HEALTH CAMPAIGN EFFECTIVENESS COALITION
Strengthen Systems. Maximize Impact.

THE TASK FORCE FOR GLOBAL HEALTH

Decision Guidance Tool for People-Centered Integration of Health Campaigns

November 2021
(Draft 1)

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. Staff of the HCE developed a technical brief on integration between health campaigns as a reference for countries and their partners wishing to explore these opportunities (see https://campaigneffectiveness.org/wp-content/uploads/2020/12/Health-Campaign-Integration-Technical-Brief-Nov-13-2020-1.pdf). The Coalition also formed a working group dedicated to campaign integration, which directly contributed to the development of this decision tool.

Purpose and Objectives of this Tool

The purpose of the tool 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 Tool for People-Centered Integration of Health Campaigns* was developed by the Health Campaign Effectiveness Coalition program, funded by the Bill and Melinda Gates Foundation at the Task Force for Global Health. The tool 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.

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; Jovana Alexandra Ocampo Cañas, Universidad de los Andes, Bogotá, Colombia; and Zainab Ali, affiliated with Alliance for Malaria Prevention (AMP). We acknowledge CIWG members for engaging in discussions related to the tool, including 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. We also thank Andrei Chell, of the State University of New York at Albany, USA and Njara Rakotonirina of Catholic Relief Services, Republic of Congo for the review of the document in mid-2021. The document was authored by David Gittelman, Vivek Patel, and Eva Bazant.

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Start Here: How to use the Decision Guidance Tool for People-Centered Integration of Health Campaigns

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

The first step is one of assessment and reflection on the potential for integrating campaigns. Please see the tool on **page 2** for suggested best practices and tips to generate or build interest: "**How do you start or continue the conversation on campaign integration in your country?**"

Step 2: Refer to the "Decision Matrix to Explore Facilitators and Barriers of Paired Health Interventions"

Once you have convened 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).

- ✔ Start by reviewing the "**Decision Matrix to Explore Facilitators and Barriers of Paired Health Interventions**" on **page 3**. This tool gives a visual representation of how to explore the pairing of different health interventions and identifying the facilitators and barriers to each combination.
- ✔ Next, review on **page 4** the table "**Key Criteria for People-Centered Integration Decisions at Various Levels."** The purpose of the tool is to suggest key criteria that decision-makers from the global to local levels should consider for pairing campaign interventions.
  Determine whether each criterion could be a facilitator or barrier, depending on the health intervention and country context.
- ✔ Examine the campaign pairing examples for facilitators and barriers on **pages 5 and 6**. This tool should stimulate ideas for applying the matrix and key criteria.
- ✔

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 using more detailed technical and operational considerations.

- ✔ Assemble existing global or national policies and standards, as well as the sub-national or local contexts, to further assess whether integration is feasible and appropriate. Global guidance on key health interventions is available on the websites of WHO, PAHO, UNICEF and their key global partners such as GAVI and the Global Fund for HIV, TB and Malaria. Campaign integration strategies and plans of action should reflect this information.
- ✔ Use **Appendix A**, "**Worksheet for Global and Country Standards on Planning Health Campaign Integration**". Fill in the cells based on the suggested criteria to help this decision and planning process.
- ✔ Review the more detailed technical and operational criteria and best practices involved in integrations suggested in **Appendix B, "Criteria Across Health Domains and Specific Interventions for Selecting Potential Campaign Integration."** While the table incorporates the latest global guidance and experience available when this tool was developed (see References), the list of criteria to consider is not exhaustive and should be modified to the country context and updated, as needed.
- ✔

Step 4: Decide Whether to Pursue Integration and Move to Collaborative Planning and Implementation

After careful discussion guided by this Tool, national programs and their partners should be ready to decide whether campaign integration of specific health interventions is promising in their settings. At that stage, national programs and their partners can then begin collaborating on strategic planning to pursue campaign integration.

How Do You Start or Continue the Conversation on Campaign Integration in Your Country?

