

## Technical Brief

# Transitioning Delivery of Health Campaign Interventions to the Primary Health Care System: Achieving a Strategic Balance of Independent and Integrated Delivery of Interventions

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### Key Messages

- Public health campaigns are part of the primary health care (PHC) system, yet service delivery of campaign interventions is commonly conducted independently to address targeted health goals
- Independent delivery of campaign-based health interventions is often moved to delivery via the PHC system in countries entering middle-income status, witnessing shifts in donor funding, experiencing positive changes in the epidemiological trends (e.g., reaching disease elimination targets), and/or aiming for universal health coverage
- Campaigns can integrate service delivery partially and incrementally with the PHC system to reach a strategic balance of interventions delivered via the PHC system and independent campaigns
- Where possible, developing an integration readiness framework is critical to transition delivery of some or all campaign-based services into PHC systems. It is important to assess experiences and opportunities, entry points, and drivers of integrating delivery of campaign interventions with the PHC system. It is also important to assess the processes, best practices, health outcomes, and impact of integrated delivery of campaign interventions with the PHC system.

### Purpose

- Introduce the concept of transitioning independent delivery of donor and/or government funded campaign interventions to integrated delivery through the PHC system
- Contribute to discussions among countries, donors, implementing partners, and other stakeholders about the benefits and tradeoffs of integrating delivery of campaign interventions with PHC
- Summarize the lessons learned from experiences and highlight the evidence gaps

### Target Audience(s)

- Policy makers and national and sub-national level stakeholders who oversee, plan, implement, or monitor health campaigns and/or work towards strengthening health systems and PHC
- Global organizations that finance, monitor, or issue guidance around health campaigns, PHC, and health systems strengthening

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## Introduction

Since the [Alma Ata Declaration](#) affirmed a universal right to health in 1978, governments, implementing partners, donors, and researchers across the globe have faced the challenge of strengthening PHC<sup>1</sup> along with the effective provision of interventions through intermittent health campaigns of vertical programs (1). In many countries, health programs rely upon campaigns (often focused on a single intervention) to reach specific health targets (See [Technical Brief: Defining Health Campaigns and Health Campaign Effectiveness](#)). High priority vertical health programs that use campaigns to rapidly address specific diseases or health needs, include neglected tropical diseases (NTDs), malaria, polio, other vaccine-preventable diseases (e.g., measles, yellow fever, typhoid, tetanus, meningitis, HPV, cholera), and nutrition (vitamin A supplementation). However, as countries are moving towards universal health coverage (2), health campaigns focusing on achieving specific health goals are being examined in terms of the sustainability of their health outcomes and missed opportunities to provide other health services.

**Health campaigns** are time-bound, intermittent activities that are deployed to address specific epidemiologic challenges to defined target groups, expediently fill delivery gaps, or provide surge coverage for health interventions.

**Vertical programs** are “a component of the health system which has specific, defined objectives, usually quantitative, and relating to a single condition or small group of health problems. The objectives focus on the short- or medium-term, and the program has centralized management and discrete means (staff, vehicles, funds)” (3).

Vertical programs that operate health campaigns are increasingly considering approaches to improve campaign effectiveness and sustainability of health outcomes. One approach is **integration between health campaigns**, addressed earlier in this series, [Technical Brief: Integration Between Health Campaigns: Intervention Co-delivery and Collaboration](#). Another approach is **transitioning independent delivery of health campaign interventions to the PHC system**, the focus of this brief.

### **Transitioning Independent Delivery of Health Campaign Interventions to PHC: Approaches and Opportunities**

Health campaigns share many functions (e.g., planning, monitoring, surveillance, procurement systems) with the PHC system, yet the intervention delivery function of campaigns continues to operate largely independently. Integration of campaign interventions with the PHC system refers to the eventual assimilation of delivery of vertical health interventions into primary health care services with integrated governance, financing, planning, service delivery, and monitoring and evaluation mechanisms (4). Within countries, several circumstances contribute to the transitioning of health campaigns from independent to integrated delivery (1,5,6):

