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ORGANISATION MONDIALE DE LA SANTE

REGIONAL OFFICE FOR THE WESTERN PACIFIC
BUREAU REGIONAL DU PACIFIQUE OCCIDENTAL

DRAFT EXECUTIVE SUMMARY

Subject	:	Lymphatic Filariasis Elimination Program
Place(s) visited	:	Samoa
Dates of mission	:	3 to 7 April 2008
Author(s) and designation	:	Dr Corinne CAPUANO, WHO Medical Officer
Name of focus	:	MVP
Participating agencies	:	WHO
Source of funds	:	

Please find attached the draft executive summary of the above report. Please note that this has not yet been edited or fully cleared by the Regional Office. The full report will be sent to you in due course.

WORLD HEALTH ORGANIZATION
REGIONAL OFFICE FOR THE WESTERN PACIFIC

MISSION REPORT EXECUTIVE SUMMARY

Dr Corinne M. Capuano	Samoa	3 - 7 April 2008
Author(s)	Place(s) visited	Dates of mission
Report series number	Project identifier	Activity code

Objectives of mission:

In collaboration with the Ministry of Health and a COMBI expert: to provide support for the development of a "Communication for Behavioural Impact" (COMBI) plan for the Program to Eliminate Lymphatic Filariasis.

Summary of activities, findings, conclusions and recommendations:

The writer worked with a COMBI expert from WHO/HQ Mrs Asiya Odugleh-Kolev. They met with the Assistant CEO of Health, the coordinator of the LF program and the LF/MDA committee. They conducted individual interviews with young males, village mayors, household members in one low compliance/high prevalence area and one high compliance/low prevalence area. They also conducted interviews with women's representatives who were involved in tablets distribution during the previous MDA. These activities were conducted with the LF coordinator from the MOH, the WHO SSA in charge of the LF program, two staff from the MOH, one of them trained in COMBI in Fiji in 2007 but who never had an opportunity to practice and use her COMBI skills. Therefore this visit was used as an on-the-spot training on interviews and on how to gather information to develop a communication plan. Youth interviews were carried out using Top-Of-the-Mind-Analysis (TOMA) and Day-In-the-Life-Of (DILO) questionnaires and opened questions with key informants.
On Saturday evening the data collected were entered into an Excel database, analysed and discussed by the MOH/WHO team. A powerpoint presentation highlighting the main findings and recommendations was prepared and presented to the ACEO on Sunday afternoon. A discussion followed the presentation on communication strategies needed in order to improve MDA coverage and reach the target of at least 85% of the general population ingesting the drugs. This plan (slides 25 to 33 of the power point presentation) will need to be further fed and developed by the MOH team based on additional interviews to be conducted in urban areas in particular.

CONCLUSIONS

Despite a low MDA coverage (below 70%) for three out of six rounds the MDA carried out since 1999 have effectively reduced antigenemia and microfilaremia prevalence to low levels. However, the target of below 1% antigenemia prevalence has not been reached and the increase of the ICT and Mf prevalence between 2004 and 2007 is a concern even if the methods used for the sampling method are not exactly the same. The fact that during the 2007 survey LF antigen and Mf has been detected in children indicating that transmission has occurred in the past five years is also of concern.
Additional rounds of "improved Mass Drug Administration" will be needed starting 2008. In order to achieve a coverage of at least 85% of the total population ingesting the drugs during the next rounds of MDA a number of activities focusing on new distribution and communication strategies will be needed as per the plan discussed with the MOH on the last day of this mission. It will be of tremendous importance to get a strong social mobilisation based on the communication plans and activities developed during this mission. Specific messages will need to be developed to reach each of the target audience identified: young males, elderly, female and usually compliant people, etc

RECOMMENDATIONS

1) A minimum of two additional rounds of "improved MDA" should be implemented starting in 2008 with a targeted coverage of at least 85% of the general population AND at least 85% of the male group. The distribution strategy should be a directly observed treatment. A special attention should be paid to the previously "too old" and "too sick" categories and a specific strategy developed for this particular group.
2) The strong leadership and new directions taken by the Ministry of Health demonstrate a high commitment and all efforts should be made to support the new strategy and the focused distribution in three days. The important shift from a long timeframe to a short time frame distribution, from a passive attitude to an active behaviour from the communities, from a non DOT to a DOT strategy will need a well organiosed and comprehensive communication plan.
3) The breakdown of the budget needed for this MDA should be urgently finalised to approach donors and partners.
4) The communication strategy discussed during this mission and presented to the MOH on the last day of this visit (attached powerpoint presentation) should be further developed and implemented. It will be of tremendous importance to mobilise and get strong support from all sectors, leaders and media if the target is going to be met.

Key words : Samoa, LF elimination program, mass drug administration, prevalence surveys

1. PURPOSE OF MISSION

The writer visited Samoa from 3 to 7 April 2008 with the following term of reference:

In collaboration with the Ministry of Health and a COMBI expert:

(1) to provide support for the development of a "Communication for Behavioural Impact" (COMBI) plan for the Program to Eliminate Lymphatic Filariasis.

2. BACKGROUND

The lymphatic filariasis parasite in Samoa is diurnally subperiodic *Wuchereria bancrofti*. The main vector is *Aedes polynesiensis* which has a daytime activity pattern and a flight range of about 100 meters.

Cases of elephantiasis have been recorded in Samoa as early as 1878. Since then, Samoa has had a long history of activities to control filariasis. Eight Mass Drug Administration (MDA) with diethylcarbamazine (DEC) were implemented between 1965 and 1995 and led to significant declines in the prevalence of microfilaremia, from 20% or 30% in the original surveys done in the 1940's to levels as low as 2%. In 1973 microfilaria prevalence has even dropped to 0.2 %, far below the level of 1% which is thought to represent the threshold for interrupting transmission. However resurgence occurred as soon as the drug pressure was released. This particular situation, similar to the one observed in other countries like American Samoa and French Polynesia is believed to be the result of the efficiency of the vector *Aedes polynesiensis.* In order to successfully interrupt transmission and due to the above specificities it is likely that the LF control programs in Samoa will need, first to achieve greater reductions in infection prevalence than would be necessary in other areas having an *Anopheles* or *Culex* vector, and then to implement for a period of at least 5 or 6 years an active surveillance system that will detect any remaining or any new foci of transmission.

In 1999, Samoa began a series of yearly MDAs for five years. Round five took place in 2003. Drug distribution was carried out by village women's committees with supervision provided by the Ministry of Health. Reported coverage ranged from 56.8% to 90.5%. However as the treatment was not always directly observed the true level of compliance is not known. Several surveys were conducted between 1999 and 2003, showing an apparent decline in prevalence from 8.1% to 1.6%. However, the sampling methodology used was by convenience and the number of villages surveyed limited, making the results difficult to compare.

In 2004 a post MDA survey was implemented using a stratified cluster sampling method. A total of 12,719 persons were tested in 16 health districts; 144 persons were ICT positive (1.13% antigenemia prevalence) and 55 persons were microfilaria-positive (0.43% Mf prevalence). Seven districts had above 1% antigenemia prevalence and 75% of the positives were adult males. Mf prevalence was 2.1% among men 31 to 40 years.

No MDA was carried out in 2004 and 2005 but a sixth round was implemented in 2006. Reported coverage was 82% overall, but there is no indication that any special effort was made

to enforce a directly observed treatment strategy and to target males to encourage their participation in MDA.

A second and straight forward post MDA survey was carried out in 2007 to assess the situation and to guide future decision. A stratified cluster sampling method was used, based on the level of endemicity as found during the 2004 survey. A total sample of 6448 people were tested by ICT, 169 were found antigenemia positives (2.6%) and 39 (0.6%) microfilaremia positives. As in 2004, 72% of the antigenemia positives and 80% of the microfilaremia positives were males.

Based on these results it is anticipated that more rounds of Mass Drug Administration will be needed if the target is to be met. The MOH has already planned to implement a seventh round of national MDA in June 2008. However "improved MDA" will be needed, using a new strategy based on a much higher involvement of the communities and groups of population or geographical areas with a usually low compliance. The need for a strong and comprehensive social mobilization has been underestimated at the regional level since the beginning of the program and it is now felt that without a Communication Plan that will impact on the behaviour of the low compliant groups the target is not going to be reached.

The purpose of this mission was therefore to work in conjunction with a COMBI expert from WHO/HQ in order to develop a communication plan for the Lymphatic Filariasis Elimination program in Samoa with a specific focus on Mass Drug Administration.

3. ACTIVITIES AND FINDINGS

3.1 Activities

The writer worked with a COMBI expert from WHO/HQ Mrs Asiya Odugleh-Kolev. They met with the Assistant CEO of Health, the coordinator of the LF program and the LF/MDA committee. They conducted individual interviews with young males, village mayors, household members in one low compliance/high prevalence area (Falefa) and one high compliance/low prevalence area (Tuanai). They also conducted interviews with women's representatives who were involved in tablets distribution during the previous MDA.

These activities were all conducted with the LF coordinator from the MOH, the WHO SSA in charge of the LF program, two staff from the MOH, one of them trained in COMBI in Fiji in 2007 but who never had an opportunity to practice and use her COMBI skills. Therefore this visit was used as an on-the-spot training on interviews and on how to gather information to develop a communication plan. Youth interviews were carried out using Top-Of-the-Mind-Analysis (TOMA) and Day-In-the-Life-Of (DILO) questionnaires (Annexes 1, 2, 3) and opened questions with key informants.

On Saturday evening the data collected were entered into an Excel database, analysed and discussed by the MOH/WHO team. A powerpoint presentation (Annex 4) highlighting the main findings and recommendations was prepared and presented to the ACEO on Sunday afternoon, before the departure of the writer and Ms. Odugleh-Kolev. A discussion followed the presentation on communication strategies needed in order to improve MDA coverage and reach the target of at least 85% of the general population ingesting the drugs. This plan (slides 25 to 33 of the power point presentation) will need to be further fed and developed by the MOH team based on additional interviews to be conducted in urban areas in particular.

