HEALTH CAMPAIGN
EFFECTIVENESS COALITION
Strengthen Systems. Maximize Impact.

THE TASK FORCE FOR GLOBAL HEALTH

Decision Guidance Toolkit for People-Centered Integration of Health Campaigns

March 2021
(draft)

Background

Health campaigns are time-bound, intermittent activities that address specific epidemiologic challenges, expediently fill delivery gaps, or provide surge coverage for health interventions. Many campaigns complement routine health service delivery. Campaigns occur in health areas, such as malaria, neglected tropical diseases (NTDs), immunization, polio, and Vitamin A supplementation. They can be used to prevent or respond to disease outbreaks, control or eliminate targeted diseases as a public health problem, eradicate a disease altogether, or achieve other health goals.

Despite the many successes of health campaigns, current vertical approaches can limit their potential impact. In settings where multiple campaigns occur, planning and implementation may be carried out with little communication or collaboration among stakeholders and with inadequate coordination with country health systems. This may result in inefficiencies and inequities that can strain health systems, burden health care workers and communities, weaken health services, and limit the potential impact of campaigns.

The Health Campaign Effectiveness program (HCE) at The Task Force for Global Health with support from the Bill & Melinda Gates Foundation has developed a cross-campaign coalition that fosters learning and systems change. The Coalition brings together country leaders, donors, multilateral organizations, and NGOs from several large-scale health campaign domains, as well as specialists in health systems, ethics, and health economics.

Purpose and Objectives of this Toolkit

The purpose of the toolkit is to assist diverse officials and stakeholders at the country and global levels to identify and collect information on the potential opportunities for health campaign integration.

The objectives are to:

1. Identify opportunities for initiating and continuing a discussion on campaign integration;
2. Provide evidence-based criteria to help country health programs and stakeholders pair campaign interventions with strong promise for effective full or partial integration;
3. Highlight the factors that are potential facilitators and barriers to such combinations in each country context; and
4. Facilitate the synthesis of global and national guidelines, standards, and criteria to inform campaign integration decisions in each country.

While not exhaustive, the two appendices--*Worksheet for Global and Country Standards on Planning Health Campaign Integration* and *Criteria across Health Domains and Specific Interventions for Selecting Potential Campaign Integration*—can be particularly helpful for the pre-planning stages of campaign integration.

Users

The intended users are policy makers and stakeholders at the national, subnational, regional, and global levels who oversee, plan, finance, implement, or monitor health campaigns, and that issue guidance around health campaigns, PHC, and health systems strengthening.

In developing this tool, special attention was dedicated to upholding the key categories of Feasibility, Accountability, Acceptability, Compatibility, Context, and Equity (see Appendix C).

Acknowledgements

The *Decision Guidance Toolkit for People-Centered Integration of Health Campaigns* was developed by the Health Campaign Effectiveness program, generously funded by the Bill and Melinda Gates Foundation at the Task Force for Global Health. The toolkit was informed by discussions of the Campaign Integration Working Group (CIWG) through an iterative process of feedback gleaned from CIWG meetings, subject matter experts, field experience, HCE funded case studies, and guidelines of the World Health Organization.

The document was developed by David Gittelman, Vivek Patel, and Eva Bazant. We thank CIWG members for specific comments on and inputs to this tool, including Andreas Hasman, UNICEF; Anitta Kamara of National Malaria Control Programme, Ministry of Health and Sanitation, Sierra Leone; Mandy Kader Kondé la Fondation Santé & Développement Durable/Centre d'Excellence de Formation et Recherche sur les Maladies Prioritaires in Guinea; Patrick Lammie, of the NTD-Support Center at the Taskforce for Global Health; Gladys Muhire and Suzanne Van Hulle, Catholic Relief Services; Laura Nic Lochlainn, World Health Organization; Pooja Pandey, Helen Keller International, Nepal; Robert Perry, Centers for Disease Control and Prevention, Atlanta, Georgia, USA; Martha Saboya, Pan American Health Organization; and Jovana Alexandra Ocampo Cañas, Universidad de los Andes, Bogotá, Colombia. We acknowledge CIWG members for engaging in discussions related to the toolkit, including Zainab Ali, Catholic Relief Services, Nigeria; Horace Cox, Ministry of Health, Guyana; Ajay Khera, EngenderHealth India; Alison Krentel, Bruyere Research Institute, University of Ottawa, Canada; Htar Htar Lin, Ministry of Health and Sports, Myanmar; Joseph Oteri, National Primary Health Care Development Agency, Nigeria; Sara Sa Silva, Gavi Secretariat; and Kwamy Togbey, Ministry of Health, Togo.

Suggested Citation: Gittelman D, Patel V, Bazant E and the Campaign Integration Working Group of the Health Campaign Effectiveness Coalition. *Decision Guidance Toolkit for People-Centered Integration of Health Campaigns.* Decatur, GA: The Task Force for Global Health, 2021.

HEALTH CAMPAIGN EFFECTIVENESS COALITION
Strengthen Systems. Maximize Impact.

THE TASK FORCE FOR GLOBAL HEALTH

Decision Guidance Toolkit for People-Centered Integration of Health Campaigns (Draft 3/29/2021)

Table of Contents

README: How to use the Decision Guidance Toolkit for People-Centered Integration of Health Campaigns?

Step 1: Identify the Problem & Start or Continue the Conversation

The first step is one of reflection, assessment, and evaluation from the perspective of your role. Please see **page 2** "How do you start or continue the conversation on campaign integration in your country?" for suggested best practices and tips to help start or continue the conversation.

Step 2: Explore the Possibilities and Identify Pairings

Once you have attracted key decision-makers and partners to the idea of integration, the next step is to explore other health interventions from the perspective of your current role (e.g. local district, country, or global level). You will find a matrix on **page 5** and key criteria on **page 6**. The matrix on page 5 is strictly a visual representation of the process that allows one to explore the pairing of different health interventions from the lens of the key criteria listed on page 6. The intent is to identify key criteria that would facilitate campaign integration and also identify key criteria that would be a barrier to campaign integration. Please see **pages 3 and 4** for an example of how to apply the matrix and key criteria. Please note: the cells on page 5 are for reference only and nothing should be filled in on page 5 itself.

Step 3: Customize According to Global, Country, and/or Local Context

Once you have identified possible health intervention(s) for integration, the next step is to customize the integration opportunity according to global, country, and/or local context. Please see **Appendix A** for a worksheet with fillable cells and selected criteria to plan the integration opportunity according to your needs. Please see **Appendix B** for selected technical guidance and best practices of selected health interventions to get you started. The list is not exhaustive, and it is imperative to use the most current guidelines that your situation requires. Feel free to add more key criteria and tweak the **Appendix A** worksheet to your needs.

How do you start or continue the conversation on campaign integration in your country?

Before using the toolkit to examine integration opportunities, key decision-makers and partners in a country need to be attracted to the idea of campaign integration and motivated to explore it further. Here are some tips to help start or continue the conversation.

Identify the problem

Pinpoint the challenges you face in planning a campaign. Are they limited funding, staff overwhelmed by overlapping campaigns and routine duties, poor intervention coverage, disease outbreaks, or others?

Determine if integrating campaigns is a viable way to address those problems

Research whether the country has conducted integrated campaigns in the past, and if so, whether they were conducted well and met their targets. Ask staff who participated in those campaigns to share their experience. Locate and review previous campaign reports and tools. Learn if different health programs have shared strategies and tools on certain parts of the campaign process such as microplanning, population census, logistics, communications or data collection; perhaps collaboration or partial-integration is more promising than co-delivery or full integration.

Engage leaders with the qualities and clout needed to generate interest in campaign integration.

Cultivate relationships with leaders and other individuals who have the knowledge, peer-recognition, and humility that can spark change. Look for key qualities such as: availability, accountability, spirit of advocacy, transparency, and ability to delegate

Identify the key decision-makers with the legal or administrative authority to approve an integrated strategy and/or to fund those efforts.

Ensure equity by reaching out to a broad array of stakeholders at the national, district and community levels in exploring campaign integration.

Include stakeholders such as health workers, community, faith and traditional leaders, community agents, medical and nursing organizations, academic institutions, and faith-based agencies. Include both supporters and opponents of integration. Take care to encourage constructive dialogue rather than imposing solutions.

Encourage individuals or organizations in-country that express interest in campaign integration to start the conversation.

Suggest or seek guidance on the best timing, setting and group of individuals or organizations for that conversation. Outline the objectives of those initial discussions and incorporate the decision-making process described below in the agenda and work plan.