- As countries enter middle-income status and lower-income countries witness a decline in disease burdens or reach disease elimination goals, donor funding (and technical support) undergoes transitions. Countries are developing plans for financing their health care systems and programs to prepare for integrated delivery of campaign interventions via strengthened PHC systems in order to maintain the achieved health goals.
- Countries view integrated service delivery as a way to enhance effectiveness of health campaigns, improve community acceptability and satisfaction with the provision of range of services, and increase efficiency by improving coordination among actors in the health system. Several high priority campaigns related to NTDs, malaria, polio, other vaccine-preventable diseases, and nutrition (vitamin A supplementation) are considering integration of campaign interventions with the PHC system to improve campaign effectiveness, sustainability, and efficiency in achieving health goals (see Appendix, Box 2).

<sup>1</sup> We use the term PHC or PHC system to refer to different elements of the broader health system (e.g., governance, financing, monitoring, health workforce [see Figure]), as several vertical program elements and functions are shared across the health system and are not limited to PHC (1).

- Countries are moving towards universal health coverage (UHC)—a specific target under the [United Nation’s Sustainable Development Goal 3](#) that aims to ensure healthy lives and promote well-being at all ages. Integrated delivery of campaigns with the PHC system is central to achieving UHC.

Increasing focus on people-centered services, transitions in donor funding and technical support, and systemic inefficiencies are driving campaign integration decisions across health domains (7-9) (see Appendix, Box 1). For example, one of the key goals of the World Health Organization’s (WHO’s) Immunization Agenda 2030 ([IA 2030](#)), the multi-organization-sponsored [Polio Endgame Strategy 2019–2023](#) and UNICEF’s [Coverage at a Crossroads Strategy for Vitamin A Supplementation Programs](#) is to deliver people-centered immunization and vitamin A supplementation services, integrated with PHC and as a part of strengthened health systems. Similarly, WHO’s [NTD 2030 Roadmap](#) emphasizes the need to integrate NTD interventions with “national health systems and coordinate action across sectors” (10) to achieve universal health coverage and improve health outcomes. WHO’s [Global Technical Strategy for Malaria 2016–2030](#) states that “malaria interventions cannot succeed unless communities adopt governmental guidance on the use of prevention tools and recommended therapies” and describes how community services that are integrated and people centered are central to the success of malaria interventions.

Some of the goals of the transition from delivery of health interventions via health campaigns to integrated delivery via the PHC system include 1) programmatic effectiveness (e.g., program coverage and utilization); 2) higher community acceptability of PHC to receive a range of services; 3) reduction in frontline health worker and community fatigue due to multiple campaigns; 4) cost-effectiveness of preventing and controlling multiple diseases or conditions; and 5) sustainability of health outcomes (4,11,12). There is an increasing interest in transitioning and integrating service delivery of campaigns with the PHC system, particularly as countries move towards a “post-COVID-19” recovery phase. However, evidence on operationalizing and financing integrated delivery of campaign interventions with the PHC system remains limited (13,14).

This brief describes when it is appropriate, feasible, and necessary to integrate health campaigns with the PHC system. We also describe how supplemental campaigns may still be needed and organized by the PHC system to meet coverage and equity gaps. The objective of this brief is to explore 1) whether and how to transition service delivery of health campaign interventions to the PHC system through integration; 2) the benefits and challenges of such efforts; and 3) factors that should guide the campaign integration decision.

## Methods

The brief was developed based on a rapid review of literature using an iterative process complemented by consultations with subject matter experts in the campaign domains, health systems, and PHC and with campaign integration stakeholders. We reviewed selected published and grey literature (1997-present) on health systems and integration of campaigns with PHC in the domains of NTDs, malaria, polio, other vaccine-preventable diseases, and nutrition (vitamin A supplementation). Articles were found through subject matter experts, online searches and in journal databases, such as PubMed. Some key search terms used included “public health campaigns,” “supplemental immunization activities,” “mass drug administration,” “primary health care,” “integration,” “routine systems,” “mainstreaming,” “health systems,” “health systems strengthening,” “vitamin A supplementation,” “malaria,” “routine immunization,” “vaccine,” “polio,” “neglected tropical diseases,” “effectiveness,” “equity,” “efficiency,” and “coverage.”

