Collaborative Action Strategy (CAS) for Health Campaign Effectiveness

December 2023

HEALTH CAMPAIGN EFFECTIVENESS COALITION

Strengthen Systems.
Maximize Impact.

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GLOSSARY

ACRONYM	MEANING
BMGF	Bill & Melinda Gates Foundation
CAS	Collaborative Action Strategy
CDC	Centers for Disease Control and Prevention
FTE	Full-time Employee
GAVI	Gavi, the Vaccine Alliance (formerly "Global Alliance for Vaccines and Immunization")
GPEI	Global Polio Eradication Initiative
HCE	Health Campaign Effectiveness
HMIS	Health Management Information Systems
LMIC	Low- and Middle-Income Countries
LOE	Level of Effort
LT	Leadership Team
M&E	Monitoring and Evaluation
MERLA	Monitoring, Evaluation, Research, Learning and Adaptation
MOF	Ministry of Finance
MOH	Ministry of Health
NGO	Non-Governmental Organization
NTD	Neglected Tropical Disease
PHC	Primary Health Care
PoC	Proof-of-Concept
SOP	Standard Operating Procedure
ToR	Terms of Reference
UN	United Nations
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WHO	World Health Organization

EXECUTIVE SUMMARY

The Leadership Team of the Health Campaign Effectiveness (HCE) Coalition recognized that, to make real progress toward strengthening health campaigns and primary health care systems, it is imperative to transition research findings, learnings and the collective strengths of its partners into practice. Over the course of the first 10 months of 2023, the Leadership Team led an inclusive, participatory process to co-develop an actionable strategy for transformative change.

The resulting **Collaborative Action Strategy (CAS) for Health Campaign Effectiveness** was designed with over 40 cross-domain partners at the global, regional and country levels. The HCE Coalition leveraged the expertise and experience of these partners – including countries already invested in reducing health campaign fragmentation – to shape the recommendations comprising the strategy.

Grounded in collective action, the CAS is a first of its kind commitment, co-developed by country leaders, campaign funders, bilateral and multilateral organizations, and NGOs from 5 major health campaign domains[1] (as well as specialists in health systems, ethics, and health economics) to plan, implement, evaluate, and importantly, finance campaigns in a fundamentally different way.

Over the last three decades, there has been a growth of disease-specific financing, which has contributed to the proliferation of disease-specific campaigns. As a result, campaign financing is often vertical and fragmented with disjointed practices, procedures and timelines for funding health campaigns.

The CAS is designed to guide global health organizations, programs and governments to a future state where health campaign programs collaborate effectively with each other and corresponding health services to maximize the impact of all health campaigns on health outcomes in countries. This means cross-campaign integration[2], which is vital if countries are to achieve global health milestones by 2030, including the UN Sustainable Development Goals (SDGs), in particular SDG 3 regarding good health and well-being, as well as universal health care and disease-specific goals.

The 12 concrete recommendations outlined in the CAS are related to planning and implementation, monitoring, evaluation, research, learning and adaptation, and financing. They are primarily intended to improve collaboration amongst preventive health campaigns – but can also serve to guide integration with health emergency response efforts when relevant. They were also developed to be contextualized and adapted to meet any given country's unique opportunities, challenges, and needs, offering different approaches to best achieve national, subnational and community health goals. Together, the recommendations provide a meaningful roadmap away from the current 'status quo' and toward improved health campaigns, which in turn will result in better health services for populations.

Critically, the recommendations are not targeted to countries alone. The CAS is also a call to action for global stakeholders to lean in and do their part to shift that status quo. Global funders, technical agencies and implementers must agree to dedicate the financial and human resources, and to align on required actions, necessary to implement the CAS and achieve its intended outcomes in countries.

At a high level, the recommendations are primarily intended to:

1. support the implementation of increased coordination and/or integration and reduce fragmentation by outlining the value, key steps, and actors
2. maximize the efficiency of campaigns and resources to address country health gaps and priorities and optimally serve target populations and communities
3. deepen information gathering on coordination and/or integration benefits and opportunities across campaigns
4. foster timely, harmonized funding processes and streams so countries are better able to implement effective campaigns
5. support the transition of health campaign interventions to the primary health care (PHC) system in the long-term
6. deliver high-quality, equitable, accessible and people-centered health services that meet multiple health needs

[1] Includes: immunizations, including polio, neglected tropical diseases (NTDs), malaria and nutrition/Vitamin A supplementation

[2] Integration covers a spectrum of activities, from collaboration, shared functionality or partial integration to full co-delivery of interventions where appropriate.

TABLE 1 HIGH-LEVEL SUMMARY OF THE CAS RECOMMENDATIONS

List of Recommendations for Improved Campaign Effectiveness

1. **Planning & Implementation**
   1a) Establish, or leverage an existing multi-sectoral, cross-campaign National Coordination Body
   1b) Identify campaigns and domains for collaboration and integration
   1c) Develop a multi-year, cross-campaign workplan and schedule for campaigns
   1d) Harmonize tools and operations (e.g., logistics, supply chain, microplanning) across campaigns
   1e) Develop a coordinated and effective approach to enable active community engagement at all levels and phases

2. **Monitoring, Evaluation, Research, Learning and Adaptation (MERLA)**
   2a) Within countries, develop a coordinated and collaborative cross-campaign MERLA strategy
   2b) Aligned with the coordinated country MERLA strategy, improve the ability of campaign implementers and partners to identify, measure, utilize, and share data on campaign effectiveness
   2c) At the global level, develop a Learning Platform and a MERLA framework as a practical guidance to countries and global stakeholders

3. **Campaign Financing**
   3a) Create a comprehensive view of campaign financing at the country level
   3b) Take incremental steps toward harmonizing and aligning campaign financing
   3c) Harmonize and align incentive payment modalities and rates across campaigns
   3d) Advance government role in campaign financing

Successful implementation of the CAS will require a strong commitment from all campaign partners at the global, regional, country and subnational levels to actively work together on the necessary actions and changes identified in the strategy. Funders, implementers and other partners may be asked to provide new or better aligned resources (i.e., human, financial, technical) and multilateral and UN agencies may need to revise their policies and normative or technical guidance on campaigns. Ministries of Health may need to take steps to adjust both financial and human resources to facilitate a more collaborative approach across disease programs to reduce fragmentation and strengthen campaign planning and implementation, such as creating a coordination unit or focal point to oversee CAS activities.

The CAS will be implemented in two phases over a 5-year period:

- Phase 1: The 'launch' phase aims to kick-start the systems change process in three focus countries and demonstrate a range of promising practices and policies. Starting in late 2023, and in collaboration with global HCE Coalition partners committed to advocating and advancing necessary changes within their respective organizations, focus countries will adapt and implement the CAS recommendations, develop country-specific operational plans, and monitor and measure their outcomes over the next 2-3 years.
- Phase 2: The 'scale up' phase will begin 2-3 years after the start of CAS implementation in the focus countries. Learnings from phase 1 will be compiled and analyzed to refine the CAS recommendations to make them a) more applicable at scale, and/or b) more applicable to a broad range of country contexts or environments.

Over the next five years, the HCE Coalition will support all partners through this transition by providing a **platform to share and learn from each other, documenting and disseminating findings and outcomes, and advocating for sustainable change.** Importantly, that change will require meaningful shifts by international stakeholders and national health systems alike. Together we will refine our understanding of what it takes for campaigns to be effective and meet health and equity goals.

INTRODUCTION

The **Collaborative Action Strategy (CAS) for Health Campaign Effectiveness** is designed to guide global health organizations, programs and governments to a future state where health campaign[3] programs collaborate effectively with each other and corresponding health services to maximize the impact of all health campaigns on health outcomes in the short- and medium-term. Importantly, it also aims to catalyze stronger, more resilient, and country-led health systems in the long-term with the ultimate goal of providing sustainable, gender-equitable health services for all people.

The strategy will inform the work of the various health campaign partners (global and regional organizations, funders, Ministries of Health and implementing partners[4]) in three focus countries and then at scale (i.e., concrete learnings related to improving campaign implementation and strengthening coordination and integration with primary healthcare services, will be leveraged and adapted to a regional and global context over the next five years.) over the next five years.

BACKGROUND

In settings where multiple health campaigns occur, planning, implementation, evaluation, and financing may be fragmented, carried out with little communication or collaboration amongst campaigns, and inadequate coordination across country health systems. This leads to strategic, financial, and operational inefficiencies and inequities that can strain health systems, burden health care workers, weaken health services and limit the potential impact of campaigns.

To address these challenges, in 2020 a diverse set of global and country stakeholders came together to form the Health Campaign Effectiveness (HCE) Coalition. Since its inception, the HCE Coalition has taken several important steps toward turning its vision of high quality, high impact health campaigns into reality on the ground in countries. These included a series of learning events and implementation research studies that identified multiple opportunities and promising practices to bolster cross-sectoral and cross-domain collaboration – and ultimately improve campaign and overall health outcomes.

The HCE Leadership Team recognized that, to make real progress toward strengthening health campaigns, it is imperative to transition research findings, learnings and the collective strengths of its partners into practice. Over the course of the first 10 months of 2023, the Leadership Team led an inclusive, participatory process to co-develop an actionable strategy for transformative change. The resulting CAS was designed with over 40 cross-domain partners at the global, regional and country levels. The HCE Coalition leveraged the expertise and experience of these partners – including countries already invested in reducing health campaign fragmentation – to shape the recommendations comprising the strategy.

[3] Campaigns are time-bound, intermittent activities which are deployed to address specific epidemiologic challenges expediently to fill delivery gaps or provide surge coverage for health interventions. They can be used to respond to disease outbreaks, eliminate targeted diseases as a public health problem, eradicate disease altogether, or achieve other health goals.

[4] Implementing partners (or implementers) refers to all stakeholders involved in the implementation of health campaigns (government, local and international NGOs, Community Service Organizations, public or private entities...). This document understands "implementation" as defined in Remme et al.'s Defining Research to Improve Health Systems: implementation "aims to develop strategies for available or new health interventions in order to improve access to, and the use of, these interventions by the populations in need."

