An Evaluation of Mass Drug Administration Compliance Against Filariasis of Tikamgarh District of Madhya Pradesh-A Household-Based Community Study

Sandeep Singh, Meena Patel, Sugriv Singh Kushwah

Departments of Community Medicine, Pediatrics, Shyam Shah Medical College, Rewa, Madhya Pradesh, India

Abstract

Background: Mass drug administration (MDA) means once-in-a-year administration of diethyl carbamazine (DEC) tablet to all people (excluding children under 2 years, pregnant women and severely ill persons) in identified endemic areas. It aims at cessation of transmission of lymphatic filariasis. Objective: To study the coverage and compliance of MDA in Tikamgarh district during the campaign in April 2010. Materials and Methods: The activities under MDA involved administration of DEC tablets to eligible population from endemic area by health staff and Integrated Child Development Scheme (ICDS) functionaries referred as drug distributors (DD) make house-to-house visits on select dates in 2010. DEC was administered to all people (excluding children under 2 years, pregnant women and severely ill persons) with the instruction to ingest the tablet preferably on the spot. Study Design: Cross-sectional population based house-to-house visit. Setting: Urban and rural areas in Tikamgarh district identified as endemic for filariasis where MDA 2010 was undertaken. Study Variables: Exploratory - Rural and urban clusters of Tikamgarh district; Outcome - coverage, compliance, actual coverage, side effects. Analysis: Percentage and proportions. Results: Four clusters, each comprising 30 households from Tikamgarh endemic district, yielded an eligible population of 641. The coverage rate was 607 (94.6% of eligible) with variation across different areas. The compliance with drug ingestion was 89.9% with a gap of 10.1% to be targeted by intensive IEC. The effective coverage (85.2%) was just above the target (85%). Side effects of DEC were minimum, transient and drug-specific. Overall coverage was marginally better in rural areas. The causes of poor coverage and compliance have been discussed and relevant suggestions have been made.

Keywords: Diethyl carbamazine, lymphatic filariasis, Mass drug administration

Introduction

Lymphatic filariasis (LF) is an important public health problem next to malaria in India. WHO had recently called on member states to identify the global elimination of LF as a public health priority. The International Task Force for Disease Eradication too had identified LF as one of the seven infectious diseases considered eradicable or potentially eradicable. Several interventions have been tried in recent times to deal with this health problem. Mass drug administration (MDA), which means once-in-a-year administration of diethyl carbamazine (DEC) tablet to all people (excluding children under 2 years, pregnant women and severely ill persons) in identified endemic areas, is one of them. It aims at cessation of transmission of LF in the community. MDA in combination with other techniques has already eliminated LF from Japan, Taiwan, South Korea and Solomon Islands and markedly reduced the transmission in China. MDA has been as effective as 12-day therapy, as a public health measure, with lesser side effects, thus enhancing public compliance and decreasing delivery costs. It does not require complex management and infrastructure, and can be integrated into the existing primary healthcare (PHC) system. In order to achieve the elimination of LF by 2015 under the National Health Policy, National Filarial Day (NFD) was proposed to be observed every year starting from 2004 in the endemic districts. Based on microfilaria surveys and the line listing of lymphoedema cases, Madhya Pradesh had identified 11 districts and accordingly they were included for observing MDA since 2004. The present communication deals only with the evaluation of coverage (distribution of drug to the community) and compliance (actual drug consumption) of
MDA in April 2010 in endemic areas (Tikamgarh district) of Madhya Pradesh.

Materials and Methods

MDA was undertaken in identified endemic areas in 2010. The activities under MDA involved administration of DEC tablets to eligible population from endemic area by health staff and Integrated Child Development Scheme (ICDS) functionaries referred as drug distributors (DD) make house-to-house visits on select dates in 2010. DEC was administered to all people (excluding children under 2 years, pregnant women and severely ill persons) with the instruction to ingest the tablet preferably on the spot.

Selection of the Survey Area

Four clusters per district (one from urban and three from rural areas) were identified for the survey. Thus, a total of 4 clusters were studied. The survey was done 2 months after the MDA and the coverage reported by the health system was used to select the clusters. Selection was done as per the following criteria:
1. One PHC with >80% coverage.
2. One PHC with 50-80% coverage.
3. One PHC with up to 50% coverage.