3.2 Findings on progress of the lymphatic filariasis elimination programme

MDA distribution, coverage and compliance

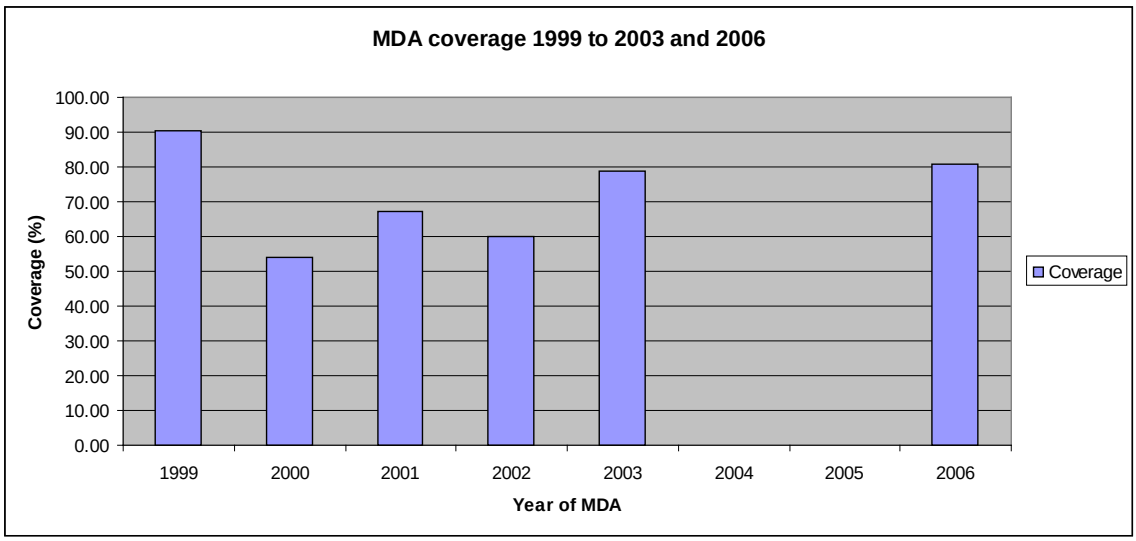
The first MDA using a combination of DEC and Albendazole took place in 1999. The following rounds took place every year until 2003, which was the year of the fifth round. An additional round took place in 2006 following the results of the post MDA survey. The coverage, as reported by the country, ranges from 56.8% to 90.50%. Using yearly population estimates from SPC the writer further calculated the reported coverage for each MDA round. They are shown in Table 1.

Table 1: Reported and corrected coverage during the 6 MDAs using DEC and ALB.

Year/round No	Reported treated population*	Reported coverage (Treated)*	Population estimates (SPC)	**Corrected coverage (estimated population)**
1999 / MDA 1	145,952	90.5	161,298	90.50
2000 / MDA 2	91,613	56.8	169,200	54.10
2001/ MDA 3	119,100	68.4	176,710	67.40
2002 / MDA 4	106,561	60.3	177,800	59.90
2003 / MDA 5	140,855	79.7	178,800	78.80
2006 / MDA 6	144,449	82.0	179,186	80.60
Average coverage 1999 to 2006 = 71.90%				

**Source: Annual reports.*

Figure 1: MDA coverage from 1999 to 2006



The important drop in the coverage between the first and second MDA is reported to be the result of a PacELF recommendation to focus on areas with high prevalence only.

Over the years the same method of distribution was always used. The women's groups at village level were in charge of the door to door distribution with support from the village mayor. During the interviews it was found that the support by the mayors was not homogenous. In Tuanai the mayor was reported to be very active, especially in dealing with the non compliant families while in Falefa the mayor was not involved. The reason provided was that he was the brother of the women's representative and felt that his sister could handle the whole exercise by her own.

The women's representative and the mayor selected the drug distributors and the timeframe for distribution. The two villages visited were about the same size (around 1300 people). Officially the last two campaigns took place over a period of three months. However during the 2003 and 2006 campaigns in Falefa eight teams of two distributors completed the distribution in four weeks while in Tuanai four teams of two people completed the distribution in three days. The distribution was done after working hours and during weekends. One of the main difficulties encountered was that a number of people were not home during the time of distribution and the tablets were left with relatives. Also, in a number of instances the distributors were requested to let the tablets for a later ingestion by the household members. The distributors believe that most of these people did not actually swallow the drugs and used this as an excuse to not upset them. A raw estimate by one of the women's representative is that about 25% of the population in her village did not ingest the drugs in front of her. The household members interviewed confirmed this situation and one of the reasons for not taking the drugs was that there was a belief that it could not be taken with the local beer. The other reason was the side effects (mainly dizziness) and the fact that the distributors did not go to the inland areas, more difficult to reach.

A complain commonly raised during the interviews with the mayors and distributors is the absence of any incentives taking into account the amount of efforts needed and the fact that distribution took place during time normally spent with families. It was identified as the main reason for the lack of follow up and non enforcement of DOT. The women's representatives suggested that an amount of 10 tala ($US 5) per person for the whole campaign would be a reasonable incentive.

In 2003 the drugs were sent by the MOH to the nurses at health centre level, who were supposed to forward the drugs to the women's group. However due to a number of shortages of drugs and lack of registration books in 2003, it was decided that all drugs and books would be sent directly to the village level for the 2006 campaign. This was seen as a relative disengagement of the MOH between 2003 and 2006.

We found that there was a number of misconception and misinformation among the youth and other people interviewed. The drugs are seen as prevention against the disease and not as a treatment. There was no link made with the effect on intestinal worms. It was also interesting to note that the youth who were found positive in 2007 thought that their body was strong enough to kill the worms and that the consequence of being infected would only be to feel dizzy and get some fever. He did not made any link with elephantiasis or "mu mu tutupa". All the members of this ICT/Mf positive household visited reported that they felt in a better physical condition after taking the drugs for treatment in 2007. The wife of one of the Mf positive males said that he did not take the drugs after 1999 because of the side effects but he was happy after the treatment in 2007 as his symptoms disappeared (chylurie). The reason for him to take the drugs in 2007 is that he was found positive as well as two of his children and he realised that he was the source of the infection for his relatives. This family was found to be now supportive of the program and claimed that they will take the drugs during the next rounds.

Monitoring and evaluation

Since 1999 several surveys were conducted using various methods of selection of households. All ICT positives were tested for circulating microfilaria.

1) Baseline survey, 1999

The first survey under the current program was carried out in 1999 using a convenient sampling method. 7006 people were tested by ICT only and 317 were found positive. The antigenemia prevalence of 4.50% led to the classification of Samoa as an endemic country. No Mf test was done at that time.

2) Post MDA 1 spot checks survey, 2000

In 2000 a sites survey was carried out in 3 villages: Matetufu, Lepale and Apai. Out of 676 people tested using a convenient sampling method and 55 ICT were positive, and 7 were microfilaremia positive. The antigenemia prevalence was 8.10% and the Mf rate was 1.0%.

3) Post MDA 2, spot checks survey, 2001

In 2001 a second site survey was carried out in another 4 villages: Aele Fu, Satuiatu, Vailuutai and Faleu Manonotai. Out of 1392 people tested using a convenient sampling method 67 were ICT positive, and 10 were microfilaremia positive. The antigenemia prevalence was 4.80% and the Mf rate 0.70%.

4) Post MDA 3, sites surveys, 2002

In 2002 a third site survey was carried out in a mix of previously and non-previously surveyed sites. 10 villages were conveniently selected. Out of 2141 people tested for ICT 96 were found positive (4.50 % prevalence) and 2265 were 6 Mf positive (0.26% prevalence).

5) Post MDA 4, sites surveys, 2003

In 2003 a fourth site survey was carried out in six villages, five of which had been surveyed in 2002. Out of 881 people tested 14 were ICT positive (1.60 % prevalence) and 6 Mf positive (0.7% prevalence).

6) Post MDA 5, national prevalence survey, 2004

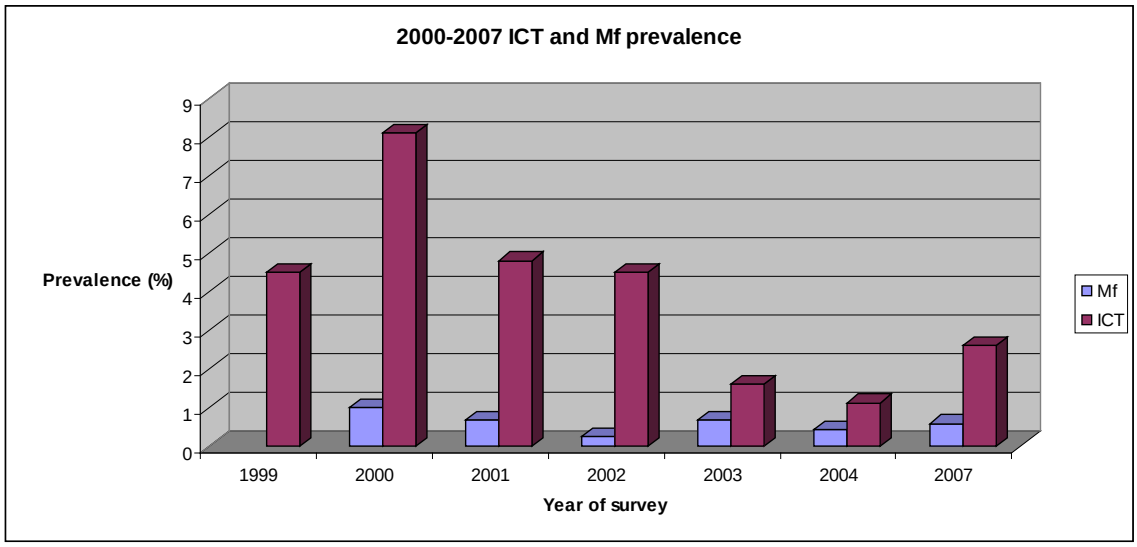
In 2004 a post MDA survey was implemented using a stratified cluster sampling method. A total of 12,719 persons were tested in 16 health districts; 144 persons were ICT positive (1.13% antigenemia prevalence) and 55 persons were Mf positive (0.43% Mf prevalence). Seven districts had above 1% antigenemia prevalence and 75% of the positives were adult males. Mf prevalence was 2.1% among men 31 to 40 years.

7) Post MDA 6, second national prevalence survey, 2007

A second and straight forward post MDA survey was carried out in 2007 to assess the situation after the sixth round of MDA and to guide future decision. A stratified cluster sampling method was used, based on the level of endemicity found during the 2004 survey. A total sample of 6448 people were tested by ICT, 169 were found antigenemia positives (2.6%) and 39 (0.6%) microfilaremia positives. As in 2004, 72% of the antigenemia positives and 80% of the microfilaremia positives were males. 13 children aged 5 to 10 years were found ICT positive and 2 were Mf positives indicating that transmission has occurred in the past 5 to 10 years.

All ICT and/or Mf positives were treated with a 12 day course of DEC. No further testing has been carried out on these positives since then.

Figure 2: ICT and Mf prevalence in four sentinel sites from 1999 to 2007



Characteristics of the population not taking drugs in 2001 (MDA 3) and 2006 (MDA 6)

A comparison of the reason for not taking drugs in 2001 and 2006 (Annex 5) show an important increase of the proportion of "too old" (from 3% to 12%), "pregnant" (from 9 to 15%) "too sick" (from 4 to 7%), and from the "away category (from 23 to 28%). There is no clear explanation for these changes. It could be assumed that some people have misunderstood the "too old" or "too sick" categories or that some people have used this as excuses for not taking the drugs. However 28% of the people who did not take the drugs in 2006 were between 15 and 39 years so it is unlikely that there were really sick or considered as old. Further analysis should be carried out on the 2006 coverage to get a better understanding of the low complain categories.

