TRACHOMA SAFE STRATEGY SERIES:
Antibiotics

Micro-planning for effective Zithromax® Mass Drug Administration

ICTC International Coalition for Trachoma Control

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Views represented are the preferred practices of the coalition and not necessarily the official views of individual member organisations or agencies.

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Front cover: Ethiopian boy taking Zithromax during an MDA.
Photo: Paul Emerson, International Trachoma Initiative

Community health workers in Nepal being trained on how to use a dosing stick. Photo: International Trachoma Initiative

Foreword

This manual for the micro-planning for effective administration of Zithromax® is one a series of preferred practices for trachoma elimination programme implementation recommended by the International Coalition for Trachoma Control. It is essential reading for all those programme managers, implementing partners, implementers and students who wish to maximize efficiency in their mass drug administration programmes.

Those living at risk of blinding trachoma deserve good service from programme managers and implementing partners. The delivery of drug to those who need it starts about a year in advance and includes an immense input of effort and resources from the drug manufacturer, supporting partners, ministries of health, implementing partners, district officials and distribution teams in order to get the right quantity in the right place at the right time.

The best performing programmes are able to mobilize more than 20,000 distribution team members and provide mass drug administration service to over 10 million people in just 5 to 7 days. When that level of coordination is witnessed it looks like a miracle-but is the result of effective micro-planning. The collective wisdom from those successful programmes is presented here and is available for you to customize to your local realities.

Distribution of Zithromax in Tanzania.
Photo: International Trachoma Initiative

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Community health worker in Ethiopia with a dosing stick.
Photo: International Trachoma Initiative

Background

The principal goal of a trachoma mass drug administration (MDA) programme is to ensure that the proper dose of Zithromax® or tetracycline eye ointment is provided to each eligible person within the target geographic area. The micro-plan is the blueprint that ensures that the correct drugs and other materials are available in the right quantities, in the right place, and at the right time to enable all participants to have access to the MDA (see **Sidebar A**). Micro-planning is a key tool to effectively manage these details. The micro-plan should be detailed enough to outline how a MDA can be done within a set timeframe. Although it can be a challenge to gather the right people and information to create a good micro-plan, it is an essential tool for success. Successful micro-planning results in capacity strengthening for all the participating partners, as each learns new skills from others with comparative advantage in those areas. Micro-planning is even more critical as countries decentralize planning and decision making, allowing districts to determine their programmatic and budgetary needs with less and less assistance from the national level. The micro-planning framework proposed here will not only facilitate planning for trachoma, but strengthen capacity for preventing NTDs and for other health initiatives.

Objective of this manual

The objective of this manual is to provide national coordinators, regional and district coordinators, and other stakeholders with the necessary information to facilitate effective micro-planning for Zithromax® MDA. The guidelines included here arose from the International Trachoma Initiative supported "Preferred Practices for Zithromax® Mass Drug Administration" project. The Kilimanjaro Centre for Community Ophthalmology (KCCO) was the lead partner on behalf of the International Coalition for Trachoma Control (ICTC) in carrying out the work. In this document, we will build on the "Preferred Practices" manual (readers are encouraged to review this manual), providing more detail on ways to improve micro-planning.

SIDEBAR A

The delivery of just one dose to one recipient requires a well-functioning system with considerable organisation and planning of tasks:

- Timetables must be set
- Inventory is needed of supplies (registers, dose poles, drug, etc.)
- Supplies must be ordered and positioned for distribution teams
- Resources (transportation, fuel, ***per diem***) must be allocated
- Distributors and supervisors must be identified and trained
- Communities (members, leaders and local health authorities) must be mobilized
- Distribution points must be well-coordinated (how personnel are used, how time is allocated, how people flow through the system, etc)
- Management of drug, supplies, resources and distribution data need to be dependable (drugs and other supplies need to be delivered on time)

SIDEBAR B

The Tool for Integrated Planning and Costing, or TIPAC (pronounced "tee-pack"), is a Microsoft Excel–based programme that helps users accurately estimate the costs and funding gaps of public health programmes. The NTD TIPAC can be used in conjunction with existing national NTD strategic plans and budgets in order to effectively plan and coordinate future programme resources. The TIPAC is not a substitute for the strategic process of developing a national plan of action or programme budget. However, the tool should strongly align with these documents and can help with resource planning and revising a national plan to meet resource constraints.

