Implementing integrated health campaigns

decision-making and planning guide

World Health Organization

HEALTH CAMPAIGN EFFECTIVENESS COALITION
Strengthen Systems. Maximize Impact.

A program of THE TASK FORCE FOR GLOBAL HEALTH

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Abbreviations and acronyms

AEFI	Adverse events following immunization
CHWs	Community health workers
EPI	Expanded Programme on Immunization
EYE	Elimination Yellow Fever Epidemics
DHIS	District health information system
GPEI	Global Polio Eradication Initiative
HBR	Home-based record
HCE	Health campaign effectiveness
HPV	Human papillomavirus
ICC	Interagency Coordinating Committee
ITN	Insecticide-treated bednets
LF	Lymphatic filariasis
LLIN	Long-lasting insecticide-treated net
LQAS	Lot quality assurance sampling
MDA	Mass drug administration
MAC	Multi-age cohort
MCV	Measles-containing vaccine
MNTE	Maternal and neonatal tetanus elimination
MR	Measles rubella combination vaccine
NIS	National Immunization Strategy
NGO	Nongovernmental organization
NTD	Neglected tropical disease
PCCS	Post-campaign coverage surveys
PIRI	Periodic intensification of routine immunization
PRSEAH	Prevention and Response to Sexual Exploitation, Abuse and Harassment
RCM	Rapid convenience monitoring
RED	Reaching every district
SIA	Supplementary immunization activity
STH	Soil-transmitted helminthiases
TTCV	Tetanus toxoid-containing vaccine
UNICEF	United Nations Children's Fund
VAS	Vitamin A supplementation
VPD	Vaccine-preventable disease
WHO	World Health Organization
YF	Yellow fever

About this guide

Health campaigns are an important and widely used delivery strategy for reaching large numbers of people quickly with essential health interventions. Many health programmes depend on campaigns to prevent or respond to disease outbreaks, or to supplement and support essential services.

Campaign integration is not a new concept. However, challenges have arisen because integration has been implemented in an ad hoc manner. In settings where multiple health campaigns regularly occur, a more holistic approach is needed. Integration has the potential to achieve greater efficiency and impact by taking a more people-centred approach, in addition to improving alignment and collaboration between programmes. With sufficient planning and careful consideration, integrated health campaigns can become an institutionalized component of health-sector or annual planning processes.

How this guide was developed

This guide was created in response to a request from regional colleagues seeking guidance for successful campaign integration. Its development involved extensive collaboration, drawing on the experiences, insights, and feedback from a diverse group of experts. The guide was shaped through a series of consultations, expert reviews, and targeted feedback sessions to ensure its relevance and effectiveness.

The guide content drew on lessons learned from country examples of integrated health campaigns across different contexts, including from Nepal, Togo, Ethiopia, India, Colombia and Nigeria. These countries were selected based on their experiences with integrated approaches to campaigns and the information from these countries can be generalized to other settings based on the relevant findings, outcomes or challenges described. Additionally, the information outlined in this guide was compiled from existing guidance including *Working together: an integration resource guide for immunization services throughout the life course (2018) (16) and Planning and implementing high-quality supplementary immunization activities for injectable vaccines using an example of measles and rubella vaccines: field guide (2016) (25)* and aligns with the HCE Collaborative Action Strategy for Health Campaign Effectiveness. *(1)*

What is the purpose of this guide?

Many countries rely on a combination of essential health services and health campaigns to extend the reach of interventions designed to prevent, control, eliminate or eradicate diseases. This guide provides a rationale to aid decision-making on the integration of campaigns between different health programmes and on how to plan for optimal integration.

The guide aligns with the Collaborative Action Strategy (CAS) for Health Campaign Effectiveness *(1)* in terms of planning and implementation, monitoring, evaluation, research, learning and adaptation, and financing for integrated health campaigns.[a]

The first part of this guide provides an overview of integrated campaigns. The second part outlines what is needed for a high-level decision-making process and for the development of a multi-year

[a] The CAS is designed with 12 concrete recommendations related to planning and implementation, monitoring, evaluation, research, learning and adaptation, and financing. The recommendations are primarily intended to improve collaboration between preventive health campaigns but can also serve to guide integration with health emergency response efforts, when relevant.

cross-campaign integrated workplan with a calendar for campaign integration. The third part summarizes the key considerations, best practices and lessons learned in implementing integrated campaigns. It draws on country case studies and is organized into planning periods – namely before, during and after an integrated campaign.

Who is the target audience?

This guide is intended for use by programme managers in the Ministry of Health and/or other programme officials responsible for decision-making and overseeing the planning of health campaigns for immunization, maternal, child and adolescent health and other health programmes (i.e. neglected tropical diseases, nutrition, malaria, and screening for noncommunicable diseases). The guide will also be useful for global, regional and national policy-makers and partners responsible for the design, financing, implementation, monitoring and evaluation of integrated health campaigns, policies or health systems strengthening.

Related resources

The guide builds on experiences and guidance from the planning tools and resources of existing campaigns to emphasize the decision-making and key planning considerations that are relevant to integrated health campaigns. The guide also highlights the need to consider equity, which comprises both health and gender equity *(2)*, in the process for planning integrated health campaigns. The guide should be used in conjunction with related resources as appropriate (Annex 1).

Part 1: What are integrated health campaigns?

The term “integrated health campaign” does not necessarily mean co-delivery of all the interventions during a campaign. Rather, these are campaigns in which there is coordination between different programmes, stakeholders and the country health systems. These campaigns can be fully integrated, whereby there is a high level of coordination and interventions are co-delivered, or partially integrated (see Box 1), and in which various functions – governance, health workforce, monitoring – or components – tools, guidelines, technologies – can be integrated, even when fully integrated service delivery may not be feasible.

Box 1. Opportunities for integrating campaign components

- **Coordination.** Are the assets and resources of other programmes being leveraged through integrated coordination?
- **Campaign planning and budgeting.** Are health programmes using the same maps and target population information? Or are different methods being used to identify and reach hard-to-reach populations that could benefit from the campaign or routine programmes?
- **Human resources.** Do other programmes have details of the number, qualifications and other information about health workers that could help campaign planning? Can training include additional topics at minimal marginal cost (e.g. additional days or materials)?
- **Supply chain and logistics.** Have other programmes conducted recent assessments that can facilitate campaign planning? Can pre-campaign assessments or training include information for other programmes? Can programmes take advantage of bulk rates to transport non-campaign supplies? Can storage and/or distribution of certain commodities be combined *(3)*.
- **Advocacy, communication and social mobilization.** Do other programmes have established links with national and subnational influencers, relationships or contracts with mobile or telecommunications companies, or other innovative channels or methods that can be leveraged for campaign messaging? Can integration bring more actors and collaboration with new and expanded partners and allow wider reach? Have other programmes recently conducted surveys or assessments that can inform the planning for campaign communication and demand-generation? Have any other programmes carried out gender analyses from which lessons can be learned?
- **Pharmacovigilance.** Safety reporting forms for an integrated health campaign been reviewed. Is training planned for all levels, from teams to causality committees and so on *(4)*? Consider what other medicines and adverse events could be included.
- **Waste management.** Do other programmes have contracts with waste management suppliers/vendors and recycling companies? Can intersectoral collaboration be leveraged to create ecological solutions to sustainable waste management?
- **Data tools, monitoring and evaluation.** Which digital tools and platforms for data collection are being used by other programmes? Can information be gathered for non-campaign programmes? Can digital tools and platforms be shared?

Rationale for integrating health interventions during health campaigns

A country's decision to carry out a health campaign is driven by a variety of factors, including epidemiology, strength of the health system, and contextual factors such as catastrophic events, the need to prevent an impending outbreak, introduction of a new vaccine, country and donor priorities*(5)* or achievement of a regional or global health target. Vaccine-preventable diseases (VPDs), malaria, neglected tropical diseases (NTDs) and nutrition are programmes that receive significant funding from agencies or donors for health campaigns. A glossary of terms relating to health campaigns can be found in **Annex 2**.

Preventive health care – including vaccination, malaria prevention, preventive chemotherapy for NTDs, and vitamin A distribution – plays an integral role in achieving Sustainable Development Goal 3 (SDG3): Good health and well-being for all *(6)*.

Figure *1*. The 17 sustainable development goals

In alignment with the SDGs (Figure 1), the strategy of the Immunization Agenda 2030 (IA2030) *(7)* aims "to extend the benefits of vaccines to everyone, everywhere" (Figure 1). This strategy includes a strong people-centred approach and emphasis on integration, recognizing the opportunities and reciprocal benefits that improved coordination and cross-sectoral collaboration can bring.

For many programmes, health campaigns are an important means to reach target populations that are missed by routine services or to supplement those services. However, in settings where multiple health campaigns occur frequently, the way in which funds are mobilized, managed, allocated, monitored and evaluated often poses challenges to integration and opportunities for integration are missed. Planning and implementation are often carried out in parallel, with little communication or collaboration between health campaigns and inadequate coordination with country health systems. The resulting strategic and operational inefficiencies and inequities can strain health systems, burden health-care workers, weaken health services and limit the potential impact of health campaigns *(8)*.

Global disease control and elimination efforts – such as the Global Polio Eradication Initiative (GPEI, *9)*, the Measles & Rubella Partnership *(10)*, the Eliminate Yellow Fever Epidemics strategy (EYE, *11)*, the Maternal and Neonatal Tetanus Elimination (MNTE) initiative *(12)*, the roadmap for NTDs 2021–2030 *(13)* – highlight the need for campaign integration. Many countries have experience of delivering multiple antigens or other health interventions during Maternal and Child Health days or weeks and World Immunization Week. The periodic intensification of routine immunization (PIRI, *14*) approach typically delivers routine doses of multiple antigens with other interventions. Despite this support and experience, many countries, often supported by donors and/or partner agencies, continue to organize separate single vaccine antigen or other single health intervention health campaigns, even when there is significant overlap in geography, timing and target population for the interventions.

Benefits and challenges of integrating multiple interventions in health campaigns

Adequate advance planning and strong coordination, including high-level government and partner/donor commitment, can improve the implementation of more efficient integrated health campaigns, leading to cost and system efficiencies and end-user satisfaction. Both benefits and challenges of integration have been summarized in Figure 2 by the WHO building blocks of health systems *(15)* and outlined in WHO guides and by the Health Campaign Effectiveness (HCE) Coalition *(16,17,18)*.

