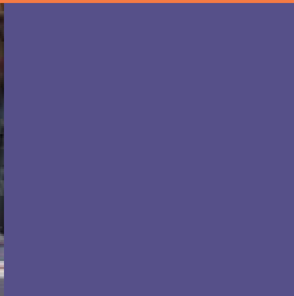
THE ALLIANCE FOR MALARIA PREVENTION

A toolkit for developing integrated campaigns to encourage the distribution and use of long lasting insecticide-treated nets



First edition
September 2008

This publication was produced by the Alliance for Malaria Prevention (AMP).
For additional copies, please email jason.peat@ifrc.org or download PDFs from the AMP shared drive by typing LLINs.4shared.com into your web browser.

Editing, layout and design by Africa's Health in 2010.
http://africahealth2010.aed.org

Cover photos by Jenn Warren (top left) and IFRC.

Acknowledgements

This toolkit has been developed on behalf of the Alliance for Malaria Prevention (AMP). This partnership has been linking long lasting insecticide-treated nets (LLIN) distribution to various platforms to rapidly scale-up malaria prevention. The toolkit is based on experiences and lessons learned since 2002.

The authors of this toolkit wish to thank the Ministries of Health in the following countries for documents used as resources: Angola, Chad, Cote d'Ivoire, Liberia, Madagascar, Mali, Niger, Nigeria, Rwanda, Sierra Leone, Togo, and Zambia.

The authors also wish to acknowledge assistance and technical support from the following partner organizations:

- Academy for Educational Development (AED)
- Africa's Health in 2010
- American Red Cross (ARC)
- Canadian Red Cross (CRC)
- Centers for Disease Control and Prevention (CDC)
- Canadian International Development Agency (CIDA)
- Global Fund to fight AIDS, Tuberculosis and Malaria (The Global Fund)
- Immunization BASICS (JSI and the Manoff Group)
- International Federation of Red Cross and Red Crescent Societies (IFRC)
- Malaria Control and Evaluation Partnership in Africa (MACEPA) a program at PATH
- Measles Initiative (MI)
- Medical Care Development International (MCDI)
- Population Services International (PSI)
- President's Malaria Initiative (PMI)
- Roll Back Malaria (RBM)
- Rotarians Action Group on Malaria (RAM)
- United Nations Children's Fund (UNICEF)
- United Nations Foundation (UNF)
- United Nations Office for Project Services (UNOPS)
- United States Agency for International Development (USAID)
- VOICES
- World Health Organization (WHO)

A number of independent consultants have also contributed to this document. We thank them for their input.

Thanks to Jenn Warren (www.jennwarren.net) and Benoist Carpenter (www.bcarpentier.com) for the kind donation of photographs.

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List of Acronyms

AMP	The Alliance for Malaria Prevention
ANC	Antenatal care
BCC	Behavior change communication
CARN	Central Africa Roll-back Malaria Network
CCM	Country coordinating mechanism
DHMT	District Health Management Team
DHS	Demographic health survey
DPT	Diphtheria, pertussis and tetanus vaccine
EARN	East Africa Roll Back Malaria Network
EPI	Expanded program on immunization
GAVI	Global Alliance for Vaccine Initiative
ICC	Inter-agency Coordinating Committee
IFRC	International Federation of the Red Cross and Red Crescent Societies
ITN	Insecticide-treated nets
LLIN	Long-lasting insecticide-treated nets
M&E	Monitoring and evaluation
MCH	Mother and child health
MDG	Millennium development goal
MOH	Ministry of Health
NCC	National Coordinating Committee
NMCP	National Malaria Control Program
POA	Plan of action
PSI	Population Services International
PMI	Presidents Malaria Initiative
PLHIV	Persons living with HIV
RBM	Roll Back Malaria Partnership
SARN	Southern Africa Roll Back Malaria Network
SEARO	World Health Organization Regional Office for South-East Asia
SIAs	Supplementary Immunization Activities
TBA	Traditional birth assistants
TOR	Terms of reference
UNICEF	United Nations Children's Fund
WARN	West Africa Roll Back Malaria Network
WHO	World Health Organization
WHO/AFRO	World Health Organization Regional Office for Africa
WPRO	World Health Organization Regional Office for the Western Pacific

Note

Referenced documents listed in "Resource" boxes are available on the accompanying CD-ROM

Foreword

Rapid scale-up of malaria prevention and control is essential to achieving the Millennium Development Goals (MDGs), particularly for reducing child mortality by two thirds by 2015. Recent findings from African countries show that when a high coverage rate of insecticide-treated nets (ITNs) is combined with diagnosis and treatment, the country can achieve the MDG aim of mortality reduction. In recognition of the importance of ITNs to child health, the Roll Back Malaria Partnership has set a goal of covering every sleeping space in malaria-risk areas with an ITN. Mass campaigns of free ITN delivery are the only proven mechanism to achieve the necessary rapid, high, equitable coverage. Since 2004, over thirty countries have delivered over 50 million nets through such mass campaigns. Between 2008 and 2010, two hundred million more nets will need to be delivered. Donors are contributing hundreds of millions of dollars to support ITN scale-up.

With the key strategy identified and funding now available, the biggest challenge to ITN delivery is planning and logistics. Mass campaigns represent an unprecedented logistical challenge. Within most countries, there is little institutional experience with ITN campaigns as most are conducting them for the first or second time. While initial efforts added ITNs to vaccination campaigns covering children under five, the desire to cover all sleeping spaces has added an additional challenge. The cost and complexity of the campaigns means that there is little room for error in implementation. At the same time, a flexible and creative approach is required to address local variation and account for uncertainties in ITN delivery, unfavorable weather and other challenges to campaign logistics.

This Toolkit represents the accumulated wisdom of those who have been most closely involved in rapid ITN scale-up. By collecting their experience and making it available to others, it provides the best guide available to campaign implementation. It provides generic lessons that can be applied to achieving the targets of universal coverage although it has been developed based on experience with vaccination/nutrition campaigns targeting children under five as primary platforms. The authors have spent enormous effort to assure that the best practices are presented in a clear and concise manner. It is hoped that the Toolkit is able to both answer common questions and provide a general approach to answer questions specific to each campaign.

While some principles are clear—such as district-based micro-planning—others remain elusive. For example, it is not always clear how many nets should be given to each household, what is the best way to assure net use, or how frequently campaigns should be repeated. It is also unclear how we will target interventions to achieve the universal coverage targets given our focus on households with children under five as the primary target. There are challenges to working out the modalities of achieving universal coverage, but the generalities of planning remain the same. Although these uncertainties represent important gaps in our knowledge, we can't wait until our knowledge is complete. Each campaign should be seen as an opportunity to further close this knowledge gap. The authors look forward to hearing lessons learned from future campaigns and incorporating additional tools to further improve our collective efforts at malaria control.

A number of partners have made essential contributions to this toolkit. These include the International Federation of the Red Cross (IFRC), Canadian Red Cross, Academy for Educational Development (AED), Population Services International (PSI), The Presidents' Malaria Initiative (PMI), United States Agency for International Development (USAID), United Nations Childrens' Fund (UNICEF) and the World Health Organization (WHO). It is through their collaborative support to countries that the goal of complete ITN coverage is within our grasp.

Mark Grabowsky
Atlanta, August 6, 2008

Integrated Child Survival Campaign
Sierra Leone
November 20-26, 2006

Introduction

Integrated campaigns complement routine health services and are successful methods of delivering multiple health interventions at community, district, regional and national levels. They allow Ministries of Health (MOH) and partners to utilize resources effectively and efficiently by rapidly scaling-up coverage of various interventions in order to improve child survival. Integrated campaigns with sustainable results are well planned, implemented, monitored and evaluated, as well as linked with routine service delivery and target communities.

Integrated interventions usually include—but are not limited to—vaccinations against measles, polio, and/or other vaccine-preventable diseases; de-worming treatments; administration of Vitamin A and other micronutrients; and the distribution of long-lasting insecticide-treated nets (LLINs). In integrated campaigns, all children under the age of five should be included, regardless of their vaccination (or household LLIN ownership) status. If the vaccination target age group is 9-59 months (as for measles), children 0-9 months may be missed—and this age group is highly vulnerable to malaria. Women of child-bearing age and pregnant women often benefit indirectly from integrated campaigns.

Country campaigns are generally managed by the MOH and its relevant national programs, such as Expanded Program on Immunization (EPI), National Malaria Control Program (NMCP), Nutrition, and Child Survival.

Currently, a number of guidelines and frameworks exist concerning the integrated delivery of vaccinations, LLINs and other child survival interventions. The goal of this toolkit is to create connections between these documents and summarize lessons learned and best practices for countries planning and implementing integrated campaigns. It includes specific examples and tools from countries that have completed such campaigns, and the toolkit can be used by national and local health planning teams in public, private, non-governmental and multilateral donor sectors.

Photo: Canadian Red Cross

Please view the videos on the accompanying CD-ROM showing integrated campaigns in Sierra Leone by the Canadian Red Cross.

Campaigns do not exist to replace routine services; however they can be extremely critical in boosting low routine coverage rates and can rapidly scale-up life-saving interventions for children. Integrated campaigns help countries achieve health objectives and can assist in the achievement of the Millennium Development Goals (MDGs).

The WHO-UNICEF measles strategic plan and the recent Global Malaria Program Position Paper on LLIN distribution emphasize that while campaigns are key to rapid scale-up of interventions, they need to be coupled with a strong routine vaccination and LLIN delivery mechanisms to maintain high coverage.

Resources

1 *WHO/UNICEF Joint Statement Global Plan for Reducing Measles Mortality.* PDF. 2006-2010.

2 *Insecticide-Treated Mosquito Nets: A WHO Position Statement. PDF.* 2007. Part 1.

Previous page: *A young girl smiles holding her campaign card at an integrated campaign in Siera Leonne.*
Photo: IFRC

1. Planning

Early planning is the most important element of designing and implementing a successful integrated campaign. Planning often begins a full year in advance for successful campaigns.

In this toolkit, early planning is subdivided into three sections:

1. Macro-planning: developing and finalizing the Plan of Action (POA) and budget
2. Establishing a chronogram (timeline) of activities
3. Micro-planning: preparing guidelines and tools for managing the logistics

For successful fundraising, the first two elements should be more or less complete up to a year prior to the campaign for circulation to partners.

Micro-planning only needs to occur about six months before the start of the campaign and is included in early stage planning to ensure it does not get overlooked. Micro-planning is crucial for implementation of successful integrated campaigns (see section 4 for more information).

1.1. Macro-planning

Developing a POA is the first step in successful campaign planning, and is usually led, owned, coordinated and overseen by the MOH, who works with the relevant national programs to set the objectives of the campaign. These objectives are presented to partners for consensus, who then work with sub-national (regional/district) levels to plan, implement and monitor/supervise the campaign.

Resources

3 *A Framework of Strategic Options for the Integrated Delivery of Insecticide-treated Nets and Immunization.* PDF. Prepared for the Global Malaria Programme, WHO, by Jayne Webster, TARGETS Consortium London School of Hygiene and Tropical Medicine, and Jenny Hill, Child and Reproductive Health Group Liverpool School of Tropical Medicine and Hygiene. Draft: May 2006.

5 *Operational Integration of Key Child Survival Interventions: A Guide for District Health Management Teams.* PDF. WHO/AFRO. Draft: 2005.

PLANNING

Photo: IFRC

A banner advertising an integrated campaign hangs in Freetown, Sierra Leone.

Previous page: *Women line up to receive interventions provided at an integrated campaign in Niger.*
Photo: IFRC

PLANNING

Developing a Plan of Action (POA)

Effective POAs are developed in partnership by the MOH and relevant national programs to reflect the country objectives as defined in the annual health strategic plan. POAs should reflect aims and strategies articulated in specific national plans, such as malaria control, child survival, nutrition and immunization. The POA is the first step towards integration of the campaign, as it illustrates the commitment of different national departments to work together to identify common objectives and activities. The POA should be developed and shared with partners at least one year in advance of the campaign dates. Partners and donors can commit to supporting campaigns more easily when the POA is made available and clearly articulates the integrated strategy, organization of operations and estimated costs associated with the planned campaign.

The POA should include the following information:

Who is involved

- The names and details of partners and their roles and responsibilities, including listings of those who will serve on the National Coordinating Committee (NCC) and on the Logistics, Communication, and Technical sub-committees.
- Existing or planned mechanisms for partner coordination and communication.

The aim and objectives of the campaign

- A list of interventions to be included in the campaign, including the method of delivery and strategy for LLIN distribution.
  - Net distribution varies by country, and could be one net per child; one net per child to a maximum of two nets per caregiver; one net per caregiver; one net per pregnant women etc.
- The strategy for implementation, which will depend on the objectives and interventions chosen. At this stage, it is important to become familiarized with the different interventions and their particular target groups.

Who the campaign should reach

- The target population and geographical area for the campaign.
  - Consider the most at-risk groups: infants 0-11 months, children 12-59 months, pregnant women, individuals in hard-to-reach areas, internally displaced persons, refugees, etc.

How the campaign will achieve the specified objectives

- A detailed implementation plan and campaign strategy
- This should include information on coordination, funding, logistics, communication, technical, follow-up and sustainability of coverage
- A chronogram or timeline for target activities such as micro-planning, campaign preparation (development of supports and guides), implementation (training and supervision), monitoring and evaluation and follow-up.

What will happen after the campaign

- A monitoring and evaluation plan for all aspects of the campaign (planning, implementation, post-campaign) will be drafted.
- A plan for EPI and malaria surveillance conducted after the campaign

The cost of the campaign

- The estimated global budget based on general magnitude and past experience: final global budget will not be determined until after the detailed micro-planning has taken place. This emphasizes the need for an early plan of action and for early micro-planning with districts.

TIPS FOR OBTAINING POPULATION DATA: *Use a reliable source!* Good population data can often be obtained through the National Bureau of Statistics or recent Demographic and Health Surveys (DHS). Population estimates for children aged 0-11 and 12-59 months can be obtained through the EPI program. District offices may need to be contacted to update the information, which could cause delays, but create an important opportunity for sharing information on campaign planning.

Review of POA

About 9-12 months before the planned campaign dates, it is recommended that a meeting take place with all potential in-country partners (including the NCC, logistics, communication and technical sub-committees, financial and operational partners) to discuss, agree on and finalize the proposed POA.

During this meeting, partners should:

- Finalize the roles of partners and determine how partner responsibilities will be divided.

- Technical oversight often depends on partners' areas of expertise.
  - Coordination
  - Technical
  - Finance (global budget, logistics budget, communication budget, etc.)
  - Logistics (stocks, transport, storage, site management, security etc.)
  - Communication
  - Monitoring and supervision
  - Evaluation

- Decide upon sub-committees required for planning and implementation. It is recommended that the NCC have the support and help of at least the following sub-committees: logistics, communication and technical.

- Consider other individuals, organizations and departments (e.g., other health units, education, etc.) that can be included in planning the campaign.

A broad support system with a range of partners contributes to successful campaigns—involving key partners and figures at all levels (international, national, district, community, etc.) early in the process provides a sense of ownership and contributes to sustainability through a functioning coordinating mechanism established early in the process.

Estimate needs

- Calculate and estimate the stock required for the chosen interventions (number of LLINs, vaccines, vitamin A supplements, de-worming treatments, equipment etc.)
- Estimate the personnel necessary for the campaign, especially additional personnel required to control crowds, deliver interventions etc.

It is important to consider the goals, strategies, target population and the overall budget when estimating needs to avoid stock-outs and disruptive re-distribution during the campaign. Needs estimations should be included in the POA and refined during micro-planning. *Please refer to section 4.3-Logistics.*

Review the overall budget (to be refined during micro-planning)

A good way to do this is to base an estimate on the magnitude of the planned campaign. Previous campaign budgets can be used as templates and new line items can be added, such as personnel costs for distributors, extra storage, and transportation costs for commodities.

- Ensure adequate supervision is included in the budget, as well as the post-campaign evaluation of coverage.

- Finalize the POA and submit to the campaign coordinating body for review and approval.

> Note that the campaign coordinating body is often composed of interested members of the Country Coordinating Mechanisms (CCM) or Inter-Agency Coordinating Committees (ICC). *Please refer to Section 2-Coordination.*

Review of POA by International Partners

Once the POA has been approved in-country by the campaign coordinating body such as the CCM, ICC or other equivalent, WHO-AFRO should take the lead in soliciting donor interest through established partnership links (e.g., the Measles Initiative and the RBM LLIN Integration Workstream) and by circulating the proposal directly to potentially interested organizations.

Organizations can commit to supporting campaigns more quickly when a POA is available and clearly articulates the strategy, organization and estimated costs of the activity.

1.2. Chronogram of campaign activities

The first step in developing a timeline or chronogram is to establish the dates the campaign will be implemented. Important factors to consider include:

- The time of year: seasonal changes (such as heavy rains) may hinder access and transportation to the campaign site. Holidays and cultural events may decrease attendance.

- Measles and malaria transmission seasons: most measles campaigns occur during the second half of the year, when measles transmission rates are lowest. Therefore, when linking measles vaccination and LLIN distribution, a primary concern is that the net distribution must not disrupt the timing or quality of the vaccination exercise. In 2005 in Kenya, the postponement of a measles vaccination campaign due to delayed LLIN delivery may have contributed to an increase in measles-related deaths.

- Resource availability: often countries have a schedule of large-scale health activities, such as mass vaccination campaigns or child health days/weeks. These can serve as existing platforms, as LLIN distribution can "piggyback" and join

Resources

3 *A Framework of Strategic Options for the Integrated Delivery of Insecticide-treated Nets and Immunization*. PDF. Prepared for the Global Malaria Programme, WHO, by Jayne Webster, TARGETS Consortium London School of Hygiene and Tropical Medicine, and Jenny Hill, Child and Reproductive Health Group Liverpool School of Tropical Medicine and Hygiene. Draft: May 2006. [please refer to the table on page 27].

6 *Measles and Malaria Campaign Plan of Action*. MS Word. Sierra Leone. January 2007.

7 *Mali Plan D'Action - Campaign Integree*. MS Word. 2007.

8 *Measles SIAs Field Guide*. PDF. WHO/AFRO. Revised: January 2006.

9 *Framework for Monitoring and Evaluation of Integrated Child Survival Interventions*. PDF. WHO/AFRO, 2006.

10 (a) *Chronogram Example – English*. MS Excel. (Also provided as Annex 1 at the end of this toolkit)

10 (b) *Chronogram Example – French*. MS Excel. (Also provided as Annex 1 at the end of this toolkit)

See also "Managing Resources" on page 5 of Resource Number 6: Operational Integration of Key Child Survival Interventions: A Guide for District Health Management Teams. MS Word. WHO AFRO Region, Draft: 2005.

with one or more of these campaigns. If this is the case, timing can be relatively fixed by the other interventions. It is important to remember not to join LLIN interventions into an existing campaign at the last moment – it is essential for the integration to be sufficiently planned.

Once the campaign dates have been established, a chronogram of activities for the overall campaign, plus for each sub-committee, should be developed.

Resources

3 *A Framework of Strategic Options for the Integrated Delivery of Insecticide-treated Nets and Immunization*. PDF. Prepared for the Global Malaria Programme, WHO, by Jayne Webster, TARGETS Consortium London School of Hygiene and Tropical Medicine, and Jenny Hill, Child and Reproductive Health Group Liverpool School of Tropical Medicine and Hygiene. Draft: May 2006.

6 *Measles and Malaria Campaign Plan of Action.* MS Word. Sierra Leone. January 2007.

1.3. Preparation of guidelines and tools for micro-planning

Micro-planning guidelines and tool need to be considered at an early stage during the planning process. Micro-planning is relevant to all aspects of the campaign, and further information can be found in the specific sections of the logistics toolkit (focused on LLINs), communication, implementation and M&E.

Resources

5 *Operational Integration of Key Child Survival Interventions: A Guide for District Health Management Teams.* PDF. WHO/AFRO. Draft: 2005

8 *Measles SIAs Field Guide.* PDF. WHO Regional Office for Africa. Revised: January 2006. [NOTE: please see pages 11-12 for planning at national and district levels]

10 (a) *Chronogram Example – English.* MS Excel. (Also provided as Annex 1 at the end of this toolkit)

10 (b) *Chronogram Example – French.* MS Excel. (Also provided as Annex 1 at the end of this toolkit)

Photo: © Jenn Warren/PSI Sudan. www.jennwarren.net

The planning committee of the Government of Southern Sudan and PSI organized for this Dinka family in Agur, a village in Western Bahr El-Ghazal state, to store LLINs for neighboring villages that are too remote to reach by road.

2. Coordination

A successful campaign begins with participation and communication among partners, under the leadership of the MOH. Coordination, as a primary responsibility of the MOH, acts to ensure ownership of and accountability for the campaign. The existence of partner coordination bodies has, in the past, proven to advance smooth campaign planning and implementation.

Often countries have existing Country Coordinating Mechanisms (CCM) or Inter-Agency Coordinating Committees (ICC) where in-country partners are represented. For integrated campaigns, the composition of these structures may change with the addition of partners directly supporting the campaign, as well as reduced participation by partners not directly involved in this particular health activity. In most countries, a National Coordinating Committee (NCC) is formed, under the leadership of the MOH, of partners with specific interest in the integrated campaign.

EFFECTIVE COORDINATION REQUIRES:
- Flexibility
- Adaptability
- Ability to meet deadlines
- Monitoring of activities to maintain chronogram timelines and schedules
- Giving credit to partners in public to encourage ownership and involvement

- The campaign coordinating body should determine the types of sub-committees required to support the planning and implementation of the campaign (e.g., technical, logistics, communication) and the composition of each. Responsibilities are often delegated and divided according to partners' areas of expertise.
  - Each committee and sub-committee should determine meeting times and places. These may vary from several times a week to once a month. Contact typically becomes more frequent when the campaign launch date is near. Partners should be encouraged to ensure representation at all meetings.
- The campaign coordinating body can benefit from actively pursuing partnerships with private, commercial or non-governmental sectors. These groups may possess important resources, either financial or in-kind, such as for local transport and storage of commodities, as well as for communication and mobilization of resources.
- Communication must remain strong throughout the entire planning, implementation, and post-campaign phases.
- Communication is necessary at a number of levels including:
  - At the national level, among partners and across MOH departments
  - Between national, regional and district levels, to ensure all stakeholders are informed
  - Between the district and facility levels, to ensure links with the community are formed and maintained

Effective coordination of campaigns involving multiple partners will depend on regular meetings, conference calls, information bulletins (print or electronic), and inclusion of all partners on any official communication.

