Operational best practices for integrated measles–rubella and polio vaccination campaigns

A young girl receives polio and measles vaccination in a nationwide integrated campaign (Afghanistan, December 2022).

Contents

Acronyms

AEFI	Adverse event following immunization
bOPV	Bivalent oral polio vaccine
EPI	Essential Programme on Immunization
GPEI	Global Polio Eradication Initiative
IPV	Inactivated polio vaccine
M&RP	Measles & Rubella Partnership
M/MR	Measles or measles-rubella vaccine
MoH	Ministry of Health
NCB	National coordination body
NIS	National Immunization Strategy
nOPV2	Novel oral polio vaccine type 2
OPV	Oral polio vaccine
SOPs	Standard operating procedures
TWG	Technical working group
UNICEF	United Nations Children's Fund
WHO	World Health Organization

About this resource

This operational resource aims to support decision-making and implementation of integrated measles and polio vaccination campaigns. Developed in consultation with the World Health Organization (WHO), United Nations Children's Fund (UNICEF), the Global Polio Eradication Initiative (GPEI), the Measles & Rubella Partnership (M&RP) and Gavi, the Vaccine Alliance, it provides countries with practical, field-level guidance and best practices to support national planning, budgeting, training and delivery for integrated measles and polio campaigns. This resource complements existing measles–rubella preventive campaign guidance and polio outbreak response standard operating procedures (SOPs). It does not replace antigen-specific technical requirements; rather it provides practical considerations for when and how integration can be assessed and implemented within existing planning frameworks.

Background

As a core principle, the integration of measles and polio vaccination campaigns should be implemented in a manner that upholds quality, safety and timeliness for the delivery of both antigens (see *Principles for integrated campaigns*). Where this cannot be ensured, antigen-specific implementation may remain the most appropriate approach.

The integration of multi-antigen vaccination aims to enhance campaign effectiveness, introduce efficiencies and strengthen health systems while reaching more zero-dose and missed children.

Measles or measles-rubella (M/MR) campaigns and polio vaccination campaigns are often implemented separately, following different delivery strategies. Polio outbreak response campaigns typically involve short, intensive door-to-door operations, while measles preventive campaigns rely on fixed or temporary posts over a longer duration of time. Target populations also differ between these two antigens, with measles campaigns often having a wider age group than polio outbreak response. Yet while both measles and polio campaign approaches have historically achieved strong results, separate campaigns can duplicate efforts, stretch limited workforce capacity, disrupt routine immunization services and contribute to community fatigue.

Principles for integrated campaigns

Regions and countries should recognize and uphold several key principles for multi-antigen campaigns, including:

- **quality**: by ensuring neither antigen's coverage nor safety is compromised;
- **efficiency**: by maximizing resources, minimizing duplication and incentivizing parents to vaccinate children due to the benefit of receiving multiple vaccines;
- **coordination**: by strengthening unified leadership and partner alignment;
- **flexibility**: by allowing regions, countries and districts to adapt modalities;
- **transparency**: by facilitating government-led reporting to communities and partners; and
- **accountability**: by using rigorous supervision, monitoring and evaluation mechanisms.

Countries are encouraged to consider integrated campaigns by delivering measles and polio vaccinations together. Integrated campaigns have become increasingly important as countries face multiple competing health priorities and as national immunization programmes face shrinking resources and persistent challenges in reaching every child. Integration offers a promising solution to these challenges. The precise scope of integration can take different forms, ranging from full co-delivery of multiple antigens to a more limited functional integration through coordination across operational planning, budgeting, training, logistics, referrals, supervision, data or communication, even if vaccines are not administered at the same encounter.

Several widely held misperceptions have limited consideration of integrated measles and polio campaigns. These include concerns that: (1) integration reduces coverage; (2) integrated campaigns cannot meet outbreak response performance standards; (3) the integration of measles and polio is feasible only with the bivalent oral polio vaccine (bOPV) and not the novel oral polio vaccine type 2 (nOPV2); and (4) a whole 12-month preparation period is always required. Experience from multiple country contexts, however, demonstrates that, when integration is carefully planned and adapted to local conditions, these factors are not absolute barriers and should be assessed on a case-by-case basis.

Preliminary considerations

When are integrated measles and polio campaigns recommended?

Integrated measles and polio campaigns are recommended whenever integration is identified early in the planning process and in cases where it will enhance campaign effectiveness, improve coverage or create efficiencies without introducing new risks or delays. Integrated campaigns are especially recommended when one campaign is already planned and conditions permit coordination for multiple antigens. Even in cases where the co-delivery of both antigens is not pursued, shared microplans, social mobilization or supervision can enhance reach for both campaigns.

When are integrated measles and polio campaigns not recommended?

The timeliness and quality of measles preventive campaigns and polio outbreak response must always take precedence over integration to reduce and prevent disease transmission. Integration, and especially multi-antigen co-delivery, should **not** be pursued in the following cases:

- when delivery strategies cannot be reconciled (e.g. polio vaccines cannot be given at fixed sites);
- when timelines cannot be aligned or when integration would delay a priority campaign;
- when target age groups differ substantially with no feasible referral option;
- when cold chain or transport systems cannot support simultaneous antigens;
- when campaign quality would be significantly compromised by integrating antigens; or
- when high disease transmission requires rapid outbreak response action.

