Plan of Action for Measles/Measles-Rubella Campaign

**[Country name]**

**Measles-Rubella catch-up campaign with MR routine introduction / Measles follow-up campaign / Measles-Rubella follow-up campaign [*delete options that do not apply*]**

**[Date]**

|  |
| --- |
| Key changes in Gavi-supported Measles/MR campaign requirements from 2021 onwards: 1. Countries should ensure that Measles/MR campaigns:
	* are designed to **reach measles un- and under-immunised children and missed communities** through differentiated planning and delivery strategies adapted to local contexts;
	* are designed to **integrate zero-dose and under-immunised children into the routine system**, and to generate demand for delivery of a full course of vaccines; and
	* identify opportunities for campaign activities and operational costs to **strengthen health delivery systems**;
2. Countries are required to **leverage all opportunities for integration** with other health campaigns (vaccine and/or health interventions) in the planning, preparation, implementation, delivery, and/or monitoring & reporting phases of the campaign, to leverage synergies and complementarity across investments, reduce adverse impact on routine immunisation, and increase cost-efficiencies.
3. Countries are required to use **campaign operational costs in a differentiated manner,** as reaching measles un- and under-immunised children is likely to require a higher proportion of the operational costs per child.
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1. **Executive summary**

Please provide a short summary describing:

* the type of campaign (M/MR follow-up or MR catch-up with MR routine introduction)
* the main objectives of the campaign
* the dates of the campaign
* the target population and age range
* the justification for the campaign, including the choice of target age range, geographic scope (national/sub-national) and timing
* the campaign strategy (selective/non-selective, phased/non-phased),
* other vaccines and/or health interventions to be integrated
* a brief description of the countries’ use of the **IRMMA framework (Identity, Reach, Monitor, Measure, Advocate for zero-dose children and missed communities**, refer to page 31 and 32 of the vaccine funding guidelines) in the application, and
* the summary costs for vaccines, devices and for operational costs – using Table 1 below.

Table 1. Financing for upcoming Measles/MR campaign

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Item** | **Category** | **Government funding (US$)** | **Gavi support request (US$)** | **Other partner support(US$)** | **Total(US$)** |
| Vaccines and injection supplies | Total amount (US$) | A | E | J | A + E + J |
| Amount (US$) per target person | B | F | K | B + F + K |
| Operational costs | Total amount (US$) | C | G | L | C + G + L |
| Amount (US$) per target person | D | H | M | D + H + M |
| Total amount for vaccines, injection supplies and operational costs (US$) | A + C | E + G | J + L | A + C + E + G + J + L |
| Total per target person (US$) | B + D | F + H | K + M | B + D + F + H + K + M |

1. **Background and justification**

## Country context

Please provide a short situation analysis of the country situation (e.g., relevant political/geographical/economic context, health care system, EPI and programmatic priorities, disease surveillance systems, etc). Keep this section brief and refer to other documents as necessary (e.g., cMYP/NIS, JA, PSR, etc).

## Equity analysis

Using table 2 below, please provide a summary of any equity analyses previously conducted in the country and explain how these analyses have been used to inform the campaign strategies. Please make sure that your equity analysis includes gender-related barriers faced by the caregivers (guardians, mothers, fathers) in accessing the service for their child, and barriers faced by health workers/vaccinators in providing the service.

Table 2. Summary of equity and gender issues

|  |  |  |
| --- | --- | --- |
| Key equity and gender issues | Description/impact of issue | Suggested campaign strategies |
|  |  |  |
|  |  |  |
|  |  |  |

## Measles and rubella context

### Measles immunisation coverage data

* MCV routine immunisation performance in the last 5 years
	+ Date of MCV2 and MR introduction, if applicable.
	+ Immunisation schedule and policy, including information on age eligibility for MCV1 and MCV2 (i.e. what is the upper age range for delivery of MCV1 and MCV2).
	+ National (WUENIC and admin) and sub-national level (admin) coverage trends and dropout rates for MCV1 and MCV2.
	+ Relevant results of EPI coverage surveys, DHS surveys, etc. Key challenges to achieving higher coverage for MCV1 and MCV2.