2.1. Coordination of partners

Partnerships supporting campaigns occur at the international, national and district/community levels.

Previous page: *A child receives a LLIN at an integrated campaign held in Koulikoro, Mali.*
Photo: IFRC

International level

This level primarily includes international partners and in-country representatives of international partners (national representatives are sometimes invited, as appropriate or available).

Successful coordination of international partners involves:

- Organization of and participation in global discussions regarding funding, complementary actions and procurement and technical issues
- Organization of and participation in one or several coordination and planning meetings among all partners

International partners often take advantage of already planned meetings, such as regional meetings of the Roll Back Malaria Partnership e.g., roll back malaria networks (WARN, EARN, CARN, SARN) and regional WHO malaria meetings where national malaria control personnel and partners are already gathering to discuss malaria strategic planning.

Immunization meetings include the annual WHO regional office meetings (SEARO, WPRO, AFRO etc.) as well as sub-regional Global Alliance for Vaccine Initiative (GAVI) and bloc meetings (e.g., sub-regional EPI managers meetings).

- Organization of country-specific conference calls in order to receive updates on in-country activities and provide technical inputs where requested
- Organization of and participation in weekly partnership calls to discuss progress in countries implementing campaigns (globally); identify action points for moving forward; and examine funding, procurement, and technical issues

Resources

3 *A Framework of Strategic Options for the Integrated Delivery of Insecticide-treated Nets and Immunization.* PDF. Prepared for the Global Malaria Programme, WHO, by Jayne Webster, TARGETS Consortium London School of Hygiene and Tropical Medicine, and Jenny Hill, Child and Reproductive Health Group Liverpool School of Tropical Medicine and Hygiene. Draft: May 2006.

11 *The Global Fund Niger Project: Integrated Polio Vaccination and Mosquito Net Distribution.* PDF. 19–24 December 2005. International Federation of Red Cross and Red Crescent Societies. Annual Report, August, 2006.

National level

Given the size of integrated campaigns and the number of interventions delivered, many partners are usually involved at the national level. The success of campaigns largely depends on effective coordination of these partners—campaigns are generally stronger where partner participation is sustained throughout the planning and implementation phases.

Coordination at the country level often poses the greatest challenge, and to assist the MOH, its role as the lead for all activities should be respected by all national partners.

Successful coordination at the national level involves:

- Existing bodies, such as ICC, CCM or MCH committee, modified in membership (national coordinating body)
- International partners as well as in-country partners and leaders
- The involvement of national partners as members of sub-committees, attendance at sub-committee meetings and teleconferences

Photo: Canadian Red Cross

Celebrating a successful integrated campaign, Madam Louise Dionne (wife of the premier of Quebec) joins the Red Cross and provincial health authorities meeting in Madagascar.

- The representation of national partners in planning and coordination meetings and teleconferences

District/community level

Integrated campaigns are implemented at the district and community levels, and therefore should understand the needs of the target population.

Resources

12 *Partnerships in Action: An Integrated Approach to Combining a Measles Campaign with a Bed Net, Vitamin A, and Mebendazole Campaign in Zambia (Malaria Case Study).* PDF. American Red Cross International Services and CORE, July 2004.

8 *Measles SIAs Field Guide.* PDF. WHO/AFRO. Revised January 2006.

Communities should be involved early in planning the campaign, in order to ensure a sense of ownership, transferability, and sustainability.

Partners at the district and community level include health staff, community health committees, religious leaders, community leaders, volunteers, and parents.

Resources

3 *A Framework of Strategic Options for the Integrated Delivery of Insecticide-treated Nets and Immunization.* PDF. Prepared for the Global Malaria Programme, WHO, by Jayne Webster, TARGETS Consortium London School of Hygiene and Tropical Medicine, and Jenny Hill, Child and Reproductive Health Group Liverpool School of Tropical Medicine and Hygiene. Draft: May 2006.

2.2. National Coordinating Committee

A National Coordinating Committee (NCC) is usually formed to focus on the campaign, and can be especially formed or a part of the ICC or CCM. An effective NCC is normally composed of technical staff from the MOH and partner organizations, especially WHO, UNICEF and major in-country donors. This coordinating committee makes many of the technical decisions regarding the campaign and is responsible for the technical review and finalization of the POA.

Since the NCC makes most of the final decisions regarding the campaign, it is vitally important to hold regular meetings during the planning and implementation phases. It is in these meetings that partners and sub-committees can present their work, for review and approval, by the NCC.

For successful communication, detailed minutes and recommendations should be recorded and openly shared with all partners—including those who were unable to attend the meeting. Minutes are effective tools to build partnerships, document lessons learned, and update the MOH and local and international partners. Minutes can also be used to ensure that recommendations and action items are monitored and followed up on.

One of the first decisions the NCC usually makes is what interventions to include in the integrated campaign. The WHO/AFRO Policy Decision Making Tool for Integration in Campaigns suggests possible interventions, reviews key policy decisions (i.e., method of distribution – free distribution vs. voucher, target age group, etc.), compares advantages and disadvantages, and makes a working group recommendation.

LLINs are often an incentive to bring families to vaccination sites. It is useful therefore to link LLIN campaigns with other interventions.

POSSIBLE INTERVENTIONS FOR INTEGRATED CAMPAIGNS INCLUDE:
- Distribution of LLINs
- Immunizations for polio
- Vaccinations for measles
- Vitamin A
- De-worming

Distribution of LLINs may help raise vaccination attendance in campaigns, while the vaccination campaign platform provides an effective way to get LLINs to the most remote parts of a country.

Resources

13 *Malaria and Measles: Focus on Zambia. (Programme Update).* PDF. International Federation of The Red Cross, March 2004.

14 *Policy Decision Making Tool for Integration in Campaigns.* MS Word. WHO-AFRO, 2005.

15 *Example of minutes from Mali campaign- Mali Compte Rendu du Comite de Pilotage.* MS Word. November 22, 2007.

2.3. Sub-committees

Sub-committees are important for the functioning of a campaign; they divide the workload and capitalize on the expertise available among partner organizations.

Typically, there are three main sub-committees: logistics, communication (including advocacy, social mobilization and behavior change communication), and technical (including monitoring and evaluation). While these three sub-committees are a minimum requirement for the organization of integrated campaigns, some countries include additional sub-committees.

Photo: IFRC

Transport of LLINs to campaigns sites for Kenya's integrated campaign was coordinated by the logistics sub-committee.

Sub-committees may split into smaller working groups to address specific aspects. For example, the technical sub-committee could divide into different working groups to a) develop field guides, b) produce training manuals, c) deliver training, d) manage tally sheets for record keeping, and e) manage the monitoring and supervision tasks.

Clear terms of reference (TOR) should be defined to guide the sub-committees in their work. TOR should list objectives for the sub-committees.

The example referenced from Sierra Leone includes TORs for sub-committees focused on operations (including monitoring and supervision), training, social mobilization, and logistics. This document can serve as a good template that countries can adapt to their local structure.

In most countries, a technical committee (composed of partners and MOH technicians from the various participating departments) acts as a coordinating body for the sub-committees and reports to the NCC, ICC or CCM.

The Democratic Republic of Congo (DRC) has used a successful ICC model since 1997, which includes sub-committees, memoranda of understanding and annual reviews.

Photo: IFRC

A young girls smiles from under her new LLIN, obtained at an integrated campaign.

COORDINATION

Sub-committees should meet on a regular basis, preferably at a particular time each week. Ideally, sub-committees would meet on different days of the week (because of overlap in membership). Setting regular days and times ensures that these meetings will actually take place; if they are organized on an ad hoc basis, often they do not occur or have limited representation.

NOTE: Detailed minutes and recommendations should be recorded and openly shared with all partners, including those partners that were unable to attend the meeting.

Resources

16 *Technical Sub-committee Terms of Reference from Sierra Leone.* MS Word.

17 *Progress Towards Planning the Integrated Measles Follow-up Campaign in Kenya.* MS PowerPoint. Presented at the Sixth Annual Measles Partnership Meeting on February 15, 2006 by Dr. Ambrose Misore.

18 *The Immunization Inter-agency Coordination Model.* An example from the DRC. PDF. BASICS II.

3. Funding: Budgets and Fundraising

3.1. Global budget

A global budget is the financial framework for planning and implementing all campaign activities. The global budget is an integral part of the campaign POA and serves as the basis—and even as a marketing tool—for fundraising.

> The primary sources of information for this budget are the POA and the chronogram. Each general activity should be broken down to separate cost elements so that the final calculation reflects realistic needs.

Similar to having an integrated POA, it is important to have an integrated budget that covers the campaign as a global whole, rather than budgets for individual activities and campaign supplies. Estimated budgets should be produced as early as possible (six to nine months before the start of the campaign) so that partners can mobilize resources and commit to activities. Partners are more inclined to offer support to countries that have a solid, integrated POA and budget.

Some partners "traditionally" support certain budget items.

- The Measles Initiative partnership covers the cost for vaccines, syringes, safety boxes and other vaccination supplies and 50% of operational costs. The remainder of operational costs usually comes from the MOH or other donors. The initiative will also support some of the costs relating to in-country logistics.
- The Micronutrients Initiative usually covers the purchase of vitamin A and *albendazole*.
- The Polio Eradication Initiative covers the cost of oral polio vaccine.
- Countries usually receive funding for LLINs and associated operational costs from the Global Fund, the World Bank, or in some cases bilateral donors such as PMI or other country aid programs. LLIN logistics are usually supported by the same sources of funds used to purchase LLINs.

The RBM LLIN Integration Workstream can help to circulate the campaign POA and budget to all partners/donors to identify funding and support. Many financial partners to the MOH malaria control program will consider requests to reprogram LLINs scheduled for routine services into campaign activities, as long as routine needs are adequately covered.

Often, integrated campaigns incur a number of special costs such as support for consultants and technical assistance, social mobilization, post-campaign activities and monitoring and evaluation. For these items, often a number of smaller donors can potentially contribute. Requests for support should come with a written plan and budget. The LLIN Integration Workstream can help to coordinate these requests from countries and link countries to donors.

Resources

19 *Sierra Leone MOHS Integrated Campaign Budget.* MS Excel. Example budget.

20 *Mali MOH Integrated Campaign Budget.* MS Excel. Example budget.

11 *The Global Fund Niger Project: Integrated Polio Vaccination and Mosquito Net Distribution.* PDF. 19-24 December 2005. International Federation of Red Cross and Red Crescent Societies. Annual Report, August, 2006

FUNDING

3.2. Budget development

Determining budget guidelines is the first step. The number of line items will vary according to the campaign needs, such as the geographic scope of the campaign, the coverage goals, the health workers and volunteers needed, the number of services to deliver (i.e., LLINs, vaccines, and other), transportation and communication needs, and the like.

To help break down the global budget into more detailed parts, start with general categories such as:

Commodities

- LLINs, vaccines, vitamin A, de-worming drugs, cold boxes, syringes, medicines for adverse events, safety boxes, trash bags, etc.

Capital expenditure

- These are items over a certain amount (usually about $1,500) that are not included in the "commodities" budget line
- Examples could include refrigeration for vaccines and other equipment

Personnel and human resources

- Including local and international travel, consultant fees etc.

Training and workshops

- Including micro-planning, reference materials and guidelines, per diems and transport for participants

Social mobilization supports

- Including radio and television spots and print materials, as well as costs for publicity and public relations events
- Social mobilization by community volunteers for house-to-house mobilization, especially in areas with known resistance or barriers to attending interventions, especially vaccination and LLIN distribution or use

Administrative costs

- Printing and copying
- Coordination and planning
- Computer expenses
- Communication costs (telephone, fax, etc.)

Logistics

- Campaign implementation costs, including transportation of commodities, site management, security, waste disposal, printing of campaign cards, tally sheets etc.
- Training of campaign staff

Monitoring and supervision

- Both before and during the campaign

Evaluation

- Baseline, post-campaign coverage and utilization

It may be useful to create a code for each general category and sub-category. This makes it easier for the host government and donors to identify those items that they wish to fund.

For example:

CODES	***ITEM***
100	Commodities & supplies
100.1	*LLINs*
100.2	*Vaccine-related supplies*
100.2.1	*Measles vaccine*
100.2.2	*Polio vaccine*
100.3	*Vitamin A*
200	Capital expenditure
300	Personnel
400	Training & workshops
etc.	etc.

Sources of information to help estimate costs include recent MOH budgets, UNICEF and other commodity catalogs, budgets developed by NGOs

for similar health activities, and budgets from past national or regional health or vaccination campaigns.

The global budget should be prepared in local currency and linked to a major currency such as the US dollar or Euro to account for foreign exchange fluctuations.

For example, suppose the global budget is calculated for a campaign in Sierra Leone and totals 29 million leones or US$10,000, using an exchange rate of 1 US$ = 2,900 leones. If the exchange rate changes to 1 US$ = 2,850 leones, the budget remains at 29 million leones but the funding to cover the difference in US dollars can easily be requested without recalculating the entire budget. A rule of thumb is to use the rate of exchange in OANDA [www.oanda.com/convert/classic] at the time the budget is finalized and approved.

All costs related to the integrated campaign should be included in the global budget including commodities that are procured outside the country by donors/funders. For example, LLINs, measles and polio vaccine, vitamin A and mebendazole for campaigns are sometimes procured by organizations outside the country in USD or Euro. These amounts should be converted to local currency and included in the global budget so that all contributions from partners are transparent.

The MOH and key partners must approve the global budget along with the campaign POA. The entire document serves as an advocacy and sales tool to gain local and international support. Ideally, campaign dates should not be set until 80% of the global budget has been secured. It is important to identify portions of the budget that can be left for final buy-in by the MOH and donors. For example, it is no good having a donor identified for LLINs if there is no funding committed for transportation.

Resources

21 *National Measles-Malaria Campaign Report.* Sierra Leone. MS Word. January 2007.

12 *Partnerships in Action: An Integrated Approach to Combining a Measles Campaign with a Bed Net, Vitamin A, and Mebendazole Campaign in Zambia (Malaria Case Study).* PDF. American Red Cross International Services and CORE, July 2004.

Photo: IFRC

A campaign helper guides a beneficiary through the integrated campaign in Ségou, Mali.

3.3. Funding and fundraising

Fundraising for integrated campaigns requires advance planning and persistence. A detailed plan and global budget—with clear justification, objectives and targets—is a precondition to successful fundraising.

Identifying funding can take months or even years, depending on the campaign and the number of partners involved. For instance, the International Federation of the Red Cross and Red Crescent Societies (IFRC) and WHO spent nearly two years fundraising for the 2005 campaign in Niger.

Successful approaches for fundraising include:

- Information sharing on the LLIN Integration Workstream partnership calls
- In-country donor meetings and international meetings. Advantage should be taken of regional and international meetings for EPI and Malaria Control to present plans and the need for campaigns.
- Links with international partners who are able to assist with fundraising
- Separate fundraising calls for specific campaigns
- Letters from the MOH to potential donors stating aims and objectives of the campaign. It is useful to include or attach the campaign budget to identify potential areas for funding.
- Availability of a well-written POA supported by a detailed global budget, that demonstrates clear thought in the cost calculations. "Estimates" can raise concerns among local authorities and donors who could be asked eventually to cover "unforeseen costs."
- Clear demonstrations, in writing, of the host government's commitment to the integrated campaign, as well as substantive financial and in-kind contributions. Preparatory work, staff, and use of health staff and volunteers should be costed out to show this contribution.
- Identification of cost sharing opportunities with district- and community-level leaders (e.g., support for transportation and social mobilization by local governments and businesses).
- Engagement by the private sector and other approaches to cover LLIN costs (e.g., a voucher system, transport, sponsoring).

More information on experiences with voucher systems can be founded in the Resource 3: Framework for Strategic Options for the Integrated Delivery of Insecticide-treated Nets and Immunization, pages 16 and 31.

- Initiation of discussions with the private sector regarding possible involvement, either financial or in-kind, can lead to significant campaign contributions.

THE PRIVATE SECTOR OFTEN OFFERS UNTAPPED POTENTIAL FOR ADDITIONAL RESOURCES.

For example, companies that deliver soft drinks or other commodities to remote areas can be approached about transporting non-sensitive materials (e.g., posters, banners etc.) within their catchment areas.

In Togo, the social mobilization sub-committee approached cell phone companies to send out SMS messages in the weeks prior to the campaign reminding parents to bring their children.

3.4. Financial reporting

A financial reporting format must be developed with the global budget, and include all line items. It is usually not prepared separately by donor. In the narrative, explanations for any significant variation from the original line items in the global budget are given. The format for the budget and narrative report will depend on MOH or donor guidelines in terms of timelines, necessary accompanying justifications (e.g., salary cards, mission orders, and receipts etc.) and other requirements.

Resources

3 *A Framework of Strategic Options for the Integrated Delivery of Insecticide-treated Nets and Immunization*. PDF. Prepared for the Global Malaria Programme, WHO, by Jayne Webster, TARGETS Consortium London School of Hygiene and Tropical Medicine, and Jenny Hill, Child and Reproductive Health Group Liverpool School of Tropical Medicine and Hygiene. Draft: May 2006

Photo: IFRC

Children receive LLINs as part of an integrated campaign in Siaya, Kenya.

4. Logistics

Logistics is critical for the successful implementation of integrated campaigns. Logistics involves getting the supplies where they need to be, when they need to be there, in sufficient quantities, and with a system of proper storage, monitoring and stock control, including safe waste disposal.

Timely and detailed planning is required at all levels (health facility, district/community, regional and national) to develop plans that reflect the actual needs and realities to the lowest level of the campaign supply chain. An example of logistics chronogram can be found in Resource 11 and at the end of this document as Annex 1.

In many previous campaigns, countries and/or partner organizations contracted logistics consultants to assist with campaign planning and implementation. To access this wealth of experience in integrated campaign logistics, it is possible to consult with focal point persons in neighboring countries. Focal point persons will be able to share a list of possible consultants, lessons learned and experiences.

The scale of logistics for integrated campaigns can be daunting, but when well planned, many countries have had enormous success.

4.1. Micro-planning

Micro-planning involves gathering detailed information from the district/community levels of the campaign, regarding the need for supplies, personnel, supports, data recording and reporting forms, social mobilization materials, and other requirements. Micro-planning is critical to finalizing need estimations, timelines, and, importantly, the global campaign budget. It occurs at the district level, based on guidelines set at the national level. A micro-plan should be completed at least 6 months prior to the launch of the campaign, with regional and district management teams working together to identify key activities and focal ppints, develop chronograms and create for activities.

The first step in micro-planning is developing or adapting tools, templates, and guidelines for the region and/or districts. The logistics sub-committee, using tools from past campaigns, can develop templates and guidelines that are then approved by the coordinating committee.

District health management teams normally assign focal point persons to lead the development of micro-plans in their district. The national level provides training (or training of trainers) focused on supporting this district-level micro-planning, and trainers will go to the districts or regions to train and supervise focal point persons.

Resources

17 *Progress Towards Planning the Integrated Measles Follow-up Campaign in Kenya.* MS PowerPoint. Presented at the Sixth Annual Measles Partnership Meeting on 15 February, 2006 by Dr. Ambrose Misore.

22 *A Treated Mosquito Net for Every Child Under 5 in Rwanda.* PDF. Rwanda Brief: PSI Malaria Control. January 2007.

10 (a) *Chronogram Example – English.* MS Excel. (Also provided as Annex 1 at the end of this toolkit)

10 (b) *Chronogram Example – French.* MS Excel. (Also provided as Annex 1 at the end of this toolkit)

23 *Logistics Chronogram Example from Sierra Leone.* MS Excel.

24 *Logistics Chronogram Example from Mali.* MS Excel.

Previous page: *A campaign helper surveys the LLIN bundles stored in a secure warehouse in Beira, Mozambique.* Photo: IFRC

Guidelines and templates are usually sent to the regional or district level in advance of field visits to allow health authorities to begin collecting necessary information from each district. This information includes the numbers in the target population by locality and broken down so the correct number of nets reach the correct district.

Please refer to Resource 10 for an example of a chronogram in English and French, also included at the end of this document at Appendix 1.

Determining the number of sites

One of the key elements of micro-planning is determining the number of sites or distribution points required to reach 100% of the population.

> Integrating LLIN distribution with measles campaigns allows all interventions to be given at the same site and facilitates the delivery of LLINs.

Generally, measles campaigns are fixed, advanced or mobile, and it is easier to integrate LLIN distribution into this type of campaign. Polio and vitamin A campaigns are often "door-to-door", making it harder to integrate LLIN distribution—because their bulk and weight do not allow them to be easily transported by door-to-door teams.

> During door-to-door campaigns, coupons can be given out and can later be redeemed for LLINs at a distribution site.

A good starting point for planning the required number and locations of LLIN distribution sites would be the micro-plans from past measles campaigns. The list of locations used previously can help in determining how to reach 100% of the population.

In measles campaigns, there are typically three types of sites:

1. Fixed sites:
   - Health facilities or MOH structures that communities access for routine health services. Vaccination teams are usually present at these sites for the entire campaign.

2. Advanced sites:
   - Sites that are set up in schools or other structures for populations who live between five and ten kilometers from a health facility. Vaccination teams, based out of health facilities, work at these sites for one or more days during the campaign.

3. Mobile sites:
   - "Sites" that are set up in communities and villages more than ten kilometers from a health facility. Vaccination teams, based out of health facilities, travel in vehicles to low access areas and set up in the community for a morning or afternoon to vaccinate all eligible children.

> The district micro-planning exercise aims to, based on geographic spread of the population, identify the number of existing fixed sites, the percentage of population that can be reached through those sites, and the number of advanced and mobile sites required to attain 100% coverage during the campaign.

Since LLIN distribution sites require security and sufficient space to stock LLINs, an alternative location needs to be identified for advanced and mobile sites, ideally nearby.

At the district or community level, micro-planning continues with the development of maps and chronograms. For campaigns based at vaccination

sites, the maps and chronograms should show the movement of each team and ensure that all sites are covered.

For door-to-door campaigns, the maps and chronograms should show the progression of teams through their geographic area of assignment and the distribution points for LLIN distribution.

FOR DETERMINING THE NUMBER OF STAFF IN TEAMS AND AT SITES

Please refer to section 6.2 on "site set-up and campaign implementation".

Resources

25 *Liberia micro-planning examples.* January 2007.

(a) *District summary form and district micro-planning templates.* MS Excel

(b) *Immunization summary sheets.* MS Excel.

