TRAINING AND PLANNING AT SUBNATIONAL LEVELS FOR INTEGRATING COVID-19 VACCINATION INTO ROUTINE HEALTH SERVICES

Facilitator's Guide

MOMENTUM Routine Immunization Transformation and Equity

USAID FROM THE AMERICAN PEOPLE

MOMENTUM A Global Partnership for Health and Resilience

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CONTENTS

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BACKGROUND

1. Rationale for integrating COVID-19 vaccine and other vaccines into routine services

The World Health Organization (WHO) and other global immunization partners recommend integrating COVID-19 vaccines into existing service delivery platforms, such as routine immunization and primary health care, and/or new entry points for vaccinating priority-use groups.[*] There are several benefits to such integration, not just for the COVID-19 vaccine but also for other vaccines that reach age groups beyond childhood (the "life course" immunization approach).[†] These include:

- Improved efficiency and performance due to the sharing of costs and resources.
- New opportunities to strengthen immunization service delivery to adults (for existing and future vaccines).
- Greater demand for and access to health services and improved user satisfaction.
- Higher coverage rates over time and increased ability to address health care inequities.

The changing landscape for funding COVID-19 vaccination promotes adopting sustainable strategies that can be carried out over the long term. Many countries have already started integrating vaccination management and delivery of COVID-19 vaccination into other essential services. Such integration requires clear definition of the priority groups for vaccination.

Regarding COVID-19 vaccines, WHO updated its recommendations for vaccination in November 2023 to underscore priority for certain target populations.[‡] Following the publication of these recommendations, WHO released an update on increasing COVID-19 vaccination uptake based on the priority populations.[§] The recommendations for these populations are shown in Table 1. Also in this update, WHO presented a single-dose regime for most COVID-19 vaccines for primary immunization. This simplified vaccination schedule should improve vaccine acceptance and uptake and provide adequate protection at a time when most people have had at least one prior infection.

[*] Source: *Considerations for integrating COVID-19 vaccination into immunization programmes and primary health care for 2022 and beyond*. WHO. 2022. https://www.who.int/publications/i/item/9789240064454

[†] https://www.who.int/teams/immunization-vaccines-and-biologicals/essential-programme-on-immunization/integration

[‡] *SAGE roadmap for prioritizing uses of COVID-19 vaccines.* Geneva: WHO. 2023. https://www.who.int/publications/i/item/WHO-2019-nCoV-Vaccines-SAGE-Prioritization-2023.1

[§] *Increasing COVID-19 Vaccination Uptake: An update on messaging, delivery strategies and policy recommendations.* WHO. 2023. https://www.who.int/publications/m/item/increasing-covid-19-vaccination-uptake

TABLE 1. WHO SUMMARY OF THE UPDATED SAGE RECOMMENDATIONS FOR COVID-19 VACCINATION

Vaccination status	Population	Recommendation
Never received a COVID-19 vaccine	All adults	1 dose[**]
	Children and adolescents with comorbidities	
	Health workers with direct patient contact	
	Pregnant persons	1 dose
	Any individual who is immunocompromised	2 to 3 doses[††]
Previously received **at least 1 dose** of a COVID-19 vaccine	**Adults over 75 or 80 years old[‡‡]**	Revaccination 6 to 12 months after the most recent dose
	Adults over 50 or 60 years old[‡‡] with comorbidities	
	Any individual who is immunocompromised	
	Adults over 50 or 60 years old‡‡	Revaccination 12 months after the most recent dose
	Adults with comorbidities	
	Health workers with direct patient contact	
	Pregnant persons	Single dose in each pregnancy
	Healthy adults	Revaccination not routinely recommended
	Children and adolescents	

Legend:

High priority-use groups	Sub-populations with special considerations

For further details, see the SAGE Roadmap for prioritizing the use of COVID-19 vaccines.
https://www.who.int/publications/i/item/WHO-2019-nCoV-Vaccines-SAGE-Prioritization-2023.1

[**] 2 doses required for inactivated vaccines
[††] In consultation with a health worker
[‡‡] Age cut-off to be decided by countries

2. Objectives of this guide

Each country is developing national policies and strategies for integrating COVID-19 vaccination into other services to reach the high-priority groups. At district and health facility levels, these policies are then transformed into practice and standard operating procedures (SOPs).

This guide is intended to support subnational health managers and health care providers in identifying and planning the steps necessary to integrate COVID-19 vaccination into existing services in their settings. If they have already adopted such practices, this guide may help refine their management practices and processes.

Users of the guide will be able to:

A. Organize a workshop at the district level and facilitate sessions with small numbers of participants (i.e., 12—18) to help them determine the approaches to COVID-19 vaccination integration that fit best with their context and promote the vaccination of populations who are high priority or have special considerations.
B. Lead workshop participants to systematically identify how COVID-19 vaccination integration focused on reaching priority populations affects service delivery and management processes, including supply chain management and human resource management.
C. Lead discussions on COVID-19 vaccination integration, drawing on content from the WHO/UNICEF document, *Considerations for integrating COVID-19 vaccination into immunization programmes and primary health care for 2022 and beyond* (hereafter referred to as "Considerations").
D. Lead workshop participants in identifying practical steps and resources needed for COVID-19 vaccination integration.

3. Who this document is for

This document is intended for district health personnel responsible for managing the integration of COVID-19 vaccination into primary health care (PHC) and other relevant services at district and facility levels in lower- and middle-income countries. This includes integration at hospitals, health centers, vaccination posts, and other facilities, as well as through outreach and mobile teams.

4. Guiding principles for integrating COVID-19 vaccination with other services

- The approach to COVID-19 vaccination integration described here recognizes the need to focus vaccination efforts to reach priority populations, particularly in low-resource communities.
- Integrating COVID-19 vaccination into service delivery for these groups requires actively engaging other health services and programs beyond immunization, such as HIV/AIDS and tuberculosis (TB), noncommunicable disease (NCD) screenings and other services that reach older populations, and antenatal care (ANC) and other maternal and child health services.
- There is no single strategy for integrating COVID-19 vaccination into essential services. Approaches may vary by setting (for example, urban versus rural), the specific target population, and by size and type of facility. However, all approaches need to be guided by the most up-to-date national policies, strategies, and recommendations from the National Immunization Technical Advisory Group (NITAG).

- The strategy described here for defining an approach to COVID-19 vaccination integration highlights how managerial responsibilities across the health service may need to change to support integration. These changes in responsibilities are particularly important to flag for health personnel who have not previously worked in immunization but will now do so.
- The approach proposed here also emphasizes that changes in service delivery strategies must be coordinated with changes in supply chain management, demand generation, health worker capacity building, and data management.
- The district health officer at the district level and the health facility manager at the facility level have key roles to play in managing the process of COVID-19 vaccination integration.