Figure 2. Benefits and challenges of integrated campaigns expanding on WHO's six building blocks of health systems

WHO Health system building blocks	**Integrated health campaigns**	
	Benefits	**Challenges**
 **Leadership and governance**	***Aligned leadership and governance.*** These help ensure the existence of strategic policy frameworks, effective oversight and coalition-building, provision of appropriate incentives, and attention to system design and accountability. ***Improved coordination.*** Cross-sector collaboration and coordination can lead to improved working relationships for the planning and delivery of interventions.	***Lack of leadership.*** As with all health campaigns, insufficient high-level commitment can lead to ineffective planning and poor outcomes. ***Lack of coordination.*** This can lead to uncoordinated leadership or governance structures. ***Perception of decentralization/loss of control.*** Programme leaders may be hesitant to include interventions outside their area of expertise, perceiving a risk of compromising the results of their programme.
 **Health systems financing**	***Cost-effectiveness.*** Joint planning and cost-sharing can make integrated health campaigns more cost-effective, cost-efficient and sustainable. ***Improved health system financing.*** Integration of health campaigns can lead to increased domestic and donor support as a result of demonstrated increased returns on investment.	***Inflexible or asynchronous funding streams.*** These can impede or prevent planning for an integrated campaign. This underscores the importance of advanced planning to ensure that both political and donor commitment are obtained for all interventions.
 **Demand and community engagement**	***End-user satisfaction.*** Receiving multiple interventions at once can improve user satisfaction due to	***Insufficient community engagement.*** Lack of adequate demand generation from communities can hinder uptake,

		savings in time and travel costs. It may also increase acceptance of one or more integrated interventions through cross-promotion.	preparation and implementation of integrated health campaigns.
	**Service delivery**	***Increased coverage/impact.*** An intervention which has historically low coverage may be able to increase its coverage and community acceptance by integrating with an intervention that has achieved a broader reach. ***Reduced disruptions to routine health services.*** With a smaller number of campaigns, the health workforce will spend less time away from the health facility.	***Increased complexity and challenging implementation.*** Without sufficient and early planning and resources, combining too many interventions can overburden programmes and health workers, resulting in poor campaign outcome – such as not achieving the desired high quality and coverage. ***Safety.*** Campaign planners must ensure that any co-delivery of interventions is clinically safe. Delivery of multiple interventions can also lead to higher potential for programmatic errors; it is critical that health workers are well trained, adverse events monitoring is in place and that a risk communication strategy is well planned to deal swiftly and effectively with any issues that may arise.
	**Health workforce**	***Strengthened health system capacity.*** Providing quality capacity-building activities and training can increase knowledge of a broad array of health programmes. ***Workforce policies aligned.*** With integration, the management, skills required and remuneration (if any) of the workforce can be standardized.	***Health worker strain.*** The additional demands placed on health workers could overburden them and/or have a negative impact on their morale. Inadequate staffing can also lead to long delays and waiting times for clients. Mitigating measures, such as increasing human resource capacity, support and incentives and/or adjustment of daily targets should be put in place for integrated health campaigns. ***More training, supervision and monitoring needed.*** Multiple interventions, especially those with target populations of different ages, may require additional simulation based on practical training and monitoring responsibilities. However, having one longer integrated training session may be shorter than the total time of two or more separate training sessions for different interventions.

			Loss of income by field-workers. Due to fragmented financing, many health workers rely on campaign per diems (incentives) as a major part of their income. Integrating activities may result in reduction of this income.
	**Health information systems**	***Improved systems performance.*** Setting up systems to capture multiple health interventions can ensure that the production, analysis, dissemination and use of data are streamlined and timely.	***Duplication of health information systems.*** Many programmes have their own information systems, and aligning these may lead to increased costs (or programmes continuing to use their own systems).
	**Access to essential medicines**	***Better reach of missed children and communities*****.** Hard-to-reach communities often miss essential health services, so ensuring that every possible and appropriate health intervention is offered is both important and efficient.	***Logistical bottlenecks causing delays.*** Despite the best planning, health campaigns can often be delayed due to logistical challenges, including stock-outs, coordination of multiple suppliers, transportation infrastructure, waste management systems, or other emergencies. Some challenges are unavoidable; however, they pose a particular risk to integrated health campaigns as they can result in missing the time window for delivery of interventions and create co-dependencies between different interventions.

Part 2: Deciding when to integrate health campaigns

The steps in decision-making for integrating health campaigns are:
Step 1: Establish or leverage an existing multisectoral cross-campaign national coordination body.
Step 2: Map planned and anticipated health campaigns over a 3–5-year period.
Step 3: Decide which health campaigns and/or components to integrate.
Step 4: Develop a multi-year cross-campaign integrated workplan, calendar and budget.
Step 5: Review the multi-year cross-campaign integrated workplan regularly and update as needed.

Step 1. Establish or leverage an existing multisectoral cross-campaign national coordination body

A successful integrated health campaign requires strong coordination, yet the various health programmes that conduct health campaigns often operate in a vertical manner. Establishing an ongoing inclusive and overarching cross-campaign national coordination body *(1)* is a key first step to identifying opportunities and facilitating campaign integration. A suggested coordination mechanism, membership and terms of reference are outlined below. When possible, build on existing groups.

The coordination body should develop a multi-year cross-campaign integrated workplan by identifying campaigns and domains for collaboration, determining the potential for integration and deciding which campaigns to integrate. Once integrated campaigns are implemented, the coordination body should closely monitor and review them.

Ideally, the coordination body should develop a multi-year cross-campaign integrated workplan that is aligned or synchronized with the national multi-year planning cycle (e.g. the National Immunization Strategy [NIS], *19*)). The coordination body should meet regularly to review and update the workplan for the current year. To function effectively, the coordination body needs:

- ✓ terms of reference with clear roles;
- ✓ consistent, representative and inclusive membership;
- ✓ written minutes of each meeting, with action points.

Membership

Members of the coordination body should include representatives from all relevant programmes conducting health campaigns with potential for integration, as well as programmes that would be affected by integrating a campaign (e.g. digital/health information management, communications, medical, nursing, allied health associations and community leaders) and any existing emergency operations centre or analogous body that leads responses to health emergencies or disease outbreaks. It is important to ensure that there is cross-representation with other coordinating bodies such as the Health Sector Coordinating Committee, the Immunization Interagency Coordinating Committee (ICC) etc. In addition, successful implementation of the shift in ways of working will require risk management and change management skills.

The coordination body should be established and led by the Ministry of Health or should have a Chair designated by that ministry, as well as a supporting secretariat with active participation by the Ministry of Finance and comprising senior leaders from key government ministries, country leads/programme managers for global health agencies and funders (e.g. Gavi, UNICEF, WHO), local and international nongovernmental organizations (NGOs) and civil society actors (to ensure a community perspective). Where relevant, the coordination body should include subnational

stakeholders and health experts across all domains and health programmes that deliver campaigns. Membership should be flexible to accommodate new members when needed (Box 2), and a balanced representation of men and women is important (Box 3). For sample terms of reference for the coordination committee, see Annex 3.

Box 2. Considerations for coordination body membership

1. **Identify leaders and champions who can engage in and generate interest in campaign integration**, such as government officials, community and religious leaders, and other persons with the technical knowledge, peer recognition and motivation for change.

2. **Ensure equity by involving a broad array of stakeholders at national, district and community levels,** including representatives of health workers, the community, traditional leaders, medical and nursing organizations, academic institutions, NGOs and faith-based agencies.

3. **Identify key decision-makers with the legal or administrative authority to approve an integrated strategy and/or to fund** (e.g. within the ministries of health, finance, education etc. and partner and donor organizations as appropriate). Foster dialogue among the relevant ministries about financing and operations of integrated health campaigns.

Box 3. Gender: the importance of a balanced representation of men and women

- **Gender equity** is the process of being fair to both women and men. It recognizes that women and men have different needs, power and access to resources, and this should be identified and addressed in a manner that rectifies imbalance. Addressing gender equity leads to equality.
- **Gender relations** can create hierarchies and unequal power relations between and among groups of women and men, disadvantaging one group over another. This may be due to social relations that are based on gender norms and roles. It is important to ensure there is equal opportunity for both women and men.
- **Implement gender-responsive actions** by making gender-equality training mandatory for all (male and female) so that everyone is aware of what is needed for a safe working environment for all.

Step 2. Map planned and anticipated health campaigns over 3–5 years

The cross-campaign national coordination body should conduct a mapping exercise of different health campaigns to see which are best positioned for comprehensive, consolidated and collaborative planning, including an assessment of opportunities for full or partial integration (Box 1). Attention should be paid to identifying health campaigns that are already planned and/or conducted at regular intervals, including routine Child Health days, Immunization weeks, PIRIs, health camps, extended outreach, mass drug administration (MDA) for NTDs, and distribution of insecticide-treated (bed)nets (ITN).

For many programmes, health campaigns help address specific epidemiological challenges, such as disease control, emergency situations and outbreaks. Within the mapping exercise, the coordination body should consider the latest **epidemiological analysis** of each health problem to determine the need for national or subnational health campaigns over a 3–5-year period.

For several VPDs – particularly measles, polio and tetanus – risk assessments are conducted regularly (typically annually or more frequently) at national and subnational levels. These assessments are crucial indicators for determining the necessity and timing of health campaigns. Alongside risk assessments, coverage data, the existence of outbreaks and population-based surveys such as Multiple-Indicator Cluster Surveys (MICS) or Demographic and Health Surveys (DHS) provide further evidence to determine the frequency of health campaigns.

See Table 1 for a sample template (which can be adapted as appropriate) for the campaign mapping exercise.