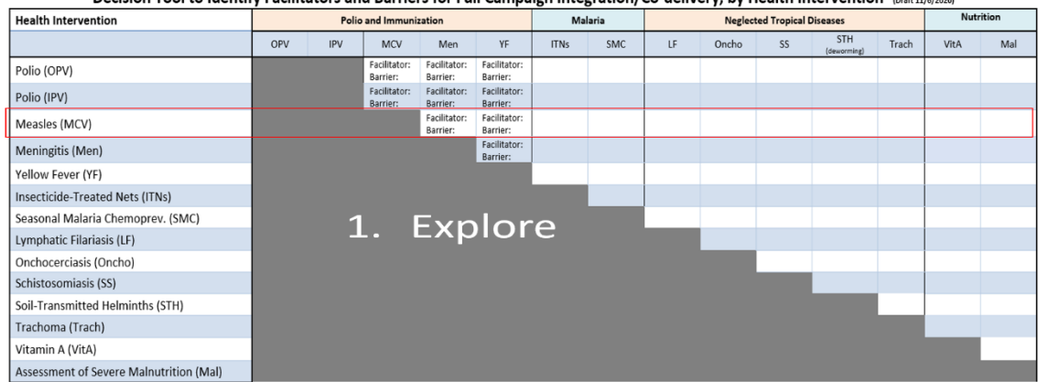
Select an optimal setting for the conversation

Take advantage of routine coordination meetings of the Ministry of Health and partners to include integration on the agenda. Bring this toolkit!

	Consult Government Ministries of Health, Finance, and Education where appropriate, along with key implementing partners who typically help finance the targeted health interventions.			

Example and Sample Pairings of Health Interventions

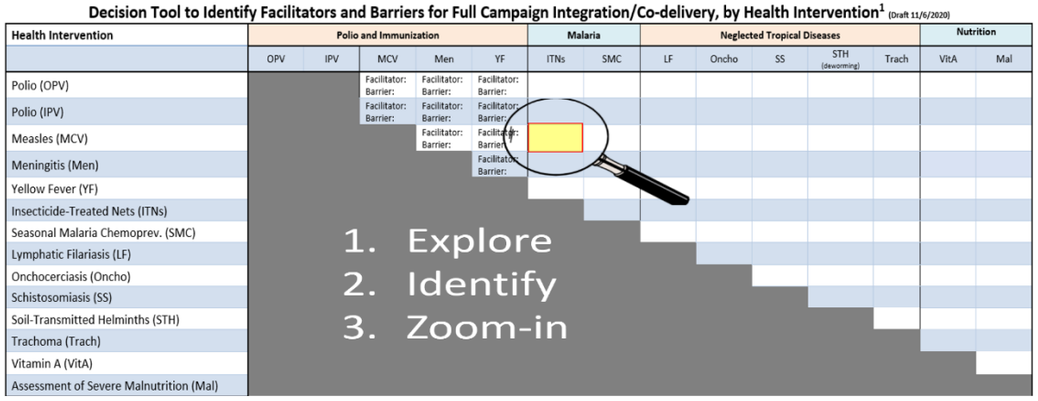
Decision Tool to Identify Facilitators and Barriers for Full Campaign Integration/Co-delivery, by Health Intervention[1] (Draft 11/6/2020)



Step 1 - Explore: Explore *other* health interventions from the perspective of your current role (e.g. local district, country, or global level).

For example, country or state-level planners of a Measles immunization campaign would research planned/ongoing campaigns in their country (e.g., immunizations, malaria, NTDs, and VitA).

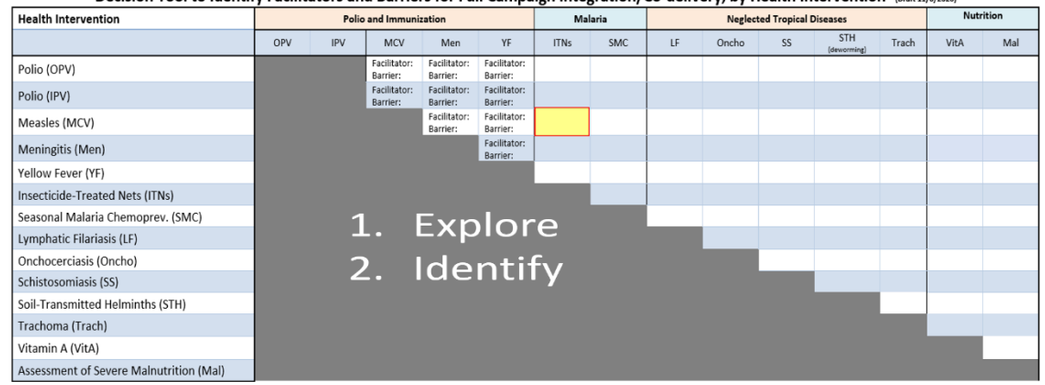
Decision Tool to Identify Facilitators and Barriers for Full Campaign Integration/Co-delivery, by Health Intervention[1] (Draft 11/6/2020)



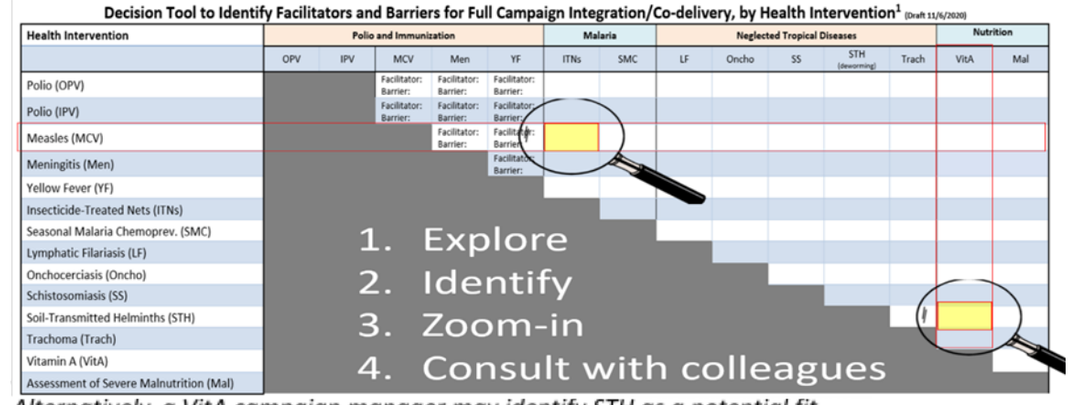
Step 3 -"Zoom-In": Once possible pairings or bundles of interventions have been identified, "zoom-in" and identify specific facilitators and barriers from the key criteria on page 5, Appendix A, and Appendix B.

An example of the pre-planning for integration between a measles and malaria ITN campaign is shown below with key facilitators and barriers identified.

Decision Tool to Identify Facilitators and Barriers for Full Campaign Integration/Co-delivery, by Health Intervention[1] (Draft 11/6/2020)



Decision Tool to Identify Facilitators and Barriers for Full Campaign Integration/Co-delivery, by Health Intervention[1] (Draft 11/6/2020)



Alternatively, a VitA campaign manager may identify STH as a potential fit.

Step 4- Consult with colleagues in the departments that oversee the campaigns on the key facilitators and barriers for integration.

Example (Cont'd): Integrating Measles Immunization with ITNs & Integrating Vitamin A with Deworming/STH

Health Intervention	Immunization					Malaria		Neglected Tropical Diseases					Nutrition	
	OPV	IPV	MCV	Men	YF	ITNs	SMC	LF	Oncho	SS	STH (deworming)	Trach	VitA	Maln
Polio (OPV)			Facilitator: Barrier:	Facilitator: Barrier:	Facilitator: Barrier:									
Polio (IPV)			Facilitator: Barrier:	Facilitator: Barrier:	Facilitator: Barrier:									
Measles (MCV)				Facilitator: Barrier:	Facilitator: Barrier:									
Meningitis (Men)					Facilitator: Barrier:									
Yellow Fever (YF)														
Insecticide-Treated Nets (ITNs)														
Seasonal Malaria Chemoprev. (SMC)														
Lymphatic Filariasis (LF)														
Onchocerciasis (Oncho)														
Schistosomiasis (SS)														
Soil-Transmitted Helminths (STH)														
Trachoma (Trach)														
Vitamin A (VitA)														
Assessment of Severe Malnutrition (Maln)														

Measles immunizations and ITNs:

Facilitators:
- Timing (both before rainy season)
- Delivery strategies (fixed post or mobile)
- Campaign intervals (every 3 years possible)
- Census/household registration
- Geographic targets can overlap

Barriers:
- Incentive to coordinate EPI and NMCP programs
- Cold chain vs. bulky net transport & warehousing
- Training targets differ (trained vaccinators vs. community distributors)
- Target ages (ITN=all ages, measles 9-59 mos)
- Procurement sources can differ (UNICEF, Global Fund, PMI-USAID)