(c) *Daily before and during implementation forms.* MS Excel.

(d) *Vaccination summary sheets.* MS Excel.

(e) *Adverse effects following immunization_ Case investigation form.* MS Word.

(f) *Adverse effects following immunization_ Line listing.* MS Word.

21 *National Measles-Malaria Campaign Report.* Sierra Leone. MS Word. Jan. 2007

8 *Measles SIAs Field Guide.* PDF. WHO/AFRO. Revised: January 2006

5 *Operational Integration of Key Child Survival Interventions: A Guide for District Health Management Teams.* PDF. WHO/AFRO. Draft: 2005.

4.2. Tools for LLIN micro-planning

Typically, due to their bulk and value, LLIN logistics are organized separately from vaccine and other intervention logistics. In planning for integrated campaigns, it is important to consider the logistical needs for all interventions being covered.

Intervention	Transport	Storage
Vaccinations	• Cold chain transport • Regular transport for syringes, safety boxes, cold boxes and diluents for vaccines	• Cold chain transport • Warehouse space for syringes, safety boxes, cold boxes and diluents for vaccines
Vitamin A / de-worming	• Regular transport	• Warehouse space
LLINs	• Large vehicles	• Large ware-house space • Security

Resources

8 *Measles SIAs Field Guide.* PDF. WHO/AFRO. Revised: January 2006.

Often the transport of LLINs from a central level to the district level is separate from other interventions. From the district center to health facilities and to advanced or mobile campaign sites, the transport and logistics operation is integrated so that all supplies are moved at once.

4.3. Needs estimations

The estimation of supplies depends on the interventions included in the integrated campaign.

Typical supplies include:

- Vaccines and vaccination-related items (e.g., syringes [both mixing and injection], cotton, safety boxes, diluents for vaccines etc.)
- Vitamin A and interventions such as de-worming that do not require cold chain logistics
- LLINs
- Stationery and forms, such as tally forms, stock tracking sheets, campaign cards and indelible ink markers (markers that cannot be easily removed)
- Personnel and social mobilization materials
- Durable goods, such as icepacks and cold chain equipment

KEY ELEMENTS TO BE CONSIDERED FOR LOGISTICS IN MANY COUNTRIES ARE
- Road infrastructure
- Site accessibility
- Types and quality of available transport

These elements are major determinants of the supply delivery strategy: trucks, boats, motorcycles, bicycles, camels and people have all been used to transport supplies, depending on the country context and community accessibility.

There are several ways to estimate the number of supplies needed. Estimations vary based on the size of the population, the target group, the strategy chosen and the rates of loss or margins of error being used for each intervention.

Rate of loss calculations differ for vaccines and for LLINs. For vaccines, it is typically factored into the needs estimate, whereas for nets, a margin of error is used. The rate of loss applied to vaccine is higher than the margin of error applied to nets because nets

Photo: IFRC

Using indelible markers on the thumb-nail of a mother is an effective way to keep track of campaign interventions received.

are far more expensive and resources are finite. For vaccines, a certain level of wastage is unavoidable due to non-utilization of the entire vial. For LLINs, this type of wastage is not a concern.

Determination of the number of supplies needed will only be as accurate as population estimates. The success of the campaign depends on obtaining the most recent and complete statistics possible from the outset of the planning period.

Please refer to the Resource Number 8: Measles SIAs Field Guide (2006) for more guidance in estimating the needs for measles vaccination campaigns.

Resources

5 *Operational Integration of Key Child Survival Interventions: A Guide for District Health Management Teams.* PDF. World Health Organization AFRO Region. Draft: 2005.

8 *Measles SIAs Field Guide.* PDF. WHO/AFRO. Revised: January 2006.

26 *WHO website for estimating vaccine annual needs:* http://www.who.int/immunization_delivery/systems_policy/logistics_annual_needs/en/index.html.

4.4. Calculating LLIN requirements

LLIN needs estimations are based on the distribution strategy and the target population, both of which should be clearly described in the POA.

The easiest method for calculating LLIN needs is a strategy of one net per child, but for many countries resources do not permit this strategy. Regardless of the strategy chosen and the subsequent formula used, always factor in a margin of error in order to avoid stock-outs.

For the strategy of one net per child, the formula would be:

Estimated number of LLINs =
Total target group + 10% margin of error

The WHO-recommended strategy that is widely implemented for integrated campaigns is that of one net per child to a maximum of two per mother.

In order to calculate net needs for this strategy, one formula is as follows:

Estimated number of LLINs =
Total number of under-5's ÷ (1.3) + 10%

In the equation, 1.3 is the average number of children sleeping under nets (from estimations of the Togo, Mozambique, and Niger campaigns), and 10% is an added margin of error.

Resources

27 *Strategic Framework for Integrating Additional Child Survival Interventions with Immunization in the African Region.* PDF. WHO/AFRO. August 2006.

Calculating needs for indelible ink markers

Many countries choose to use indelible markers on the thumb nails of mothers and/or children to prevent caregivers from returning for additional nets and the risk of re-vaccinating children or giving multiple doses of other interventions.

Indelible ink marking can also be useful for monitoring of missed children during supervision visits and for the immediate post-campaign evaluation.

It is difficult to calculate needs for indelible ink markers, as there are quality, user and environmental elements to consider. Most indelible ink markers are said to mark 500 nails, but when caps are not put on immediately after use or when used in dry climates, the total is less.

Experience has shown that one marker generally makes between 250 and 375 marks. A method for calculation that includes a margin of error for "loss" is shown:

Total LLINs to be distributed ÷ 125 = total markers + 3% buffer

i.e., one marker can mark the distribution of 125 nets, which could be the minimum of 250 marks (mother and 1 child) or the maximum of 375 marks (mother and 2 children).

For example:
Total number of nets to be distributed
2,236,532 ÷ 125 =17,892
+ (3% of 2,236,532) = 537
Total number of markers required =18,427

Resources

28 *Instructions for the proper use of the indelible markers.* MS Word. January 2007.

LOGISTICS

Storage and transport of markers

Markers require storage space that is dry and not in direct sunlight. Excessively hot storage spaces will dry out the markers out more quickly. Markers should not be stored in homes or where people are living or sleeping, as large quantities of markers emit powerful fumes.

In many integrated campaigns, the transport of markers is linked to the transport of LLINs. Using the calculations above, an estimate should be made of the number of markers for a given site depending on the number of nets being shipped. Markers can be packaged into boxes or bags and labeled by drop off point. They should be loaded on the trucks with the nets and included in the waybills accompanying the shipments to the drop off points. The consignee and quantity should be clearly marked on each well-sealed package.

4.5. Centralized versus decentralized LLIN logistics

Logistics is essentially about getting the supplies down the supply chain, from the supplier (top of the chain) to the end user (bottom of the supply chain). The choice of the in-country logistics strategy depends on many factors (such as road infrastructure, site accessibility and the type and quality of transport available). There is no formula that can be applied successfully for all campaigns, but most countries choose either a centralized or decentralized approach.

- Centralized logistics involves first shipping containers of LLINs to a central warehouse in the country, then dividing the supplies up and shipping them out to the various regions or districts.

Photo: IFRC

Storing LLIN bundles at a secure warehouse in Niamey, Niger before transporting the nets for distribution to remote campaign sites.

- Decentralized logistics ships entire containers of LLINs directly to the region or district, omitting the central warehouse.

The first step in deciding on a logistics strategy is to analyze all the possible options (comparing them in a table with pros and cons) and decide on the most practical and efficient strategy, given the local conditions and constraints.

What is clear about LLIN logistics is that the approach will vary from country to country and will need to be adapted to local conditions and constraints. Costs will vary widely. Lessons are being learned regarding logistics with each new campaign.

Centralized LLIN Logistics

One of the greatest advantages of a centralized transport or delivery operation is that it allows for overall control and maximum security for the nets.

Country examples

Niger:

A centralized approach worked very well and was also very cost-efficient. In Niger, 2 million nets were received in 46 containers of 40 feet high. Niger, being land-locked, shipped the containers from the factory to the port of Cotonou (Benin) and then transported them by road through Benin to Niamey. Bales were off-loaded into a central warehouse in Niamey. Before the arrival of the nets, a call for tenders was issued and a transporter was selected to deliver the bales from the warehouse to each district. Micro-planning specific to LLINs was undertaken at the district level, determining the number of nets to be delivered to each of the districts (the micro-planning also required the districts to secure temporary storage space, which has proven relatively easy to find and, in most cases, at no cost).

The logistics sub-committee, with support from a logistics consultant, worked with the selected transporter to develop a precise transport plan to the districts, including routes that optimized truck capacity and efficiency (to save time and reduce distance), and a dispatch plan with a precise calendar that detailed truck loading schedules, rotations and re-loading. The transport operation involved 20,000 bales traveling to 42 districts with 12 semi-trailers in 18 consecutive days. The entire operation covered over 32,000km (the furthest districts were 1,600km from Niamey) at a cost of US$0.06 per LLIN paid to the transporter. Throughout the operation total control was maintained on deliveries to each district who received the exact number of nets as determined during the micro-planning.

Togo:

In 2004, a similar strategy to Niger was used in Togo, with the difference being that bales were not off-loaded into a warehouse prior to transport to the districts. Instead, negotiations took place with the port of Lome authorities to position the containers in an area of the port where trucks could enter for direct loading of the containers. As in Niger, there was a reliable transporter and dispatch teams worked in parallel to load two trucks simultaneously and issue the waybills. All details of the whole operation were planned in advance. In total, 735,000 nets (17 containers) were delivered to 35 districts in 7 days with 6 semi-trailers at a total cost of US$0.08 per LLIN.

Rwanda:

The delivery of 1.3 million LLINs was done in three stages using the Population Services International (PSI) central warehouse.

> Stage 1: from the PSI central warehouse to the district levels | Stage 2: from districts to health centers | Stage 3: from health centers to mobile sites

At each stage, PSI turned over ownership of the LLINs to the MOH at sites pre-determined in the national distribution plan. Stock delivery and reception forms were signed and stamped by PSI and MOH at each level to counter-insure accountability for the safe transport and storage of nets.

Decentralized LLIN logistics

The key concept in decentralized logistics is that the operative unit is an entire container, not a bale or individual net. It is important to consider the container size, for example a 20 foot container can take approximately 20,000 nets, and a 40 foot container about 40,000 nets.

> In Zambia, the logistics team worked out how many nets were required at each district, and then shipped containers directly to the districts, leaving out the central warehouse. Before ordering the nets, PATH established secure drop-off points for each container at district levels, usually District Health Offices, and organized for containers to be directly delivered at these points.

One benefit of decentralized logistics is the added security—nets are secure at least until the container is opened. However, this strategy does require conducting a thorough needs assessment and accurate micro-planning for the district at the provincial or regional levels before ordering supplies.

Data collected by PATH in Zambia shows there are no additional costs for having different destinations for different containers because they are sent on separate trucks anyway. In fact, some data shows that this approach often results in relatively low in-country transport costs (about US$0.50 per LLIN), lower storage costs and faster availability for usage (1-2 weeks versus 4-8 weeks from the border), and a better insured product further to the district level.

In 2007, PATH used a decentralized approach to transport 1 million World Bank LLINs. According to PATH, the World Bank estimated that this method saved $250,000. This decentralized strategy worked well in Zambia, but this method must be carefully considered given geographical and other country-specific constraints.

Resources

29 *Analysis of Distribution Costs.* MS Excel. PATH, MACEPA obtained from Paul Libiszowski.

30 *Overall Logistics budgets-Comparisons of Selected Countries.* MS Excel. Obtained from Alain Daudrumez, logistics consultant.

Some of the issues to consider in the decision of whether to use a decentralized approach include:

- The road infrastructure must allow semi-trailer trucks to reach as far down as the district level (this was not possible in Equatorial Guinea or Madagascar).
- Buy either the containers (end-usage containers, at a cost) or negotiate a longer-than-normal retention period and pay a deposit for each container taken out of the port or customs-bonded area.
- Heavy equipment (a crane or forklift) is needed to off-load a 40 foot container from a flat-bed truck and is usually very difficult to find at district level (and if found, it implies a cost).
- Returning containers, if necessary, requires a major pick-up operation of containers scattered all over the country.
- Control and monitoring of stock appears more problematic when container drop-off points are serving more than one district.

4.6. Monitoring and control of logistics

Whether a country opts for centralized or decentralized logistics, monitoring and control of stock are important elements to consider.

Monitoring of stock: waybills and stock books

Monitoring of stock begins with detailed planning and effective supports and tools. When campaign supplies are moved from one level to another, they must be tracked systematically and recorded at all points.

Waybills: Waybills are produced to monitor stock sent out and stock received. Waybills are typically produced with four copies for each delivery. One waybill is usually distributed in the following way:

1. The first copy goes to the transporter
2. The second copy stays at the warehouse where the nets are stored
3. The third copy is sent to the receiving warehouse/recipient
4. The forth copy is kept by those responsible for the logistics operation.

By issuing a waybill for each delivery, stocks are tracked down to each district or sub-district drop-off point.

Warehouse journals and stock books: Warehouse journals and stock books are used to monitor supplies in and out of central, regional, or district warehouses. The number of journals or books required is equal to the number of facilities being used for warehousing.

Equipment for campaigns should be recorded and tracked separately from routine supplies. Sufficient stock and storage of campaign supplies are required to avoid stock-outs or "borrowing" from routine stocks for use during the campaign.

Resources

31 *Stock control examples from Sierra Leone.* MS Excel. Example of waybill, stock report, inbound and outbound stock ledgers and goods received note.

8 *Measles SIAs Field Guide.* PDF. WHO/AFRO. Revised: January 2006.

Photo: IFRC

Unloading LLINs to secure warehouse in Niamey, Niger

For vaccine supplies, the same system for routine immunization can be used but additional funding for transport (additional cold chain equipment and staff) is needed to ensure quality of transport and adherence to cold chain requirements.

Identification and training of conveyors

In centralized net logistics operations, it can be helpful to have conveyors accompany the trucks carrying the supplies in order to monitor and control loading, transport and off-loading.

Conveyors are usually trained in stock management, including the use of waybills. Roles and responsibilities are clearly defined, and it is helpful to provide conveyors with telephone credit and numbers to call in case of major problems.

In Niger, dispatch teams followed the transport plan meticulously, loading the trucks as scheduled and preparing waybills. A trained conveyor traveled on each truck and was responsible for security, getting the waybills signed at each destination, and returning to the central warehouse.

Similar strategies were used in Togo, Mozambique and Sierra Leone, and have been found to improve the control and monitoring of supplies.

In Rwanda, PSI assigned a national staff person or a hired temporary consultant to accompany every vehicle during deliveries. These staff and temporaries were responsible for the safe arrival and correct accounting of LLIN deliveries.

Staff was trained by National Malaria Control Program (NMCP) on the national distribution plan, the stock delivery and reception forms, and the management of allocated transport budget.

Resources

32 *Conveyor Training Outline.* MS Word.

33 *Terms of Reference for Conveyors.* MS Word.

District-level supervision of supplies

There is an increased security risk from the time supplies (especially LLINs, due to their value) arrive at the district level to the time they are distributed to the target population.

> In order to help reduce the possibilities for net leakage, district level supervision of supplies should be formalized and systematic.

In Rwanda, PSI developed a unique system to supervise LLIN stock. Team leaders were identified and charged with the distribution in each of the five provinces. Each team leader supervised a team of district-level supervisors who managed distribution in their zones or districts.

Teams were coordinated by one central program manager and performed spot checks on supplies, tracked movements of nets and generally monitored leakage and security at the lower levels of the supply chain.

Resources

34 *Insecticide Treated Nets and Vitamin A Supplementation: An integrated approach to control malaria and micronutrient deficiency (Literature Review Paper and Malawi Case Study).* PDF. Prepared for The Micronutrient Initiative by Dr. Mark Young, Health Advisor; Dr. Peter Berti, Nutrition Advisor; Sian Fitzgerald, Executive Director, PATH Canada. April 2000.

5 *Operational Integration of Key Child Survival Interventions: A Guide for District Health Management Teams.* PDF. WHO/AFRO. Draft: 2005.

4.7. Call for tenders and contracting transporters

Successful transportation of campaign supplies for all inteventions is essential for an effective integrated campaign. Resources must be sufficient at the end of the supply chain, and the choice of transporter(s) is crucial to ensure the timely delivery of supplies.

Below are several suggestions to improve the planning for the transportation of supplies:

- Maintain an up-to-date inventory of existing transportation methods and providers.
- Examine the possibility of using public or private sector partners for transportation, including assessment of security risks.
- Examine distances covered during a normal supply circuit (e.g., the provision of routine service supplies from medical stores to district or community level health facilities). This information can be used as a base for estimating costs and timelines for delivery of all supplies to (1) interim storage areas and (2) actual campaign sites.
- Prepare an integrated transport plan and budget, based on district-level information. As mentioned earlier, it is typical for LLINs to be transported and stored separately from other intervention supplies until the district level. From the district level to campaign sites, all intervention supplies are moved at the same time.
- Devise a precise transport plan to the districts: 1) Define transport routes/axes in order to optimize truck capacity and take best advantage of the road network, 2) Define a dispatch plan with a precise calendar
- Determine truck loading schedules, rotations and re-loading.

Resources

35 *Call for Tenders Transport, example from Mali.* PDF. October 2007.

36 *IFRC Log Purchase Request for Quotation.* MS Word. Example facsimile.

37 *Request for Quotation, explanation.* MS Word.

Calls for tenders

The process through which a transport company is hired should be clear and transparent as there are normally major financial implications involved with large-scale logistics operations.

Using an inventory of existing transportation providers it is helpful to set up visits or meetings to discuss the scope of work in order to identify transport companies that have the capacity to bid for the contract(s).

In a transparent procedure, calls for tenders should be sent out with deadlines for submission of bids clearly stated. When received, the bids should be opened by a committee (usually members of the logistics sub-committee who represent different partner organizations) in a closed session. Bids should be evaluated and the best offer accepted through a group decision. All companies that offered submissions should be informed in writing as to the decision of the reviewing group.

Resources

38 *Example Transport Contract from Rwanda.* MS Word.

39 *Example Transport Contract from Sierra Leone.* MS Word.

CONTRACTING TRANSPORTERS: NOTES FROM EXPERIENCE

The best offer is not always the least expensive—consider monitoring and control as key elements for a good service, which sometimes require a slightly higher payment.

In some countries, it may be advisable (or even necessary) to contract more than one transport organization in order to ensure supplies are pre-positioned in a timely manner before the campaign.

Contracting a transporter that is going to sub-contract the work should be carefully reviewed—in past campaigns, there have been problems with coordination between the two parties, leading to delays in the delivery of supplies. In some countries there may not be a sufficient number of transport companies or vehicles.

For example, Rwanda saw challenges in contracting quality transport and vehicles, as there were other activities in the country at the same time as the campaign.

Contracting transporters

The logistics sub-committee members discuss how to contract transporters and through which channels. Sometimes, donors or partners who are funding the net portion of the logistics independently (given enormous costs) may contract transporters through their own means.

Regardless of who is going to be in charge of the contracting, the draft contract should be reviewed and revised by all members of the logistics sub-committee as well as a legal expert to ensure that all necessary clauses have been included.

To avoid delays of LLIN arrival, PSI in Rwanda included a clause in the transporter contract that in the event of any breakdown of a vehicle, the owner was responsible for fixing the vehicle or finding a replacement. If the owner was not able to fix/replace the vehicle, PSI had backup companies on call to fill in (these were transporters who had not won the initial bid, but who agreed to serve as alternatives).

Resources

40 *Integrated Measles Follow-up (Measles, OPV, vitamin A, and LLINs): Training and Field Guide*. MS Word. Kenya National Expanded Programme on Immunization (KEPI). The Republic of Kenya MOH, WHO & UNICEF, 2006.

11 *The Global Fund Niger Project: Integrated Polio Vaccination and Mosquito Net Distribution*. PDF. 19-24 December 2005. International Federation of Red Cross and Red Crescent Societies. Annual Report, August, 2006.

4.8. Minimizing LLIN leakage

While many factors can cause LLIN leakage, typically it occurs due to poorly monitored logistics and/or corruption. Leakage can occur during transportation, warehousing and pre-positioning of the nets (i.e., getting the nets to the storage facilities in advance of the campaign). Lack of security resources can also lead to leakage, especially during storage.

In Rwanda, padlocks were purchased and given to district and health center directors for safer storage of LLINs before the start of the campaign.

A number of precautions can be implemented to prevent leakage, including:

- Improved security during transport, through the use of conveyors who travel with the trucks to the drop-off points.

- Improved security during storage through the use of guards. Security needs vary, and it may be important to consider whether the nets will be stored in urban or rural locations. In Rwanda, local defense forces were hired to safeguard stock at each storage point.
- Decrease the amount of time LLINs are kept in district-level storage spaces, but still have security guards monitoring the storage sites.
- Regular supervision at facilities where nets are being warehoused, loaded and sent to lower points in the supply chain.
- Use proper packaging and marking of nets. LLIN packaging should contain warnings in large print, such as "NOT FOR RESALE." In addition, LLINs can be given to the caregivers with the packaging already torn open to decrease resale value.
- Conduct market surveys during and after the campaign to assess the availability of leaked campaign nets.

4.9. Logistics supervision and monitoring

The logistics operation requires careful attention to supervision and monitoring, starting with micro-planning. The logistics sub-committee should plan to make regular visits to review activities in the district level in order to ascertain that logistical elements are in place so supplies can be distributed from the central level.

Visits by the logoistcs team can also be used to assess the state of preparedness of districts to implement campaign activities.

Timing of visits by the logistics team is important.

There are four potentially crucial periods:

1. During micro-planning
2. 1-2 months before campaign supplies arrive at the district or community level (earlier if the first visit highlighted many issues to be followed up)
3. During the shipping operation (where necessary), which provides an opportunity to also follow-up supplies for the other interventions such as vaccines, cold chain management etc.
4. Post-distribution, to research lessons learned, collect documentation and tally sheets and examine the utilization of supplies

Resources

41 *Implementation Supervisory Checklist. Example from Liberia.* MS Word.

Terms of reference should be developed for all visits, and should include goals of supervision and monitoring and specific measurable outcomes where relevant.

Reports should be written after each trip, and provided to the sub-committees, with highlights of key areas for attention.

4.10. Evaluating logistics activities

For LLINs, much of the work of the logistics sub-committee "ends" once the nets have been dispatched from the central warehouse (assuming centralized logistics) and become the responsibility of the District Health Management Team (DHMT) or campaign site MOH staff.