In developing this brief, the following questions were used to guide the review:

1. *What is the process of transitioning delivery of interventions from the campaign mode to the PHC system?*
2. *What are the benefits and challenges of integrating delivery of campaign interventions with the PHC system?*
3. *What factors guide the decisions on integrating delivery of campaign interventions with the PHC system, considering health system functions?*

Findings are summarized under each of the three questions.

## Key Findings

### 1. *What is the process of transitioning delivery of interventions from the campaign mode to the PHC system?*

According to WHO, the majority of an individual’s lifetime health needs, including physical, mental, and social well-being, can be covered through PHC. PHC is people-centered rather than disease-centered. “PHC is a whole-of-society approach that includes health promotion, disease prevention, treatment, rehabilitation and palliative care.”<sup>2</sup> The key components of PHC include meeting health needs of people throughout their lives; addressing the broader determinants of health through multisectoral policy and action; and empowering individuals, families, and communities to take charge of their own health.

A useful starting point for understanding integrated delivery of campaign interventions with the PHC system is through the **Primary Health Care Performance Initiative (PHCPI) Conceptual Framework**,<sup>3</sup> which has been modified for this discussion (see Figure). Programs using campaigns are part of the health system. These programs can integrate the functions that support delivery of independent campaign interventions with the PHC. Integration can be ‘full,’ leading up to co-delivery of interventions in PHC, or partial. The degree of integration with the PHC system depends on the level of vertical organization of the campaigns based on external partner and/or government funding for different campaign functions (See Appendix, Table), government policy, and the health needs of the population.

Effective full integration requires coordination and collaboration at the service delivery level and across different elements of the PHC system (see Figure) (1). Full integration involves integration of administrative functions, wherein planning, organization, management, and monitoring of health campaign activities are assigned to the local PHC level (15). For example, full integration of vitamin A supplementation with the PHC system could involve operational integration wherein PHC providers document and administer vitamin A capsules along with interventions from other programs during delivery of routine immunization services.

***Full integration**, per the PHCPI framework, involves sharing of both operational and administrative functions and responsibilities and delivery of campaign interventions via PHC. It occurs when interventions that were formerly delivered via independent health campaigns are delivered at the PHC level with other ongoing health services.*

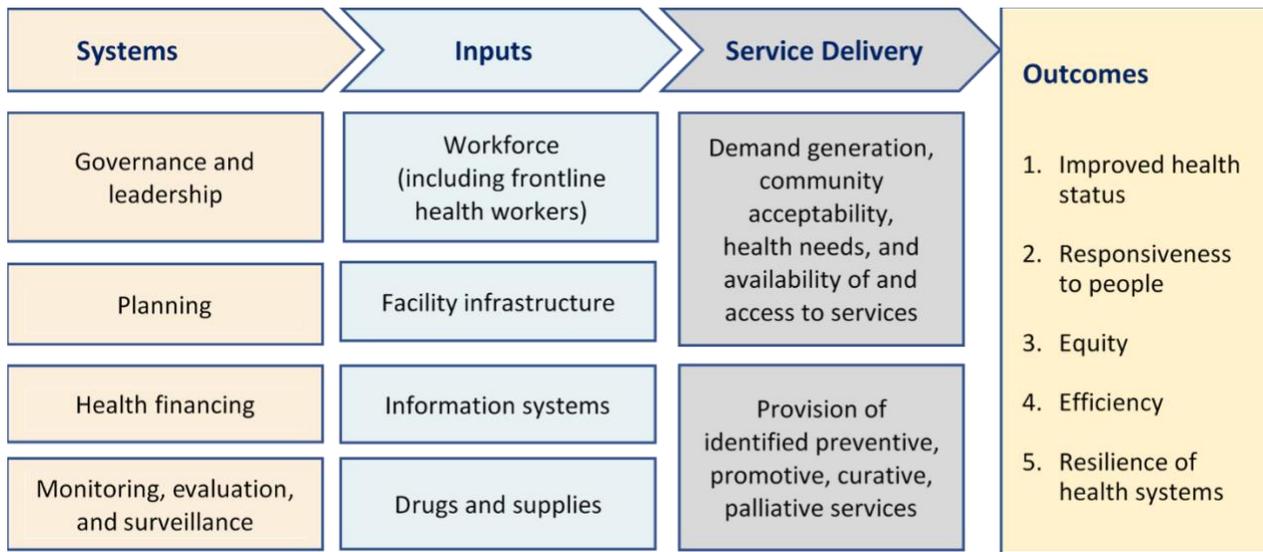
***Partial integration** refers to a spectrum or continuum, in which campaigns share different operational and/or administrative components with any of the PHC system elements per the modified PHCPI framework—at the systems or inputs levels or both, while continuing to deliver services independently. For example, several Global Fund investments have supported integration of the public-sector health product supply chain for multiple disease programs in several sub-Saharan African countries (Kenya, Ethiopia, Uganda, Tanzania, Zambia, Zimbabwe, Nigeria and Ghana) (16).*