What operational areas are key to effective integrated measles and polio campaigns?

This guidance explores key operational pillars for effective integrated campaigns, which include:

1. governance and coordination
2. decision-making
3. timeline harmonization
4. planning and microplanning
5. financing and budgeting
6. logistics and supply chain
7. capacity-building
8. service delivery
9. communication and demand generation
10. community ownership and sustainability; and
11. monitoring, evaluation and accountability.

Scope

Which vaccines are addressed in this guidance?

This document addresses the following vaccines: oral polio vaccines (OPV), including bOPV and nOPV2; the inactivated polio vaccine (IPV), including its administration as a fractional dose (fIPV); and measles or measles-rubella (M/MR) vaccines (**Fig. 1**). Antigen-specific technical requirements, including regulatory considerations, and reverse logistics for nOPV2 are not addressed in this document.

Fig. 1. Polio and measles vaccines for integrated campaigns

bOPV = bivalent oral polio vaccine; IPV = inactivated polio vaccine; MR = measles-rubella vaccine; nOPV2 = novel oral polio vaccine type 2.

What additional interventions can be included in integrated measles and polio campaigns?

Where feasible, integrated measles and polio campaigns may align with other health interventions such as vitamin A, deworming tablets, nutritional screening, activities related to neglected tropical disease or long-lasting insecticidal net distribution for malaria control. Additional health interventions are not addressed in this document.

A health worker in Somalia prepares to administer the measles vaccine in an integrated campaign that will deliver polio and measles vaccines, deworming tablets and vitamin A to boost children's immunity.

Photo © WHO / Ismail Taxta

Operational pillars for integrated campaigns

1. Governance and coordination

Strong governance is essential for successful integrated campaigns. At both the global and regional levels, coordination and technical support are provided by WHO, UNICEF, Gavi, the M&RP, the GPEI and the Health Campaign Effectiveness Coalition. Technical resources, guidance and support are aligned across regions through regular partner meetings.

At the national level, the Ministry of Health (MoH) retains decision-making authority on whether and how integration will occur. When considering integrated campaigns, national governments should designate or utilize an existing coordination mechanism (for example, a multi-sectoral national coordination body [NCB] or technical working group [TWG]) to assess the potential benefits, risks, scope, timing and feasibility of integrating measles and polio vaccination activities. Where appropriate, civil society organizations and community groups may also be engaged to promote transparency, trust and community oversight.

Where an NCB is not established or fully functional, countries may form or expand a technical working group (TWG) to manage integrated planning. In many settings, a compact task team comprising the Essential Programme on Immunization (EPI), WHO, UNICEF and key national partners will be sufficient, as these teams already work closely together on both polio and measles campaigns.

Best practices for governance and coordination

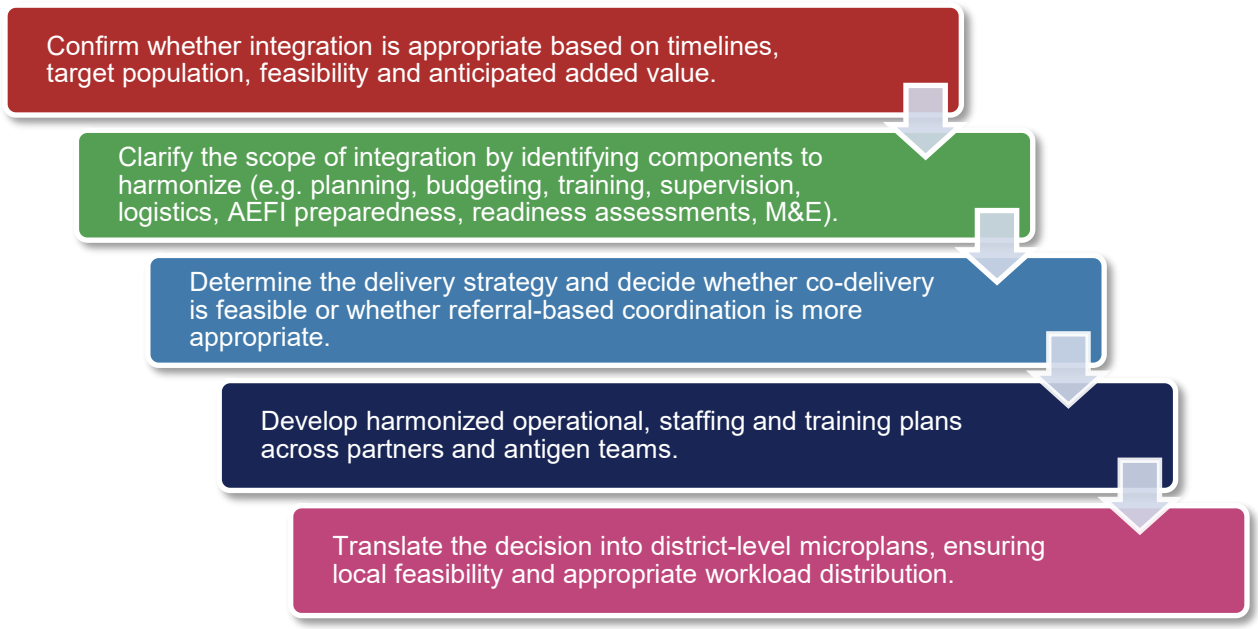
- **Ensure early and sustained alignment among all implementing partners.** Fragmented funding streams, separate tracks and differing partner requirements can quickly complicate planning. Early partner coordination and a unified process is necessary to achieve alignment across budgeting, microplanning, training, communication, logistics and monitoring.
- **Secure MoH commitment early in the planning process** to ensure national leadership will drive decision-making, advocate for the prioritization of integrated measles and polio campaigns and facilitate coordination in-country.
- **Use an existing national structure** (NCB or a streamlined TWG/task team) to coordinate all technical decisions. The coordinating body should include experts in routine immunization, polio, surveillance, logistics, social and behavioural change communication, as well as key implementing partners, with civil society involvement where relevant.
- **Hold regular (at least quarterly) coordination meetings**, beginning ideally 12 months (or a minimum of six months) before the planned integrated campaign, to jointly map campaign schedules, identify targeted populations and priority geographies, and determine where integration is operationally feasible. Polio and measles campaign planning cycles may differ. In some contexts, however, integration has been implemented within accelerated timelines while maintaining readiness and quality standards.
- **Embed integration considerations within national planning cycles,** including Gavi applications, the National Immunization Strategy (NIS) annual operational planning cycle and the OPV response calendar developed by the GPEI Outbreak Response & Preparedness Group (ORPG). This helps to harmonize timelines, create operational efficiencies, optimize communication strategies and streamline readiness assessments and resource mobilization.