5. Rationale for a two-day workshop

Given the challenges of integrating COVID-19 vaccination into routine service delivery and management, it is suggested that districts convene a two-day workshop that brings together all stakeholders involved in developing or refining an approach to COVID-19 vaccination integration. The workshop setting allows different stakeholders to suggest workable approaches, discuss the pros and cons, define how such integration will affect their roles and responsibilities, and identify new tools or procedures that may need to be developed to integrate COVID-19 vaccination with routine services. The workshop is also an opportunity to assess integration-related practices introduced during the acute phase of the COVID-19 pandemic, for example, synergies with HIV services, providing NCD screening for hypertension and diabetes when COVID-19 vaccine is provided to older populations, COVID-19 vaccination as part of ANC together with tetanus toxoid administration, or co-administration of COVID-19 vaccine with influenza vaccination, where relevant.

6. Links to useful resources

Several documents already exist that are useful for planning for integrating COVID-19 vaccination into routine services. They include the following:

- *Building on country experiences: An operational framework for demand integration of COVID-19 vaccination into routine immunization services and primary health care.* UNICEF and WHO. 2023. https://demandhub.org/operational-framework-for-demand-promotion/
- *Considerations for integrating COVID-19 vaccination into immunization programmes and primary healthcare for 2022 and beyond*. WHO. 2022. https://www.who.int/publications/i/item/9789240064454
- *Increasing COVID-19 Vaccination Uptake: An update on messaging, delivery strategies and policy recommendations.* WHO. 2023. https://www.who.int/publications/m/item/increasing-covid-19-vaccination-uptake
- *SAGE roadmap for prioritizing uses of COVID-19 vaccines.* Geneva: WHO. 2023. https://www.who.int/publications/i/item/WHO-2019-nCoV-Vaccines-SAGE-Prioritization-2023.1
- *Vaccinating older adults against COVID-19.* WHO. 2023. https://apps.who.int/iris/bitstream/handle/10665/369450/9789240066045-eng.pdf

FACILITATOR'S GUIDE FOR PLANNING AND IMPLEMENTING A SUBNATIONAL/DISTRICT WORKSHOP ON COVID-19 VACCINATION INTEGRATION WITH OTHER SERVICES

1. Overview of process for district-level workshop

a. **Overall approach:** Two-day workshop that convenes all stakeholders at the subnational/district level involved in integrating COVID-19 vaccination with other services.

b. **Goal of the workshop:** To prepare district, subdistrict, and facility-level health personnel to identify and plan the steps needed to integrate COVID-19 vaccination into existing services in their health care settings.

c. **Objectives of the workshop:** At the end of the workshop, participants will be able to:

- Discuss the rationale, guiding principles, and potential risks and benefits of integrating COVID-19 vaccination into other health services.
- Identify national policies and decisions that impact local, context-appropriate approaches and processes for COVID-19 vaccination integration.
- Identify contextually appropriate approaches to integration that enable COVID-19 vaccination of high-priority populations, particularly in low-resource communities, including provision through a package of services, such as integrated with NCD screening for older adults.
- Systematically describe the potential impact of these approaches on existing service delivery and management processes needed to support integrated COVID-19 vaccination, such as supply chain, data management, and human resource management.
- Identify specific steps and resources needed to implement the selected approaches within their program plans.

d. **Who should participate**:

- District focal points/managers for health programs affected by integration, including immunization, HIV/AIDS, TB, ANC, NCD, and wellness clinics.
- District health team members responsible for cross-cutting areas, including data management/information systems, supply chain management, training and supervision, communication, and social mobilization.
- Health facility managers, at least one from a smaller facility and one from a larger facility.
- A few frontline health care providers and, if appropriate, community health workers (CHWs).
- Relevant private sector providers, including those from key civil society organizations (CSOs) and nongovernmental organizations (NGOs).
- Representatives from relevant community organizations or nongovernmental service providers.
- Representatives from WHO, UNICEF, and other in-country implementation partners.

e. **Who should facilitate:** The district health team should facilitate the workshop, with leadership from the District Health Officer or their designees. It is beneficial to arrange for two or more people to share facilitation

responsibilities.

f. Overall process for the workshop:

The workshop is organized around six steps that build on each other, as shown in Figure 1.

Step 1. Briefly review the rationale for COVID-19 vaccination integration and relevant policies.

Step 2. Review local options and existing context, policies, plans, experience, and local data related to COVID-19 vaccination.

Step 3. Participants draft an approach to service delivery focused on reaching high-priority populations, particularly in low-resource communities, through the routine health services used by these groups.

Step 4. Participants review the initial model for integrating COVID-19 vaccination into routine services through a management lens, identifying the changes to existing responsibilities that would be needed and how feasible they are to implement.

Step 5. Participants revise the initial service delivery (SD) model (Step 3) based on the outcome of Step 4.

Step 6. Participants identify follow-up actions needed after the workshop is over.