LOGISTICS

Workers contracted from Khartoum transport LLINs to campaign sites in Southern Sudan.

Photo: © Jenn Warren/PSI Sudan. www.jennwarren.net

An evaluation of the logistics operation should be planned just prior to and during the week of the campaign with the following objectives:

1. Verifying delivery of the correct quantities of LLINs to the districts.

2. Verifying storage and security at the different fixed campaign sites.

3. Verifying completed stock and waybill documentation during the distribution process.

4. Providing assistance for any last minute logistic problems prior to the start of the campaign.

The logistics sub-committee is usually required to produce a final report for submission to the NCC or MOH campaign coordinating body. This is to ensure transparency among partners and, importantly, demonstrate a "team" approach for all logistics activities.

Some of the general areas that are covered in logistics final reports include:

- Customs clearing and preferential rates
- How, through who and when did customs clearances take place?
- In terms of customs/handling fees at selected port of entry, what preferential rates were obtained and how?

5. Communication

Communication is a vital activity before, during, and after a campaign, with key activities for national and international partners. As we have seen, coordination is vital at each stage of the campaign—and communication among partners is vital to ensure that messages are clear, cohesive, and supportive of MOH efforts. A chronogram of communication activities can be found in Resource number 10 (English and French) which is also included at the end of this document.

The LLIN Integration Workstream partnership has a sub-committee of communicators who are dedicated to ensuring coordination both among international partners and between and in-country and international partners (notably the MOH). This sub-committee will help identify priority countries each year and work to coordinate media and advocacy at the global and national levels.

> Communication comes in a variety of forms, from broadcasting messages to encouraging turnout, training health personnel, delivering LLIN-use messages, facilitating VIP and media visits, and assuring international press coverage.

Sometimes the different types of campaign communication can overlap, but generally communication forms fall into one of three categories:

1. Advocacy for LLIN campaigns describes the "activities designed to place child survival on the political and development agenda, foster political will, increase financial and other resources on a sustainable basis, and hold authorities accountable to make sure pledges are fulfilled and results are achieved."[1] Advocacy is done in-country, engaging political leaders and media in the campaign, as well as at an international level to promote in-country activities and raise further support (often financial) for the planned activities.

2. Social mobilization is the process of assembling "societal and personal influences with the aim of prompting individual and family action.[1]" In the case of integrated campaigns, this means mobilizing communities to take full advantage of campaign and post-campaign interventions.

3. Behavior change communication (BCC) aims to foster positive behavior; promote and sustain individual, community, and societal behavior change; and maintain appropriate behavior. Behavior change communication (BCC) is part of an integrated, multilevel, interactive process with communities aimed at developing tailored messages and approaches using a variety of communication channels.[2]

Resources

1 WHO Stop TB Partnership, 2006. Advocacy, Communication and Social Mobilization to Fight TB. A 10-year framework for action. WHO Library Cataloguing-in-Publication Data.

2 www.fhi.org - Behavior Change Communication and Reproductive Health in Reproductive Health Publications.

[1] WHO Stop TB Partnership, 2006. Advocacy, Communication and Social Mobilization to Fight TB. A 10-year framework for action. WHO Library Cataloguing-in-Publication Data.

[2] www.fhi.org - Behavior Change Communication and Reproductive Health in Reproductive Health Publications.

At the international level, advocacy is an important tool for raising awareness and funding for campaign activities. International organizations work to ensure publicity for the campaign by generating press coverage, arranging appearances/interviews with influential individuals, and mobilizing groups and communities to advocate for and support campaigns. International partners work through a variety of channels, and messages are tailored to reach specific groups to generate awareness.

At the national level, social mobilization is a vital activity for ensuring that communities and caregivers are made aware of the campaign (dates, venues, targets and how to proceed), understand the benefits for children's health, and understand their responsibility to bring children to campaign sites to receive interventions. The goal of communication is to mobilize relevant sectors of society from the national level to the community level to actively participate in campaign preparation and implementation. Communication serves to inform and motivate families to take full advantage of interventions during and after the campaign.

Most countries have established methods of communication for mobilizing communities and partners. The "Communication for Polio Eradication and Routine Immunization" document offers specific suggestions for special groups, border areas and how to work with different communication channels.

Community education campaigns involving teachers, village leaders, children, parents and volunteers providing education, are often a reported source of prevention and treatment messages.

Lessons learned are:

- Outreach schemes using community members for information and message dissemination have been relatively successful when proper materials and training have been provided for the participating community members.

Resources

42 *Kenya Red Cross Society Community Mobilization Guide.* MS Word. From "Community Mobilizer Manual for Integrated Measles Campaigns, Kenya".

8 *Measles SIAs Field Guide.* PDF. WHO/AFRO. Revised: January 2006.

40 *Integrated Measles Follow-up (Measles, OPV, vitamin A, and LLINs): Training and Field Guide.* MS Word. Kenya National Expanded Programme on Immunization (KEPI). The Republic of Kenya MOH, WHO & UNICEF, 2006.

43 *Communication for Polio Eradication and Routine Immunization. Checklists and easy reference guides.* PDF. WHO, UNICEF, USAID (BASICS II and CHANGE projects), 2002.

- Small groups of committed individuals can plan and execute a project as well as, if not better than, a large committee.

- When using volunteers in the community it is essential to sustain interest and ensure that relevant and achievable goals are set.

Community involvement and participation is important for every communication intervention. The community, in this sense, may include health workers, medical vendors, teachers, government officials, caregivers, people living in the village, etc., all of whom can provide invaluable insight to help make programs successful.

Mass media delivery of BCC messages can target caregivers and decision makers with messages about measles, malaria and other preventable childhood illnesses; interventions offered to prevent childhood illness and death; attending integrated campaigns with children; and understanding that all services provided during the campaign will be free of charge.

Photo: © Jenn Warren/PSI Sudan. www.jennwarren.net

Elderly women receive their pre-registration vouchers and communication materials during an integrated campaign, as part of the Government of Southern Sudan, Ministry of Health and PSI initiative to combat malaria.

Local and mass media campaigns have been used to promote increased and proper use of LLINs.

Some critical lessons learned include:

- 'Shock' messages around malaria are not well received.
- In all countries where campaigns ran, there was an increase in awareness of malaria and the importance of using LLINs. This often led to an increase in local net sales.
- Continuous, repetitive information is important for the accurate transmission and reception of messages.
- Messages tailored to a country or region are preferable and more effective to holistic pan-African approaches.
- Generic mass media campaigns need clear branding of messages to ensure awareness-raising of appropriate products.

Once the delivery of LLINs has been completed, national partners must continue to promote and monitor the correct and consistent use of LLINs.

> Experience has shown that the use of LLINs tends to plateau at around 50-60% post campaign, even with much higher net coverage among households.

Partners should include "Hang-Up" strategies and BCC efforts into campaign plans in order to encourage the correct and consistent use of LLINs, regardless of the season. Additional messages should promote continued routine vaccination and antenatal clinic attendance for both pregnant women and children under-five years of age.

Interpersonal communication is considered a good method of promoting malaria prevention and treatment.

Interpersonal communication targeting key stakeholders can be effective in improving treatment-seeking behavior.

House-to-house strategies are effective in increasing appropriate use of LLINs, as some people have difficulty hanging the nets and benefit from a demonstration.

Advocacy at the international level

At the international level, key partners to the MOH will undertake advocacy activities to raise awareness of the campaign and its organization at a global level. Advocacy at the international level occurs through press releases, media events and other publicity and is most often directed towards increasing awareness and raising funds for future campaigns in other countries.

Some points for consideration include:

- Donors' advocacy plans should be shared with the MOH early in the planning process to ensure effective coordination.
- It is more effective to focus initial approaches with the media around efforts of child survival, rather than on individual interventions, such as malaria. Child survival also helps satisfy donors' needs for focusing on the most vulnerable populations.
- Attaching campaign efforts to attainment of broader development goals, such as the MDGs or the Abuja targets, will help develop interest in the activity.
- Integration and partnership are key elements of advocacy, and can be used to generate interest on a broad scale.
- Immediately prior to and during the campaign, MOH and campaign organizers will be committed to their workplans and may not be able to provide full assistance to distinguished visitors and the media. Identifying one or more in-country communication facilitators who can be on the ground early to help prepare site visits, do social logistics, and assist guests can be very useful.
- Broader-scale advocacy focused on political leadership should be considered. For example, a campaign could collect signatures of all those who receive interventions to save their child's life. These signatures can then be used to petition the G-8 and individual governments.
- Begin communication planning early, through the communication sub-committee.

It is important for partners to coordinate outreach to the press, ensure cohesive and consistent messaging, and promote the MOH and partnerships above their own organizations.

While it is understood that certain partners need notoriety for their specific organization or campaign support mechanism, this should be done as part of an overall strategy to promote the agreed on objectives and messages of the partners for the campaign.

Planning for Distinguished Visitors

Often, international organizations will bring high-level personalities (from government, sports, religious and other organizations) to see how a campaign is actually implemented, and thereby continue to advocate for integrated campaigns.

Helpful experiences for both international and national partners in terms of planning for visitors include:

- Plan early and set deadlines for announcements of arrivals to facilitate protocol issues (such as visa, use of VIP rooms and other services at airport, etc.), as well as meeting and activity planning.

- Plan for the launch to be one (or two) days before the start of the campaign to allow for this event to be (a) used as a social mobilization activity and (b) attended by the high-level donors and visitors.

- Ensure that each organization bringing visitors is "attached" to an in-country host organization or that a central planning person is identified to facilitate planning and travel arrangements.

- A central planning person or a small group of individuals representing organizations with visitors coming to a country should draft itineraries for all arriving groups. Working together will ensure no overlap on field trips planned to avoid overcrowding at sites.

- International partners should be asked whether their preference is to go to the field (and if so, for how long and how far) or if they prefer to stay around the capital city. Planning should be done accordingly.

- For site visits, ensure that the MOH provides a list of appropriate sites and that the site supervisor has been informed of the arrival of visitors.

- Visitors should receive a briefing that explains what they are going to see, how the campaign was planned, the interventions to be received and what they are for, and the importance of the campaign for child health. In addition, visitors should receive briefing documents, including safety advice, key contact numbers, restaurant options and a list of "places to visit" during off-time.

Photo: © Benoist Carpentier. www.bcarpentier.com

In Benin, the king of the region of Ouidah attended the integrated campaign in his region, drawing attention and crowds.

- If possible, a reception can be planned for international partners and donors, and hosted by the MOH and in-country partners.

- When planning for visitors, it is important to balance site visits with other cultural activities, such as museum and market visits. If visitors are coming from long distances, be sure to allocate rest times in the first days.

- Often organizations will wish to arrange "high-level" protocol visits for their most important visitors. If possible, organizations should arrange together to meet with key individuals, such as the Minister of Health or the President of the country, to minimize the number of requests for visits.

Photo: © Benoist Carpentier. www.bcarpentier.com

From left to right, His Honorable Marc Ravalomanana, president of Madagascar, Laéticia Halliday, UNICEF ambassador and Yvonne Chaka Chaka, South African singer, UNICEF ambassador and RBM goodwill ambassador at the launch of the Madagascar integrated campaign.

- When organizing for vehicle rentals, make sure that there are functioning safety belts and that the car and driver are insured.

The campaign is the key activity and visitor delegations should not take away from the ongoing work of implementing the campaign. The MOH and in-country partners need to set limits on how much can be asked of them to maintain focus on the activities at hand. International partners need to be sensitive to the amount of work and planning required for implementation of campaigns of this magnitude. Visitors are important, but they also require work: planning needs to begin early.

Advocacy at the national level

It is important for countries to promote campaign activities and ensure that there is understanding and support for the campaign at the highest national levels.

Advocacy aims to gain support for and ensure visibility of the campaign.

Advocacy at the national level is often part of the work of a communication or social mobilization sub-committee, which reports regularly to the technical sub-committee and/or the NCC. If there is not already a functioning committee, efforts should be made to ask the MOH to mobilize partners—most partner organizations have a communication and/or social mobilization focal point who can participate.

Resources

43 *Communication for Polio Eradication and Routine Immunization. Checklists and easy reference guides.* PDF. WHO, UNICEF, USAID (BASICS II and CHANGE projects), 2002.

44 *Advocacy Planning Timeline.* MS Word. (Also presented in Annex 2 at the end of thisdoucment).

45 *Developing An Advocacy Strategy.* PDF.. Adapted from the brief "Developing An Advocacy Strategy," Washington, DC: Population Reference Bureau, 2007. In English and French.

46 *An Introduction to Advocacy - Training Guide.* PDF. Support for Analysis and Research in Africa (SARA), Health and Human Resources Analysis in Africa (HHRAA), USAID Bureau for Africa, Office of Sustainable Development, 1997.

47 *Advocacy: A Practical Guide with Polio Eradication as a Case Study.* PDF. Geneva: WHO, 1999.

In Madagascar, a communication committee was formed prior to the campaign, led by the MOH and UNICEF communication teams, to prepare logos, posters, banners and radio and TV spots for the bi-annual mother and child health weeks. The social mobilization sub-committee for the campaign was able to capitalize on already prepared materials to adapt and diffuse for the campaign.

The communication or social mobilization sub-committee usually drafts a calendar of key activities in-country that can be used to mobilize the population to attend campaign sites. Activities may include radio or television advertisements featuring key figures in the country (such as high level political figures, musicians or other cultural figures), official ceremonies to handover the campaign supplies from partners to the government, and newspaper articles discussing the benefits of the campaign and state of planning. Press conferences and the national launch, which can be organized once key visitors have arrived in the country, are important activities for publicity and high-level endorsement of the campaign.

Advocacy activities must be included from the outset in the social mobilization budget to avoid a last minute search for funding for key events.

At national level, some points for consideration in terms of advocacy include:

Coordination with partners

- Copies of the communication and advocacy plans are usually shared with international partners and donors, so they are aware of the planned activities and they can generate broader interest at a global or international level.

- Existing communication and social mobilization materials and interventions can often be used and adapted.

- In Madagascar, there are more than 30 NGOs already active in community level communication around malaria prevention, via the work of more than 5,000 community agents.

- Organize an initial briefing or reception for in-country and international partners to provide information about activities and vaccination sites. If the briefing is before the campaign begins, put together a rolling slideshow of photos showing the steps that have been taken and the various activities that are complete. Prepare briefing packages for visitors, media and observers to take with them and read.

- Organize a time for visitors, media and technical

observers to debrief about their visit, what they have seen and allow them to discuss their visit. If this proves difficult given arrival and departure dates and times, assign focal point in-country to be responsible for collecting and collating written comments into a brief report.

- Advocacy should focus on ensuring understanding of the purpose of the campaign (rather than just time and place) and what the campaign's impact will be on the health of children in the country.

Press and media relations

- Obtain a letter from the country president or prime minister and send it to major media outlets four to six months before the campaign, who will usually be interested in visiting the campaign on a presidential invitation.

- Send broadcast media footage (such as film) to partners (national and international) ahead of time for production of mass media materials.

- Plan for the possibility of negative rumors being published or spread, and have a shared strategy ready for roll-out to counter such rumors. Identify individuals who will perform as spokespeople in charge of positive and negative communication.

- Ensure that spokespeople are in contact with one another and are passing similar messages. Preparing a talking points document with agreed messages and statements is helpful to make sure that messages are consistent and effective for the audience and stakeholders.

- Avoid discussion of individual interventions, but focus on the integrated campaign and its impact on improving overall child survival.

- Put the MOH at the front and center of all outreach to the press. Work closely with their communication division and protocol offices to ensure visibility and MOH-led decisions around all communication activities.

- Involve media such as television and radio early in the campaign process in order for the media to get a full picture of what is going on. Often, media are telling a story without understanding the background of it.

- Media tools should involve local people and should be done at regional and district levels to be sure to reach the targets. Video, photos and radio are very effective if the target population can identify with the content.

- Local journalists should be trained and briefed on the campaign. They should be encouraged to use their role to promote and support activities. Journalists should be encouraged to get in touch with doctors and community leaders to get better stories and to use these stories to mobilize support for the campaign, as well as to mobilize the population to participate.

- Regional journalist workshops can be very effective. Journalists can include prevention messages in their articles and reports, as well as indicate effective ways to get further information.

- Journalists should be encouraged to visit a village where a bed net campaign takes place.

- Post-campaign advocacy with the media can focus on follow-up, including the utilization of LLINs and continued promotion of routine vaccination and child health services.

Resources

48 *Mali Social Mobilization Sub-Committee Communication Plan.* MS Word. 2007.

Advocacy at the district Level

Advocacy at the district level is important for ensuring that every district health management team is informed about the campaign, is ready to support activities, and has the tools needed from the national and regional levels to effectively manage the process. The MOH at the regional or central level manages district level facilities who in turn manage health center staff. The MOH is normally in charge of informing district managers of both the campaign and expectations of health centers. District level managers need to inform and supervise health center and advance post participation in the campaign.

Advocacy at the district level focuses on prioritizing the campaign and its planning and implementation in the context of having numerous equally pressing priorities. When this is not done properly, time and resources may be lost. For example, in Mozambique in 2005, there were problems at the national level in terms of getting and maintaining the involvement of the key departments and individuals for campaign planning. A great deal of energy was expended at the national level, before recognizing that the district and provincial health authorities were already engaged. The Mozambique experience demonstrated that the work at the district level, where the campaign was to be implemented, was much more important to the success of the campaign than attempting to organize coordination meetings at national level, where the program was being planned.

Advocacy at the Regional Level

Advocacy at the regional level is important for ensuring, through follow-up and supervision, that each and every district health management team is informed of and supports the campaign. The regional MOH staff manages and supervises district level facility supervisors, who in turn manage health center and campaign site staff. The regional MOH should be in charge of informing district managers of the campaign and global MOH expectations of regions, districts and health centers.

Advocacy at the regional level needs to focus on prioritizing the campaign and its planning and implementation in the context of having numerous equally pressing priorities. When this is not done properly, time and resources may be lost (see example under "Advocacy at the District Level"). The regional level, given a linking role between the district and national levels, has an important role to play to engage both levels to work together for the common objectives that have been set.

5.1. Social mobilization

The WHO defines social mobilization as the "process of mobilizing all societal and personal influences with the aim of prompting individual and family action." In the case of integrated campaigns, this means mobilizing communities to take full advantage of campaign and post-campaign interventions.

> Social mobilization surrounding integrated campaigns can occur in a variety of ways and through a myriad of channels. The objectives of social mobilization efforts should be clearly identified in advance and agreed upon by all partners/stakeholders (including community representatives).

Social mobilization activities are an essential element to promote participation at the community level. Selection of communication channels and development of clear and simple messages that reflect the community context are key to ensuring community involvement in campaign activities. Often countries have a very good idea of what has worked or not worked in the past and communication plans can be developed based on lessons learned both in-country and internationally.

Social mobilization must be context specific: what works in one country, one part of a country, or one community may not work (or may need to be adapted to work) in another.

Photo: IFRC

A volunteer in Bamako, Mali marks the gate to indicate that the household has received a pre-campaign social mobilization visit.

Messages should be clear, simple and easy to understand, action-oriented, feasible and relevant, and sensitive to cultural, political, and religious beliefs. Equally important are decisions on key locations for undertaking social mobilization activities. Markets, religious gatherings, sporting events and other community activities offer situations where large groups of people can be sensitized with key messages at the same time.

Using local radio—and timing of radio messages to coincide with popular programs—can increase the reach of messages.

For social mobilization, audiences range from typical parents to local leaders to decision-makers. In asking members of various audiences to communicate with their peers, it is important to identify potential barriers to participation, possible elements of motivation or support, and the best channels for reaching the target groups.

In Mali, the social mobilization sub-committee identified various target groups to be involved in informing and motivating the population, including the media, religious leaders, community leaders, traditional communicators, NGOs and parents. Training and messaging focused on each of these groups specifically and what they could do to improve participation in the campaign at the community level. This type of training and messaging allows the target audience to identify the actions that can be taken to improve understanding of the intervention and promote attendance at vaccination sites.

General guidelines for effective messaging

For social mobilization activities, some general concepts to keep in mind are:

- Clear selection of communication channels and objectives will assist in ensuring that activities have the desired effect.

Resources

10 (a) *Chronogram Example – English.* MS Excel. (Also provided as Annex 1 at the end of this toolkit)

10 (b) *Chronogram Example – French.* MS Excel. (Also provided as Annex 1 at the end of this toolkit)

42 *Kenya Red Cross Society Community Mobilization Guide.* MS Word. From "Community Mobilizer Manual for Integrated Measles Campaigns, Kenya".

8 *Measles SIAs Field Guide.* PDF. WHO/AFRO. Revised: January 2006.

49 *La Campagne Intégrée de Vaccination Contre la Rougeole et la Poliomyélite, d'administration de Vitamine A, d'Albendazole et de Distribution de Moustiquaires Imprégnées d'Insecticide, du 13 au 19 décembre 2007.* MS PowerPoint. December 2007.

50 *The Roll Back Malaria Strategy for Improving Access to Treatment through Home Management of Malaria.* PDF. Roll Back Malaria Department, WHO, 2005.

51 *Participatory Malaria Prevention and Treatment Toolkit.* MS Word. UNICEF.

52 *A Participatory Communication Toolkit for Southern Sudan.* MS Word. PSI, 2008.

53 *Communication for Malaria. Abstract from Melanie Renshaw.* MS Word. UNICEF.

54 *Identifying the Routes of Malaria Transmission.* MS Word. PSI, 2008.

55 *Blocking the Routes of Malaria Transmission.* MS Word. PSI, 2008.

- Messages should be of two types:
  - Information, Education, Communication (IEC): Information about what services are being provided, the diseases that will be prevented, the dates and places of the campaign, any associated costs or rewards, etc.
  - Behavior Change Communication (BCC): Communication for proactive prevention such as receiving vaccinations and correctly using LLINs.

- Messages to the public should focus on the benefits of participating and what people have to do to get those benefits. Advertising a free LLIN may help motivate caregivers to attend the campaign.

- Clear messages stating who is included in the target population and why, and stressing the importance of protecting children under five years, may help the population understand that resources are limited and the campaign can only cover those most at-risk.

- Messages should specify the target age groups. Where possible, target age groups should be similar (e.g., children under five for vaccination and distribution of LLINs), though the interventions received will vary depending on actual age.

Countries that have expanded the target group have had more difficulty with management of sites.