2. Decision-making

Achieving clarity on the scope of integration – whether the full co-delivery of antigens or the integration of functions such as planning, budgeting, training, logistics or other areas – should always be informed by a review of both the epidemiological context and practical considerations related to operational capacity.

The decision to implement an integrated M/MR–OPV campaign should follow a structured assessment (**Fig. 2**). Integration should proceed only where it demonstrates enhanced campaign effectiveness and improved coverage, particularly for zero-dose and missed children, and creates efficiencies without introducing risks or delays.

Fig. 2. Decision-making process for integrated measles and polio campaigns



AEFI = adverse event following immunization (vaccine safety monitoring); M&E = monitoring and evaluation.

Best practices for decision-making

- **Analyze recent coverage data, surveillance indicators and operational performance** to determine whether integration will add value or introduce risk.
- **Assess operational trade-offs**, weighing efficiencies gained through joint implementation against any risks related to workload, cold chain, safety or community access.
- **Define clearly which elements will be integrated and how**, recognizing that some functions such as planning, communication, supervision and readiness assessments may be harmonized even when the co-delivery of antigens is not feasible.
- **Document the decision and the rationale for integration or non-integration**, ensuring transparency around decision-making and enabling continuous learning for future rounds.
- **Adapt the scope of integration as needed**, allowing for partial or functional integration when full co-delivery of antigens cannot be safely or operationally implemented.
- **In contexts where integration is considered within a shortened planning timeframe** (that is, with significantly less advance planning time), the programme proposing integration must work with the implementing team to ensure broad alignment on administration, service delivery and reporting.

3. Timeline harmonization

Predictable and harmonized timelines are essential for an effective integrated M/MR–OPV campaign. Early alignment across planning, procurement, financing, supply chain arrangements, training, communication and supervision helps to prevent delays and ensure that neither antigen is compromised in quality or timeliness. Beyond the standard single-antigen planning processes, integration-related milestones should include:

- joint M/MR–OPV geographic prioritization to identify areas where integration is most feasible and beneficial;
- alignment of delivery modalities (oral or injectable workflows) and confirmation on whether co-delivery or referral-based integration will be used; and
- coordination of the M/MR and OPV supply chain schedules, including whether vaccines will move together or separately based on cold chain requirements.

A high-level overview of key milestones is provided in **Fig. 3** (see next page). Detailed milestone templates are also provided in **Annex 1**.