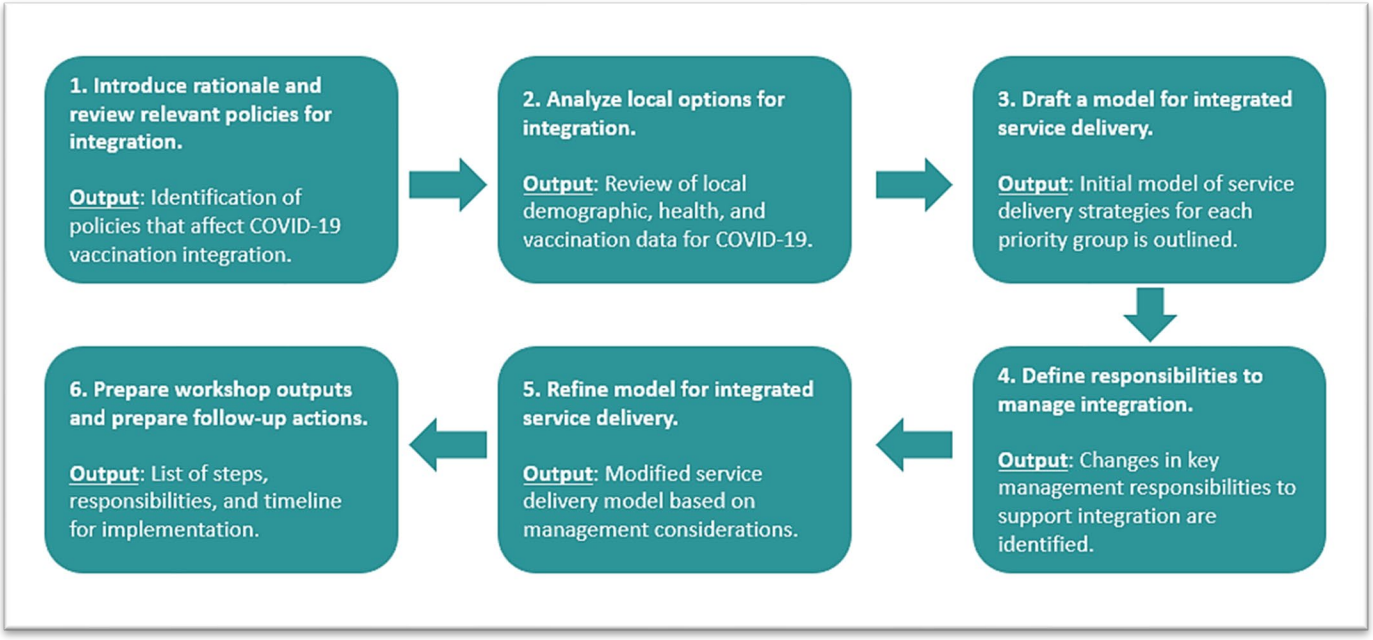

Figure 1: Overview of the steps in the district workshop for integrating COVID-19 vaccination into essential health services

g. Workshop outputs:

1. Identification of next steps for revising microplans (see note on microplanning on page 11), including identifying necessary outstanding data.
2. Designation of roles and responsibilities for integration, particularly the responsibilities for those responsible for coordinating it (district health officers and facility managers).

3. Identification of next steps for management responsibilities: updating training and supervision tools, data management instruments, social behavior change (SBC) strategies, and SOPs for the supply chain and delivery of vaccines, including in collaboration with other programmes (e.g., vaccine for pregnant persons as part of ANC.
4. Identification of the elements needed from the national level and other relevant health programs (for example, HIV/AIDS, ANC), such as written policies, guidelines, and tools. If the country is developing a National Immunization Strategy, the workshop can also identify processes related to COVID-19 vaccination integration to include in it.
5. Mapping of other partners/community representatives to engage for successful integration of COVID-19 vaccination.

2. Roles and Responsibilities of Workshop Facilitators and Organizers (Before, During, and After)

BEFORE: PREPARING FOR THE WORKSHOP

The workshop organizers and facilitators will need to carry out a number of tasks in advance of the workshop, as delineated. Note that the *Facilitator's Checklist for Workshop Preparation*, found in Annex E on page 36, can assist with tracking the completion of these tasks.

1. **Collect background information that will be used during the workshop, including:**

- ***National-level policies, strategies, circulars, plans, and tools that affect the integration of COVID-19 vaccination with other services.*** Other materials may include data on COVID-19 vaccine availability, assessment reports, plans/policies for integration, COVID-19 vaccine availability and access, results from any national self-assessments, analyses of sub-national readiness or other implementation support documents, COVID-19 SOPs, NITAG recommendations, National Immunization Strategy (if available), and additional related information, including identified best practices and lessons learned. For instance, information about what national decision-makers have determined regarding priority populations and vaccine schedules can be collected.

- ***Existing local/national data on COVID-19 and related health indicators.*** These may include data on the high-priority groups for COVID-19 vaccination, such as the prevalence of common comorbidities like HIV and TB, or data on ANC.

- ***Other relevant demographic data,*** **such as:**

    - number of potential beneficiaries by priority group, such as the number of older people and health care workers in the district.
    - number, ownership, and locations of service delivery sites; the services they provide; and the status of the cold chain equipment and vaccine storage capacity.
    - vaccination coverage rates for the general population and high-risk groups.
    - number and list of catchment communities and existing outreach sites for vaccination or other services.
    - distribution of health workers and the types of services they provide to high-priority groups and existing vaccination outreach sites.

Note: If immunization microplanning documents exist for the district, they will contain much of this information.

- **Locations of high-priority populations** for COVID-19 vaccination because integration will best be achieved by going to where they are. CSOs and other community groups/stakeholders working with older persons, those with co-morbidities, those who are immunocompromised or pregnant, etc., may be able to help map the priority groups and identify local champions who can assist. How to best provide vaccination to health workers also needs to be decided. Understanding where high-priority populations are located and how they can access services is critical to identifying where and when to provide outreach services (particularly for older populations) and how outreach can complement vaccination services provided within health facilities.
- **Information on existing activities to integrate COVID-19 vaccination** with routine services already underway in the country/district on which additional plans can be built. Also, information about previous health care integration efforts in the district (e.g., family planning [FP] with HIV) can be compiled, including how they were planned and implemented, and any lessons learned.

2. Determine **who should attend** the workshop. Refer to section 1d for a detailed list.
3. **Ask the invited facility managers to talk with the staff** they supervise about their concerns, experience, and ideas for COVID-19 vaccination integration.
4. **Ensure that local directors/managers/coordinators are aware of and supportive of the workshop,** as these key decision-makers will be responsible for making sure that the decisions made during the workshop are finalized, approved, implemented, and evaluated. Whenever possible, these people should attend and participate in the workshop.
5. Plan the **logistics of the workshop** (i.e., dates, venue, meals/snacks, budget, invitations) and make sure supplies/equipment needed are available (e.g., laptops, screens for projecting, flipcharts/paper/markers).
6. **Review the content of the workshop sessions** in order to be prepared to facilitate the required discussions. Review the illustrative templates (annexes, pages 28–36) in order to understand the tasks and outputs needed for the group activities, adapting the templates as necessary. Pre-select the members of breakout groups for each activity. Review slides and adapt/complete them as appropriate, especially those that require local information. Printouts and/or electronic files of the annexes and slides can be provided to participants.

DURING: FACILITATING THE WORKSHOP

A sample workshop agenda for facilitators is presented on the following pages. This shows the topics, modalities, and resources needed. The “Workshop at a Glance” is followed by detailed instructions for facilitators on how to manage each session.

Note that it is beneficial to have two or more facilitators for this workshop. In addition to sharing presentation duties and monitoring the small group work, one facilitator can function as the recorder, documenting discussion points and decisions on flip charts or electronic files, while the other leads the discussions.

Note on Microplanning: While this two-day workshop will refer to some aspects of microplanning that incorporate COVID-19 vaccination into other services, it is not a microplanning workshop and will not result in a separate stand-alone microplan on integrating COVID-19 vaccination into other services. Instead, one expected follow-up action from the workshop is to update existing plans or microplans to include COVID-19 vaccination to reach high-priority populations.