Download the TIPAC and User Guides:

- English (8.5x11)
- English (A4)
- French
- Portuguese
- Bahasa
- Spanish

Tools for micro-planning

There are a number of templates and tools available for micro-planning. While these templates, most often in MS Excel, vary somewhat across programmes, they essentially focus on providing a mechanism for calculating materials (based upon the number of teams), per diem, logistics, drugs, etc. We recommend that planners review available templates and tools to avoid "reinventing the wheel" and to build upon these tools to develop a micro-planning tool that is suited for the local programme environment (see **Sidebar B**).

Micro-planning to strengthen health systems

Micro-planning for Zithromax® MDA should be viewed as a mechanism to strengthen health systems at the "district" level. In strengthening health systems, micro-planning improves accountability, reporting, problem-solving, and a myriad of other characteristics necessary to have a health system that meets the needs of the population in an efficient and effective way. That said, health systems change; there is a general trend to more decentralization of health systems in developing countries. In addition, with the advent of new technologies for recording and transmitting information, there will be new opportunities to further strengthen health systems that are not included in this document. Readers are encouraged to provide thoughts on additional ways to improve micro-planning.

Underlying parameters of micro-planning

There are a few underlying concepts to micro-planning. These include transparency and inclusiveness, consistency, and efficiency. Transparency means that all stakeholders have access to information on all aspects of micro-planning, including budgets, plans, and reporting. Transparency throughout the micro-planning process helps to ensure district-level ownership and more straight-forward reporting and accounting, as well as promoting a more problem-solving approach to all activities. Besides being transparent, successful micro-planning is also inclusive; all relevant stakeholders need to be present. By including a wide range of stakeholders, ownership is also fostered and problem solving is enhanced.

Micro-planning needs to be done consistently each year. Micro-planning can incorporate changes based upon lessons learned from the previous year's MDA, as well as any changes in disease prevalence (due to either baseline mapping or impact assessments done) and budgets. Lessons learned come in the form of recommendations arising from post-MDA programme review meetings from the previous year, coverage data from the previous year, and/or findings from coverage surveys. Understanding why coverage was low (see **Sidebar C**). will assist in adjusting the micro-plan just as understanding why it was high in areas can then be applied to those areas lagging behind.

Efficiency often does not garner the level of priority it should in the implementation of many health interventions. Improved efficiency leads to better use of all resources, personnel, financial, and social capital. Micro-planning, as a process, should be approached as a mechanism to improve MDA efficiency. The high cost of MDA distribution as well as the high value of the drug, Zithromax®, suggests that it is critical to find ways to improve efficiency within MDA initiatives. Many of the guidelines in following sections strive to achieve better efficiency within health systems in trachoma endemic countries.

SIDEBAR C

Reasons for poor MDA coverage may include:

- Inadequate and ill-functioning ordering and receiving system leading, in particular, to late receipt of the drug(s) and other supplies
- Poor record keeping
- Inadequate community mobilisation
- Insufficient human resources trained and deployed
- Weak leadership of distribution teams
- Inadequate supervision
- Lack of local ownership

Local nurses administer Zithromax in Vietnam.
Photo: International Trachoma Initiative

Suggested guidelines for pre-micro-planning activities

Prior to starting micro-planning there are some key activities that need to be undertaken. Some of these activities will require sufficient time to complete and should be started a few months before micro-planning is started.

Timing of MDA

Start scheduling by identifying the date when the distribution is proposed and then work backward. This includes setting dates for when each activity should be completed (see **Sidebar D**).Some of these activities may actually take place 10-12 months prior to the MDA.

Community leaders and other stakeholders should be contacted to learn when community members will be available; this often depends on seasonal activities, religious observances, holidays, etc. Community leaders can also tell the programme where the best locations are for distribution, and respond to queries from villagers on behalf of the programme. When planning MDA, consider the agricultural calendar, climate, health services available in the area and competing/coinciding health activities in the targeted area, and whether this time period/ calendar repeats each year.

Creating (and updating) community registers

Community registers are a necessary and valuable part of a successful Zithromax® MDA. Creation and use of community registers enable programmes to effectively measure antibiotic (administrative) coverage. At present community registers are paper-based; in the coming years it is likely that many will be electronic, stored on tablets or other devices.

