FAILED TAS1 RESPONSE

CHECKLIST 3

Population Selected	Completed
1. Was sample size lower than the target and the number of positives less than the cut-off value?	☐
2. Was sample size higher than the target and the number of positives more than the cut-off value?	☐

Distribution of Results	Completed
3. How were positive results distributed by cluster (school or enumeration area)?	☐
4. How were positive results distributed by team?	☐

Diagnostic Test Quality	Completed
5. Were tests used before the expiration date?	☐
6. Was the lot used in the failed TAS EU also used in EUs which passed TAS?	☐
7. Were positive controls conducted on all lots within 6 weeks of survey?	☐
8. Did team members participate in TAS training and demonstrate capacity to use the test and interpret results?	☐
9. Were teams evaluated frequently by the supervisor in the field?	☐
10. Is area co-endemic for *Loa loa*?	☐

EU Setting	Completed
11. Was the baseline infection prevalence of areas in the EU considered high?	☐
12. Is the primary parasite in the EU *Brugia* ssp.?	☐
13. Are contiguous areas endemic and implementing MDA?	☐

MDA Evaluation Using Available Data	Completed
14. Was coverage calculated and reported correctly? - Were drug registers updated before each MDA?	☐
15. Are there sub-district areas with low coverage?	☐
16. Are there age/sex/ethnic/occupation groups with low coverage?	☐

Accompanies the WHO LF TAS Manual

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FAILED TAS1 RESPONSE

CHECKLIST 3

MDA Evaluation Using Available Data, continued	Completed
17. Did drug distribution platforms ensure delivery of medicines to all communities and groups? - What platforms were used? - Were a buffer stock of supplies available during MDA at all levels? - If fixed posts were used, was the ratio of posts to number of people targeted and the geographic location of posts appropriate?	☐
18. Did drug distribution platforms ensure proper dosage of medicines to all communities and groups?	☐
19. Did the MDA take less than 2 months to implement?	☐
20. If drugs are locally procured, have they been quality controlled?	☐

MDA Evaluation Using Newly Collected Data	Completed
21. Is there evidence of systematic non-compliance (consistent refusal to take medicines)?	☐
22. Is there evidence of systematic exclusion (medicines consistently not delivered/offered)?	☐
23. Was directly observed treatment used?	☐
24. Was MDA conducted at a time of year when most people are available?	☐
25. Was the MDA integrated with other activities?	☐
26. Were drug distributors trained and motivated? - Were roles and responsibilities for drug distributors written and distributed? - Were drug distributors selected because they were well known and respected by the community? - Were training aides and a manual provided? - Was information on responding to real or perceived side effects included in trainings? - Were standard post-tests used to test ability of drug distributors at end of trainings?	☐
27. Did social mobilization strategies and IEC materials contain appropriate messages and use community preferred means of dissemination? - Were community leaders involved in planning the MDA? - Were individuals with lymphedema or hydrocele involved in the campaign, if willing? - Were one-page job aids with photos of persons with the disease used as visual aids in discussions with communities? - Were side effects addressed in key communication messages?	☐
28. Was there adequate supervision of MDA? - Were roles and responsibilities for supervisors at each level written and distributed? - Did supervisors use supervision monitoring forms? - Were during and/or post-MDA review meetings held with communities to problem solve? - Did a system exist for handling reports of serious side effects?	☐
29. What is the drug distributor-supervisor ratio? (At least 1:10 is appropriate.)	☐