Definition of a microplan for COVID-19 vaccination: A COVID-19 vaccination microplan is an action-oriented summary of the human, financial, and logistical resources needed for COVID-19 vaccination of targeted high-priority groups in a catchment area.

Source: WHO/UNICEF COVID-19 microplanning guidelines, May 2023. https://www.who.int/publications/i/item/WHO-2019-nCoV-vaccination-microplanning-2023.1

SUBNATIONAL/DISTRICT WORKSHOP ON COVID-19 VACCINATION INTEGRATION: WORKSHOP AT A GLANCE

DAY 1			
Time	**Title**	**Modality**	**Resources**
8:30 a.m. (45 min)	**Introduction to Workshop:** Welcome, housekeeping, introductions, ice breaker, learning objectives	Discussion	Laptop/projection method
9:15 a.m. (75 min)	**Step 1. Introduce rationale and review relevant policies for COVID-19 vaccination integration:** • COVID-19 vaccine basics and evolving strategies; integration defined, rationale, benefits/risks. • National guidance (national context and data, self-assessment results, national-level checklists, priority populations, resulting action plans, if available). • Introduction to *Considerations* document. • National/district experience with past integration efforts for COVID-19 vaccination (e.g., with ANC, HIV/AIDS, NCD, etc.).	PPT/presentation, discussion	Laptop/projection method *Considerations document (URL/hardcopy)*
10:30 a.m.	TEA BREAK		
11 a.m. (90 min)	**Step 2. Analyze local options for integration and review the local context:** • Finding/using local data about priority populations and mapping who/where they are. • Previous integration efforts: is the district typical of the country or ahead/behind (data or anecdotal)? • Contingencies depending on upcoming national decisions?	Discussion	Documents with local demographic and health service data *Vaccinating older adults document* (Annex A)
12:30 p.m.	LUNCH		
1:30 p.m. (90 min)	**Step 3. Draft a model for integrated service delivery:** • Who are the priority populations? Where and how to reach them? How often? How to integrate with other health services? • What is the patient flow at facilities and community? • Implications for staff/operations/management? • Involvement of stakeholders.	PPT/Breakout group work: completing template (Annex B)	Laptop/ projection method or flipchart Blank SD Model template Documents with local data
3 p.m.	TEA BREAK		

3:30 p.m. (75 min)	**Step 3. Draft a model for integrated service delivery (continued):** • Plenary discussion, a compilation of group work, consensus on the SD model, and patient flows.	Discussion	Laptop/projection method Completed service delivery models
4:45 p.m.	**Closing of Day 1**, looking ahead to Day 2	Discussion	
DAY 2			
8:30 a.m. (30 min)	**Recap of Day 1** (What was learned, questions, plan for today)	Discussion	
9 a.m. (45 min)	**Step 4. Define responsibilities to manage integration (demo):** • Using the template (Annex C), start completing sample items as a group.	PPT Plenary discussion: completing template (Annex C)	Laptop/projection method Blank Managerial Responsibilities template
9:45 a.m. (90 min)	**Step 4. Define responsibilities to manage integration (activity):** • Breakout groups complete plan template for one or more prioritized items, discussing requirements and barriers for implementation in detail.	Breakout group completion of management template (Annex C)	Plan template (electronic and/or hard copy) Laptop or flipchart
11:15 a.m.	TEA BREAK		
11:45 a.m. (75 min)	**Step 4. Define responsibilities to manage integration (continued):** • Plenary presentation/discussion of breakout group work/plans.	Breakout groups each present/discuss their work	Laptop/projection method or flipchart
1 p.m.	LUNCH		
2 p.m. (60 min)	**Step 5. Refine model for integrated service delivery:** • Revisit the integrated service delivery model created in Step 3 and discuss how it aligns with changes to management responsibilities.	PPT Discussion	Laptop/projection method
3 p.m.	TEA BREAK		
3:30 p.m. (75 min)	**Step 6. Prepare workshop outputs and assign follow-up actions for the next steps:** • These will include steps for planning, coordination, monitoring, and sharing of best or promising practices for COVID-19 vaccination integration and may consist of the need to develop or request new documents or tools from the national level.	PPT Discussion	Laptop/projection method Annex D, list of follow-up tasks
4:45 p.m.	**Summary and workshop closing**		

SESSION-BY-SESSION INSTRUCTIONS FOR FACILITATORS

DAY 1

8:30 a.m.: Introduce workshop

(Welcome, housekeeping, introductions, ice breaker)
Slides: Title, Welcome, Objectives, 6 Steps

9:15 a.m.: Step 1. Introduce rationale and review relevant policies for COVID-19 vaccination integration

(Presentation, plenary discussion)
Slides: Step 1. Definition, Considerations, Rationale, Benefits, Risks, Priority-Use Groups, Aligning with National/Local Policies
Output: *Identification of policies that affect COVID-19 vaccination integration.*

- COVID-19 vaccination basics, including data on local vaccination rates and evolving national strategy.
- Definition/rationale of integration (from WHO *Considerations*).
- Integration benefits/risks.
- National/district experience with past integration efforts, i.e., FP/HIV, immunization/postpartum family planning (PPFP).
- Existing/expected country guidance/policies/data/plans on COVID-19 integration.
- Focus on priority populations and those with special considerations (SAGE roadmap).

Resource for participants: *Considerations for integrating COVID-19 vaccination into immunization programmes and primary healthcare for 2022 and beyond. WHO. 2022. https://www.who.int/publications/i/item/9789240064454*

Note to Facilitator: Priority populations are country-specific and subject to change. In your workshop, in addition to the latest global SAGE/WHO recommendations (https://www.who.int/publications/m/item/increasing-covid-19-vaccination-uptake**) make sure you are using the latest national guidance regarding the priority population groups in your setting.**

10:30 a.m.: Tea Break

11 a.m.: Step 2. Analyze local options for integration and review the local context

(Plenary discussion)
Slides: Step 2. Local Situation
Output: *Review of relevant local demographic, health, and vaccination data for COVID-19.*

- Local contextual factors to be considered.
- Identifying/using local data.
- Identifying/mapping local priority populations (avoiding double counting) and stakeholders.
- Reaching local priority populations (Example: Annex A for older adults).
- Contingencies depending on upcoming national decisions.

Resources for participants: *Vaccinating older adults against COVID-19*. WHO. 2023. **(summary matrix in Annex A). https://www.who.int/publications/i/item/9789240066045.** Other documents containing local demographic information.