- It is very important to pre-test all messages and supports before reproduction and dissemination. Pre-testing ensures that messages used are culturally appropriate and understandable, that they will reach the target populations and have an effect in terms of increased awareness and willingness to participate.

Resources

12 *Partnerships in Action: An Integrated Approach to Combining a Measles Campaign with a Bed Net, Vitamin A, and Mebendazole Campaign in Zambia (Malaria Case Study).* PDF. American Red Cross International Services and CORE, July 2004.

34 *Insecticide Treated Nets and Vitamin A Supplementation: An integrated approach to control malaria and micronutrient deficiency (Literature Review Paper and Malawi Case Study).* PDF. Prepared for The Micronutrient Initiative by Dr. Mark Young, Health Advisor; Dr. Peter Berti, Nutrition Advisor; Sian Fitzgerald, Executive Director, PATH Canada. April 2000.

56 *Saving Young Lives – Ghana's Public-Private Partnerships & Integrated Child Health Campaign (November 1-5, 2006).* MS Word. Various partners, 2006.

50 *The Roll Back Malaria Strategy for Improving Access to Treatment through Home Management of Malaria. PDF.* Roll Back Malaria Department, WHO, 2005.

40 *Integrated Measles Follow-up (Measles, OPV, vitamin A, and LLINs): Training and Field Guide.* MS Word. Kenya National Expanded Programme on Immunization (KEPI). The Republic of Kenya MOH, WHO & UNICEF, 2006.

3 *A Framework of Strategic Options for the Integrated Delivery of Insecticide-treated Nets and Immunization.* PDF. Prepared for the Global Malaria Programme, WHO, by Jayne Webster, TARGETS Consortium London School of Hygiene and Tropical Medicine, and Jenny Hill, Child and Reproductive Health Group Liverpool School of Tropical Medicine and Hygiene. Draft: May 2006.

- Local sayings may complement the messages being conveyed. Messages should be adapted to the local context. Where and when possible, use local celebrities to participate in messages for campaigns (posters, radio, TV etc.) Celebrities prove to be very effective in reaching large populations.

- In written materials, pictures, diagrams, and symbols should supplement any words to increase understanding.

- In populations where illiteracy is high, the most effective means for transferring messages are radio and interpersonal communication.

THE RADIO : National and community radio are very effective communication channels. Radio messages should be translated into two or three of the most spoken languages in a country. As much as possible it should be avoided to translate messages into all languages, as the time and financial expenditure is large for limited results.

Pre-campaign communication

Pre-campaign communication serves to sensitize the target community prior to the integrated campaign.

Messages are designed to inform the population of who the beneficiaries of the campaign are and why this group is being targeted, where and when the campaign will take place and what services will be provided.

In the pre-campaign period, it is important to ensure targeted messages about the importance of the campaign reach the most at-risk populations, to encourage these families to bring their children and receive all campaign interventions.

Hard-to-reach populations should be a primary focus as these communities are more likely to positively

Photo: © Benoist Carpentier. www.bcarpentier.com

A social mobilization campaign in where Red Cross volunteers go to remote parts of Madagascar, to ask parents to bring children to the integrated campaign.

respond to interpersonal communication, rather than mass media messaging.

Pre-campaign messaging should begin, through mass communication channels, at least four to six weeks before the start of the campaign. Interpersonal communication should begin one or two weeks before the campaign, targeting highly vulnerable and at-risk populations.

Communication during the campaign

During the campaign period, it is important to continue to reach communities with social mobilization messages.

While the campaign is being implemented, interpersonal communication can continue, specifically focused on families whose children have not yet received interventions.

Often, if interpersonal communication is used, these families are identified in the pre-campaign social mobilization period. It is effective to go directly to houses to discuss the importance of campaign interventions with caregivers.

In some cases, parents or caregivers have given permission to campaign staff to physically take the children to the campaign site.

Information for caregivers leaving the campaign site should include points on hanging LLINs, referring to an actual demonstration, and a focus on who should sleep under the net and the need to sleep under it all year round, regardless of mosquito density.

> Additional messages can focus on the importance of routine health services, including vaccination and supplementation schedules for children.

Posters, banners, net demonstrations and other visual supports that identify the campaign site and provide information on interventions should be in place prior to the campaign and remain in place during the implementation period.

Resources

40 *Integrated Measles Follow-up (Measles, OPV, vitamin A, and LLINs): Training and Field Guide.* MS Word. Kenya National Expanded Programme on Immunization (KEPI). The Republic of Kenya MOH, WHO & UNICEF, 2006.

57 *Togo Integrated Immunization Campaign. Coverage survey results.* MS PowerPoint from MIM conference, Cameroon 2005.

Post-campaign communication

Integrated campaigns involving LLINs require a significant component of behavior change communication (BCC) to ensure that people do hang and use the nets that they have received, and that these nets are used by the target groups. Interpersonal communication is often more effective in promoting change in behavior. Messages can be reinforced by mass media, visits by community volunteers, and/or health clinic staff.

For example, in most countries where Red Cross volunteers participated in social mobilization efforts, a period of 5–7 days immediately after the campaign is used to do a 'hang-up' campaign (to show beneficiaries how to properly use the nets).

- Hang-up activities involve house-to-house visits by community volunteers or community mobilization meetings with leaders and beneficiaries.
- Hang-up activities ideally take place immediately after the distribution of LLINs, but can also take place during targeted periods (such as the start of the rainy season) to increase utilization rates.

These types of community sensitization activities offer a good opportunity to inform pregnant women and families with children under-12 months of age about routine immunization, antenatal care, vitamin A supplementation and other health services.

Post-campaign visits provide an opportunity to follow-up with children who missed the campaign, and provide information on the importance of routine health services. Promotion of routine services is crucial to sustaining gains achieved during a campaign.

5.2. Behavior change communication

BCC aims to foster positive behavior change through increasing knowledge, encouraging dialogue, and promoting services. BCC is especially important in the case of LLINs because, although nets may be distributed, impact will be low unless caregivers exercise proper behaviors concerning net usage for the most vulnerable groups (i.e., proper hanging and sleeping under LLINs every night).

In terms of communication regarding integrated campaigns, it is important to ensure that community leaders are actively involved from the planning stages through the implementation of the campaign.

In Malawi, close ties between the community and partners, as well as a focus on the community level, assisted the community to readily adapt new practices.

Post-campaign BCC activities usually focus on improving the usage of nets and promoting routine immunization and ANC attendance.

In Togo and Sierra Leone, post-campaign coverage and utilization surveys showed a significant difference between net-hanging rates in houses that had received a visit from a community volunteer versus houses that had not received a visit. Anecdotal evidence from Equatorial Guinea indicates that houses generally did not install nets without the assistance of community volunteers.

Research is ongoing regarding the role of community volunteers for providing information and working

with services and communities to track defaulters and missed children and to improve routine vaccination completion rates.

Resources

26 *Strategic Framework for Integrating Additional Child Survival Interventions with Immunization in the African Region.* PDF. WHO/AFRO. August 2006.

58 *Madagascar SSME examples* (a) banner and (b) poster. JPEGs.

59 *Examples:* (a) Sierra Leone Flyer and (b) Kenya Poster. JPEGs.

Mass and interpersonal communication

There are two main ways that information can be communicated to the target population: mass communication and interpersonal communication.

Mass communication: involves messages passed through broadcast and print media. It generally includes radio, television, newspapers, magazines, posters, banners, and flyers.

Community radio has proven to be the most effective source of information for community members, while television is an expensive communication channel with limited reach outside urban areas. Posters and banners can be useful for identifying campaign distribution sites, especially in non-clinic sites in urban or very rural areas.

For integrated campaigns, key messages should be developed and pre-tested at the national level by members of the social mobilization sub-committee. Materials, once approved, should then be translated into selected major local languages (where appropriate and budget permitting) and sent to the regions and districts for dissemination.

District and community radio can target specific cultural and language groups, as well as groups with access barriers related to beliefs or misunderstandings about the interventions. Dissemination of messages in local languages ensures that the communication will reach even those who do not speak the official languages of the country. This is important to reach groups that may otherwise lack information about the campaign and its value.

Resources

12 *Partnerships in Action: An Integrated Approach to Combining a Measles Campaign with a Bed Net, Vitamin A, and Mebendazole Campaign in Zambia (Malaria Case Study).* PDF. American Red Cross International Services and CORE, July 2004.

34 *Insecticide Treated Nets and Vitamin A Supplementation: An integrated approach to control malaria and micronutrient deficiency (Literature Review Paper and Malawi Case Study).* PDF. Prepared for The Micronutrient Initiative by Dr. Mark Young, Health Advisor; Dr. Peter Berti, Nutrition Advisor; Sian Fitzgerald, Executive Director, PATH Canada. April 2000.

21 *National Measles-Malaria Campaign Report.* Sierra Leone. MS Word. January 2007.

27 *Strategic Framework for Integrating Additional Child Survival Interventions with Immunization in the African Region.* PDF. WHO/AFRO. August 2006.

50 *The Roll Back Malaria Strategy for Improving Access to Treatment through Home Management of Malaria. PDF.* Roll Back Malaria Department, WHO, 2005.

Red Cross Supervisor and Volunteer Support Documents in MS Word:

60 *Supervisor Duties, Sierra Leone (English).*

61 *Supervisor Duties, Mali (French).*

62 *Volunteer Duties, Sierra Leone (English).*

63 *Volunteer Duties, Burkina Faso (French).*

In some countries, the national level will produce radio spots in the national and major languages, and regional, district and community radio stations will translate them to local languages either free of charge or for a limited fee.

All social mobilization supports should be developed early in the planning process (see social mobilization chronogram in Resource 10, which is also included at the end of this toolkit) and sent to the districts in a timely manner. One of the common weaknesses of campaigns is the late arrival of social mobilization supports and communication materials at the district or community levels.

Community and/or interpersonal communication: the best ways of reaching the most vulnerable and marginalized individuals and allow for specific messaging related to the barriers to vaccination attendance.

Community health workers or volunteers who are familiar with the population and the context are able to tailor messages to include community-specific issues affecting attendance during mass vaccination activities. Community health workers and volunteers, given their knowledge of their area, are also best placed to be able to follow-up children who have not been vaccinated and discuss with parents and caregivers the importance of health interventions. Facility-based health workers are also effective agents for communication as they are respected by community members and considered as a reliable source of information.

At the community level, some of the most effective and influential means of communicating messages (in addition to face-to-face contact) include drama, songs, stories, football matches, and street-by-street announcements by volunteers, town criers and school children. Another option for reaching the community is school-based communication from teachers or MOH personnel. Children will talk about what they have done at school, leading to the caregivers receiving the information through this channel.

It is important to consider activities that are effective for passing messages, versus large-scale events that maybe of interest to donors in terms of visibility, but may not actually reach the targets or beneficiaries.

Resources

64 *National Measles-Malaria Campaign Report.* MS Word. Sierra Leone. January 2007.

62 *Volunteer Duties, Sierra Leone (English).* MS Word.

63 *Volunteer Duties, Burkina Faso (French).* MS Word.

42 *Kenya Red Cross Society Community Mobilization Guide.* MS Word. From "Community Mobilizer Manual for Integrated Measles Campaigns, Kenya".

43 *Communication for Polio Eradication and Routine Immunization. Checklists and easy reference guides.* PDF. WHO, UNICEF, USAID (BASICS II and CHANGE projects), 2002.

65 *Madagascar Red Cross Training Agenda and Training Guide.* MS Word. 2007. French.

Training for social mobilization

The target of social mobilization is usually first identified, and then training is adapted to meet the need. The media, community and religious leaders, health agents, community health workers and/or volunteers can all participate in training. The importance of training on methods and venues for communication and reaching the most vulnerable and at-risk groups should be included in any training conducted. An understanding of which segments of society are mobilized, through which channels, will help refine the training for agents of communication and social mobilization accordingly.

Photo: Canadian Red Cross

A campaign volunteer reminds a client to sign her campaign card when collecting a net at an integrated campaign site in Madagascar.

In general, training for all individuals involved in social mobilization should include:

- Developing an understanding of campaign interventions and their importance for child survival.
- Provision of skills to provide basic information regarding why children should receive interventions.
- Knowledge and directions to the closest campaign site, and what is available at that site.
- Identification of community-level barriers to interventions or service access and how to discuss them with the population.
- Understanding of the importance of behavior change.

Communities may face different barriers to attending the vaccination campaign, ranging from geo-graphical (limited access to health facilities), to information (lack of knowledge regarding mobile posts), to misinformation (rumors and stories convincing people that interventions are inappropriate or must be paid for).

> Delivery of communication may need to vary from community to community, but the underlying messages should all be consistent and direct.

Community leaders and volunteers, as well as community-based organizations, should be encouraged to assist in conducting social mobilization. For instance, in Zambia and other countries, volunteers of Red Cross National Societies and members of the Church of Jesus Christ of Latter Day Saints were trained to mobilize the community.

The social mobilization sub-committee, with support from the technical sub-committee, should collectively develop training tools, including guides, volunteer supports and checklists, to make sure that all social mobilization activities have taken place and reached the most vulnerable populations.

5.3. Monitoring and evaluating communication activities

In order to monitor and evaluate (M&E) the effectiveness of social mobilization activities, the communication sub-committee should develop a budget and conduct field trips immediately prior to and during the campaign. The committee should discuss their activities with regional and district MOH representatives, participating partners and beneficiaries to have a full understanding of the impact of the communication and mobilization activities.

Communication elements and indicators should be included in all of the monitoring and supervision tools for the integrated campaign (before, during and after).

Key questions to ask when conducting M&E for communication activities include:

1. Were the planned activities completed, including timely arrival of communication materials at the furthest campaign sites?
2. Were the materials and messages effective?
3. Did messages reach the majority of the population?
4. Did the target population attend the campaign and receive the interventions?

Based on the answers to these questions, suggestions for communication in future campaigns should be made. Evaluation of effectiveness of communication activities should be included in the final report, so that others implementing integrated campaigns may be made aware of what works and what does not, especially for particular countries, communities, or minority groups.

Before communication activities are launched, it is helpful to create monitoring mechanisms to receive feedback on the interventions and identify problems early, so that they can be addressed quickly.

The first step is to determine objectives for day-to-day monitoring of activities and operations. These objectives should measure whether activities are on track, how close they are to meeting the projected timeline and budget, and whether staff members understand and perform their roles correctly. The specifics of the intended communication activities will determine the elements and objectives to be included in the process evaluation. This type of information should be collected and reviewed regularly to make program adjustments and to assure that the incoming data is reliable, complete, and timely.

Indicators for each country will depend upon specific communication approaches utilized by partners in that country. Therefore, process and output indicators can vary from country to country to reflect the specific communication plan. While the overall objectives of communication are behavioral, the process indicators and most of the output indicators for communication activities are not behaviors. The success of communication activities are evaluated by outputs and (contribution to) outcome indicators.

The effectiveness of communication can be monitored before the campaign, by interviewing potential beneficiaries regarding the upcoming activity and the importance of their attendance. (Questionnaires and short interviews can be conducted with mothers to determine the understanding of services being provided during campaigns.) Alternatively (or in addition), exit interviews can be conducted with mothers as they leave vaccination posts to determine the source of information for their participation, as well as the key messages that they have retained.

A post-campaign survey can be conducted immediately, to gather information about the messages that reached the target population. Results from the evaluation of communication efforts should be shared with partners. Lessons learned from the evaluation should be used to support the planning of post-campaign communication activities focused on the correct and continued use of LLINs as well as attendance at routine EPI and MCH services.

Resources

27 *Strategic Framework for Integrating Additional Child Survival Interventions with Immunization in the African Region.* PDF. WHO/AFRO. August 2006.

66 *Process and Output Indicators for Communication, Recall, Intention and Behavior.* MS Word.

67 *Campagne Integrée De Vaccination Contre La Rougeole, La Poliomyélite, L'administration De La Vitamine A, De L'albendazole Et La Distribution De Moustiquaires Impregnées D'insecticide.* MS Word. 2007

6. Technical

The technical sub-committee (often a sub-group of the NCC) is responsible for technical planning and oversight of activities. A chronogram of activities for the technical committee can be found in Resource 10 and Annex 1 at the back of this document.

The technical sub-committee is involved with all elements of campaign planning and implementation. It should participate in all other committee and sub-committee meetings.

The technical sub-committee and the national coordinating committee work together to:

- Review technical content and finalize the POA.
- Provide input into the development and finalization of the TOR for sub-committees, as well as suggestions for leadership and membership.
- Contribute to the calculation of the budget for campaign planning and implementation, including M&E and surveillance post-campaign.
- Review micro-plans and budgets for the various sections of the campaign.
- Prepare technical training guides for campaign staff.
- Develop multi-level supervisory guidelines, develop checklists for supervisors and individuals responsible for site supervision.
- Design the post-campaign evaluation methodology and budget.
- Plan for and implement the post-campaign survey.

The technical sub-committee and the logistics sub-committee work together to:

- Review the determination of needs for all interventions: vaccines, vitamin A, de-worming drugs, polio vaccination, LLINs, other campaign supplies.
- Provide technical contributions to cold-chain logistics and other activities related to vaccination supplies.
- Ensure tax exoneration for LLINs and/or other supplies.
- During the campaign, gather data and make necessary adjustments (including redistribution strategy).
- Prepare recommendations on how to determine and set-up sites, manage crowds, security and waste disposal.
- Prepare micro-plans and budgets for logistic operations, and training guides for staff involved in logistics.
- Devise and finalize tally sheets.
- Determine the process needed to ensure that campaign supplies pass through customs without delay. Often this facilitation requires a request for a letter from the MOH to the Ministry of Finance.
- During and immediately after the campaign, synthesize data from all districts and regions for an initial assessment of coverage rates for all interventions.

The technical sub-committee and the communication sub-committee work together to:

- Develop communication materials and campaign branding.
- Create programs for house-to-house visits to encourage mobilization
- Prepare training guides for social mobilization
- Develop logistic operations for the delivery of social mobilization and communication materials to districts or regions.
- Design packaging guidelines for LLINs, including partner logos and other additions to normal packaging.

6.1. Training support for campaign staff

In many countries, training takes place in a cascade format: the first level of training occurs at national level, where individuals are identified and trained in order in turn to train the next level (regional or district) of campaign staff.

While cascade training (from the national level down to the community level) can be helpful and save time and resources, care must be taken to maintain high-quality training even at lower levels of the system. It is important to make guidelines clear and to ensure high-quality supervision at all levels of training, as well as to monitor retention of information by trainees and practice campaign implementation. Distribution of training guides is not sufficient training for campaign staff, and cannot substitute for training.

Training should be tailored to the needs of the campaign staff, the program and the campaign activities, and should include input from experts on each intervention.

During training, it should not be assumed that health providers already know how to conduct an integrated campaign, nor should it be assumed that health providers have retained the correct methods for providing an intervention from their last training. Time permitting, some information on past training, results from previous campaigns and staff knowledge, attitudes and practices (KAP) should be collected beforehand to assist with development of the campaign training plans, guidelines and monitoring tools.

The Measles SIA Field Guide (see pages 20-21) provides a summary on what training plans should include and this summary can be adapted to address

Photo: Canadian Red Cross

Before the integrated campaign in Sierra Leone, training encourage staff and community volunteers to play the important role of mobilizing families to attend vaccination posts, and ensure that the distributed LLINs are used correctly.

TECHNICAL

campaign interventions added on in any country. Field monitoring during campaign preparation visits, as well as during the campaign itself, should include on-the-job training as well as observations and recommendations on immediate corrections to make and on improvements for future campaigns and routine services.

Resources

8 *Measles SIAs Field Guide.* PDF. WHO/AFRO. Revised: January 2006

27 *Strategic Framework for Integrating Additional Child Survival Interventions with Immunization in the African Region.* PDF. WHO/AFRO. August 2006.

49 *La Campagne Intégrée de Vaccination Contre la Rougeole et la Poliomyélite, d'administration de Vitamine A, d'Albendazole et de Distribution de Moustiquaires Imprégnées d'Insecticide, du 13 au 19 décembre 2007.* MS PowerPoint. December 2007.

68 *Madagascar: Guide de Mise en Œuvre SSME.* MS Word. October 2007.

6.2. Site set-up and campaign implementation

Based on the interventions integrated in the campaign, activities are implemented either through the distribution of LLINs, the injection of vaccines (classically measles) and administration of other interventions all at the same campaign site, or through the door-to-door distribution of oral vaccines (classically polio) and other interventions, together with the distribution of LLINs at a nearby distribution point.

The number and location of sites (fixed sites, advanced sites and mobile sites) or distribution points required is determined during the micro-planning exercise (please refer to section 4 on Logistics).

The number of sites or distribution points, their locations, the number and movement of campaign teams is based on the number of people living in each catchment area, the population density, and how far the area is from the nearest health facility.

Fixed site delivery of interventions

Often integrated campaigns include all interventions at the same site. With this type of campaign, site organization should be determined early in the planning process as it is one of the most important elements for overall success and for identifying staffing requirements and site suitability.

Urban and rural sites will differ in requirements: urban sites typically have a larger need for crowd control.

The number of vaccinators and distributors needed for all interventions, as well as record keepers and individuals for crowd control, should be determined during the micro-planning. By doing effective planning for site set-up and staffing early in the campaign planning process, the MOH can ensure that all services receive adequate attention and can avoid overloading staff with responsibilities that may result in reduced quality or longer waiting times. Having a good idea of the number of staff per site required and including it in the final budget will help avoid last minute gaps and ensure effective functioning of sites.

Site structure

Typically, a site will have a waiting area, registration table, oral intervention table (where vitamin A and de-worming drugs can be administered), immunization table and a LLIN table at the end, with a demonstration of a hanging net.

All sites should include one or more stations where people will be given basic information on such topics, such as appropriate use of bed nets and the importance of children completing basic

immunizations before they reach their first birthdays. In some countries, health talks are given in addition to individual advice, though the latter is often difficult to implement at crowded campaign sites.

Sites should be a client- and child-friendly environment, with clear banners or signs to direct people, as well as appropriate shade and bathroom/toilet facilities. LLINs or other materials are stored at sites, it is important for the site to be secured with locked doors and windows, and possibly protected by night security guards.

Resources

69 *Site Set Up: Sierra Leone National Integrated Child Survival Campaign.* MS PowerPoint.

8 *Measles SIAs Field Guide.* PDF. WHO/AFRO. Revised: January 2006

40 *Integrated Measles Follow-up (Measles, OPV, vitamin A, and LLINs): Training and Field Guide.* MS Word. Kenya National Expanded Programme on Immunization (KEPI). The Republic of Kenya MOH, WHO & UNICEF, 2006.