Photo Credit: The Task Force for Global Health

PRIMARY AIM AND ANTICIPATED OUTCOMES OF THE CAS

The CAS is designed to deliver tangible added value across several key areas. **Critically, the CAS is not only a practical guide for countries. It is also a call to action for global stakeholders to lean in and do their part to shift the 'status quo.'** Global funders, technical agencies and implementers must agree to dedicate the financial and human resources, and to align on required actions, necessary to implement the CAS. **Anticipated outcomes that will bring significant added value to countries include, but are not limited to:**

- reducing fragmentation of public health programs by improving effectiveness, collaboration and coordination amongst partners (e.g., MOH, implementers, funders, subnational and community stakeholders) during the planning and implementation phases
- creating more efficient, targeted and integrated campaigns – including co-delivery when and where appropriate – that optimize financial, technical and human resources, and reach underserved or zero-dose communities
- streamlining approaches to measurement, monitoring, evaluation, and learning while fostering information sharing on the effectiveness of interventions and missed populations among the different programs
- harmonizing funding processes and streams to decrease the burden on countries, mitigate health program fragmentation, support integrated and cost-sharing approaches and reprogram cost savings for other activities, and improving the timely release of funds to countries
- strengthening and integrating selected functions of health campaigns to the PHC system over the short-term (e.g. supply chain logistics, HMIS and surveillance, financing, health workforce)
- transitioning health campaign interventions to the PHC system in the long-term
- achieving global health goals, including SDG 3, UHC2030 and goals laid out in the Immunization Agenda 2030, A Road Map for NTDs 2021-2030, Global Technical Strategy for Malaria, the Global Polio Eradication Initiative strategy, the Global Task Force on Cholera Control's Roadmap 2030, and by the Global Alliance for Vitamin A
- accelerating progress toward closing public health gaps in the wake of the COVID-19 pandemic
- aligning partners around an expanded definition of campaign effectiveness
- increasing equitable campaign coverage and genuine community engagement at all levels and phases of health campaigns

CAS CO-DEVELOPMENT PROCESS

Grounded in collective action, the CAS is a first of its kind commitment, co-developed by country leaders, campaign funders, bilateral and multilateral organizations, and NGOs from five major health campaign domains[5] (as well as specialists in health systems, ethics, and health economics), to plan, implement, evaluate and finance campaigns in a fundamentally different way. The CAS includes a dozen concrete recommendations (presented in the next section), developed by a diverse group of Coalition partners (organized into 4 task teams) and endorsed by the HCE Coalition Leadership Team[6], to improve health campaign effectiveness at the national and subnational level. Together, the recommendations provide a meaningful roadmap away from the current 'status quo' and toward improved health campaigns, which in turn will result in better health services for populations.

The recommendations were generated by four cross-campaign task teams focusing on:

1) campaign planning and implementation
2) MERLA (monitoring, evaluation, research, learning and adaptation)
3) campaign financing
4) political commitment and leadership

Each task team (see Annex H, Acknowledgements, for complete list of task team members and represented organizations) was led by two co-chairs, held virtual meetings approximately five times between June and October 2023, asynchronously developed and refined recommendations, and participated in two all-task team workshops. The development process was facilitated and coordinated by the HCE Program Office at the Task Force for Global Health with consultant support from Camber Collective. While preparing the recommendations, each task team reviewed recent and relevant published literature and the HCE-supported

[5] Includes: immunizations, including polio, neglected tropical diseases (NTDs), malaria and nutrition/Vitamin A supplementation
[6] The HCE Coalition Leadership Team consisting of representatives from WHO, UNICEF, BMGF, GAVI the Vaccine Alliance, Global Fund, Centers for Disease Control and Prevention, The Carter Center, and the Nigerian National Primary Health Care Development Agency

implementation research portfolio outputs to identify promising practices and opportunities for improved collaboration and integration of campaign planning, implementation, monitoring, evaluation and financing.

Through this interactive process, the teams clarified and defined:

1. the problem or challenge each recommendation is intended to solve and how the recommendation would be of benefit or service to countries
2. the actors and the specific actions or activities required of them
3. broadly, the resources needed to implement the recommendations
4. key milestones or measures of success.

COUNTRY ENGAGEMENT

Although this initial version of the CAS has been reviewed and approved by the HCE Leadership Team, from the perspective of country leadership, these recommendations may be viewed as a starting point for discussion, deliberation, and refinement. Beginning in November 2023 and facilitated by the HCE Program Office, a shortlist of countries will be formally engaged by the HCE Leadership Team, along with their organizations' regional and country-level representatives to foster additional input on the CAS and its recommendations and to invite them to 'opt-in' to adapt and implement the CAS, with support from HCE Coalition partners.

The HCE Coalition intends the CAS to be used as a resource to work with and alongside countries to find a strategic balance of highly effective, targeted campaigns in conjunction with ongoing primary health services, with the goal of achieving and sustaining health-development goals for all populations.

The HCE Coalition does not intend the CAS to be used to compel existing funders to cut health campaigns or health services, to reduce total budget envelopes for health campaigns or cross-cutting health system priorities, or to disrupt or contradict existing collaborative entities or efforts.

Photo Credit: The Task Force for Global Health

The HCE Coalition seeks trust-based partnership with country leaders that see value in the CAS and its preliminary recommendations, and who are interested in engaging, in the months and years to come, in an authentic co-development process driven by countries' immediate and future health priorities and goals. **Interested parties are encouraged to share questions, critiques and requests for information as they consider the value to them and the health campaigns, services and populations they represent.**

After countries opt-in (i.e., 'focus countries'), there will be opportunities to **contextualize and customize the recommendations and activities to their needs.** During the initial implementation of the CAS in two to three "focus countries," information on the operationalization and uptake of the recommendations will be shared and used to adjust as needed. In early 2024, a CAS Year 1 Action and Monitoring Plan will be developed by the HCE Program Office and Leadership Team in collaboration with the focus countries. Additional workgroups or Coalition support structures may be identified to support this plan. **The intent is for the CAS to continue to be a living and relevant document that has been co-created by the HCE Coalition partners and reflects the priorities and needs of country, regional and global campaign stakeholders.** Critically, it is also a roadmap guiding the way towards lasting systems change that will empower governments to provide all people with the chance to lead healthier, longer and more productive lives.

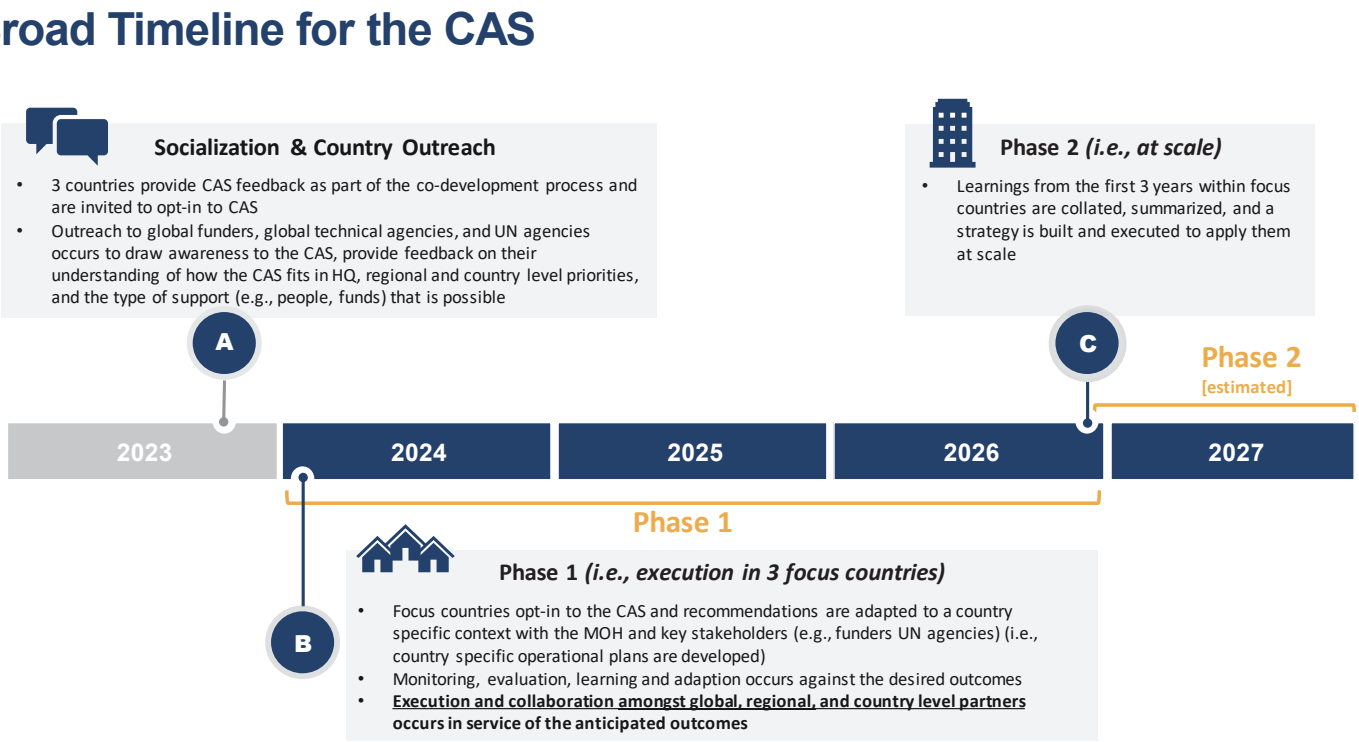
IMPLEMENTATION APPROACH

Successful implementation of the CAS will require a strong commitment from all campaign partners at the global, regional, country and subnational levels to actively work together on the necessary actions and changes identified in the strategy. Funders, implementers and other partners may be asked to provide new or better aligned resources (i.e., human, financial, technical) and multinational and UN agencies may need to revise their policies and normative guidance on campaigns. Ministries of Health may need to take steps to adjust both financial and human resources to facilitate a more collaborative approach across disease programs to reduce fragmentation and strengthen campaign planning and implementation.