Table 3. Routine immunisation coverage for MCV1 and MCV2

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| ****Surviving infants**** | ****2016**** | ****2017**** | ****2018**** | ****2019**** | ****2020**** |
| ****MCV1**** | **Total no. vaccinated** |  |  |  |  |  |
| **% coverage (admin)** |  |  |  |  |  |
| **% coverage (WUENIC)** |  |  |  |  |  |
| **% coverage (survey)\*** |  |  |  |  |  |
| ****MCV2**** | **Total no. vaccinated** |  |  |  |  |  |
| **% coverage (admin)** |  |  |  |  |  |
| **% coverage (WUENIC)** |  |  |  |  |  |
| **% coverage (survey)\*** |  |  |  |  |  |

\*Specify type of survey

* Measles (M) / Measles-Rubella (MR) campaigns in the last 5 years
	+ National and sub-national administrative coverage for past campaigns; coverage results from post-campaign coverage surveys;
	+ If a survey assessing coverage was done after each of the three last campaigns, please provide information on survey date, methodology, sample size, number of clusters and number of children, and provide the reports at attachments with the application.

Table 4. Summary of previous M/MR campaigns

|  |  |  |  |
| --- | --- | --- | --- |
|  | ****Year**** | ****Year**** | ****Year**** |
| ****Target age range**** |  |  |  |
| ****Target population**** |  |  |  |
| ****Geographic extent (national, sub-national)**** |  |  |  |
| ****Number vaccinated**** |  |  |  |
| ****Wastage rate (%)**** |  |  |  |
| ****Administrative coverage (%)**** |  |  |  |
| ****Coverage by coverage survey (%)**** |  |  |  |
| ****Proportion of U5 children previously unvaccinated for measles reached (%)**** |  |  |  |
| ****Additional comments**** |  |  |  |

### Measles, rubella and CRS surveillance and epidemiology

* Measles and rubella case-based surveillance system, including surveillance quality
	+ National and sub-national surveillance performance data indicating the sensitivity and geographic representativeness of the surveillance data (for at least the past 5 years)
	+ Describe definitions for suspect, laboratory confirmed, discarded, and epidemiologically linked cases as well as suspect and confirmed outbreak definition.
	+ Total number of suspect measles cases reported via case-based surveillance compared to total number of suspect measles cases reported via aggregate reporting in the health management information system or integrated disease surveillance (for at least the last 5 years). Data should be presented at the national and the first sub-national level.
* Epidemiological pattern of measles and rubella from surveillance data
	+ Epidemiological trends and patterns of confirmed measles and rubella (for at least the past 5 years—disaggregated at least by the first subnational level), including seasonality of occurrence of measles and rubella, distribution by age group and geography.
	+ Age-specific incidence rates of measles and rubella at national and subnational levels, for at least the following age groups: <9 months, 9-23 months (or 0-11 months and 12-23 months), 24-59 months, 5-9 years, 10-14 years, 15+years, by calendar year.
	+ Vaccination status of cases by age group of both suspected and laboratory confirmed measles and rubella cases at national and subnational levels, for at least the following age groups: <9 months, 9-23 months (or 0-11 months and 12-23 months), 24-59 months, 5-9 years, 10-14 years, 15+years, by calendar year, and the number of cases by place and time.
	+ Graph and analysis of trends in MCV1 (and MCV2) coverage, MCV SIA coverage, and confirmed measles (and rubella) cases over time.
	+ If available, please include genetic sequencing data
	+ Population susceptibility: birth cohort analysis of population immunity (using the measles strategic planning tool or modelling to estimate susceptible children at subnational level or serosurveys). If possible, consider linking to previous 1-2 years of surveillance data.
	+ Map or table showing high risk areas/districts for measles transmission, indicating how these have been identified (e.g., using measles SP, measles risk assessment tool, other methods)
	+ CRS disease burden: sentinel surveillance and retrospective record review please include data (for up to 5 years) and serosurvey information where available, including trends and maternal age of confirmed cases.
* Outbreak investigations, root cause analysis and outbreak response activities
	+ Using available reports on outbreak investigations, vaccination responses, and root cause analyses, please provide a description and maps of recent measles and/or rubella outbreaks in last 3 years (or since last MR SIAs), including analysis by age, vaccination status and coverage in the area, as well as dimensions of equity. This should allow for identification of pockets of unimmunised or under-immunised children or poorly performing areas and the underlying reasons for outbreaks (e.g., service delivery and social/cultural barriers). This in turn should inform the differentiated strategies for the upcoming campaign.
* Serological data (if available)
	+ If available, please provide information on data from seroprevalence studies and how this may be linked to the identification of measles zero dose children.
* Geospatial mapping (if available)

### Measles immunity profile

Please use this section to insert the measles immunity profile, if available, along with a description of the methodology used, the results, and how the profile has informed the campaign strategies.

