Lessons learned implementing NTD programs during COVID-19

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Introduction

Neglected tropical disease (NTD) activities were halted during the onset of the COVID-19 pandemic. Following World Health Organization (WHO) guidelines, NTD programs are resuming worldwide.

The USAID Act to End NTDs | East program has supported countries in Africa, Asia, and the Americas to reach their NTD control and elimination goals.

Currently, we are supporting countries to conduct risk benefit assessments to determine when and how to resume NTD programming. As activities resume, we are continually learning lessons and new ways of adapting during this global pandemic. We plan to rapidly share summaries of these learnings to support the wider NTD-fighting community.

For questions or more information contact ActEast@rti.org
COVID-19 and NTDs: Resources

• In partnership with USAID and the Act to End NTDs | West program, Act | East has developed a series of practical approaches to help countries figure out how to safely resume NTD activities, adapting to their country-specific needs.

• Suggested resources:
  • Practical Approaches to Implementing WHO Guidance for Neglected Tropical Disease (NTD) Programs in the Context of COVID-19: Mass Drug Administration (MDA)
  • Practical Approaches to Implementing WHO Guidance for Neglected Tropical Disease (NTD) Programs in the Context of COVID-19: Lymphatic Filariasis (LF) Surveys
  • Practical Approaches to Implementing WHO Guidance for Neglected Tropical Disease (NTD) Programs in the Context of COVID-19: Trachoma Surveys

• For more COVID-19 and NTDs resources, visit the NTD Toolbox
1. **Perceived risk** of getting COVID-19 was very low in rural areas where people believe COVID-19 to be an urban issue.

2. **Handwashing** practices were good.

3. As people moved out of urban areas, the population in rural areas increased. This resulted in drug shortages.

4. Physical distancing methods for ‘treating without touching’ meant MDA took longer.

5. Treatment of households only by their kinship persons was important.

6. **COVID-19 supervision checklist** was very useful
1. Pre-visit by the National Ministry of Health to the District Health Management Team before MDA increased participation in MDA planning and supervision.

2. Close coordination with district COVID-19 committees was helpful. They supported supervision of risk mitigation practices and provided daily updates on changing case numbers.

3. Adapting MDA materials for training, community sensitization, and supervision to the COVID-19 environment was essential.

4. Additional time during training is needed to practice some measures such as maintaining physical distance while using a dose pole. Additional time was also needed for data collection/compilation to follow COVID-19 protocols.

5. Handwashing was time consuming, use of sanitizers for village health teams was faster.
1. **Community demand** for schistosomiasis MDA was high.

2. It was critical to emphasize COVID-19 prevention to village leaders and communities before and during MDA. Many didn’t perceive COVID-19 as a risk and questioned use of masks and other preventive measures.

3. Enforcing **physical distancing** was difficult due to high student-teacher ratios and because distancing was not generally reinforced during other school activities. The team focused on keeping distance between students and staff and the MDA teams from outside the community.

4. **Remote supervision can be successful:** use photos, texts and calls; develop checklist for remote supportive supervision; engage zonal coordinators in supervision; dedicate more attention to historically low performing districts; and intensify training for district team and zonal coordinator on supervision of MDA & COVID-19 prevention measures.
1. **Physical distancing** is the most challenging COVID-19 protocol to enforce. Children especially like to crowd around the testing area to observe.

2. Personal **hygiene** measures and **mask-wearing** are generally well-adhered to.

3. Additional **pre-survey coordination** with communities is necessary. It is imperative that survey teams have detailed conversations about how protocols will be followed prior to their arrival, so that communities have time to prepare.

4. COVID-19 **reporting processes** should be determined in advance, in case of a positive COVID-19 case.

5. **Door to door sample collection** is preferred. This process takes more time but is easier to organize and safer for the communities, since large groups of people are not being asked to congregate in a central location. Door to door collection also attracts fewer onlookers.
Vietnam
Trachoma impact surveys and surveillance surveys, July & December 2020

1. Restarting activities under COVID-19 has meant that many more people need to be informed, consulted, and updated during survey planning. It is important to set expectations about the additional time that will be needed.

2. In this unprecedented challenge of COVID-19, preceded challenges must still be considered. Additional time spent preparing for COVID-19 restart pushed survey implementation into the start of rainy season, causing access problems for survey teams.
Democratic Republic of Congo
Trachoma impact surveys and pilot of the integrated loupes-face shield, November 2020

1. The **Supervision checklist** and **household exit interviews** provided real-time feedback to supervisors and surveyors.

2. The **community perceived** that the survey team took adequate precautions against COVID-19.

3. Graders reported that the **loupe-face shield**: was easy to put on and remove and held together throughout the fieldwork; did not cause any discomfort; did not impede ability to grade trachoma; did not interfere with communication between grader and recorder; and were easily disinfected between households.

4. **Community awareness**-raising is critical to success of the survey and should be started well in advance of the survey team’s arrival. Surveyors need to plan adequate time with the village chief, community health guide, and household members.

5. **Safe waste disposal is a critical component of COVID-19 protocols**, which must also be accounted for in transport vehicles.
1. Teams engaged a village guide and the village head to mobilize participants to a fixed location. This enabled the survey team to work more quickly and helped **prevent crowds** from gathering (crowding was observed when survey teams traveled house to house).

2. Many villages lacked adequate **hand washing** facilities despite radio/TV messaging on COVID-19 prevention. Setting up the survey near schools and church compounds enabled the team to use existing hand washing facilities and reduce considerable use of hand sanitizer.

3. Many children did not **wear masks** or face coverings and it was difficult for children to look away from the phlebotomist during sampling collection. Provision of disposable masks to children would increase protection of both the survey team and participants.

4. Each team (phlebotomist, card reader, register) had its own **vehicle** to adhere to COVID-19 protocols for safe transportation.

5. Involvement of the **district health office** made the community feel more confident that the survey was safe. The district health office also linked the survey team to the district COVID-19 taskforce that tracks new cases and kept the team informed.
1. Changing from school-based to community-based was successful where schools were closed. In other communities it was more challenging as schools had partially re-opened by the start of the survey. It is important to coordinate closely with teachers.

2. Communication with district authorities and communities is very important before fieldwork: to inform them about the sample collection that is going to take place, to outline the precautions that the survey team will take to make sure there is no transmission of COVID-19 and to communicate that the survey team also expects the same cooperation with risk mitigation from them.

3. Community support can be requested in managing participants and maintaining a queue with proper distance between participants. Female Community Health Volunteers brought people to the sample collection booths to avoid gathering crowds.

4. A sufficient quantity of masks must be planned for and procured. **More masks are needed** in remote communities where mask wearing is not common and for respondents’ parents, where survey participants are minors.

5. Additional community meetings prior to the survey and additional protective materials increase survey costs but are necessary. **Eight surveys were conducted safely and without incident, following the risk mitigation measures.**
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