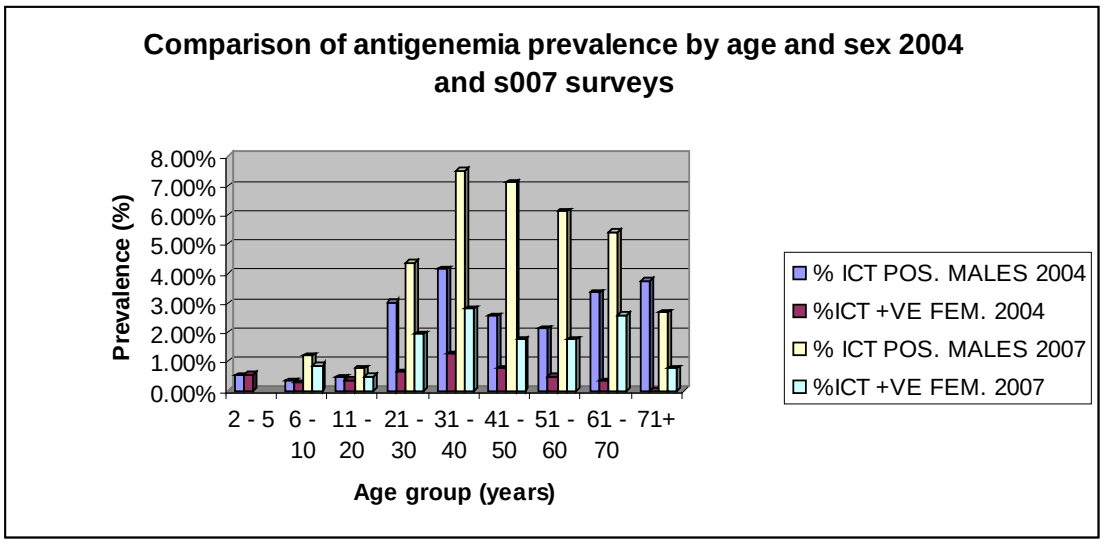
Characteristics of the positives from 2004 and 2007 surveys

Data from the 2004 and 2007 surveys indicate that LF continues to be a potential problem, particularly in males. Of antigen-positive persons, 75% were adult males in 2004. Antigen prevalence in males (1.7%) was three-fold higher than in females in 2004. This difference was apparent in adults, but not in children. As a more direct measure of potential transmission, among men aged 31 to 40 years, Mf prevalence was 2.1%. This pattern was confirmed in 2007 with 72% of the antigenemia positives and 79% of the Mf positives being males. As in 2004 the age group with the highest prevalence was the 21 to 50 year old. In 2007 13 children aged 5 to 10 years were found positives and 2 of them were Mf carriers, indicating active transmission in the past few years.

Thus, men represent the most important reservoir of infection.

These data are consistent with the previous conclusion that MDA compliance has been lower among men. However infection prevalence in males was much higher than in females, even prior to the use of DEC. It is therefore difficult to exclude the possibility that this difference may also reflect gender-specific patterns of infection.

Figure 3: antigenemia prevalence by gender in 2004 and in 2007



Preparation for MDA 7 scheduled from 23 to 26 June 2008

Following the results of the 2007 prevalence survey the MOH made a decision to implement another national MDA in 2008 and to change the strategy.

Samoa is made of 3 islands, 330 villages and 13 health districts. There are 13 health managers and six health centres. In 2008 the distribution will be carried out for a period of 3 days only, from Friday to Sunday mobilising the whole health system and about 1000 people for distributions of drugs. All staff will be involved and trained on how to give drugs. Each team will be made of a health staff, and two volunteers from the village: one mayor representative and one women's representative. The health staff will be responsible for the registration books. Each team will be responsible for the distribution of drugs to an average of 500 people. The 13 managers will be crucial points for each cluster. The teams will be stationed in one area for the three days and the distribution will take place from 7 am to 10 pm. Debriefing will be held after each distribution day. Managers will report to the base at central level in Savai and in Upulu and report any need for next day. The current plan is to start the media awareness campaign 9 weeks before the actual beginning of the distribution. A strict directly observed treatment strategy is planned.

4. CONCLUSIONS AND RECOMMENDATIONS

4.1 Conclusions

Despite a low MDA coverage (below 70%) for three out of six rounds the MDA carried out since 1999 have effectively reduced antigenemia and microfilaremia prevalence to low levels.

However, the target of below 1% antigenemia prevalence has not been reached and the increase of the ICT and Mf prevalence between 2004 and 2007 is a concern even if the methods used for the sampling method are not exactly the same. The fact that during the 2007 survey LF antigen and Mf has been detected in children indicating that transmission has occurred in the past five

years is also of concern. Additional rounds of “improved Mass Drug Administration” will be needed starting 2008.

In order to achieve a coverage of at least 85% of the total population ingesting the drugs during the next rounds of MDA a number of activities focusing on new distribution and communication strategies will be needed as per the plan discussed with the MOH on the last day of this mission. It will be of tremendous importance to get a strong social mobilisation based on the communication plans and activities developed during this mission. Specific messages will need to be developed to reach each of the target audience identified: young males, elderly, female and usually compliant people, etc

4.2. Recommendations

1) A minimum of two additional rounds of “improved MDA” should be implemented starting in 2008 with a targeted coverage of at least 85% of the general population AND at least 85% of the male group. The distribution strategy should be a directly observed treatment. A special attention should be paid to the previously “too old” and “too sick” categories and a specific strategy developed for this particular group.

2) The strong leadership and new directions taken by the Ministry of Health demonstrate a high commitment and all efforts should be made to support the new strategy and the focused distribution in three days. The important shift from a long timeframe to a short time frame distribution, from a passive attitude to an active behaviour from the communities, from a non DOT to a DOT strategy will need a well organiosed and comprehensive communication plan.

3) The breakdown of the budget needed for this MDA should be urgently finalised to approach donors and partners.

4) The communication strategy discussed during this mission and presented to the MOH on the last day of this visit (attached powerpoint presentation) should be further developed and implemented. It will be of tremendous importance to mobilise and get strong support from all sectors, leaders and media if the target is going to be met.

5. ACKNOWLEDGEMENTS

The writer would like to thank the ACEO of health, the coordinator of the LF program and his team for their availability including for long working hours during Saturday and Sunday and all the people she met for their kindness and support during her stay.

CONTENTS

ANNEX 1

Determining perceptions through a Top-Of-the-Mind Analysis (TOMA)

Location_____ Age _____

Occupation _____ Gender _____

The Top of the Mind analysis or TOMA allows one to explore people's perceptions of and immediate associations with the outbreak and the outbreak control interventions. It involves a simple exercise of asking individuals to state the first thing that comes to their mind when they hear a particular word or phrase (linked to the behaviour/service being explored), then the second thing that comes to mind, then the third. In this way, after a round of questioning, one acquires a sense of what is at the top of the mind of your beneficiary group. This can be quickly done on the spot as you are carrying out interviews or meeting with individuals. This gives a rapid insight into what people are thinking and feeling about a certain issue and helps you in the development of your behavioural and communication objectives.

Step 1: Identify the purpose of using the tool e.g. one could compare perceptions and associations between different groups on the same topic, for example community members and health workers on "isolation" or "cholera " and so on.

Step 2: Explain the process so people understand what you are trying to do. Try out a few word associations with words not related to the topic you are exploring.

1. Question: What is the first thing that immediately comes to your mind when I say “mu mu”?

_____
_____
_____
_____

2. Question: What is the second thing that comes to mind when I say the word "mu mu"?

_____
_____
_____
_____

3. Question: What is the third thing which comes to mind when I say the word "mu mu"?

_____
_____
_____
_____

Step 3: Interpret the results. Simple software such as excel can be used to generate graphs from the data gathered.

Step 4: Use the data. TOMA can provide useful information for developing messages and interventions. Look for where there is overwhelming consensus or dissention as this will give you clues of areas that need to be further investigated or where current perceptions and associations need to be changed.

ANNEX 2

Date _____

Tablets Association

Determining perceptions through a Top-Of-the-Mind Analysis (TOMA)

Location_____ Age _____

Occupation _____ Gender _____

Marital status single/married_____ Ethnicity Fijian/Indo-Fijian _____

Explain the process so people understand what you are trying to do. Say that you are going to show them an item and want them to tell you the first 3 thoughts or feelings that come into their mind. ***Give them the tablets to hold in their hands.***

1. Question: What is the first thing that immediately comes to your mind when I show you this…. (show tablets)

_____
_____
_____

2. Question: What is the second thing that immediately comes to your mind when you look at the tablets?

_____
_____
_____

3. Question: What is the third thing that immediately comes to your mind when you look at the tablets?

_____
_____
_____

Observations of reactions of interviewee

ANNEX 3

Date _____

Day-in-the-Life-Of (DILO)

A Day-in-the-Life-Of Analysis (DILO) is used to explore the situation and daily context in which risk reduction behaviours are being recommended. A DILO analysis calls for examining the daily activities of those whom we wish to engage. It lists daily activities from the time that people get up to the time they go to sleep. The DILO analysis helps us to identify communication contact points, settings and channels and to locate the suggested behaviour within their daily lives and so understand better the factors which would support or act as barriers to the behaviour being adopted. It helps us answer the questions: How do we reach individuals/families with information? What would be the most appropriate channel or location to provide information? How can we reduce the "cost" of the proposed behaviour if it poses a problem in carrying out daily activities?[1]

Location_____ Age _____

Occupation _____ Gender _____

Sunday

Time of day or segment e.g. morning/afternoon/ evening	Activity	Observations/notes: Ask when reads newspapers, listens to radio, watches television (favourite programmes and channels)
Morning		
Afternoon		
Evening		

Any there any foreseen challenges/difficulties or opportunities in relation to distributing LF prevention pills on Sundays?

_____

_____

_____

[1] For instance, a DILO analysis in one community where you are planning a may reveal that most adults are out of the home for most of the day, working in the fields, and this will raise a variety of strategic questions such as: How do we reach these individuals with information? How can we reduce the 'cost' of the recommended behaviour in terms of making it not too burdensome for them to leave their fields to take the tablets on Filaria Days?

COMBI "Market Research"

Friday 4th & Saturday 5th April 2008

INTERVIEW TEAMS: FEILOAIGA; SELAUPASENE; SIATUA; FUATAI,CORINNE, ASIYA

INTRODUCTION

- The COMBI "market research" was implemented in 2 villages:
    1. Tuanai – low prevalence, high compliance village
    2. Falefa – high prevalence, low compliance villagE

Interviewees included: village mayor; government woman representative; households and men aged between 20 – 50yrs.