Table 1. Sample template to map campaign frequencies and characteristics

	Vaccine-preventable diseases								Malaria		Neglected tropical diseases					Vitamin A
											SCH	STH	LF	ONC	TRA	
Intervention	Cholera	Measles/ rubella	Meningitis	Oral polio virus	Inactivated polo virus	Tetanus	Typhoid	Yellow Fever	ITNs/ LLINs	SMC	Praziquantel	Albendazole Ivermectin	Albendazole Ivermectin Diethylcarbamazine	Ivermectin	Azithromycin	Vitamin A
Planned frequency																
Seasonality																
Target population																
Geographical target level (national/sub national)																
Delivery methods (personnel required)																
Point of delivery (e.g. school-based, door-to-door etc.)																
Distribution requirements																
Funding																

SCH-schistosomiasis; STH-soil transmitted helminths; LF-Lymphatic Filariasis; ONC- Onchocerciasis; TRA-Trachoma; ITN-Insecticide-treated net; LLIN-Long-lasting insecticide-treated net. Source: Adapted from: Ref. *(5)*.

Step 3. Decide which health campaigns and/or components to integrate

Assess potential for integration

Once a comprehensive mapping is completed of the planned health campaigns for the next 3–5 years, the coordination committee should examine which campaigns and interventions have potential for integration. Overlaps in timing, geography, target populations, supplies, logistical and personnel requirements should be considered.

If this approach initially proves challenging for the country, one could aim to identify 1–3 integration priorities annually and develop targeted plans to achieve them. This approach can help streamline the decision-making process by focusing on achievable campaign integration goals based on existing knowledge of potential opportunities and can be adapted with time and experience.

The coordination committee should also assess opportunities for partial integration of certain campaign components, as described in Box 1.

The Health Campaign Effectiveness Coalition has developed a decision matrix as part of its *Decision guidance toolkit for people-centered integration of health campaigns (1)* that can be used as a simple starting point to explore possible integration of health interventions (Figure 3). Further instructions for use of the tool are available on the HCE webpage, and countries can adapt it for their own situation.

Figure 3. Sample decision matrix to explore facilitating factors and barriers for integrated health interventions (Please modify to compare different health interventions, as applicable)

	Immunization				Malaria		Neglected Tropical Diseases					Nutrition	
Health Intervention	**OPV**	**IPV**	**MR**	**YF**	**ITNs**	**SMC**	**LF**	**Oncho**	**Sch**	**STH**	**Trach**	**VitA**	**Maln**
Oral polio virus (OPV)		Facilitator: Barrier:	Facilitator: Barrier:	Facilitator: Barrier:									
Inactivated polio virus (IPV)			Facilitator: Barrier:	Facilitator: Barrier:									
Measles/rubella (MR)				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)													

Source: Adapted from Ref. *(20).*

To determine the facilitating factors and barriers for combing interventions, consider the following:

Technical and operational compatibility

- ✓ **Age range.** Is the target age range the same? If not, will it be difficult or time-consuming to triage during the campaign and monitor and supervise for accuracy? Could effective training and monitoring address this?
- ✓ **Delivery mechanisms.** Interventions that require skilled staff or take a longer time (such as administering injectable versus oral vaccines) may be less feasible for integration in some situations. Would there be sufficient campaign staff with appropriate technical skills to deliver multiple interventions?
- ✓ **Operational strategies.** Which strategies (door-to-door, health facilities, mobile sites) are most appropriate to the local context, considering the supplies, human resources and data-recording tools needed?
- ✓ Is **timing** of the campaign flexible (i.e. if one intervention is delayed due to logistics or funding, is there an imminent risk of disease outbreak for the others)? Is it possible for the timing of one campaign to be modified and kept on track to match the timing of another campaign?
- ✓ Can interventions be **safely** co-delivered in line with available data and WHO guidelines?
- ✓ Are the **logistics** for the combined health campaigns feasible and cost-effective?
- ✓ Are there **sufficient resources**? Can more resources be mobilized and from where?

Feasibility

- ✓ Has the country **previously** conducted integrated health campaigns with these interventions? Did they meet their targets?
- ✓ Is there **acceptance** of integrated health campaigns among political leaders, stakeholders, health workers and communities?
- ✓ Are health programmes willing to share **strategies, guidelines and tools** on similar campaign processes (e.g. functions such as microplanning, population census, logistics, communications, data collection)?
- ✓ Is the **training** required for co-delivery of certain interventions reasonable or too complex for health workers?
- ✓ Following an extended interruption of routine services or campaign delays (e.g. supply shortages or system disruptions caused by outbreaks, natural disasters, acute conflict, population displacements, insecurity etc.), is it practical to plan health campaigns with an **adjusted target age range** to reach those who were missed due to service disruption *(21)*?

Decide which health campaigns to integrate

On the basis of assessment of the criteria above, examination of the benefits and risks, and costs of integration, the coordination committee should decide which health campaigns can or cannot be integrated. This should involve additional consultations with the programmes concerned, as needed, as well as donors and domestic funding bodies. A strong recommendation for or against campaign integration made with full justification will make the decision easier for authorities (i.e. health minister, finance minister, donors) to endorse.

Final points to consider *(20)*:

Potential challenges and opportunities

- Would integration have advantages for programmes, the ministry and the populations they serve?

- Are there enough human resources with the appropriate technical skills and operational experience to implement an integrated campaign? Can more resources be mobilized, and from where?

Financial implications

- What is the cost of integrating these interventions versus the cost of not integrating? Consider conducting a costing analysis to better understand the cost implications of various options.
- What is the government budget cycle for funding these activities? Are the financing cycles the same for both/all interventions that may be integrated?
- Are there barriers to combining the financial resources?
- What donors are funding campaign activities? Are these donors amenable to integration/cost-sharing?
- What are the deadlines for submitting a proposal for funding or drug donation?
- Would an integrated campaign proposal be acceptable and to whom?
- Is there a financial scheme that makes cost-sharing feasible?

Community acceptability

- Is one intervention more highly sought-after than the other(s)? Depending on the community, integration may improve acceptance of the second intervention offered, or may backfire and lead to lower uptake of both.
- Are multiple injections involved? This can create concern regarding adverse events following immunization (AEFI) on the part of health workers and/or caregivers, and must be carefully managed in campaign planning, including with additional emphasis on training, communication and safety/AEFI management.
- Have providers and communities been consulted?
- Is it possible to include a pilot scheme at district or other lower subnational level to assess community acceptability before scaling up?

Step 4. Develop a multi-year cross-campaign integrated workplan, calendar and budget for integrated health campaigns

Once agreement is reached on which health campaigns can be integrated, the coordination committee should prepare a detailed multi-year cross-campaign integrated workplan, calendar and budget that lays out the campaigns to be conducted, with necessary planning timelines and actions to ensure effective, efficient integrated delivery.

There is often a lack of awareness and transparency regarding integration opportunities as resources for campaign schedules and planning cycles are not always accessible. The coordination committee should ensure that all activities defined in the multi-year workplans are in line with existing planning opportunities and strategic plans of each of the programmes involved (e.g. NIS, cervical cancer elimination, Eliminate Yellow Fever Epidemics strategy, Malaria control strategy, national NTD masterplans). The multi-year integrated workplan should include catch-up and preventive vaccination campaigns (e.g. measles, polio).

Once the multi-year cross-campaign integrated workplan is developed, it should be disseminated within the country by all applicable means (e.g. ministry circulars, webpages, newsletters) and with partners.

Most of the detailed planning and budget refinement will be carried out by each campaign planning committee. However, at a minimum, the following basic information should be included in the multi-year workplan:

- **projected campaign dates** (including advocacy and planning timelines);
- **target population** (by age, geographical location);
- **delivery strategies**;
- **preliminary cost estimates**; and
- **potential funding sources** (including donor application deadlines).

Consider including a small-scale pilot

Countries can consider implementing integrated health campaign strategies as a small-scale pilot scheme (e.g. in selected districts or areas) for assessment and learning before later scale-up. The pilot scheme can also be built into the timelines of the integrated workplan.

Step 5. Review the multi-year cross-campaign integrated workplan regularly and update as needed

The feasibility of the multi-year cross-campaign integrated workplan should be reviewed and reassessed every six months, or as needed.

For instance, an outbreak may occur that necessitates a response campaign with a very short planning period. In this case, the coordination committee can facilitate conversations with other health programmes on other antigens or interventions that might be feasible for inclusion. *Note that it may not be operationally possible to integrate other interventions in the initial phase of an outbreak response campaign; efforts to integrate must not jeopardize or delay the outbreak response. Often, integration can be considered later in the outbreak response, allowing time for more planning and coordination.*

Risk assessments are conducted annually or even more frequently at national and subnational levels for certain VPDs. The need for, and timing of, health campaigns may therefore shift and may present new opportunities for integration and updating of the cross-campaign integrated workplan.

When there is an extended interruption of routine services or a delay in conducting a campaign (e.g. due to supply shortages, natural disaster, acute conflict, population displacements, insecurity etc.), campaign strategies may need to be modified. For instance, the target age range or geographical area may need adjusting *(21)*. Such circumstances give rise to renewed discussions on the feasibility and desirability of integration.

Part 3: Key considerations

The third part of this guide outlines key considerations for implementing integrated campaigns, including best practices and lessons learned. It draws upon country case studies and is organized into planning time periods – **before, during** and **after** an integrated campaign *(22)*. Detailed guidance on campaign planning for specific health interventions is widely available (see Annex 1 for resources).

Key considerations before implementing an integrated health campaign

Planning and coordination

Planning for an integrated health campaign should begin by establishing a **cross-campaign national coordinating body** or by **leveraging use of an existing planning committee** that will oversee the integrated campaign. This is critical to ensure that planning is coordinated from the outset. Roles and responsibilities need to be agreed, especially when multiple programmes are involved. See the country example in Box 4.

The composition of the cross-campaign national coordinating body will vary between countries and campaign types, but typically will include at least:

- a national integrated campaign coordinator (if an integrated health campaign involves interventions managed by multiple disease programmes, a decision should be made as to whether one programme will officially lead or if co-leadership is possible);
- representatives from all programmes/interventions included in the campaign;
- representatives from different government ministries (including Ministry of Finance) from which intersectoral support and coordination are needed; and
- partner agencies.

An effort should be made to have equal representation of men and women on the coordinating committee (Box 3).