The CAS will be implemented in multiple phases over a 5-year period:

- Phase 1: The 'launch' phase aims to kick-start the systems change process in three focus countries and demonstrate a range of promising practices and policies. Starting in late 2023, and in collaboration with global and regional HCE Coalition partners committed to advocating and advancing necessary changes within their respective organizations, focus countries will adapt and implement the CAS recommendations, develop country-specific operational plans, and monitor and measure their outcomes over the next 2-3 years. **The intention is to concretely advance campaign effectiveness in those countries,** while at the same time providing 'proof-of-concept' before global scale up in a second phase set to begin in 2026. As active members of the HCE Coalition, the Ministry of Health and other key stakeholders in the focus countries will engage with the broader campaign community to share insights on how country and global partners are collaborating and working differently to facilitate change and achieve improved campaign outcomes.
- Phase 2: The 'scale up' phase will begin two to three years after the start of CAS execution in the two to three focus countries. **Learnings from phase 1 will be compiled and analyzed to refine the CAS recommendations to make them a) more applicable at scale, and/or b) more applicable to certain country contexts/environments.** Facilitated by the HCE Program Office, the specific process for scale up will be co-developed by the HCE Leadership Team and countries beginning at the end of year 2.

Figure 1: High-level overview of CAS phases and timeline



Over the next five years, the HCE Coalition will support all partners through this transition by providing a **platform to share and learn from each other, documenting and disseminating findings and outcomes, and advocating for change.** Importantly, that change will require meaningful shifts by international stakeholders and national health systems alike. Together we will refine our understanding of what it takes for campaigns to be effective and meet health and equity goals.

OVERVIEW OF COUNTRY-LEVEL RECOMMENDATIONS TO IMPROVE HEALTH CAMPAIGN EFFECTIVENESS

The sections below present the **12 recommendations that form the foundation of the CAS** and its **vision for deeper collaboration and increased effectiveness at all levels**, resulting in greater impact at the country level, including improved health outcomes and strengthened health systems. The recommendations are organized around three key topics (i.e., campaign planning & implementation; MERLA[7]; campaign financing) and are primarily intended to:

1. support the implementation of increased coordination/integration and reduce fragmentation by outlining the value, key steps, and actors
2. maximize the efficiency of campaigns and resources to address country health gaps and priorities, and optimally serve target populations and communities
3. deepen information gathering on coordination/integration benefits and opportunities across campaigns
4. foster timely, harmonized funding processes and streams so countries are better able to implement effective campaigns
5. support the transition of health campaign interventions to the PHC system in the long-term
6. deliver high-quality, equitable, accessible and people-centered health services that meet multiple health needs

Presented below is a high-level summary of the CAS recommendations followed by each recommendation in detail:

TABLE 2 HIGH-LEVEL SUMMARY OF RECOMMENDATIONS

List of Recommendations for Improved Campaign Effectiveness

1. Planning & Implementation

1a. Establish, or leverage an existing multi-sectoral, cross-campaign National Coordination Body

1b. Identify campaigns and domains for collaboration and integration

1c. Develop a multi-year, cross-campaign workplan and schedule for campaigns

1d. Harmonize tools and operations (e.g., logistics, supply chain, microplanning) across campaigns

1e. Develop a coordinated and effective approach to enable active community engagement at all levels and phases

2. Monitoring, Evaluation, Research, Learning and Adaptation (MERLA)

2a. Within countries, develop a coordinated and collaborative cross-campaign MERLA strategy

2b. Aligned with the coordinated country MERLA strategy, improve the ability of campaign implementers and partners to identify, measure, utilize, and share data on campaign effectiveness

2c. At the global level, develop a Learning Platform and a MERLA framework as a practical guidance to countries and global stakeholders

3. Campaign Financing

3a. Create a comprehensive view of campaign financing at the country level

3b. Take incremental steps toward harmonizing and aligning campaign financing

3c. Harmonize and align incentive payment modalities and rates across campaigns

3d. Advance government role in campaign financing

[7] Monitoring, evaluation, research, learning, and adaptation

1. CAMPAIGN PLANNING & IMPLEMENTATION RECOMMENDATIONS

Overview: At national and subnational levels, campaign planning and implementing phases are often fraught with challenges, including limited coordination between multiple campaigns, limited long-term and flexible planning, limited early engagement with communities, lack of inclusion of key stakeholders, uncoordinated operations (e.g., supply and logistics) processes, and different priorities from disease-specific initiatives. Highly coordinated, integrated and effective campaigns necessitate new ways of working. The recommendations below aim to overcome these challenges and support the achievement of health system objectives through highly effective, coordinated, and equitable use of campaigns.

RECOMMENDATION 1A:
Establish, or leverage an existing multi-sectoral, cross-campaign National Coordination Body

Establish (or leverage an existing structure) a functional, tailored, transparent, multisectoral, and well-resourced cross-campaign national coordinating and decision-making body, that includes national leadership (and subnational structures, where applicable and appropriate).

How would this recommendation benefit or be of service to countries?

A functional cross-campaign coordination body will offer countries highly coordinated and streamlined campaign oversight, including collaboration and integration.

Coordination among multi-sectoral campaigns will streamline national efforts and leverage existing resources more efficiently to sustainably accelerate achievement of health-related development goals.

Which stakeholders should act on this recommendation?

The **National Coordination Body** should be established and led by the Ministry of Health[8] with active participation of the Ministry of Finance and comprised of senior leadership from key government ministries, country leads/program managers for global health agencies and funders (e.g., UNICEF, WHO, GAVI), local and international NGOs, and civil society actors (to ensure community perspective). Where relevant, the coordination body should include subnational stakeholders and health experts across all domains and health programs that deliver campaigns.

What are the specific tasks of the actor(s) and related stakeholders (e.g., activities and actions)?

This recommendation requires an initial stakeholder analysis to identify structures that currently exist at the national and subnational level (e.g. the ICC for Immunization) and stakeholders who should be included within this body. As a preliminary step, a mapping of relevant partners involved in all of the health campaigns should occur to identify who should be part of the body. Thereafter, the activities required for the establishment and functioning of the **National Coordination Body** will include:

1. developing Terms of References (ToRs) and initiation of the body (leveraging existing coordinating bodies where feasible, or creating a new structure, if needed)
2. overseeing all CAS recommendations, campaigns, and cross-campaign integration as well as formation of all technical working groups required to execute the recommendations (e.g., budget, logistics/supply chain, MERLA, community engagement)

[8] Placement (e.g. within MOH) organization and composition to be determined by the MOH

3. managing cross-campaign strategies, budget, procedures and supportive oversight, and
4. developing and implementing a communication and advocacy plan

What is the estimated timeline[9] and what are the key milestones for this recommendation?

- 1 month for the preliminary stakeholder analysis and identification of existing coordinating structures
- 2 months to draft ToRs and engage potential members
- 2 months to formally stand up the national coordinating body and begin execution
- 3 months to develop and implement a communication and advocacy plan (1 month for development, 2 for execution)

[estimated time for implementation: 8 months]

RECOMMENDATION 1B:
Identify campaigns and domains for collaboration and integration

The multi-sectoral **National Coordination Body** will identify the campaign domains that are best positioned for comprehensive, consolidated, and collaborative planning, including an assessment of opportunities for full integration ("co-delivery") and partial integration ("collaboration").

How would this recommendation benefit or be of service to countries?

Certain campaigns and contexts are better placed than others to benefit from increased and improved collaboration and integration. A proper assessment of collaboration and integration opportunities and overlap can facilitate better understanding of when and how to integrate campaigns and improve overall efficiency in the management and utilization of campaign resources.

The implementation of the recommendation will allow for a clear and dynamic view of campaigns suited for such integration, and ultimately improve the local health system.

Which stakeholders should act on this recommendation?

This recommendation is intended for the **National Coordination Body** outlined in 1a and should be included within its ToRs. Operational-level representatives from the MOH and relevant partners should be included as needed.

What are the specific tasks of the actor(s) and related stakeholders (e.g., activities and actions)?

1. develop criteria to support the identification of campaigns for integration (n.b., routine reevaluation and adaptation of these criteria should occur)
2. fully map integration opportunities across campaigns/domains (e.g., co-delivery or collaboration) among campaigns and programs with overlapping target populations, data management and logistics, and geographies
3. develop a process and platform to facilitate dynamic mapping of opportunities and updates to integration criteria

What is the estimated timeline and what are the key milestones for this recommendation?

- 2 months to develop criteria to identify campaigns to integrate
- 2 months to map campaigns and opportunities for collaboration and integration
- Establish a process and platform for dynamic mapping and consistent updating to the integration criteria within the first year

[estimated time for implementation: 4 months after implementation of **National Coordination Body**]

[9] This estimated timeline (and all others within the document) are indicative and directional and should be adapted to local context. For this section and similar ones in other recommendations, a directional GANTT chart highlighting sequencing and an indicative timeline is available in Annex D.

RECOMMENDATION 1C:
Develop a multi-year, cross-campaign integrated workplan, & schedule (e.g., calendar) for campaigns

Develop a multi-year comprehensive, integrated, and inclusive, cross-campaign plan and schedule for campaigns that is less reactive/more proactive, more dynamic, and better leverages opportunities for impactful collaboration and integration.

How would this recommendation benefit or be of service to countries?

Collaborative, proactive cross-campaign planning and schedule development will allow campaigns, the PHC system, and funders to better anticipate the required level of effort and improve the management and timely utilization of local human and financial resources. Furthermore, countries will be able to adapt the plan periodically when facing more reactive needs, leveraging the resources outlined in the plan.

Which stakeholders should act on this recommendation?

This recommendation targets the **National Coordination Body** and falls under its TOR and remit. Operational-level and subnational representatives from the MOH and relevant partners should be included where relevant.

What are the specific tasks of the actor(s) and related stakeholders (e.g., activities and actions)?

1. the coordination body (1a) will develop an integrated 3–5-year a) workplan, b) budget (based on information collected by the implementation of Recommendation 3a and 3b), and c) schedule for campaigns to support coordination and integration
2. while this recommendation focuses mainly on preventive health campaigns, a process and plan for identifying how to include emergency campaigns should be developed
3. develop a process and plan for annual reevaluation and adaptation of the schedule, budget, and workplan as needed

Note: the workplan should be aligned with the National Health Strategy and the National Immunization Strategy where possible; if there is no language in a national health strategy around campaign integration, there could be advocacy actions for the relevant national strategy to include this workplan

Note 2: this recommendation should be implemented alongside recommendation 2a (MERLA strategy), ideally in one document to ensure coherence and avoid duplication.