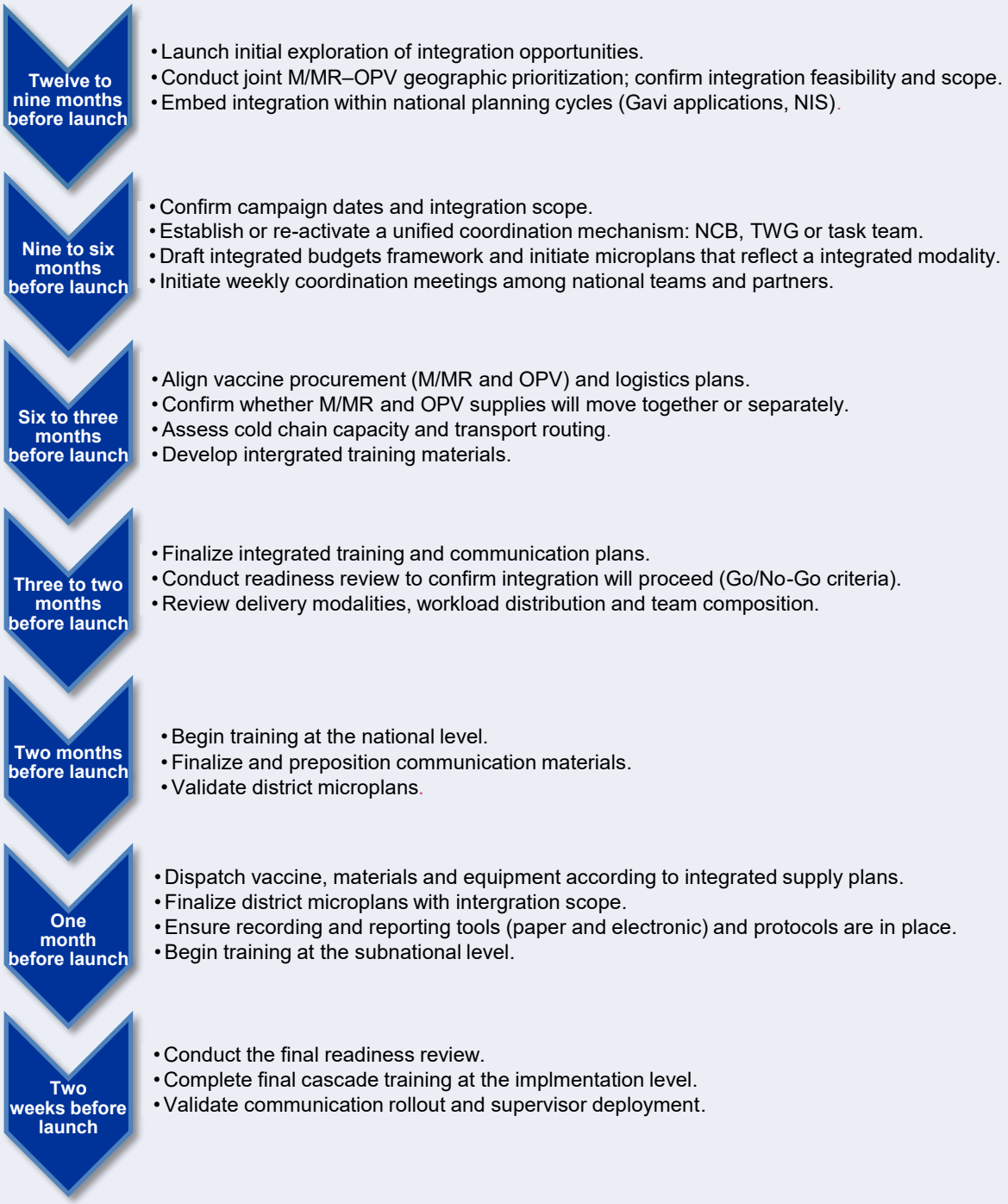
Best practices for harmonized timelines

- **Use a unified timeline** at the national and subnational levels to ensure that campaign planning, supply chain arrangements, training and communications reflect the agreed-upon integration scope.
- **Adapt integrated planning templates, tools and checklists**, such as training agendas, supervision tools, readiness criteria and tally sheets, to reflect both M/MR and OPV requirements.
- **Sequence operational activities logically** and confirm that decisions on delivery modalities, logistics and personnel deployment are finalized before district-level microplanning begins.
- **Embed integrated milestones into partner coordination meetings** to ensure alignment across supply, financing, communication and surveillance workstreams.
- **Conduct structured readiness reviews at critical points** (i.e. three months, one month, and two weeks before launch) to validate that integration remains feasible and to adjust plans if risks emerge.

Vaccines are set out for health workers during a vaccination day in Cameroon. Even in cases where the delivery of multiple antigens cannot be integrated, functions related to campaign planning can be considered for integration to increase efficiencies.

Photo @ Gates Archive / Dominique Catton

Fig. 3. Illustrative milestones for harmonizing integrated campaign timelines*



* Integration initiated within less than six months before launch should undergo formal feasibility review and may have more compressed timelines and milestones.

M/MR = measles or measles-rubella vaccine; NCB = national coordination body; NIS = National Immunization Strategy; OPV = oral polio vaccine; TWG = technical working group.

4. Planning and microplanning

High-quality integrated campaigns rely on strong microplans that translate national decisions into feasible operational delivery at the district and community levels. A single, harmonized microplan ensures consistency in team composition, referral pathways, social mobilization, supply chains and supervision.

Microplans should be field-driven and highly contextualized, reflecting local geography, population density, team workload and access barriers. When antigens differ in delivery modality, such as injectable M/MR at fixed posts and oral drops of OPV at the door of households, microplans should explicitly define how the two delivery pathways interact and how caregivers will be referred between them. Referral pathways should be validated during microplanning to ensure clear caregiver flow and to maximize vaccination opportunities.