12:30 p.m.: Lunch

1:30 p.m.: Step 3. Draft a model for integrated service delivery

(Breakout group work completing SD model template)
Slides: Step 3. Service Delivery Model, Sample Strategies (Annex A), Discussion Tool (Annex B), Breakout Groups
***Output*:** *Initial model of service delivery strategies for each priority group.*

Facilitator preparation:

- Review the SD model template (partially completed illustrative example on page 17 and blank template for participant use in Annex B) and adapt the first column to reflect the COVID-19 vaccination priority groups as designated in your country.
- Plan how to divide the participants into breakout groups so that each reflects a diversity of health system workers. For instance, each group should include workers from the public and private sectors, frontline workers, and managers. Further, the group that discusses older populations can include representatives from long-term care facilities; the group that discusses the immunocompromised can include workers from HIV clinics.
- Decide how the breakout groups will complete the template (e.g., electronically on a laptop computer or a large sheet of flipchart paper) and prepare accordingly.
- **Activity:**
    - Note: Before dividing into the breakout groups, the partially completed example on page 17 can be displayed and discussed by the plenary group, if desired.
    - Divide the participants into three to four breakout groups of five to six participants, assigned as described above.
    - Assign each breakout group one to two priority groups so all priority groups are covered at least once.
    - Tell the groups that they will each complete the SD model template for their assigned priority group(s), basing their decisions on the local data provided (i.e., demographics, national guidance, other) regarding where and how to reach priority populations and implications for staff/management/operations.
    - Ask each group to appoint a **facilitator** to lead discussions, a **secretary** to document their decisions on the template (electronic or flip chart), and a **rapporteur** who will present their findings in the plenary session.
    - Tell each group they have 90 minutes to complete the activity.

Resource for facilitator: *Service Delivery Model Template* (illustrative, partially completed for demonstration. (See page 17.)
Resource for participants: *Annex B: Service Delivery Model Template* (blank for breakout group activity).

3 p.m.: Tea Break

3:30 p.m.: Step 3. Draft a model for integrated service delivery (continued)

(Plenary presentations/discussion)

Process the service delivery activity:

- Reconvene group in plenary. Ask each breakout group to present their findings and suggested strategy, explain their thinking behind it, and lead a discussion of their thinking (10 minutes per group).
- Summarize the work of the groups and explain that this service delivery model will be used in tomorrow's work.

4:45 p.m.: Close Day 1 of the workshop

Slide: Closing

Note to facilitator:

Collect the service delivery models developed by each breakout group. Overnight, compile all group comments electronically into one service delivery model so that you can project and reference it during day two. Note any outstanding issues or questions that need further discussion.

TABLE 2. FOR FACILITATORS: EXAMPLE OF THE PARTIALLY COMPLETED VERSION OF ANNEX B SERVICE DELIVERY MODEL TEMPLATE, WITH ILLUSTRATIVE EXAMPLES

Priority group (WHO priority groups are shown. Adapt to local context)	Service delivery setting (i.e., fixed, outreach, mobile)	How frequently will COVID-19 vaccination be provided?	How is patient flow affected at the facility?	Which workers (program, cadre) provide vaccination?	Which other staff need to be involved and in what ways?	Who else should be involved, and in what ways?

Older people
 	
(Please also refer to Annex A: *Vaccination strategies for older adults*)
	• **Fixed sites:** Clinics, hospitals, long-term care facilities.
	• **Outreach:**
	  ○ Community sites
	  ○ Religious organizations
	  ○ Social security/pension sites
	• **Mobile:** remote sites
		• **Fixed site:** Daily
		• **Outreach:** Monthly
		• **Mobile:** to be determined
			• Health care providers in hypertension clinic screens clients for eligibility and refers them to the vaccination room	• Vaccinators
				• Clinical officers
				• Others?
					• Supervisors/Managers
					• NCD clinic staff to screen and vaccinate or refer to a vaccination clinic
					• CHWs to help organize outreach sessions to reach older populations
						• Community organizations to inform constituents on who/where/when to get a vaccination
						• Religious organizations
						• Social security/pension offices

Health workers	• **Fixed:** worksites	• **Fixed:** Semi annual check and vaccination as per policy		• PHC nurses • Clinical officers	• Supervisors/Managers	• Professional associations • Training institutions

Immunocompromised people	• **Fixed:** HIV clinics, hospitals
	• **Outreach:**
	  ○ Community sites
	  ○ Religious organizations
	  ○ HIV treatment clubs
		• **Fixed:** daily or weekly
		• **Outreach:** Monthly
			• Provider screens client for eligibility and refers them to the vaccination clinic	• PHC nurses
				• Other?
					• Supervisors/Managers
					• Drivers
					• Community reps
						• HIV support organizations

People with comorbidities	• **Fixed:** TB and wellness clinics, hospitals
	• **Outreach:**
	  ○ Community organizations
	  ○ Religious organizations
		• **Fixed:** daily or weekly
		• **Outreach:** Monthly
				• PHC nurses
				• Other?
					• Supervisors/Managers
					• Drivers
					• Community reps
						• Community organizations
						• Religious organizations

Pregnant people	**Fixed:** ANC clinics **Outreach:** community sites	● **Fixed:** Daily ● **Outreach** Monthly		● PHC nurses ● Clinical officers ● CHWs	● Supervisors/Managers ● Drivers ● Community reps	● Community organizations ● Religious organizations ● Women's groups
Other high-priority groups (in accordance with national policy)						

Day 2

8:30 a.m.: Recap of Day 1 (What was learned, questions, plan for today: management responsibilities, compiled service delivery model)

Slide: Welcome to Day 2

9 a.m.: Step 4. Define responsibilities to manage the integration

(Demonstration, plenary discussion)
Slides: Step 4. Discussion Tool (Annex C), Breakout Groups
Output: *Changes in key management responsibilities to support integration identified.*

- Discuss management responsibilities and roles that need local revision, for instance, who will enter data about vaccinated persons.
- Discuss functions in alignment with national guidance for COVID-19 vaccination, for example, priority groups, vaccination schedule, patient flow (e.g., vaccine to person or person to vaccine), and service delivery strategies, if applicable.
- Introduce blank management responsibilities template (Annex C).
- Lead the group in a discussion of the template by partially completing it for one management category as an example (see example on page 20 as a guide). (45 minutes)

Resource for facilitator: *Management Responsibilities Template* (illustrative, partially completed for demonstration. (See page 20.)

Resources for participants (document in electronic folder of guide): *Building on country experiences: An operational framework for demand integration of COVID-19 vaccination into routine immunization services and primary health care.* UNICEF. 2023.
Annex C: Management Responsibilities Template (blank for breakout group activity).