Vitamin A and deworming/STH:

Facilitators:
- Biannual or annual
- Children <5 (deworming to 14 years)
- Delivery strategies (fixed post or mobile)
- Procurement sources (UNICEF)

Barriers:
- Training, monitoring problems swallowing deworming tablets
- Incentive to coordinate between nutrition and STH programs

Decision Guidance Tool to Identify Facilitators and Barriers for Full Campaign Integration/Co-delivery, by Health Intervention

Health Intervention	Immunization					Malaria		Neglected Tropical Diseases					Nutrition	
	OPV	IPV	MCV	Men	YF	ITNs	SMC	LF	Oncho	SS	STH (deworming)	Trach	VitA	Maln
Polio (OPV)			Facilitator: Barrier:	Facilitator: Barrier:	Facilitator: Barrier:									
Polio (IPV)			Facilitator: Barrier:	Facilitator: Barrier:	Facilitator: Barrier:									
Measles (MCV)				Facilitator: Barrier:	Facilitator: Barrier:									
Meningitis (Men)					Facilitator: Barrier:									
Yellow Fever (YF)														
Insecticide-Treated Nets (ITNs)														
Seasonal Malaria Chemoprevention (SMC)														
Lymphatic Filariasis (LF)														
Onchocerciasis (Oncho)														
Schistosomiasis (SS)														
Soil-Transmitted Helminths (STH)														
Trachoma (Trach)														
Vitamin A (VitA)														
Assessment of Severe Malnutrition (Maln)														

Key Criteria for People-Centered Integration Decisions at Various Levels

(Note: Please see page 25 for definitions of selected criteria)

Intervention	**Local/Subnational**	**National**	**Global**
• Age Range • Seasonality • Intervention complexity (e.g. injectable cold chain, directly observed therapy) • Place of delivery and distribution mode • Duration/frequency (recurring, rotating, one time, catch up)	• Community acceptance of all individual interventions & of integration • Health worker acceptance of all individual interventions & of integration • Community capacity to ensure effective integration (e.g., training) • Incentives for integration (e.g. monetary or non-monetary) • Communication in place (e.g. to address rumors, hesitancy) • Equity (e.g. access, gender, human rights) • Values (active community participation throughout planning/implementation) • Preferences of caregivers/families/beneficiaries • Local epidemiology of targeted health intervention • Capacity to monitor post campaign adverse events if applicable	• Government commitment & policy • Coordination mechanisms, including public health workforce • Incentives or willingness to explore integration • Financing by government & donors • Options and feasibility for pooling partner resources to support integration • Geographic overlap of campaign per program • Population acceptance of individual interventions & principles of integration • Operational complexity (procurement, supply chain, logistics, communications, waste management) • Equal priority given to each intervention being co-delivered • Capacity for & commitment to monitoring, data collection, evaluation, surveillance • Duration & Frequency (recurring, rotating, one-time) • Partial integration (census data, social mobilization, education, messaging) • Planning or implementation of other health campaigns • Planning for monitoring post campaign adverse events if applicable	• Global partner dialogue facilitation (e.g., HCE Coalition, WHO) • Global policy & operational guidance • Equal priority given to each intervention being co-delivered • Linkage to global/regional goals & local/regional priorities • Structural barriers • Advocacy, programmatic Incentives for integration • Awareness of other campaign interventions being planned or in progress. • Monitoring post campaign adverse events if applicable

Appendix A: Worksheet for Global and Country Standards on Planning Health Campaign Integration

Country: _____ Month/Year of Planned Integration: _____ Agencies involved: _____

Directions: Campaign planners discussing integration should list the campaigns below and write in the cells a summary of their thoughts or observations.

Intervention 1: _____ Intervention 2: _____

Criterion		Global Guidelines or Standards	Country's Guidelines, Policy, Standards	Local Context: Issue and Challenges
Government acceptance of integration/policy	Intervention 1			
	Intervention 2			
Coordination mechanisms	Intervention 1			
	Intervention 2			
Financing/funding sources	Intervention 1			
	Intervention 2			
Partner/donor support	Intervention 1			
	Intervention 2			
Timing/intervals	Intervention 1			
	Intervention 2			
Household registration or target population census	Intervention 1			
	Intervention 2			
Procurement complexity	Intervention 1			
	Intervention 2			
Supply chain	Intervention 1			
	Intervention 2			
Logistics/transportation	Intervention 1			
	Intervention 2			

Waste Management	Intervention 1			
	Intervention 2			
Acceptance & Incentives (Health workers, Community/Population, stakeholders)	Intervention 1			
	Intervention 2			
Monitoring Post Campaign Adverse Events	Intervention 1			
	Intervention 2			
Monitoring, Evaluation & Surveillance Capacity	Intervention 1			
	Intervention 2			
Age range	Intervention 1			
	Intervention 2			
Seasonality (e.g. disease peaks, transmission, weather conditions/climate)	Intervention 1			
	Intervention 2			
Intervention complexity (e.g, injectable vs oral vaccine, cold chain, directly observed therapy**)**	Intervention 1			
	Intervention 2			
Point/place of delivery (e.g. fixed post - permanent and/or temporary, mobile post, fixed or mobile post with house to house canvassing, etc.)	Intervention 1			
	Intervention 2			
Duration at delivery site and district	Intervention 1			
	Intervention 2			

Appendix B: Criteria across Health Domains and Specific Interventions for Selecting Potential Campaign Integration

(Blank cells are in need of specific information and references. Please see list of references at the end.)

Campaign Criteria	Immunizations		Malaria		Neglected Tropical Diseases		Nutrition	
Coverage objectives per WHO Global partner dialogue facilitation (e.g., HCE Coalition, WHO) Global policy & operational guidance	**POLIO (OPV)**	High (≥95%) immunization coverage two doses	**INSECTICIDE-TREATED-NETS**	≥80% for both ITN ownership and use, targeting universal coverage, or one for ITN for every two household members regardless of age.	**LYMPHATIC FILARIASIS**	>65% of the entire population.[3]	**VITAMIN A**	Effective coverage of ≥80% as threshold to improve child survival[4] [5]
	POLIO (IPV)				**ONCHOCERCIASIS**	80% therapeutic coverage (population eligible for treatment)[6]	**MALNUTRITION**	
	MEASLES	High (≥95%) immunization coverage two doses	**SEASONAL-MALARIA-CHEMOPREVENTION**	>95% of eligible children receive sulfadoxine-pyrimethamine + amodiaquine at monthly intervals during period of highest malaria risk. Countries may distribute sulfadoxine-pyrimethamine + amodiaquine at between two and 5 monthly intervals depending on their stratification maps and criteria used.	**SCHISTOSOMIASIS**	75% school-aged children and adults in high risk communities		
	MENINGITIS	High (> 95%) vaccination coverage?			**SOIL-TRANSMITTED HELMINTHS**	Global target: by 2020, treat at least 75% of children in countries endemic for soil-transmitted helminthiases		
	YELLOW FEVER	>80% with a 60-80% security threshold, to interrupt local transmission; one dose confers lifetime immunity			**TRACHOMA**	80% of the entire population[7]		
Seasonality of disease	**POLIO (OPV)**	No seasonal pattern in tropical climates; national immunization days are best during cool, dry seasons when circulation lowest and higher seroconversion occurs.	**INSECTICIDE-TREATED-NETS**	Peak during and after rainy season	**LYMPHATIC FILARIASIS**	Transmission may be seasonal (i.e., associated with rainfall), but infection and disease are chronic.	**VITAMIN A**	No seasonal pattern observed, seasonal data is not available
	POLIO (IPV)				**ONCHOCERCIASIS**	Transmission may be seasonal[6] (i.e., associated with rainfall), but infection and disease are chronic.	**MALNUTRITION**	
	MEASLES	After rainy season in tropical climates; late winter and early spring in temperate climates	**SEASONAL-MALARIA-CHEMOPREVENTION**	Peak during and after rainy season in Sahel sub-region.	**SCHISTOSOMIASIS**	Transmission may be seasonal (i.e., associated with rainfall),		