See **Annex 2** for a sample high-level integrated microplan.

Best practices for planning and microplanning

- **Use one unified integrated microplan** per catchment area that clearly defines delivery strategy, daily targets, team workload and referral flows.
- **Incorporate logistics and cold chain planning directly into microplans**, accounting for vial sizes, expected wastage rates and vaccine carrier needs for both M/MR and OPV.
- **Define clear roles for M/MR and OPV vaccinators** to ensure clarity for teams and supervisors.
- **Include integrated supervision checklists and data tools** to prevent parallel reporting or duplicated workload.
- **Tailor social mobilization** to address different age groups so caregivers understand where and how each vaccine will be delivered.
- **Conduct workload analysis**s during microplanning to ensure that combined antigen delivery does not exceed expected daily targets per team.

5. Financing and budgeting

Integrated campaigns are most effective when they are funded through a harmonized budget rather than parallel allocations (see **Annex 3** for a sample harmonized budget). Equitable and timely payment is essential to maintain frontline motivation, particularly when teams deliver multiple antigens through a single operation, which may necessitate additional workdays.

Best practices for financing and budgeting

- **Use a harmonized budget** to reduce duplication and help identify cost-efficiencies. Integrated budget templates should be developed and made available nine to six months before the campaign launch date to support alignment and ensure transparency.
- **Harmonize payment rates**, including provisions for logistics, communication and supervision and ensure timely disbursement to the last mile. One common challenge faced by integrated campaigns is that per diems often differ between M/MR and OPV teams.
- **Ensure adequate funds** for hard-to-reach, mobile and special teams.
- **Harmonize payment schedules** to ensure all frontline workers for polio and measles are paid at the same time. Use digital payment mechanisms and direct payment to beneficiaries, where feasible, to improve timeliness and accountability.
- **Enforce payment roster integrity** by verifying names, roles and operational units against deployment records before payment. Replace inactive team members to prevent ‘ghost’ or duplicate disbursements.

6. Logistics and supply chain

Strong, well-coordinated logistics underpin success with integrated multi-antigen campaigns. Vaccine forecasting, procurement and bundled distribution should be jointly planned and executed. Cold chain capacity, transport scheduling and storage arrangements must be integrated to avoid bottlenecks. Communities quickly lose trust when vaccinators arrive unprepared or without vaccines.

Best practices for logistics and supply chain

- **Bundle M/MR and OPV supplies** wherever cold chain capacity and storage space allows. Closely align delivery schedules to minimize gaps, with supplies arriving ideally two weeks before launch at the district level and one week before launch.
- **Consider the stock capacity of health zones** to ensure they are equipped with enough cold storage for the required vaccines or to adjust the supply cycle according to available capacity.
- **Use simple daily stock balance tools** to track vaccine and supply availability and to anticipate replenishment needs during the campaign.
- **Establish real-time stock monitoring mechanisms** to identify shortages early and enable redistribution, where necessary.
- **Develop contingency plans** to address real-time logistics and supply chain challenges, including the delayed release of funds or vaccines, personnel shortages or natural disasters that could disrupt campaign implementation.
- **Where nOPV2 is used, ensure compliance** with reverse logistics and monitoring requirements in accordance with the established SOPs.

7. Capacity-building

Training ensures integration works in practice. Polio vaccinators can deliver OPV and mobilize families for M/MR vaccination. Measles vaccinators can administer M/MR safely at fixed, temporary or mobile posts. Joint training clarifies roles, referral flows, safety protocols and data capture. Supervisors oversee both functions using harmonized checklists and integrated reporting tools.

Best practices for capacity-building

- **Deliver comprehensive training** that outlines how M&RP and GPEI operational approaches will be coordinated during the campaign, how standalone and integrated campaigns will differ operationally, and how data collection will work.
- **Consider daily refresher vaccinator training** that reinforces proper vaccine handling, thorough use of data tools, correct dose administration and appropriate adverse event reporting.
- **Conduct daily evening debriefs** to assess team performance and address identified gaps.
- **Train vaccinators and supervisors on safety protocols and contingency plans** should an incident occur, particularly in insecure areas or geographies with access constraints.
- **Provide visual job aids optimized for digital channels** (WhatsApp, Telegram or social media) that clearly depict who vaccinates, who documents, what data elements need to be recorded (at a minimum) and how referral pathways should proceed, with reminders for case-based surveillance (e.g. acute flaccid paralysis [AFP], measles).

8. Service delivery

Integrated teams operate according to coordinated daily implementation plans. Service delivery arrangements should reflect the previously confirmed integration scope and modality. as the roles of polio and measles vaccinators vary according to the chosen integration approach. Supervisors should manage the integrated campaign as a single operation, which reduces the duplication of key functions and mitigates community fatigue while enhancing trust in public health services.

