How you will draw stakeholders together to bring everyone's learnings at the end of the process**
- **How you will use these learnings to shape future planning activities**

Some faces have been blurred in photographs to protect confidentiality.

FOLLOWING THE ACTION PLAN

In order to ensure each of the activities that you propose in your action plan are implemented effectively, there is need to set up a mechanism to follow up each task, so that they are carried out as and when they are due.

SHARING OF THE ACTION PLAN WITH KEY STAKEHOLDERS

The first step in ensuring that action plans are implemented effectively is to share them with key stakeholders at all levels of governance, especially those who have been involved in the development of the action plan so that they can follow up with the activity. In addition, everyone that has been allocated a task on the action plan needs to be aware of the details and the deadline for when their task requires.

During the action planning meeting a communication strategy should be agreed on to allow for easy sharing of information about the action plans and monitoring the implementation process. Below are options of communication strategies that can be explored:

WHATSAPP OR OTHER INSTANT MESSAGING SERVICE: **This is for sharing the document, quick questions and feedback on the progress of actions executed.**

EMAIL ADDRESS: **This will be used to share an e-copy of action plans and an updated version when applicable.**

PRINTED VERSIONS OF THE ACTION PLAN: **This will be given to people who do not have access to the previous options above or prefer a hard copy. However, a copy of the action plan should be printed and pasted on the wall at strategic places in the LGA secretariat and at all Health facilities within the LGA.**

Note: The choice/choices of communication must be based on feasibility of using such communication strategy.

IDENTIFICATION AND CONSTITUTION OF ACTION PLAN MONITORING TEAM AT THE LGA LEVEL

For an effective monitoring of action plans and tasks assigned to people, there is need to constitute an action plan monitoring team at the LGA level. This set of people should be respected leaders at the LGA and community level that can support the LGA supervisory team for NTD programme in ensuring that planned activities are executed as planned. It should be a voluntary service to their people, hence they should not expect to be paid. Examples of people that can be assigned this task are listed below but should not be limited to this list alone. Try to be as inclusive as possible when establishing this team and ensure you have equal representation of men, women as well as including diversity based on age, geographic location within the LGA, Persons With Disabilities (PWDs) represented etc.

This group of people will be assigned the responsibility of overseeing the implementation of tasks and activities within the action plan in an area close to them and to help document; what was done, how it was done, what worked well, what did not work well and what needs to be improved upon or strategies that need to be changed. This group of people will give feedback to any member of LGA supervisory team assigned to their area.

Members of the LGA supervisory team can get feedback from the monitoring team by calling them or during supervision visit to their area during programme implementation.

Below is a sample of a template that can be used to constitute the committee and assign the tasks and roles (Table 1).

The LGA supervisory team are top health officials at the LGA administrative level. Their role is to oversee and ensure successful implementation of the MAM programme within their LGA. They are available to answer questions and respond to challenges relating to the implementation of NTD programme at the LGA level. The member of LGA supervisory team are:

- **The MOH/DPH at the LGA**
- **The LNTD Coordinator**
- **The Health Educator**
- **Number one Nurse**
- **Number one Community Health Extension workers**

TABLE 1: SAMPLE OF TEMPLATE FOR ASSIGNING ROLES TO MONITORING TEAM

MEMBER OF LGA SUPERVISORY TEAM MONITORING MEMBER REPORTS TO	MEMBER OF ACTION PLAN MONITORING TEAM	DESIGNATION OF ACTION PLAN MONITORING TEAM MEMBER	ACTIVITIES TO BE MONITORING	LOCATION	WHEN TASK SHOULD HAVE BEEN COMPLETED
The LNTD Coordinator	Segun Adeola*	Youth leader, [X] community	Pasting of posters, MAM	[X] community	8th of June 2019
The LNTD Coordinator	Adamu Balarabe*	CDA chairperson, [X] LGA	Selection of CDDs, Mass Administration of Medicine	[X] LGA	30th of June 2019
The Health Educator / FLHFs	Afolabi Adeyanju*	CDA chairperson, [X] LGA	Sending of posters from LGA to health facility in [X]	[X] LGA	6th of June 2019
The Health Educator	John Chawai*	Chairperson, CAN	Letters to all church leaders in [X]	[X] LGA	15th of June 2019

**These are pseudonyms used only as examples.*

ACTION PLAN ACTIVITY REMINDER PRIOR TO ACTIVITY DATE

It will be good practice that those assigned responsibility for a task in the action plan are reminded of their assigned task a few days (3-5 days) prior to the execution of such activity. In doing so, the following will be achieved:

- **The level of preparedness of the individual for the assigned task will be known.**
- **It will be a wakeup call for the individual in case they have forgotten the assigned role to play in the action plan.**
- **It will help the individual to think about the activity and put finishing touches to his/her preparation for the activity.**

The task of reminding people about their assigned task can form part of the role of the members of the action plan monitoring team.

