COR-NTD 2020
Virtual Meeting, November 12 – 14
Integrating for Impact

Engaging hard-to-reach populations to achieve equity

Session Date: 14th November 2020

Session Time: 9:00 AM - 12:00 PM EST

Session Description: Certain social groups are difficult to access because of social or physical location, vulnerability, or hidden nature. Population heterogeneity, mobility, community buy-in, and public health infrastructure are explored to identify methods to increase MDA coverage in rural and urban areas.

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KEY DISCUSSION POINTS

What key findings and data did the group identify via presentations? What issues were raised in discussions?

- Key populations with low MDA coverage were identified and categorized in the following categories: migrant, urban, conflict zones, and males.
    - For all of these populations, better understanding of the dynamics of their role in transmission is needed. For example, which groups in heterogeneous urban populations require treatment, the impact of migrants on transmission, the scale of conflict's interruption of MDA, etc.
    - Also needed are documented examples of successfully adapted MDA strategies involving these key groups, i.e. locally-informed risk mitigation tactics in conflict zones, mobilization strategies targeting men and women of reproductive age, key urban stakeholders, etc.
- Maps were produced in Massangam health district, Cameroon to identify potential nomad camps using satellite imagery and markers identified by previous knowledge of camp locations.
    - The satellite identification of nomad camps demonstrated 65% sensitivity and 32% specificity. There is no differentiation between occupied vs unoccupied using this method, but it does provide added value at the planning stage, using community knowledge for cross-validation.
- Analysis of patterns of individual non-treatment over time from the TUMIKIA trial in Kenya showed that around half of all individuals either participated in both rounds of treatment or received no treatment. The remaining half received partial treatment.

    - Key risk factors for non-treatment over two rounds were: the least poor households, large households, ages 20-25 years, and females. School attendance and ages ≥30 years were both associated with treatment over two rounds.
    - Those who were not treated during the first round were more likely to not be treated in second round.
- Systematic non-compliance to MDA raises the coverage levels/time needed to achieve elimination, and is thus a major obstacle to the elimination of soil-transmitted helminthiasis (STH). A biometric census was conducted to explore individual non-compliance for STH MDA in Ethiopia.
    - Pre-SAC, adolescents, and men ages 21-35 were consistently absent from MDA. Household compliance varied and there was heterogeneity within communities. Major drivers of non-compliance identified were communication issues/hesitancy to provide biometrics, households distant from community centres, and lack of motivation.
        - As prevalence decreases, so does motivation, so targeted messaging is all the more critical.
    - Individual treatment history using this technology requires a lot of training, high enumerator skill, heavy community sensitization, and increased data management and cleaning.

KNOWLEDGE GAPS IDENTIFIED

What data and tools need to be generated to address the issues raised by the group?

- How to best gather data on non-compliance and the reasons behind it at individual and community levels?
    - People who don't want to participate in MDA are also unlikely to participate in data collection.
    - Are technological solutions (i.e. biometrics, satellite imagery) cost-effective in locating hard-to-reach groups and identifying their MDA coverage levels over time?
        - What are the potential considerations for ethics, sensitization, and complex acceptability issues among communities?
    - What is the scale of the impact that hard-to-reach populations have on transmission of various NTDs, and on MDA coverage & compliance at the community level?
    - What are the opportunities for integration of interventions and building local capacity, as reaching and gathering data on these populations is complex and expensive?

        - How do these groups differ across NTDs, and which ones could provide opportunities for collaboration?
        - What about other public health programs and diseases outside of NTDs?
- What contextual guidance is needed, and would be most useful to target these key risk groups for interventions?
    - Published case studies are needed, including what types of populations were identified, how they were identified, what tools and messaging were used for sensitization and mobilization?
        - Both overarching guidance and compilations of specific lessons learnt would be helpful.
    - Beyond MDA coverage, how can mapping, monitoring, and evaluation tools be inclusive of hard-to-reach pops?
        - What tools are needed across the program cycle and how can they be adapted to include these populations?

RECOMMENDED NEXT STEPS

What operational research and other actions need to be taken to address the knowledge gaps identified by the group?

- Current data on successful intervention strategies involving hard-to-reach populations, as well as key challenges and lessons learnt, should be curated and made available to program managers.
    - How can survey methodology be adapted to reflect special populations within NTD endemic districts? For example, if there are refugee or IDP camps within the district how should cluster selection be adapted to ensure they are (or not) included?
    - MDA is not the only challenge in hard-to-reach populations. Mapping, and monitoring and evaluation are also big challenges. How can we provide tools to countries to address challenges on the different actions needed in the program cycle in these populations?
    - How important are migrants (of different types) to on-going and recurring transmission?
    - What is the appropriate geo-spatial technology that also considers movement due to livelihood patterns?
- In developing targeted social mobilization and sensitization strategies, it is imperative that we move beyond convincing people to take medication. Rather, a participatory approach – engaging the community in the scheduling and planning of MDAs and gathering their inputs when determining which groups needs more encouragement – is critical.

- More information is needed on compliance patterns within populations, namely whether these patterns change over time with control, and whether compliance is related with pre-control levels of infection.
- What indicators for routine program monitoring & evaluation could help program managers assess coverage and compliance among hard-to-reach groups? Are current program indicators focused on internal processes, external factors at the community level, or both?
- Opportunities for collaboration across diseases and integration within health system should be sought when planning efforts to reach key risk groups. Also, strengthening local capacity should be built into any intervention efforts.