LYMPHATIC FILARIASIS

MASS DRUG ADMINISTRATION

REPORT

7 OCTOBER 2015

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ABBREVIATIONS:

CEO	Chief Executive Officer
DEC	Diethylcarbamazepine
EU	Evaluation Unit
NWU	North West Upolu
DOTS	Directly Observed Treatment Strategy
LF	Lymphatic Filariasis
MDA	Mass Drug Administration
ROU	Rest of Upolu
AUA	Apia Urban Area
TAS	Transmission Assessment Survey
MOH	Ministry of Health
NHS	National Health Services
MWCSD	Ministry of Women Community & Social Development
WHO	World Health Organisation
SBS	Samoa Bureau of Statistics

EXECUTIVE SUMMARY:

Despite series of rounds of LF MDA since 1999, results of the Transmission Assessment Survey done by the MOH in 2013 showed that NWU region had an antigen prevalence of 1.49%, which was far higher than what WHO considered too low (<0.5%) to sustain transmission of LF. Result of TAS with its recommendations prompted implementation of a LF MDA in the NWU region in February 2015 with the hope of a maximum coverage especially in areas where positive ICTs were found. The village of Faleasiu with the highest number of ICT positive, had a MDA coverage of 91%. However this high coverage was compromised by the low coverage rates from other constituencies, thus the overall coverage of 72%. Complementing MDA were vector control awareness programs in terms of source reduction and promoting the use of mosquito nets at home. The Health Sector needs to find out why NWU continues to be a problem area despite several rounds of LF MDAs in the past.

BACKGROUND:

North West Upolu has a population of 62,390 people (2011 Census) which is about 1/3 of the total population of Samoa. It has 8 different political constituencies with 54 villages. The administration of each constituency likewise the villages are generally similar but have small but vital unique settings which contributed to the success and failure of the program.

A Transmission Assessment Survey (TAS) was carried out by the MOH in 2013 to assess whether or not LF was near elimination following a series of rounds of MDAs since 1999. The antigen prevalence of <0.5% is considered by WHO too low to sustain transmission of LF in a country. However, results of the TAS finds NWU region with a antigen prevalence of 1.49%, a rate far too high when compared to ROU, AUA and Savaii with antigen prevalence of as low as 0.08%. NWU has been continuously a problem area for unknown reasons despite a series of rounds of MDAs. The decision to carry out this 8th LF MDA specifically for the NWU was due to the results and recommendations from TAS to conduct 2 more MDAs in the NWU, to be followed by another TAS in 2-3 years.

METHODOLOGY:

The implementation of the LF MDA for NWU was transferred from MOH to NHS to be part of its service delivery. A working committee comprising of representatives from the MOH, MWCSD and NHS was formulated to spearhead the planning and coordination of the LF MDA. Series of meetings were held to fast track the planning process, and giving time for NHS to get a hold of things given its very first experience with the MDA implementation.

The NWU region or Enumeration Unit (EU) as in TAS, was divided according to the chronological order of villages per constituency. Prior to field implementation, we sought the assistance of the MWCSD on their role in community mobilisation. The Ministry in turn searched and confirmed fixed sites per traditional village, and church leaders in non traditional villages.

Trainings were conducted for village representatives through the MWCSD. A total of 94 SN, STN, STTN attended the first training on the transmission of LF, prevention of breeding sites, and introduction to the MDA program with basic knowledge on dispensing the drugs and how to enter the data. An additional 78 village assistants attended the second training on how to carry out the pre registration utilising the left over books from the past MDAs, and touch base on the previous training. Incentive of $20 per participant per day was given out to all the participants. The actual implementation was incentivised in terms of food and drinks throughout the day for all instead of money.

There was also special training for the employees of the two ministries as well as NHS earmarked for the program. Assistance for extra personnel was also sought from MOH and MWCSD given the limitations at NHS. One of the major areas of concern during training was the change in the number of DEC tablets to be consumed. Originally the DEC tablet came in 50mg, and the required consumption was 100mg meaning 2 DEC were taken. This amount to a total of 9 DEC for the 20-49years in previous MDAs. For this round, the DEC tablet was 100mg; therefore the consumption was 1 DEC of 100mg instead of 2 of 50mg as in previous rounds. What used to be 9 DECs is now 5. Albendazole remains the same at 1 tablet. Modification to the register book was made accordingly

Additionally, there were public awareness programs on TV1 (Lali, E te Silafia & TV spots) radio talk back to further promote awareness. Indication of fixed sites in each village was given out several times on TV as well as on radio. Further communication in forms of formal letters to institutions like Tafaigata Prison, Malua Theological College and Methodist Faleula were given out for inclusion in the program.