INTRODUCTION

- Semi-structured interviews conducted for men using the TOMA & DILO assessment tools, interview duration: 10-15minutes.
- More intense key informant interviews done with Mayor, Women rep. & households: 30min.- 2hrs
- Purpose of interviews:
  1. Young men – to assess their perception of LF / MDA through word & tablet association; to explore events / activities in men daily lives.

INTRODUCTION

2. Key informant interviews focused on perceptions / beliefs on what worked; what did not work; challenges; people behaviors and innovative ideas on how best to approach national MDAs and bests days to implement MDA

- The two groups of interviewees have been compiled, analyzed and put together for this report.

Key informants interviews

- 2 outgoing village mayors
- 1 outgoing women’s representative
- 1 women’s representatives
- 2 households
- 1 household with positives cases in 2007

Key informant interviews

Findings	Implications/ Issues	Recommendations
Limited involvement of MOH	Lack of technical support	Hw to lead the distribution
Leadership of MDA- women's gps & support- village mayors	-The new strategy may threaten the authority of the women's groups in the villages -inconsistency of commitment of village mayors in different villages	Find a role for women's group to retain value of involvement To involve the village mayors in partnership with others e.g. women's groups for the drug distribution in their villages
No uniformity of implementation of DD	Reported coverage higher than actual coverage	Enforce DOTs & ensure proper registration Facilitated by pre-registration

Key informant interviews

Findings	Implications/ Issues	Recommendations
No involvement of churches and schools	Incomplete mobilization of community	Churches and schools to be key advocates and channels of information dissemination to families
Training to hw, village mayors, and women's reps previously focused on technical matters	social communication issues not addressed	Comprehensive training (rationale + technical)
No Incentives	Distributors de-motivated	Consider incentives for support staff. Sponsorships (bed nets, torches, umbrellas, shoes)
Misconception & misinformation	Decrease compliance	Clear com strategy & old age criteria

General recommendations

- Strengthen partnership-working relationship with key stakeholders; MESC, MOF, MWCSD, NHS, police, NGOs, Development Partners (WHO, JICA) Churches etc through active representation as members of the LF National Committee
- Strengthen Commitment at all levels of Govt, community-100% coverage
- Political support endorsed by Prime Minister and Cabinet

Fixed sites (FS)

Pros	Cons	Recommendations
Less work for Drug Distributors	Difficult to motivate people to go to FS	-Incentive for motivation -use authority of community leaders for motivation
	Handicapped people unable to go to FS	Should have a plan in place for Handicapped people
Queries/confusion/misunderstanding cleared on the spot by HW	Concern/fear FS-will reduce coverage	Develop Comprehensive Com plan using these findings
Active participation in MDA by community members/ consumers	Big shift/change from passive HH distribution to active FS participation -fear of change	Develop Comprehensive Com plan using these findings

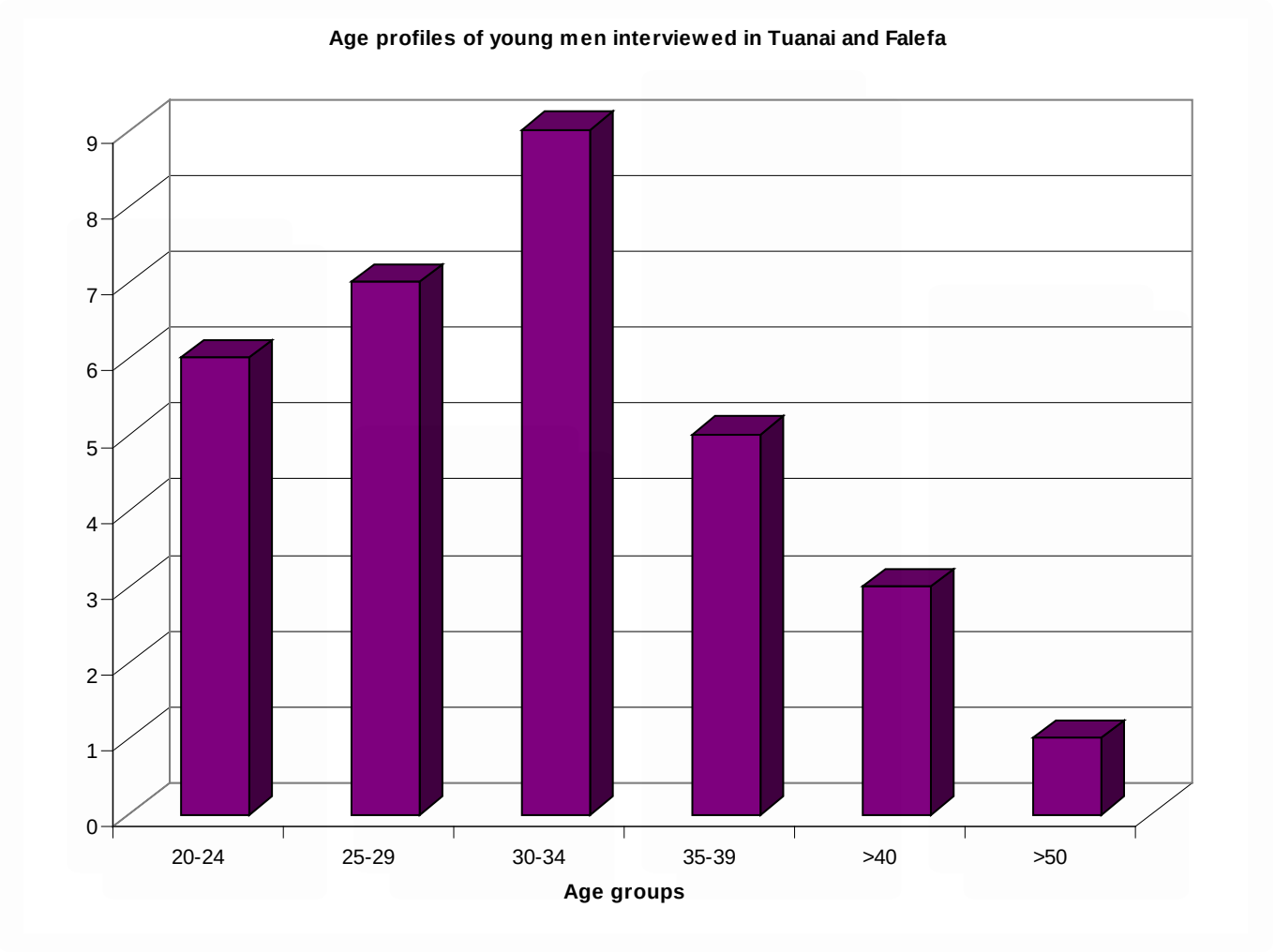
House-to-House (HH)

Pros	Cons	Recommendations
People used to HH approach as well as meeting their expectations	No DOTs for absentees during distribution	Everyone should be DOTed
	Exhaustive work for DD without incentive	Provide incentive/support
	Remote HH hard to access	Provide incentive/support
Benefit people-physically handicapped		
Easier to access most HH members		
	DD didn’t have complete authority & adequate knowledge to do MDA properly	Do HH with HW

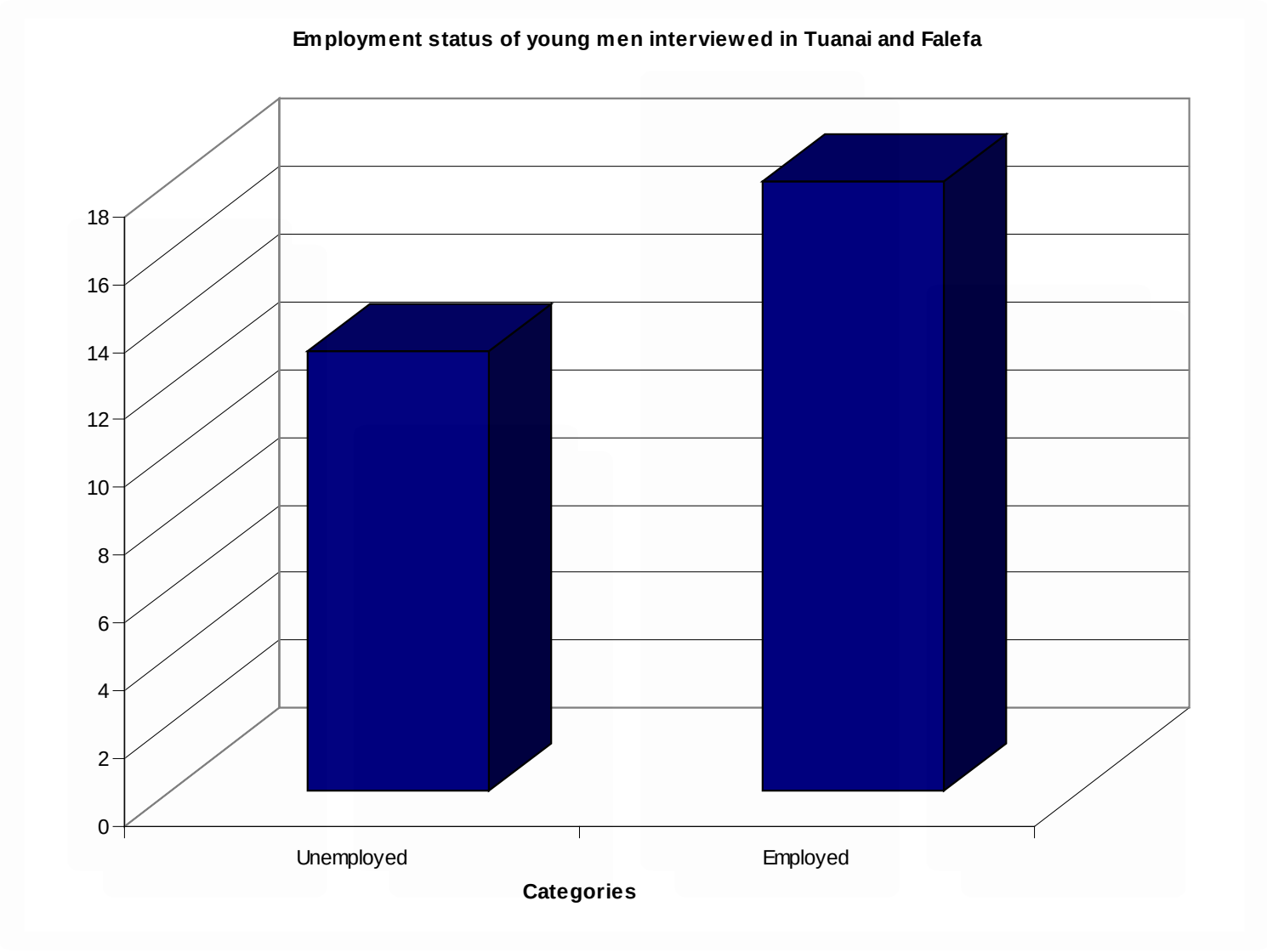
Semi-structured interviews in Tuanai and Falefa