Table 1. Service delivery options

	Option 1	Option 2	Option 3
Service delivery	**Door-to-door mobilization with fixed-post vaccination**	**Phased fixed-post delivery with OPV mop-up**	**Hybrid door-to-door OPV with fixed-site continuity**
Team composition	Two (2) social mobilizers (house-to-house) linked to a fixed, temporary outreach post staffed by M/MR and OPV vaccinators.	M/MR and OPV teams at fixed, temporary and mobile posts for the first seven (7) days; on Day 8, OPV teams conduct house-to-house mop-up. Mobile micro-team should establish short-duration posts at convenient community points to serve small clusters of households.	One (1) dual-role OPV vaccinator (house-to-house vaccinator + mobilizer) + one (1) OPV vaccinator stationed at the fixed/temporary site with M/MR vaccinators and other team members.
Modality	The house-to-house pair does not vaccinate at the doorstep; they mobilize caregivers, verify eligibility and direct families to the nearest fixed, temporary or outreach post, where both M/MR and OPV are administered. Clear referral-tracking mechanisms should be in place to monitor caregiver follow-through to fixed posts.	Days 1–7: Both antigens (M/MR and OPV) are administered from posts. Day 8: OPV teams go door-to-door to vaccinate missed children with OPV and to identify communities/children missed for measles. Results and missed lists are shared with supervisors for targeted M/MR follow-up.	The dual-role vaccinator conducts door-to-door OPV vaccination and mobilizes families to the site for M/MR; simultaneously, the stationed OPV vaccinator continues administering OPV at the site alongside the M/MR vaccinator.
When to use	Urban/peri-urban areas with dense populations and reliable access to posts; contexts prioritizing safety and cold chain integrity at posts.	Areas with good initial turnout at posts but with a risk of residual pockets of un-/under-immunized children; insecurity or access constraints that favor a brief mop-up.	Mixed-density settings where house-to-house OPV increases reach while maintaining strong fixed-site throughput.
Advantages	Strengthens community mobilization; reduces cold chain and AEFI risks at the doorstep; provides clearer quality assurance at posts.	Concentrates resources at posts initially; dedicated mop-up maximizes OPV coverage and generates actionable lists for M/MR follow-up.	Extends reach and reduces missed OPV opportunities; maintains continuous service at posts.
Additional considerations	Requires robust referral flow and post capacity to handle peaks.	Requires real-time data synchronization and logistics for rapid follow-up; ensures community notification of mop-up day.	Requires strong supervision and real-time tally reconciliation to prevent double-counting and to minimize caregiver fatigue.

AEFI = adverse event following immunization; M/MR = measles or measles-rubella vaccine; OPV = oral polio vaccine.

Best practices for service delivery

- **Maintain operational safeguards for all delivery modalities**: (a) microplans with team ratios and daily targets; (b) unified supervision with a single checklist; (c) standardized referral tools (slips/codes) to track movement from households to posts; and (d) real-time tally reconciliation across M/MR and OPV to prevent double-counting.
- **Aim to leverage efficiencies wherever possible** by having staff play multiple roles (such as a single supervisor for both vaccines, a single social mobilizer per team) and utilizing temporary sites (such as schools, places of worship, markets or motor parks).

9. Communication and demand generation

Unified messaging should emphasize a single integrated effort to protect children against measles, rubella and polio (and other health concerns when additional interventions are provided). Address misinformation proactively through coordinated messaging.

Best practices for demand generation and communication

- **Use social and behavioral data to guide strategy**: review refusal reasons, misinformation trends, awareness levels, barriers and community preferences.
- **Develop clear and simple messaging**, explaining why vaccines will be administered together and what ages will be prioritized by the campaign. Use one unifying slogan with easy-to-understand antigen-specific secondary messaging that emphasizes safety and urgency. Include instructions on referrals from households to M/MR posts, as appropriate.
- **Tailor outreach to different settings**: use radio, posters, interpersonal communication in rural areas; use digital channels in urban settings; and use motorized campaigns in hard-to-reach areas.
- **Tailor messaging for high-risk groups** such as nomads, displaced populations, border communities, the urban poor, minority language groups and households with past refusals. In security-compromised areas, engage trusted influencers and channels, as well as local and humanitarian organizations, to inform and mobilize parents and caregivers.
- **Use radio call-in shows and other media platforms** to sustain awareness and generate demand.
- **Establish digital community engagement and misinformation management teams** to prevent the spread of rumours and false information and to proactively disseminate accurate information.
- **Pre-test and pre-position communication materials**. Ensure posters, leaflets, radio scripts and digital content are all culturally relevant, translated and available early. Use visuals that show safe administration of multiple vaccines.
- **Strengthen the capacities of social mobilizers** through training in interpersonal communication so they can respond to concerns in real-time and mobilize caregivers to immunize children.
- **Engage trusted community leaders and local influencers** to raise awareness and mitigate vaccine hesitancy.
- **Consider ways to attract a higher turnout** such as organizing live performances or roadshows to increase community demand for vaccines.

10. Community ownership and sustainability

Community ownership is central to sustaining vaccination gains. Through the engagement of local leaders, civil society groups and trusted influencers, integrated campaigns reflect local realities and strengthen long-term community trust in immunization. Similarly, by leveraging existing health system structures and mechanisms, the gains achieved through the campaign – often through high-quality microplanning, specially trained personnel and improved communication networks – can be sustained for long-term use beyond the outbreak response period.