If there was no PHC falling in a particular coverage category, the PHC was selected from next category. A total of 30 households (HHs) in each cluster were selected in such a way that the entire ward/village was represented. For this purpose, the area was divided into four quadrants, and in each quadrant, a central point was identified and the first house was selected randomly (any number between 1 and 9) and thereafter another seven HHs (total eight) serially (open with available family members) were covered. The exercise was repeated in other three quadrants. In fact this was an improvement over 30 HHs suggested per cluster by NVBDCP for evaluation. All the data were collected in a predesigned and structured proforma. After data collection, analysis was done with the help of Epi Info.

Study teams

The study team constituted faculty members of department of community medicine for each of the four clusters of Tikamgarh district.

General objective

What has been the coverage and compliance of MDA in Tikamgarh district during the campaign in November 2010?

Specific objectives

Objectives dealt in this communication were:
1. To review the progress of activities of single dose DEC mass administration in the selected district.
2. To make independent assessment of the program implementation with respect to process and outcome indicators.
3. To recommend mid-course correction and suggest necessary steps for further course of action.

Place of study

Four clusters (Named Dhajrai, Larpur, Durganagar rural cluster) and Brahman Kaloni ward urban of Tikamgarh district.

Observations and Discussion

A total of 4 clusters including 1 from urban and 3 from rural areas were studied. Together, these 4 clusters covered a total of 120 HHs (90 rural and 30 urban) and yielded a population of 692 (547 - rural and 145 - urban). In the studied clusters, against a population of 692, 641 (92.6%) were eligible for MDA [Table 1]. Adhering to the criteria of NVBDCP, the eligible population in various clusters varied between 90.2 and 94.4%. The proportions of eligible population in rural and urban clusters were 92.1 and 94.4%, respectively. The rest was either below 2 years of age (27), pregnant females (17) or severely ill (07). Out of 641 eligible persons, 607 (94.6%) received DEC [Table 1]. Against overall coverage rate of 94.6%, it was highest in Durga Nagar Chhingawa (99%) and lowest in Tikamgarh Brahman kaloni near hospital urban cluster (89%). The remaining (n = 34) although eligible did not get the drug for various reasons. The common reasons they were not present when DD come to home or houses were locked (n = 23), followed by DD did not give drug (n = 11). All these problems require powerful advocacy tools and strategies.

The overall rate of 94.6% coverage observed by us was just satisfactory because under the MDA, the target was to ensure effective coverage of 85% - a product of coverage as well as compliance. The main reasons for noncoverage were that workers could not cover the population or did not administer drug and importantly the misclassification of persons rendering them not eligible. It can be improved by making efficient micro-plans, improved supervision and emphasizing more strongly the selection criteria in training.

Compliance rate (ingestion of drug by those who received it) was 89.9% with lowest in Tikamgarh Brahman kaloni near hospital urban cluster (77.8%) and highest in Dhajrai and Larpur (93.6%). A total of 61 persons accounted for this gap. The main reason for this was refusal without any reason (n = 29). Some of them (n = 20) did not take it for fear of side effects and the rest (n = 12) either forgot to take or misplaced the drug. Effective

| Table 1: Distribution of population of surveyed districts |
|---------------------------------------------------------|
|District | Total population | Eligible population | Population covered (out of eligible) |
|---------|-----------------|---------------------|-------------------------------------|
|         | N   | %   | N  | %   | N  | %   |
| Tikamgarh urban brahman kaloni | 145 | 137 | 122 | 89  |
| Dhajrai | 157 | 147 | 140 | 95.2|
| Larpur  | 174 | 157 | 147 | 93.6|
| Durganagar | 216 | 200 | 198 | 99  |
| Total   | 692 | 641 | 607 | 94.6|
coverage rate is the end product of coverage by the health system and compliance by community. It was just above (85.2%) the target (85%) for the entire district as a whole. It was highest in Durga Nagar (91%) and lowest in Tikamgarh Brahman kaloni near hospital urban cluster (69.4%) [Table 2]. Effective coverage rate is the end product of coverage of the health system and compliance by community. In fact this should be 85% or above for the elimination of disease. Overall, it was 85.2% for the district. Good coverage in the absence of good compliance and similarly motivated community (for good compliance) with poor coverage will be of little use. In fact, except the Tikamgarh Brahman kaloni near hospital urban cluster, rest 3 clusters achieve the targeted coverage of 85%. The coverage in the districts of 85.2% was just above the target of 85%. Both coverage and compliance were marginally better in rural areas (96.2%, 92.9%) than in urban areas (89%, 77.8%), and accordingly the actual coverage too was better in rural areas [Table 3]. CCG helps to understand why people fail to consume the drug. It was around 10.1% and needs to be bridged with side by side efforts through IEC from all possible channels to motivate people for ingestion (preferably on the spot) of the drug. It seems that LF is not perceived as a serious public health problem or people think that they will not be affected by this disease. All these point out to one thing that there is no resistance in the community for DEC; however, more important is to emphasize on supervised “on the spot” DEC consumption.