- Purpose of interviews:
  - 31 young men interviewed to assess their perception of LF / MDA through word & tablet association; to explore events / activities in men daily lives to understand best day for drug delivery and channels for media strategy.
- Tools
  - Top-of-the-mind Analysis
  - Day-in-the-Life-of Analysis

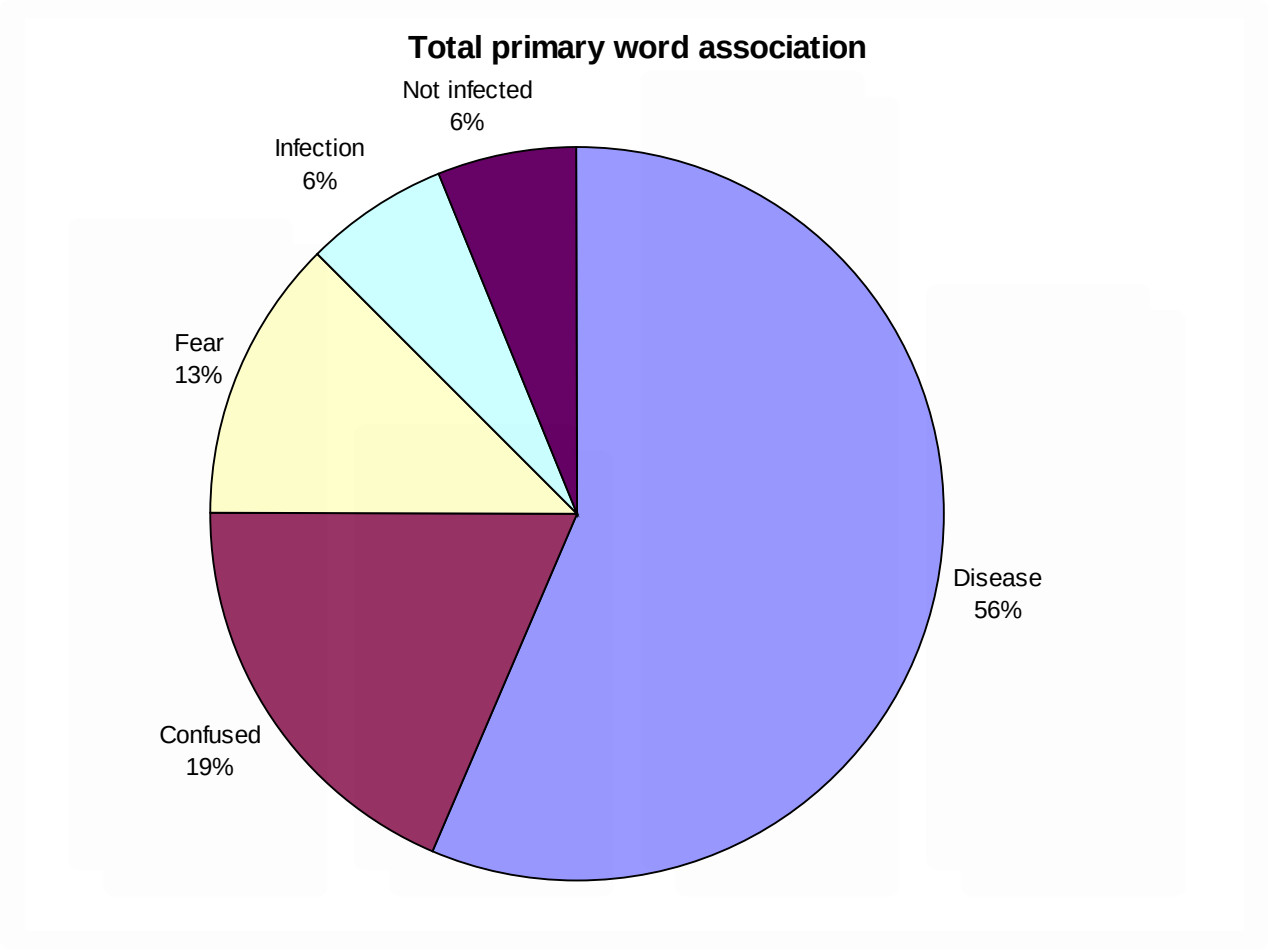
Age profiles



Employment Status

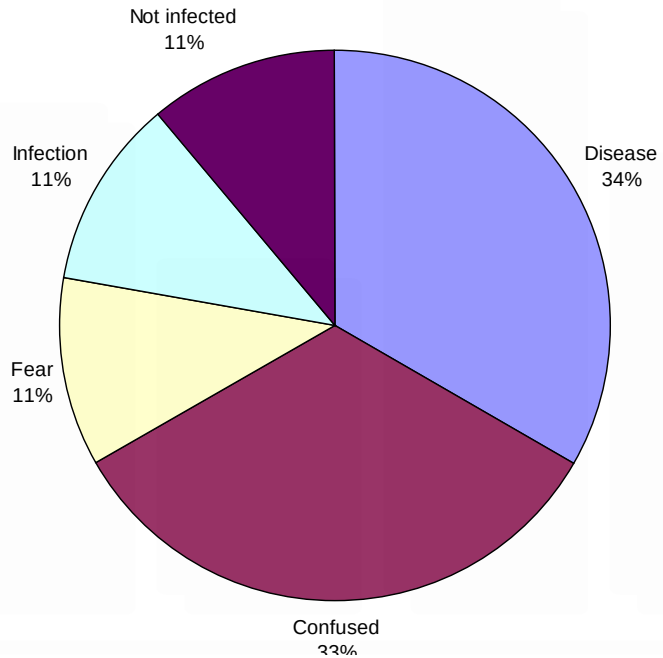


Word Associations "Mumu tutupa"

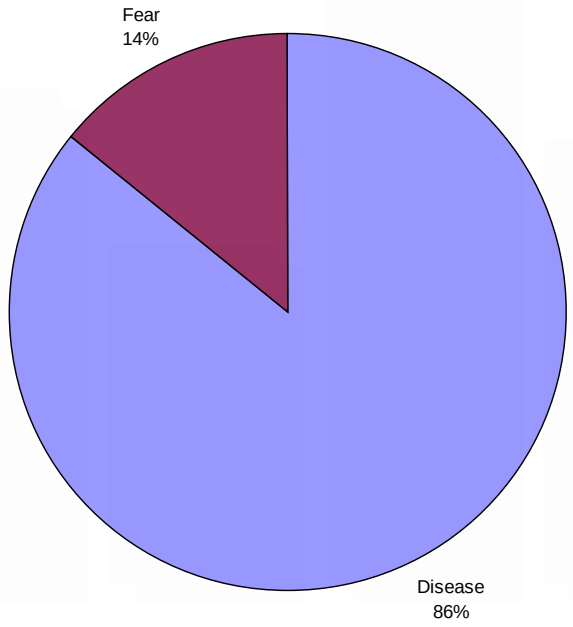


Primary word association "Mumu tutupa"

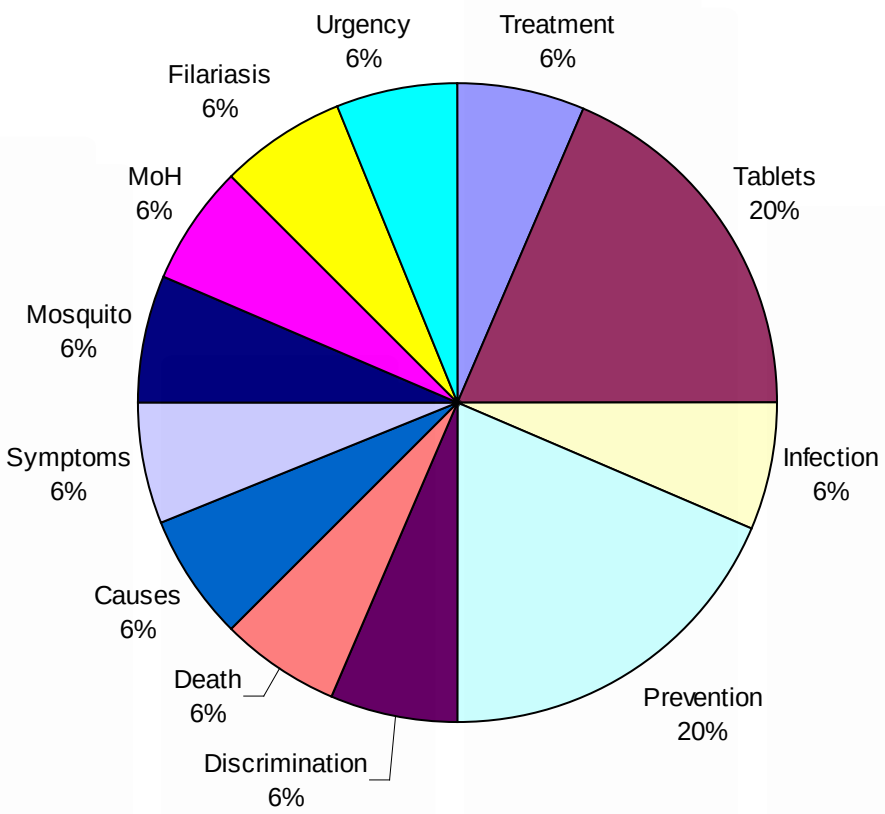
Tuanai



Falefa

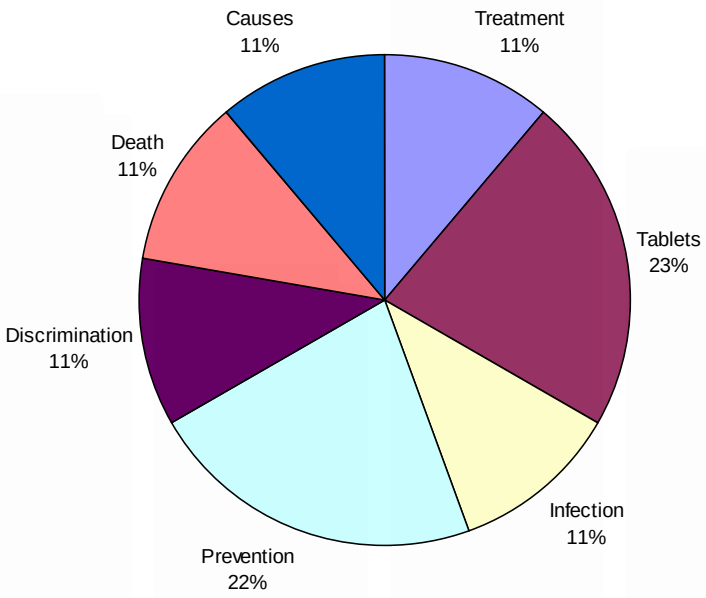


Total secondary word association "Mumu tutupa"