5 *Operational Integration of Key Child Survival Interventions: A Guide for District Health Management Teams.* PDF. WHO/AFRO. Draft: 2005.

27 *Strategic Framework for Integrating Additional Child Survival Interventions with Immunization in the African Region.* PDF. WHO/AFRO. August 2006.

12 *Partnerships in Action: An Integrated Approach to Combining a Measles Campaign with a Bed Net, Vitamin A, and Mebendazole Campaign in Zambia (Malaria Case Study).* PDF. American Red Cross International Services and CORE, July 2004.

Staffing and personnel for sites

Each campaign team needs a team leader or supervisor who is responsible for site organization, assigning tasks, overseeing daily activities, monitoring and ordering supplies, and making sure that tally sheets are correctly completed.

The team leader/supervisor is responsible for collating data at the end of the day and communicating this to his or her counterpart at the national level. In addition, the leader/supervisor is responsible for monitoring, reporting on and investigating any suspected adverse effects from immunization (AEFI).

The number of campaign site personnel should be based upon the average number of beneficiaries expected to receive services on any given day, as well as on the interventions to be administered.

- In integrated campaigns, staff are likely to see more than 500-800 children per day (versus the typical 300-400 in single intervention campaigns).

- Campaigns giving away LLINs further increase attendance in the early days, for fear the campaign will run out of stock early.

- Crowd control is a major consideration during the first days of a campaign and extra staff should be available for this purpose.

To achieve equitable distribution, assign vaccinators, distributors, record-keepers and volunteers carefully to particular districts and health facilities. Also consider staffing for security, especially in urban areas.

The 2006 measles-malaria campaign in Sierra Leone had four on-site personnel: two vaccinators (being trained health agents), one volunteer/health facility staff for screening and crowd control and one volunteer/health facility staff for recording and

issuing of nets. Additional volunteers were deployed at urban and peri-urban sites to assist with various tasks, including crowd control.

In Madagascar in October 2007, the size of campaign teams depended on the estimated target population.

On average, fixed sites had about seven staff: one trained vaccinator (health worker), two or three community health workers (CHWs) for vitamin A supplementation, administration of mebendazole and LLIN distribution, one person responsible for registration (CHW or community mobilization agent (CMA)), one person responsible for record-keeping (CMA or volunteer), and at least one community mobilization agent.

Photo: IFRC

Tally sheets and campaign cards used at the Vitamin A distribution table during an integrated child survival campaign in Sierra Leone.

Resources

21 *National Measles-Malaria Campaign Report. Sierra Leone.* MS Word. January 2007.

11 *The Global Fund Niger Project: Integrated Polio Vaccination and Mosquito Net Distribution.* PDF. 19-24 December 2005. International Federation of Red Cross and Red Crescent Societies. Annual Report, August, 2006

40 *Integrated Measles Follow-up (Measles, OPV, vitamin A, and LLINs): Training and Field Guide.* MS Word. Kenya National Expanded Programme on Immunization (KEPI). The Republic of Kenya MOH, WHO & UNICEF, 2006

49 *La Campagne Intégrée de Vaccination Contre la Rougeole et la Poliomyélite, d'administration de Vitamine A, d'Albendazole et de Distribution de Moustiquaires Imprégnées d'Insecticide, du 13 au 19 décembre 2007.* MS PowerPoint. December 2007.

At many sites additional CMAs or volunteers were available for crowd control, outreach, clean-up and waste disposal, particularly managing filled safety boxes.

In some campaigns, the number of volunteers has been sufficient to undertake social mobilization at sites, including messaging regarding hanging and using LLINs and the importance of routine services for children under five and pregnant women. At times, these additional volunteers have been successful in using drama and other communication methods.

Another important task that extra site personnel and volunteers can undertake is house-to-house follow-ups, before and during the campaign to ensure that all eligible children are brought to sites, and after the campaign to ensure LLINs are being used correctly and all the time.

Door-to-door delivery of interventions and fixed site LLIN distribution

Where possible, synchronized, fixed site delivery is the preferred mechanism for integrated campaigns. This method allows for simultaneous delivery of interventions in campaign sites.

However, some integrated campaigns include LLIN distribution with the provision of interventions given door-to-door, such as vitamin A or oral polio vaccine. Door-to-door teams usually give a coupon that can be redeemed for a LLIN at a separate distribution point. With this type of campaign, the characteristics (number, location, catchment population and staffing) of sites should be determined early in the planning process, as it is one of the most important elements for overall success.

Many of the considerations described in fixed site campaigns apply to door-to-door campaigns. Additional considerations include the number and qualifications of staff in door-to-door teams and staffing of distribution sites. The distribution sites should have a team made up of a team leader, a stock manager, a recorder, and one or more crowd controllers.

> When planning for this type of campaign, careful budgets for the required number of personnel are required for two different periods of activity (door-to-door and distribution).

Campaign card

Resources

11 *The Global Fund Niger Project: Integrated Polio Vaccination and Mosquito Net Distribution.* PDF. 19-24 December 2005. International Federation of Red Cross and Red Crescent Societies. Annual Report, August, 2006

Integrated campaigns often have several interventions targeted at different age groups within the 0-59 month group. In order to manage these different age groups, as well as to facilitate the job of campaign staff, a campaign card can be filled out at a registration table, identifying which interventions each child should receive (according to his or her age). Each intervention the child receives should be marked off on the card as having been administered.

In Sierra Leone and Mali, the campaign card proved useful in cases where there were stock-outs, particularly of LLINs, but it was also useful for other campaign supplies. If a mother did not receive a LLIN because supplies were finished, her campaign card was not marked and could be used as a voucher the following day when supplies were replenished.

The campaign card is also useful for immediate post-campaign evaluation and for later coverage and surveys for the utilization of nets in the rainy season.

During these post campaign activities, caregivers can show the card to verify what interventions were received. Where children did not receive interventions, appropriate messages can be given to caregivers about the importance of taking children for routine services.

Resources

70 *Mali Carte de campagne.* MS Excel. 2007.

71 *Madagascar campaign card.* PDF.

72 *Rwanda campaign card.* PNG.

40 *Integrated Measles Follow-up (Measles, OPV, vitamin A, and LLINs): Training and Field Guide.* MS Word. Kenya National Expanded Programme on Immunization (KEPI). The Republic of Kenya MOH, WHO & UNICEF, 2006

Where countries have a well-functioning child health card or vaccination card systems, children 0–11 months who received their routine vaccination during the campaign, as well as their vitamin A/de-worming treatment, should have this information noted on their routine cards.

Health providers should also update their routine registers with this information. In a campaign setting, this is best done by separating children 0–11 months from those 12–59 months at the site and following normal procedures for vaccinating and tracking 0–11 month old children.

Planning for redistribution of supplies

Due to the high and relatively unpredictable volume in the initial days of integrated campaigns with

Resources

9 *Framework for Monitoring and Evaluation of Integrated Child Survival Interventions.* PDF. WHO/AFRO, 2006.

13 *Malaria and Measles: Focus on Zambia. (Programme Update).* PDF. International Federation of The Red Cross, March 2004..

21 *National Measles-Malaria Campaign Report.* Sierra Leone. MS Word. January 2007

76 *Monitoring and Evaluation Plan for Integrated Measles, ITN, Vitamin A and Mebendazole Campaign. Rwanda*. MS Word. September 2006.

77 *Zambia National Measles Campaign Evaluation Plan.* MS Word. April 2003.

Photo: © Benoist Carpentier. www.bcarpentier.com

Net demonstrations and communication materials (posters) are displayed at the refugee camp of Gassire in the eastern Chad.

LLIN distribution, stock-outs for supplies are quite common. Early planning and pre-positioning of surplus stock can assist with minimizing the risks of running out of supplies.

Contingency planning and monitoring of stock are part of the supervisors' duties to ensure smooth functioning of the campaign. Stock-outs should be reported to supervisors and then communicated to the regional managers. Supervisors who move from site to site should have adequate fuel budgeted, so they can assist with redistribution of campaign supplies during implementation as needed. Training of supervisors for coping with stock-outs is an important part of the standard guidelines and checklists.

6.3. Tally sheets

Tally sheets are used at each site to record the number of children who have received each intervention. In addition, tally sheets provide an indicator of stocks of campaign supplies that have been provided to the site, what has been used and what is remaining. This can assist with redistribution of supplies during campaign activities.

> It is important for tally sheets to be simple and to clearly indicate how many persons in each target age group received each intervention.

Separate tallying should be done for each intervention. It is useful, notably for vaccination that routinely targets children 0–11 months, to divide the target group into children 0–11 months and children 12–59 months.

In many countries, correctly filling out tally sheets has been problematic, and a major part of training for campaign staff and supervisors should be to ensure a minimum of errors (either over- or under-counting). The more complicated the tally sheets are, the more chances there are of errors.

Tally sheets can be used in two ways. First, there can be a single, global tally sheet for all interventions that one person is responsible for completing, usually as caregivers leave the site.

In this situation, the campaign card or verbal information from the mother can be used to complete the tally sheet. Second, and easier to manage, a tally sheet can be provided at each table for each intervention.

> In this system, the person administering the intervention is responsible for completing the tally sheet for each child.

Tally sheets for monitoring problems

Tally sheets should include daily information from sites on the rate of loss of vaccine and other supplies, as well as the management of waste. Although often overlooked, this is pertinent information for both managing the ongoing campaign and for planning future campaigns. Where rates of loss are very high, there is often a problem with the vaccination or administration technique and this can be addressed by the supervisor.

Stockouts or overstocks of LLINs can occur if team members do not understand the local policy of the number of nets to give per family. When this information is not collected, these problems cannot be rectified during the campaign, so stock-outs may occur more quickly.

Tally sheets for reporting

At the end of each day, the team leader/supervisor collects all the tally sheets and collates the information on a summary sheet for reporting to the next level.

This allows for an assessment of the progress of the campaign and where there are potential problems that supervisors should address. A good cross-check

TECHNICAL

is to compare the number of supplies in stock with the number of beneficiaries. Accomplishments can also be examined through review of tally worksheets and comparison of the number of children who received interventions versus micro-planning targets.

Resources

73 *Examples of Tally Sheets.* MS Excel.

74 *Example of tally sheets from Mali.* MS Excel.

75 *Spreadsheet examples from Liberia integrated campaign.* MS Excel.

6.4. Monitoring and supervision

In this section, this toolkit examines monitoring and supervision of integrated campaigns. We look at evaluation in the following section.

> "Monitoring is the routine tracking of the key elements of program performance through record keeping, regular reporting, surveillance systems, and periodic surveys."[1]
> "Evaluation is the periodic assessment of the change in targeted results that can be attributed to an intervention."[1]

The WHO "Framework for Monitoring and Evaluation (M&E)" notes that an M&E work plan should focus on the district level as the main level of implementation. The national level provides technical guidance, summarizes key information, and generates national-level reports. Ideally, supervision occurs from all levels—district, regional and national—with areas requiring additional attention identified at each level. Monitoring and supervision should be carefully budgeted in campaign planning.

[1] WHO Framework for Monitoring and Evaluation of Integrated Child Survival Interventions

The purpose of monitoring and supervision is to assess the many facets of the integrated campaign, to identify areas needing mid-campaign correction, to report major findings to the District Health Management Teams, and to provide support to health workers and volunteers working in the campaign.

Resources

80 *Kenya Integrated Measles Follow-up Campaign. Measles SIAs Preparedness Checklist (a) 1st phase and (b) close to campaign.* MS Word.

81 *Pre-Implementation Checklist. Annex 8 of Liberia's Micro-planning documents.* MS Excel.

82 *Implementation Supervisory Checklist. Annex 6 of Liberia's Micro-planning documents.* MS Excel.

83 *Nigeria Campaign Implementation Checklist.* PDF.

84 *Mali Liste de Vérification.* MS Excel.

85 *Madagascar MCHW Monitoring List for Supervisors. Supervision Checklist District, Supervision Checklist CSB.* MS Word. 2007.

86 *The Polio Eradication Initiative: Monitoring Service Delivery during National Immunization Days and Assessing the Local Capacity to Strengthen Disease Surveillance.* PDF. BASICS, 1998.

5 *Operational Integration of Key Child Survival Interventions: A Guide for District Health Management Teams.* PDF. WHO/AFRO. Draft: 2005.

8 *Measles SIAs Field Guide.* PDF. WHO/AFRO. Revised: January 2006.

9 *Framework for Monitoring and Evaluation of Integrated Child Survival Interventions.* PDF. WHO/AFRO, 2006.

It is important to plan for monitoring and supervision, as it needs to occur throughout all phases of the campaign (including monitoring of preparation, of the campaign itself, and of post-campaign activities such as the evaluation and report writing).

Monitors

Monitoring can be done by program managers from the various departments and intervention areas (e.g., EPI officers, malaria officers, MCH advisors, disease control officers), independent monitors (e.g., medical staff from the private sector or medical students—see section 6.5) and NGOs and donor representatives.

Monitors require advance training and should be familiar with all interventions covered, checklists and tools, and reporting processes.

Monitors and supervisors should provide on-the-job training to campaign teams in order to correct mistakes and/or address any problems. They should also know who to inform for resolving urgent issues.

Most local personnnel policies state that only supervisors have the authority to take official corrective action. Monitors, therefore, should work closely with local supervisors to ensure such corrective action is taken when needed.

Supervisors

Training of supervisors is crucial to ensure the provision of quality services according to national guidelines. Training normally takes place in a cascade style, similar to the training of campaign workers. Supervisors are usually trained at national level to train regional/district supervisors. In general, national supervisors should train and supervise district supervisors, who train and supervise campaign teams. District supervisors monitor all campaign activities and report to the district coordinating team and regional and/or national supervisor on a daily basis during the campaign.

Resources

89 *Mali campaign summary data sheets.* MS Excel

Photo: IFRC

A Red Cross volunteer conducts "hang-up" activities in Ségou, Mali, as part of the integrated campaign.

Supervisors should be trained on all technical and operational elements of the integrated campaign, including the distribution and tracking requirements for each intervention, vaccine use, site administration, cold chain and storage requirements, correct waste management, and crowd control. Supervisors should also be trained to report on the effect and success of communication and social mobilization activities.

Supervisors of campaign teams ensure that tally sheets are completed correctly for all interventions, that unused equipment (remainder of vaccines and nets) is secured and returned to the appropriate storage center or cold chain each day, and that safe vaccine waste disposal is practiced.

Resources

78 *Mali Agenda Briefing Superviseurs.* MS Word. French.

79 *Mali Terms of Reference_superviseurs.* MS Word. French.

Monitoring and supervision checklists

Checklists should be developed for monitoring and supervision visits taking place prior to and during the campaign activities.

Checklists used before the campaign should help confirm that preparations are adequate and supplies and supply chain elements are in place.

Photo: IFRC

Training the logistics team in Antananarivo, Madagascar as preparation for the integrated campaign.

Other checklists should include:

- Technical aspects (cold chain, safety boxes, etc.)
- Communication aspects, including, if possible, short interviews (4-5 questions) with mothers on their campaign understanding, participation and information sources

Checklists remind monitors and supervisors of key campaign activities or services to observe before and during the campaign. Monitoring checklists were used in Zambia by national supervisors and independent monitors to ensure that implementation was undertaken correctly, supplies for all interventions were adequate, and children in particular catchment areas were not missed. Daily updates were given during coordination meetings (or phone calls) during the campaign.

Supervision checklists normally focus on (but are not limited to):

- Site management
- Crowd control and flow
- Registration
- Immunization techniques and cold chain management
- Care and distribution of LLINs
- Administration of vitamin A and mebendazole
- Waste management
- Stock control
- Mobilization of local communities
- Other communication or advocacy activities
- Completion of tally sheets
- Transfer of information to district, regional and/or national levels
- Any other issues identified by the MOH

Supervision schedule

Checklists are normally developed for supervision trips taking place prior to and during campaign activities. Checklists are useful for the supervision of each stage of the campaign.

Supervision of logistics: adequate preparations in place for transport and site management.
Supervision of technical: cold chain transport and storage are operational, LLINs have secured storage.
Supervision of communication: materials will reach sites in time for social mobilization, communication materials reach the audience (this can be achieved with short interviews of three or four questions with target groups such as mothers/caregivers).

Independent observers

Independent observers come from external organizations, either in-country (e.g., university students, NGOs) or international technical organizations (e.g., CDC).

Independent observers participate during campaign implementation at different stages, including:

- One week before the start of the campaign (to check if supplies are in place, trainings are complete, sites are ready),

- During the campaign (to see how sites function, are organized and are supervised),

- After the campaign (to help with returning unused stocks, closing down sites and evaluation).

Normally, independent observers have technical backgrounds in epidemiology, public health or other relevant areas, as well as past campaign experience, that qualify them to provide insight and observations regarding the MOH's campaign preparations and implementation. The MOH should identify the geographical and technical areas that international observers should focus on. It is helpful for international observers to speak the main language of the country so they are able to effectively communicate their observations and recommendations.

Independent observers support the country's supervision, monitoring and evaluation plans. Their presence provides an objective assessment of preparations and service delivery, and demonstrates international support. Independent observers should work with the MOH to help identify and recommend strategies to address critical policy or program issues that arise before and during the campaign. In addition, observers should help transfer lessons learned during the campaign to future child survival campaigns and routine distribution activities.

Before starting campaign activities, independent observers normally receive a briefing that reviews the status of preparations to date. The MOH provides instructions for monitoring visits and provides campaign checklists to use when on trips to the districts. Where necessary and when possible, international observers assist with finalizing campaign supervision checklists and participate in any campaign-related training. Independent observers should attend all campaign meetings held at the district level.

During the campaign, independent observers are normally paired with MOH trained supervisors in order to observe service delivery at campaign sites. Observations focus on the areas identified by the supervision checklists. As they are made, observations should be discussed both with the MOH counterpart and local campaign supervisors. These discussions should quickly rectify any dangerous situations and provide supportive supervision to the local supervisor and the campaign team.

At the end of the visit, independent observers should participate in a debriefing with the MOH and partners (where possible, especially if observers are leaving prior to end of campaign) and should provide a written report of their observations and recommendations for future campaigns and routine service delivery.

In Zambia, independent monitors were trained to assist in monitoring the quality of the campaign. Independent monitors were responsible for "in-process" and "end-process" monitoring.

> "In-process" monitoring is the assessment of whether any under five-year-olds did not receive interventions, and ensuring that they are reported to the district team covering that area. "End-process" monitoring is conducted a day or two after the campaign to give a more accurate picture of the coverage.

Resources

87 *Terms of Reference for International Observers.* Mali Integrated Child Health Campaign, 13-19 December 2007. English version.

88 *Termes de Référence pour les Observateurs Internationaux.* Campagne Intégrée en Santé de l'Enfant au Mali, du 13 au 19 décembre 2007. French version.

6.5. Data collection during campaign implementation

During campaigns, data is collected on tally sheets and collated daily on a summary sheet. These results are then communicated up from the campaign site to the district, and from there to the regional and national levels. Data collected allow organizers to assess the coverage attained and, if necessary, make strategic changes to improve coverage. The data can also highlight the need to restock sites, including redistribution of campaign supplies between sites. Reviewed data is used to make recommendations and develop summary reports on the overall campaign.

Supervisors are usually responsible for the transfer of data collection. To aid the process, responsibility should be clearly assigned to a particular person or team. The budget for fuel should allow appropriate extra trips for data collection.

6.6. Rapid monitoring surveys

Rapid monitoring surveys are a non-scientific, programmatic tool to help determine quickly whether children in targeted areas are being reached during the campaign and to identify pockets of missed children. Often, rapid monitoring surveys are undertaken in areas at risk of low coverage (due to geographical, cultural or other access barriers) to ascertain whether the campaign is reaching the target population.

Rapid surveys are a method for validating coverage and identifying areas requiring immediate attention from campaign teams, rather than a means to determine campaign coverage in a statistically sound manner (hence "convenience" surveys).

> Rapid surveys should not be used to calculate the vaccination coverage for an area.

Supervisors responsible for implementing rapid monitoring surveys should partner with local individuals to conduct convenience household surveys in specific neighborhoods. A standard method is to visit 10 households, identify all children in the target age group and determine how many have received campaign interventions. If more than one household is found to have a child who did not participate in the campaign, an additional 10 households are visited. If a second household is found to have a child who did not participate in the campaign, teams are deployed in a 'mop-up' strategy to ensure that all children are reached.

In areas that are serving populations through mobile or advanced campaign sites, rapid monitoring surveys can be done at the end of each day before the campaign site moves to the next area. In urban areas and areas being served through fixed sites, rapid monitoring surveys are usually undertaken close to the end of the campaign when most children have already visited the campaign sites.

During rapid surveys, campaign cards are often used to verify that children have received all interventions. If there has been a stock-out at a campaign site, it is possible that a child might have received two or three of the four interventions, but not all. In this case, it may be possible for the supervisor to administer or deliver the missing intervention(s) if supervisors are able to travel with extra stock, or the supervisor may report to the nearest health center to send out campaign teams in follow-up visits.

Resources

90 *Use and abuse of rapid monitoring to assess coverage during mass vaccination campaigns*. PDF. ET Luman, KL Cairns, R Perry, V Dietz and D Gittelman. Bulletin of the WHO, September 2007.

12 *Partnerships in Action: An Integrated Approach to Combining a Measles Campaign with a Bed Net, Vitamin A, and Mebendazole Campaign in Zambia (Malaria Case Study)*. PDF. American Red Cross International Services and CORE, July 2004.

91 *Tchad fiche de monitorage et d'evaluation des avs rougeole au tchad fiche-N°8* (used for phase 2 of the 2005/6 measles SIA)

92 *Fiche de monitorage et d'Evaluation Rapide de la campagne rougeole.* MS Excel. Cote d'Ivoire 2005.

93 *Rapid Convenience Surveys for Measles Vaccination Campaign.* MS Word. Zambia 2003.

7. Sustaining campaign results

Photo: Canadian Red Cross

Campaigns are one way of rapidly scaling up coverage of a number of child survival interventions. However, campaigns should not be seen as an isolated event—they are part of a long-term approach that includes resources and strategies for sustaining the results, both in terms of coverage (vaccinations, vitamin A, mebendazole, LLINs, received etc.), and in terms of sustained and increased LLIN utilization rates.

For sustained LLIN coverage and utilization, four basic elements need to be in place:

1. Resources (financial) to implement long-term policies designed to maintain LLIN coverage and utilization
2. Strategies for LLIN delivery to sustain net coverage
3. Behavior change communication for increasing and sustaining utilization
4. Monitoring and evaluation

(The diagram on page 70 summarizes these elements).