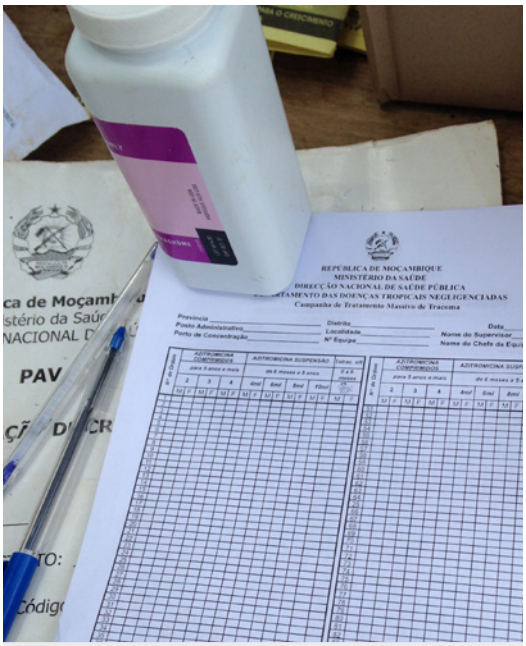
There are a number of templates for community registers (see **Annexes**) all of which share the following characteristics:

- Registers include all residents of eligible communities
- Registers can be updated by adding new residents (births and in-migration)
- Registers can be updated by removing entries (deaths or out-migration)
- Registers include distribution for the entire period (either annually for three years or five years)
- Registers include age and sex for each household member; all are listed under the household head.
- Registers generally cover an administrative unit, however they should not have more than 50 households or they become too bulky

SIDEBAR D

In the pre-planning phase, set dates for:

- Inventory
- Ordering supplies
- Training at various levels
- Distribution of materials
- Community mobilisation
- Deployment of teams



Registers used in MDA of Zithromax in Mozambique. Photo: International Trachoma Initiative

In some settings registers may include MDA for other NTDs in addition to MDA for trachoma.

Creating community registers for a defined area requires a dedicated effort 4-6 months before the start of micro-planning. In most settings, health workers will need to visit the communities to complete the registers. Supervisors should:

- Review community registers soon after completion in order to correct any mistakes in their completion.
- Review all community registers to ensure that no communities are missed accidentally. This has been a particular problem in settings where community-based distributors are used for Zithromax® MDA.
- Collect summary information from the registers in order to calculate the antibiotic needs (for paediatric oral suspension [POS], tablets, and tetracycline 1% eye ointment[TEO]) for the target area. Of note, for many different reasons, findings from registers may not match government census figures. Supervisors need to identify differences and inform national personnel accordingly. It is important that there is agreement, from the national level down to the implementation level, on the denominator used to calculate coverage.

Community registers should be kept near to the community, depending upon the administrative organisation as well as the distribution strategy. They should be protected; ideally, there should be a bag or tote in which they can be kept. Each year, prior to the start of MDA the register should be updated. This can best be done by a health worker most familiar with the community.

Organizing drug movement

Early in the pre-planning process it will be necessary to organize drug movement. Drug movement should be carefully described, starting from central medical stores all of the way to the point in which the distributor is provided with Zithromax®.

Organizing participants

Micro-planning participants should be informed sufficiently in advance (at least one month is suggested) to ensure their participation and to give them sufficient time to review evidence and lessons learned from the previous year (next item). The span of time between micro-planning and training of the supervisors and the teams should be kept to a minimum. Similarly, the span of time between the training and the distribution should be kept at a minimum. Thus, participants at micro-planning also need to be informed of the expected dates for training, distribution of supplies, and other logistic steps.

Using evidence and lessons learned

Planning is always best carried out from a base of information. Key information includes, but is not limited to, population figures, previous coverage figures, studies of coverage and of reasons for poor coverage. The more information people involved in micro-planning have, the better they will be able to problem-solve and design an effective micro-plan. Thus, those responsible for organizing the micro-planning should be able to provide all participants (in advance of the micro-planning session) with evidence and lessons learned (see **Sidebar E**).

Organizing budgets for the micro-planning activities

There will be budgetary implications for conducting the micro-planning as well as for the entire MDA programme. Budget templates have been developed by different organisations to assist with budgeting (see **Sidebar B** on page 6). These should be reviewed by the relevant personnel at least one month in advance to ensure that the budgets developed are in line with government procedures.