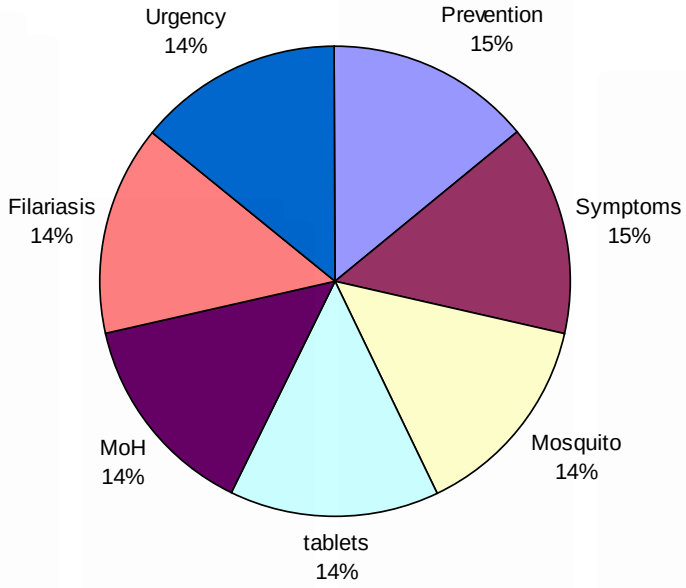


Secondary word associations "Mumu tutupa"