Before using the tool 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. Identify key actors in previous campaigns and ask them to share their experiences, both successful and not successful. 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). Consider all the information and discuss with key actors whether partial-integration-- is more promising than full integration based on previous experience.

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

Identify leaders or key actors who have the following qualities: availability, accountability, spirit of advocacy, transparency, and ability to delegate.

Cultivate these relationships with leaders and others who have the knowledge, peer recognition, and humility that can bring about meaningful change in communities.

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

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

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 tool!

Step 2a: Explore the Possibilities and Identify Pairings - *This tool gives a visual representation of how to explore the pairing of different health interventions by facilitators and barriers to each combination.*

Decision Matrix to Explore Facilitators and Barriers of Paired Health Interventions

Health Intervention	Immunization				Malaria		Neglected Tropical Diseases					Nutrition	
	OPV	MCV	Men	YF	ITNs	SMC	LF	Oncho	Sch	STH (deworming)	Trach	VitA	Maln
Polio (OPV)		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 (Sch)													
Soil-Transmitted Helminths (STH)/ (deworming)													
Trachoma (Trach)													
Vitamin A (VitA)													
Assessment of Severe Malnutrition (Maln)													

Step 2b: Explore the Possibilities and Identify Pairings - *The purpose of the tool is to suggest key criteria that decision-makers from the global to local levels should consider for pairing campaign interventions. Each criterion could be a facilitator or barrier, depending on the health intervention and country context.*

Key Criteria for People-Centered Integration Decisions at Various Levels

(Note: See glossary 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

Step 2c: Explore the Possibilities and Identify Pairings - *This tool depicts campaign pairing examples for facilitators and barriers and should stimulate ideas for applying the matrix and key criteria.*

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Decision Matrix to Explore Facilitators and Barriers of Paired Health Interventions

Health Intervention	Immunization				Malaria		Neglected Tropical Diseases					Nutrition	
	OPV	MCV	Men	YF	ITNs	SMC	LF	Oncho	Sch	STH (deworming)	Trach	VitA	Maln
Polio (OPV)		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)													
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Soil-Transmitted Helminths (STH)													
Trachoma (Trach)													
Vitamin A (VitA)													
Assessment of Severe Malnutrition (Maln)													

1. Explore

Decision Matrix to Explore Facilitators and Barriers of Paired Health Interventions

Health Intervention	Immunization				Malaria		Neglected Tropical Diseases					Nutrition	
	OPV	MCV	Men	YF	ITNs	SMC	LF	Oncho	Sch	STH (deworming)	Trach	VitA	Maln
Polio (OPV)		Facilitator: Barrier:	Facilitator: Barrier:	Facilitator: Barrier:									
Measles (MCV)			Facilitator: Barrier:	Facilitator: Barrier:									
Meningitis (Men)				Facilitator: Barrier:									
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Soil-Transmitted Helminths (STH)													
Trachoma (Trach)													
Vitamin A (VitA)													
Assessment of Severe Malnutrition (Maln)													

1. Explore
2. Identify

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 Matrix to Explore Facilitators and Barriers of Paired Health Interventions

Health Intervention	Immunization				Malaria		Neglected Tropical Diseases					Nutrition	
	OPV	MCV	Men	YF	ITNs	SMC	LF	Oncho	Sch	STH (deworming)	Trach	VitA	Maln
Polio (OPV)		Facilitator: Barrier:	Facilitator: Barrier:	Facilitator: Barrier:									
Measles (MCV)			Facilitator: Barrier:	Facilitator: Barrier:									
Meningitis (Men)				Facilitator: Barrier:									
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Schistosomiasis (Sch)													
Soil-Transmitted Helminths (STH)													
Trachoma (Trach)													
Vitamin A (VitA)													
Assessment of Severe Malnutrition (Maln)													

1. Explore
2. Identify
3. Zoom-in

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 and another example for integration between a Vitamin A and deworming/STH campaign is shown on page 7 with key facilitators and barriers identified.