Even with full integration, campaigns can still be implemented by the PHC system (using health system resources) to meet coverage gaps. One example is the “periodic intensification of routine immunization” (“PIRI”), a campaign approach used to enhance immunization coverage reached through PHC (17,18).

<sup>2</sup> [https://www.who.int/health-topics/primary-health-care#tab=tab\\_1](https://www.who.int/health-topics/primary-health-care#tab=tab_1)

<sup>3</sup> [The PHCPI Conceptual Framework | PHCPI \(improvingphc.org\)](#)

**Figure. Framework for integrating campaign functions with the PHC system\***



\*Adapted from the [Primary Health Care Performance Initiative \(PHCPI\) Conceptual Framework](#)

Integration is an incremental process. The local context and the strength of the PHC system will drive the integration process. There can also be intra-country variations in transitioning delivery of campaign interventions to PHC service delivery. Countries may gradually move from partially integrated campaign functions to full-service integration—maintaining a strategic balance, with occasional need-based campaigns that are planned, managed, and implemented by the PHC system.

In settings where health systems are weak, campaigns may be the only way to deliver interventions more equitably, reach previously unreached populations, and make progress towards health goals. Even in countries with strong PHC systems, campaigns may be needed depending on 1) the operational capacity of health systems to address changing epidemiological trends and disease outbreaks and 2) the population needs. Countries may start with improving partial integration of multiple campaign functions with the PHC system, while continuing to prepare and strengthen PHC to eventually fully integrate (1). The delivery of campaign interventions with the PHC system in scenarios of full and partial integration is described in the Table in the Appendix.

**2. What are the benefits and challenges of integrating delivery of campaign interventions with the PHC system?**

The idea of integrating delivery of campaign interventions with the PHC system is not new. The challenge lies in the operationalization of campaign integration strategies with the PHC system and in sustaining political will for campaign integration policies and strategies. A vertical program with centralized management and decision-making and a separate budget may hesitate to undertake integration of their campaigns with the PHC system (1,3). In addition, full integration through PHC may not always address the health needs of the population. For example, countries may fully integrate delivery of certain interventions with other ongoing health services (e.g., provide vitamin A supplementation, bednets, and deworming medication during routine immunization), yet they may have to organize health campaigns to meet any coverage gaps in the target population. Also, poorly or hastily planned integration may lead to adverse health outcomes. **Potential benefits and challenges** at the program, individual, and community levels should be considered when exploring opportunities for integration of health campaigns with the PHC system.