SIDEBAR E

Evidence needed for planning:

- Information on coverage from the previous MDA (highlighting both successes and failures and reasons)
- Information on impact assessments, coverage surveys, or other findings relevant to Zithromax® MDA
- Information on community registers (updated figures with particular comment on any substantial changes)
- Information on national level changes to the MDA programme (and implications for micro-planning)
- Information on any changes to other service delivery (e.g., where to refer patients with trichiasis or vision problems)
- Information on the cost (per person receiving treatment) from the previous MDA

Ethiopian girl being measured on the Zithromax dosing stick.
Photo: International Trachoma Initiative

Suggested guidelines for the micro-planning workshop/meeting

The actual micro-planning workshop/meeting for a district can be conducted in one to two days, based upon the size of the programme, the maturity of the programme (new programmes generally need a bit more time), and whether there have been substantial changes to the strategies involved. An agenda is given in the annex; this can be modified based upon the local context.

Setting timetables for specific tasks

During district micro-planning the team should consider how many sub-districts can be covered simultaneously with MDA. The number of sub-districts planned for MDA will dictate the number of supervisors and team members required. Simultaneous MDAs can save time; however, tackling a large area at one time brings logistic challenges. During the micro-planning session, specific dates need to be agreed upon, including:

- Training of supervisors and team members (distributor, registrar, height/dose calculator)
- Distribution periods for all areas in the district
- Dates and locations of supervisory visits
- Date for collection of unused drugs and distribution supplies
- Date for the post-MDA review meeting
- Date for reporting (to the national programme, local health authorities, stakeholders, and communities)

Planning for training

Training of supervisors and training of distribution teams need to be carried out every year, even if the personnel involved have not changed. MDA is only done once a year; it is human nature for people to forget. Just as important, teams need to be informed of performance from the previous year. In settings with poor performance (less than 80% antibiotic coverage) it is critical to review performance and to ensure that any lessons learned in the previous year are incorporated in plans for the next round. In settings with high performance, it is an opportunity to identify the success factors and to congratulate the teams on their good work.

The actual training of supervisors and training of teams is described in a separate document, and not covered in this document. The ideal structure to training takes into consideration specific characteristics of MDA and the trainees (see **Sidebar F**).

SIDEBAR F

Consider the following when designing training:

- Training focuses on ensuring that all participants learn the key skills
- Too much information leads to a failure to prioritize key skills
- Training is cascade in nature; skill sets build on one another
- Monitor the cascade of knowledge and skills at each level of the cascade
- Training is backed up with adequate supervision
- Personal accountability is encouraged
- Teamwork is essential

Planning for the organisation of distribution

There is no single approach to MDA; each country or region in a country will adopt an approach based upon many different factors including the local context, funding available, integration with other PCT MDAs, as well as external factors. Furthermore, in every setting there may be a need to adopt more than one distribution strategy to reach the target population. Ideally, these decisions are based upon evidence and lessons learned from previous MDA activities. Personnel are strongly encouraged to learn "what works and what doesn't work" and communicate ideas up and down the supervisory chain.

Problem solving

As indicated in **Sidebar C** on page 7, there can be many reasons for poor antibiotic coverage in a district. These need to be investigated. It is impossible to fix problems if they are not recognized and investigated. Helping supervisors become problem-solvers can be assisted by reviewing, individually and as a group, case studies. Time should be allocated at each micro-planning session to review specific problems that have been noted. The supervisors should lead this discussion, ensuring that all participants contribute ideas and solutions. This will help all participants to "own" the problem. By coming up with one or more solutions to the problem as a group it is more likely that the solutions will be implemented—this engenders accountability to the programme as well as to the population being served.

Preventing, managing, and reporting Severe Adverse Events

Severe Adverse Events (SAEs) are those that result in death, hospitalization, disablement, or a congenital defect. Zithromax® is an extremely safe drug, used routinely for infants and pregnant women, in addition to all other age groups, in the United States and Europe. SAEs have occurred with donated drugs because of choking, roughly forcing children to take the drug, or pre-existing medical conditions. SAEs as a result of choking and rough handling can be prevented by clear training.

Mass drug administration (MDA) can be a stressful experience, particularly if the administration environment is poorly managed. Young children who become the centre of attention when given their drug may panic. If they are forced to take the drug by holding the nose and squeezing the cheeks, they can choke as a result. Further, if they fail to swallow the drug and are shaken, or generally handled roughly, severe or life-threatening injury may occur. During training, teams should understand the importance of managing the distribution site in an ordered and calm fashion. Additionally, for young children, medicines should be given to the caretaker who then gives it to the child, so that the child feels that they are in control of taking it. If the child is reluctant to take the medicine, the child and caretaker should go to a quiet, nearby area to take the medicine. If a child refuses to take the drug, they should NEVER be forced to take it.