Through this concerted approach to community ownership, integrated campaigns can reinforce rather than replace routine immunization and primary health care.

Best practices for community ownership and sustainability

- **Prioritize marginalized and high-risk populations** while involving local leaders and civil society to foster trust and ownership.
- **Promote awareness and demand** for routine immunization and essential services.
- **Document low-cost practices that improve quality** such as morning huddles to reinforce roles, visual job aids optimized for WhatsApp, and standardized referral slips. Scale these low-cost practices into workflows for routine immunization and primary health care.
- **Transition campaign-based delivery** over time into primary healthcare platforms.

11. Monitoring, evaluation and accountability

Intra- and post-campaign monitoring should use harmonized tools and indicators wherever possible.

Intra-campaign monitoring includes direct observation and supervision of vaccination teams and may include rapid convenience monitoring to identify missed areas or populations.

Post-campaign reviews assess joint deployment and supervision, operational efficiencies, community perception, zero-dose or missed children, campaign coverage and campaign quality metrics. All campaign interventions should be included in the post-campaign coverage survey. See **Annex 4** for a post-campaign review template.

Best practices for monitoring, evaluation and accountability

- **Supervisors track both vaccines together on a single reporting form** to enable real-time corrective actions. Before the campaign begins, ensure alignment on denominators for M/MR and OPV in accordance with targeted age groups for each vaccine.
- **Conduct daily multi-level reviews** (team→ health facility/subdistrict→ district→ province→ national) to monitor progress, identify gaps and guide rapid corrective action.
- **Make campaign data readily available** with daily updates for various stakeholders through shared subnational and/or national-level dashboards. Look into reasons for outliers in the data.
- **Track adverse events jointly across both vaccines**, ensuring teams know how to identify events, how to immediately respond and how to report through the integrated workflow. Compile a consolidated adverse event following immunization (AEFI) report within 30 days after the campaign has ended.
- **Conduct an after-action review and document lessons learned** to help inform future M/MR–OPV campaigns.

Additional resources

The following resources provide additional guidance on integrated campaigns.

- WHO developed a field guide for planning and implementing high-quality supplementary immunization activities (SIAs), using measles and rubella vaccines as an example.
- A decision-making and planning guide, developed jointly by WHO and the Health Campaign Effectiveness Coalition, provides practical considerations for multi-antigen campaigns, as well as best practices and lessons learned.
- The Health Campaign Effectiveness Coalition offers resources, including knowledge resources and tools for countries to consider when planning and implementing integrated campaigns, as well as a Collaborative Action Strategy for Health Campaign Effectiveness and an Integration Decision Tool.
- A briefing note, developed by the GPEI and UNICEF, WHO and Gates Foundation Immunization teams, on considerations for multi-antigen campaigns.
- The GPEI regularly updates SOPs for countries that are responding to a polio outbreak or event, available on the GPEI website.

A health worker in Somalia administers measles and polio vaccines as part of an integrated campaign.

Photo @ WHO / Ismail Taxta

Annexes

Annex 1: Integrated campaign milestones (illustrative timing template)

This template supports the planning and tracking of key activities and responsibilities related to integrated campaign planning.

Timeline (before launch)	**Key activities**	**Responsible units**	**Deliverable / output**	**Verification / status**
12 months before *(preventive planning phase)*	• Initiate early partner alignment and explore potential for integration. • Begin joint M/MR–OPV geographic prioritization. • Embed integration into national planning cycles (GPEI Action Plan /NIS, Gavi applications).	MoH / NIP / NCB / WHO / UNICEF	Initial feasibility assessment	Meeting minutes; planning calendar
6 months before	• Confirm campaign dates and integration scope (co-delivery or functional integration). • Establish or re-activate unified coordination mechanism: NCB, TWG or other task team. • Initiate integrated budget framework and procurement planning • Begin weekly coordination meetings.	MoH / NCB / TWG	Coordination mechanism operational	ToRs; meeting minutes Documented decision and rationale
5 months before	• Finalize integrated risk assessment. • Draft integrated budget (harmonized template). • Initiate development of microplans reflecting integration modality	EPI / Finance / Logistics / Partners	Draft budget and microplans	Risk assessment; budget file
4 months before	• Align M/MR and OPV procurement and logistics plans. • Confirm whether vaccines will move together or separately. • Assess cold chain capacity and transport routing,	Supply and logistics unit / EPI / Partners	Integrated supply plan	Procurement orders; cold chain assessment
3 months before (pre-microplanning validation phase)	• Finalize integrated training and communication plans. • Conduct structured readiness review (Go/No-Go 1). • Confirm delivery modalities: fixed post, house-to-house, hybrid or mini-post.	Training unit / SBC / NCB	Approved training plan; readiness report	Readiness checklist (Round 1)
2 months before	• Begin district-level training. • Finalize and pre-position communication materials. • Validate district microplans: team roles, referral pathways, cold chain routing.	District teams / EPI / Partners	Validated microplans	Training reports

EPI = Essential Programme on Immunization; M/MR = measles or measles-rubella vaccine; MoH = Ministry of Health; NCB = national coordination body; NIP = National Immunization Programme; NIS = National Immunization Strategy; OPV = oral polio vaccine; SBC = social and behavioural change; ToRs = terms of reference; TWG = technical working group; UNICEF = United Nations Children's Fund; WHO = World Health Organization.