Promising[b] planning and coordination practices from country experiences *(23)*

- ✓ **Engage stakeholders early in the process.**
- ✓ **Facilitate intersectoral collaboration to discuss and agree on roles and responsibilities of staff from different government departments or agencies.**
- ✓ **Establish a coordination entity and workgroups to promote collaborative planning and shared decision-making.**
- ✓ **Convene regular coordination meetings with stakeholders at national, regional, health district and local levels.**
- ✓ **Integrate key macroplanning activities, including developing timelines of the integrated campaign.**
- ✓ **Leverage existing and familiar platforms or approaches (e.g. village health nutrition days, National Immunization Week, Child Health days).**
- ✓ **Partners can play an important role by providing strategic guidance, funding, planning and operational support for the integrated campaign.**

[b] Promising practices are drawn from the case studies for collaborative planning, conducted by the Health Campaign Effectiveness Coalition at the Task Force for Global Health with various partners. See: Refs. *(22, 23* and *24)*.

Box 4. Country example: **Collaborative campaign planning of vitamin A and lymphatic filariasis elimination in Nepal**

Vitamin A supplementation (VAS) health campaigns are conducted annually in Nepal, and since 2010 have been integrated with deworming (albendazole) treatment. In addition, 10 districts in Nepal are still endemic for lymphatic filariasis (LF) and annual health campaigns are conducted in these districts. An integrated approach combining VAS and LF was tested in a pilot study in one municipality.

Campaign planning involved the formation of a Campaign Integration Working Group comprising division directors, focal persons from the Epidemiology & Diseases Control Division, the Family Welfare Division, the crosscutting management division (Logistics section) and HEAL Group (a local NGO). The working group held formal meetings, approved a project workplan and guidelines, and issued directives for implementation activities.

Following the pilot campaign, the HEAL group examined the collaborative planning process for lessons learned to inform the scale-up.

Relevant findings:

- **Leadership in the concerned divisions within the Ministry of Health plays an important role** in promoting the programmatic need and policy mandate for integration.
- **Collaborative planning should involve stakeholders from both programmes and at multiple levels**.
- Collaborative planning is **an opportunity to identify local community groups to mobilize for the campaign.**
- To encourage intersectoral collaboration, **sectors such as education, agriculture, women and children, veterinary and ayurveda should be included in collaborative planning** meetings at municipal level.

Source: See Ref. *(24)*

Monitoring campaign readiness

One recommendation of the CAS[1] is that a coordinated and collaborative cross-campaign Monitoring, Evaluation, Research, Learning and Adaptation (MERLA) strategy should be developed by countries conducting integrated campaigns. Access to data is important to increase the understanding and measurement of integrated campaign effectiveness.

The national integrated campaign coordinator should regularly report to the cross-campaign national coordination body on the status of preparations. It is especially important to **monitor preparedness continually across each programme** as delays in one intervention will have an impact on the entire campaign. If an activity is postponed the multi-year integrated workplan should be updated.

To monitor readiness to conduct a high-quality integrated campaign, some management tools can be adapted and used, namely:

- **WHO's supplementary immunization activity (SIA) readiness assessment tool** was developed to monitor preparation of measles and rubella vaccination campaigns at all levels but it is applicable and easily adaptable to integrated campaigns *(25).* It provides a simple-to-use quantitative and periodic assessment of preparedness at both national and subnational levels. It identifies: strengths and weakness related to campaign preparations over time; gaps and needed actions; and responsible persons to address those gaps at local level. The tool facilitates reporting of preparedness data to higher-level authorities so that timely action can be taken – including potential decisions to postpone or partially postpone (i.e. in some districts) the campaign until adequate readiness is achieved. The readiness assessment tool stresses that, at any given point in time prior to the campaign, certain critical activities should be completed to ensure a high-quality campaign.

- A sample **preparedness checklist for an integrated campaign** developed by UNICEF and Ghana Health Services for an integrated polio (mOPV2) and vitamin A supplementation campaign can be downloaded here for adaptation: https://campaigneffectiveness.org/wp-content/uploads/2022/04/Integration-Preparedness-Checklist_GHS.docx (accessed 8 June 2024).

The readiness findings collected from the above tools should be presented in a dashboard to track progress in real-time. Campaign dashboards that can be adapted are available:

- A sample **implementation readiness dashboard** developed by the Clinton Health Access Initiative (CHAI) as part of a study of integrating measles and meningitis A health campaigns in Nigeria can be downloaded here: https://campaigneffectiveness.org/wp-content/uploads/2022/04/Implementation-Readiness-Dashboard-Template-1.xlsx (accessed 8 June 2024).

Cost-sharing and financing

Donors often fund individual programmes vertically with differently timed funding cycles. In consequence, the co-delivery of interventions in an integrated health campaign is likely to require a cost-sharing agreement between programmes to determine how and by whom the campaign will be financed.

As recommended by the CAS, a comprehensive view of campaign financing by combining detailed campaign financing information from major funders and government should be carried out to enable better planning and execution *(1).* This should be part of the multi-year integrated workplan, and should be shared with donors to give them an overview of the opportunity for more aligned and coordinated funding. The CAS also recommends that countries take incremental steps toward harmonizing and aligning campaign financing as well as incentive payment modalities and rates across campaigns for health workers *(1).*

Financing an integrated campaign can be challenging. Early forecasting of operational costs and adequate and reliable financing are needed to ensure success.

Consideration must be given to government budget cycles, especially in relation to when the funds for the integrated campaign need to be made available. The Ministry of Finance should be engaged early in the planning process to ensure agreement and timely disbursement of campaign funding. For donor funds, it is critical to be aware of application deadlines and to allow sufficient time for donors to approve and disburse funding (See Box 5).

Promising financing practices from country experience

- ✓ **Ensure early and effective engagement of the Ministry of Finance in the multi-year cross-campaign integrated workplan planning process.**
- ✓ **Establish administrative and financial procedures that promote transparency and accountability.**
- ✓ **Address budgetary issues and remuneration of health workers during the pre-planning and planning processes. An increase in workload without an increase in remuneration can hinder the success of an integrated campaign.**
- ✓ **Ensure early forecasting of operational costs to reduce delays in fund disbursement.**

Box 5. Country example: **Coordinated financing from global partnerships for an integrated nationwide campaign in Togo**

In 2004, Togo used a measles SIA targeting all children aged 9–59 months as an opportunity to integrate oral poliovirus vaccine (OPV), mebendazole (deworming) and the first-ever nationwide distribution of insecticide-treated bednets (ITNs) for prevention of malaria.

The Interagency Coordinating Committee (ICC) approved the campaign plan, mobilized resources, monitored campaign preparations and disbursed funds. A National Steering Committee under the ICC oversaw three working groups: 1) a technical working group (preparation of guidelines, reporting forms and evaluation tools); 2) a logistics working group (preparation of plans for procuring and distributing vaccines, injection materials, ITNs and mebendazole tablets, and waste management); and 3) a social mobilization working group (development of communications and social mobilization plan and materials).

International partner organizations of the Measles Initiative* and local agencies, such as the Togolese Red Cross, provided funding and consultants to support campaign planning, implementation and evaluation.

Outcomes: A post-campaign survey indicated coverage for eligible children was 93.1% (measles-containing vaccine, or MCV), 93.7% (OPV), 90.8% (ITN), 92.7% (mebendazole).**

Challenges: Although successful, the campaign faced some challenges:

- ITN distribution was not clearly communicated to health posts. Fear of shortages prompted health posts in one region to switch from the ministry-recommended one-net-per-child policy to a one-net-per-household policy.
- The age group targeted was optimal for a follow-up measles SIA but not for the other health interventions provided. Children aged <9 months are especially vulnerable to malaria and OPV is also indicated for <9 months; however, this age group was not included in the campaign.
- Children <2 years had difficulty swallowing or chewing mebendazole tablets; breaking up tablets in water and administering them directly was time-consuming.

Factors for success:

✓ **Commitment and oversight** by the Ministry of Health.

✓ **Financial and technical support from the global partnership** and nongovernmental agencies.

✓ **Effective coordination** of the global partners' inputs through the ICC.

✓ **ICC-approved campaign plan** to mobilize resources and oversee campaign implementation.

Source: Ref. *(26).*
*See report for full list of Measles Initiative partner agencies and other contributors to the Togo campaign under Ministry of Health leadership. ** See report for confidence intervals on coverage figures.

Microplanning

Microplanning is the term used in health campaigns for planning at the level closest to service delivery. A good microplan includes and budgets for all the necessary components of planning and implementing the campaign. It includes engaging with communities in order to identify underserved and hard-to-reach populations. Many programmes have developed and are using novel microplanning approaches; an integrated campaign provides an opportunity for different programmes to share good practices.

High-quality data are essential for microplanning. Inaccurate or insufficient data can result in imprecise microplans that overlook critical populations, lead to the misallocation of staff and supplies, or improperly calculate coverage statistics. Some programmes use geographical information systems (GIS) to validate and improve the quality of baseline population data *(27)*, which can increase confidence and consistency in coverage statistics and population targeting. Those preparing the microplan should determine, as far as feasible, how information from all sources will be shared and validated.

Microplans should be developed in partnership with community health workers and leaders to ensure relevance and proper engagement. The microplan should indicate resources for supervisory and monitoring visits, particularly focusing on weaker-performing teams and hard-to-reach populations (See Box 6).

Promising microplanning practices from country experience

- ✓ **Develop an integrated microplan based on a situational analysis.**
- ✓ **Integrate microplanning by coordinating facility assessments and population data-gathering.**
- ✓ **Calculate the duration of the integrated campaign to allow for the time needed to deliver additional interventions.**
- ✓ **Develop plans to reach migrant/mobile populations in partnership with community health workers and local leaders.**
- ✓ **Embrace the practices and lessons learned from highly successful health campaigns.**

Box 6. Country example: **Bottom-up microplanning for an integrated SIA in Ethiopia**

In Ethiopia, a rigorous microplanning approach was used for measles SIAs in 2010–2011 and included integration with polio, deworming and vitamin A supplementation activities. The approach was designed to incorporate **best practices** learned from other SIAs and countries that were deemed relevant to the local context.

- ✓ Microplans were developed with **health extension workers and the local administration** via a **standardized planning template**, emphasizing hard-to-reach communities.
- ✓ The **Central Statistics Authority** was also engaged to ensure that planning and forecasting of target populations was accurate.

At the end of the SIAs, over 8.9 million children had received the measles vaccine (106% of target), 12.8 million received the polio vaccine (97% of target), 7.2 million received vitamin A supplementation (97% of target) and 5.1 million received deworming medication (102% of target).