Decision Matrix to Explore Facilitators and Barriers of Paired Health Interventions

Health Intervention	Immunization				Malaria		Neglected Tropical Diseases					Nutrition	
	OPV	MCV	Men	YF	ITNs	SMC	LF	Oncho	Sch	STH (deworming)	Trach	VitA	Maln
Polio (OPV)		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)													
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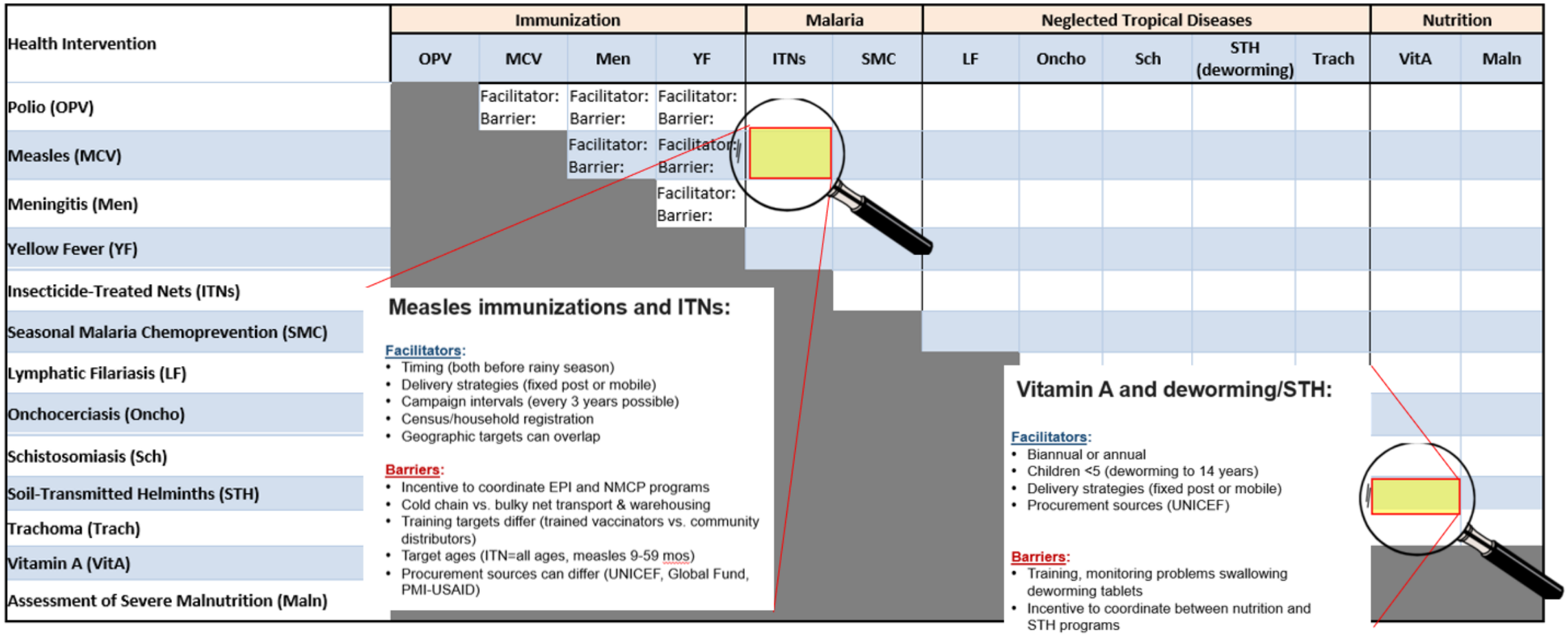
Soil-Transmitted Helminths (STH)													
Trachoma (Trach)													
Vitamin A (VitA)													
Assessment of Severe Malnutrition (Maln)													

1. Explore
2. Identify
3. Zoom-in
4. Consult with Colleagues

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

Step 2 - Identify Pairings: Identify a specific campaign(s) that may be a possible target for integration.
A planner of an immunization campaign may identify Malaria ITN's as a potential fit. Alternatively, a VitA campaign manager may identify STH as a potential fit.