What is the estimated timeline and what are the key milestones for this recommendation?

- 3-4 months to develop a workplan, budget and schedule, including a process and plan for emergency campaign inclusion and annual evaluation

[estimated time for implementation: 3-4 months after implementation of **National Coordination Body**]

RECOMMENDATION 1D:
Harmonize tools and operations across campaigns

Develop a detailed plan for harmonizing tools, logistics, data management, and supply chains across campaigns, using topic-specific cross-campaign technical working groups.

How would this recommendation benefit or be of service to countries?

Harmonization of tools and operations can improve efficiency and save planning and implementation time and resources, reduce strain on the primary health care system, and allow for better transparency across campaigns.

Which stakeholders should act on this recommendation?

The **National Coordination Body** (1a) will develop multiple cross-campaign technical working groups comprised of technical leads from relevant campaign programs and domains (e.g., logistics leads). These technical working groups should engage with actors at the national and subnational level (e.g., program directors, subnational MOH representatives, and community members) to help harmonize and standardize tools and logistics.

What are the specific tasks of the actor(s) and related stakeholders (e.g., activities and actions)?

1. analyze which technical working groups are needed and conduct a mapping of which stakeholders are best placed to comprise them
2. develop Terms of References (ToRs), and initiate each technical working group (leveraging existing bodies where feasible and prudent, or creating a new structure, if needed)
3. develop a detailed strategy, workplan, and timeline by each technical working group to harmonize tools or operations, including identification of budget needs and related constraints

Development of Activities would include analyzing and developing processes for cross-campaign integration and harmonization of tools, logistics, operations, data management, and supply chains.

What is the estimated timeline and what are the key milestones for this recommendation?

- 2 months to identify which technical working groups are needed, who should be included within them, and budget/LOE required
- 1 month to develop working group specific ToRs and establish technical working groups
- 3 months to develop a detailed strategy, workplan, and timeline for harmonization of tools and operations
- 6 months to harmonize tools and operations

[estimated time for implementation: 12 months after implementation of **National Coordination Body**]

RECOMMENDATION 1E:
Develop a coordinated and effective approach to engage communities at all levels and phases

Develop a cross-campaign coordinated approach that fosters purposeful engagement of communities at all levels through all stages and phases of campaign planning and implementation, integration, and post-campaign (e.g., learning, adaptation), that builds on existing approaches and increases credibility.

How would this recommendation benefit or be of service to countries?

Decisions made in a participatory manner and validated by stakeholders at all levels (e.g., government, indigenous communities) will foster sustained participation of the local communities and increase the effectiveness and acceptance of proposed interventions. Multicultural, community-based, and interdisciplinary approaches to campaign implementation maintain the potential to unlock understanding of problems and provide greater possibilities for solutions.

Which stakeholders should act on this recommendation?

A community engagement working group made up of and led by community and civil society leaders, implementers, relevant national/subnational MOH members (e.g., department(s) responsible for community health workers/systems, health promotion) and relevant cross-campaign program staff should be developed. The coordinated approach to engage communities at all levels should target campaign teams at all levels, including the national coordinating body, subnational structures, and local community leaders and stakeholders.

What are the specific tasks of the actor(s) and related stakeholders (e.g., activities and actions)?

1. map stakeholders to comprise the community engagement working group
2. develop Terms of References (ToR) and initiation the working group
3. map current practices for community engagement to determine what's worked well and what can be improved
4. develop a collaborative strategy, mechanisms, and identification of platforms for community participation and feedback at different levels and phases
5. develop recommendations/guidelines for campaign managers on how to effectively engage/ sensitize communities to campaign initiatives and socialize

What is the estimated timeline and what are the key milestones for this recommendation?

- 2 to 3 months to identify who should be included within the community engagement working group, develop ToRs, and initiate working group
- 2 months to identify current practices for community engagement
- 3 to 5 months to develop a strategy, mechanisms, and identification of platforms to community participation, guidelines advocating for new mechanisms for community participation
- 3 months to develop recommendations and guidelines, finalize tools, and socialize guidelines and tools amongst stakeholders

[estimated time for implementation: 12 months after implementation of **National Coordination Body**]

2. CAMPAIGN MONITORING & EVALUATION RECOMMENDATIONS

Overview: Currently, measuring the quality and impact of inherently complex health campaigns accurately and comprehensively represents a significant challenge for campaign decision-makers, managers and implementers. Because of this challenge, funders, decision-makers, campaign managers and health workers are often unable to adjust campaign delivery, strategies and practices to: i) optimize the benefits of their public health interventions; ii) reach the full target population, especially those who have never been reached; and iii) strengthen the broader country health system to deliver interventions sustainably and with country ownership. Furthermore, some campaign partners suggest that "coverage" is an essential but insufficient proxy measure of health campaign effectiveness[10] and could be adequately expanded through additional indicators.

What is campaign effectiveness?

Traditionally, campaign effectiveness is measured through coverage with indicators that primarily measure targets, prevention, detection, treatment and results/outcomes.

Given the desire for an expanded definition beyond coverage, it can also be understood as a combination of additional parameters, including: efficiency, equity, availability, access, service quality (including timeliness), clinical outcomes, resilience, responsiveness, community acceptance and engagement. Indicators to measure these additional parameters are suggested in the Annex of this strategy (see Annex E for additional information).

The recommendations below aim to support the development and monitoring of an agreed upon definition of campaign effectiveness between global and country-level health campaign decision- makers, funders and implementers.[11]
These recommendations can be understood as guidance, a first step in a longer-term effort to achieve 6 key goals:

1. enhance country level clarity and agreement on the meaning of campaign "effectiveness"
2. expand the understanding of "effectiveness" beyond coverage
3. improve the ability to measure an expanded view of "effectiveness" without adding a significant burden to countries to collect data
4. utilize data and measurement to improve learning and campaign performance
5. enhance understanding of the causal relationships between campaign inputs, outputs, mediating factors, and ultimate outcomes or "effects"
6. improve understanding of how campaigns contribute to broader country-level goals

[10] Beyond Coverage: Measuring Vitamin A Supplementation Program Effectiveness in Mauritania and Sierra Leone Defining Health Campaigns and Health Campaign Effectiveness https://campaigneffectiveness.org/publications/measuring-and-assessing-effectiveness-in-preventive-nutrition-and-public-health-programmes-a-closer-look-at-the-global-vitamin-a-supplementation-programme/ ; Measuring and Assessing Effectiveness in Preventive Nutrition and Public Health Programmes: A closer look at the global vitamin A supplementation programme

[11] Both flexibility/adaptability to countries' contexts and priorities and comparability among countries at the global level are important principles to respect in the implementation of the recommendations below

RECOMMENDATION 2A:
Within countries, develop a coordinated and collaborative cross-campaign MERLA[12] strategy

Following local priorities, existing country best practices and from an analysis of country needs, define a coordinated process of cross-campaign MERLA to be used by all implementing partners to effectively measure campaign effectiveness, learn from findings, and adapt program strategies.
To define/update this strategy, MOH and local partners can build upon use cases and a suggestion of a process/action cycle around key questions provided by the HCE Coalition as part of this recommendation.

How would this recommendation benefit or be of service to countries?

The effectiveness of campaigns will be better understood and measured. Ministries of Health will appreciate how campaigns contribute to their broader goals and where coordination and collaboration is relevant to them.

Which stakeholders should act on this recommendation?

This recommendation is targeted to Ministries of Health (MOH) who will need to lead the development of the MERLA strategy (in consultation with relevant stakeholders). Multiple MOH teams will need to be involved in a cross-cutting unit – potentially through the **National Coordination Body** recommended above (Rec 1a). A cross-governmental approach with other local partners such as Ministries of Finance is needed to secure buy-in and ensure that the framework is taken up.
The recommendation will be acted upon by campaign implementers who will need to report to the MOH and adapt their own MERLA plans to the national strategy.

What are the specific tasks of the actor(s) and related stakeholders (e.g., activities and actions)?

The country-level campaign team (or coordinating body) in charge of developing the cross-campaign MERLA strategy should conduct regular analysis and ensure campaigns are timely, equitable and adapted to local priorities, and that they collaborate/integrate where relevant.
To develop such a relevant MERLA with cross-program emphasis, they can adapt international best practices to their local context and priorities along the following process:

Step 1. Answer and monitor key questions about campaigns

Key Questions	Secondary Questions
What do we want to achieve through campaigns in our country?	• Do campaigns fit into local priorities? • Do we need additional campaigns to fulfill these priorities?
How do we enable that to happen successfully?	• Who are the stakeholders that can help us achieve our goals? • What activities will need to be undertaken to achieve our goals?
What are the key enablers of success (volume, coverage, infrastructure, equity...)?[13] What are the potential barriers to success?	• Is there an opportunity for integration across programs and sectors?
How do we measure these enablers/ barriers?	• What kind of information is already measured by local stakeholders? How can we leverage already-collective data to minimize the burden?

[12] Monitoring, Evaluation, Research, Learning and Adaptation

[13] Countries can use Annex E or the HELP-UNICEF report on "A 'knowledge architecture' to improve the measurement of health campaign effectiveness" in order identify the key enablers of effective campaigns

Step 1. (Continued) **Answer and monitor key questions about campaigns**	**Key Questions** (Continued) How do we measure these enablers/barriers?	**Secondary Questions** • How do we measure the benefit/costs of integrating campaigns? • What kind of additional indicators should we monitor? • What kind of questions do we want answers to for adaptation and additional learning? • What kind of tools can we use to track progress and facilitate learning (e.g., data visualization, real time data sharing)?
Step 2. Operationalize and harmonize activities based on the answers to the questions above	**Suggested Process** Undertake a preliminary assessment of existing in-country campaign MERLA practices and of globally relevant frameworks Mobilize internal capacity and resources for the development of the MERLA strategy, sustain MERLA practices and serve as a champion in this space Report to the relevant authorities (e.g., planning & implementation coordinating body) able to take decisions during regular review meetings Manage a learning and adaptation agenda answering learning questions (e.g., after action reviews, technical deep dives, qualitative evaluations to determine why and how results are/are not being achieved). Share these results with relevant stakeholders (e.g., Ministry of Finance, implementing partners, community representatives to foster engagement, and the Learning Platform established as part of Recommendation 2c)	

To truly be cross-campaign, the MERLA strategy should give special attention to campaign integration and make sure to include specific criteria and indicators (synergies/differences, modalities, route of administration, timeline).