Annex 1: Integrated campaign milestones (continued)

Timeline	Key activities	Responsible units	Deliverable / output	Verification / status
1 month before	• Dispatch vaccines, materials and equipment per integrated routing. • Align delivery schedules closely to minimize gaps. • Finalize supervisor deployment and transport arrangements. • Ensure recording and reporting tools (paper and electronic) and protocols are in place.	Supply and Logistics Unit / MoH / NCB / TWG	Distribution completed	Delivery notes; cold chain logs
2 weeks before	• Conduct final readiness review. • Confirm team deployment lists and supervisor assignments. • Validate communication roll-out and social mobilization coverage. • Confirm functionality of reporting systems (paper and electronic). • Verify AEFI preparedness and referral pathways.	MoH / NCB / TWG	Final Go/No-Go decision	Readiness checklist (Round 2); supervisor confirmation; AEFI readiness validation
Campaign week	• Implement integrated campaign per modality. • Daily morning briefings & evening performance reviews. • Daily tally reconciliation (M/MR + OPV).	Field Teams / Supervisors / Districts	Daily performance data	Daily summary reports
≤ 30 days post-campaign	• Compile a consolidated AEFI report. • Reconcile final administrative coverage data across both antigens.	EPI / AEFI committee / NCB / Surveillance unit	Consolidated AEFI report; final coverage reconciliation report; operational debrief summary.	Submission of reports to national authorities and partners; documented lessons learned.
≤ 3 months post-campaign	• Complete lessons learned/evaluation.	MoH / NCB / Partners	Campaign reports Best practices Lessons learned	Final campaign reports

AEFI = adverse event following immunization (vaccine safety monitoring); EPI = Essential Programme on Immunization; M/MR = measles or measles-rubella vaccine; MoH = Ministry of Health; NCB = national coordination body; OPV = oral polio vaccine; TWG = technical working group.

Annex 2: Sample integrated microplan

This sample, highly simplified integrated microplan supports micro-level planning to cover geography, population, logistics and supervision.

District / location	Target population (0–59m)	Delivery approach (fixed/mobile/H2H)	No. of teams	Team composition	Cold chain and storage	Transport arrangements	Supervisor	Remarks
Sample District A	8,750	Fixed + mobile	12	1 OPV + 1 M/MR + 1 mobilizer	3 vaccine carriers, 2 cold boxes	4 motorcycles + 1 truck	Dr. X (EPI)	Difficult terrain, extra support needed
Sample District B	12,300	Door-to-door + fixed	18	2 OPV + 2 M/MR + 1 mobilizer	5 vaccine carriers	6 motorcycles	Nurse Y	Urban area, low refusal risk

EPI = Essential Programme on Immunization; H2H = house-to-house (campaign delivery); M/MR = measles or measles-rubella combination vaccine; OPV = oral polio vaccine; UNICEF = United Nations Children's Fund.

Annex 3: Sample harmonized budget

This template supports joint budgeting across programmes to harmonize resources and ensure transparency.

Budget line item	Description	Responsible unit	Estimated cost (USD)	Funding source	Remarks
Vaccine procurement	OPV and M/MR vaccine supply	Supply and logistics		Gavi / GPEI	Includes shipping and handling
Social mobilization	Radio, posters, community outreach	Communication unit		UNICEF / MoH	Cost shared with polio
Training	Joint training for vaccinators and supervisors	EPI / Polio / Partners		MoH/Partners	Per diem and materials included
Cold chain logistics	Fuel, cold boxes, maintenance	Logistics		MoH/Partners	Include contingency reserve
Team payments	Allowances for skilled and unskilled vaccinators & supervisors	Finance		MoH/Partners	Harmonized rates
Monitoring and evaluation	Supervision, data tools, post-campaign review	EPI		MoH/Partners	Post-campaign review included

EPI = Essential Programme on Immunization; GPEI = Global Polio Eradication Initiative; M/MR = measles or measles-rubella vaccine; MoH = Ministry of Health; OPV = oral polio vaccine; UNICEF = United Nations Children's Fund.

Annex 4: Post-campaign review template

This template supports structured debriefs and documentation of campaign performance, lessons learned and follow-up actions. It can be adapted for regional, national or district-level reviews.

Review area	Key questions / indicators	Strengths / best practices	Gaps / challenges	Recommended actions	Responsible person(s)	Timeline
Governance and coordination						
Planning and microplanning						
Finance and budgeting						
Logistics and supply chain						
Safety and AEFI						
Service delivery						
Communication and demand generation						
Monitoring (zero-dose / missed children) and data quality						

AEFI = adverse event following immunization (vaccine safety reporting).