## Campaign justification

Using the data and analyses in sections 2.1-2.3, please provide a detailed justification for the campaign, including the chosen campaign strategies (e.g., nationwide, sub-national, selective, phased, etc.).

## Lessons learned from past campaigns and routine introductions

Using the table below, please identify the lessons from previous campaigns and routine introductions (including MCV2 introduction and establishment of 2nd year of life platform) and indicate how they are being addressed in planning the current campaign. Include information and lessons obtained through SIA technical reports, Post Introduction Evaluations, post campaign coverage surveys, and outbreak response vaccination reports.

Table 5. Using lessons learned to inform the upcoming M/MR campaign

|  |  |  |
| --- | --- | --- |
| ****Key programmatic areas**** | ****Lessons learned in previous campaigns or introductions**** | ****How these lessons have been incorporated in the plan for the upcoming campaign**** |
| **Preparation & planning** |  |  |
| **Microplanning** |  |  |
| **Capacity-building and training materials** |  |  |
| **Advocacy, communication & social mobilisation** |  |  |
| **Delivery strategies** |  |  |
| **Coverage & equity** |  |  |
| **Supervision, Reporting & monitoring** |  |  |
| **Evaluation (post campaign coverage survey)** |  |  |
| **[insert as needed]** |  |  |

1. **Campaign objectives and targets**

## Campaign objectives

Please list the main campaign objectives below and add more as needed. Please ensure that one of the objectives pertains to reaching measles un- and under-vaccinated children in the campaign.

* Objective 1:
* Objective 2:
* Objective 3:

## Campaign targets

Please provide the campaign targets and source/methodology on how the campaign targets were calculated, including for any interventions that may be integrated in the Measles/MR campaign, and the type of strategies that will be used to reach them.

Table 6a. Campaign targets

|  |  |  |  |
| --- | --- | --- | --- |
| Campaign strategy | Proportion of the target population | Target population for Measles/MR campaign | Target population for integrated intervention(add more columns as needed) |
| Permanent posts  |  |  |  |
| Temporary posts/outreach sites |  |  |  |
| Mobile teams |  |  |  |
| Other (please specify)  |  |  |  |
| Total | 100% |  |  |

Table 6b. Source and methodology for campaign targets

|  |  |  |
| --- | --- | --- |
|  | Target population for Measles/MR campaign | Target population for integrated intervention(add more columns as needed) |
| Source |  |  |
| Methodology |  |  |

1. **Identification of measles un- and under vaccinated children**

The principle of developing differentiated delivery strategies for different intra-country contexts is aimed at ensuring that all children, and particularly those which have been consistently missed in previous measles vaccination efforts, are reached as part of the Gavi-supported Measles or MR campaign.

Please use table 7 below to:

(1) **identify** and describe the different **intra-country contexts**, focusing on those contexts with measles un- and under-vaccinated children and missed communities (e.g., easy-to-reach, remote rural, urban / peri urban, and hard-to-reach). Please note that these groups do not need to be mutually exclusive.

(2) determine the **level of difficulty** to reach the children living in these different contexts. Determining the level of difficulty should help inform the share of the operational cost grant that should be allocated to each context, when developing the campaign budget.

This analysis should build on the Gavi 5.0 zero-dose funding guidelines on how to identify zero-dose children and missed communities, other analyses included in this plan of action (e.g. equity & gender analysis in section 2.2), and other existing information (e.g. microplans from previous campaigns; reports from previous campaigns). For e.g., if looking at previous campaign reports, consider who were the hardest to reach / hardest to vaccinate populations, where they were and what strategies worked and did not work.