Regional and global implementing partners and funders should be willing to adapt their own program-specific campaign indicators and reporting requirements to the local cross-campaign MERLA strategy, acknowledging the demonstrative goal of the 'proof-of-concept' phase. They should engage with countries undertaking a cross-campaign MERLA strategy to ensure that they fulfil their requirements and support them through the supply of documentation and advice.

Note: this recommendation should be implemented alongside recommendation 1c (3-5 year workplan), ideally in one document to ensure coherence and avoid duplication.

What is the estimated timeline and what are the key milestones for this recommendation?

- 2 months to form a specific working group
- 3 to 6 months of technical input and discussion with key partners, identifying relevant best practices, parameters and indicators – formalization of the cross-campaign MERLA strategy
- 6 months to implement the strategy

[estimated time for implementation: 11 months after implementation of the **National Coordination Body**]

RECOMMENDATION 2B:
Aligned with the coordinated country MERLA strategy, improve the ability of campaign implementers and partners to identify, measure, utilize, and share data on campaign effectiveness

Develop a strategy to share and utilize available data and measurements to improve learning and adaptation, including identifying 'data gaps' and cost-effectively acquiring this critical but missing data.

How would this recommendation benefit or be of service to countries?

Countries and implementers will be able to utilize relevant data and measurements to improve learning and campaign performance in a collaborative and coordinated way.

Which stakeholders should act on this recommendation?

This recommendation is targeted to Ministries of Health (and/or other relevant governmental bodies) and funders asking for data collection (e.g., GPEI, Global Fund, CDC, UNICEF, USAID, etc.).
It should be acted upon by subnational (including local) governments and funders, and by country campaign implementing partners responsible for funding, collecting, managing, and disseminating campaign data.

What are the specific tasks of the actor(s) and related stakeholders (e.g., activities and actions)?

This recommendation can be implemented along different steps, mobilizing country, regional and global stakeholders:

- Step 1: identify existing information and harmonizing / develop tools and strategies between stakeholders, leveraging on local digital transition strategies
- Step 2: develop a strategy on how best to use available data in a collaborative way, to inform cross-campaign MERLA and support prioritization/integration
- Step 3: identify data and tool gaps / capacity gaps and develop a plan to better be able to effectively measure campaign effectiveness

These steps will require implementers to provide details about what they effectively monitor, why and how data is collected, stored and managed – allowing for identification of opportunities.

Countries will:

- reflect on data being collected and why it is being collected by the country
- determine how they receive and house campaign data from implementers
- establish data governance practices and procedures (e.g., determining what data is needed at the microplanning level, who will have access, how data will be accessed, etc.)
- in the long term, identify gaps in data collected that may hinder the country from measuring campaign effectiveness

What is the estimated timeline and what are the key milestones for this recommendation?

- 3 to 6 months to comprehensively map existing campaign data
- 6 months to develop a collaborative strategy to use existing information and to update sharing mechanisms
- longer term to identify data gaps and solve complex issues (e.g., interoperability, data structure)

[estimated time for implementation: 11 months after implementation of the **National Coordination Body**]

RECOMMENDATION 2C:
At the global level, develop a Learning Platform and a MERLA framework as a practical guidance to countries and global stakeholders

Develop a simplified, relevant, and adaptable guidance on parameters and indicators that can be used to sustainably measure campaign effectiveness to enable evidence-based programmatic learning and adaptation, with the aim to align expectations and the M&E process across global funders and technical organizations and to foster effective and coordinated MERLA at the country level.

How would this recommendation benefit or be of service to countries?

It will add value for countries to have access to a generic measure/guidance on the definition of an effective campaign that they can adapt to their specific context.
Countries will benefit from additional knowledge-sharing between members of the global community, and from their better-informed decisions.

Which stakeholders should act on this recommendation?

This recommendation is targeted to the broad global community represented by the HCE Coalition (e.g., countries (MOH), local and international campaign implementing partners, global organizations and campaign funders such as WHO, GPEI, GAVI, Global Fund, CDC, UNICEF, USAID) building off the learning and implementation of Recs 2a and 2b and country inputs. The recommendation specifically fits into the remit of the HCE Coalition as a knowledge-sharing hub for the global community, which will develop, disseminate and use the guidance.

What are the specific tasks of the actor(s) and related stakeholders (e.g., activities and actions)?

The global community shares and maintains a body of knowledge through a common Learning Platform and repository. This knowledge is used to develop guidance for a coordinated approach of campaigns including guidance on key indicators.
The suggested process for this knowledge sharing is as follows:

1. compile information: countries/regional partners share their implementation experience with global partners in charge of conceiving the guidance, who also collate relevant existing MERLA guidelines
   - e.g., focus country learnings from Recommendation 2a and 2b
2. members of the global community analyze this information and formalize, endorse and socialize the content of the guidance. Specifically, they adopt recommendations for processes and measurement
3. an identified global body (e.g., WHO) spearheads/endorses the framework to legitimize its content
4. all stakeholders use the guidance in their decision-making process, making educated guesses about cross-campaign integration

What is the estimated timeline and what are the key milestones for this recommendation?

- 3 months to compile existing MERLA guidelines and form a campaign MERLA workgroup
- 6 to 15 months for focus countries to share their implementation experience
- 3 months to formalize into global guidance and for WHO to spearhead/endorse its content
- longer term, use of the guidance by all stakeholders

[estimated time for implementation: 12 to 18 months]

3. CAMPAIGN FINANCING RECOMMENDATIONS

Overview: Campaigns have historically been organized within disease-specific (vertical) programs, which are often funded, planned, and implemented independently from one another and from routinely offered primary health care (PHC) services. Over the last three decades, there has been a growth of disease-specific financing, which has contributed to the proliferation of disease-specific campaigns, with little coordination between programs and among campaigns. As a result, campaign financing is often vertical and fragmented with disjointed practices, procedures and timelines for funding health campaigns.

This fragmented financial system results in high transaction costs for countries as they manage and report on each investment.

Furthermore, it is challenging for countries to increase collaboration and promote integration across campaigns as there are few incentives for integrating campaign functions, as the improved efficiencies or cost savings are not accrued back to the programs or communities. In addition, variation in the type and amount of financial and non-financial incentives provided to campaign workers (e.g. community health workers), can serve as a disincentive to campaign coordination or integration.

Many LMICs rely partially or fully on partner support and extra-governmental funding to cover the costs of health campaigns. Reliance on extra-governmental funding poses challenges to sustain funding for campaigns when countries transition from external funder support. The level of government contribution to campaigns is often unknown.

The recommendations below aim to contribute to better alignment and coordination of health campaign funding to support integrated planning and joint interventions. This will be accomplished through:

- more holistic mapping of external funder and government funding of campaigns
- better coordinating funding flows amongst external funders and countries
- harmonization of payment rates and modalities to campaign workers
- governments further planning and budgeting their own contributions to campaign financing as part of their strategic and operational planning processes

These recommendations aim to contribute to better harmonized and integrated campaigns that will reflect a more efficient use of resources. **Improvements in campaign effectiveness could allow funders and countries to do more with existing resources and/or reprogram cost savings for other activities (e.g., PHC strengthening).**

RECOMMENDATION 3A:

Create a comprehensive view of campaign financing at the country level by combining detailed campaign financing information from major funders and government, to enable better planning and execution

How would this recommendation benefit or be of service to countries?

A country-specific database of past and planned campaign funding information would improve planning and budgeting, and potentially be useful to determine opportunities for campaign integration.

Having an overview of future health campaign funding could also facilitate HR management in the country, ensuring routine services can be maintained and not severely affected by campaigns.

Countries and funders will have greater awareness around potential redundancies or gaps in financing, which can help to target investments to greatest benefit.

Which stakeholders should act on this recommendation?

This recommendation is targeted to country governments (e.g., Ministries of Health – potentially through the **National Coordination Body**) and funders (e.g., GPEI, GAVI, Global Fund, CDC, UNICEF, USAID, etc.).

This recommendation will need to be acted upon by governments and funders, and by a lead agency at country level responsible for collecting, managing, and disseminating funding information. Specifically, funder coordination offices within MOF and/or MOF need to be involved from the start.

What are the specific tasks of the actor(s) and related stakeholders (e.g., activities and actions)?

Local authorities and funders will need to provide specific details about planned campaign funding in countries. Information to share can include:

- amount of funding as a total and broken down by line item
- funding cycle/timing
- target population (including age and size)
- geographical scope
- recipient agency/ies

Countries will need to: a) determine how they will receive and house campaign finance data from funders; and b) establish data governance practices and procedures (e.g., who will have access to data, how data will be accessed, etc.). The implementation of the recommendation will need to be country-specific, notably with regard to how much data is made public.

What is the estimated timeline and what are the key milestones for this recommendation?

- 3 to 4 months to collect available information from stakeholders
- 3 to 6 months of analyzing and socializing shared information

[estimated time for implementation: 6-10 months after implementation of **National Coordination Body**]

RECOMMENDATION 3B:
Take incremental steps toward harmonizing and aligning campaign financing

How would this recommendation benefit or be of service to countries?

By mitigating or solving the challenge of fragmented campaign financing, countries will have greater managerial oversight and ownership over campaign funding. There will be greater alignment with national health planning. Transaction costs for government for managing and reporting on separate funding streams will be reduced. Joint application and management of investments may be possible.

Which stakeholders should act on this recommendation?

This recommendation is targeted to the appropriate counterparts in the health sector financial management team and MOF counterparts focusing on health and social sectors, as well as the country-level campaign leadership team (or coordinating body). This recommendation will need to be acted upon by country governments (MOH, MOF) and funders (e.g., GPEI, GAVI, Global Fund, CDC, UNICEF, USAID, END, etc.).

What are the specific tasks of the actor(s) and related stakeholders (e.g., activities and actions)?