**Potential Benefits**

Program level

- **Improve program coverage and outcomes**
  - In the Dominican Republic, the integration of the lymphatic filariasis (LF) elimination program into PHC resulted in a 21% increase in the number of municipalities achieving mass drug administration (MDA) target coverage of 80%. PHC also benefitted from this integration in terms of improved information systems and stronger relationships with the community (19). Integration of the LF program started with the operational integration of MDAs with the PHC prevention clinics and included training of managerial and technical staff, regular supervision, and reorientation of staff roles (19).
- **Improve utilization of health centers**
  - In Cameroon, integration of targeted schistosomiasis control interventions into PHC improved the population's knowledge about the disease and enhanced utilization of health centers. Local health centers and teachers performed health education, treatment, and snail control. Governance, planning, service delivery, and monitoring and evaluation were fully integrated, and funding was partially integrated in this program. Service provision was the responsibility of general health workers, and the "PHC service was accountable for schistosomiasis control" (4).
- **Increase job satisfaction of health workers**
  - In areas with few campaigns per year, the effects of the polio program on worker motivation were generally neutral or slightly positive (20). An increase in the number of campaigns can leave the posts and centers understaffed and health workers feeling overburdened. Integration of campaigns with the PHC system may affect worker retention and satisfaction if the systems can absorb them.
- **Improve efficiency of interventions and sustainable political support**
  - Integration of campaigns such as LF elimination, into health systems "can result in greater efficiency, place the elimination priority in the context of other services, and have more sustainable political and community support" (21)
- **Foster sustainability following or alongside eradication/elimination efforts**
  - Integrated delivery of interventions with community-based PHC services can foster sustainability of health interventions and outcomes as several diseases or health conditions may have the same target populations but different service delivery platforms. For example, "Countries are urged to move towards integrating malaria programmes into people-centered primary health care services in order to ensure long-term sustainability of malaria responses" (22).

Individual and community level

- **Increase satisfaction of beneficiaries**
  - In Bangladesh, the government integrated nutrition services for pregnant women and children (including vitamin A supplementation) with PHC services to reduce maternal and child undernutrition. The majority of women reported higher satisfaction of the nutrition services delivered during management of sick, under-five children due to reasons such as longer consultations (23).
- **Decrease fatigue in the community**
  - Community members assigned to support several health campaigns may feel burdened. Diseases with similar manifestations (e.g., NTDs with skin conditions) can be integrated with PHC (24)
- **Reduce missed public health opportunities**
  - Provision of timely, age-appropriate interventions, such as immunizations, can increase if services are integrated with PHC (25)
- **Address individuals' health needs more holistically**
  - Comprehensive patient and family-centered care can be provided at the PHC level instead of focusing on health needs through vertical campaign approaches (25)

### **Potential Challenges**

#### Program level

- **Diluting political attention**
  - Integration of campaign delivery with PHC may dilute political attention and divert resources for the programs, thus adversely affecting program outcomes and health goals (1)
- **Logistical challenges**
  - Procuring adequate supply of stocks for multiple interventions at the same time can limit the success of integration and lead to stock outs. Lack of a common supply chain system for immunization and other PHC commodities can be a key challenge to integration (26).
- **Lower coverage**
  - Integrating delivery of campaign interventions with PHC may lower coverage rates. In Cambodia, coverage of vitamin A supplementation declined when the capsules were provided at health facilities after transitioning from distribution through the campaign mode during national immunization days (1).
- **Substantial and continuous training needs of health workers to deliver integrated services**
  - Integration of human African trypanosomiasis control activities into PHC in the Democratic Republic of the Congo demonstrated the need for effective training of primary care staff to maximize the quality of integrated services (27)
- **Resentment among campaign managers and health workers**
  - Integration can result in the dilution of campaign leadership authority (28) and a decline in campaign-related health worker incentives (29)
- **Loss of incentives for health workers**
  - Health workers involved in implementation of vertical campaigns can lose incentives when delivery of campaign interventions is transitioned to the PHC system. In India and Nepal, several community health workers (CHWs) receive incentives for activities such as “providing immunizations and accompanying mothers to health facilities to give birth”; in India, CHWs make on average \$15 to \$30 a month and in Nepal CHWs make a bit less from incentives (30).
- **Threatened disease eradication/elimination goals**
  - Goals can be threatened when the health system lacks sufficient capacity for integration. In 2015, one year after elimination was verified in the country, Mongolia experienced a large nationwide outbreak of measles due to the inadequate preparation of the health system to maintain high, two-dose vaccination coverage (31).