Resources

94 *Sustained high coverage of insecticide-treated bednets through combined catch-up and keep-up strategies.* PDF. Mark Grabowsky, Theresa Nobiya, and Joel Selanikio. Tropical Medicine and International Health, 12(7): 815-822. July 2007.

95 *Scaling Up Insecticide-treated Netting Programs in Africa: A Strategic Framework for Coordinated National Action.* PDF. Roll Back Malaria, 2006.

96 *Which delivery systems reach the poor? A review of equity of coverage of insecticide-treated nets, treated nets, and immunization to reduce child mortality in Africa.* PDF. J Webster, J Lines, J Bruce, JRM Armstrong Schellenberg and K Hansen. 2005. Lancet Infectious Diseases 5: 709-719.

Previous page: *Women in Kuajiena, a village in Western Bahr El-Ghazal state, Southern Sudan, wait to receive their LLINs at an integrated campaign.* Photo: © Jenn Warren/PSI Sudan. www.jennwarren.net

Sustaining post-campaign LLIN coverage and utilization

Resource mobilization for long-term LLIN coverage strategy	Access to sustained funding to ensure ongoing availability and easy access to LLINs and related costs
Strategies and concrete plans for LLIN delivery to sustain coverage	Routine service (normally under-fives and pregnant women)—free or highly subsidized
	Community channels (CHWs, NGOs, volunteers)—free or highly subsidized
	Social marketing
	Commercial market (not covered in toolkit)
Behavior change communication (BCC) for increased use	Mass media communication
	Community and household communication
	School-based education and communication
	Health facility based communication
Monitoring and evaluation for impact	Monitoring uptake: supply and demand
	Monitoring use: post-campaign household surveys, EPI and ANC contact method
	Monitoring use: non-governmental organizations (NGOs)
	Regular progress and gap analysis meetings with key stakeholders (MOH, NGOs, community leaders, etc)

7.1. Resource mobilization: ensuring access to sustained funding for maintaining LLIN coverage

Large-scale campaigns to rapidly scale-up LLIN coverage should be part of a long-term strategy to increase and sustain malaria prevention and control efforts. Resource mobilization is necessary to maintain the gains achieved and needs to be considered in advance of the campaign.

Given the increase in funding available to government structures (The Global Fund, PMI), as well as the proliferation of organizations focusing on malaria control in past years, there are a number of options for National Malaria Control Programs (NMCPs) in terms of resource mobilization, in addition to traditional partners who have been supporting malaria prevention and control activities in countries (e.g., UNICEF, WHO).

> Many NMCPs are now recipients of The Global Fund and/or PMI funding for malaria activities.

LLINs that are programmed for distribution through routine services using funding from these organizations can, sometimes, be reprogrammed for campaign or mass distribution activities if gaps in campaign supplies are identified. Alternatively, LLINs available from these sources can also be used to leverage partner involvement in campaigns.

In order to effectively undertake resource mobilization, the NMCP national strategic plan should outline campaign and routine activities as well as available resources. The plan should identify key partners who are supporting the program and should address needs, strategies and process indicators and associated budgets. The NMCP strategic plan should be presented as an Annex to the campaign POA in order to indicate the future vision of the NMCP and to secure additional funding for activities outside the campaign.

7.2. Strategies for LLIN delivery to sustain coverage

Figure 1 identifies four main strategies for delivering LLINs to populations:

1. Routine health services delivering either free or highly subsidized LLINs (normally targeting children under five and pregnant women)
2. Community channels delivering either free or highly subsidized LLINs (CHWs, NGOs, volunteers)
3. Social marketing
4. Commercial market sales (which will not be covered in this toolkit)

> A combination of the four activities is the most effective means of achieving the WHO objective (2007) of universal coverage of LLINs.

Strategy 1: The delivery of LLINs through routine service (e.g., ANC, EPI)

> Ongoing, routine delivery of LLINs through facility-based health services, including ante-natal care (ANC) and EPI, is a cost-effective strategy for maintaining high levels of LLIN coverage and ensuring sustained access to nets after mass distribution activities.

LLIN delivery through routine services provides direct access to the principal malaria risk groups through pre-existing structures, and leverages the consultation opportunity between mother and health care provider to reinforce key messages regarding malaria prevention and treatment.

Delivering LLINs through clinics for antenatal care and children-under-five services provides an opportunity for getting nets directly to those who need them most.

The benefits of this approach include:

ACCESS: ANC and EPI services provide efficient and direct access to the highest risk groups.

ATTENDANCE: Antenatal clinic attendance, at least once during pregnancy, is above 70% in most parts of Africa.

DISTRIBUTION: Public health facilities are distributed throughout rural areas and are often capable of securely storing large quantities of LLINs, which increases distribution efficiency.

PROMOTION: The one-to-one consultation between nurses and mothers/caregivers offers an unparalleled opportunity for promoting appropriate and correct LLIN use.

ACCOUNTABILITY: Ensuring accountability is straightforward since reconciliation between stock and records can be done at any time at the health facility.

NMCPs in at least 18 countries in Africa have already adopted policies to deliver LLINs through facility-based health services as part of an integrated approach to sustained access. However, as of early 2008, only four countries have scaled up delivery nationwide, so LLINs are not yet available through every health facility offering routine ANC and EPI services.

Developing an appropriate policy framework

Reaching consensus on key policy and operational issues during the planning stage can greatly facilitate the rapid scale-up of facility-based delivery. This can typically be achieved through: (1) a MOH-led review of existing policy documents, (2) development of guidelines for the delivery of LLINs and (3) production of a detailed implementation plan for nationwide scale-up.

MOH policy

The LLIN delivery approach developed by a NMCP for facility-based health services should be consistent with national health policies and frameworks. The NMCP and partners may wish to review the National Malaria Control Policy to ensure nationwide access to LLINs through facility-based delivery is part of the overall strategy for sustained access. If facility-based delivery is not part of the strategy, the policy framework should be modified to facilitate this approach. Plans of action for immunization, antenatal care, nutrition and other national health programs may also include policies on integration with LLIN delivery.

Guidelines for the management of LLINs

Although the NMCP typically sets the framework for delivery of LLINs, it may not provide sufficient detail to address key issues associated with facility-based delivery, including procurement procedures, assuring equity, maintaining and establishing appropriate distribution channels and program monitoring and evaluation.

NMCPs are strongly encouraged to develop LLIN delivery guidelines with key stakeholders as part of the planning process.

Key policy and operational issues that may be addressed within the guidelines include:

Procurement and logistics

- Type of LLINs to be procured and distributed (according to WHO guidelines and approvals) through the different channels.
- Standards and specifications for the type of insecticides used for the treatment of nets (as appropriate). These are established by WHO for all public health insecticides and LLINs. Countries may need to carry out local tests and register insecticides suitable to their local situations.
- If and how re-treatment will be made available (mass campaign, routine through health system and/or other outlets, free, subsidized etc.).

- Procurement procedures, including which unit or agency will manage the procurement, the tendering and selection process, and the treatment of tariffs on the importation of nets.
- Transportation and storage of nets including identification of infrastructure to be utilized and partners who may be able to assist with logistics.

Distribution, eligibility, cost recovery

- Priority populations to be reached through facility-based services and criteria for determining eligibility, e.g., pregnant women, children under five, the poorest of the poor, PLHIV and victims of disaster.
- Mechanisms for consistently reaching these populations with a uniform supply of LLINs, e.g., at first contact with a health facility or upon completion of the basic childhood vaccination series.
- Determining if nets will be distributed free of charge or sold at a heavily subsidized rate.

Training and supervision

- Who should be trained to support LLIN delivery, which unit or organization will be responsible for developing guidelines and implementing training and supervision, and how often both will occur.

Photo: IFRC

A Red Cross worker helps a family put-up a LLIN received at an integrated campaign in Madagascar. The family is encouraged to use the net correctly, and keep it up.

Promotion and advocacy

- Coordinated and targeted promotion and advocacy activities are crucial to scaling-up distribution and assuring proper LLIN usage year-round.
- Guidelines should specify which units within the MOH/NMCP will oversee the development of IEC/BCC materials, what materials are to be produced and how they are to be disseminated.

Partners in implementation

- The promotion of large-scale distribution and use of LLINs often requires a wide participation of government, public, private, bilateral, and multilateral organizations as well as teaching institutions.

In the government system, a number of sectors/ministries will be expected to play an important role in the management and distribution of LLINs.

- The MOH may want to consider organizing an inter-agency coordinating committee to oversee macro-level issues including, but not limited to, donor coordination and fund raising; advocacy and social mobilization; lobbying for the removal of tariffs and taxes on LLINs and related raw materials; and formulation and /or adaptation of policy, as required.

Monitoring and evaluation

- Post-campaign coverage and utilization survey.
- Procedures for routine monitoring of LLIN activities.
- Type and periodicity of evaluations to be performed.
- Identification of units and agencies responsible for carrying out monitoring and evaluation activities.

Resources

97 *WHO recommended LLINs.* PDF.

Implementation plan

The final step in the planning process is to develop a comprehensive implementation plan that outlines steps to be taken for nationwide scale-up, sets the timeline for program roll out and identifies partners to assist with the process.

Key program components for facility-based delivery

Facility-based delivery of LLINs builds on existing infrastructure and human resources. Essential elements to ensure success of this approach include:

Leadership

- Developing an appropriate facility-based delivery strategy for LLINs is a primary responsibility of the MOH, so that it ensures ownership and accountability at all levels of the public health system.
- Close coordination between the NMCP and district health offices ensures LLIN distribution activities are routinely integrated into ongoing health services.
- The scheme must be seen as a MOH activity so health providers perceive LLIN activities as an integral part of their job. Therefore, national and district health officers must be committed to, and participate fully in, this approach.

Reliable supply of LLINs

- Experience through implementation is the best way of determining the average number of LLINs required at different health facilities. The district health office can assist by estimating the number of nets needed as a starter stock and decrease or increase the number required depending upon actual need and demand.
- Health facilities should have secure storage available on-site, to guard against theft.
- A system of reporting stock-outs and ensuring timely delivery of additional LLINs must be developed and supported by the NMCP and partners.

> Stock-outs reduce consumer confidence that nets will be available when they come for routine services and cast doubt on the importance of LLIN use as a health intervention.

Training

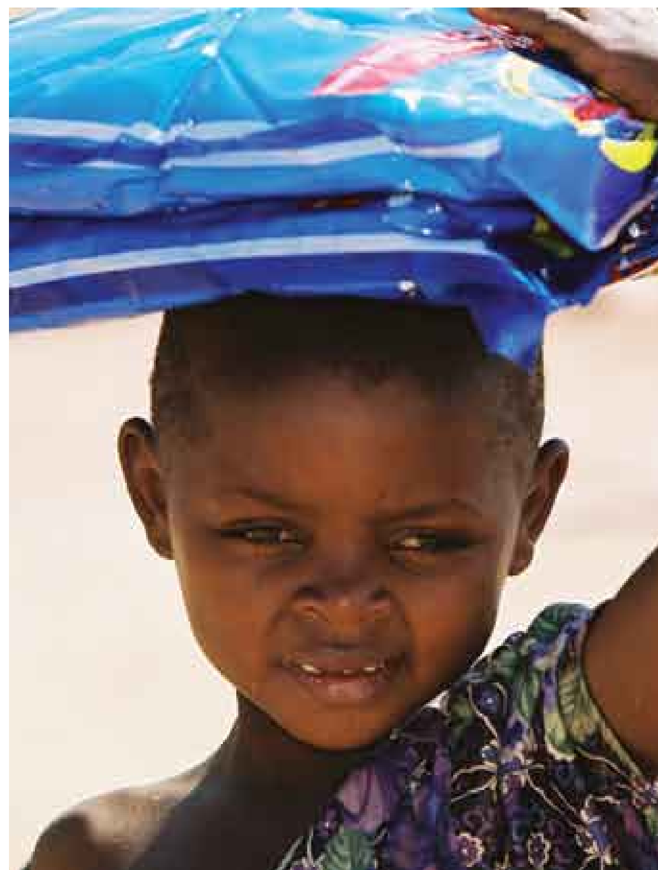
- Training for supervisory and implementation staff should cover both technical and operational issues. Technical training includes basic information about malaria prevention and the correct use of LLINs. Operational training includes record keeping and reporting. Standard training guidelines can be developed at the national level and adapted to suit the local context.
- District-level training for stakeholders can be conducted to ensure that partners understand and support the delivery model. The training typically involves an adaptation of the delivery model to the local situation (where relevant) and all aspects of LLINs and their delivery.
- Implementer-level training should be given to all health providers and other relevant implementers on both technical and operational training. The course can be taught by the district-level management team or other implementing agency (where appropriate).

Behavior change communication (BCC)

- Key messages for malaria prevention and treatment can be reinforced through one-on-one consultations with mothers/caregivers as well as through group talks while mothers are waiting to be seen by a health provider.
- Good support materials facilitate discussion and can include demonstration boards, to be used during regular health talks to educate mothers, and mini flip charts, to structure discussions with mothers during consultation.
- Key messages encouraging correct and consistent LLIN use can be reinforced through mass media channels.

Monitoring and supervision

- Routine supervisory visits from representatives of the district health management team help to ensure accountability. Activities to be carried out during a routine visit include:
  - Reconciling commodity stocks with records
  - Verifying record keeping by health facility staff and provision of guidance where necessary
  - Restocking LLINs, where appropriate
  - Checking availability of communication materials
  - Observing how health workers communicate with patients about the need to hang-up and use the nets
  - Conducting refresher training on technical or operational issues
  - Responding to any questions from implementing staff
- Integration of routine reporting mechanisms for LLIN distribution into existing HMIS tools can streamline reporting.



Scaling up nationwide delivery: An example from Malawi

The MOH/NMCP in Malawi achieved nationwide coverage of facility-based LLIN delivery through a partnership approach.

The NMCP and key stakeholders developed comprehensive guidelines for the management of LLINs that set the criteria for eligibility and outlined the mechanisms for distributing nets as follows:

- Only pregnant women or children under-five registered at that clinic (i.e., with a card) are eligible to receive a net.
- Only one net can be distributed to each card carrier.
- The nurse/health provider must follow record-keeping procedures learned at training (stamping the cards, stamping the name in the registration book, writing a receipt).
- A customer must never take nets out of the clinic except with a receipt as proof of eligibility.
- The nurse-in-charge is responsible for all nets and record keeping.

The process for rolling out the program at the district level was outlined in the implementation plan and includes the following steps:

- Meeting between local health management structure (e.g., DHMT) and other locally relevant stakeholders to discuss proposed delivery model and to draw up a locally appropriate plan for that district.
- Formation of joint LLIN committee (usually consisting of three DHMT members and one NGO representative).
- Training of the committee (trained as trainers).
- Training of all district nurses or other relevant implementers by the DHMT committee members with support from NGO partners.
- Examination for all implementers (a pass mark of 80% was rewarded with a LLIN).
- Provision of ongoing supply of LLINs through all appropriate clinics.
- Regular supervisory visits of the LLIN committee to supply new nets, check all records and ensure adherence to procedures.

Points for consideration

The experience from Malawi highlights the importance of pre-implementation planning with all partners, ownership of the program at the national and district level, and need for close monitoring and supervision to ensure proper control and minimize leakage.

It is the responsibility of the MOH and the NMCP to determine the most appropriate model for delivering LLINs through routine services. Points to consider include:

- Heavily subsidized sale of LLINs vs. free delivery
  - Free delivery of LLINs ensures equitable access for even the most vulnerable populations.
  - However, subsidized LLIN sales can provide a potential source of revenue for peripheral health facilities and source of incentive for implementers.
- Sub-contracting logistics
  - Existing supply chain management systems for essential medicines and supplies may not be appropriate for LLINs. Nets are bulky and can place a strain on supply chain management infrastructure. Programs may want to consider sub-contracting the logistics component of LLIN delivery from the central level to peripheral health facilities to a private-sector partner.

Strategy 2: LLIN distribution through community channels

Community-based distribution is an effective means of ensuring that LLINs reach all target populations. Community-based distribution is a broad term that can encompass:

- Free distribution through NGOs, health workers, volunteers or other community-based organizations to beneficiaries. Often, where distribution of LLINs is free, there are beneficiary groups targeted to have greatest impact with limited resources. Free community-level distribution may target children under-five, pregnant women, PLHIVs, refugees/displaced people and other highly vulnerable groups.

- Subsidized distribution through NGOs, health providers, volunteers or other community-based organizations. Money from the sale of the subsidized nets is used as incentive for continued involvement of the sales person, as well as for ongoing LLIN purchase.

- Subsidized or full price distribution through community-based organizations on a revolving fund basis, where different pricing and payment methods are based on community knowledge of the beneficiaries and the strategy is modified according to individual circumstances.

Community distribution is important to consider in countries where access to health facilities is low. Even where geographical access is not a problem, people in many countries may distrust the quality of health services provided and choose not to access facilities. If traditional birth attendants (TBAs) are the primary source of information for pregnant women, they should be trained in methods of BCC and provided with a stock of LLINs for their clients.

Remote communities are sometimes accessed through outreach and mobile services that bring the health facility staff to the village or community. These clinics provide an opportunity to disseminate messages about malaria prevention and distribute LLINs to target populations (whether universal or most vulnerable). Activities to promote prevention in remote communities are extremely important given that cases of fever are unlikely to be treated appropriately within the 24-hour timeframe recommended. Where curative services are inaccessible, prevention is paramount to reduce morbidity and mortality.

Strategy 3: LLIN distribution through social marketing

The private sector has a role to play in ensuring sustained access to LLINs as part of a comprehensive post-campaign keep-up strategy. A social marketing approach is defined in this case as the use of public funds to support market-based approaches to delivery for increased health impact.

NMCPs have several options for leveraging the private sector as a delivery channel depending upon the country context:

Subsidized sale through commercial sector outlets:

- Highly subsidized sales through the private sector may be the only option for ensuring sustained access to affordable LLINs for populations not otherwise reached through public sector health facilities, for example in post-conflict settings where the public health systems are either non-existent or do not have the capacity for rapid delivery of effective malaria control interventions. In these situations, using public-sector funds to heavily subsidize LLINs can result in the lowest possible consumer prices whilst ensuring the generous trade margins that provide the incentive to drive distribution.

Photo: © Jenn Warren/PSI Sudan. www.jennwarren.net

Young girl in the village of Tonj, Warrap State, airs out her family's LLIN, which she received at an integrated campaign in Southern Sudan.

- Private-sector outlets such as kiosks, markets, and shops, as well as community-based organizations, can be utilized as a sustained delivery channel.

Bundling long-lasting insecticide treatment with untreated nets:

- Untreated locally produced or imported nets are available through the commercial sector and in markets. NMCPs and partners can significantly increase health impact by working with local manufacturers and distributors to bundle insecticide treatment kits.

WHO recommends the use of LLINs versus nets that require periodic treatment. LLINs should always be the preferred distribution product.

Public–private partnerships:

- In settings where financial resources are limited but private-sector infrastructure is relatively strong, NMCPs may want to consider public and private-sector partnerships. The aim of this approach is to stimulate the private sector through incentives while creating increased demand amongst consumers.

Through the social marketing approach, highly subsidized sales are supported by a combination of branded advertising campaigns and compelling generic communication to create demand and improve LLIN use. Messages are disseminated through a mix of mass media and interpersonal channels including radio, drama, mobile video shows and antenatal consultations.

7.3. Behavior change communication for increased use

Behavior change communication (BCC) is defined earlier in the toolkit (please refer to section 5: Communication) as a communication strategy that aims to foster positive behavior; promote and sustain individual, community, and societal behavior change; and maintain appropriate behavior.

The mass distribution of LLINs through integrated campaigns does not guarantee the correct use of nets. It is important to combine distribution with an effective and targeted communication strategy.

A great deal of effort is expended in developing messaging and communication tools to encourage caregivers to bring children to mass campaigns. For the EPI and nutrition interventions, the exercise is finished once the child has received the interventions, but for malaria, BCC is extremely important after the caretaker has received the net—to ensure that the net is correctly hung and used on a nightly basis, prioritizing utilization by the most vulnerable groups.

BCC through mass media channels

One means of undertaking BCC is through mass media channels, which have the possibility of reaching large numbers of beneficiaries at a low to moderate cost. As with the methods for sustaining LLIN coverage, the means for achieving impact through BCC is to combine a number of approaches to reach the maximum number of beneficiaries.

Mass communication channels include radio and television, as well as print media such as newspapers, posters and other visual materials. Mass media can be used year round to promote acquisition and utilization of LLINs, and efforts can be intensified around the high transmission season to ensure messages are reaching their targets with the desired impact of increased use.

Mass media channels have the ability to reach large numbers of people, but for the messages to actually reinforce positive behavior change they must be clear, culturally and contextually relevant and endorse simple-to-do behaviors. The language of choice for mass media in a country is also of importance, notably where a number of official languages and dialects exist. In situations where a number of major languages are used, it may be beneficial to consider using district or community radio rather than national, especially where literacy levels are low in terms of the "national" language.

Resources

98 *Behavior Change through Mass Communication: Using Mass Media for AIDS Prevention.* PDF. AIDSCAP/FHI.

BCC through community and household channels

Behavior change communication is very effective when done at the community and household levels. Specific attention to particular behaviors, as well as the individual context, allows messages to be more targeted.

Since the Togo integrated campaign in 2004, Red Cross volunteers have been participating in a program called "Keep Up," which is focused on sustaining the achievements of the mass campaign. The Red Cross "Keep Up" program is a long-term, intensive effort to improve mother and child health. It includes volunteer-delivered messaging on malaria (cause, prevention and fever treatment),

vaccination (the importance of the routine EPI series), vitamin A supplementation, de-worming, and health promotion. Red Cross volunteers go door-to-door and/or organize community meetings to not only pass messages, but to also ensure that LLINs are hanging correctly and are being used by the intended target group. Red Cross volunteers keep registers of the households they are following and record new pregnancies, new births and other events. They deliver messages promoting the use of routine service for pre-natal care and for routine vaccination services.

UNICEF is engaged in demand creation through participatory communication at the community level. Participatory approaches have been used to stimulate community based planning for malaria control and prevention and a toolkit for undertaking this process has been developed. In addition, UNICEF has developed a number of guides and tools to be used at the community level for promoting behavior change and encouraging net hanging and use.