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



Step 3a: Customize According to Global, Country, and/or Local Context - *Assemble existing global or national policies and standards, as well as the sub-national or local contexts, to further assess whether integration is feasible and appropriate. Fill in the cells based on the suggested criteria to help this decision and planning process.*

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

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

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

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			
Mechanism of community participation	Intervention 1			
	Intervention 2			

Step 3b: Customize According to Global, Country, and/or Local Context – *This tool depicts detailed technical/operational criteria and best practices involved in integration. While the table incorporates the latest global guidance and experience available when this tool was developed (see References), the list of criteria to consider is not exhaustive and should be modified to the country context and updated as needed.*

Appendix B: Global Guidance on Specific Interventions According to Select Criteria

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

Campaign Criteria	Immunization		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]
	MEASLES	High (≥95%) immunization coverage two doses			**ONCHOCERCIASIS**	80% therapeutic coverage (population eligible for treatment)[6]	**MALNUTRITION**	
	MENINGITIS	High (> 95%) vaccination coverage	**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		
	YELLOW FEVER	High (>95%), 1 dose, with a 60-80% security threshold, to interrupt local transmission; one dose confers lifetime immunity[20]			**SOIL-TRANSMITTED HELMINTHS**	Global target: by 2020, treat at least 75% of children in countries endemic for soil-transmitted helminthiases		
					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
	MEASLES	After rainy season in tropical climates; late winter and early spring in temperate climates			**ONCHOCERCIASIS**	Transmission may be seasonal[6] (i.e., associated with rainfall), but infection and disease are chronic.	**MALNUTRITION**	

			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)[21] See YF risk assessment reference			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
	MEASLES	4-7 days to one month, including a weekend, during low transmission season, local events & festivals, avoiding rainy seasons			ONCHOCERCIASIS	Not in the rainy season.	MALNUTRITION	Not available
	MENINGITIS	4-7 days to a month, including a weekend, during low transmission season, local events and festivals, avoiding rainy seasons	SEASONAL-MALARIA-CHEMOPREVENTION	Monthly intervals during the high transmission season	SCHISTOSOMIASIS	Typically, when school is in session.		
	YELLOW FEVER	Not available			SOIL-TRANSMITTED HELMINTHS	Typically when school is in session		
					TRACHOMA	Not in the rainy season.		
Considerations/Contraindications of Medicines* *Disclaimer: Information provided for illustrative purposes only and does not account for laws, regulations, and protocols of different geographic targets. Please consult the most recent global, national, and local guidance for current contraindications. Any person on therapy for a chronic medical condition should consult a health care provider	POLIO (OPV)	OPV can be given at any time before or after MCVs without interference in the response to either vaccine[19]	INSECTICIDE-TREATED-NETS	n/a	LYMPHATIC FILARIASIS		VITAMIN A	
	MEASLES	Antibody-containing blood products and MCV should not be co-administered. Live vaccines should be given either simultaneously or at intervals of 4 Weeks[19]			ONCHOCERCIASIS		MALNUTRITION	
					SCHISTOSOMIASIS			
	MENINGITIS	MenACWY preferred for high-risk adults less than 55 or previously vaccinated greater than 56 years olds. MPSV4 for greater than 56 years old			SOIL-TRANSMITTED HELMINTHS			
	YELLOW FEVER	Live vaccines should be given either simultaneously or at intervals of 4			TRACHOMA			

for that condition before taking multiple medications.		weeks						
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)
	MEASLES	Most measles campaigns are non-selective SIAs co-administered with rubella. Catch-up vaccination for measles and/or to introduce rubella for ages 9 months-14 years or wider based on epidemiology; 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.			**ONCHOCERCIASIS**	All eligible persons >90 cm in height or >15 kg in weight[8]	**MALNUTRITION**	
	MENINGITIS	Initial Catch-up vaccination: 1-29 years; 1-5 year follow-up campaign.	**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		
	YELLOW FEVER	In high-risk populations, all persons ≥ 9 months, or in outbreak response, infants ≥ 6 months and pregnant and/or breastfeeding women.			**SOIL-TRANSMITTED HELMINTHS**	Children ages 12 months through school age (about 12 years)		
					TRACHOMA	Eligible members of the community >6 months of age.		
Campaign Strategies Intervention complexity (e.g. injectable cold chain, directly observed therapy) Vaccination strategies 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
	MEASLES	Fixed post, mobile post, fixed or mobile with house-to-house canvassing, house to house immunization[10]			**ONCHOCERCIASIS**	Typically house-to-house	**MALNUTRITION**	

