Revisiting Integrated ITN Campaigns

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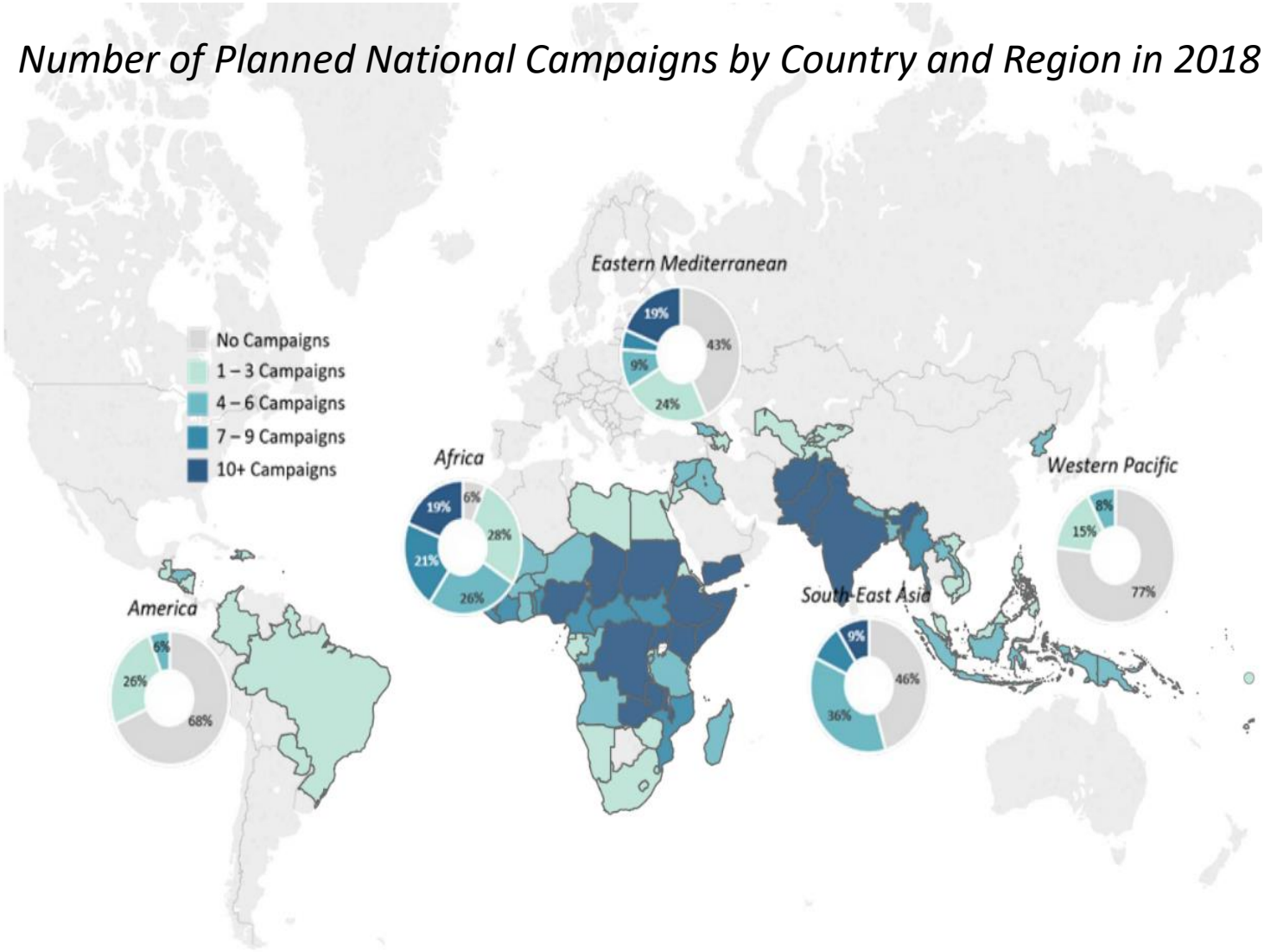
Global Fund and other partners: renewed interest in integration

- 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  ?

- 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

Early development of ITN campaign integration (2002 – 2009/2010)

- 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

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

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

Intervention	Ideal timing	Target groups	Procurement	Logistics
ITNs	Before rainy season	**All HH members**	GF 6-7m, PMI 10m, UNICEF 5-8m	Bulkiness, warehousing, multiple procurement sources & methods
Measles	Before end rainy season	**Catch-up 9m-14y; follow-up 9-59m**	9-12m before campaign	Cold chain, waste mgt
Polio	Dry season	**<5 years**	3-5m + 4 weeks to deliver vacc supplies	Cold chain, waste mgt
Vitamin A		**6-59m & pregnant women**		
Deworming		**12m – school age (about 12y)**		
Yellow fever		**High-risk ≥9m; outbreak 6-12m, preg & BF women**	Fluid given limited production capacity	Cold chain, waste mgt
SMC	**During and after rainy season**	**3-59mos**	**PMI: 12m given limited SP/AQ production capacity**	**CHW system must be functional, timely delivery supplies in rainy season**

Benefits of integration

1. Build campaign experience for linked interventions
2. **Create economies of scale from operational efficiencies**
3. Implement at low unit costs per net delivered
4. **Fewer campaigns can allow focus on campaign quality**
5. **Reach the chronically underserved**
6. **Increase health system productivity by training & monitoring same HWs**
7. Potentially improve outcomes for all interventions vs. stand-alone
8. **Allow efficiencies with specific campaign components**
9. Promote equity in service access and delivery
10. Build leadership and technical capacity
11. Implement campaigns at similar time intervals
12. **Adapt to complex operating environments**
13. Coordinate evaluations of process and outcomes

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?