						but infection and disease are chronic.		
	MENINGITIS	After the rainy season in tropical climates, the end of winter and the beginning of spring in temperate climates			SOIL-TRANSMITTED HELMINTHS	Transmission may be seasonal (i.e., associated with rainfall), but infection and disease are chronic.		
	YELLOW FEVER	Highest risk West Africa: during end of rainy season, start of dry season (July-October); South America highest rainy season (January-May)			TRACHOMA	Transmission is more common during dry seasons.		
Timing of campaign	POLIO (OPV)	2-3 days to a week during cool, dry season	INSECTICIDE-TREATED-NETS	Ideally soon before the rainy season	LYMPHATIC FILARIASIS	Not in the rainy season.	VITAMIN A	Biannual distribution, Child health weeks
	POLIO (IPV)				ONCHOCERCIASIS	Not in the rainy season.	MALNUTRITION	Not available
	MEASLES	4-7 days to one month, including a weekend, during low transmission season, local events & festivals, avoiding rainy seasons	SEASONAL-MALARIA-CHEMOPREVENTION	Monthly intervals during the high transmission season	SCHISTOSOMIASIS	Typically when school is in session.		
	MENINGITIS	4-7 days to a month, including a weekend, during low transmission season, local events and festivals, avoiding rainy seasons			SOIL-TRANSMITTED HELMINTHS	Typically when school is in session		
	YELLOW FEVER	Not available			TRACHOMA	Not in the rainy season.		
Contraindications of Medicines	POLIO (OPV)		INSECTICIDE-TREATED-NETS		LYMPHATIC FILARIASIS		VITAMIN A	
	POLIO (IPV)				ONCHOCERCIASIS		MALNUTRITION	
	MEASLES				SCHISTOSOMIASIS			
	MENINGITIS				SOIL-TRANSMITTED HELMINTHS			
	YELLOW FEVER				TRACHOMA			
Target groups/ages	POLIO (OPV)	Interrupt circulation of poliovirus by immunizing every child under five years with two doses of oral polio vaccine (OPV), regardless of previous immunization status, location and social condition	INSECTICIDE-TREATED-NETS	All household members in malaria-endemic areas, regardless of age, ultimately providing one net for every two household members.	LYMPHATIC FILARIASIS	Diethylcarbamazine/albendazole to all eligible persons age 2 years; Ivermectin/Albendazole all eligible persons >90 cm in height or >15 kg in weight[3]	VITAMIN A	Children ages 6-59 months of age, and pregnant women.[4] (although many countries have stopped this)

	POLIO (IPV)				ONCHOCERCIASIS	All eligible persons >90 cm in height or >15 kg in weight[8]	MALNUTRITION	
	MEASLES	Initial catch-up: ages 9 months-14 years; follow-up ages 9-59 months, depending on one-dose coverage, measles incidence, time since last SIA. Vaccinate all eligible children regardless of previous immunization history.	SEASONAL-MALARIA-CHEMOPREVENTION	Children ages 3-59 months; two dosage age groups: 3-11months and 12-59 months.	SCHISTOSOMIASIS	School-aged children and adults in high risk areas or professions		
	MENINGITIS	Initial Catch-up Campaign: 1-29 years; 1-5 year follow-up campaign.			SOIL-TRANSMITTED HELMINTHS	Children ages 12 months through school age (about 12 years)		
	YELLOW FEVER	In high risk populations, all persons ≥ 9 months, or in outbreak response, infants ≥ 6 months and pregnant and/or breastfeeding women.			TRACHOMA	Eligible members of the community >6 months of age.		
Campaign Strategies Intervention complexity (e.g. injectable cold chain, directly observed therapy) Place of delivery and distribution mode	POLIO (OPV)	Fixed, house-to-house or transit point teams; two rounds national immunization days, one month apart, over 3-5 years till eradication. Mop-up campaigns conducted in areas showing poor coverage.	INSECTICIDE-TREATED-NETS	Fixed post or mobile, depending on complexity of transportation and other logistics. Mop-up campaigns discouraged in favor of strengthened planning and monitoring.	LYMPHATIC FILARIASIS	Fixed posts (including schools) and house-to-house	VITAMIN A	Fixed or mobile, along with immunization and other child health services[9] Two days for each round of Vitamin A; 1st day at fixed community site and second day door to door visit by community health volunteers for missed children
	POLIO (IPV)				ONCHOCERCIASIS	Typically house-to-house	MALNUTRITION	
	MEASLES	Fixed post, mobile post, fixed or mobile with house-to-house canvassing, house to house immunization[10]	SEASONAL-MALARIA-CHEMOPREVENTION	Mostly door-to-door distribution by community health workers; some countries use mixed models such as fixed point distribution in urban/populated settings; door-to-door in rural settings; and mobile teams to reach nomadic populations	SCHISTOSOMIASIS	Typically school-based		
	MENINGITIS				SOIL-TRANSMITTED HELMINTHS	Fixed or mobile, along with immunization and other child health services		
	YELLOW FEVER	Fixed; ideal with measles campaigns for children <5 years. Preventive, catch-up (if low routine coverage and population immunity threshold for			TRACHOMA	Typically house-to-house		

		protection <70%) and reactive campaigns for outbreaks.						
Geographic targets Geographic overlap of interventions; Check if other interventions happening/planned	**POLIO (OPV)**	National or subnational; promote synchronizing ; national immunization days with other countries.	**INSECTICIDE-TREATED-NETS**	National preferred, or sub-national based on such factors as geography, local malaria epidemiology, availability of resources.	**LYMPHATIC FILARIASIS**	Usually sub-national (most often district, but sub-district or village may be used)	**VITAMIN A**	National or sub-national, in areas with ≥1% night blindness or ≥20% prevalence vitamin A deficiency in young children. All levels, national to village level
	POLIO (IPV)				**ONCHOCERCIASIS**	Usually sub-national[6]	**MALNUTRITION**	
	MEASLES	National preferred; phased or rolling with large territories; sub-national where high-risk areas, heterogeneity immunity, localized outbreaks, resource constraints; elimination is absence of measles for >12 months with surveillance	**SEASONAL-MALARIA-CHEMOPREVENTION**	Countries or areas in Sahel sub-region with highly seasonal malaria transmission.	**SCHISTOSOMIASIS**	Usually sub-national		
	MENINGITIS	National or localized to the meningitis belt, or according to the risk analysis			**SOIL-TRANSMITTED HELMINTHS**	National or sub-national, in areas with ≥20% prevalence of any soil-transmitted helminth.		
	YELLOW FEVER	National or sub-national; may have to be phased over 2-3 years if total targeted population exceeds 15m and vaccine supplies not available.			**TRACHOMA**	Usually sub-national (most often district)		
Campaign intervals/ frequency Duration/frequency (recurring, rotating, one time, catch up)	**POLIO (OPV)**	Two rounds of national immunization days per year, 4-6 weeks apart.	**INSECTICIDE-TREATED-NETS**	Every three years, based on median ITN survival rate in terms of physical durability and insecticide retention.	**LYMPHATIC FILARIASIS**	Annual	**VITAMIN A**	Two rounds (6 months apart) children ages 6-59 months
	POLIO (IPV)				**ONCHOCERCIASIS**	Annual[6]	**MALNUTRITION**	
	MEASLES	Initial supplementary immunization activity (SIA) to eliminate susceptible pool, follow-up SIA 2-5 years later when accumulation of susceptible preschool children approaches the size of one birth cohort;	**SEASONAL-MALARIA-CHEMOPREVENTION**	Every year, during highest period of malaria transmission season	**SCHISTOSOMIASIS**	Annual or less frequent depending on prevalence		
	MENINGITIS	Initial Catch-up Campaign;			**SOIL-TRANSMITTED HELMINTHS**	Annual if ≥20% prevalence, biannual if ≥50% prevalence		

		Follow-up campaign after 2-5 years or depending on the epidemiological risk.						
	YELLOW FEVER	Not specified			**TRACHOMA**	Annual		
Special populations, groups at high risk Focus on equity (e.g. gender, rights etc.)	**POLIO (OPV)**	Populations in areas of recent polio circulation or low performance national immunization day rounds, urban poor settlements, remote rural populations, minority populations, mobile populations, nomads, and indigenous peoples.	**INSECTICIDE-TREATED-NETS**	Urban and peri-urban poor, migrants, migrant workers, refugees/IDPs, populations difficult to reach, populations with documented low ITN use despite adequate access, nomadic populations, indigenous peoples, persons in civil conflict, marginalized groups, populations with highest malaria burden or previous low campaign coverage.	**LYMPHATIC FILARIASIS**	Urban and per-urban settings often present challenges in achieving coverage targets Refugees / displaced people, nomadic populations, indigenous peoples, people in civil conflict, marginalized groups.	**VITAMIN A**	Children <5 years and pregnant women in areas of high prevalence of malnutrition.
	POLIO (IPV)				**ONCHOCERCIASIS**	Areas with co-endemic Loa require additional planning to address risk of Serious Adverse Experiences[8] Refugees / displaced people, nomadic populations, indigenous peoples, people in civil conflict, marginalized groups	**MALNUTRITION**	
	MEASLES	Urban poor, migrants, migrant workers, refugees/internally displaced peoples, difficult to reach, nomadic populations, indigenous peoples, persons in civil conflict, marginalized groups, populations with highest measles burden.	**SEASONAL-MALARIA-CHEMOPREVENTION**	Children 3-59 months in areas of unstable malaria transmission and with high malaria burden.	**SCHISTOSOMIASIS**	Populations in high prevalence settings		
	MENINGITIS	Refugees / displaced people, nomadic populations, indigenous peoples, people in civil conflict, marginalized groups, workers, and populations in mines within the meningitis belt			**SOIL-TRANSMITTED HELMINTHS**	Children <5 years in ages identified with high prevalence infection due to helminths; women of childbearing age (including pregnant women in the 2nd and 3rd trimesters and lactating women), and adults at high risk in certain occupations (e.g. tea-pickers and miners).[11]		