WEEKLY REVIEW OF ACTION PLAN

The SNTD assigned to an LGA and the LNTD of that LGA may need to review the action plan on a weekly basis so as to ensure that proposed activity can still be carried out as planned. In cases where there is need for review of activities due to unforeseen circumstances e.g. delay in medicine arrival, public holiday, impromptu government activities, that can disrupt the planned activities in the action plan, the LNTD and SNTD should update the action plan after consultations and share the updated version with stakeholders and those concerned early enough so as to prevent wasting of resources, energy and time that may result from following an older version of the action plan.

CAPTURING AND USING LEARNING DURING IMPLEMENTATION

Learning from the past to better the future is something we need to apply to our everyday life. Hence to document learnings from each cycle of treatment and use it to improve on future MAM cycle, the following can be considered.

REVIEW OF EVERY ACTIVITY AFTER ITS COMPLETION

It will be good to have a quick review of every activity after completion in order to document:

WHAT WORKED WELL **WHAT DID NOT WORK WELL** **AREAS THAT NEED IMPROVEMENT**

This mini review is to help make a good critique and reflection of the activities immediately after their completion. Experience has shown that it is not easy to remember everything about an event several days after it has taken place. The information documented from this mini-review will be useful during the general review meeting. The mini-review should be done mainly by health official's i.e. FLHFs, LNTD and SNTD which can be done individually or by a group of two or three depending on how many of them are together in an area where the activity was implemented. It is an opportunity to cerebrate the success of MAM and to seek solutions for any challenges raised.

> *So many of us do a lot of work but we don't report. We do a lot of advocacy, sensitisation to achieve success but we don't report.'*
>
> (NTD implementer 2019)

THE USE OF AN ACTION LOG COLLECTED BY FLHFs AND LNTD

Another way of capturing the learnings from the MAM implementation process is for FLHFs and LNTDs to keep an action log of activities they carried out as part of MAM implementation process. A template of the action log is shown below. A 40 leaves exercise book can be used for this exercise. This exercise book can be a reference material during the review meeting on how to improve on programme delivery.

EXAMPLE OF AN ACTION LOG:

DATE	ACTION THAT YOU HAVE TAKEN TOWARDS ACHIEVING PLANNED ACTIVITIES (If no actions, state why and discuss any problems/ barriers)	WHO WAS INVOLVED AND WHAT WAS THE OUTCOME?	WHAT WORKED WELL?	WHAT WILL YOU DO DIFFERENTLY NEXT TIME?	DID THIS DIFFER FROM PREVIOUS MAM CYCLES?	LEVEL (LGA/HF common and location (HF code/ common code)
16/01/ 2020	Stakeholders meeting	The following were involved: • Chief IMAM • CAN chairman • Okada association • WDC chairman amongst others. The health educator and the LNTD were also involved.	• Stakeholders pledged support to the programme with resources and community advocacy. • Stakeholders appreciate their involvement in the meeting and were more engaged throughout MAM.	Invite more stakeholders.	Yes. More stakeholders were involved compared to last MAM.	LGA

LEARNING FROM PHOTOGRAPHS OF EVENTS/ISSUES DURING PROGRAMME IMPLEMENTATION

Photograph of activities or issues that can help improve or affect programme implementation can be taken during implementation activities, this is to help jog your memory on how the event happened or issues raised that affected or assisted the programme delivery. E.g. taking a photograph of dose pole donated by community members to complement the insufficient ones supplied by the programme. Keep a record of what you have taken pictures of so you are able to share learning in the review meetings. Where people may be included in the photograph make sure you gain consent to take the picture. Photographs can be very powerful in lobbying for additional resources or programmatic change based on what has worked during your implementation experiences.

REVIEW AND REFLECTIONS

At the end of each MAM cycle it is important that a review meeting is organised with all stakeholders involved in the implementation process.

Two levels of review meeting should be organised:

LEVEL ONE
LGA LEVEL REVIEW MEETING

LEVEL TWO
STATE LEVEL REVIEW MEETING

The aim of each review meeting is to do a critical and unbiased review of the implementation process to document, what worked well, what did not work well and the area of improvement or change of strategy. Organising a review meeting has funding implications and this needs to be included as part of the action plan and well budgeted for. To have an effective review meeting, the following need to be carefully considered when planning for your review meeting:

DRAWING AN AGENDA FOR THE MEETING

The first step in preparing for the review meeting is to develop an agenda for the meeting. A sample of an agenda for a review meeting is shown below.

