Revisiting Integrated ITN Campaigns

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Global Fund and other partners: renewed interest in integration

• Despite progress, ITN coverage flat-lined since 2015
  – Most countries not achieve UC.

• Campaigns effective and equitable, but need human, financial and logistical resources.

• Multiple stand-alone campaigns by intervention strain capacity.

• To increase efficiency, partners exploring integration.
  – Global Fund engaged AMP CG member to review options
  – GAVI, WHO-EPI support
  – Gates: interest in integration within context of increasing overall campaign effectiveness and reach
MANY COUNTRIES CONDUCT >7 LARGE-SCALE CAMPAIGNS ANNUALLY

Number of Planned National Campaigns by Country and Region in 2018

Source: BMGF Campaign Effectiveness Team 2018
Purpose and scope of review

• Historical development
• Factors leading countries away from integration
• Methods and target groups
• Benefits and drawbacks
• Recommendations to countries
• Focus:
  – Operations, not coverage (M&E indicators evolved);
  – Most frequently linked interventions, plus yellow fever and seasonal malaria chemoprevention
What’s meant by integration?

• WHO definition (2008):
  “...the organization and management of health services so that people get the care they need, when they need it, in ways that are user-friendly, achieve the desired results and provide value for money.”

• Integration feasible at two operational levels:
  – All campaign operations
  – Specific components

- Pre-2002: social marketing, routine visits, CHWs.
  - Poor coverage & use, far from 2005 Abuja targets

- Proven measles immunization campaign platform adopted:
  - Incentive to use existing platform given limited malaria-specific funding.
  - Proof of concept: sub-national Ghana, Zambia & Tanzania, national Togo.
  - Ghana: low marginal cost US$0.32 per net, coverage 10x higher in poorest quintile than pre-campaign wealthiest quintile (90% vs. 9%), high measles coverage not compromised.

- WHO-UNICEF Joint Statement 2004:
  - Free ITNs to children <5 years via EPI campaigns.

- Integration with EPI campaigns: through about 2010.
## Characteristics of 17 integrated campaigns 2002-2017

<table>
<thead>
<tr>
<th>Areas of review</th>
<th>Observations</th>
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<tbody>
<tr>
<td>Geographic focus</td>
<td>Largely nationwide, set periods or phased/rolling</td>
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<tr>
<td>Target groups for ITNs</td>
<td>Varied: at start 1 ITN per child &lt;5y; with UC, 1 per 2 persons up to 3 per HH; others set 2 per HH</td>
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<tr>
<td>Linked interventions</td>
<td>Varied: most measles or polio, vit A, deworming; others ivermectin (Nigeria, Togo), praziquantel (Togo), HIV-AIDS counseling (Kenya)</td>
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<tr>
<td>Distribution strategies</td>
<td>Mostly fixed HCs or temporary sites; vouchers redeemed in 6 campaigns</td>
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<td>Cost</td>
<td>Data for 5 campaigns, not comparable</td>
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<td>Equity</td>
<td>In 11 campaigns with data, all pro-poor</td>
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<tr>
<td>Effects on coverage ITNs and linked interventions</td>
<td>Rapid ITN coverage increases; Mozambique 2009 found increases measles and ITN coverage</td>
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Universal coverage and integration

• WHO guidance change 2007:
  – From “vulnerable” to “all community members.”
  – Evidence-based (e.g., Kenya): targeting “all” increases coverage vulnerable population & community effect.
  – Campaigns needed to supplement routine delivery.