Source: Ref, *(28)*. https://www.unicef.org/evaldatabase/files/2011_Esaro_Regional_-_SIA_evaluation_report.pdf

Estimate target population for each integrated intervention

National population estimates are typically based on projections using the most recent census. In areas with significant population movement, target numbers may become less reliable at lower administrative levels. If accurate population figures are not available at national or local levels, the target population size may be estimated in several different ways:

- Follow the WHO guidance on determination of denominator data *(29)*.
- Carrying out triangulation with related data is preferred (e.g. compare estimates for a minimum of five calendar years of annual births ending with the year of the most recent available estimate) *(30)*. The World Population Prospects estimates produced by the United Nations Population Division could be used as an alternative source, and or other global available population sources such as WorldPoP, GRID3 or META.
- Review previous health campaigns or implementation activities of any programme and triangulating information on target populations used.
- Use remote sensing or house count satellite imagery to identify households/clusters.
- If time and resources permit, field teams can work with communities – particularly women's groups – and leaders to conduct household registration/line-listing of the target age range.

When determining what source of data to use, campaign planners should document and justify the choice of method(s) used. Biases, which are common when these numbers are used for resource allocation or estimation of hard-to-reach populations, should be acknowledged and taken into account.

Key information on populations should be fed back to the cross-campaign national coordination body during the planning process. The coordination body should **consolidate the lists of hard-to-reach populations, influencers and successful approaches, and share them across programmes**.

Partial integration can facilitate target population estimation

Collaboration between programmes to **exchange of data and other information resources**, such as population line-lists/household registrations, is an example of partial integration:

- In Ghana, community-wide registration lists of children under 5 years, generated for a lymphatic filariasis treatment campaign, were used the following year for an integrated measles vaccination and ITN distribution campaign.
- In Nigeria, the polio programme's high-resolution settlement maps have also been used by the National Malaria Programme to plan ITN campaigns to reach nomadic populations.
- In India, the Pulse Polio Programme has been the biggest and most successful campaign of its time. Lessons learned have been adopted in other successful health campaigns in the country, such as those for measles and Japanese encephalitis *(31).*

Identify the hard-to-reach and high-risk populations

Good planning entails making special efforts to identify hard-to-reach and high-risk populations such as never-reached populations in remote, insecure or urban slum settings, zero-dose or missed-dose communities for immunization, nomadic and/or migrant populations, refugees and other marginalized communities.

Each programme may have different definitions and use different data sources to identify groups that can enrich the information of others. The integration of health campaigns can be especially helpful in increasing the reach of all programmes involved.

Surveys such as Multiple-Indicator Cluster Surveys (MICS) and Demographic and Health Surveys (DHS), frequently include useful information (e.g. ethnic groups, barriers to health care and reasons for not accessing services) to identify hard-to-reach populations. In some countries, these populations have been well mapped and programmes have developed strategies to reach them, which should be considered when planning an integrated campaign. For example, GPEI has made extensive efforts to identify, locate and work with hard-to-reach populations.

When mapping hard-to-reach populations, efforts should also be made to develop relations with their trusted leaders and influencers. Hesitant individuals and communities differ by intervention. Successful approaches to overcome resistance have been developed by most programmes and others can benefit from their experiences *(16)*.

Make adjustments based on final microplans

Once microplans are finalized, resourcing should be adjusted accordingly in terms of time required to deliver the intervention package to the target population, and staffing required. Given the additional time an integrated health campaign will take with different interventions, age ranges and so on, daily targets may need to be reduced.

Human resources and training

Mass campaigns, particularly for VPDs, rely heavily on health workers who also provide routine services. Ideally, time spent in training, meetings, supervision and implementing the campaign should not disrupt routine services. However, in places where repeated health campaigns occur this can be a major challenge. Integrating health campaigns can provide an opportunity to streamline activities and train staff.

Human resources and training are areas where gender considerations are very important. Experiences from other programmes such as GPEI have identified gender barriers that affect the success of campaigns. To ensure equal access to vaccinations and the engagement of women, GPEI developed four gender-sensitive indicators for monitoring progress *(32).*

Training for an integrated campaign can be a chance to strengthen the technical knowledge of health workers and add new intervention skills from a different programme. Training should consider innovative approaches such as remote, digitally-enabled training and supervision. This is more cost-effective and reduces interruptions in the workforce (avoiding the need to travel for training).

Team composition for an integrated campaign will be determined by the interventions to be delivered and refined during microplanning:

- Which interventions require specially-qualified staff? Will different skill-sets be needed for different interventions?
- How many specially-qualified staff are needed?
- How many staff are needed for other roles (e.g. registration/screening, social mobilization, health promotion, ITN demonstration, directly-observed therapy for medications dispensed)?
- Who will be trained and made responsible for recording each intervention delivered?
- Is the team gender-inclusive? Are there areas where only female health workers or volunteers are permitted to enter households? How does access (or lack of it) affect planning for frontline workers such as social mobilizers and vaccinators?

Ideally, the Ministry of Health maintains records of staff by qualification that can be used for planning. If not, individual health programmes and their partners may maintain staff records; campaign preparation can be an opportunity to make such a list.

Campaign assessments have revealed the importance of recruiting local health workers who have established links to the community, can speak the local language and can use their existing rapport to increase uptake, rather than bringing in staff from other regions *(33).* However, local recruitment depends on the availability of skilled workers and can also place additional workloads on overburdened staff. In the case of shortages, nursing and medical students, retirees, teaching faculty etc. may be recruited to make up the difference.

Many programmes work with community health workers (CHWs). Even if they do not deliver services during health campaigns, CHWs can be trained to assist with some campaign activities such as social mobilization, crowd control or referring communities to routine health services. Given the low-to-no-compensation of CHWs during routine activities, the opportunity to work on a campaign can be an incentive for them. In the longer term, there may be an opportunity to advocate for ongoing and standardized remuneration of CHWs (See Box 7).

Compensation of CHWs is an example of a key harmonization issue that needs to be addressed during planning. The coordination committee should advocate for **uniform compensation of CHWs across programmes.**

As noted earlier, any increased workload resulting from additional intervention(s) should be considered when determining the daily targets of the health workers/community distributors to ensure adherence to protocols without compromising quality of delivery. If necessary, the number of days allocated to training, delivery, supervision and monitoring should be increased to accommodate the adjusted daily targets (see Annex 4).

Promising human resource practices from country experience

- ✓ **Human resource capacity, training and local epidemiological need should inform the decision of which campaign interventions are to be integrated.**
- ✓ **Understand the views of managers, health workers and CHWs/volunteers early.**
- ✓ **Strengthen training, monitoring and supportive supervision for health workers and community mobilizers, as well as their timely remuneration or incentives, to minimize confusion about implementing integrated campaign activities and to ensure clear messaging to the community.**
- ✓ **Align training days and materials to harmonize health campaigns and maximize human resources.**
- ✓ **Use an integrated training manual for health workers and supervisors to ensure relevant information is available.**
- ✓ **Allocate sufficient time to train health workers in the use of integrated tools; this may increase the training time needed for an integrated campaign.**
- ✓ **Adjust daily targets and extend the duration of the integrated campaign to support the additional workload, as needed.**
- ✓ **Engage CHWs/volunteers to serve as links between communities and the health-care system.**

Box 7. Country example: **The importance of community health workers and their training and compensation: findings from an exploration study in Uttar Pradesh, India**

Uttar Pradesh has a high prevalence of communicable and noncommunicable diseases. In most districts, vertical disease control campaigns occur sequentially throughout the year. A study by the International Institute of Health Management Research (IIHMR) explored the potential for integration of health campaigns to identify opportunities for cost, time and human resource savings.

In-depth interviews and focus group discussions were conducted with medical officers, programme managers, CHWs, nurse-midwives and community members.

The key role of community came up strongly in study findings, which identified the following **factors for success:**

✓ **CHWs are key** to successful campaign integration. Their training, supportive supervision and incentivization should be priorities.

✓ **Community sensitization and mobilization is critical** for the success of integrated health campaigns.

✓ **Collaboration with local influencers and governing bodies facilitates local decision-making** and instills confidence in health campaigns within the community.

Challenges identified:

- Stakeholders expressed concern about the heavy dependence on CHWs as points of service delivery as they are already overburdened
- CHWs expressed concern about possible decreased/delayed incentives due to integration.

Source; Ref. *(34).*

Prevention of and response to sexual exploitation, abuse and harassment (PRSEAH)

The **prevention of and response to sexual exploitation, abuse and harassment (PRSEAH)** is critical for any health campaign to safeguard both communities and workers. Campaigns can increase the risk of sexual exploitation and abuse, especially when recruiting large numbers of temporary workers. To ensure ethical and respectful interactions throughout a campaign, thorough screening of personnel and consultants should be carried out. All involved in the campaign should carry out mandatory training on PRSEAH, and accessible mechanisms for reporting and responding to potential sexual, exploitation and abuse allegations should be in place.

A chapter on PRSEAH during campaigns can be found in the polio outbreak guidelines.

Source: Ref. *(35).*

Communication and social mobilization

Integrated health campaigns are opportunities to promote health programmes and often enjoy high visibility. Community engagement is critical to instill trust and generate the necessary support and acceptance to reach campaign coverage targets.

A comprehensive communication plan with clear target audiences, dissemination channels, messages and strategies should be developed by campaign planners. The plan should include high-level advocacy as well as tailored/strategically-targeted messages to reinforce the importance of each health intervention (See Box 8).

Channels of communication

Many individual programmes have established effective communication through both traditional and innovative channels. Key messaging for an integrated campaign should include essential information about:

- ✓ the target diseases or health conditions;
- ✓ which interventions will be provided during the integrated campaign;
- ✓ which audiences (age groups and other eligibility requirements) are targeted;
- ✓ when and where the campaign will happen; and
- ✓ the role of primary health-care facilities and communities.

Integrated messaging should promote the advantages/convenience of receiving multiple health interventions together. Messages should be planned well in advance and should avoid confusing people for whom an integrated campaign is not familiar.

Community engagement and social mobilization

When co-delivering multiple interventions, rumours and/or fear of side-effects may be compounded. Hesitancy towards one intervention may affect uptake of the other(s) *(16)*.
Assessing community acceptability and concerns is a key part of the collaborative planning process. A pre-campaign survey or pilot study of integrated delivery in selected areas can help assess acceptability, identify community concerns and proactively address them early on.