CONTENT AND STRUCTURE: The agenda should include a presentation to give feedback on the performance of the LGA in terms of how effective the last MAM exercise was and the major challenges encountered during implementation. A quality time should be allotted to identifying what worked well, what did not work well and how to improve on each of the implementation activities. An important point that should also be discussed is how to raise funds and resources at the LGA/State level to support the implementation programme activities aside the one provided by international organisations. This is important as sustainability of the programme after the exit of international organisations is a subject of discussion.

AGENDA FOR MAM REVIEW MEETING			
ACTIVITY	**START TIME**	**END TIME**	**PERSON RESPONSIBLE**
Opening prayer	10:00am	10:05am	All
Introduction	10:05am	10:10am	All
Welcome address	10:10am	10:15am	The MOH
Key note address	10:15am	10:20am	The Executive chairperson
Presentation on performance of LGA during last MAM	10:20am	10:45am	LNTD
Tea break	10:45am	11:00am	All
Review of last MAM process (breakout into groups for each MAM phase). What worked well, what did not work well, suggestions for improvement	11:00am	1:00pm	All
Lunch break	1:00pm	1:30pm	All
Continuation of review process (Presentation by each group)	1:30pm	2:30pm	All
Closing	2:30pm	2:35pm	All

To ensure full involvement of everyone, the participants should be assigned into groups to review the activities during the implementation. This should be done after the presentation. At the LGA level, members of the LGA supervisory team can facilitate each of the groups and ensure everyone participates well.

DURATION: The review meeting should not be more than 5 hours to encourage concentration and participation for the whole meeting, hence time should be allocated for discussion on each implementation activity.

DEVELOPING A TEMPLATE FOR THE REVIEW MEETING

In planning for the review meeting, there is need to develop a template that will be used for the review of the implementation activities carried out in each LGA. Consider using the template at group level. Below is a sample of a template that can be adapted:

IMPLEMENTATION PROCESS	SPECIFIC TASK IN THE IMPLEMENTATION PROCESS	WHAT WORKED WELL	WHAT DID NOT WORK WELL	AREAS OF IMPROVEMENT OR CHANGE FOR NEXT MAM ROUND
ADVOCACY AND SENSITISATION	• Pasting of IEC materials on the wall • Sensitisation meeting with village heads	Village leaders were fully engaged and supportive of MAM.	Not enough notice was given and therefore one village head could not attend.	Ensure correct protocols are followed and village heads are invited with enough time.
DELIVERY OF MEDICINES TO COMMUNITIES	• House to house distribution • Distribution at religious centres • Distribution at health facility	Engaging the leaders of churches and Mosques.	Some people were not at home during house to house and CDDs needed to go back which used a lot of their time.	Ensure adequate time and resources are allocated to CDDs for medicine distribution and consider additional mechanisms like fixed point and Mop up.

It may be helpful to review MAM in terms of geographic and therapeutic coverage by wards not only by LGAs. This may help to closely monitor progress and probably help programme implementers to identify communities where transect walk, social mappings are required to identify gaps that will help better planning for improvement.

As part of the review process it is important to understand who is left behind and why. A toolkit called 'Towards universal coverage for preventive chemotherapy for Neglected Tropical Diseases: guidance for assessing who is being left behind and why' has been designed to support NTD programmes to collect and analyse additional quantitative and qualitative data, to show the differences in access to and impact of preventive chemotherapy treatment according to a person's sex, age and other social factors. The link to this tool is:

https://apps.who.int/iris/bitstream/handle/10665/259487/WHO-FWC-17.3-eng.pdf

IDENTIFICATION OF KEY STAKEHOLDERS THAT WILL BE AT THE REVIEW MEETING

Individuals that will be invited for the review meeting should be key stakeholders in the LGA or at the State level (depending on the level of the review meeting) that can influence acceptability of programme by the community, support the implementation of actions agreed upon and pass across messages/lessons learnt to the people at the community level. Examples of people that can be invited are listed below. The list is not exhaustive and should be based on availability of these group/associations in the LGA/State where the review will be conducted. It is advisable you return to the stakeholder analysis you completed in module 2 so as to identify who should attend the review meeting for each level.

SELECTION OF AN APPROPRIATE DATE FOR THE REVIEW MEETING

The date and time for the review meeting should be carefully selected based on the area, an understanding of the itinerary of people that are invited is key in making a decision of the date that will be selected for the review. A good example is that Friday may not be a good day to have a meeting because of Muslim prayers and it is a day most people want to travel from their work place to see their family. In summary, the date and time of the meeting should be selected after proper consultation.