#### Individual and community level

- **Integrated services may result in missed delivery and longer waiting or service times**
  - In some countries, vitamin A supplementation has been added to PHC through health clinics and immunization outreach through polio supplemental immunization activities (SIA). However, ensuring that children receive their first supplementation dose at 6 months and that they continue to receive vitamin A twice a year at a health facility until age 5 years has been a challenge (32).
- **Integration can lead to reduced quality of care for beneficiaries**
  - Child Health Days (CHDs) may negatively impact the quality of PHC services because of increased workload and incentives present during CHD that are lacking in PHC (33)
- **Development and dissemination of communication messages**
  - Communication efforts to mobilize the community for the uptake of integrated services in PHC can become complex due to the diversity of disease or health conditions and population groups these services target
- **Stigma surrounding an integrated service**
  - Some services, such as HIV testing, may be associated with stigma in the community. If not addressed by appropriate social and behavior change messaging and practices, such stigma may reduce community acceptability of other services being integrated. For example, “integrating HIV testing with vaccination affected the demand for vaccines adversely in rural areas in Tanzania due to HIV-related stigma” (25).

**3. What factors guide the decisions on integrating delivery of campaign interventions with the PHC system, considering health system functions?**

Several factors and risks must be considered for initiation of integration efforts with PHC. These have been categorized as follows:

Governance and Health Financing		
<p><b>Policy support.</b> Global, national, and sub-national support for campaign integration with PHC and strong leadership are needed to ensure the policy is implemented. The growing momentum for UHC, which aims to deliver an essential package of health services, can guide decisions around integration.</p>	<p><b>Political and administrative will.</b> Integration should be on the agenda of politicians/policy makers and health and finance officials who oversee health reform efforts and closely guide public health decision-making. This multi-actor engagement at the <b>highest level</b> is crucial so that the integration initiatives align with broader health policies, strategies, and goals (1).</p>	<p><b>Financial support.</b> It is critical to mainstream funding of different program components into the national/state health budgets to support budget negotiations and resource allocations for integrated delivery of campaign interventions with the PHC system.</p>
<p><b>Risks.</b> Decision-makers most closely tied to the goals of the vertical program may see the potential dilution or de-prioritization of those goals from integration.</p>		
Integration Planning Per Epidemiological Trends		
<p>Integration efforts can be guided by a decline in specific health needs due to the successful outcomes of the health campaign. Positive changes in the epidemiological trends provide an opportunity to substitute blanket coverage through campaigns with robust surveillance and case management strategies integrated with services offered via PHC.</p>		
<p><b>Risks.</b> Inadequate preparation of the health system for integration can reverse positive epidemiological trends and lead to disease outbreaks. For example, in 2011 the Central African Republic experienced a large measles outbreak 3 years after a national immunization campaign was conducted with high reported coverage. This outbreak was likely due to poor measles vaccination coverage through routine immunization services after the campaign (34).</p>		
Contextual Factors		
<p>Local health system factors (e.g., strength of the PHC, skills of health workers, supply chains) and community acceptability of co-delivered interventions need to be considered to determine the extent to which health campaign delivery, and the choice and number of campaign components, can be integrated with PHC.</p>		
<p><b>Risks.</b> Poor consideration of contextual factors during integration may adversely affect not only the health outcomes and quality of the integrated campaign but also existing PHC services (35). For example, inadequate number of appropriately trained health workers can limit the delivery of the full range of integrated services (36).</p>		