Promising communication practices from country experience

- ✓ **Engage a diverse group of stakeholders early, including the communities.**
- ✓ **Involve community leaders and influencers to promote community acceptance of the integrated campaign.**
- ✓ **Leverage existing, familiar and well-accepted platforms or approaches (e.g. Village Health nutrition days, Child Health days, Immunization Week etc.).**
- ✓ **Develop a communication strategy that addresses all included diseases and/or interventions.**
- ✓ **Develop tailored information, education and communication materials about the safety and importance of each integrated health service offered.**
- ✓ **Interact with communities to understand views, opportunities and barriers to integrated health campaigns.**
- ✓ **Assess community acceptability with small-scale pilots before scaling up.**

Box 8. Country example: **Participatory planning for integrated health campaigns in rural Colombia**

The Vaupés Department in the south-eastern Amazon Region of Colombia has a high burden of trachoma and other NTDs among its mainly indigenous population. The communities are highly dispersed and remote, resulting in high costs for outreach services. Integrating National Immunization Days for these communities could lead to cost savings and greater health impact; however, cultural beliefs about NTDs affect the acceptance of medical interventions.

The Universidad de los Andes conducted a study to identify which health promotion and disease prevention strategies can be integrated to reduce the prevalence of trachoma and soil-transmitted helminthiases (STH) infections in these communities.

Relevant findings:

- **Active participation of indigenous leaders and communities throughout all phases** of an integrated campaign enabled them to exercise their right to agency in health decisions, regulated the actions of institutions and increased acceptance of proposed interventions.
- **Community participation should aim to provide tools** for community agency in diagnosis, treatment and control/elimination of disease.
- **Decisions must be made in consensus with all key stakeholders** and must respond to the community's needs and way of life.
- **Health workers/promoters who speak the language(s) of the indigenous communities** and understand their way of life can contribute to successful integration.
- To prevent lack of decision-making that delays the microplanning process, **health authorities (rather than representatives) should be directly involved** and/or mechanisms should be in place to delegate decision-making.
- The microplanning process demonstrates the need to **incorporate indigenous communities actively** and to guarantee the **full exercise of their right to health and agency** in decisions related to their health.

Source: Ref. *(36).*

Supply chain and logistics

In an integrated campaign, common problems with supplies and logistics management (e.g. forecasting challenges, procurement/distribution delays etc.) are compounded with each additional health commodity required. At the same time, planning for an integrated campaign can be an impetus to update programme inventories or conduct a supply chain assessment. Many immunization programmes conduct regular Effective Vaccine Management Assessments (EVMAs, *37*) that may be useful for other programmes. Inventory of the cold chain (including cold boxes and vaccine carriers) and dry store capacity is also commonly required before an immunization campaign or introduction of a new vaccine. These can be expanded to include the storage requirements for other interventions.

As calculating targets at lower levels can be challenging and sometimes inaccurate, an agreed buffer stock of all commodities can be kept at intermediate levels (if storage capacity is sufficient) to allow resupply during the campaign.

Each programme has its established distribution network and practices for commodities that require special handling (e.g. vaccines in cold chain) and those that can be handled like any other freight (e.g. ITNs). Care needs to be taken to ensure that integration does not compromise the handling and distribution of individual interventions. In preparation for an integrated campaign, some goods can be shipped earlier if storage capacity is sufficient at local levels. Integrated health campaigns may require rental of additional transport or storage. This can also be an opportunity to negotiate lower rates for greater volumes (See Box 9).

Promising supply and logistics practices from country experience

- ✓ **Harmonize supply chain and logistics processes to much as possible, especially with respect to timing of procurement and distributing commodities to lower levels.**
- ✓ **Account for additional volumes needed for vaccine/commodity storage and waste disposal**.
- ✓ **Address any supply or infrastructure gaps prior to integration.**

Box 9. Country example: **Importance of early planning and forecasting for a multi-antigen vaccination campaign in Nigeria**

In 2019–2020, the Nigeria National Primary Health Care Development Agency (NPHCDA) implemented the first simultaneous fully-integrated campaign for multiple injectable vaccines. The campaign included co-delivery of two antigens (measles, yellow fever, or meningitis A) across 20 states.

The decision to integrate co-delivery was driven by funding gaps, competing timelines of stand-alone health campaigns, the need to free up time for other primary health care activities, and overlap in target populations, epidemiology, programme implementation and logistics.

The NPHCDA and other stakeholders carried out **pre-campaign research** to review countries that had successfully implemented integrated health campaigns. This review informed decisions about which antigens were best suited for integration and which areas of campaign planning could be integrated.

Stakeholders at the national, state and local levels were involved in collaborative planning and implementation of the campaign. The process benefitted from **defined roles**, **transparency**, **equal and active involvement** and **performance appraisal**.

Relevant findings and factors for success

- ✓ **Forecast operational costs** early and **advocate for release of funds on defined dates** to ensure timely incorporation of operational costs into relevant budgets.
- ✓ **Assess technical capacity** to identify and address any gaps in technical skills**.** Include capacity and skills related to **data management and analysis, tool modifications and implementation design**.
- ✓ **Harmonize plans, tools and systems** from stand-alone health campaigns **to support integration.** Data tools and readiness templates of the stand-alone health campaigns were redesigned for the integrated campaign.
- ✓ **Adapt logistics for vaccine storage and waste disposal**. Supply and cold chain infrastructure must accommodate the greater volume of vaccines needed for integrated health campaigns. Plan to address any **supply or infrastructure gaps prior to integration**. Some states utilized solar freezers. States with inadequate or nonfunctional incinerators developed a memorandum of understanding with a private company to dispose of immunization waste in a timely manner.

Source: Ref. *(38).*

Waste management

Health campaigns can produce a large amount of waste in a relatively short timeframe (compared with routine service delivery). Also, different programmes may have different requirements for waste management (e.g. novel oral poliomyelitis vaccine type 2 (nOPV2) requires containment and a particular emphasis on disposal and reporting) *(39).* Therefore, during the planning phase proper attention must be paid to waste management practices and options to decide on a safe strategy.

WHO guidance on the treatment of infectious and sharp waste from health-care facilities puts emphasis on using technologies such as high temperature incineration, autoclaving or microwaving which do not form and release chemicals or hazardous emissions *(40).* Uncontrolled combustion (e.g. burn pits) should be used only as a last resort.

Efforts should be made to improve waste management incrementally and engage in multisectoral efforts to strengthen systems change. With intersectoral collaboration, an integrated campaign may provide opportunities to strengthen waste management practices across programmes.

Key considerations during an integrated health campaign

When an integrated health campaign is underway, it is essential to ensure that all activities and teams are performing according to the overall plan and local microplans.

The coordination team at each level should oversee the management and coordination of daily activities and address any challenges that arise. Key activities during any health campaign are the supervision and monitoring of the teams and intra-campaign monitoring to find anyone who has been missed.

Data, supervision and monitoring

Supervision and monitoring during the campaign aim to ensure that all activities and teams are performing according to the campaign microplan. During the campaign, administrative coverage data also provide important information to monitor delivery/distribution of interventions and utilization rates. Combined with the supervisory and monitoring data, these data should be reviewed to identify when and where corrective actions need to be taken while the campaign is still underway.

Promising monitoring practices from country experience

- ✓ **Where possible, use existing government-owned data collection platforms to capture campaign data.**
- ✓ **Harmonize and align field tools (tally sheets, monitoring tools).**
- ✓ **Develop shared digital tools (e.g. dashboards) to monitor campaign progress.**
- ✓ **Use technology (e.g. virtual platforms) for real-time monitoring and supportive supervision.**
- ✓ **If one technology cannot satisfy every need, utilize multiple complementary and interoperable platforms.**
- ✓ **Establish a national command centre to support real-time monitoring and response.**
- ✓ **Conduct field observations as part of monitoring activities.**
- ✓ **Use bulk SMS and WhatsApp to share regular campaign messages with field teams.**

Tally sheets

Tally sheets should be simple for health workers to understand and use. During integrated health campaigns, separate tally sheets are often used to record each intervention administered but this can be burdensome for health workers. Where feasible, use **combined tally sheets** and consider the use case for digital tally sheets. An example of an integrated tally sheet combining vaccination and dosing (e.g. Vitamin A, deworming drugs) developed by UNICEF for an integrated campaign in Ghana can be downloaded here: https://campaigneffectiveness.org/wp-content/uploads/2022/03/UNICEF-Ghana-Planning-Tools.zip.

Administrative data collection and digitalization

Health campaigns require daily reporting of key performance indicators. If time and resources permit, electronic data collection and transmission through digital platforms can streamline the reporting and aggregation of data. Use of digital platforms can also facilitate real-time supervision and monitoring, allowing for quick, corrective actions where needed.

The use case for campaign digitalization can be considered on the basis of the evidence and experience of the implementers and especially if one of the campaigns to be integrated is already digitized. Digital solutions for campaigns can include commodity tracking, training and payments for campaign staff.[42]

Home-based records

Recording vaccines and other health interventions given during health campaigns in a home-based record (HBR) is important for the verification of coverage during **post-campaign surveys** *(41,42)*. Depending on the type and availability of HBR in the country, vaccines and other health interventions received during health campaigns can be recorded:

- in the individual HBR for vaccination and/or maternal/child health (if there is space for recording campaign doses and other interventions);
- on a campaign specific card that records all interventions given.

During planning it is necessary to agree on a systematic method that allows for effective post-campaign evaluation and verification of coverage for each intervention provided.

Supervision

Supervision of field activities is often regarded as the weakest link in health campaigns. Care must be taken to ensure that supervision of field activities in an integrated health campaign is adequate without overburdening field-workers. During the campaign, integrated supervisory checklists can help review processes and address any programme issues. Checklists should be short enough so that easy-to-use electronic versions can be developed and installed on smartphones or tablets (see example of supervisory checklist in Annex 5).

Daily review meetings are recommended at district, regional and national levels with all programmes represented. These meetings serve to identify successes and areas that are at risk of not achieving campaign objectives. The discussions are important to find solutions and take decisions for corrective action.