	YELLOW FEVER	Urban areas, any populations with confirmed cases, border areas with countries experiencing outbreaks			TRACHOMA	Refugees / displaced people, nomadic populations, indigenous peoples, people in civil conflict, marginalized groups		
Microplanning considerations	POLIO (OPV)	Similar process to ITNs. Resource estimates, cold chain and logistics, operations, supervision, recording and reporting tools, monitoring. Microplans validated at operational level.	INSECTICIDE-TREATED-NETS	Must begin preparations 9-12 months in advance. Include pre-positioning locations, budgeting, personnel needs, time for data collection, cleaning and synthesis, tools needed, training, transportation, supervision, communication needs, and evaluation. Informed by household registration of all beneficiaries, often supplemented with vouchers or coupons for net redemption at fixed sites.	LYMPHATIC FILARIASIS	Not always employed, but needed to address full coverage of all households and at-risk groups	VITAMIN A	Usually employed; Resource estimates, Vitamin A procurement and transportation, supervision, recording and reporting tools, community mobilization.
	POLIO (IPV)				ONCHOCERCIASIS	Not always employed, but needed to address full coverage of all households and at-risk groups	MALNUTRITION	
	MEASLES	Must begin preparations 9-12 months before supplementary immunization activity (SIA). Similar process to ITNs: estimating target population with census, community registers, line list from women's groups and leaders, previous polio or measles SIA data, number of children vaccinated with BCG (Bacillus Calmette–Guérin vaccine is a vaccine primarily used against tuberculosis) or first dose DTPCV Diphtheria, Tetanus, Pertussis containing vaccine; Joint External Evaluation	SEASONAL-MALARIA-CHEMOPREVENTION	Must place orders at least 8 months in advance of campaigns. Operational preparations starting at least 6 months in advance of the start of the campaign, including personnel needs, procurement of materials need by community health workers and other supplies, data collection tools and planning, pharmacovigilance, training personnel, transportation, supervision, communication needs, and post-campaign coverage surveys.	SCHISTOSOMIASIS	Focused on schools.		
	MENINGITIS	Preparations should start 9-12 months before national immunization days. Process relates to the stages: count or estimate of the target population with census, community registers, list of			SOIL-TRANSMITTED HELMINTHS	TBD		

		community agents, community relays, community leaders previous data on polio or measles supplementary immunization activity, number of children vaccinated with BCG or Penta 1 (first dose). Monitor the level of preparations for the online Health District campaigns as practiced with the polio national immunization days.						
	YELLOW FEVER				TRACHOMA			
Estimating Target Populations	POLIO (OPV)	Target populations can be based on the administrative population, the number of children vaccinated during previous supplementary immunization activities, and/or quality micro-planning if time allows. [12]	INSECTICIDE-TREATED-NETS		LYMPHATIC FILARIASIS	Usually based on official census projections minus 10–15%, depending on estimates of the ineligible population, or calculated by house-to-house registration done directly before the mass drug administration [3]	VITAMIN A	Estimation by Health Management Information System; target 6-59 month and postpartum mothers
	POLIO (IPV)				ONCHOCERCIASIS	Census estimates or households registers or school enrollment estimates depending on neglected tropical disease.	MALNUTRITION	Based on the prevalence of malnutrition provided by population based national level surveys; Demographic and Health Surveys.
	MEASLES		SEASONAL-MALARIA-CHEMOPREVENTION	Household registration	SCHISTOSOMIASIS			
	MENINGITIS				SOIL-TRANSMITTED HELMINTHS			
	YELLOW FEVER				TRACHOMA			
Methods of estimating supply requirements	POLIO (OPV)	OPV wastage in 20-dose vials during supplementary immunization activity: 15%; 1.2 wastage factor; mOPV2 (Monovalent type 2 oral polio vaccine) supply = Target population x 1.15[12]	INSECTICIDE-TREATED-NETS	For ITN procurement: calculate 1.8 nets per person, accounting for use of each net by 2 persons and adjusting for odd numbers of household occupants. Countries now allow for wastage factor.	LYMPHATIC FILARIASIS	Estimates generated automatically through WHO Joint Application Package[13]	VITAMIN A	If no population data denominators separated by age group, the proportion of children who are 6 – 11 months old is generally estimated to be 0.111 and the proportion of children who are 12 – 59 months old is generally estimated to be 0.889.

								Based on the target population provided by Health Management Information System
	POLIO (IPV)				**ONCHOCERCIASIS**	Estimates generated automatically through WHO Joint Application Package[13]	**MALNUTRITION**	
	MEASLES	Vaccine: based on target population and vaccine wastage rates; cold chain & other supplies estimated by varying methods.	**SEASONAL-MALARIA-CHEMOPREVENTION**	For calculating the total number of sulfadoxine-pyrimethamine + amodiaquine blister-packs needed for procurement: Consider the total number of children 3-59 months living in the seasonal areas of high transmission, and multiply by the number of monthly intervals. Consider adding a buffer stock of 5%-10% depending on the country context and budget to accommodate for any inaccuracies of original planning data or population movement.	**SCHISTOSOMIASIS**	Estimates generated automatically through WHO Joint Application Package		
	MENINGITIS	Vaccine: depending on target population and vaccine wastage rates; cold chain and other supplies estimated by different methods.			**SOIL-TRANSMITTED HELMINTHS**	Estimates generated automatically through WHO Joint Application Package[13]		
	YELLOW FEVER				**TRACHOMA**	Estimates generated through the International Trachoma Initiative application process		
Communications/ Social and Behavior Change Communication (e.g. to address rumors, hesitancy) Focus on equity (e.g. gender, rights etc.) Values (Active community participation throughout phases Partial integration (census data, social mobilization, education, messaging)	**POLIO (OPV)**	Identify target age for immunization; prepare to manage issues such as negative publicity, rumors, refusals	**INSECTICIDE-TREATED-NETS**	Messages for each stage of campaign (pre, during and post) to instruct on hanging, when to use, care and repair, washing, disposition of older nets	**LYMPHATIC FILARIASIS**	Messages on purpose, benefits and side effects associated with mass drug administration.	**VITAMIN A**	PSA through community radio stations and place, TV announcements, push messaging, social media, loudspeaker announcements, mothers group meetings
	POLIO (IPV)				**ONCHOCERCIASIS**	Messages on purpose, benefits and side effects associated with mass drug administration.	**MALNUTRITION**	
	MEASLES	Identify target age for immunization; prepare to manage issues such as negative publicity, rumors, Adverse Event Following Immunization	**SEASONAL-MALARIA-CHEMOPREVENTION**	Messages for each stage of campaign (pre, during and post) to communicate the dates of the campaign,	**SCHISTOSOMIASIS**	School and community-based education on causes and benefits of mass drug administration.		