Management of people who may have experienced an SAE related to the MDA will be shaped by the context in which the MDA is taking place. During MDA micro-planning, a reporting procedure from the field to the national level should be developed and shared so that the national programme coordinator is aware of any developing situation.

In the rare instances that SAEs occur, it is vitally important to report the incident to Pfizer. The purpose of the report is not to apportion blame or judge a programme, but to determine why the SAE occurred. This is important in case MDA needs to be halted. The contact details for Pfizer Safety are renewed every year and included in the country Memorandum of Understanding (MOU) with ITI. It is advisable for national programmes to review this information during MDA micro-planning and to put in place a reporting system for every distribution team.

Setting coverage targets

The micro-plan should be based on treating the entire population; coverage rates of less than 80% are not acceptable (other NTDs have different treatment and coverage protocols). Supervisors need to explain how coverage estimates will be calculated—simply put, coverage is defined as the number of people treated (with either Zithromax® or tetracycline eye ointment) divided by the total number of residents. During the micro-planning session it will be important to discuss coverage targets, and the accountability that MDA participants have toward meeting targets. Care should be taken to balance the creation of targets against the possibility of cheating. For example, cheating can occur when distribution was reported but did not take place. Accountability requires a sufficiently robust supervisory system to ensure that reporting back truly reflects progress in the field.

Planning for supervision

Supportive supervision is the driver for success. Without robust supervision, there is a high likelihood that problems will occur; when they do occur, there is a high likelihood that they will not be addressed. Excellent supervision is critical to the sustainability and effectiveness of the programme. Supervision cannot be over-emphasized and is the topic of a companion manual. During the micro-planning session, the supervision of the teams, recognition and management of severe adverse events, and of reporting needs to be clearly outlined (see **Sidebar G**). Before participants at the micro-planning session leave for the field, the supervisory plan should be documented, reviewed, and clearly understood.

Planning for reporting

It is advisable to assess coverage during the MDA to ensure that distribution teams are doing their job: distributing the drug to the appropriate group and reaching everyone who is currently residing in the area. Frequent reporting is more likely to identify problems early and the capacity to address them before the MDA ends. The reporting schedule should be outlined during the micro-planning workshop. A timetable for field supervisors to review with the coordinator, either in person or through mobile phones, should be established. Ideally, there should be some pre-set "triggers" for action. For example, if reports from the first few days of MDA indicate low coverage figures in a wide number of areas, the coordinator may consider immediate intervention.

There are different approaches to reporting; in some settings, daily remaining drug stocks are recorded. In some settings daily coverage figures are reported. Approaches to reporting will have to fit the context in which MDA is being undertaken. Nevertheless, the longer the delay between the start of MDA and receipt of a report, the greater the likelihood of not recognizing problems or addressing them.

SIDEBAR G

Robust supervision should have the following characteristics:

- It is supportive and meant to help teams meet the coverage targets primarily by problem-solving
- All team members should know who their supervisor is and what is expected from the supervisor; as well, the supervisor should know the names of all of the team members he or she is supervising and what the team members expect
- The supervisor should view him/her self as a part of the team
- Supervisors should be mobile, both in terms of transport and in terms of communication
- Team members should feel comfortable to ask the supervisor any question or to address any problem
- Supervisors need to be pro-active, constantly looking for problems
- Supervisors should be ready to give praise to teams; even when things are going wrong, there are aspects of the team work that needs praise
- Daily communication with all teams should enable the supervisor to identify potential problems and address them in a timely fashion

MDA of Zithromax in Vietnam.
Photo: International Trachoma Initiative

Suggested guidelines for the post MDA review meeting

There is a direct link between the post MDA review meeting and the micro-planning meeting.

The post MDA review meeting has a number of objectives, all of which are important (see **Sidebar H**). First and foremost, this is an opportunity to provide feedback to teams, allowing well-performing teams to be rewarded and teams who need additional guidance and/or support to be identified. An agenda for the post MDA review meeting is given in Annex B; this should be modified for the local context.

The post MDA review meeting should also ensure that community registers and log books and MDA supplies (dose sticks, etc.) are well-organized and stored for the following year. Remaining drug supplies also must be collected.

The results, lessons learned, recommendations and the minutes of post-MDA review meeting should be widely communicated with and distributed among all relevant stakeholders within two weeks after the post MDA review meeting.