Table 7. Campaign intra-country contexts and level of difficulty to reach them

Please add and delete rows as needed.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Campaign intra-country contexts | Relevant regions or districts | Number or proportion of children in target population | Source of data (e.g., equity analysis, geospatial mapping, local experience, hypotheses) | Level of difficulty to reach intra-country context (0-3) |
| Rural remote |  |  |  |  |
| Rural non-remote |  |  |  |  |
| Urban (inc. slums) |  |  |  |  |
| Peri urban |  |  |  |  |
| Conflict-affected/insecure |  |  |  |  |
| Vaccine-hesitant |  |  |  |  |
| Gender-related barriers |  |  |  |  |
| (Please add other relevant intra-country contexts by inserting new rows as needed, or delete rows that may not be relevant) |  |  |  |  |

1. **Differentiated campaign strategies for reaching measles un- and under-vaccinated children**

Using tables 8a-8f below[[1]](#footnote-2), **please** **describe in detail** **the differentiated delivery strategies to reach the different intra-country contexts in table 7**, using local programme experience, available guidance on tailored immunisation delivery strategies and data on behavioural and social drivers of vaccination where available. There is a table per intra-country context (e.g. 7a for rural remote). Please edit the intra-country contexts and add tables as needed.

Examples of differentiated delivery strategies that may be implemented as part of a campaign for different levels of difficulty include:

* Communities that live close to a fixed or outreach vaccination site with children who are already enrolled in the routine programme could be considered as difficulty level 0.
* Children living in urban slums who are socially marginalized (e.g., migrants with language or cultural barriers) may require additional advocacy with local leaders and community volunteers to conduct social mobilization to build trust in the community and may be considered as difficulty level 1.
* Children living in remote rural areas that require mobile teams and additional transport and daily subsistence allowances could be considered as difficulty level 2.
* Children living in inaccessible conflict-affected or insecurity areas will require negotiation with community leaders/militia, security measures for vaccination teams, as well as additional transport and may be considered as difficulty level 3

It will be important for countries to describe all the activities that will be necessary to ensure the success of the campaign in each setting, and all these activities should subsequently be reflected in the campaign budget.

Table 8a-8h. Differentiated delivery strategies to reach different intra-country contexts

Editcontexts as needed in line with table 7.

8a. Rural remote

|  |  |
| --- | --- |
| **Intra-country context: Rural remote**  | **Difficulty level to reach:**  |
| **Estimated target pop (as a % of total target pop):** |  |
| Barriers to immunisation | Supply-side barriers | * *xxxx*
* *xxxx*
* *xxxx*
 |
| Demand-side barriers | * *xxxx*
* *xxxx*
* *xxxx*
 |
| Differentiated planning and delivery strategies for the campaign to address identified barriers | Supply-side strategies | * *xxxx*
* *xxxx*
* *xxxx*
 |
| Demand-side strategies | * *xxxx*
* *xxxx*
* *xxxx*
 |
| Key stakeholders to be engaged (e.g., community leaders) | * *xxxx*
* *xxxx*
* *xxxx*
 |
| Budgeting implications of differentiated activities (e.g., key cost drivers) | * *xxxx*
* *xxxx*
* *xxxx*
 |

8b. Rural non-remote

|  |  |
| --- | --- |
| **Intra-country context: Rural non-remote** | **Difficulty level to reach:**  |
| **Estimated target pop (as a % of total target pop):** |  |
| Barriers to immunisation | Supply-side barriers | * *xxxx*
* *xxxx*
* *xxxx*
 |
| Demand-side barriers | * *xxxx*
* *xxxx*
* *xxxx*
 |
| Differentiated planning and delivery strategies for the campaign to address identified barriers | Supply-side strategies | * *xxxx*
* *xxxx*
* *xxxx*
 |
| Demand-side strategies | * *xxxx*
* *xxxx*
* *xxxx*
 |
| Key stakeholders to be engaged (e.g., community leaders) | * *xxxx*
* *xxxx*
* *xxxx*
 |
| Budgeting implications of differentiated activities (e.g., key cost drivers) | * *xxxx*
* *xxxx*
* *xxxx*
 |