	MENINGITIS	Identify the target age for vaccination; prepare to deal with issues such as negative publicity, rumors, Adverse Event Following Immunization		eligibility to receive sulfadoxine-pyrimethamine + amodiaquine , remind caregivers to take daily doses 2 and 3, importance of going to health center in case of side effects, and on general malaria prevention and treatment.	SOIL-TRANSMITTED HELMINTHS	Messaging on target ages; need train volunteers to communicate in handling children who cannot swallow pill, and to crush pill for children <3 years.[11]		
	YELLOW FEVER	Risk communication, target mobilization to highest-risk populations			TRACHOMA	Messages on purpose, benefits and side effects associated with mass drug administration and on elements of the SAFE (Surgery i.e. in-turned eyelashes, Antibiotics, Facial Cleanliness, Environmental improvement) strategy.		
Procurement and timeframe considerations Financing—Government & donors; Incentives for integration Discussion and agreement with partners (advantages of integration and pooling of resources)	POLIO (OPV)	Vaccines all shipped by air, require 3-5 months; up to 4 weeks for delivery of immunization equipment by sea.	INSECTICIDE-TREATED-NETS	Global Fund: minimum 6-7 months between order and delivery President's Malaria Initiative: 10 months from request to delivery in country (as of January 2018) UNICEF: 5-8 months minimum to place order, receive funds by UNICEF, shipping and freight lead time, and arrival and positioning in country	LYMPHATIC FILARIASIS	Place order 9-12 months before mass drug administration	VITAMIN A	
	POLIO (IPV)				ONCHOCERCIASIS	Place order 9-12 months before mass drug administration	MALNUTRITION	
	MEASLES	Place order 9-12 months before campaign; comprehensive multi-year strategic plans.	SEASONAL-MALARIA-CHEMOPREVENTION	Global Fund: Minimum 8 months lead time. PMI: plan for minimum 12-month lead time given limited sulfadoxine-pyrimethamine + amodiaquine production capacity	SCHISTOSOMIASIS	Place order 9-12 months before mass drug administration		
	MENINGITIS	Place order 9-12 months before campaign.			SOIL-TRANSMITTED HELMINTHS	Place order 9-12 months before mass drug administration		
	YELLOW FEVER	Fluid: limited production capacity constrains supplies, UNICEF prioritizes campaigns. International Coordinating			TRACHOMA	Place order 12 months before mass drug administration		

		Group for Vaccine Provision manages a GAVI-supported emergency stockpile.						
MENINGITIS	**MENINGITIS**	UNICEF Supply Division	**INSECTICIDE-TREATED-NETS**	Global Fund, President's Malaria Initiative and others directly from net manufacturers; UNICEF Supply Division	**LYMPHATIC FILARIASIS**	WHO with possible review by the Mectizan Donation Program	**VITAMIN A**	UNICEF Supply Division,
	MENINGITIS				**ONCHOCERCIASIS**	WHO - reviewed by Mectizan Donation Program[6]	**MALNUTRITION**	UNICEF Supply Division
	MENINGITIS	UNICEF Supply Division; UNICEF, PAHO Revolving Fund, Gavi Roadmap, healthy market framework, MI4A	**SEASONAL-MALARIA-CHEMOPREVENTION**	Global Fund: Pooled Procurement Mechanism directly from supplier (Guilin) President's Malaria Initiative: TBD	**SCHISTOSOMIASIS**	WHO		
	MENINGITIS	UNICEF Supply Division			**SOIL-TRANSMITTED HELMINTHS**	UNICEF Supply Division[14]		
	YELLOW FEVER	UNICEF Supply Division			**TRACHOMA**	International Trachoma Initiative		
Training Coordination mechanisms, including public health workforce Health worker acceptance of all individual interventions & of integration Community capacity to ensure effective integration (e.g., training)	**POLIO (OPV)**	Vaccinators, supervisors, monitors, volunteers, district-level program managers, logisticians, communication focal persons.	**INSECTICIDE-TREATED-NETS**	Supervisors, monitors, health workers, volunteers, district-level program managers, logisticians, communication focal persons.	**LYMPHATIC FILARIASIS**	Community health workers, supervisors, monitors, health workers, volunteers, district-level program managers, logisticians, communication focal persons	**VITAMIN A**	Supervisors, monitors, health workers, volunteers, district-level program managers, logisticians, communication focal persons. Health workers, Community Health Volunteers
	POLIO (IPV)				**ONCHOCERCIASIS**	Community health workers, supervisors, monitors, health workers, volunteers, district-level program managers, logisticians, communication focal persons	**MALNUTRITION**	Health workers, Community Health Volunteers.
	MEASLES	Vaccinators, supervisors, monitors, volunteers, district-level program managers, logisticians, communication focal persons.	**SEASONAL-MALARIA-CHEMOPREVENTION**	Community health workers, supervisors, monitors, health workers, volunteers, district-level program managers, pharmacovigilance point persons, logisticians, communication focal persons.	**SCHISTOSOMIASIS**	Teachers, supervisors, monitors, health workers, volunteers, district-level program managers, logisticians, communication focal persons.		
	MENINGITIS	Vaccinators, supervisors, monitors, volunteers, district program managers,			**SOIL-TRANSMITTED HELMINTHS**	Teachers, supervisors, monitors, health workers, volunteers,		

		logisticians, communication focal persons.				district-level program managers, logisticians, communication focal persons.		
	YELLOW FEVER	Vaccinators, supervisors, monitors, volunteers, district-level program managers, logisticians, communication focal persons.			TRACHOMA	Community health workers, supervisors, monitors, health workers, volunteers, district-level program managers, logisticians, communication focal persons		
Supply, supply chain, transportation and logistics Operational complexity (procurement, supply chain, logistics, communications, waste management)	POLIO (OPV)	Cold chain maintenance and supplies, waste management; It is not recommended to implement Multi-dose vial policy in mOPV2 (Monovalent type 2 oral polio vaccine) campaigns[12]	INSECTICIDE-TREATED-NETS	Bulkiness of ITNs, warehousing challenges; timeliness of ITN delivery and positioning in field given multiple procurement sources and methods	LYMPHATIC FILARIASIS	Managed through national pharmacy with support from partners	VITAMIN A	Manage through logistic management division of Ministry of Health and Provincial Health Directorate
	POLIO (IPV)				ONCHOCERCIASIS	Managed through Mectizan Donation Program, national pharmacy with support from partners[6]	MALNUTRITION	Manage through logistic management division of Ministry of Health and Population and Provincial Health Directorate
	MEASLES	Cold chain maintenance, immunization supplies, waste management	SEASONAL-MALARIA-CHEMOPREVENTION	Community health worker system must be highly functional in implementation area for success; ensuring availability of monthly sulfadoxine-pyrimethamine + amodiaquine supplies critical. Timely delivery of supplies critical to match malaria season and 28-day interval between monthly administration of doses. Drug supply delivery must occur during logistically challenging rainy season.	SCHISTOSOMIASIS	Managed through national pharmacy with support from partners		
	MENINGITIS	Cold chain maintenance, immunization supplies, waste management			SOIL-TRANSMITTED HELMINTHS	Must administer medication before measles immunization in campaign setting.		
	YELLOW FEVER	Cold chain maintenance, immunization supplies, lyophilized vaccine—reconstitution with diluent. Limited vaccine supply (demand increase, production problems), limited to 15m people per year for preventive campaigns; challenging in urban areas. Need distribute immunization cards.			TRACHOMA	Managed through International Trachoma Initiative with support from governments and partners.		
Monitoring and supervision	POLIO (OPV)	Independent monitoring with Lot quality assurance sampling or other established method; GIS mapping to locate catchment areas. Cold chain	INSECTICIDE-TREATED-NETS	Promote engagement of both supervisors and independent monitors, depending on population served and number	LYMPHATIC FILARIASIS	Need monitor drug administration for difficulties swallowing	VITAMIN A	Supervision of community health workers managed through health system, Bi-annual review meetings with health service providers

(Monitoring Post Campaign Adverse Events, capacity for & commitment to monitoring/surveillance)		and Adverse Event Following Immunization monitoring required.		of campaign personnel overseen		Supervision of community health workers managed through health system		
	POLIO (IPV)				**ONCHOCERCIASIS**	Supervision of community health workers managed through health system	**MALNUTRITION**	
	MEASLES	SIA Readiness Assessment Tool; pre-SIA supervision & monitoring; checklists; rapid convenience monitoring to find & vaccinate any unreached children. Cold chain and and Adverse Event Following Immunization monitoring required; Measles and Rubella Strategic Framework 2021-2030/IA2030[15]	**SEASONAL-MALARIA-CHEMOPREVENTION**	Intense supervision needed given dosage requirements and 28-day timing interval, specific age range, importance of not giving SMC for children with fever at the time, and observing child for 30 minutes in case of vomiting. Especially important for first cycle and first month to identify and address problems.	**SCHISTOSOMIASIS**	Need monitor drug administration for difficulties swallowing		
	MENINGITIS	Adverse Event Following Immunizations			**SOIL-TRANSMITTED HELMINTHS**	Need monitor drug administration for difficulties swallowing[11]		
	YELLOW FEVER	Monitor for vaccine availability, injection safety, immunization card availability, cold chain, Adverse Event Following Immunization and reporting. Strict border control.			**TRACHOMA**	Supervision of community health workers managed through health system		
Data collection	**POLIO (OPV)**	Tally sheets divided as 0-11 and 12-59 months; other recording strategies similar to measles campaigns.	**INSECTICIDE-TREATED-NETS**	Careful planning needed for data collection and analysis in integrated versus stand-alone campaigns. GPS and electronic databases used more widely, but need to reconcile multiple collection modalities implemented within countries.	**LYMPHATIC FILARIASIS**	Drug treatment registers or tally sheets.[3]	**VITAMIN A**	Vitamin A register filled by Female Community Health Volunteers in campaign and reported to higher level as per Health Management Information System reporting system
	POLIO (IPV)				**ONCHOCERCIASIS**	Drug treatment registers or tally sheets.[13]	**MALNUTRITION**	Nutrition Register, Integrated Management of Acute Malnutrition register, Primary Health Care Outreach register, Female Community Health Volunteers register
	MEASLES	Review immunization cards/home-based records; tally sheets divided as 9-11 months, 1-4 years, 5-14 years; daily review	**SEASONAL-MALARIA-CHEMOPREVENTION**	Simple registers and reporting forms must be developed for community health workers to complete; every child is	**SCHISTOSOMIASIS**	Drug treatment registers or tally sheets.		