Implementation will depend on the country context and funder legal and procurement requirements. The MOH, MOF and country-level campaign leadership team (or coordinating body) will need to:

- understand the feasibility of aligning and potentially pooling campaign financing
- lead the analytic work (with technical support) to develop the evidence base related to campaign funding flows
- investigate and possibly work toward common application and investment processes

MOH and MOF counterparts should work with partners to pursue joint financing and/or establish/leverage pooling arrangements.

Tasks may also include working toward common timelines, application processes, and reporting requirements between funders to lessen transaction costs and facilitate integration of campaigns.

What is the estimated timeline and what are the key milestones for this recommendation?

- 3 to 6 months to collect information on current campaign funding flows and to analyze and disseminate existing pooling or other collaborative funding arrangements
- 3 to 6 months for stakeholders to deliberate on opportunities for joint financing, pooling, application procedures, and harmonized reporting requirements
- 3 to 6 months to determine the feasibility of new collaborative practices (pooling, joint applications etc.)
- longer term, develop and implement potential joint financing and application arrangements

[estimated time for implementation: 9-18 months after implementation of **National Coordination Body**]

RECOMMENDATION 3C:
Harmonize and align incentive payment modalities and rates across campaigns

How would this recommendation benefit or be of service to countries?

By solving the challenge of different incentive payment modalities, potential disincentives to integrating campaigns would be mitigated and the quality and effectiveness of campaigns improved.

Which stakeholders should act on this recommendation?

This recommendation is targeted to country governments (e.g., Ministries of Health) and funders (e.g., GPEI, GAVI, Global Fund, CDC, UNICEF, USAID, END Fund, etc.).

Leadership for harmonization of payment rates and modalities should come from the Ministries of Health. The country-level campaign leadership team (or coordinating body) would be engaged to ensure greater alignment.

At the global level, the leadership of the HCE can support the implementation of this recommendation by advocating for it in their application and funding guidance and promoting the need for equity of pay in their technical guidance.

What are the specific tasks of the actor(s) and related stakeholders (e.g., activities and actions)?

Funders and governments will need to:

- provide specific information about the payment rates (per diems), payment modalities, and non-financial payment practices they use to support campaign workers
- agree to implement better aligned payment practices. The degree of alignment will depend upon the various tasks being conducted by health workers

This recommendation can be potentially undertaken alongside 3a.

After analysis, extra-governmental funded programs should be aligned to national per diem rates. This will need to be a MOF/MOH led initiative, with partner support.

What is the estimated timeline and what are the key milestones for this recommendation?

- 3 to 6 months to collate and share incentive information
- 6 months for funders to commit to aligning with target per diem rates

[estimated time for implementation: 3-12 months after implementation of **National Coordination Body**]

RECOMMENDATION 3D:
Advance government role in campaign financing.

Support and advocate for national and subnational governments to take increasing responsibility for funding campaigns by **building the investment case.**

How would this recommendation benefit or be of service to countries?

By mitigating or solving the challenge of limited contribution of governments to campaign financing, governments will be better able to financially sustain needed campaigns as they transition from external funder support.

Another potential benefit from this recommendation is better planning and budgeting for health programs. The cost to countries (financial and human resources) for outbreak response will be better utilized in preventive campaigns.

Demonstrating the costs and efficiency gains related to integration of campaigns in an **Investment Case** will be a motivating factor for governments to mobilize additional funding.

Which stakeholders should act on this recommendation?

This recommendation is targeted to country governments (e.g., Ministries of Health, Ministries of Finance) at national and subnational levels, leveraging their catalytic role in campaign financing.

What are the specific tasks of the actor(s) and related stakeholders (e.g., activities and actions)?

Countries will need to:

- understand the current level of funding provided by their government to support health campaigns
- determine the best place to include campaign financing in their budgets
- build an Investment Case to support domestic investment in health campaigns
- advocate for the resources and commitment necessary to increase domestic funding for health campaigns

An **Investment Case** will be prepared by government counterparts in collaboration with key partners and used in policy dialogue with relevant stakeholders.

Health campaign funders will develop funding policies or mechanisms to facilitate greater country co-financing and inputs into campaign financing. Campaign funders that have eligibility requirements shall work with transitioning countries to ensure campaign financing requirements are being planned and budgeted for.

What is the estimated timeline and what are the key milestones for this recommendation?

- 3 months for costing health campaigns and measuring the amount of potential government finance
- 12 to 24 months to develop and implement an investment case (including government financing and advocacy plan - including disease modelling)
- longer term, governments are increasing their contributions in the national budget year by year; government funding for health campaigns is pooled with other funders

[estimated time for implementation: 15-27 months after implementation of **National Coordination Body**]

CAS MANAGEMENT AND MONITORING

In late 2023, the HCE Program Office and the Coalition Leadership Team (LT) will embark on an assessment of the Coalition's current management and governance structure against the management and governance needed to execute the CAS. This will likely include development of a revised HCE Coalition Governance Operating Model and an evaluation of the composition of the Leadership Team, working groups or task teams (where necessary), and HCE Coalition Program Office to ensure the HCE Coalition is appropriately constituted for its mandate and successful implementation of the CAS.

Furthermore, in early 2024, the HCE Program Office and Leadership Team, in partnership with the focus countries, will develop a **Year 1 Action and Monitoring Plan for the CAS**. This process may lead to the identification of additional workgroups or support structures within the Coalition to assist in development and implementation of the Plan.

SCALING-UP OF RECOMMENDATIONS

Around 2027, after recommendations are successfully demonstrated to improve campaign performance in focus countries, the objective is to implement them at-scale. The HCE Program Office, in collaboration with LT, HCE partners, and participating countries, will initiate the process of gathering and scrutinizing data with the goal of enhancing the CAS recommendations. This process may involve making them either a) more universally applicable, or b) better suited to specific country contexts or types. The precise method for scaling up will be jointly developed by the HCE Program Office, LT, and the participating countries, commencing at the close of the second year. Relatedly, the HCE Coalition Program Office, LT, and focus countries will need to jointly develop a plan and process for communicating and reporting on progress to secure the evidence base for scale up.

The International Development Innovation Alliance (IDIA) of which some of the HCE Coalition partners are members have identified scaling up as a six-step process:

1. Ideation (e.g., pre-CAS development)
2. Research & Development (i.e., Task Team CAS development)
3. Proof of Concept (i.e., first phase of CAS in two to three focus countries)
4. Transition to scale (i.e., between years two and three within CAS timeline; process TBD)
5. Scaling (i.e., second phase of the CAS; years 3-5)
6. Sustainable scale[14] (years 5+; process and objectives TBD)

The proof-of-concept will be undertaken during the first phase of implementation of the CAS (e.g., within two to three focus countries). After that phase, CAS governance (e.g., LT, HCE Program Office, country leadership) will need to **develop and implement a plan to go from the proof-of-concept step (3) to sustainable scale (6) via the following high-level process:**

- Step 1: Identify small-scale successes from the proof-of-concept to develop and gaps to fill before scaling (Transition to scale)
- Step 2: Replicate and adapt the recommendations in new geographies (expansion - Scaling)
- Step 3: Anticipate and support the wide-scale adoption of recommendations where campaigns are undertaken (institutionalization – Sustainable scale)

Suggested best practices for scale up (from the IDIA Insights on Scaling Innovation report)

1. Measure progress and impact of recommendations in the focus countries, and identify key learnings
2. Assess what recommendations are scalable and sustainable, by examining the influencing factors of their success in the focus countries
3. Identify which partners to work with in the new geographies
4. Plan the scaling journey with a look for impact, identifying where support is needed
5. Implement scaling-up support teams with dedicated resources (including funding)

[14] Insights on Scaling Innovation – International Development Innovation Alliance – June 2017

ANNEXES

In the sections below are compiled the following annexes:

A. High-level synthesis of the socialization plan for the CAS

B. Visualization of the suggested timeline of implementation of recommendations

C. Suggested resources to allocate for optimal implementation of recommendations

D. Description of what would represent a successful implementation of recommendations

E. Adaptable list of parameters and indicators meant as guidance to an expanded definition of campaign effectiveness

F. Suggested incremental steps for harmonization of campaigns

G. Additional Resources

H. Acknowledgements (lists of Task Team Members and Additional CAS contributors)

Photo Credit: Marcus Perkins for GSK

A. Socialization Plan for the CAS

The CAS socialization approach aims to gather feedback and secure commitment for the CAS from partner organizations, relevant stakeholders, and an 'opt-in' (i.e., agreed collaboration) from 2-3 focus countries.

Furthermore, and as part of the socialization process, the plan seeks to foster a shared understanding of the CAS objectives and potential impact; obtain diverse perspectives and feedback from relevant stakeholders at the country, regional and global level, and across campaign domains, and; ensure alignment and commitment from critical organizations and 2-3 focus countries.