8c. Urban (inc slums)

|  |  |
| --- | --- |
| **Intra-country context: Urban (inc slums)** | **Difficulty level to reach:**  |
| **Estimated target pop (as a % of total target pop):** |  |
| Barriers to immunisation | Supply-side barriers | * *xxxx*
* *xxxx*
* *xxxx*
 |
| Demand-side barriers | * *xxxx*
* *xxxx*
* *xxxx*
 |
| Differentiated planning and delivery strategies for the campaign to address identified barriers | Supply-side strategies | * *xxxx*
* *xxxx*
* *xxxx*
 |
| Demand-side strategies | * *xxxx*
* *xxxx*
* *xxxx*
 |
| Key stakeholders to be engaged (e.g., community leaders) | * *xxxx*
* *xxxx*
* *xxxx*
 |
| Budgeting implications of differentiated activities (e.g., key cost drivers) | * *xxxx*
* *xxxx*
* *xxxx*
 |

8d. Peri urban

|  |  |
| --- | --- |
| **Intra-country context: Peri urban** | **Difficulty level to reach:**  |
| **Estimated target pop (as a % of total target pop):** |  |
| Barriers to immunisation | Supply-side barriers | * *xxxx*
* *xxxx*
* *xxxx*
 |
| Demand-side barriers | * *xxxx*
* *xxxx*
* *xxxx*
 |
| Differentiated planning and delivery strategies for the campaign to address identified barriers | Supply-side strategies | * *xxxx*
* *xxxx*
* *xxxx*
 |
| Demand-side strategies | * *xxxx*
* *xxxx*
* *xxxx*
 |
| Key stakeholders to be engaged (e.g., community leaders) | * *xxxx*
* *xxxx*
* *xxxx*
 |
| Budgeting implications of differentiated activities (e.g., key cost drivers) | * *xxxx*
* *xxxx*
* *xxxx*
 |

8e. Conflict-affected/insecure

|  |  |
| --- | --- |
| **Intra-country context: Conflict-affected/insecure** | **Difficulty level to reach:**  |
| **Estimated target pop (as a % of total target pop):** |  |
| Barriers to immunisation | Supply-side barriers | * *xxxx*
* *xxxx*
* *xxxx*
 |
| Demand-side barriers | * *xxxx*
* *xxxx*
* *xxxx*
 |
| Differentiated planning and delivery strategies for the campaign to address identified barriers | Supply-side strategies | * *xxxx*
* *xxxx*
* *xxxx*
 |
| Demand-side strategies | * *xxxx*
* *xxxx*
* *xxxx*
 |
| Key stakeholders to be engaged (e.g., community leaders) | * *xxxx*
* *xxxx*
* *xxxx*
 |
| Budgeting implications of differentiated activities (e.g., key cost drivers) | * *xxxx*
* *xxxx*
* *xxxx*
 |

8f. Vaccine-hesitant

|  |  |
| --- | --- |
| **Intra-country context: Vaccine-hesitant** | **Difficulty level to reach:**  |
| **Estimated target pop (as a % of total target pop):** |  |
| Barriers to immunisation | Supply-side barriers | * *xxxx*
* *xxxx*
* *xxxx*
 |
| Demand-side barriers | * *xxxx*
* *xxxx*
* *xxxx*
 |
| Differentiated planning and delivery strategies for the campaign to address identified barriers | Supply-side strategies | * *xxxx*
* *xxxx*
* *xxxx*
 |
| Demand-side strategies | * *xxxx*
* *xxxx*
* *xxxx*
 |
| Key stakeholders to be engaged (e.g., community leaders) | * *xxxx*
* *xxxx*
* *xxxx*
 |
| Budgeting implications of differentiated activities (e.g., key cost drivers) | * *xxxx*
* *xxxx*
* *xxxx*
 |