TABLE 3. EXAMPLE OF PARTIALLY COMPLETED VERSION MANAGEMENT RESPONSIBILITIES TEMPLATE WITH ILLUSTRATIVE EXAMPLES

Categories of management responsibility	Process changes needed and actions to take (Illustrative examples)	Inputs needed to make changes (e.g., tools, commodities, estimated costs, and funding sources)	One key question remaining	Connection to other management categories
Health Workforce				
Training	• Example: Identify the new competencies needed, especially for staff who have not been involved in immunization previously. • Example: Develop a system for assessing the effectiveness of training on worker performance	• Updated training curricula andsupervision or mentoring tools. • Training plan for rollout. • M&E plan for transfer of learning.	Are national integration training curricula available for adaptation (for programs, facilities, universities)?	• Leadership and governance • Data management processes and HIS
Supervision	• Example: Incorporate duties for COVID-19 vaccination into supportive supervision tools. • Develop a system to roll out supervision on new content (for providers and supervisors). • System for assessing the effectiveness of training on supervisor performance.	• Updated supervision/ mentoring tools • Training plan for the rollout of updated supervision/mentoring tools • M&E plan for supervision/mentoring.	Are national supervision tools updated to reflect integration? Can districts modify the tools that they use?	• Leadership and governance
Other (participants to add as needed)				
Supply Chain Management				
Forecasting vaccine requirements				
Assessing cold chain storage capacity	Identify extra vaccine cold chain equipment and capacity needed to offer continuous COVID-19 vaccination.	Updated vaccine cold chain inventory.		• Health workforce • Leadership and Governance
Waste management				

Categories of management responsibility	Process changes needed and actions to take (Illustrative examples)	Inputs needed to make changes (e.g., tools, commodities, estimated costs, and funding sources)	One key question remaining	Connection to other management categories
Other (participants to add as needed)				
Communication and Community Engagement				
Interpersonal communication	Example: Identify key information that needs to be communicated to priority groups, who will provide it, and when.			▪ Leadership and governance ▪ Health workforce ▪ Data management
Mass media or social media	Example: Work with local radio stations to broadcast messages on COVID-19 vaccination integration.			• Leadership and Governance • Health workforce
Other types of demand generation				
Other (participants to add as needed)				
Data Management Processes and Health Information Systems				
Data recording	Example: Identify which tools to be used to record COVID-19 vaccine doses administered and who needs to fill them.			• Leadership and Governance • Health workforce
Data reporting	Example: Clarify responsibilities for reporting from health facility to district and to whom data will be sent.			• Leadership and Governance • Health system workforce

Categories of management responsibility	Process changes needed and actions to take (Illustrative examples)	Inputs needed to make changes (e.g., tools, commodities, estimated costs, and funding sources)	One key question remaining	Connection to other management categories
Data analysis and feedback				
Other (participants to add as needed)				
Governance and Leadership				
Roles and accountability at district and facility levels	Agree on who is responsible at the district and facility level for overseeing the integration of COVID-19 vaccination into routine services.			• Health workforce • Supply chain management • Data management processes • Communication and community engagement
Planning and budgeting other (participants to add as needed)	Clarify responsibilities for planning COVID-19 vaccination and budgetary responsibilities.			• Health workforce
Other (participants to add as needed)				

9:45 a.m.: Step 4. Define responsibilities to manage the integration
(Breakout group activity completing Management Responsibilities template)

Following the demo on completing the template, breakout groups work independently, preparing a template for presentation in plenary, each group concentrating on their assigned management category and using relevant local data and other resources.

Preparation:

- Plan to divide the participants into breakout groups so that each reflects a diversity of health system workers. For instance, each group should include workers from the public and private sectors, frontline workers, and managers. Further, the group that discusses the health workforce should include facility managers and supervisors; the group that discusses communication and community engagement should include representatives from community groups.
- Decide how the groups will complete the template (e.g., electronically on a laptop computer or a large sheet of flipchart paper) and prepare accordingly.

Activity:

- Divide the participants into three to four breakout groups of five to six participants, assigned as described above.
- Assign each breakout group one to two categories to cover all categories with minimal duplication.
- Tell the groups they will complete the Management Responsibilities template for their assigned categories, as shown in the demonstration. They will need to base their decisions on the local data provided (i.e., demographics, national guidance, and other information).
- Ask each group to appoint a **facilitator** to lead the discussions, a **secretary** to document the decisions on the template (electronic or flip chart), and a **rapporteur** who will present their findings to the plenary group.
- Tell each group they have 80 minutes to complete the activity.

11:15 a.m.: Tea Break

11:45 a.m.: Step 4. Define responsibilities to manage integration (continued)
(Plenary discussion)

Process the managerial function activity:

- After the groups complete the template, each presents their findings in plenary, electronically or on a flip chart, leading a discussion of their thinking.
- At the end of the discussion, the output will be an agreed-upon list of the key management responsibilities that will need to change to accommodate the integration of COVID-19 vaccination into other services. Identify any changes needed to the service delivery model to make it more manageable.

1 p.m.: Lunch

Note to facilitator: Collect all work from the breakout groups. During lunch, compile all group comments into one table in an electronic file to be projected and referenced during the afternoon sessions. Note any outstanding issues or questions that need further discussion.

2 p.m.: Step 5. Refine model for integrated service delivery (Plenary discussion)

Slides: Step 5. Discussion
Output: *Modified service delivery model based on management considerations.*

Project the compiled version of the service delivery model created in Step 3 and lead a discussion of how the newly identified management responsibilities align with the model. Bring attention to any interconnections raised by the breakout groups. Note any outstanding issues, identified barriers, and "further information needed." Adapt the service delivery model, as appropriate, noting changes on a flip chart or electronically.

3 p.m.: Tea break

3:30 p.m.: Step 6. Prepare workshop outputs and assign follow-up actions for next steps

(Plenary discussion)
Slides: Step 6. Revised SD Model, Managerial Responsibilities, Discussion, Discussion Tool (Annex D)
Output: *List of steps, responsibilities, and timeline for implementation.*

Summarize the workshop findings, emphasizing that this is just a start but that the decisions should be helpful for integration efforts in the district.

Project the *Workplan for Follow-up Actions* template (Annex D) and, as a group, fill in the tasks, the person responsible, and the timeframe. See the partially completed example on page 25 for guidance.

Resources for facilitator: *Template for Workplan for Follow-up Actions* (illustrative, partially completed for demonstration. (See page 25). "Post-workshop" list of tasks (See page 27).