BCC through school-based education and communication

Schools provide a venue for reaching attending children. Education and communication in schools accomplishes two objectives:

1. The information shared with children in schools is often taken back to the household where it is discussed as "what was learned today."

   In this way, not only is the child receiving the key messages, but these are being disseminated to a broader audience in the home setting.

2. The delivery of early and positive messaging on healthy behaviors and understanding of risks.

   If children are told early and repeatedly about, for example, the importance of LLINs for malaria prevention, this message will remain with them as they grow and have their own families. Targeting messages to young people who will soon be making decisions strengthens the "culture" of LLIN use; communication and education in schools will help ensure that those decisions are positive and healthy.

Resources

99 *Red Cross "Keep Up" Concept Paper.* PDF (a) English (b) French (c) Spanish

100 *Participatory Malaria Prevention and Treatment Toolkit.* PDF. UNICEF.

101 *Comic Curves: How to Hang a Net.* PDF. UNICEF.

102 *Comic: Family Musa and Isaka.* PDF. UNICEF.

BCC through health facility channels

Health providers working at facilities provide another opportunity for disseminating key messages and BCC to mothers/caregivers. Often, health providers are respected and trusted by the community, and they normally have a good understanding of the socio-economic and cultural context.

Health facilities are a well-placed avenue for giving and receiving messages about malaria prevention and treatment. Routine services targeted at vulnerable populations, such as children under-five years of age for vaccination and pregnant women for antenatal care, are ideal opportunities to discuss and interact with caregivers about the risks associated with malaria, the importance of

early treatment in cases of fever, and the necessity of using a LLIN on a nightly basis. Women and infants attend at least four ANC or EPI visits in many countries. These contacts are cost-effective opportunities to educate about correct LLIN use.

Health facilities can be used as venues for informational sessions. For example, pictures and written messages posted on walls or distributed to people attending health facilities can be used for communication. Health staff can organize times where simple films are displayed on television. In areas where people are waiting for care, messages about malaria recorded on tape can be played or, where possible, health workers can talk about malaria to patients.

Photo: IFRC

An effective and targeted communication strategy encourages the correct use of nets.

Annex 1: Examples of Chronograms

Example of a technical chronogram

Activities		Indicators	8				7			
1	Determine the terms of reference for the members of the social mobilization sub-committee	Organizing committee officially constituted	■	■						
2	Officially constitute the social mobilization sub-committee at national level	POA finalized	■	■						
3	Constitute the communication/social mobilization sub-committees at the regional and district levels	TOR defined			■	■				
4	Determine the needs for all interventions (vaccines, syringes, vitamin A supplements, security boxes, nets, indelible markers, etc.)	Needs determined			■	■				
5	Begin work on ensuring tax exoneration for LLINs	Tax exoneration process started					■	■		
6	Place order for nets (type and number)	Order placed					■	■		
7	Follow up the tax exoneration with Ministry of Finance and Ministry of Health	MOF approached for tax exoneration. Exoneration received								
8	Determine needs for personnel, tally sheets, other support	Needs determined								
9	Follow the planning and activities of the sub-committees	Planning done					■	■	■	■
10	Organize regular meetings with all partners to inform about actions taken in planning for campaign. Circulate minutes to partners.	Meetings organized, minutes circulated					■	■	■	■
11	Finalize the preliminary budget and send to partners	Preliminary budget finalized and circulated							■	■
12	Finalize micro-planning templates with logistics sub-committee	Micro-planning templates finalized								
13	Finalize and circulate the definitive budget to partners	Definitive budget available and shared								
14	Finalize the supports and tools for all training sessions	Supports and tools finalized								
15	Finalize all the technical tally forms for all interventions in the campaign	Tally forms finalized								
16	Develop the planning for supervisors during the implementation of the campaign	Planning of supervisors finalized								
17	Gather and record coverage data each day during the campaign	Data collected								
18	Analyze the coverage data for each intervention at the end of the campaign	Data analyzed								
19	Plan for and implement the post-campaign coverage survey	Post-campaign survey complete								
20	Write the final report for the campaign and circulate to partners (in-country and international)	Report finished and distributed								

Months before Campaign						Campaign week	Responsible person or group
6	5	4	3	2	1		

ANNEX

Example of a logistics committee chronogram, for the period before the arrival of nets

	Activities - before the arrival of nets	Indicators	8				7				
1	Follow up the tax exoneration request with the Ministry of Finance and the Ministry of Health	Request sent to MOF			■	■	■	■			
2	Determine needs for all interventions, including indelible ink markers	Needs determined			■	■					
3	Order all supplies for the campaign	Order placed					■	■			
4	Officially constitute the logistics sub-committee at the national level and the regional and district support teams	Logistics sub-committee officially constituted					■	■			
5	Obtain from the regions and districts an up to date list of health centers or facilities, including the distances to each from the district center	Information obtained					■	■			
6	Develop the logistics POA	Logistics POA available							■	■	
7	Prepare regional/district briefing documents and prepare micro-planning documents for all interventions	Documents prepared							■	■	
8	Send the briefing documents/micro-planning templates to regions/districts with dates of micro-planning missions	Documents sent									■
9	Undertake the micro-planning mission in the regions and districts	Mission accomplished									
10	Synthesize the data from the micro-planning at national level	Data synthesized									
11	Calculate preliminary budgetary allocations for the districts using the information from the micro-planning	Budget allocation table available									
12	Research options for transportation of supplies to the districts	List of transporters available					■	■	■	■	
13	Research options for warehousing of nets at central, regional and district levels	List of warehouses available					■	■	■	■	
14	Prepare a call for tenders for moving supplies from the central level to the regions and districts	Documents for call for tenders prepared									
15	Launch call for tenders for transportation of supplies	Call for tenders launched									
16	Reconfirm that the tax exoneration is in place. Send the exoneration to the clearing agent(s)	Exoneration received and sent							■	■	
17	Prepare a draft of the transportation contract	Draft available									
18	Finalize the budget for the implementation of the logistics operation	Budget finalized									

Months before Campaign: 6	5	4	3	2	1	Campaign week	Month after	Responsible person or group

ANNEX

Example of a logistics committee chronogram, for the period before and at the time of net arrival

	Activities - before and at the time of net arrival	Indicators	8				7			
19	Discuss and define the mechanisms for access to operational funds in the logistics budget and for the transfer of the budgetary allocations to the districts	Mechanisms in place								
20	Review the transport contract draft with the legal service of the MOH and get their input (additions and modifications). Finalize the contract	Contract finalized								
21	Open the bids received and decide who will be awarded the contract	Transporter(s) chosen								
22	Sign the contract with the transporters	Contract signed								
23	Undertake a training and follow up planning mission in the regions/districts. Bring examples of bills of lading and warehouse journals (+others) to demonstrate their utilization	Mission accomplished								
24	Print the determined number of blocks of bills of lading and the determined number of warehouse journals	Supports available								
25	Arrival of containers at port (wherever). Mission of members of the logistics team to follow the processes with the authorities and clearing agents	Arrival of containers at port								
26	Arrival of containers at central level (esp. in landlocked countries). Facilitate clearing formalities. Recruit labourers, open containers and discharge bales in the warehouse.	Containers received and emptied at warehouse								
27	Update of positioning plan if any new information of importance	Positioning plan updated								
28	Prepare the descriptions of the tasks of conveyors and supervisors	Documents prepared								
29	Select conveyors, prepare briefing documents and do a 2-hour training the first day and then a 'test' and revision of 1 hour the second day.	Conveyors selected and have received adequate training								
30	Transport operation according to planning. Management, coordination and control of the operation. Don't forget to send the bills of lading to the districts.	Transport operation executed as planned in logistics plan								
31	Undertake a supervision mission in all the districts to verify that the nets are in place as planned and to follow the implementation of the operation	Mission accomplished								
32	Prepare the logistics operation report	Report available								

Months before Campaign						Campaign week	Month after	Responsible person or group
6	5	4	3	2	1			

Example of a social mobilization chronogram, for activities before the campaign

	Activities	Indicators	8				7			
1	Determine the terms of reference for the members of the social mobilization sub-committee	Terms of reference elaborated								
2	Officially constitute the social mobilization sub-committee at national level	Social mobilization sub-committee officially constituted								
3	Constitute the communication/social mobilization sub-committees at the regional and district levels	Social mobilization sub-committees constituted at regional/district levels								
4	Elaborate a social mobilization and integrated communication plan for the campaign	Communication plan elaborated								
5	Advocacy for support at all levels (national, international)-contacts and correspondences with interest groups, economic operators, key people in civil society, military, etc.)	Advocacy done								
6	Elaboration of messages for the campaign (for posters, banners, flyers, radio, television, etc.)	Messages elaborated								
7	Follow up the tax exoneration with Ministry of Finance and Ministry of Health	Supports elaborated								
8	Elaboration of publicity supports (posters, flyers, banners, etc.)	Media dossier elaborated								
9	Elaboration of dossier for NGOs, religious groups, village chiefs and other actors to inform them about the campaign and its purpose	Partners dossier elaborated								
10	Elaboration of unique campaign songs to be diffused in all languages via radio	Songs elaborated and diffused								
11	Elaboration of publicity spots (production of audio messages, development of first versions in national language, pretesting, finalization and airing)	Publicity spots developed and diffused								
12	Develop and reproduce all the supports and terms of reference for all the trainings for those involved with social mobilization	Supports and terms of reference produced								
13	Training of journalists	Number of journalists trained								
14	Press conference by the Minister of Health	Press conference done								

ANNEX

Months before Campaign							
6	5	4	3	2	1	Campaign week	Responsible person or group

...cont'd on next page

ANNEX

(...cont'd) **Example of a social mobilization chronogram, for activities before the campaign**

	Activities	Indicators	8				7			
15	Training for community radio and television animators	Number of animators trained								
16	Training of women's groups	Number of women's groups trained								
17	Training of community health information focal points (les relais)	Number of focal points trained								
18	Training of town criers	Number of town criers trained								
19	Training of Red Cross volunteers	Number of volunteers trained								
20	Production of visibility supports (e.g. t-shirts, hats, etc.)	Visibility supports produced								
21	Assure media coverage of the reception of the LLINs (nets) at national level as method for sensitization of population	Reception of nets covered in local media								
22	Social mobilization (mass) through radio and television	Mass social mobilization done								
23	Social mobilization (proximity) through town criers, women's groups, volunteers, community workers	Social mobilization of proximity done								
24	National launch of campaign	National launch done								
25	Launch of campaign at regional and district levels	Launch of campaign at peripheral levels done								
26	Campaign supervision and mission to evaluate effectiveness of social mobilization	Supervision and evaluation finished								
27	Report on campaign communications and social mobilization	Report available								

Months before Campaign							
6	5	4	3	2	1	Campaign week	Responsible person or group

Annex 2: Advocacy and Communication Planning timeline for International Partners

This is a general timeline of suggested activities to guide planning and coordination of communication and advocacy (national and international) in support of a multi-partner integrated health campaign. This timeline should be updated on a routine basis as more details take shape, tasks are developed and plans evolve. The in-country social mobilization sub-committee should coordinate with international partners to ensure maximum impact of activities. The should also ensure both the active participation of beneficiaries (normally mothers and caretakers of children under five) in the country and the engagement of the international community, to raise awareness and funds for continued activities.

Month	Activity	Lead	Coordinate with	Status
THREE OR FOUR MONTHS BEFORE CAMPAIGN				
Week ***16***	Social mobilization sub-committee should share communication plans with technical and organizing committees for approval. Communication plans should also be shared with partners not regularly attending meetings but who have been involved in communication activities in the past. Once approved, communication plans should be shared with international partners.			
	Social mobilization sub-committee (which includes in-country communication partners) should meet with appropriate host government officials to outline campaign activities and communication priorities, including handover of campaign supplies from donors to government, press conferences, receptions for key visitors and campaign launch.			
	Campaign program/planning team should identify communication focal points and back-ups from the Government and all partners. Set up e-mail distribution list and contact list of communication group members. Send e-mail inviting reps to join a regular communication/advocacy planning call.			
	Conduct first communication and advocacy planning call.* Identify overall coordinator and rapporteur. International partners are best organized to coordinate this call, given access to international conference lines and ability to link with partners in the field. At a minimum, calls should take place every 2 weeks, and in the final month, every week.			
Week ***15***	Identify focal points for development of key supports. Begin to compile boilerplate, logos, key messages and FAQs. Assign leads for drafting media materials (executive summary, talking points, speaker biographies, fact sheets, media advisory, op-ed, news releases and other materials needed for press conferences or outreach).			
	Have members of social mobilization sub-committee discuss outcomes desired by host government. International partners should identify their objectives and goals for communication and advocacy.			
	Update e-mail distribution list and contact list of communication group members based on participation during first communication and advocacy conference call.			

Month	Activity	Lead	Coordinate with	Status
Week **14**	Begin rough outline of international/national communication plan based, where possible, on an existing MOH communication plan, to include training CHW, local leaders, development agents, media outreach, advocacy, event management, visitors and field trips. Determine in-country and international partner roles and responsibilities vis-à-vis plan and objectives.			
	Identify desired high-level speakers for campaign events (including handover, receptions, press conference and launch) and those to invite to events.			
	Develop draft invitation letter for speakers and conduct outreach to secure participation.			
Week **13**	Conduct communication and advocacy planning call.			
TWO MONTHS BEFORE CAMPAIGN				
Week **12**	Social mobilization sub-committee should develop draft activity and event budgets and share it with technical committee and coordinating group for comment/review and approval.			
	Events budget should be shared with international partners for discussion during the communication and advocacy planning call. International partners should commit contributions based on approved budget.			
	Request comments on first draft media outreach plan and event plan.			
	Plan country-level and global advocacy and media outreach for campaign-related activities.			
	Develop "save-the-date" invitations for events.			
	Assign lead for product development – signage, media materials, talking points, translation, etc.			
	Conduct communication and advocacy planning call			
Week **11**	Detail key participant list (photographer, video crews, VIPs, key officials) for events. Identify high-level attendees for event (host government, MOH, key partners) as well as priority events for key individuals.			
Week **10**	Draft visitor list for MOH. Identify reception requirements if any. Identify potential sites for field visits. Determine possible group events, depending on visitors attending (e.g., meeting with religious leaders). Start discussions regarding protocol for visitors, media, and technical observers.			
	Update boilerplate, logos, key messages and FAQs.			
	Conduct conversations with MOH regarding venue logistics (e.g., audio, staging, etc.) Look at gaps, bottlenecks and budget shortfalls			
Week **9**	In-country team should visit potential sites for events and the launch of the campaign.			
	Conduct communication and advocacy planning call.			

Month	Activity	Lead	Coordinate with	Status
Week **8**	Continue to refine "run-of-show" for campaign-related activities.			
	Continue outreach to high-level participants, both in-country and internationally.			
	Distribute "save-the-date" to event guests. Invite foreign reporters to attend.			
	Ensure that high-level government officials are informed by the coordinating committee regarding event planning, reception, launch and campaign logistics and ensure necessary participation.			
Week **7**	Review and feedback on media materials (executive summary, talking points, speaker biographies, fact sheets, media advisory, op-ed, news releases) needed for press conference or outreach.			
	Finalize media outreach list for press conference, site visits, receptions, launch.			
	Organize handover of campaign supplies from partners to government. Ensure media coverage to begin social mobilization in-country. If the Minister of Health or other high-level personalities attend the handover, word of the campaign will begin to spread.			
	Identify needs – secure cars, drivers, phones, translators. Note anticipated arrivals, departures of visitors, hotels, cell numbers. Determine protocol requirements to facilitate airport arrivals and departures.			
	Conduct communication and advocacy planning call			
Week **6**	Ensure that high-level government officials are informed by the coordinating committee regarding event planning and ensure necessary participation. Secure necessary clearances for media, film crews and photographers.			
	Finalize key messages, boilerplate and op-eds. Translate materials			
	Produce event and press conference scene setter – minute-by minute			
	Send design materials (e.g., events signage) to the printer for production			
	Draft agendas and itineraries for visitors, media and technical observers to be shared with the MOH and coordinating body for feedback and approval. A broad description of the objectives of the visiting organization should be provided, as well as an indication of places to visit. Coordinating committee should provide feedback for discussion on conference call.			
Week **5**	Conduct communication and advocacy planning call			
	Share speaker talking points and/or remarks for editing			
	Finalize media kit and outreach materials for press conference/press outreach			
	Begin call-downs, leverage reporter relationships, pitch op-ed placement			
	Undertake training of local media and people of influence. Ensure that package is provided to all media with correct boilerplate, FAQs, key messages and calendar of campaign events.			
	Conduct communication and advocacy conference call.			

Month	Activity	Lead	Coordinate with	Status
Week **3**	Finalize venue logistics (e.g., sound, access, staging, minute-by minute). Ensure translation services available where necessary.			
	Distribute partner staff and dignitary lists (contact, hotel, cell, etc.)			
	Finalize speaker talking points/remarks for launch event. Translate where necessary.			
	Conduct communication and advocacy conference call.			
	Conduct press conference walkthrough with all key organizations represented.			
Week **2**	Test AV, digital video teleconference, phone, etc.			
	Conduct communication and advocacy final conference call pre-campaign activities.			
	Conduct walk-through of event venue.			
	Conduct pre-event briefing for speakers.			
Week of launch	Conduct press conference/media briefing.			
	Organize reception for international guests and in-country organizers.			
	Undertake launch activities.			
AFTER THE LAUNCH				
	Track media coverage			
	Prepare final report on activities and after-action report			
	Organize final conference call with all partners to debrief and discuss lessons learned.			

Annex 3: List of Resources

The Canadian Red Cross Campaign Against Malaria

Video about the Integrated Campaign in Sierra Leone, in French and English.

INTRODUCTION

1 WHO/UNICEF Joint Statement Global Plan for Reducing Measles Mortality. PDF. 2006-2010.

2 Insecticide-treated Mosquito Nets: A WHO Position Statement. PDF. 2007. Part 1.

SECTION 1 - PLANNING

3 A Framework of Strategic Options for the Integrated Delivery of Insecticide-treated Nets and Immunization. PDF. Prepared for the Global Malaria Programme, WHO, by Jayne Webster, TARGETS Consortium London School of Hygiene and Tropical Medicine, and Jenny Hill, Child and Reproductive Health Group Liverpool School of Tropical Medicine and Hygiene. Draft: May 2006.

4 Delivery systems for insecticide treated and untreated mosquito nets in Africa: categorization and outcomes achieved. Abstract. MS Word. By Webster J, Hill J, Lines J, Hanson K. Health Policy Plan. 2007 Sep;22(5):277-93. E-pub June 28, 2007.

5 Operational Integration of Key Child Survival Interventions: A Guide for District Health Management Teams. PDF. WHO/AFRO. Draft: 2005.

6 Measles and Malaria Campaign Plan of Action. MS Word. Sierra Leone. January 2007.

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8 Measles SIAs Field Guide. PDF. WHO/AFRO. Revised: January 2006.

9 Framework for Monitoring and Evaluation of Integrated Child Survival Interventions. PDF. WHO/AFRO, 2006.

10 (a) Chronogram Example – English and (b) Chronogram Example – French. MS Excel.

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11 The Global Fund Niger Project: Integrated Polio Vaccination and Mosquito Net Distribution. PDF. 19-24 December 2005. International Federation of Red Cross and Red Crescent Societies. Annual Report, August, 2006.

12 Partnerships in Action: An Integrated Approach to Combining a Measles Campaign with a Bed Net, Vitamin A, and Mebendazole Campaign in Zambia (Malaria Case Study). PDF. American Red Cross International Services and CORE, July 2004.

13 Malaria and Measles: Focus on Zambia. (Programme Update). PDF. International Federation of The Red Cross, March 2004.

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18 The Immunization Inter-agency Coordination Model. An example from the DRC. PDF. BASICS II.

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19 Sierra Leone MOHS Integrated Campaign Budget. MS Excel. Example budget.

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21 National Measles-Malaria Campaign Report. Sierra Leone. MS Word. January 2007.

22 A Treated Mosquito Net for Every Child Under 5 in Rwanda. PDF. Rwanda Brief: PSI Malaria Control. January 2007.

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23 Logistics Chronogram Example from Sierra Leone. MS Excel.

24 Logistics Chronogram Example from Mali. MS Excel.

25 Liberia micro-planning examples. January 2007.

(a) District summary form and district micro-planning templates. MS Excel

(b) Immunization summary sheets. MS Excel.

(c) Daily before and during implementation forms. MS Excel.

(d) Vaccination summary sheets. MS Excel.

(e) Adverse effects following immunization_Case investigation form. MS Word.

(f) Adverse effects following immunization_Line listing. MS Word.

26 WHO website for estimating vaccine annual needs: http://www.who.int/immunization_delivery/systems_policy/logistics_annual_needs/en/index.html

27 Strategic Framework for Integrating Additional Child Survival Interventions with Immunization in the African Region. PDF. WHO/AFRO. August 2006.

28 Instructions for the proper use of indelible markers. MS Word. January 2007.

29 Analysis of Distribution Costs. MS Excel. PATH, MACEPA obtained from Paul Libiszowski.

30 Overall Logistics budgets-Comparisons of Selected Countries. MS Excel. Obtained from Alain Daudrumez, logistics consultant.

31 Stock control examples from Sierra Leone. MS Excel. Example of waybill, stock report, inbound and outbound stock ledgers and goods received note.

32 Conveyor Training Outline. MS Word.

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34 Insecticide Treated Nets and Vitamin A Supplementation: An integrated approach to control malaria and micronutrient deficiency (Literature Review Paper and Malawi Case Study). PDF. Prepared for The Micronutrient Initiative by Dr. Mark Young, Health Advisor; Dr. Peter Berti, Nutrition Advisor; Sian Fitzgerald, Executive Director, PATH Canada. April 2000.

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36 IFRC Log Purchase Request for Quotation. MS Word. Example facsimile.

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39 Example Transport Contract from Sierra Leone. MS Word.

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CD-ROM

The accompanying CD-ROM contains the reference documents listed throughout the toolkit. Internet access is not required to view the documents.

This toolkit to brought to you by **The Alliance for Malaria Prevention (AMP)**, a subgroup of the Roll Back Malaria Partnership, which consists of more than 20 partners, including government, business, faith-based and humanitarian organizations.

AMP's goal is to expand ownership and use of LLINs, which have been shown to reduce malaria incidence by 50 percent and reduce child mortality by 20 percent. Local and international partners are coming together under the AMP umbrella to deliver LLINs to vulnerable groups via mass delivery in conjunction with other child survival campaigns.

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