Service Delivery		
<p><b>Service integration.</b> In certain settings, the decision is not always about whether to integrate services at all but rather about deciding whether and how to <i>further</i> integrate. For example, diagnosis and treatment of malaria in the public sector health facilities is largely integrated into PHC, but malaria prevention measures such as bednet distribution are typically not (1).</p>	<p><b>Demand generation/acceptability.</b> It is critical to consider that the level of acceptability in the population of the integrated intervention is similar to that of other services delivered through PHC. For example, because of the high acceptability of maternal and child health services in Pakistan, oral polio vaccination coverage increased when services were integrated (37).</p>	
<p><b>Risks.</b> Poor capacity of health workers, overburdened staff, unequal resource allocation, and logistical difficulties can challenge the degree of integration of campaigns with the PHC system (38,39).</p>		
Monitoring Systems for Integration		
<p>Mechanisms must be established to monitor each stage or element of integration of interventions so that obstacles and any adverse effects of integration can be identified and correct course.</p>		
<p><b>Risks.</b> Weak monitoring of integrated services impedes identification of pitfalls in integrated service delivery resulting in poor health outcomes. Integrated information systems must be established and strengthened to monitor the integrated services alongside PHC performance.</p>		
Health Outcomes		
<p>Integration should positively impact the existing health outcomes of PHC services and campaigns.</p>		
<p><b>Risks.</b> Often in low-resource settings, vertical programs may hesitate to undertake campaign integration with PHC to protect and sustain the health gains made through targeted approaches (1).</p>		
System-level Outcomes		
<p><b>Equity.</b> Integrating delivery of campaign interventions with PHC services must not negatively affect or benefit certain population groups more than others. Equity-related benefits and trade-offs need to be assessed thoroughly while considering integration (40-42).</p>	<p><b>Efficiency.</b> Integration should improve efficiency in the provision of interventions through PHC. Efficiency is the ability to achieve higher levels of performance (coverage, access, or equity) relative to the inputs (resources, time, money) (e.g., decrease cost of delivery for the intervention).</p>	<p><b>Coverage.</b> Campaign interventions integrated with the PHC system must reach similar program coverage targets to those of independent intervention delivery approaches in order to maintain health outcomes. Fixed-site delivery methods may provide high coverage if the community is well informed (31). Supplemental campaigns may still be organized to meet any coverage gaps.</p>
<p><b>Risks.</b> Integrating delivery of campaign interventions with the PHC can lower costs but could be at the expense of lower coverage or decreased equity, resulting in reduced health outcomes, if not planned correctly.</p>		

## Conclusions

Campaign integration is increasingly fostering higher levels of interest, attention, and engagement among program planners, implementing partners, donors, and researchers. Several programmatic roadmaps (e.g., [IA 2030](#), [NTD 2030 Roadmap](#), [Global Technical Strategy for Malaria 2016–2030](#), [Polio Endgame Strategy 2019–2023](#), [Coverage at a Crossroads Strategy for Vitamin A Supplementation Programs](#)) articulate the urgent need for integrated service delivery to achieve (UHC). Health campaigns exploring integrated delivery of interventions with the PHC system should plan the operationalization of integration efforts “to maximize positive synergies and minimize potential conflicts” and meet the objectives of both, the campaigns and the PHC system (7). Evidence gaps exist on the drivers and processes of transitioning the delivery of campaign interventions to the PHC system through integration, the impact of integration of campaign interventions on PHC services, the outcomes of the campaign interventions integrated with PHC, and the reasons behind success and/or failure of past and future campaign integration and transition efforts (see below).

### Evidence Gaps

1. What are the health system readiness factors or minimal health system requirements needed to integrate campaign interventions with PHC services?
2. Which programs (and in which countries/areas) have previously integrated delivery of campaign interventions with the PHC system (and to what degree)?
3. What are the key barriers to transitioning delivery of campaign interventions to PHC systems? Which of the identified barriers should be prioritized for implementation research?
4. Which systems/inputs can (or should) be integrated in the context of partial integration?
5. Which campaign interventions can be integrated with the PHC system in a low-resource health system with many campaigns? Are there any exemplars?
6. What drivers or factors influence identification and prioritization of the packages of essential interventions at the PHC level? What types of PHC financing mechanisms are required?
7. What are examples of best practices at national and sub-national levels on planning, implementation, and monitoring of efforts around integrating delivery of campaign interventions with PHC services?
8. How does integrated delivery of health campaign interventions with the PHC system impact the health outcomes of vertical programs and system-level outcomes (e.g., equity, efficiency) of the PHC system?

Taking stock of the evidence gaps can inform our current and future actions.

## Future opportunities

It is important to develop an integration readiness framework for transitioning delivery of health interventions from the campaign mode to PHC systems. It is also important to build a robust evidence base on integration as countries consider transitioning their independent delivery of campaign interventions to the PHC system. Documenting and disseminating the evidence, lessons learned, and opportunities around operationalization of strategies for integrating delivery of campaign interventions with PHC services will help clarify what has or has not worked and in which settings to help reach health and programmatic goals. This will be particularly helpful for programs and countries that are planning donor transitions to ensure effective scale-up and sustainability of campaign interventions and outcomes. It will also help in assessing the practical implications of integrating delivery of campaign interventions with PHC on other health programs (e.g., introduction of the COVID vaccine), policies, and outcomes.