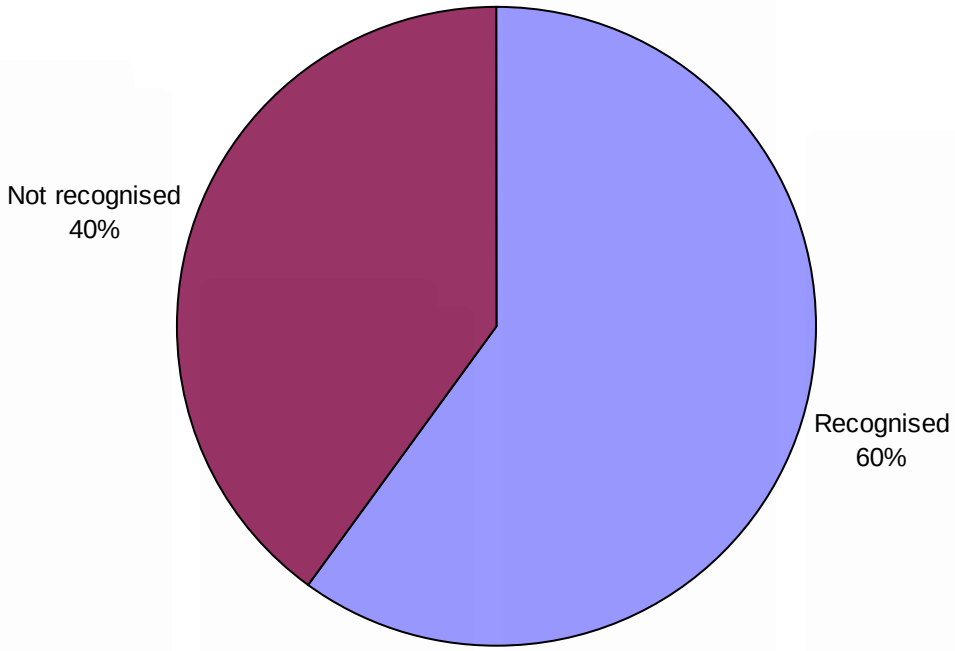
Tuanai



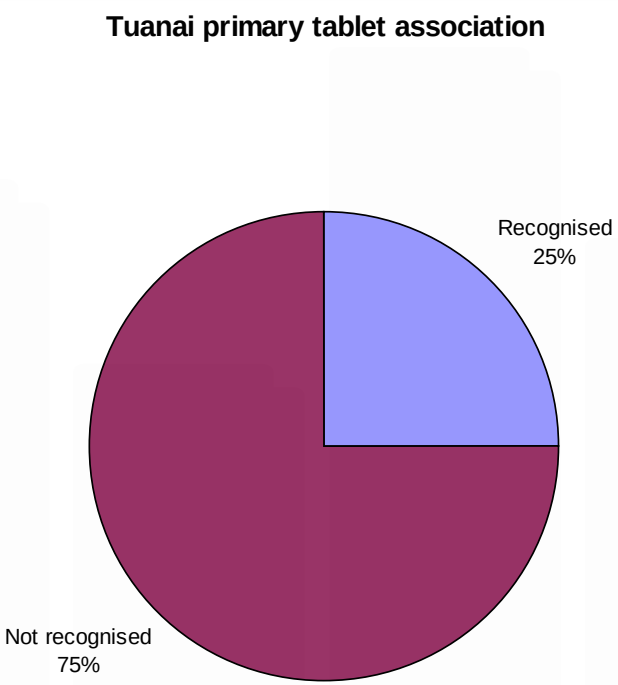
Falefa

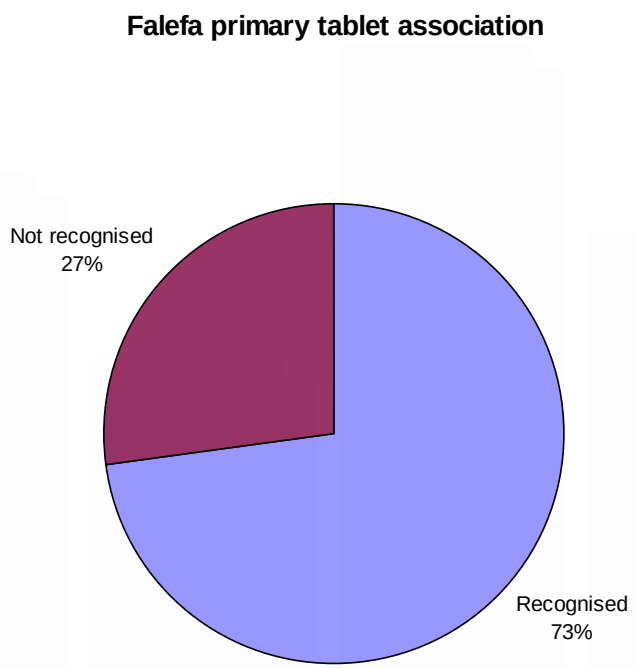


Total primary tablets association

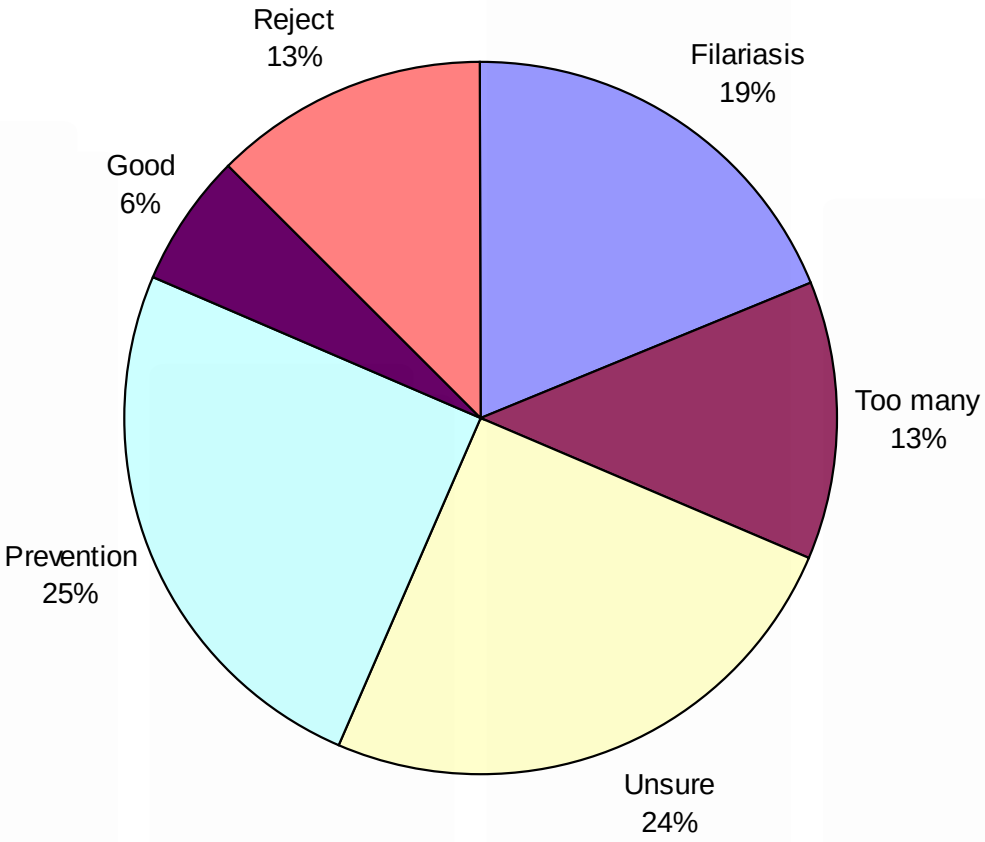


Primary tablets association



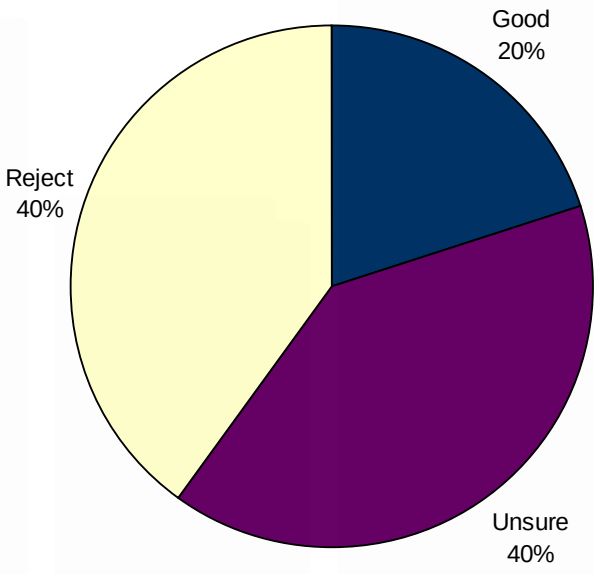


Total secondary tablets association

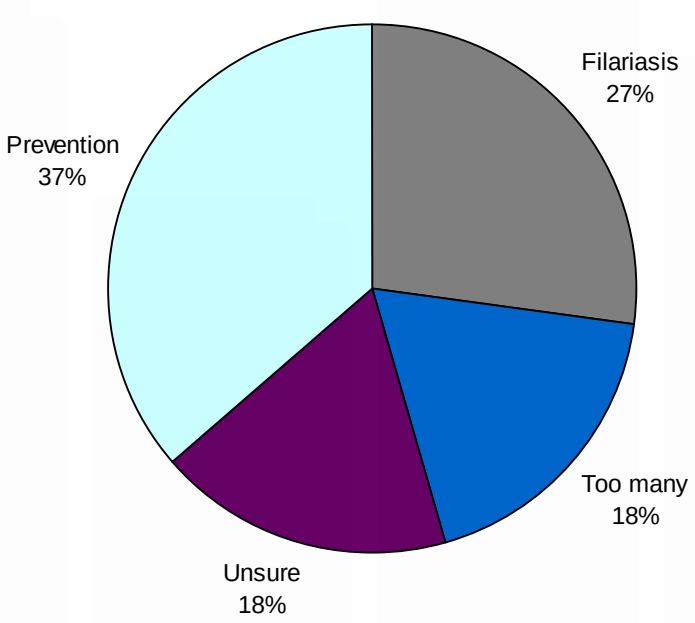


Secondary tablets association

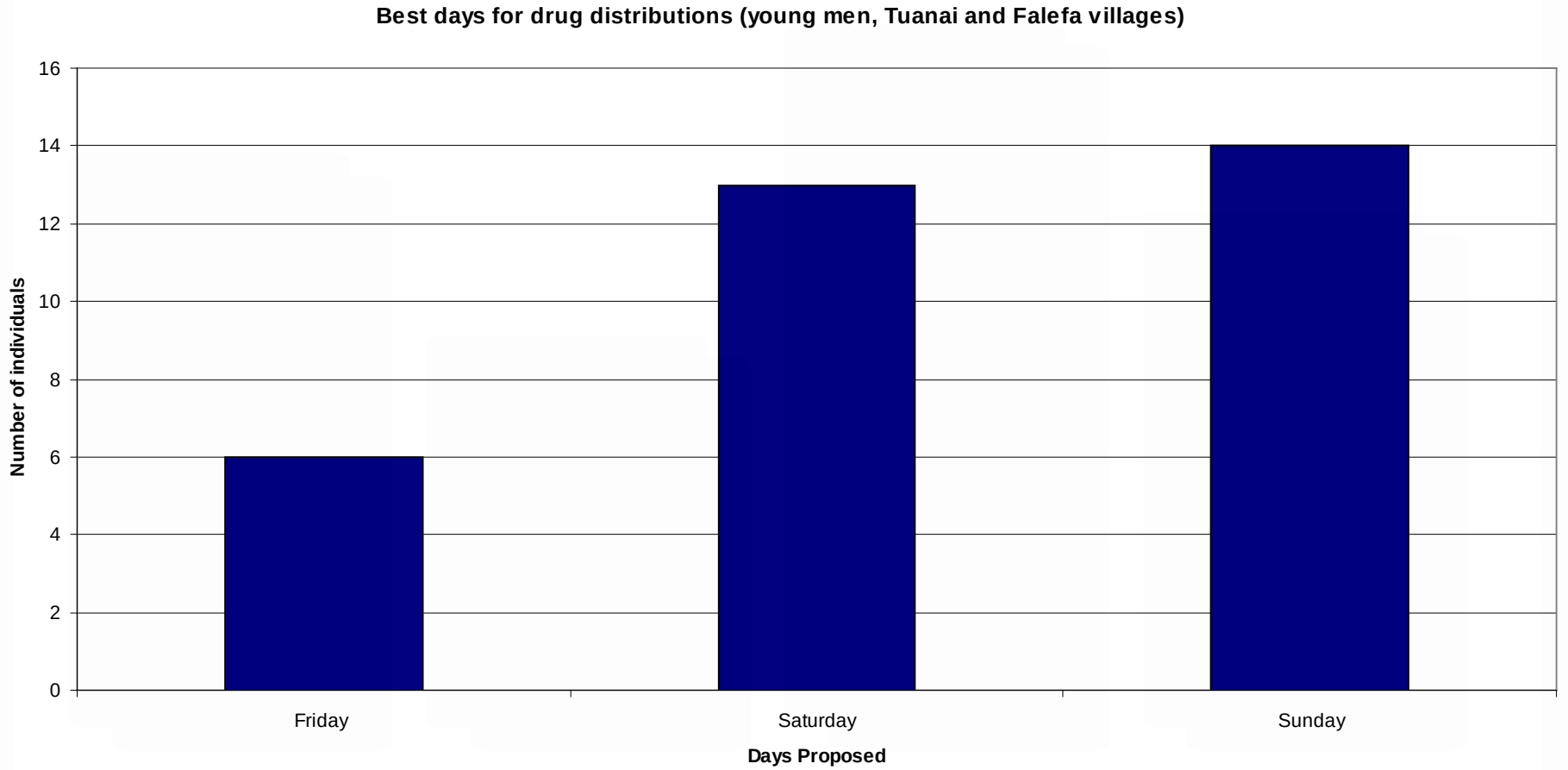
Tuanai secondary tablet association



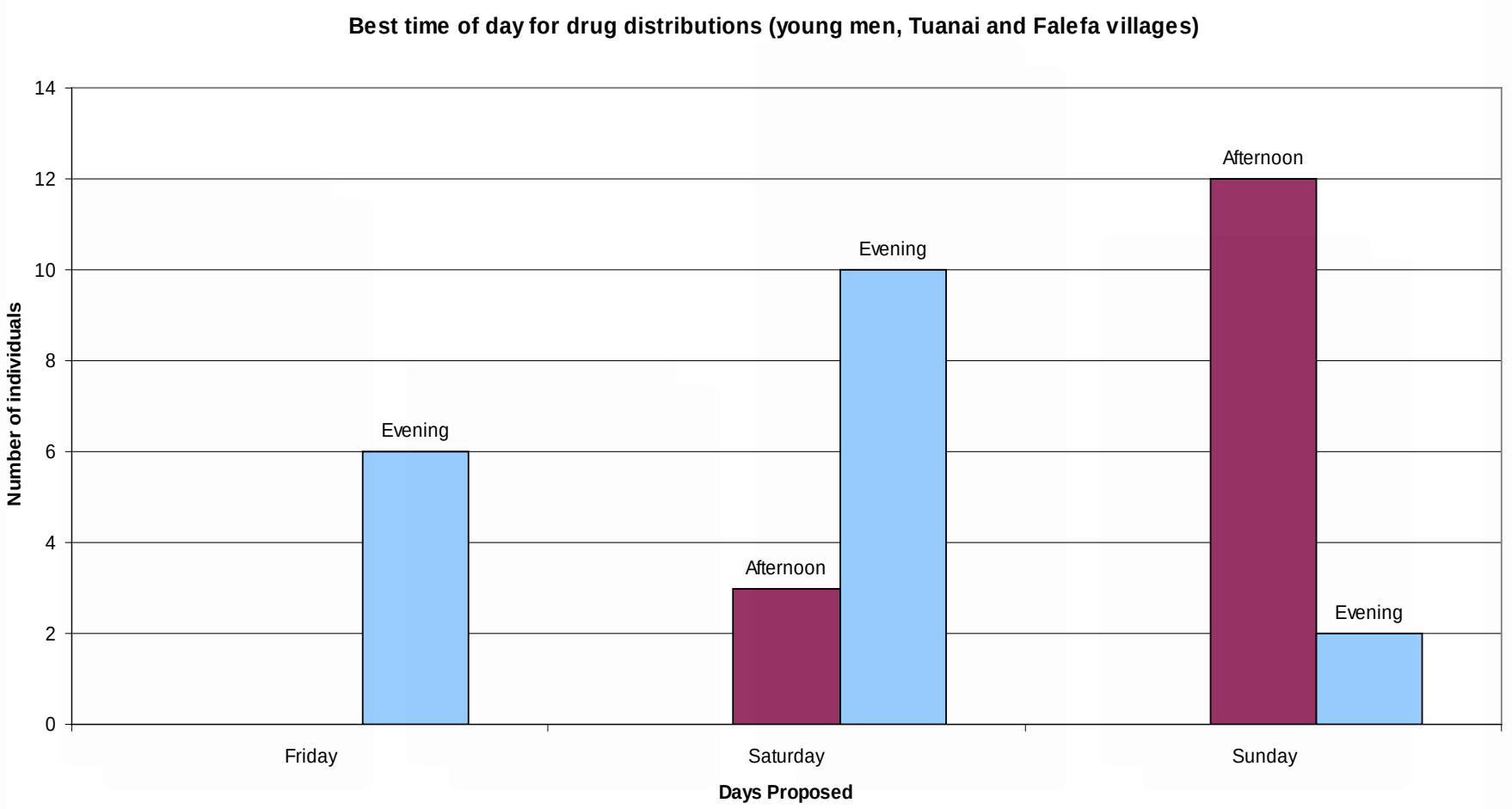
Falefa secondary tablet association



Best days for drug distribution

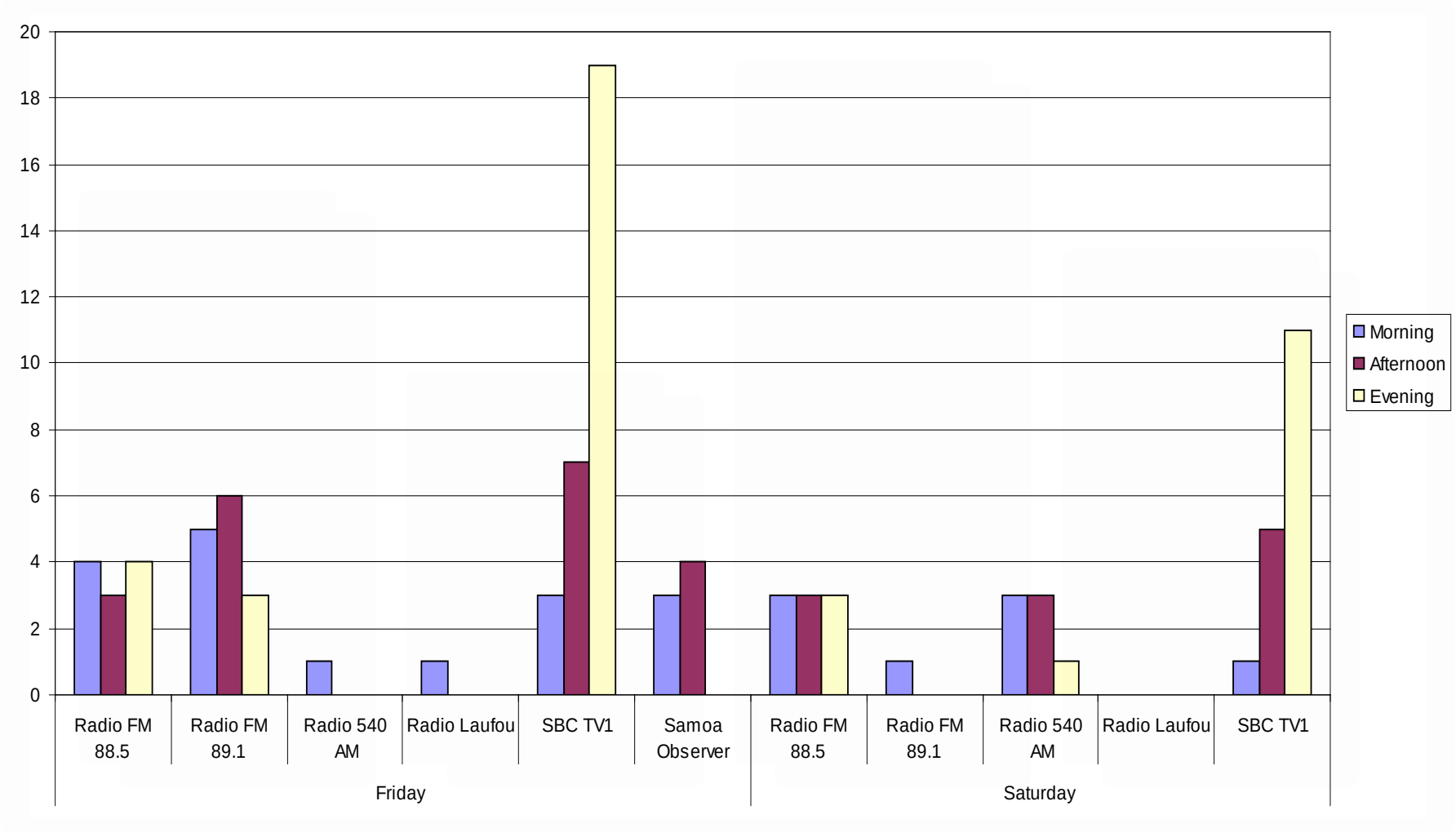


Best time for drug distribution



* First set of interviews in Tuanai, were not given the option of Sunday so this may underestimate the popularity of Sundays

Popular channels and times for media awareness



General Communication Issues

- Decide on a single national drug distribution strategy. It is extremely difficult to communicate two different types of strategies and leaves the opportunity for confusion.

- Advertise limited drug distribution days e.g. "Filariasis Weekend". If people know they have 3 days, they will usually wait for the last possible day to take the tablets.

- Deal with the issues of side effects up-front so people know that this is due to the tablets working and what to do if they experience nausea or fever.

General Communication Issues

- Develop different messages for different target groups e.g. young men, older people, those who have previously taken the tablets, those who have never taken the tablets before, etc and ensure that all messages have the behavioural focus of taking the tablets on "Filaria Weekend", when and how.
  - A stronger knowledge base needs to be established as those interviewed focused on prevention rather than treatment, they didn't know how the tablets worked, and confused intestinal worms with LF worms.
  - Consider wide distribution of written material that informs and educates to all households as well as through women's groups, schools, churches and work places. Plan for intensive interpersonal communication leading up to the MDA to give opportunities for people's questions and concerns to be answered. It is too late if people don't know what the tablets are for during the MDA
- Use multiple channels, but clearly specify the expected actions and co-ordinate the input and activities leading up the MDA e.g. schools, churches, village mayors and councils, NGOs

Developing a COMBI plan for LF in Samoa

1 State the overall goal to which the COMBI plan will contribute

E.g. To contribute to the elimination of lymphatic filariasis in Samoa by the year XXX

Developing a COMBI plan for LF in Samoa

2. Define and state the behavioural objective that will be the basis for your COMBI strategy and implementation framework:

Example from Sri Lanka. To prompt approximately 9 million individuals (i.e. everyone other than pregnant women and children under 2 years of age) in all 8 districts (Colombo, Gampaha, Kalutara, Galle, Matara, Hambantota, Kurunegala, and Puttalam) of three provinces of Sri Lanka (Western, Southern, and North West) to accept the hand-delivered set of LF prevention pills (maximum 4) and to swallow these pills in the presence of a health worker/volunteer on June 16th, 2002

Be as specific as possible: Does it answer the 4+1 Ws?
Who will do What, Where, When,… and, by the way, Why?

Developing a COMBI plan for LF in Samoa

3. Carry out a situational "market" analysis" to understand the desired behavioural result from the perspective of the "consumer" before planning communication interventions. Use this to test out the feasibility of the drug delivery strategy and communication challenges.

Findings from research in two villages allowed us to understand that the choice of drug distribution strategy is critical to gaining compliance, that there are significant "costs" associated with fixed sites and with taking the tablets on certain days e.g. young men on Fridays and Saturday during the day. There is a basic lack of knowledge and confusion of the disease, its causes, and treatment and how the drugs work. That there is a lack of personal risk of the long term effects of LF because the direct results e.g. hydrocele are not common. That intensive community mobilization is a required in the lead up to the MDA.