			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 protection <70%) and reactive campaigns for outbreaks.			TRACHOMA	Typically house-to-house		
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% prevalence of night blindness or ≥20% prevalence vitamin A deficiency in young children. All levels, national to village level
	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			ONCHOCERCIASIS	Usually sub-national[6]	MALNUTRITION	
			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
	MEASLES	Initial supplementary immunization activity (SIA) to eliminate susceptible pool, follow-up SIA 2-5 years later when accumulation of susceptible preschool			ONCHOCERCIASIS	Annual[6]	MALNUTRITION	

		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; Follow-up campaign after 2-5 years or depending on the epidemiological risk.			**SOIL-TRANSMITTED HELMINTHS**	Annual if ≥20% prevalence, biannual if ≥50% prevalence		
	YELLOW FEVER	*Eliminate Yellow Fever Epidemics* strategy risk assessment process[21]Mass vaccination campaigns best for short term but immunity only for 25-30 years. Catch-up campaigns not a substitute for routine immunization[20]			**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.
	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.			**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**	
	MENINGITIS	Refugees / displaced people, nomadic populations, indigenous peoples, people in civil conflict, marginalized groups, workers, and populations in mines within the meningitis belt	**SEASONAL-MALARIA-CHEMOPREVENTION**	Children 3-59 months in areas of unstable malaria transmission and with high malaria burden.	**SCHISTOSOMIASIS**	Populations in high prevalence settings		
					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. Travellers. High risk areas according to temperature, rainfall, vegetation coverage. [21]			**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.
	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			**ONCHOCERCIASIS**	Not always employed, but needed to address full coverage of all households and at-risk groups	**MALNUTRITION**	
			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 community agents, community relays, community leaders, previous data on polio or measles supplementary immunization activity, number of children			**SOIL-TRANSMITTED HELMINTHS**	TBD		

		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
	MEASLES				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.
	MENINGITIS		SEASONAL-MALARIA-CHEMOPREVENTION	Household registration	SCHISTOSOMIASIS			
	YELLOW FEVER	Multistage Cluster Design from *Eliminate Yellow Fever Epidemics* strategy risk assessment process[21]			SOIL-TRANSMITTED HELMINTHS			
					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
	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.	**ONCHOCERCIASIS**	Estimates generated automatically through WHO Joint Application Package[13]	**MALNUTRITION**	
	MENINGITIS	Vaccine: depending on target population and vaccine wastage rates; cold chain and other supplies estimated by different methods.			**SCHISTOSOMIASIS**	Estimates generated automatically through WHO Joint Application Package		
	YELLOW FEVER				**SOIL-TRANSMITTED HELMINTHS**	Estimates generated automatically through WHO Joint Application Package[13]		
					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
	MEASLES	Identify target age for immunization; prepare to manage issues such as negative publicity, rumors, Adverse Event Following Immunization			**ONCHOCERCIASIS**	Messages on purpose, benefits and side effects associated with mass drug administration.	**MALNUTRITION**	
	MENINGITIS	Identify the target age for vaccination; prepare to deal with 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, 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	**SCHISTOSOMIASIS**	School and community-based education on causes and benefits of mass drug administration.		
					SOIL-TRANSMITTED HELMINTHS	Messaging on target ages; need train volunteers to communicate in handling children who cannot swallow		