		meetings; daily reporting forms; data electronic input aggregated at district, provincial, national levels; testing and use of available and reliable technology encouraged, such as GPS to monitor geographic coverage.		provided with a SMC child card used to record monthly doses; quality control essential through supervision and monitoring. More and more countries are moving to electronic data collection forms.				
	MENINGITIS	Epidemic Meningitis A Supplementary Immunization Activity Readiness Assessment Tool; supervision and monitoring prior to the supplementary immunization activity; checklists; rapid convenience monitoring to find and immunize unaffected children. Independent monitoring with Lot Quality Assurance Sampling, Cold chain, and monitoring of adverse events after vaccination are important; Adverse Event Following Immunization notification and investigation forms Monitor the level of preparations for online health district campaigns as practiced with polio national immunization days. Need to monitor administration of medication for swallowing difficulties			**SOIL-TRANSMITTED HELMINTHS**	Drug treatment registers or tally sheets.		
	YELLOW FEVER	No information.			**TRACHOMA**	Drug treatment registers or tally sheets.		
Evaluation Linkage to global/regional goals & local/regional priorities Structural barriers	**POLIO (OPV)**	Post national immunization days coverage surveys not recommended; focus on Acute Flaccid Paralysis surveillance for children <15 years	**INSECTICIDE-TREATED-NETS**	Campaign quality: qualitative and/or quantitative process review, or post-campaign review meetings. Outcomes (coverage, access, use): generally rely on existing schedule of population-based surveys such as Demographic Health Survey, Malaria Indicators Survey or Multiple	**LYMPHATIC FILARIASIS**	Periodic coverage surveys and impact assessments.[3]	**VITAMIN A**	Population-based coverage surveys (e.g., Demographic and Health Surveys, Multiple Indicator Cluster Survey

				Indicator Cluster Survey; if those are scheduled far in future, stand-alone post-campaign surveys conducted in rainy season per country guidance				
	POLIO (IPV)				**ONCHOCERCIASIS**	Impact surveys carried out after many years of mass drug administration	**MALNUTRITION**	National level survey : Demographic and Health Surveys, Multiple Indicator Cluster Survey, Medical nutritional supplements
	MEASLES	Post-supplementary immunization activity independent monitoring using rapid coverage monitoring to find unvaccinated children and target mop-up activities immediately post-campaign; coverage surveys soon after SIA if population-based survey (Demographic Health Survey , Ministry of Industry, Commerce, and Supplies, stand-along Expanded Program of Immunization survey) not done for a few years and one not planned for few years	**SEASONAL-MALARIA-CHEMOPREVENTION**	No established method for monitoring programmatic effectiveness as of 2013 guidance. Potential random sampling of children for parasitemia during second or third course to determine “breakthrough infections” after first course. Post-campaign coverage surveys to evaluate for example the coverage per monthly cycle, adherence to home doses 2 & 3, treatment of older children, caregiver SMC knowledge, and intervals between cycles	**SCHISTOSOMIASIS**	Impact surveys after 3-5 years of mass drug administration		
	MENINGITIS				**SOIL-TRANSMITTED HELMINTHS**	Population-based coverage surveys e.g., Demographic and Health Surveys, Multiple Indicator Cluster Survey Impact surveys after 3-5 years of mass drug administration		
	YELLOW FEVER				**TRACHOMA**	Impact surveys after 3-5 years of mass drug administration		

Appendix C: Key Categories of Considerations for Campaign Integration

	**FEASIBILITY** Operational and financial viability of integrating the interventions
	**ACCEPTABILITY** Integrated interventions are acceptable to the community and health workers
	**ACCOUNTABILITY** “The obligation to report or give account of one’s actions, for example, to a governing authority through scrutiny, contract, management and regulation or to an electorate.” (WHO and UNICEF 2020) In the context of integrated campaigns, it is having clearly defined roles, responsibilities, and monitoring and evaluation strategies to assess outcomes pre- and post-co-delivery/collaboration (e.g., coverage and utilization rates, disease occurrence, quality, acceptability of services).
	**CONTEXT** The circumstances that influence the co-delivery/collaboration decision, such as geographical setting (rural or urban areas), target population of the interventions, political will to promote co-delivery/collaboration among different interventions, existing health care structures for the delivery of interventions; monitoring responsibilities for each intervention, and availability and ability of health workers to work on multiple interventions at the same time.
	**COMPATIBILITY** Alignment between different intervention components and shared campaign characteristics, such as overlaps in the target population, type of intervention, seasonality of the disease, timing and frequency of service delivery; procurement, supply chain, and logistics mechanisms and timing, behavior change requirements and skill level and training of health workers.
	**EQUITY** “The absence of systematic or potentially remediable differences in health status, access to health care and health-enhancing environments, and treatment in one or more aspects of health across populations or population groups defined socially, economically, demographically or geographically within and across countries” (WHO and UNICEF 2020). Integrated campaigns should not reduce service access among vulnerable groups, and should provide high-quality interventions uniformly and in a fair and impartial manner to all target populations including underserved groups.

Abbreviations/Acronyms

AEFI	Adverse Event Following Immunization	**MIS**	Malaria Indicators Survey
AFP	Acute Flaccid Paralysis	**MMRV**	Measles, Mumps, Rubella, Varicella
ALB	Albendazole	**MoH**	Ministry of Health
BCG	Bacillus Calmette–Guérin vaccine primarily used against tuberculosis	**mOPV2**	Monovalent type 2 oral polio vaccine
CDC	U.S. Centers for Disease Control and Prevention	**MOV**	Missed Opportunities for Vaccination
CHD	Child Health Day	**NID**	National Immunization Day
cMYP	Comprehensive Multi-Year Strategic Plans	**ONCHO**	Onchocerciasis
DEC	Diethylcarbamazine (citrate)	**OPV**	Oral Polio Vaccine
DOT	Directly observed therapy	**PECS**	Post event coverage survey
DHS	Demographic and Health Surveys	**POS**	Pediatric Oral Suspension
GAVA	Global Alliance for Vitamin A	**PZQ**	Praziquantel
GPS	Global Positioning System	**RI**	Routine Immunization
HCD	Human Centered Design	**SAE**	Serious Adverse Experience
HCE	Health campaign effectiveness	**SAGE**	Strategic Advisory Group of Experts
HCW	Healthcare Worker	**SC**	Subcutaneous
HH	Household	**SCH**	Schistosomiasis
HKI	Hellen Keller International	**SIA**	Supplementary Immunization Activity
HMIS	Health Management Information System	**SMART**	Specific, Measurable, Achievable, Relevant, and Timebound
HPV	Human Papillomavirus	**SMS**	Short Messages Services (text messaging)
IDP	Indigenous displaced peoples	**SP/AQ**	Sulfadoxine-Pyrimethamine + Amodiaquine
IPV	Inactivated Polio Vaccine	**STH**	Soil-transmitted helminthiasis
IU	International Units	**TIP**	Tailoring Immunization Programs
IVM	Ivermectin	**Trach**	Trachoma
JEE	Joint External Evaluation	**UNICEF**	United Nations Children’s Fund
LF	Lymphatic filariasis	**VAS**	Vitamin A supplementation
LMIS	Logistics Management Information System	**WHO**	World Health Organization
LQAS	Lot Quality Assurance Sampling	**WHO JAP**	World Health Organization Joint Application Package

MDA	Mass Drug Administration	**WMF**	Wastage multiplication factor
MDVP	Multi Dose Vial Policy	**YF**	Yellow Fever
MI4A	Market Information for Access to Vaccines		
MICS	Multiple Indicator Cluster Survey		

Definitions of Criteria (illustrative)

