Sustaining Universal Coverage of LLINs

Vector Control TEG Update
Geneva September 2013
For the majority of countries in Africa – universal coverage campaigns are planned on a 3 year basis with routine distribution through EPI and ANC to infants and pregnant women.

Some countries are piloting other delivery mechanisms e.g. school based distribution in Tanzania, community based distribution in South Sudan.
Background: LLIN deliveries to Africa
Background: LLIN Gap analysis

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<thead>
<tr>
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<th>2013</th>
<th>2014</th>
<th>2015</th>
<th>2016</th>
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</thead>
<tbody>
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<td>Need</td>
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<td>Financed</td>
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<td>Gap</td>
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<td>58,006,280</td>
<td>108,103,853</td>
<td>180,569,349</td>
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![Bar chart showing need, financed, and gap from 2013 to 2016]
LLINs have contributed significantly to the successes seen in malaria control to date and remain the priority intervention moving forward.

With a successful GF replenishment, joint global forecast and long term tenders, as well as continued support from DFID, PMI and others we are confident that funding gaps will be filled and will result in a smoothing out of funding flows and LLIN deliveries.
LLINs and Universal Coverage – Background
LLINs and Universal Coverage – Background summary

- Universal Coverage remains the goal but countries need clear guidance on practical methods to maintain coverage.
- Some partners have been pushing for routine distribution alone to sustain coverage but mass campaigns remain a necessary delivery mechanism.
- More experience is required for other delivery strategies such as schools and community level.
- Resources should be sufficient to sustain universal coverage to 2016.
- Indicators for monitoring LLIN coverage needed to be revisited to better inform programming decisions.
Technical Expert Group On Malaria Vector Control
Recommendations for MPAC's consideration
Universal coverage remains the goal: this is defined as full coverage with effective vector control of all people at risk of malaria.

To maintain universal coverage, WHO recommends mass distributions, complemented by continuous or “routine” distributions through multiple channels, esp. ANC and EPI.

The interval between mass campaigns is normally 3 years unless evidence indicates otherwise (e.g. routine distribution is maintaining high coverage or nets are lasting longer).

When planning campaigns - if coverage <40% NOT worthwhile to consider existing LLINs in calculation of need. If coverage >40%, existing LLINs could be considered.
Recommendations

- Campaign and routine distributions should be planned and coordinated as a unified program, with shared national plan, resources, communications and supplies and complementary continuous distribution channels should be in place BEFORE, DURING and AFTER campaigns.
- Mass free distribution campaigns will remain an important component for maintaining universal LLIN coverage.
- Antenatal, immunisation and child health clinics should be considered as the highest priority LLIN continuous distribution channels in countries where contact rates are high, as they are in much of Africa south of the Sahara.
Recommendations

- Other potential channels (based on country context)
  - Schools
  - Religious institutions (mosques, churches)
  - Employer schemes
  - Community networks
  - Retail

- Need to ensure EQUITY
Recommendations

- Eventual objective is a gradual shift from campaigns towards continuous distribution systems as the primary means of sustaining coverage.

- Programmes need to track coverage and relative contributions of the various delivery channels:
  - repeated longitudinal estimates of % population with access to an ITN/LLIN within the household
  - Operational coverage through ANC and EPI services
  - Relative contributions of different delivery channels

- WHO recommends that all LLIN programmes should collect their own data on LLIN durability in local conditions, using standardised methods:
  - In the meantime, programmes can use the RBM HWG 8% : 20% : 50% method of estimation or alternatively the NetCalc model

- WHO recommends that data on durability and ‘value for money’ e.g. ‘cost per median year of net life under local conditions of use’ are used to inform product choice decisions in procurement.
Way forward

- For the foreseeable future, mass free LLIN distributions to at-risk populations will continue to be necessary.
- Where large-scale distribution through routine health systems is absent, or achieves low coverage, campaigns should occur every ≤3 years.
- Antenatal, immunisation and child health clinics should be considered as the highest priority LLIN continuous distribution channels in countries where contact rates are high.
- Other distribution mechanisms should be investigated and explored.
- Enhanced monitoring and evaluation is required to better inform programming decisions.