• Implications:
  – Different services to different age groups.
  – Manage multiple sources commodities.
  – NMCP expertise increased, divided ITN and EPI focus.
  – Commodity delays meant poor timing for best outcomes by intervention (i.e., measles vaccination delay for ITNs).
Evolution to stand-alone campaigns

- New, expanded malaria resources (GF, PMI, DFID) decreased reliance on EPI platform.
- Incentivized to focus on managing ITN scale-up.
- Less concerned with logistics of linked interventions.
- By 2010, most countries switched approaches.
## Considerations for linked interventions

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Ideal timing</th>
<th>Target groups</th>
<th>Procurement</th>
<th>Logistics</th>
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<tbody>
<tr>
<td>ITNs</td>
<td>Before rainy season</td>
<td>All HH members</td>
<td>GF 6-7m, PMI 10m, UNICEF 5-8m</td>
<td>Bulkiness, warehousing, multiple procurement sources &amp; methods</td>
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<tr>
<td>Measles</td>
<td>Before end rainy season</td>
<td>Catch-up 9m-14y; follow-up 9-59m</td>
<td>9-12m before campaign</td>
<td>Cold chain, waste mgt</td>
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<td>Polio</td>
<td>Dry season</td>
<td>&lt;5 years</td>
<td>3-5m + 4 weeks to deliver vacc supplies</td>
<td>Cold chain, waste mgt</td>
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<td>Vitamin A</td>
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<td>6-59m &amp; pregnant women</td>
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<td>Deworming</td>
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<td>12m – school age (about 12y)</td>
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<td>Yellow fever</td>
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<td>High-risk &gt;9m; outbreak 6-12m, preg &amp; BF women</td>
<td>Fluid given limited production capacity</td>
<td>Cold chain, waste mgt</td>
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<td>SMC</td>
<td>During and after rainy season</td>
<td>3-59mos</td>
<td>PMI: 12m given limited SP/AQ production capacity</td>
<td>CHW system must be functional, timely delivery supplies in rainy season</td>
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<td>Benefits of integration</td>
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<tr>
<td>1. Build campaign experience for linked interventions</td>
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<td>2. Create economies of scale from operational efficiencies</td>
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<td>3. Implement at low unit costs per net delivered</td>
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<td>4. Fewer campaigns can allow focus on campaign quality</td>
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<td>5. Reach the chronically underserved</td>
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<td>6. Increase health system productivity by training &amp; monitoring same HWs</td>
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<td>7. Potentially improve outcomes for all interventions vs. stand-alone</td>
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<td>8. Allow efficiencies with specific campaign components</td>
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<td>9. Promote equity in service access and delivery</td>
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<td>10. Build leadership and technical capacity</td>
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<td>11. Implement campaigns at similar time intervals</td>
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<td>12. Adapt to complex operating environments</td>
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<td>13. Coordinate evaluations of process and outcomes</td>
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Drawbacks to integration

1. **Impact of poor planning worse on quality & outcomes**

2. **Adjusting to different target-age groups by intervention**

3. **Differing optimal timing by intervention to impact disease**

4. **Varied intervention complexity**

5. **Diverse procurement systems and funding cycles to coordinate**

6. **Increased workloads for HWs and community volunteers**

7. **Lack high-level incentive or commitment to re-visit integration**

8. **Stock outs of individual commodities can affect all interventions**

9. **Varied storage, transportation and security requirements**

10. **Increased complexity of HHR and data collection**

11. **Differing rules and procedures for local procurement and transferring funds**
Overall conclusions

• Integration is viable and promising

• Essential conditions:
  1) Commitment to early planning
  2) Strong collaboration program managers & partners
  3) Coordination of funding streams, procurement processes & in-country logistics
  4) Commitment & investment in additional training, supervision and monitoring to address all interventions adequately
Recommendations

1. **Encourage** countries to explore integration, if local context allows.

2. Invest in strong **partnership coordination** from the start.

3. Consider **partial integration** if full integration too challenging.

4. Explore **new opportunities** for integration (SMC, yellow fever).

5. **OR priorities**: e.g., economic & health value of integration vs. stand-alone; “missed opportunities for integration;” impact ITN access, equity.

6. Apply campaign lessons to **routine**, and vice versa.

7. Develop policy, strategy and operational **guidance** for integration.
Your thoughts on integration

• Is there country-level interest (NMCPs and partners) in revisiting integration?

• What are other pro’s and con’s?

• How do we make integration a data-driven decision?

• What should AMP’s role be in exploring integration, and what additional resources are required to do so?