				on general malaria prevention and treatment.		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**	
	MEASLES	Place order 9-12 months before campaign; comprehensive multi-year strategic plans.			**ONCHOCERCIASIS**	Place order 9-12 months before mass drug administration	**MALNUTRITION**	
	MENINGITIS	Place order 9-12 months before campaign.	**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		
	YELLOW FEVER	Fluid: limited production capacity constrains supplies, UNICEF prioritizes campaigns. International Coordinating Group for Vaccine Provision manages a GAVI-supported emergency stockpile.			**SOIL-TRANSMITTED HELMINTHS**	Place order 9-12 months before mass drug administration		
					TRACHOMA	Place order 12 months before mass drug administration		
Procurement Sources	**POLIO (OPV)**	UNICEF Supply Division	**INSECTICIDE-TREATED-NETS**	Global Fund, President's Malaria Initiative and others directly from	**LYMPHATIC FILARIASIS**	WHO with possible review by the Mectizan Donation Program	**VITAMIN A**	UNICEF Supply Division,

				net manufacturers; UNICEF Supply Division				
	MEASLES	UNICEF Supply Division; UNICEF, PAHO Revolving Fund, Gavi Roadmap, healthy market framework, MI4A			**ONCHOCERCIASIS**	WHO - reviewed by Mectizan Donation Program[6]	**MALNUTRITION**	UNICEF Supply Division
			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
	MEASLES	Vaccinators, supervisors, monitors, volunteers, district-level program managers, logisticians, communication focal persons.			**ONCHOCERCIASIS**	Community health workers, supervisors, monitors, health workers, volunteers, district-level program managers, logisticians, communication focal persons	**MALNUTRITION**	Health workers, Community Health Volunteers.
			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, logisticians, communication focal persons.			**SOIL-TRANSMITTED HELMINTHS**	Teachers, supervisors, monitors, health workers, volunteers, district-level program managers, logisticians, communication focal persons.		
	YELLOW FEVER	Vaccinators, supervisors, monitors, volunteers, district-level program			**TRACHOMA**	Community health workers, supervisors, monitors, health		

		managers, logisticians, communication focal persons.				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
	MEASLES	Cold chain maintenance, immunization supplies, waste management			**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
	MENINGITIS	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		
	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.			**SOIL-TRANSMITTED HELMINTHS**	Must administer medication before measles immunization in campaign setting.		
					TRACHOMA	Managed through International Trachoma Initiative with support from governments and partners.		
Monitoring and supervision (Monitoring Post Campaign Adverse Events, capacity for & commitment to monitoring/surveillance)	**POLIO (OPV)**	Independent monitoring with Lot quality assurance sampling or other established method; GIS mapping to locate catchment areas. Cold chain and Adverse Event Following Immunization monitoring required.	**INSECTICIDE-TREATED-NETS**	Promote engagement of both supervisors and independent monitors, depending on population served and number of campaign personnel overseen	**LYMPHATIC FILARIASIS**	Need monitor drug administration for difficulties swallowing Supervision of community health workers managed through health system	**VITAMIN A**	Supervision of community health workers managed through health system, Bi-annual review meetings with health service providers
	MEASLES	SIA Readiness Assessment Tool; pre-SIA supervision & monitoring; checklists; rapid convenience monitoring to find & vaccinate any unreached children. Cold chain and Adverse Event Following			**ONCHOCERCIASIS**	Supervision of community health workers managed through health system	**MALNUTRITION**	

		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. Rapid Convenience Monitoring[19]			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
	MEASLES	Review immunization cards/home-based records; tally sheets divided as 9-11 months, 1-4 years, 5-14 years; daily review 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.			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
			SEASONAL-MALARIA-CHEMOPREVENTION	Simple registers and reporting forms must be developed for community health workers to complete; every child is 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.	SCHISTOSOMIASIS	Drug treatment registers or tally sheets.		