Resource for participants: *Template for Workplan for Follow-up Actions (Annex D)*

4:45 p.m.: Step 6. Close workshop

Slide: Summary and Closing

Summarize the workshop findings, reiterating that integration will depend on implementing the decisions, updating the process as needed, and tracking their success. Discuss how to ensure these next steps happen and who will be responsible.

Thank the participants for their time and contributions.

TABLE 4: WORKPLAN FOR FOLLOW-UP ACTIONS (ILLUSTRATIVE WITH SELECTED EXAMPLES)

	TASK	Person Respon-sible	Month 1				Month 2				Month 3				Month 4				Month 5				Month 6				Month 7				Month 8				Month 9				Month 10				Month 11				Month 12			
			1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4
1	**Planning and budgeting**																																																
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2	**Training and capacity building**																																																
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3	**Vaccine and supply chain management**																																																
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4	**Social mobilization and**																																																

	community engagement																																														
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4.3																																														
5	**Data management/ HMIS**																																														
5.1																																															
5.2																																														
5.3																																														

AFTER: POST-WORKSHOP FOLLOW-UP:

TASKS TO COMPLETE IN THE WEEKS/MONTHS AFTER THE WORKSHOP

After the workshop, district teams will need to carry out the following tasks to help make sure that the suggestions and decisions from the workshop are implemented and evaluated.

Using the completed *Workplan for Follow-up Actions* (Annex D) as a guide:

1. Follow up with workshop participants to ensure that the tasks assigned to each of them are being carried out in a timely manner. Note barriers and challenges encountered and work with the group to resolve them.
2. When possible, include COVID-19 vaccine integration as an agenda item for monthly meetings.
3. Ensure that the new tasks align with national directives, especially if national guidance is undergoing revision. This can include national guidance, tools, SOPs, and revised tools.
4. Work to integrate the tasks in Annex D into existing district policies, plans, and tools, such as—
    - Microplans for routine immunization and plans for other programs.
    - SOPs for vaccines, other health commodities, and supply chain management.
    - Health worker training materials, job aids, and supportive supervision tools.
    - Tools and procedures for recording, reporting, analysing, and providing feedback on data.
    - Communication strategy for informing priority populations and communities about where and when to obtain COVID-19 vaccination and promoting the use of the services.
5. Work with participants to develop plans for any essential topics not discussed during the workshop as needed.
6. Develop plans with the participants to monitor the progress of the implemented tasks.
7. Determine how the resources for implementing integration will be secured.

ANNEX A. VACCINATION STRATEGIES FOR OLDER ADULTS (SUMMARY TABLE)

Source: Vaccinating older adults against COVID-19, WHO, 2023. https://www.who.int/publications/i/item/9789240066045

SETTINGS DELIVERY STRATEGIES[1]	 **Fixed health care facilities** (e.g., public or private – hospitalks, primary care cliniics, NCD Clinics, physiotherapy clinics)	 **LTC facilities** (e.g., residential facilities, old-age homes, nursing homes, assisted-living facilities, mental health facilities)	 **Community outreach** (e.g., markets, places of worship, pharmacies, community centres, social clubs, workplaces, weekly markets and routine vaccination sites)	 **Outreach** (e.g., house to house and teams for hard-to-reach sparse populations, detention centres, prisons)	 **Mass campaigns** (i.e., mass vaccination centres set up in stadiums, shopping malls, social or religious gathering places and school gymnasiums or large spaces)
Geographical access	• Known location • Different care pathway might be required • Can integrate into disease and function management care pathway	• Older adults may already be on-site • Does not reach older adults within the community	• Shorter travel to the site within the community	• Mobile vehicles or posts can be positioned closer to where older adults live • Easier access points when using house-to-house visits	• Require travel to site • Information on the location needs to be shared with older adults and caregivers
Physical access	• May already be accessible by public transit, suitable for wheelchairs or equipped with ramps • Signage to vaccination site may need to be in large print	• May be wheelchair accessible • May already have signs in large print • Residents are likely already familiar with the site	• Arrangements may need to be made to ensure accessibility for those with mobility assistive products (e.g., cane, wheelchair) • Signage needed to direct to vaccination site • Site may need to be modified to allow for noise dampening and good lighting	• More accessible for those with loss of mobility or disability and who are homebound or bedridden	• Arrangements may need to be made to ensure accessibility for those with mobility assistive products and signage to direct to vaccination site • Site may need to be modified to allow for noise dampening and good lighting

1 Many countries report using multiple delivery methods to reach older adults; these strategies may therefore be complementary. COVID-19: coronavirus disease; IEC: information, education and communication; LTC: long-term care; NCD: noncommunicable disease; NGOs: nongovernmental organizations.

SETTINGS DELIVERY STRATEGIES[1]	 **Fixed health care facilities** (e.g., public or private – hospitalks, primary care cliniics, NCD Clinics, physiotherapy clinics)	 **LTC facilities** (e.g., residential facilities, old-age homes, nursing homes, assisted-living facilities, mental health facilities)	 **Community outreach** (e.g., markets, places of worship, pharmacies, community centres, social clubs, workplaces, weekly markets and routine vaccination sites)	 **Outreach** (e.g., house to house and teams for hard-to-reach sparse populations, detention centres, prisons)	 **Mass campaigns** (i.e., mass vaccination centres set up in stadiums, shopping malls, social or religious gathering places and school gymnasiums or large spaces)
Community mobilization	• May need more intensive and targeted mobilization for older adults to attend • Engage reception, pharmacy staff and physicians at the health facility to identify vaccination needs and refer older adults to the vaccination site • Display of IEC materials related to COVID-19 vaccine at prominent places, and availability of vaccination at the facility	• Client base is well defined to allow focused mobilization • Facility staff can assist with communication and demand generation • Ministry of health can engage facility staff in vaccination activities on vaccine clinic days	• Requires engaging health workers, community mobilizers, NGOs, religious leaders and community representatives to inform and mobilize older adults • Displaying IEC materials such as banners and posters help to generate demand • Having the same outreach locations as for other vaccinations may make mobilization easier than a new site would	• Requires engaging health workers, community mobilizers, NGOs, religious leaders and community representatives to provide information on the importance of vaccination and the date of visit to the area/house • Displaying IEC materials such as banners, posters and leaflets in a community setting could help to generate demand	• Needs strong mobilization • Engage local newspaper, radio, FM and TV channels for awareness • Displaying IEC materials such as banners, posters and leaflets may help to generate demand
Vaccine supply	• Vaccine storage may be available at some facilities; for others a vaccine distribution plan needs to be prepared	• Preparation of vaccine logistics distribution plan from nearest vaccine store will need to be detailed	• Challenging to know the exact number of older adults who will attend outreach sessions • Preparation of vaccine logistics distribution plan from nearest vaccine store will need to be detailed	• Challenging to know the exact number of older adults who will attend a mobile clinic or who will accept vaccine (house to house) • Preparation of vaccine logistics distribution plan from nearest vaccine store will need to be detailed	• Large volume of vaccine needed over short duration • Distribution challenges (must be able to redistribute/ resupply quickly during campaign) may exist and require plans • Plan to replenish vaccine in case of shortage

