MDA PREFERRED PRACTICES

MASS DRUG ADMINISTRATION (MDA) / NEGLECTED TROPICAL DISEASES

Objective: To provide an evidence-based practical guide for an effective mass drug administration program. Not all of these recommendations need to be followed all of the time. In easier-to-treat populations, a simpler program will attain the coverage necessary. However, where populations are especially hard to reach, where coverage has been low or where baseline prevalence is high, then efforts should be made to include as many of these practices as is feasible. This list was developed based on a review of literature that associated specific practices with positive or negative MDA outcomes and reviewed by experts.

DRUG DISTRIBUTION PLATFORMS

- ☐ Identify the target populations (e.g. farmers, fishermen, factory workers, refugees, migrants, urban slum dwellers, school-aged children in schools, school-aged children out of school) in the targeted IU and decide on the best platform to reach them. Be prepared to re-evaluate this decision. Platforms commonly used include:
  - House-to-house.
  - Fixed point.
  - School-based.
  - Work-based.
  - A mix of the above.

SELECTION AND RETENTION OF DRUG DISTRIBUTORS AND OF SUPERVISORS

- ☐ Have written roles and responsibilities for drug distributors and for each level of supervision.
- ☐ Intentionally build trust between community members and the drug distributor.
  - Select drug distributors that are known and respected by the community either because of their position (e.g. health worker, leader, teacher) or because they live in the area where they are distributing drugs.
  - When selecting supervisors put increased emphasis on their being known and respected and on having experience with similar activities.
  - Provide drug distributors with identity cards and/or t- shirts.
- ☐ Consider the optimal number of drug distributors to the target population.
- ☐ Have a small (at least 1:10) ratio of drug distributors to first level supervisors (first level supervisors may also be community volunteers).
- ☐ Consider how to incentivize drug distributors to encourage high performance and low turn-over.

SUPERVISION AND MONITORING

- ☐ Implement directly observed treatment and enforce this policy through communication, training, supervision, and evaluation.
- ☐ Have supervisors use supervision monitoring form.
- ☐ Have supervisors hold during- and post-MDA review meetings at the community level to assess what is working well and to problem solve.
- ☐ Have supervisors review daily data on persons treated and assess against targets, extending the length of MDA and adding mop-up activities as necessary.
- ☐ Use recommended formats of drug registers or tally sheets, tested at the local level. Ensure that registers are updated before the MDA.
- ☐ Ensure that program supplies, log books, and registers are stored properly for future access after conducting post-review meetings.

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TRAINING OF DISTRIBUTORS

- ☐ Normally about two days training for first-time drug distributors with annual one-day refresher trainings is needed.
- ☐ Key topics to address during training include:
  - Participation expectations and objectives.
  - Information on the disease(s) - but not too much.
  - Information on the drug to be administered.
  - Determining appropriate dosages.
  - Reporting requirements and use of forms.
  - Simulation/ role play of treatment and communication.
  - How to respond to real or perceived side effects.
- ☐ Test ability of drug distributors and supervisors to perform critical functions in their roles before end of training, address deficiencies when apparent.
- ☐ In larger countries, cascade training is required. Note that care should be taken to avoid the dilution of content effect often found in training. For the sake of quality assurance, consider:
  - Providing training aides and a manual.
  - Providing standard post-training tests.
  - Reducing the number of levels of trainers and/ or have overlap between levels of persons being trained and performing the training (e.g. national level trains regional level; teams with a national and a regional level person in each train district level, etc.).

SOCIAL MOBILIZATION STRATEGIES

- ☐ Determine the best time of day, week, and year to reach the different target groups. Consider: Religious observances, Seasonal activity, Climate, Agricultural habit, Existing health programs, Holidays.
- ☐ Determine the length of the MDA considering recommendations of community leaders and based on average number of persons 1 distributor can treat in a day.
- ☐ Base communications strategy on information collected by population surveys, or from tried and tested practices, or based on other public health programs reaching similar populations with similar interventions.
- ☐ Branding through measures such as drug distributors and supervisors wearing boldly colored T-shirts to create a strong visual impact in the community during MDA campaigns. T shirts also serve as a form of identification, facilitating trust in the drug distributor.
- ☐ Provide drug distributors with a one-page job aid exhibiting photos of persons with the disease(s), to be used as a visual aid when discussing drug distribution with the community.
- ☐ Involve community leaders in planning the MDA and ensure local authority approval .
- ☐ Identify individuals with NTDs in the community and involve in the campaign if they are willing.

DRUG SUPPLY MANAGEMENT

- ☐ Have clear documentation of drug movement from suppliers to patient administration.
- ☐ Maintain a buffer stock of supplies at each level.
- ☐ Have clear information on what to do in the event of a stock-out.
- ☐ Conduct inventory of remaining drug supplies on a weekly basis.

ADDRESSING SIDE EFFECTS

- ☐ Train drug distributors on potential side effects, both minor and severe.
- ☐ Address side effects in key communication messages.
- ☐ Maintain a system for handling reports of severe side effects in the event of their presentation.

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