Four types of stakeholders have been identified for CAS socialization:

1. Shortlisted Focus Countries
2. UN Agencies (i.e., WHO, UNICEF)
3. Funders & Global Implementing Agencies
4. Broad Campaign Ecosystem (e.g., domain specific initiatives, health campaign-related convenings)

Next Steps in terms of engagement between Mid-November 2023 and February 2024 are the following:

Stakeholder Type	Level	Objectives
Type 1	Country	Shortlisted focus countries will be engaged to allow them to provide feedback on the CAS and an opportunity to opt-in to the CAS and join the in-person meeting at the end of January
Type 2 & Type 3	Global	Global funders and implementing agency HQs (LT[1] and non-LT organizations) will be engaged to draw awareness to the CAS, secure buy-in and support, and obtain limited feedback on the CAS
Type 4	Global	The broader campaign ecosystem will be engaged through one key initiative per domain, and then opportunistically as events occur, to develop awareness and a shared understanding of the CAS

[1] HCE Leadership Team

B. [Directional] High Level Timeline and Major Milestones for Recommendations

	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12	M13	M14	M15	M16	M17	M18
1. Planning & Implementation																		
1a. National Coordination Body	Stakeholder analysis and drafting of ToRs			Create and engage body		Communication & advocacy												
1b. Identify campaigns for collaboration & integration						Develop criteria for integration		Map campaigns & opportunities		Establish process for dynamic mapping								
1c. Multi-year cross-campaign workplan						Develop workplan – aligned with NHS schedule												
1d. Harmonize operations and tools						Identify WG needs		TORs	Dvlp strategy & timeline for harmonization			Harmonize tools and operations						
1e. Enable community engagement						Identify WG needs		Identify current practices		Develop strategy and mechanisms for community participation				Develop and socialize guidelines/tools				
2. MERLA																		
2a. Country level cross-campaign MERLA strategy						Establish WG within NCB			Technical inputs & dvlpment of MERLA strat.			Implementation of MERLA strategy						
2b. Improvement of data use						Mapping of existing data			Development of a collaborative data use strategy						Solve data gaps and complex issues			
2c. Global MERLA Framework	Establish WG & compile MERLA guidelines			Organize meetings, engage with stakeholders for continuous sharing of MERLA experience in focus countries											Formalize global guidance			
3. Financing																		
3a. Mapping of campaign financing							Collect information			Analyze and socialize information								
3b. Incremental harmonization							Collect info on funding flows & collab			Deliberate on opportunities			Study feasibility of new collaborative practices					
3c. Align incentives to health workers							Collate and share info on incentives			Funders commit to align			Alignment on target incentives					
3d. Increase government role in campaign financing							Cost campaigns and identify gvt funding			Develop investment case (incl. disease modelling)								
Overall CAS monitoring				**Progress meeting 1**						**Progress meeting 2**						**Progress meeting 3**		

C. [Directional] Guidance on Additional Resourcing Needs for the Recommendations

The table below presents guidance from Task Teams on additional resources needed to implement the recommendations. This suggestion can be used as a first estimate of the necessary level of effort in terms of time, staff, and additional funding during the proof-of-concept phase within focus countries.

Furthermore, there will likely be a need for an uncertain number of human resources from each LT organization (i.e., funder/implementer) at the country level to meaningfully execute and implement the CAS and recommendations. This will be determined as recommendations are adapted to focus countries' contexts. These resources are therefore not included in precise detail in the table below. All references to FTE amounts are only estimates and calculated for the estimated timeline of the recommendation (see sections above).

Recommendation	Suggested resources needed
Planning and Implementation	
1a: Establish, or leverage an existing multi-sectoral, cross-campaign National Coordination Body	The coordination body should self-assess its resourcing needs (including where current resources can be leveraged). That said, the coordination body likely will require one or several ministerial staff assigned and LOE/technical support and resources in its initial phase, for capacity strengthening, and for initial recommendation and cross-program support. Operational-level support and resources will be determined via recommendation 1d. More specifically, resources for the following types of activities will likely be required *(0.5-1 FTE):* • Resources for meetings, workshops or mobilization events to develop the coordination body, technical working groups and communication/advocacy • Resources/LOE to help coordinate and stand up the national coordinating body and technical support for various coordination and recommendation-related activities.
1b: Identify campaigns and domains for collaboration and integration	• Resources required for this work will be identified by the coordination body (1a). • Additional LOE and resources may be needed for related technical assistance (*0.25 FTE)*
1c: Develop a multi-year, cross-campaign workplan	• Resources required for this work will be identified by the coordination body (1a). • Additional LOE and resources likely needed for related technical assistance (*0.25 FTE)*

and schedule for campaigns	
1d: Harmonize tools and operations across campaigns	Resourcing should be determined by the national body (1a) with input from technical experts and the coordinating bodies themselves. Resources for the following types of activities will likely be required *(0.5 FTE):* • Funding and LOE for meetings, workshops or mobilization events to develop the harmonization plan • Funding and LOE for technical assistance to support harmonization working groups (e.g., to draft the strategy) • Resources for improvements to operations systems (e.g., digitization)
1e: Develop a coordinated and effective approach to enable active community engagement at all levels and phases	• Expert and technical support likely needed to assist in development of the working group, analyzing current practices, and developing and disseminating the strategy, guidelines, and tools
Planning and Implementation Summary	• 1-2 local FTE for initial phase, analysis, and strategy development to support the work of the National Coordination Body and technical working groups • [TBC] Funding for organization of meetings, workshops, and updates to operational systems
MERLA	
2a: Within countries, develop a coordinated and collaborative cross-campaign MERLA strategy	• Countries (and regional partners) will need to mobilize internal resources to create and sustain the MERLA strategy. Regional and global implementing partners will also need to allocate internal resources to foster cross-country capacity sharing and learning • Additional LOE and resources are likely needed for technical assistance during the early development of the MERLA strategy (*minimum 1 FTE for 1 year)* • When possible, funding should be allocated for additional data collection, learning activities, data visualization tool development and maintenance, capacity strengthening and capacity sharing, and data-driven programmatic adaptation (*amount TBD)*
2b: Aligned with the coordinated country	Resources for the following type of activities will likely be required (*0.5 FTE for 6 months*):

MERLA strategy, improve the ability of campaign implementers and partners to identify, measure, utilize, and share data on campaign effectiveness	• Funding of a local consultant compiling existing information on databases and their use and outlining cross-program data sharing opportunities • Funding to leverage in a more systematic and coordinated way, the volume of existing information: investment in HMIS and digital systems/tools to support integrated and higher quality data collection and analysis (*amount TBD)* • Funding to organize additional training and support for operational teams to fully utilize data in a coordinated way *(depending on solutions advocated at the local level)*
2c: At the global level, develop a Learning Platform and a MERLA framework as a practical guidance to countries and global stakeholders	Resources for the following type of activities will likely be required *(0.25 FTE):* • Funding and internal resources from the global community to organize meetings, collate and analyze strong continuous research on relevant and globally aligned indicators (for coverage and an expanded definition of campaign effectiveness) • Funding to establish and maintain a knowledge-management platform, including multi-country evaluations/studies • Internal resources from a UN agency to spearhead/endorse the developed guidance and bring it legitimacy ○ Potential funding and LOE for technical assistance to support the development of an advocacy plan *(0.5 FTE for 3-6 months)* • Internal resources from countries and regional partners to participate in meetings and regularly engage with the members of the global community to share their cross-campaign MERLA experience
MERLA Summary	• 1.25 local FTE for first year • 0.25 global FTE • Additional funding for data visualization, HMIS and cross-country sharing and learning
Financing	
3a: Create a comprehensive view of campaign financing at the country level	Implementation of this recommendation will require leadership and involvement by the Ministry of Health. Ideally, the Ministry of Health will be committed to maintaining the overview and institutionalize this process. This will require the mobilization of internal staff (part-time). Support from a local consultant with a strong prior working relationship with the government (*0.4 FTE*) is likely to be needed to:

	• Collect and analyze funding information • Organize the information into an easy-to-use database • Identify areas of overlap, gaps and opportunities for integration in the short-, medium- and long-term • Work with the government to determine how the information will be shared and updated • Disseminate the key results of the analysis to relevant stakeholders (e.g., governments, other funders)

3b: Take incremental steps toward harmonizing and aligning campaign financing	• This recommendation requires ongoing and long-term engagement at the country level (Office of Minister within the MOH, Director General or planning division)
	  o Additional LOE and funding will be needed for a government counterpart from the MOH, working with an in-country partner, to drive this process forward, including ongoing policy dialogue with relevant stakeholders at the MOF and development agencies
	• Additional internal resources from focus country governments and funders will need to be mobilized to determine the governance, reporting, financial management and ongoing management around use of the harmonized resources
	• Additional LOE and resources are likely needed for technical assistance to conduct critical initial assessments, including *(0.3 FTE – potentially undertaken by the same consultant as 3a)*:
	  o Study of current and past pooled financing arrangements for the health sector
	  o Evaluation of health campaign funding flows and budget procedures
	  o Assessment of governance requirements and opportunities for pooling and joint investment from multiple funders (including benchmarking)
	  o Opportunities related to harmonizing application procedures and timelines

3c: Harmonize and align incentive payment modalities and rates across campaigns	• LOE and funding will be needed for an initial analysis exploring payment rates and modalities across funding agencies, and of variation in financial and non-financial incentives for campaigns *(0.3 FTE – potentially undertaken by the same consultant as 3a)* • After this analysis, aligning external funder-financed programs to national per diem/salary rates will need to be a MOF/ MOH-led initiative, with partner support

3d: Advance government role in campaign financing	• Implementation of this recommendation will require robust engagement with national health programs, Ministries of Health and Finance, as well as subnational level stakeholders.
	• It will potentially require the procurement of an external Research Institute *(local or potentially one for all focus countries)* to develop the investment case including:
	  ○ an estimation of current and future cost of health campaigns, of effects in terms of mortality and morbidity averted (requiring disease modelling) and of the cost-effectiveness of campaigns
	  ○ a financing and advocacy plan for additional resources, elaborated in close collaboration with government counterparts. This advocacy plan could define how national and subnational governments can mobilize resources for health campaign financing in the short-, medium-, and long-term (1-10+ years). This could be facilitated through an in-country partner.

Financing Summary	• 1 local FTE in each focus country • 1 procurement contract with an institution for 3d (investment case) either for all focus countries or per focus country • Additional funding to MOH depending on LOE
Overall Summary for Year 1	• 3-5.5 local FTE in each focus country • 1 procurement contract for 3d • 0.25 global FTE • Additional funding for improvements to operations systems and tools

D. Measures of Success

The table below presents what would represent a successful implementation of each recommendation according to Task Team members. It can help serve as the foundation for a country-level CAS MERLA plan during the proof-of-concept phase. Furthermore, content in the table below will assist in measurement, evaluation, and accountability, and support recommendation scale up for the CAS more broadly.

Recommendation	What does success look like for the recommendation?
Planning and Implementation	
1a: Establish, or leverage an existing multi-sectoral, cross-campaign National Coordination Body	• Participation across the major health domains and from the PHC system • Clear membership and TORs for the coordinating body • Identification of campaigns for collaboration and integration (1b) and establishment of an integrated campaign workplan, budget, and schedule (1c) • Development of technical working groups for the recommendations as required • A strong communication and advocacy strategy • Regular meetings and participation to review plans for collaboration and integration
1b: Identify campaigns and domains for collaboration and integration	• Mapping and identifying campaigns for integration and a periodic assessment to determine future opportunities for integration • In the medium term, a process developed for identification and alignment of continual assessment and campaign integration
1c: Develop a multi-year, cross-campaign workplan and schedule for campaigns	• A multi-year, cross-program, timely workplan, budget, and schedule for preventive campaigns to facilitate proactive planning of resources and LOEs • Countries are able to adapt the plan periodically according to more reactive needs
1d: Harmonize tools and operations across campaigns	• Operational tools, logistics, operations, data management, and supply chains are harmonized across relevant campaigns • A process is developed for assessing and streamlining harmonization periodically.
1e: Develop a coordinated and effective approach to enable active community engagement at all levels and phases	• Active community participation in planning and implementation of integrated campaigns at all levels achieved through a truly coordinated cross-campaign community engagement strategy • Additionally, well-informed campaigns that are accepted and trusted by the targeted populations.