After the campaign, information from the supervisory checklist can be compiled to highlight problem areas to be addressed by routine programmes. This might involve revising the content of training and developing better checklists for supervision. Any new training strategies used in the campaign should be evaluated to ensure that they were effective and that the training achieved its objectives.

Monitoring

Rapid convenience monitoring (RCM) is a tool used in the supervision and monitoring of vaccination campaigns to review the general performance of the campaign, identify where individuals are being missed and why, and quickly refine strategies for reaching them on the basis of predefined indicators. Such monitoring is referred to as intra-campaign RCM during the campaign, and post-campaign independent monitoring at the end.

Daily review of RCM results should be conducted by the district or health centre coordination teams, and corrective action taken if any of the predefined indicators are not met (e.g. potential discrepancies in results if a co-delivered intervention has lower coverage than another). As RCM is conducted while the health teams are in the area, corrective actions should be taken immediately. In-school monitoring is also recommended when a high proportion of the target age range attend school, or when schools are being used as temporary health posts. Applying these practices to an integrated health campaign can help ensure that no one misses out on essential health interventions.

Traditional monitoring is paper-based and involves manual submission and/or compilation of data. Because traditional monitoring is slow, labour intensive and more prone to error, it limits the rapid review of progress and prompt course correction. Consequently, campaign planners are increasingly using digital technologies to facilitate data collection and enable **real-time monitoring** (See Box 10).

Box 10. **Real-time monitoring**

Real-time monitoring (RTM) uses digital technologies (computers, tablets, mobile telephones, sensors etc.) and specialized software applications (e.g. RapidPro, DHIS2, ODK) to enable and accelerate the collection, sharing, management, analysis and reporting of data. RTM can enhance campaign quality, efficiency and cost-effectiveness by enabling ongoing review against targets, rapid identification of problems and gaps, tracking of supplies, human resources and delivery sessions, and facilitating corrective action.

A UNICEF literature review found that RTM was associated with outcomes that bolster campaign effectiveness, including: improvements in data quality, timeliness and completeness; more accurate microplans; stronger accountability of field teams; and better collaboration, partnership and communication at all levels.

Challenges spanned both technological and programmatic areas. In some places, there were very short timeframes for planning, leading to insufficient stakeholder and user engagement. Network connectivity was a common challenge, and some countries' field teams had difficulty accessing their data on the same day due to requirements for data from the central level to be cleaned/downloaded/approved.

The UNICEF and Gavi resource Use of digital technologies and approaches for real-time monitoring of supplementary immunization activities documents good practices and lessons learned, including a number of country experiences *(43).*

A companion resource Planning and implementing real-time monitoring approaches to strengthen vaccination health campaigns provides guidance to country partners on how to introduce digitization and RTM *(44).*

Explore partial integration – complementary monitoring

Where health campaigns are conducted in close succession, a complementary monitoring approach has been used to identify gaps in coverage with the first campaign intervention, while distributing the second (subsequent) intervention.

In situations where full co-delivery of interventions is not feasible, **complementary monitoring** provides opportunities for combining monitoring and mop-up efforts with an additional health intervention.

Pharmacovigilance and safety

The national pharmacovigilance system usually serves all programmes and is managed independently to maintain objectivity. The components of the pharmacovigilance system include notification by health workers of side-effects or adverse events in relation to the use of medications and medical devices, investigation, causality assessment by an independent review committee, risk communication planning and management, and monitoring *(45).*

An immunization campaign for injectable vaccines often represents an opportunity to strengthen the pharmacovigilance system by catalysing the creation of committees, training committee members and providing them with field experience, particularly in causality assessments.

Adverse events following immunization (AEFI), and/or concerns about adverse drug reactions, are a common reason for refusals. Therefore, community sensitization and crisis response planning are essential for the success of an integrated campaign. For health campaigns that integrate multiple injectable vaccines, concerns may arise among caregivers and health workers. Pre-campaign training and supportive supervision should emphasize safe vaccine co-administration practices as well as interpersonal communication skills to ensure that vaccinators are comfortable and confident to communicate on the safety and acceptability of multiple injections.

Key considerations after an integrated health campaign

After an integrated health campaign is completed, the coordinating body should evaluate the campaign's effectiveness, document any best practices/lessons learned and share these with the routine programmes and communities. Independent monitoring, mop-up activities and coverage surveys should take place. In addition, committee members, supervisors, monitors and coordinators at each level should hold a post-campaign review meeting and prepare a summary report.

Post-campaign independent monitoring

Post-campaign independent monitoring aims to provide an objective, independent source of timely and reliable information, and should be conducted by trained independent monitors who were not directly involved in campaign operations. Independent monitoring can provide information that could be useful for future integrated health campaigns and relevant programmes.

Independent monitoring should take place immediately after all integrated health campaign activities have been completed in all areas where initial data or local knowledge suggests that there was poor coverage. Findings from independent monitoring will inform mop-up activities, which are typically conducted 1–2 weeks after a campaign.

Mop-up activities

Mop-up activities should be carried out following the completion of the integrated campaign. The mop-up strategy should be based on inputs from the local coordination committee, information on low coverage areas and reasons for not receiving the health intervention from RCM and other sources.

Independent post-campaign coverage survey

Immunization and other programmes regularly conduct post-campaign coverage surveys as a final verification of administrative coverage and are often a donor requirement *(46).* These are representative surveys designed to give estimates of coverage at national and potentially subnational levels and should be conducted within three months of the campaign. If a post-campaign survey is required, it should ideally be designed to assess the coverage of all interventions included in the integrated campaign.

Documenting the integrated campaign

After an integrated campaign is carried out (or activities other than service delivery training were integrated) a **post-campaign process evaluation** is recommended to document learning and best practices for future campaigns. Where problems are identified – e.g. low coverage, poor coordination – it is necessary to identify the root causes and locally-generated solutions *(47).*

The results of the evaluation (both quantitative and from field teams) should be used to assess the effectiveness of the integrated campaign planning and implementation activities and their impact on health outcomes and on the programmes *(48).* The lessons learned should be used to improve subsequent integrated health campaigns, to inform routine health programmes to reach persons missed, and to assist other countries that plan similar integrated campaigns *(49)*.

The post-campaign process evaluation can be coordinated by the national coordination committee or an in-country implementing partner. Either way, results should be shared with the coordination body to improve planning and implementation of future integrated health campaigns.

Findings should be widely disseminated through national bulletins, meetings or webinars. It is important to ensure feedback and dialogue with the communities concerned through mechanisms such as review meetings. If possible, the coordination body should publish the findings as a case study or article in a peer-reviewed journal so that others can learn from the experience.

Conclusion

In the current campaign landscape, opportunities for integration are being missed. Strategic and operational inefficiencies and inequities place a strain on our health systems, weaken health services, and limit the potential health impact of health campaigns on our communities.

Integrating health campaigns can be successful in increasing efficiencies and accelerating achievement of health goals. However, adequate planning, high commitment at all levels and strong coordination need to be in place to ensure that a successful and effective integrated health campaign can be implemented.

There is continuing and growing momentum for the integration of health services and systems. In the long term, progress will be needed to transition the delivery of health campaign interventions to the primary health care system. Inclusion of integration in national health policies and strategies is a key first step toward a more holistic primary health care model, as is the design of health service packages. By institutionalizing integration opportunities, programmes will be set up to reach country, disease and global goals more efficiently while maximizing resources.

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Annexes

Annex 1. Related resources

This guide is built upon experiences and guidance from existing campaign planning tools and resources, and aims to emphasize the **decision-making and key planning considerations of particular relevance to integrated health campaigns**. The guide also highlights the need to take equity, which comprises health and **gender** equity,[c] into consideration across the entire integrated health campaign process. This guide should be used in conjunction with the following resources, as appropriate:

Working together: an integration resource guide for immunization services throughout the life course (2018)		*Planning and implementing high-quality supplementary immunization activities for injectable vaccines using an example of measles and rubella vaccines: field guide (2016)*
Periodic Intensification of Routine Immunization: lessons learned and implications for action (2009)		*Reaching Every District (RED) strategy (2017)*
Best practices in microplanning for polio eradication (2018)		*Best practices for planning a vaccination campaign for an entire population (2018)*
Geo-enabled microplanning handbook (2023)		*Decision guidance toolkit for people-centered integration of health campaigns (2021)*
Alliance for Malaria Prevention (AMP) toolkit 2.0, a foundation for planning and executing a mass ITN distribution campaign (2012)		*Options for linking health interventions for adolescents with HPV vaccination (2014)*
Ending the neglect to attain the Sustainable Development Goals: a rationale for continued investment in tackling neglected tropical diseases 2021–2030 (2022)		*Microplanning manual to guide implementation of preventive chemotherapy to control and eliminate neglected tropical diseases (2022)*
Why gender matters: Immunization Agenda 2030 (2021)		*Collaborative Action Strategy (CAS) for health campaign effectiveness* (2023)
The use of Digital Technologies and Approaches for Real-Time Monitoring of Supplementary Immunization Activities (2021)		Planning and Implementing Real-time Approaches to Strengthen Vaccination Campaigns (2022)

[c] Why gender matters: immunization agenda 2030. Geneva: World Health Organization; 2021 (https://www.immunizationagenda2030.org/images/documents/Why_Gender_Matters.pdf, accessed 13 June 2024).