8g. Gender-related barriers

|  |  |
| --- | --- |
| **Intra-country context: Gender-related barriers** | **Difficulty level to reach:**  |
| **Estimated target pop (as a % of total target pop):** |  |
| Barriers to immunisation | Supply-side barriers | * *xxxx*
* *xxxx*
* *xxxx*
 |
| Demand-side barriers | * *xxxx*
* *xxxx*
* *xxxx*
 |
| Differentiated planning and delivery strategies for the campaign to address identified barriers | Supply-side strategies | * *xxxx*
* *xxxx*
* *xxxx*
 |
| Demand-side strategies | * *xxxx*
* *xxxx*
* *xxxx*
 |
| Key stakeholders to be engaged (e.g., community leaders) | * *xxxx*
* *xxxx*
* *xxxx*
 |
| Budgeting implications of differentiated activities (e.g., key cost drivers) | * *xxxx*
* *xxxx*
* *xxxx*
 |

8h. Other context – to be used as needed

|  |  |
| --- | --- |
| **Intra-country context: Other context – to be used as needed** | **Difficulty level to reach:**  |
| **Estimated target pop (as a % of total target pop):** |  |
| Barriers to immunisation | Supply-side barriers | * *xxxx*
* *xxxx*
* *xxxx*
 |
| Demand-side barriers | * *xxxx*
* *xxxx*
* *xxxx*
 |
| Differentiated planning and delivery strategies for the campaign to address identified barriers | Supply-side strategies | * *xxxx*
* *xxxx*
* *xxxx*
 |
| Demand-side strategies | * *xxxx*
* *xxxx*
* *xxxx*
 |
| Key stakeholders to be engaged (e.g., community leaders) | * *xxxx*
* *xxxx*
* *xxxx*
 |
| Budgeting implications of differentiated activities (e.g., key cost drivers) | * *xxxx*
* *xxxx*
* *xxxx*
 |

1. **Supply chain management for the campaign**

## Procurement and distribution of Measles/MR vaccine

* Please describe the procurement and distribution of Measles/MR vaccine, including vaccine licensing.

## Cold chain, logistics, and vaccine management

Leveraging existing information and tools (e.g. supply chain sizing tool, CCE inventory), please provide the information below:

* Summarise the cold chain capacity at central and lower levels and readiness to accommodate the vaccines for the campaign, taking into consideration training, cold chain equipment and other logistical requirements.
* Summarise availability of passive containers and dry storage capacity.
* Describe how the surge capacity for campaigns will be managed. If cold chain expansion is required, state how it will be financed, and when it will be in place.
* Indicate if the supplies for the campaign will have any impact in the shipment plans for your routine vaccines and how it will be handled.
* Describe any considerations for other planned vaccination activities, such as COVID-19 vaccination, which can impact the supply chain (either positively or negatively).

## Waste management

Please provide a detailed waste management plan as appropriate for the campaign immunisation activities, based on the assessment of existing local practices. This should include details on sufficient availability of waste management supplies (including safety boxes), safe handling equipment, storage, transportation and final disposal of immunisation waste, as part of a healthcare waste management strategy.

1. **Preparatory activities and implementation of Measles/MR campaign**

## Campaign coordination committees and sub-committees/task forces

Provide list of campaign coordination committees and sub-committees (also called “task forces”) to be created for the campaign planning. The establishment and work of sub-committees are recommended to be included in the detailed campaign timeline. Typical sub-committees include communications, logistics, advocacy and inter-sectoral coordination, technical/implementation, etc.

## Engagement with Ministry of Education

For campaigns involving school-aged children (e.g., MR catch-up): please describe a) engagement with Ministry of Education and involvement of teachers for school-based delivery strategies.; b) strategies for identifying and reaching out-of-school children.

## Integration (coordination and/or co-delivery) of immunisation campaigns and/or other health interventions

Countries are **required to leverage opportunities for integration** with other campaigns (as collaboration or co-delivery), vaccine-related activities or health interventions (e.g., Vitamin A) at any stage, either fully or partially in the planning, preparatory, implementation, delivery, and/or monitoring & reporting phases of the campaign, to leverage synergies and complementarity across investments, reduce adverse impact on routine immunisation, and increase cost-efficiencies. **Strong justification needs to be provided if the country decides not to leverage the delivery of Measles/MR vaccines in the campaign for integration.**