Pre-registration was carried out by the village representatives to give us an idea of the estimated number in each village, for packing purposes. Each village in the district had a team or two comprising of 1-2 workers, SN, STN, STTN and two other village representatives. The plan was for 3 of them on site while the other 3 would be going out to attend to the elderly and those who found it hard to commute to the fixed site. A van or two were allocated to each constituency, with the exception of the inner land areas including Aleisa where transport was individually assigned to these densely populated areas.

To complement LF MDA, source reduction was also carried out by the MOH with more media releases to promote awareness.
The implementation was actually done on the 21st of February using the DOTs approach, with the instructions to the implementers to notify the centre (operating from the old NHS Pharmacy) whether or not it needed continuation on Sunday 22nd. About half continued on Sunday mainly at church premises. Almost each constituency was given a megaphone to assist in the relaying of information on the day.

Mop up with village representatives was carried out for the next two weeks after the MDA. TTM was also opened for the public whether from within the NWU region or outside. Those who had their drugs taken at TTM were ensured to have had their details entered in their respective villages, mainly those from the Faleata West inland areas

RESULTS:

The following tables present summary of LF MDA results

Table 1 - summary of LF MDA by constituencies

Constituency	Targeted population (2011 Census)	Actual Population Participated	Coverage per constituency
Vaimauga East	7,730	4,344	56%
Faleata West	18,895	14,182	75%
Sagaga le Usoga	5,741	3,934	68%
Sagaga le Falefa	12,104	9,775	81%
Aana Alofi 1	5,964	4,292	72%
Aana Alofi 2	3,258	2,495	77%
Aana Alofi 3	5,530	4,033	73%
Gagaemauga 1	3,168	2,217	70%
Total NWU	**62,390**	**45,272**	**72%**

Table 2 - Gender distribution

NWU	Female	Male	Total
	21,933 (48%)	**23,339 (52%)**	**45,272 (100%)**

Table 3 - Age distribution

2-4 years	**2, 598**	**5.7%**
5-9 years	**4,654**	**10.2%**
10-14 years	**4,313**	**9.5%**
15-19 years	**5,812**	**13%**
20-49 years	**19,360**	**43%**
50+	**8,535**	**19%**
Total	**45,272**	**100%**

DISCUSSION:

Coverage was defined as the percentage of eligible individuals who received the drugs DEC and Albendazole distributed during the MDA in February 2015.

The total coverage may look satisfactory at the constituency level, but there is a vast difference among the villages. For example at Vaimauga East, despite the highest coverage of all at Letogo, villages of Laulii and Vailele both have <50% coverage. Extremely low coverage of only 26% at the village of Afega really impacted on the overall coverage for Sagaga le Usoga and the whole of NWU. We are mindful of Afega having 1 ICT positive according to the TAS results. On the other hand, Faleasiu also according to TAS results is recorded to have had the most ICT positive cases, interestingly it was one of the highest LF MDA coverage for Aana Alofi 1.

The inclusion of the MWCSD right from the beginning made things a lot easier at the community level. Various areas need to be improved on the preparatory phases.

CONCLUSION & RECOMMENDATIONS:

The 72% coverage of this 8th round of LF MDA may be considered low for the actual purpose of interrupting transmission, it is quite fulfilling to know that it was the first time ever NHS was implementing LF MDA, and there is always room for improvement.

Given the very low coverage in some of the villages where ICT was positive, we recommend to:

- carry out the 2nd MDA for NWU in 2016 to be followed by another TAS to assess effectiveness of the two MDAs
- strengthen the commitment from the Health Sector to ensure collaboration is maintained throughout.

REFERENCES:

1. Samoa Bureau of Statistics (2011), Population and Housing Census 2011
2. World Health Organization –Western Pacific Region (2006), The PacELF Way towards the elimination of lymphatic filariasis from the Pacific 1999-2005
3. Transmission Assessment Survey 2013