SETTINGS DELIVERY STRATEGIES[1]	 **Fixed health care facilities** (e.g., public or private – hospitalks, primary care cliniics, NCD Clinics, physiotherapy clinics)	 **LTC facilities** (e.g., residential facilities, old-age homes, nursing homes, assisted-living facilities, mental health facilities)	 **Community outreach** (e.g., markets, places of worship, pharmacies, community centres, social clubs, workplaces, weekly markets and routine vaccination sites)	 **Outreach** (e.g., house to house and teams for hard-to-reach sparse populations, detention centres, prisons)	 **Mass campaigns** (i.e., mass vaccination centres set up in stadiums, shopping malls, social or religious gathering places and school gymnasiums or large spaces)
Cold chain	• Cold chain is usually available	• Vaccine carriers and ice packs most likely need to be prepared to maintain the cold chain	• Vaccine carriers and ice packs must be prepared to maintain the cold chain	• Vaccine carriers, cold boxes and ice packs must be prepared to maintain the cold chain	• Vaccine carriers, cold boxes, and ice packs are needed • Temporary vaccine storage at a large site may be needed
Integration opportuities	• Help to strengthen older adult health services (e.g., screening for NCDs, coadministration with influenza vaccine)	• Help to strengthen older adult health services (e.g., screening for NCDs, coadministration with influenza vaccine)	• Co-delivery with short-duration interventions possible (i.e., NCD screening) • Co-delivery with routine vaccination	• Co-delivery with other home interventions such as NCD screenings and home-based long-term care that include other family members (neonatal, pregnancy care) – i.e., whole family care	• Integrate with other health services (e.g., health check-ups, NCD screening) and campaigns (e.g., influenza vaccine), whole family care
Cost	• Low if supported by health care budget • Additional training for health facility staff • might be required	• Medium-high (depends whether using existing LTC staff is possible or whether COVID-19 vaccination services can be integrated into existing services) • Additional training for facility staff may be required	• Medium-high (depends whether using existing outreach sessions that are already planned and funded)	• Generally high (but for small and hard-to-reach populations may be more cost-effective) • Additional budget for per diems, transport, demand generation, etc.	• Generally high (but may be more costeffective for small and hard-to-reach populations) • Additional budget for set up of new vaccination site, per diems, transport, demand generation, etc.

ANNEX B. TEMPLATE FOR SERVICE DELIVERY MODEL

Priority group	Service delivery setting (i.e., fixed, outreach, mobile)	How frequently will COVID-19 vaccination be provided?	How is patient flow affected at the facility?	Which workers (program, cadre) provide vaccination?	Which other staff need to be involved and in what ways?	Who else should be involved, and in what ways?
Older people						
Health workers						
Immunocompromised people						
People with comorbidities						
Pregnant people						
Other high-priority groups (in accordance with national policy)						

ANNEX C. TEMPLATE FOR IDENTIFYING CHANGES IN MANAGERIAL RESPONSIBILITIES

Categories of management responsibility	Process changes needed and actions to take (Illustrative examples)	Inputs needed to make changes (e.g., tools, commodities, estimated costs, and funding sources)	One key question remaining	Connection to other management categories
Health Workforce				
Training				
Supervision				
Other (participants to add as needed)				
Supply Chain Management				
Forecasting vaccine requirements				
Assessing cold chain storage capacity				
Waste management				
Other (participants to add as needed)				
Communication and Community Engagement				
Interpersonal communication				
Mass media or social media				
Other types of demand generation				

Categories of management responsibility	Process changes needed and actions to take (Illustrative examples)	Inputs needed to make changes (e.g., tools, commodities, estimated costs, and funding sources)	One key question remaining	Connection to other management categories
Other (participants to add as needed)				
Data Management Processes and Health Information Systems				
Data recording				
Data reporting				
Data analysis and feedback				
Other (participants to add as needed)				
Governance and Leadership				
Roles and accountability at district and facility levels				
Planning and budgeting				
Other (participants to add as needed)				

ANNEX D. WORKPLAN FOR FOLLOW-UP ACTIONS

	TASK	Person Respon-sible	Month 1				Month 2				Month 3				Month 4				Month 5				Month 6				Month 7				Month 8				Month 9				Month 10				Month 11				Month 12			
			1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4
1	**Planning and budgeting**																																																
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2	**Training and capacity building**																																																
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3	**Vaccine and supply chain management**																																																
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4	**Social mobilization and community engagement**																																																	
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4.3																																																		
5	**Data management/ HMIS**																																																	
5.1																																																		
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ANNEX E. FACILITATOR'S CHECKLIST FOR WORKSHOP PREPARATION

This tool can help guide facilitators' steps before the workshop.

3-4 WEEKS IN ADVANCE

- ☐ Engage with national-level decision-makers and immunization partners to ensure their participation and support before, during, and after the workshop and to ensure coordination with national-level activities.
- ☐ In collaboration with other relevant district health officials, review and discuss all workshop materials, including the tools, slides, and facilitator guide. Agree on the objectives for implementing the workshop and the follow-up actions that will be needed.
- ☐ Meet to discuss the workshop process and content. Agree on specific adaptations needed to the guide/tools/slides and decide who will make them and when.
- ☐ Assign roles for who will do what during the workshop (i.e., who will lead which sessions and who will document discussions).
- ☐ Plan and secure workshop logistics (i.e., venue, meals/snacks, accommodations).
- ☐ Identify and invite attendees. (See section 1d for a suggested list of "Who Should Participate.")

1-2 WEEKS IN ADVANCE

- ☐ Collect local demographic data and other background information. Plan how this information will be used during discussions. Document key information on slides or handouts, as appropriate.
- ☐ Continue to become familiar with the guide to help ensure seamless workshop facilitation.
- ☐ Meet to review newly adapted guide/tools/slides.
- ☐ Preselect members of each breakout group.

LESS THAN 1 WEEK IN ADVANCE

- ☐ Finalize an adapted version of the guide/tools/slides.
- ☐ Continue to become familiar with the guide to help ensure seamless workshop facilitation.
- ☐ Prepare copies of adapted handouts (i.e., annexes, slides, resources), hardcopy and/or electronic.
- ☐ Confirm venue, attendees, etc.