* List any other vaccine introductions, vaccine campaigns or health, nutrition and hygiene interventions planned for the same year as the campaign, describe how the campaign will be leveraged for joint planning, preparation and co-delivery of interventions.
* Describe stakeholders, funding sources of integrated activities (i.e. how the costs will be shared across programmes) and coordination required to achieve successful integration.
* Taking into account the COVID-19 context and likely impact on immunisation coverage across all antigens, please describe how this measles/MR campaign will be leveraged as a catch-up opportunity, including any antigens that may be co-delivered with measles/MR, target age range and geographical or sub-population scope, and related considerations (recording and reporting, etc.). Please describe whether this campaign may also be used for delivery of other health interventions. Please refer to the latest WHO guidance on catch-up immunisation.
* Please provide a justification if the country will not leverage the delivery of Measles/MR vaccines in the campaign for integration, including of catch-up vaccination.

## Capacity building and training

Please describe the capacity building and training activities, including any cost-saving opportunities (e.g., synergies with other ongoing trainings).

## Microplanning

Please describe how microplanning will be conducted, including timelines of when microplanning will occur and the process for microplanning to be validated. Please also include a description on different strategies and/or mop-ups to address under-performing regions and how previous experiences will inform future microplanning.

## Advocacy, communication and social mobilisation

Please describe social mobilisation and community-based activities to generate community support for the campaign and how these will be built on to strengthen routine immunisation following the campaign, with particular focus on high-risk areas for low campaign or routine immunisation coverage, describing how these have been identified.

## AEFI monitoring and preparation for crisis communication

Please describe performance of adverse events following immunization (AEFI) surveillance system in country (to include minimal capacity indicator – AEFI reporting rate per 100 000 surviving infants per year, rate of case-based serious AEFI for last available year/s, and if possible, number, type, and rates of adverse events following MCV by age group in the routine programme and in the last campaign, and any samples of causality assessment reports after serious AEFI) and the approach for organisation of monitoring of serious and non-serious AEFI monitoring during campaign. Plans should include roles and responsibilities in the campaign operational management, how potential AEFIs will be detected, recorded, and investigated, flow of reporting, how causality will be established and information fed back to the health facility and public, and how risk and crisis communications will be planned and managed.

## Operation of vaccination posts

Please describe the organisation of the vaccination posts and composition of vaccination teams, depending on campaign strategy (e.g., hard-to-reach, special population). This should also include non-vaccinating staff (e.g., volunteers for screening, crowd control, other interventions, recording, etc.) and their daily workloads including details on the specific vaccination strategy, and other personnel requirements for specific staff (e.g., number of team supervisors per strategy and per level, coordinators, drivers, etc.).

Table 9. Operation of vaccination posts

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Campaign strategy | Vaccination team composition | Number of teams | Number of children vaccinated per day | Number of children vaccinated per vaccinator per day |
| Fixed post permanent urban |  |  |  |  |
| Fixed post permanent rural |  |  |  |  |
| Temporary fixed post urban |  |  |  |  |
| Temporary fixed post rural |  |  |  |  |
| Mobile post |  |  |  |  |
| Other (add as needed; e.g. mobile post with h-t-h canvassing) |  |  |  |  |
| Total |  |  |  |  |

## Monitoring and supervision

Describe the approach to monitoring and supervision for the campaign, including:

* **Pre‐campaign**, describing how the SIA readiness assessment tool will be used at national and sub-national level; collecting baseline data.
* **Intra-campaign**, e.g., description of how the campaign doses will be documented (e.g., use of cards, use of technology) (indicating how receipt of vaccination will be verified during the post-campaign coverage survey), recording, transmission, and timely and completeness of reporting of data on doses administered and all other interventions given during the campaign, supervision, monitoring to detect pockets of unvaccinated children using standard WHO tools (intra-campaign Rapid Convenience Monitoring usually carried out by supervisors).
* **Post‐campaign**, including methods to establish whether previously unreached children were reached through the campaign and plans to act on data obtained, e.g., post-SIA independent monitoring (RCM) to determine the need for mop-up activities in areas that did not meet coverage targets

## Mop-up immunisation activities

Please describe how mop-up immunisation activities will be carried out and funded, including criteria for conducting mop-up activities, timing and duration (days).

## COVID-19 adaptations

Due to the uncertainty of how the COVID-19 situation will evolve, please provide a summary on how the campaign implementation activities and budget will be adapted should SARS-CoV-2 transmission be ongoing at the time.