One reason commonly given by the community for not consuming DEC on the spot was that it causes gastric upsets and so they prefer to take it after the meal. In this regard, a suggestion came to us that DD may carry small packets of biscuits (costing Rs. 2) to facilitate spot consumption of DEC. As such, the side effects were very few and they were also minor, transient and drug-specific. However, they also need to be addressed as they constitute the cause of noncompliance. Information about the Rapid Response Team (RRT) must be widely publicized in order to increase the faith of people and will indirectly result in better compliance.

Coverage and Compliance of MDA for Elimination of Lymphatic Filariasis in Endemic Areas of Bijapur district, Karnataka by Ravish et al. also observed that the survey coverage rate was 85.9% in the study population. The difference of 14% could be attributed to people not having received tablets either because they were not at home when distributors visited or distributors having not visited their houses at all. Distributors have not visited few houses because of confusion in area demarcation. In the study compliance rate was 45.9%. There was hardly any stress on supervised “on the spot” consumption of tablets. Compliance rate was bit better where health staff was deputed for drug distribution.

Kumar et al. the coverage was 85.2% and compliance was 60% and in B.V. Babu Study in Orissa it was seen that coverage was 67% and compliance was 42%[10,11,12].

Among the 989 people who did not consume tablets – 512 i.e., 51.8% people said that they have not been informed properly about why and how much they should consume. Fifteen percent of people did not consume tablets for the fear of reaction. Seven percent of the people did not consume tablets because either they feel they are healthy or sick. So almost 74% people did not consume because of inadequate information from drug distributors. 15.7% of people were not at home during the activity. 10.3% people have not received tablets though they were at home.

Adverse reactions among study population were only 0.6%, which is negligible. The following adverse reactions noted were giddiness, vomiting, gastric irritation, etc., which were mild. Even though adverse reactions were negligible, people should be made aware of it through IEC, because only sustained high compliance can lead to elimination of filariasis.

MDA coverage evaluation survey for LF in Bagalkot and Gulbarga districts by Prakash Kurubarahalli Patel in their study found that Approximately 79% in Bagalkot and 39% of the study subjects in Gulbarga district reported that they actually consumed both DEC and albendazole tablets. The remaining were, either who did not consume at all or consumed inadequate dosage of the tablets, the prime reasons for not consuming the tablet was, not received tablet (27.9%), followed by not present at home (18.4%) and drug given at home but...
Conclusions and Recommendations

1. Coverage and compliance were marginally better in rural areas. Coverage-compliance gap was around 10.1% as whole (22.2% in urban and 7.1% in rural area). There was hardly any resistance in the community for the program and no one refused to accept drug. Similarly, refusal to taking drug for fear of side effects accounted for about (n = 20) of noncompliance. Efforts are needed to reduce this gap before increasing the coverage. It needs motivating and sensitizing the community through IEC.

2. Incidence of side effects after MDA was minimal. All side effects were mild and needed no medical intervention; however, the community was largely unaware of RRT.

3. DD hardly insisted on supervised “on the spot” administration of drugs; therefore, supervised drug intake was nil or poor and the commonest answer was “will take after meal”. Efforts should be made to insist on “on the spot” consumption. This alone can bring down the coverage-compliance gap considerably.

4. Inclusion criteria were misunderstood. In some clusters DD, by mistake of their own, DEC was not given to persons who were having diabetes or hypertension. In our evaluation, we considered such persons eligible. Therefore, the coverage and effective coverage decreased in our evaluation. Training of DD in future should focus on the point that anybody who is above 2 years of age, nonpregnant and not critically ill (having some acute illness or hospitalization) must receive the drug.

5. DEC tab should be dispensed in 100 mg, 200 mg and 300 mg single doses that may be color coded for effectively implement in field as per requirement, because there is a misbelieve and fear in person to taking more than one tab on single time and they prefer to take after it at regular interval of about 8 hours.

6. Various modes of pre-MDA IEC can be utilized such as radio, TV, cable, newspapers, recorded messages or SMS (mobile or landline phones) and should be done just few days before the campaign. IEC should focus on the following:
   a. Threat perception of filariasis was very poor among people as it is not a visible disease, but still it is a threat as many people are at risk, and taking DEC only once in a year can prevent it.
   b. The single-dose DEC once in a year is an effective preventive tool while in treatment a person may have to take it for 21 days. Even many practicing doctors are also not clear about it.

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