SIDEBAR H

Objectives of a post MDA review meeting include:

- Provide feedback to teams (progress to targets, problems identified, etc.)
- Discuss specific lessons learned
- Make recommendations for the following year's MDA campaign
- Discuss and plan any impact surveys (if indicated)
- Discuss and plan coverage surveys (if indicated)
- Highlight parts of the micro-plan that need to be improved next year
- Discuss how to improve supportive supervision

Annex A: Proposed agenda for micro-planning meeting

Topics of Discussion	Time	Presenter/Facilitator
Day 1		
Introduction/Climate Setting/Participant expectations	09:00-09:15	
Micro-planning Objectives; Expected Outputs & Leveling of Expectations	09:15-09:45	
Overview of trachoma, SAFE strategy, active trachoma in area undergoing MDA	09:45-10:30	
Tea break	10:30-10:45	
Key factors associated with a successful MDA	10:45-11:15	
Micro-planning tools (for planning, finances, etc.)	11:30-12:00	
Severe adverse events: prevention, management & reporting	12:00-12:30	
Lunch break	12:30-13:30	
Review of previous MDA (coverage, coverage surveys, reasons for poor coverage, etc.) and discussion	13:30-14:30	
Review of supply chain management issues	14:30-15:00	
Review of community registers	15:00-15:30	
Tea break	15:30-15:45	
Scheduling of MDA (personnel, time, areas covered, supervision, etc.)	15:45-17:00	
Day 2		
Planning for training	09:00-09:30	
Review of the organisation of drug delivery (discussion of challenges, revisions, etc.)	09:30-10:30	
Tea break	10:30-10:45	
Setting targets for distributors & supervisors	10:45-11:15	
Supervision activities and reporting by supervisors	11:15-11:45	
Steps to be taken if coverage is <80% (discussion and agreement)	11:45-12:30	
Lunch break	12:30-13:30	
Conclusion and remaining issues	13:30-14:00	

Annex B: Proposed agenda for post MDA programme review meeting

Topics of Discussion	Time	Presenter/Facilitator
Day 1		
Introduction/climate setting/participant expectations*	09:00-09:15	
Review meeting objectives and expected outputs	09:15-09:30	
Brainstorm: what went well, what did not go well during MDA (including training, distribution, supervision, recording and reporting)	09:30-10:00	
Review of coverage findings from MDA: acknowledge/reward successful teams (if needed: discuss steps to address low coverage)	10:00-10:30	
Tea break	10:30-10:45	
[if relevant] Discussion of coverage surveys, impact assessments	10:45-11:15	
Recommendations for MDA in next year and closing	11:30-12:30	
Lunch break	12:30-13:30	

Trachoma Contral Programme: Census and Antibiotics Mass Treatment Form

Page No ____

Sub-District_____ Village _____ Sub-village _____ House No_____

Census date _____

Enumerator _____ Date of 1st round treatment ____/____/____

Signature _____ Date of 2nd round treatment ____/____/____

Supervisor (enumeration) _____ Date of 3rd round treatment ____/____/____

Signature _____

Sr. No.	Full Name	Sex	Age	Relationship	Died or Moved out	Treatment type and quantity by round of treatment									Other
						First round			Second round			Third round			
						Zx tablet	Zx POS	TEO	Zx tablet	Zx POS	TEO	Zx tablet	Zx POS	TEO	

1st round

1. Person who filled treatments _____
   Signature _____
2. Dispenser _____
   Signature _____
3. Supervisor _____
   Signature _____

2nd round

1. Person who filled treatments _____
   Signature _____
2. Dispenser _____
   Signature _____
3. Supervisor _____
   Signature _____

3rd round

1. Person who filled treatments _____
   Signature _____
2. Dispenser _____
   Signature _____
3. Supervisor _____
   Signature _____

International Coalition for Trachoma Control (ICTC)

OUR VISION:
The global elimination of trachoma as a public health problem by 2020.

OUR MISSION:
To act as a catalyst for the comprehensive implementation of the SAFE strategy at scale in support of trachoma elimination programmes in endemic countries.

ICTC has a highly committed and professional multi-stakeholder membership, including non-governmental, donor, private sector and academic organisations working together to support the Alliance for the Global Elimination of Trachoma by 2020.

ICTC members at time of publication:

ICTC observers at time of publication:

ICTC International Coalition for Trachoma Control

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