Annex 2. Health campaign glossary

Health campaigns:		
		● Time-bound, intermittent activities that address specific epidemiological challenges, expediently fill delivery gaps, or provide surge coverage for health interventions. ● Can be used to prevent or respond to disease outbreaks, control or eliminate targeted diseases as a public health problem, eradicate disease altogether, or achieve other health goals. ● Allow for high consumption of supplies, where there is need for fast distribution of the commodity (e.g. nearing expiry of shelf-life). ● Play a particularly critical role to reach hard-to-reach communities in countries with weak health systems. High-priority health programmes that use campaigns as a significant part of their strategy include neglected tropical diseases (NTDs), malaria, immunization and vitamin A, deworming etc.
Supplementary immunization activity (SIA):		
		● A vaccination campaign that provides “extra” or “additional” doses of vaccine to a specified target group, regardless (may or may not be screened) of their prior vaccination history (i.e. even persons who are fully vaccinated receive a “supplemental dose”). ● Conducted at national or subnational level, with the aim of reducing susceptible persons and boosting population-level immunity through reaching everyone in the target group (especially those who may be unvaccinated, incompletely vaccinated, or failed to seroconvert). ● Most commonly associated with measles and rubella (MR) vaccination, but the term SIA can be used for vaccination health campaigns of other antigens, such as polio. ● SIAs can be nationwide, termed as National Immunization Days or, when targeted subnationally, termed as Sub-National Immunization Days (SNIDs).
Outbreak Response Immunization:		
		● Vaccination after detection of an epidemic of a vaccine-preventable disease. Specific targets depend on the epidemiology of the disease and extent of the outbreak. ● National or targeted to specific areas affected by or surrounding the outbreak. ● Specific age ranges and geographical scope depend on the vaccine-preventable disease and extent of the outbreak. ● Common for polio, measles, cholera, yellow fever, Ebola and meningitis.
Child Health Week:		
		● A time-limited activity that aims to deliver integrated maternal and child health services to all pregnant women and children less than five years of age. ● Usually occurs one or two times per year, as part of routine planning.
World Immunization Week (African Vaccination Week, Immunization Week in the Americas etc.):		
		● Typically in April of each year. ● Specific themes by region and country. ● Themed week of activities aiming to: ○ raise awareness of vaccination;

		○ target unimmunized and under-immunized children and/or adults.
Integrated health campaign:		
		● A health campaign in which more than one health intervention is co-delivered. ● Health campaigns can be fully or partially integrated.
Periodic Intensification of Routine Immunization (PIRI):		
		● PIRI activities are an extension of routine immunization services but delivered in a campaign-style manner in areas of low coverage. ● Intended to enhance routine immunization rather than be the primary means of providing it. ● Aim to ensure that eligible individuals who miss routine vaccine doses for any reason can be identified and vaccinated at the earliest opportunity. ● An example of PIRI is "pulse" immunization – extending outreach and/or mobile sessions to populations every few months – which, in areas with extremely weak infrastructure, security problems or major geographical and resource challenges, is often the only way to provide routine immunization services. ● Doses administered during PIRI are considered routine and must be captured in the Health Management Information System, on home-based records and included in the WHO/UNICEF Joint Reporting Form.
Measles/rubella vaccination campaigns:		
		● Target population is risk group-specific. ● Need staff who are qualified to provide injections. ● Require cold chain up to the point of vaccination.
	Catch-up	● Wide age range to "catch up" those missed by long-term low routine coverage (i.e. where data analysis shows that MCV1 and/or MCV2 have been below targets for several cohorts). ● Usually nationwide but can be subnational in locations where routine measles vaccination has been inconsistent or interrupted for several months or more than one year. ● May be started in conjunction with a measles campaign or introduction of a rubella vaccine component. ● Typical age is 9 months to 15 years (measles), or 9 months to 14 years (rubella); can vary depending according to local epidemiology.
	Follow-up	● Conducted every 2–5 years, according to risk assessment of accumulated susceptibles not being reached by routine services. ● Conducted after a catch-up campaign to: ○ target children eligible since the most recent campaign; ○ help programmes where routine immunization does not reach the target population. ● Typical age range is 9–59 months but can be as young as 6 months and may include children older than 59 months, depending on local epidemiology.
Polio vaccination campaigns:		
		● Strategies often use house-to-house vaccination and teams at temporary posts such as transit points, markets and public places, as well as fixed posts and outreach.

		● Vaccinators can be minimally qualified to administer oral drops.
Other vaccination campaigns:		
	Cholera	● Often outbreak response vaccination. ● Ages targeted depend on epidemiology of the disease. ● Generally subnational in area of outbreak (“hot spots”).
	COVID-19	● Can be used to deliver other health interventions, particularly for adult population (e.g. noncommunicable disease screening, co-administration with influenza vaccination for adults).
	HPV multi-age cohort (MAC)	● HPV vaccination campaign whereby more than one age or birth cohort is targeted. ● Typically at time of introduction of HPV vaccine to catch up older cohorts. ● Usually 9–14 years, depending on the country. ● Note: Many countries have opted for a routine HPV vaccination strategy that uses once- or twice-yearly health campaigns (often school-based).
	Influenza (seasonal)	● Usually targeting WHO high-risk priority groups (e.g. older people, health workers, people with comorbidities, pregnant women, children under 5 years).
	Meningitis	● Ages targeted depend on epidemiology of the disease. ● Can be implemented prior to introducing meningitis A vaccine into the national immunization calendar.
	Typhoid	● Often outbreak response vaccination. ● Ages targeted depend on epidemiology of the disease.
	Tetanus Toxoid-Containing Vaccine (TTCV)	● Supplementary TTCV vaccination campaigns targeting women of reproductive age in high-risk areas as part of the maternal and neonatal tetanus elimination (MNTE) strategy.
	Yellow fever	● One-time preventative health campaigns in countries where yellow fever is endemic. ● Outbreak response in subnational areas. ● Age range typically all above 9 months of age
	Other	● Any other new or under-utilized vaccines.
Common strategies in immunization health campaigns:		
	Selective	● Intent is to reach specifically those who have been missed previously. ● Vaccination record or history is verified before vaccination; only missing vaccinations are administered. ● Requires time and staff for screening. ● Difficult in areas where home-based records retention is low (oral history required).
	Non-selective	● Intent is to vaccinate all people in the target age, without regard to prior vaccination status.
	Mop-up	● Revaccination of a community or area determined to have low coverage during or immediately after a campaign.
	Monitoring	● **Administrative reporting** by the health system on all antigens administered and additional interventions delivered; disaggregated by age, sex and vaccination site; information usually transmitted daily during a campaign.

		● **Rapid convenience monitoring** (intra-campaign RCM) is an internal process which requires visiting high-risk communities and areas to verify if they have been vaccinated during the campaign. Additional variables include awareness of the campaign and reasons for non-vaccination. ● **Independent monitoring** is conducted by external staff hired by partners; takes place during and immediately after a campaign; a random sample of communities is used to determine vaccination status, identify missed communities and validate administrative reporting; additional questions can be included; representativeness depends on methods. ● **Lot quality assurance sampling** (LQAS) conducted following polio and tetanus vaccination campaigns to verify coverage reported through administrative reporting; lots are selected at central or regional levels. Additional questions cannot be added. The methodology provides a pass/fail of a "lot" meeting a minimum threshold level of coverage and not actual estimates of coverage. ● **Post-campaign coverage surveys** (PCCS) are formal coverage surveys with sample size and frame set to be representative at national or lower levels. Coverage of all interventions provided during the campaign can be included and additional variables can be added.
Mass Drug Administration (MDA):		
		● MDA involves giving treatment to all targeted people, often in a defined geographical area, regardless of whether or not they are infected. ● Often conducted to control or eliminate neglected tropical/infectious diseases (NTDs) (e.g. deworming and malaria control).
Vitamin A		
		● Vitamin A supplementation is administered to children 6–59 months of age in settings where vitamin A deficiency is a public health problem. ● Often given twice yearly through health campaigns or during child health days/weeks.

Annex 3. Terms of reference for a cross-campaign national coordination body

The cross-campaign national coordination body should develop clear terms of reference that outline its mandate to:

- compile planned or anticipated health campaigns into a multi-year (e.g. 3–5 years), cross-campaign integrated workplan and calendar in order to identify opportunities for integration;
- assess and determine feasibility to integrate certain health campaigns, make recommendations to the relevant programmes, identify co-financing opportunities and decide on which health campaigns or component of the campaign to integrate – e.g. consider both partial integration and full integration, where appropriate (see Box 1);
- develop a workplan and calendar for integrated health campaigns, with timelines and actions necessary to ensure effective, efficient integration;
- develop a detailed plan for harmonizing tools, logistics, data management and supply chains across campaigns, using topic-specific cross-campaign technical working groups;
- ensure a comprehensive overview of campaign financing by combining detailed information from major funders and government to enable better planning and execution (these should be included in the national health sector plan and strategic plans for each implicated programme);
- coordinate between programmes to facilitate the development of integrated workplans in time for submission to appropriate government entities and donors for approval and funding;
- develop a cross-campaign coordinated approach that fosters purposeful engagement of communities at all levels through all stages and phases of campaign planning and implementation, integration and the post-campaign period that builds on existing approaches and increases credibility;
- liaise with campaign planning/coordinating committees and facilitate communication and coordination for planning, procurement and implementation through to final campaign evaluation;
- oversee the deployment of appropriate technology and innovation for greater efficiency and effectiveness during health campaigns;
- oversee post-campaign process and outcome evaluations; and
- document lessons learned and promising practices about the integrated aspects of health campaigns.

Annex 4. Example of the personnel requirements and estimated time to deliver interventions during an integrated campaign

Task	Qualifications of staff	Time for task
Validate patient information – age, interventions to be given	Read/write	3 minutes
Verify eligibility; administer oral medicines (bOPV, deworming….)	Minimal	3 minutes per oral medicine
Administer vaccine	Qualified to give injections per local codes	6 minutes with dilution 4 minutes without dilution
Record interventions received on home-based record or campaign card	Read/write	3 minutes
Record interventions given on tally sheets	Read/write	2 minutes
Compile information at end of session	Qualified data staff	1 hour per session
Distribute ITN or voucher	Minimal	2 minutes
Selective vaccination or referral to routine immunization services	Medical training or teacher equivalent with specific training and knowledge of national immunization schedule.	5 minutes

Annex 5. Example of integrated health campaign supervisory checklist

Name of health site: outreach / mobile team / health post	**Yes/No**	**Issues identified**	**Corrective action**
Health site organization			
Health site well organized (e.g. no bottlenecks)			
Sufficient health workers and volunteers			
Every child is tallied immediately after receiving health intervention(s)			
Safety and waste management practices			
Vaccines			
VVM checked			
Expiry date checked			
Vaccine given correctly			
Used syringes inserted into safety boxes without recapping			
AEFI reporting forms present at site and procedures applied			
Safety boxes correctly used and filled			
Number of vials used and children vaccinated as per tally sheet match (wastage between 5 and 20%)			
Missed children properly accounted for			
AEFI kit available			
Other health interventions			
Expiry date checked			
Intervention given correctly			
Waste disposed of correctly			
Essential services mobilization			
Health workers explain to caregivers about times and locations for essential services			