MERLA	
2a: Within countries, develop a coordinated and collaborative cross-campaign MERLA strategy	• A country-level strategy is conceived and implemented that is feasible, cost-effective and aligns with local priorities • The Ministry of Health requires/insists on its use and implementing partners act in line with the strategy and share data and results
2b: Aligned with the coordinated country MERLA strategy, improve the ability of campaign implementers and partners to identify, measure, utilize, and share data on campaign effectiveness	• Existing information is leveraged in a more systematic and coordinated way • Indicators of the MERLA framework are populated and processes function to facilitate learning and use. • In the long term, relevant data is collected and analyzed to build the case for an expanded definition of campaign effectiveness, collaboration, and integration
2c: At the global level, develop a Learning Platform and a MERLA framework as a practical guidance to countries and global stakeholders	• A Learning Platform of campaign effectiveness and MERLA activities, results and use cases is established and country, regional and global partners ensure that it is resourced, maintained and sustained • Cross-campaign MERLA guidance is formalized and endorsed by the global community • Guidance is taken up and used by local campaign implementers
Financing	
3a: Create a comprehensive view of campaign financing at the country level	• Campaign financing information is brought together and shared among relevant stakeholders • It is actively used by governments and their partners for campaign planning and programming, including potential integration of campaigns
3b: Take incremental steps toward harmonizing and aligning campaign financing	• Governments mobilize campaign resources in a timely manner through use of pooled funding sources and experience reduced transaction costs to the extent that applications and reporting procedures are harmonized • Campaign funders contribute to more holistic planning and management of health campaign investments with the government

	• There is the potential for greater integration of health campaigns through use of common or pooled resources
3c: Harmonize and align incentive payment modalities and rates across campaigns	• Government and funding agencies use the same or similar per diem/incentive rates for health care workers involved in health campaigns • Greater integration of campaigns is facilitated, which contributes to campaign effectiveness by ensuring increased transparency in per diem rates, limiting the competition for health care workers
3d: Advance government role in campaign financing	• A strong investment case is made and increased and reliable government contributions to health campaign financing occur, ideally linked to any pooling arrangement developed in Recommendation 3b • In the medium/long term, countries transition from campaigns to routine services in order to strengthen their PHC systems

E. Expanded Definition of Campaign Effectiveness – Proposed list of parameters and indicators

This table below is a proposed list of parameters and indicators meant to act as guidance for countries developing a cross-campaign *Monitoring, Evaluating, Learning and Adaptation* (MERLA) strategy (recommendations 2a-c). Informed by implementation research, international best practices, and feedback from global, regional, and country level funders and implementers, it expands the definition of campaign effectiveness and gives example of indicators and measures of these parameters.

The annex is organized in two parts:

1) Indicators linked to the traditional definition of campaign effectiveness, centered on coverage. Indicators in this list come from a compilation and harmonization of indicators used by global organizations and countries (e.g., WHO, GAVI, UNICEF, PAHO, Global Fund) crowdsourced during co-development of the CAS
2) Parameters and indicators that can be used in an expanded definition of campaign effectiveness, beyond coverage

Countries can select all or part of these parameters and adapt the indicators to their country-specific definitions and context. This list is intended as adaptable guidance.

Parameter	Definition	Suggested indicators	
Traditional definition of campaign effectiveness			
Coverage	Proportion of eligible individuals receiving the campaign intervention	Target	• Age of the target population • Sociodemographic indicators for the target population (age, gender, income, etc.) • Geographic indicators for the campaigns (areas covered) • Disease to prevent
		Prevention	• Number (proportion) of target population who have benefitted from preventive intervention (vaccine, drug or other) • Immunization coverage among the target population (*to be monitored across life)* • Number (proportion) of zero-dose (eligible people who have not benefitted from intervention) within the target population
		Detection	• Number of large or disruptive outbreaks (*to be defined by disease)* • Number (proportion) of cases detected and reported
		Treatment	• Number (proportion) of reported cases treated • Number (proportion) of treated cases in the target population • Number of people fully treated (vaccines or other)
		Results/Outcomes	• Number of deaths (included future) averted through treatment

			• UHC (Universal Health Coverage) Index of service coverage
Expanded definition of campaign effectiveness			
Efficiency	Optimal use of resources to achieve the desired outcomes	• Budget consumption of the campaign • HR mobilized • Timing of the campaign • Existence of management and organizational learning strategies • Cost per person reached	
Equity	Degree of fairness in the ultimate distribution of the campaign intervention	• Disaggregation of access and coverage data through socioeconomic, gender, geographic, and ethnic factors	
Availability	Capacity of the health system to provide the necessary services	• Number of products available for the target population • HR resources that can be mobilized for campaigns • Budget available for the campaign (+ source)	
Access	Ability (physical, financial, cultural) of the target population to utilize the health services provided	• Mean distance to services for the target population • Cost of getting the treatment for the target population • Perceived service quality for the target population • Share of target population eligible for the services	
Service quality	Experience of the program's delivery by stakeholders (healthcare workers, campaign managers, beneficiaries, funders...)	• Timeliness (i.e., proper choice of when to undertake a campaign to maximize its impact) • Existence of safety-ensuring measures • Share of health workers participating in the campaign trained about service quality • Perception of service quality by the target population • Perception of service quality by the health workers in charge of the campaign • Number of defects in health products	

Clinical outcomes	Individual and epidemiological outcomes or effects, through which campaigns aim to deliver value	• Share of treated patients who have experienced an improvement in symptoms • Disease prevalence • Incidence • Mortality rates • Health-related behaviors in the target population • Side effects and complications encountered as a result of the campaign

Resilience & responsiveness	Ability of the program to modify its delivery strategy in response to shocks or challenges	• Number of delivery platforms in the same geography
		• Supply chain indicators (with reserves)
		  o Number of staff available
		  o Number of vehicles available
		  o Number of IT systems
		• Number of experienced managers available for the campaign
		• Existence of a data and information repository
		• Existence of an emergency response plan
		• Existence and monitoring of a risk matrix

Community awareness	Result of efforts to publicize and explain the campaign within the relevant population or geography	• Share of the target population informed about the health issue • Share of the target population informed about the campaign • Share of the target population perceiving the campaign as trustful
Community acceptance and engagement	Community's authorization for the campaign to carry out its activities + perception of the campaign as "acceptable" by relevant stakeholders. Developing relationships that enable stakeholders to work together to address health-related issues and promote well-being to achieve positive health impact and outcomes.	• Share of the target population actively opposing the intervention • Share of the target population apprehensive of the intervention • Share of the target population neutral about the intervention • Share of the target population open to the campaign and participating • Share of the target population actively involved in the campaign

F. Suggested Incremental Steps for Harmonization (Rec. 3b)

Recommendation 3b describes a process for increased harmonization of funding sources and elements between campaigns and implementers. The description below provides a high-level overview of the different levels of potential harmonization between funders (and countries), starting with initial harmonization between funders and countries (level 1; reporting and budgeting) to a more robust type of harmonization (level 3; e.g., pooled funding).

Level 1. Initial harmonization (i.e., reporting, monitoring, and measuring):

a. Reporting and budget
b. Ex-post financial reporting
c. Monitoring and measuring the impact of funding

Level 2. Moderate harmonization (i.e., processes):

d. Timelines
e. Eligibility requirements
f. Supply chain and financial management tools
g. Operations

Level 3. Robust harmonization (i.e., common management of funds):

h. Funding flows
i. Disbursement practices
j. Common beneficiaries
k. Pooled funds

G. Additional Resources

Select HCE-Produced Technical Briefs & Reports

- Considerations for Integrating Health Campaigns: A Synthesis of Findings from Implementation Research Studies in Immunization, Neglected Tropical Diseases, Malaria, and Vitamin A Supplementation
- Synthesis Report: Considerations for Health Campaigns' Transition to and Linkages with the Primary Health Care System
- Coordination Mechanisms for Integrated Health Campaigns: A Descriptive Review
- Campaign financing analysis: opportunities for cross-campaign integration
- Defining Health Campaigns and Health Campaign Effectiveness

Select Individual Implementation Research Projects (from Nigeria, Vanuatu, Ghana, Rwanda, Mauritania and Sierra Leone, Ethiopia, Cameroon, Indonesia, Bangladesh, Guinea, Cote d'Ivoire, Colombia, and other global studies)

- Achieving Equitable and Feasible Campaign Integration through SMC and Vitamin A Collaboration: Findings from Bauchi State Nigeria
- Health Campaign Integration: A Scoping Review (Sub-Saharan Africa)
- Beyond Coverage: Measuring Vitamin A Supplementation Program Effectiveness in Mauritania and Sierra Leone
- Country Campaign Manager Perspectives on Health Campaign Integration: A Snapshot in 2022 (Africa, Americas, Europe, Southeast Asia)

Case Studies on Collaborative Planning (from Guinea, India, Nigeria, Nepal, India, Nigeria, Colombia, and Ghana)

HCE Publications

- Rethinking public health campaigns in the COVID-19 era: a call to improve effectiveness, equity and impact
- Promising practices for the collaborative planning of integrated health campaigns from a synthesis of case studies

H. Acknowledgements

This strategy was developed in partnership with the following individuals (listed immediately below by Task Team) – a total of 47 individuals, representing more than 20 organizations – in close coordination with the HCE Coalition Leadership Team (listed below) with the support of the Task Force for Global Health HCE Coalition Program Office and dedicated consultants, and the Camber Collective (all listed below). The dedication and commitment of the Task Team and Coalition Leadership Team members is commended, honored, and woven into the bedrock of the CAS.

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