	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 Indicator Cluster Survey; if those are scheduled far in future, stand-alone post-campaign surveys conducted in rainy season per country guidance	**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

	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	**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
	MENINGITIS				**SCHISTOSOMIASIS**	Impact surveys after 3-5 years of mass drug administration		
	YELLOW FEVER	Post-SIA 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 (DHS, MOICS, stand-alone EPI survey) not done for a few years and one not planned for few years.[20]			**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		
					TRACHOMA	Impact surveys after 3-5 years of mass drug administration		

Appendix C: Key Categories of Considerations for Campaign Integration[24]

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	**MDA**	Mass Drug Administration
AFP	Acute Flaccid Paralysis	**MDVP**	Multi Dose Vial Policy
ALB	Albendazole	**MI4A**	Market Information for Access to Vaccines
BCG	Bacillus Calmette–Guérin vaccine primarily used against tuberculosis	**MICS**	Multiple Indicator Cluster Survey
bOPV	Bivalent Oral Polio Vaccine containing types 1 and 3	**MENAV**	Meningococcal A Conjugate Vaccine
CDC	U.S. Centers for Disease Control and Prevention	**MENACYW**	Meningococcal quadrivalent conjugate vaccine for serotypes A, C, Y,W-135
CHD	Child Health Day	**MIS**	Malaria Indicators Survey
cMYP	Comprehensive Multi-Year Strategic Plans	**MMRV**	Measles, Mumps, Rubella, Varicella
DEC	Diethylcarbamazine (citrate)	**MoH**	Ministry of Health
DOT	Directly Observed Therapy	**mOPV2**	Monovalent Type 2 Oral Polio Vaccine
DHS	Demographic and Health Surveys	**MOV**	Missed Opportunities for Vaccination
GAVA	Global Alliance for Vitamin A	**MPSV4**	Meningococcal polysaccharide vaccine
GPS	Global Positioning System	**NID**	National Immunization Day
HCD	Human Centered Design	**nOPV2**	novel oral polio vaccine type 2 which is a modified version of mOPV2
HCE	Health Campaign Effectiveness	**ONCHO**	Onchocerciasis
HCW	Healthcare Worker	**OPV**	Oral Polio Vaccine
HH	Household	**PECS**	Post Event Coverage Survey
HKI	Hellen Keller International	**POS**	Pediatric Oral Suspension
HMIS	Health Management Information System	**PZQ**	Praziquantel
HPV	Human Papillomavirus	**RI**	Routine Immunization
IDP	Internally Displaced Peoples	**SAE**	Serious Adverse Experience
IPV	Inactivated Polio Vaccine	**SAGE**	Strategic Advisory Group of Experts
IU	International Units	**SC**	Subcutaneous
IVM	Ivermectin	**SCH**	Schistosomiasis
JEE	Joint External Evaluation	**SIA**	Supplementary Immunization Activity
LF	Lymphatic filariasis	**SMART**	Specific, Measurable, Achievable, Relevant, and Timebound
LMIS	Logistics Management Information System	**SMS**	Short Messages Services (text messaging)
LQAS	Lot Quality Assurance Sampling	**SP/AQ**	Sulfadoxine-Pyrimethamine + Amodiaquine
STH	Soil-transmitted Helminthiasis	**UNICEF**	United Nations Children's Fund
TIP	Tailoring Immunization Programs	**VAS**	Vitamin A Supplementation
tOPV	Trivalent Oral Polio Vaccine	**WHO**	World Health Organization
Trach	Trachoma	**WHO JAP**	World Health Organization Joint Application Package
WMF	Wastage Multiplication Factor		
YF	Yellow Fever		

Glossary (Illustrative)

Criteria	Definition
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. [16]
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. [16]
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. [16]
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). [26]
Denominator	The total number of a population for an indicator. [16]
Disaggregation (of data)	Analysis of data by different sub-groups, for example, analysis of data by smaller administrative units or by different age groups. [16]
District	For the purpose of this guide, "district" refers to a defined sub-national administrative area. [16]
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. [25]
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. [16]
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. [16]
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. [16]

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). [16]
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. [16]
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. [26]
House-to-house vaccination	SIA strategy recommended mainly as a mop-up strategy in areas where there is prior evidence of refusal of vaccination. [16]
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). [16]
Non-selective campaigns	Campaigns that do not consider immune status of individuals, previous vaccinations, or infection. [25]
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. [26]
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. [16]
Preferences of beneficiaries	Consider community activities/celebrations and local events such as religious festivals, key agricultural activities, and timing of political activities. [1]
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. [1]

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