1. **Post campaign coverage survey**

Please describe plans to conduct a technically and statistically sound **post-campaign coverage survey** with probability based sampling. The survey must measure, at a minimum, nationwide coverage and the percentage of under 5 children previously unvaccinated against measles who received a Measles/MR dose in a Gavi-supported measles/MR campaigns . For countries with multiple campaign phases, there must be description of plans to conduct a post campaign coverage survey within three months after the completion of each phase. **Please refer to annex 2 of the Vaccine Funding Guidelines**.

1. **Routine immunisation and surveillance strengthening**

## Strengthening routine immunisation through campaign activities

Please describe:

a) the key challenges to achieving higher coverage for MCV1 and MCV2

b) how the activities, tools and methods undertaken during planning and implementation to achieve high campaign coverage will be used to strengthen routine immunisation. Please refer to Section 3.1 on the WHO SIA field guide for additional information; some suggestions provided below:

* Review of micro-plans to improve data on denominator populations at local level;
* Review of rapid convenience monitoring and post campaign coverage survey results for identification of underserved populations and improve provision of routine immunisation services;
* Review of effectiveness of social mobilisation and discussions of how to build on this for routine immunisation;
* Review of any vaccine hesitancy encountered during the campaign, the reasons, and how this was addressed, and whether similar issues and solutions may apply to routine immunisation
* Review of use of measles surveillance data and other methods to determine high risk districts for measles transmission and discussion of how to improve routine immunisation in these areas
* Use of information from post campaign coverage survey on zero-dose children to cross-check with previous estimates of coverage
* Post-campaign meeting of the national co-ordination committee to review lessons learned
* Presentation of lessons learned to the ICC
* Revision of annual EPI plan to take the above into account

For countries choosing to use the **operational cost flexibilities for an M/MR follow-up campaign,** please elaborate on RI strengthening activities and how the funds will be used. Please refer to annex 4 of the vaccine funding guidelines.

## Leveraging the campaign as an entry point for enrolment in routine immunisation

Please describe how zero-dose children and missed communities identified during the campaign will be followed up for the provision of all missing vaccines and enrolment in routine immunisation as an entry point for provision of primary health care services. This should include details on 1) identification and follow-up of defaulters; 2) vaccination of children 12-24 months, leveraging elements such as the second year of life platform.

## Disease surveillance strengthening

Describe how disease surveillance will be strengthened or expanded after the campaign.

1. **Technical assistance**

Please list the technical assistance needs to ensure a high-quality campaign and identify the agencies (local and international) that may be able to fulfil this need.

Table 9. Technical assistance for the Measles/MR campaign

|  |  |  |  |
| --- | --- | --- | --- |
| ****Area of technical assistance**** | ****Scope of technical assistance and duration**** | ****Agency****  | ****Source of funding (TCA, Ops cost, etc.)**** |
| **e.g., Campaign planning and readiness assessment** |  | **e.g., WHO**  |  |
| **e.g., Monitoring and supervision** |  | **e.g., WHO, CDC** |  |
| **e.g., Procurement and logistics** |  | **e.g., Unicef** |  |
| **e.g., Communications** |  | **e.g., Unicef** |  |
| **e.g., Routine immunisation strengthening** |  | **e.g., JSI** |  |

1. **Costing and financing**

Provide a budget for the upcoming campaign as an attachment. Countries must use the Gavi template, reflecting the campaign activities, costs, costs assumptions, and financing sources. The budget should include all the activities indicated in this campaign plan of action, ~~WHO SIA field guide~~, including but not limited to implementation of differentiated strategies to reach the different intra-country contexts, use of the SIA readiness assessment tool, intra-campaign monitoring, mop-up immunisation, routine immunisation strengthening activities, post-campaign coverage survey etc. In addition, provide a summary of the campaign budget below. Please refer to the cost and financing of previous campaigns to inform the budget development.

1. **Chronogram**

Please provide a chronogram for the campaign activities at the national and subnational levels.

1. With the aim of simplification, please note that tables 7 and 8 in the July 2021 version of the POA have been condensed into a single section – Table 7a-7f. [↑](#footnote-ref-2)