Actions: Identify what further research needs to be carried out e.g. in Urban settings and with women to get a more representative understanding of your "market", their perceptions and the most appropriate channels and methods to engage them

Developing a COMBI plan for LF in Samoa

4. Set out the communication objectives to be achieved in order to contribute to the behavioural objective and the overall COMBI strategy for achieving the stated behavioural objective

E.g.

1) Ensure that XX population understand the causes and treatment of lymphatic filariasis and the rationale for MDAs
2) Ensure that XX population understand the rationale for 85% coverage rates
3) Ensure that young men between the ages of XX and XX have access to information about the cause, treatment and prevention of lymphatic filariasis and the dormant nature of the disease and how it can manifest in adulthood
4) Ensure that there is clarity about the tablets being used and the distinction and benefits of albendazole and DEC

Describe the overal COMBI strategy for the following:

1. Advocacy/Public Relations/Administrative Mobilization
2. Personal Sellers/advocates
3. Community Mobilization and Promotional Activities
4. Massive Advertising
5. Point-of-Service Promotion

Developing a COMBI plan for LF in Samoa

5. Present the COMBI plan of action and budget. This is the primary instrument for managing the implementation of the COMBI programme. It should clearly and comprehensively spell out the detailed activities and related costs which will need to be undertaken to operationalize the communication strategy outlined in step 4.

Consider detailed actions under each of the communication action areas

Advocacy/Public Relations/Administrative Mobilization (Official Circulars/Memoranda, Staff Meetings, Mass Media, Group Meetings)

Personal Sellers/advocates: including existing health workers, trained and appropriately "dressed", church/women/college volunteers going door-to-door in the lead up to the MDAs, use of publicly known figures e.g. sports starts, politicians to endorse the campaign

Community Mobilization and Promotional Activities: Community meetings, Filariasis awareness Rugby matches, Schools Promotion XX children; Promotional Flags-Danglers; Ribbon-type "Flags" to indicate that households have taken the tablets; Posters; Leaflets/pamphlets, promotion at Bingo events.

Massive Advertising: Community Public Address Broadcasts; Radio, Television and Newspaper Advertising.

Developing a COMBI plan for LF in Samoa

6. Decide how the COMBI Plan will be managed most effectively.
Define a management structure. Include technical advisory groups or government bodies from which the group receives technical support or to whom the management team should report.

E.g. In relation to the LF Committee. Is there the need to set up a smaller COMBI group to oversee the development of the COMBI plan and reports to the LF committee, who should be its members and what will be their roles? Does there need to be a wider inclusion e.g. representatives from Ministry of Education if schools will be involved, NGOs,… others…?

Developing a COMBI plan for LF in Samoa

7. Monitoring implementation

Describe how the implementation of the COMBI plan will be monitored. E.g. using the work plan as a monitoring tool.

Plan for small random tracking surveys to assess the impact of the communication interventions leading up to the MDAs.

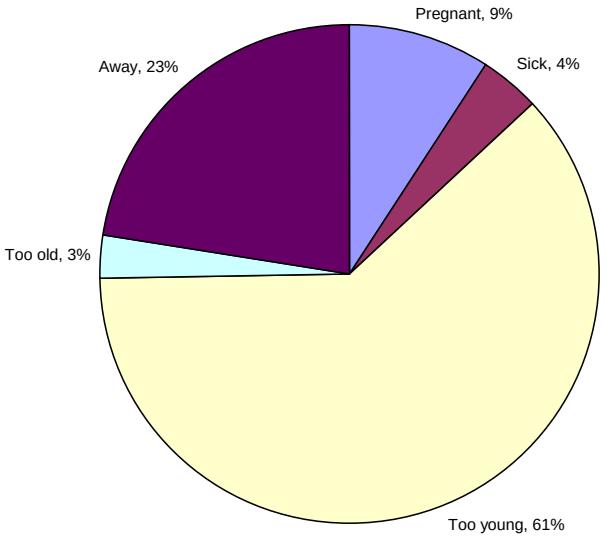
8. Evaluate Impact

Plan for a structured evaluation after the MDA focusing specifically on communications e.g. surveys/questionnaires measuring the reach and penetration of communication interventions. Supplement with key informant interviews etc at the specific target audiences for the communications interventions e.g. impact and effect on young men

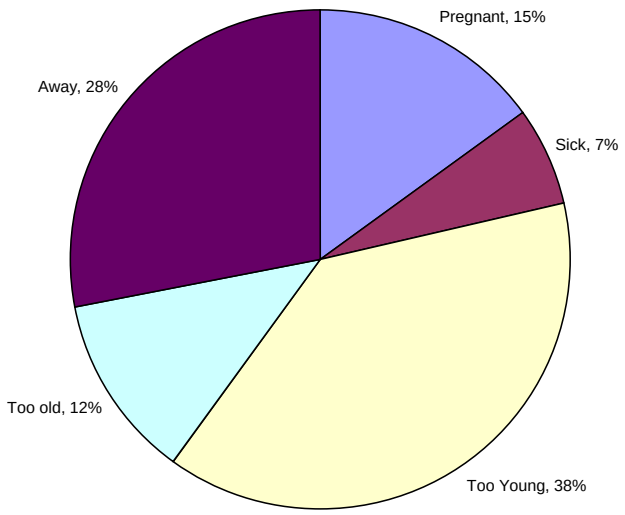
ANNEX 5

COMPARISON OF REASONS FOR NON TREATMENT IN 2001 (MDA 3) and 2006 (MDA 6)

Reasons for non-treatment during 2001 MDA in Samoa



Reasons for non-treatment during 2006 MDA in Samoa



NON TREATMENT BY AGE GROUP in 2006 (MDA 6)

Non-treatment during 2006 MDA in Samoa by Age Group