Adverse reaction (to a drug)	Noxious and unintended reaction, which occurs at doses normally used in humans for the prophylaxis, diagnosis or treatment of disease, or for the modification of physiological function.[11]
Campaign (health)	Time-bound, intermittent activities deployed to address specific epidemiologic challenges, expediently fill delivery gaps, or provide surge coverage for health interventions.
Catch-up SIA	One time SIA, usually nation-wide, to vaccinate the main target population responsible for disease transmission in order to rapidly reduce the number of susceptible individuals.
Catch-Up Vaccination	"Refers to vaccinating an individual with any vaccines missed per the national immunization schedule. It can be delivered through regular routine immunization service delivery (fixed, outreach, mobile, school), periodic intensification of routine immunization (PIRI) activities, or any other strategy to ensure individuals have the opportunity to receive routine immunizations for which they are eligible. This is distinct from the concept of 'catch-up SIAs' that are one-time campaigns to vaccinate the main target population responsible for disease transmission in order to rapidly reduce the number of susceptible individuals, other 'catch-up campaigns' that sometimes accompany new vaccine introductions, or from the strategy of 'catch-up, keep-up, follow-up, speed-up' used for measles elimination in the Region of the Americas" [16]
Community Acceptance	Consider factors that are convenient for the community. Collaborate with local community groups to determine the best dates, times, and locations to promote ownership. Consider community activities/celebrations and local events such as religious festivals, key agricultural activities, and timing of political activities. Adapt the TIP and HCD approaches to design more people-centered strategies to improve vaccine delivery and uptake.
Coverage	A proportion (%) that reflects the number of people receiving (an) intervention(s) divided by the total number of people eligible to receive the intervention(s).
Denominator	The total number of a population for an indicator.
Disaggregation (of data)	Analysis of data by different sub-groups, for example, analysis of data by smaller administrative units or by different age groups.
District	For the purpose of this guide, "district" refers to a defined sub-national administrative area.
Drug coverage	Proportion of individuals, expressed as a percentage, in a targeted population who swallowed a drug, or a combination of drugs.[3]
Effectiveness	The ability of a campaign to achieve specific objectives related to coverage, equity, efficiency and impact.
Equity	Providing high-quality interventions uniformly and in a fair and impartial manner to all target populations including underserved groups.

Ethical Use	Morally right, rooted in equality, and aiming to prioritize good and minimize harm.
Fixed permanent vaccination posts	Posts located at permanent health facilities and community health posts as a part of the fixed vaccination posts SIA strategy for the entire duration of the SIA.
Fixed post with house-to-house canvassing	SIA strategy with added social mobilization element, which involves a trained volunteer/ community mobilizer ("canvasser") encouraging the population to come to the vaccination post.
Fixed temporary vaccination posts	Posts that may be set up at schools, churches, mosques, local administrators' offices, for the time estimated to complete the vaccination of the targeted population of that area (may be less than the duration of the SIA).
Fixed vaccination posts	Effective SIA strategy in settings where there is high demand for vaccination, social mobilization is strong and house-to-house visits are not needed; includes permanent and temporary vaccination posts.
Full integration	Full integration involves coordinating most or all campaign components (e.g., microplanning, registration, logistics, implementation, evaluation) to allow simultaneous or *co-delivery* of two or more health interventions at the point of service delivery.
House-to-house vaccination	SIA strategy recommended mainly as a mop-up strategy in areas where there is prior evidence of refusal of vaccination.
Ineligible population	Group of individuals not qualified or entitled to receive anthelminthic treatment in preventive chemotherapy interventions. Ineligibility is usually determined by exclusion criteria based on drug safety. [3]
Mass drug administration (MDA)	A modality of preventive chemotherapy in which anthelminthic medicines are administered to the entire population of an area (e.g. state, region, province, district, sub-district, village) at regular intervals, irrespective of the individual infection status.[3]
Mobile vaccination posts	Posts required at distant villages and rural settlements with very small and/or disperse populations, set up for the time needed to complete the task (usually less than one day).
Partial Integration	Partial integration involves collaboration or sharing of specific campaign components between vertical health programs to improve efficiency and effectiveness of multiple campaigns, but without co-delivery of interventions at the same service delivery points.
People-centered care	An approach to care that consciously adopts individuals', caretakers', families' and communities' perspectives as participants in, and beneficiaries of, trusted health systems that are organized around the comprehensive needs of people rather than individual diseases, and respects social preferences. People-centered care also requires that patients have the education and support they need to make decisions and participate in their own care and that caretakers are able to attain maximal function within a supportive working environment. People-centered care is broader than patient and person-centered care, encompassing not only clinical encounters, but also including attention to the health of people in their communities and their crucial role in shaping health policy and health services.[17]
Place of Delivery and Distribution Mode	Options include fixed post (permanent and/or temporary), mobile post, fixed or mobile post with house to house canvassing, etc.

Preferences of beneficiaries	Consider community activities/celebrations and local events such as religious festivals, key agricultural activities, and timing of political activities.
Seasonality	Consider disease peaks, transmission, weather conditions/climate (rainy seasons, winters with heavy snowfalls), [18]
Social mobilization	A group of broad-scale activities to engage with all segments of society aiming to disseminate information and ensure appropriate awareness.

References (draft)

1. Lavery J V. Wicked problems', community engagement and the need for an implementation science for research ethics. *J Med Ethics*. 2018;44(3):163-164. doi:10.1136/medethics-2016-103573
2. Lavery J V. Building an evidence base for stakeholder engagement. *Science*. 2018;361(6402):554-556. doi:10.1126/science.aat8429
3. WHO. *World Health Organization Global Programme To Eliminate Lymphatic Filariasis*.; 2010. Accessed April 23, 2020. https://apps.who.int/iris/bitstream/handle/10665/44473/9789241500722_eng.pdf?sequence=1
4. Dalmiya N, Greig A, Knowles J. *GAVA - Monitoring of Vitamin A Supplementation - A Guide for National Managers*.; 2017. http://www.gava.org/content/user_files/2017/08/GAVA-district-vas-monitoring-guide-1.pdf
5. WHO. *Vitamin A Supplementation in Infants and Children 6-59 Months of Age II Vitamin A Supplementation in Infants and Children 6-59 Months of Age*.; 2011. Accessed April 23, 2020. https://apps.who.int/iris/bitstream/handle/10665/44664/9789241501767_eng.pdf?sequence=1
6. WHO. Guidelines for stopping mass drug administration and verifying elimination of human onchocerciasis: Criteria and Procedures. *World Health Organization WHO/HTM/NTD/PCT Geneva, Switz*. 2016;14(3):62-75. Accessed April 23, 2020. https://apps.who.int/iris/bitstream/handle/10665/204180/9789241510011_eng.pdf
7. International Coalition for Trachoma Control (ICTC). Micro-planning for effective Zithromax ® Mass Drug Administration. Published online 2015.
8. Etya D. Vision 2020 : Update on Onchocerciasis. *Community Eye Heal*. 2010;14(38):19-21.
9. Dalmiya N, Greig A, Knowles J. *GAVA - MONITORING OF VITAMIN A - District Guide*.
10. United Nations Children's Fund. UNICEF Immunization Roadmap 2018–2030. *UNICEF*. Published online 2018:1-48.
11. Crompton DWT (David WT, World Health Organization. *Preventive Chemotherapy in Human Helminthiasis : Coordinated Use of Anthelminthic Drugs in Control Interventions : A Manual for Health Professionals and Programme Managers.* World Health Organization; 2006.
12. mOPV2- Technical Guidance (Dated: 9 May 2020) 1. 2020;1(May):1-2.
13. WHO. *Joint Request for Selected Preventive Chemotherapy Medicines and Joint Reporting Form 16:50:16*.; 2013. http://www.who.int/neglected_diseases/en
14. WHO. *Preventative in Human Helminthiasis Chemotherapy*.; 2006. Accessed April 23, 2020. https://apps.who.int/iris/bitstream/handle/10665/43545/9241547103_eng.pdf?sequence=1
15. WHO. Immunization Agenda 2030. 2019;(August):1-24. https://www.who.int/immunization/ia2030_Draft_One_English.pdf?ua=1
16. Measles & Rubella Initiative. Measles and Rubella Strategic Framework 2021 - 2030. Published online 2021.
17. Vaccine acronyms and abbreviations. (2016, May 31). Retrieved March 20, 2021, from https://www.cdc.gov/vaccines/terms/vacc-abbrev.html
18. World Health Organization (WHO). Framework on integrated, people-centered health services: Report by the Secretariat. *World Health Assem*. 2016;(A69/39):1-12. doi:10.1111/igs.13866
19. WHO. *Planning and Implementing High-Quality Supplementary Immunization Activities for Injectable Vaccines Using an Example of Measles and Rubella Vaccines Field Guide*.; 2016. Accessed April 23, 2020. https://www.who.int/immunization/diseases/measles/SIA-Field-Guide.pdf