INVITATION LETTER TO STAKEHOLDERS

There is need to send invitation letters to all invitees at least two weeks prior to the meeting date. It will be good to give an overview of the expectations at the meeting and how long the meeting may last. This will enable the intending participants to plan and prepare for the meeting. It is a good practice to send a reminder by text to participants a few days prior to the meeting (3 days) to remind them of the meeting and to get confirmation that they will be able to attend the meeting. This will help in finalising the logistics and budget preparation for the meeting.

Dear Sir / Ma,

INVITATION TO ATTEND REVIEW OF MASS ADMINISTRATION OF MEDICINE (MAM) IN KOBITI LGA

I write to invite you to the review of Mass Administration of Medicine (MAM) in Kobiti LGA coming up on the 20th of November ----. The aim of the meeting is to do a critical review of the just concluded MAM in the LGA in order to identify what has worked well, what did not work well and what can be improved upon during future rounds of the treatment. You have been invited for this meeting because of your position in the society and the role you played during the last programme implementation. We believe your participation in the meeting is important and you will be able to provide useful information on how best to improve on the delivery of the MAM programme in the future. It is expected that the meeting will be about 4 hours. Below are the details about the meeting:

Venue: Oba Alafin town hall, Imeko
Time: 10am
Date: 20th November ----

We would appreciate if you can confirm your availability for this meeting so as to help us prepare the logistic adequately.

Thank you,

Adeola Adeeko, LNTD Kobiti LGA

Draft letter

**These are pseudonyms used only as examples.*

VENUE FOR THE REVIEW MEETING

The proposed venue for the review meeting should be carefully considered before selection. The following should be put into consideration:

- **AVAILABILITY OF FACILITIES NEEDED FOR THE REVIEW.** e.g. If you need to use a projector where will you hang your screen?
- **CONDUCIVENESS OF THE ENVIRONMENT.** e.g. It must be well ventilated and there should be minimal or no distraction.
- **SPACE FOR BREAK OUT SESSION** - The hall should be spacious to allow for division into four groups for the breakout sessions.

USING YOUR LEARNING IN FUTURE MAM ACTIVITIES

In order to ensure that the learnings from the review meeting are used to improve future planning for programme implementation, it is a good practice to ensure someone is given the responsibility of collating and documenting all the learnings from the review process. The learnings can be used to make recommendations for improving programme performance. These recommendations should be sent to policy makers for their review and approval into policy.

In planning for future MAM activities, reviewing the learnings from previous MAM should be given top priority on the meeting agenda. Information from it should guide decision making for activities that will be in the action plans for the next MAM activities.

NOTES

COUNTDOWN

Calling time on Neglected Tropical Diseases

ANNEX

ACTION LOG TEMPLATE

Date	Actions that you have taken towards achieving planned activities (if no actions, state why and discuss any problems/barriers)	Who was involved and what was the outcome?	What worked well?	What will you do differently next time?	Did this differ from previous MAM cycles?	Comments

NOTES

ACKNOWLEDGEMENTS

COUNTDOWN
Calling time on Neglected Tropical Diseases

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).

RESEARCH ASSISTANTS IN BOTH STATES:

Azeez Abolaji
Sadiq Abubakar
Joshua Adams
David Adekunle
Awayi Namo Angela
Mathew Ayegboyin
Akintunde Albert Ayodeji
McRae Ayuba
Adedoyin Ademola Bernard
Adewumi Taiye Christiana
Filimon Musa David
Sogbuyi Imisioluwa Elijah
Bello Elizabeth
Chigaiti Faith
Hannah Ojone Hussaini
Damina Ibrahim
Adeniran Adebola Ismail
Shiabu James
Emmanuel Kachiro
Adebanji Adedayo Mathew
Oluwasewa Ogunkoya
Busola Ogunlana
Bukola Olagunju
Adeniran Gideon Olusanjo
Foluke Oluyemi
Olasupo Esther Opeyemi
Ozigi Emmanuel Samuel
Ide Siddi
Sodimu Samuel Sunday
Jimoh Nimot Temitope
Stella Udu
Dupe Yahemba

RESEARCHERS FROM SIGHTSAVERS:

Tosin Adekeye
Samson Ayuba
Ruth Dixon
Noela Gwani
Sunday Isiyaku
Gideon Kevin
Luret Lar
Damian Lawong
Akinola Oluwole
Bolanle Surakat
James Yashiyi

RESEARCHERS FROM LSTM:

Efundem Agboraw
Pamela Bongkiyung
Laura Dean
Julie Irving
Kim Ozano
Helen Piotrowski
Kelly Smyth
Sally Theobald
Rachael Thomson
Eve Worrall

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).