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## Appendix

### Box 1. Reasons for transitioning delivery of health campaign interventions to the PHC system

Vertical programs are often introduced in weak health systems as they often lack the ability to achieve high coverage of interventions and/or are inadequately prepared to respond during a crisis. Independent delivery of campaign interventions has enabled countries to reach several global health goals and milestones. Donor organizations work with governments to provide financial and/or technical support in implementing targeted health campaigns to achieve these specific health outcomes. A study involving high level policy leaders in Pakistan and Cambodia demonstrated that donors' influence on health priority setting, policy implementation, and decision making in countries is directly linked to their ability to "control indirect financial and political incentives, as well as [to] direct control of financial resources" (43).

Targeted funding (by donors, governments, or both) and campaign-specific health goals results in high visibility of campaigns with event-based launches and media and political attention. However, continued delivery of interventions through vertical structures only challenges the sustainability of meeting health outcomes (1). Considerations for transitioning service delivery of health campaign interventions to the PHC system include the following:

- Health campaigns are often costly as they may create **parallel structures** such as separate planning, monitoring, and evaluation systems, supply chains, health workforce, delivery channels, and funding mechanisms within the PHC system (1,44,45). For example, interventions delivered during campaigns are often tallied but not recorded on home-based records or in registers maintained at the PHC facility. This can lead to an underestimation in coverage achieved during subsequent population-based surveys, thus increasing the likelihood for populations to receive multiple rounds of an intervention that they may have already received due to lack documented evidence.
- In some contexts, the "**fast chain**" nature of campaign-type events and the need to have quick processes to roll out campaign events encourages parallel structures of delivery of campaign interventions. This "fast chain" aspect is especially true in relation to commodities and mass communication/mobilization. Further, the need to create parallel structures is amplified in countries with weaker health systems (e.g., those with lower core indicators of health system performance such as availability of the health workforce, distribution of health facilities, etc.)
- **Technical, programmatic, and financial benefits** resulting from donor-supported campaigns create incentives for national governments towards continuation of independent delivery of campaigns. They can also create financial incentives at the local level for community health workers with the delivery of different vertical campaign interventions (46).
- Repeated vertical campaigns can lead to **fatigue among communities**, resulting in decreased demand and hesitancy to participate in future campaigns. For example, several countries have had more than 15 rounds of MDA for lymphatic filariasis and more than 20 years of campaigns for onchocerciasis.<sup>4</sup> While MDA rounds work towards the achievement of elimination goals, prolonged periods of intense delivery of campaign interventions can cause fatigue in health providers and in the targeted communities.
- Repeated health campaigns can also **strain limited human and financial resources**, particularly in settings with weak health systems where staff and other resources may be diverted from their duties at health facilities to the vertical campaign, potentially resulting in delay or cancelation of routine services (38,39).

As such, transitioning appropriate campaign-related interventions to the PHC system based on the local context, health system capacity and local needs is critical to ensure sustainable, cost-effective and equitable achievement of health goals. However, countries with weak health systems may rely on independent campaigns to reach global and national health goals. Strategically maintaining a balance between delivery of interventions via campaigns and through the PHC system is critical to reach and maintain health goals.

<sup>4</sup> Patrick Lammie, Neglected Tropical Disease Support Center, personal communication, September 29, 2020.

**Box 2. Health domains considering integration of campaign interventions with the PHC system**

**NTDs:** Programs using key strategies such as MDA or preventive chemotherapy strategy to control diseases such as lymphatic filariasis, onchocerciasis, schistosomiasis, soil-transmitted helminth infections, and trachoma have found that MDA campaigns alone may not result in disease elimination (21,47). Integration of NTD interventions with the PHC system is necessary for intervention scale-up, sustainability, and elimination of these diseases (21). Also, people living with acute and chronic suffering associated with NTDs, including long-term disabilities, are in need of care offered through the PHC system (48). To this end, in Ghana, NTD indicators have been included in the District Health Information System.<sup>5</sup> Once low levels of disease prevalence are achieved, a holistic approach to reach NTD elimination goals can include a) the integrated delivery of targeted NTD interventions through the PHC system and b) addressing the risk factors associated with the social determinants of NTDs (e.g., poor hygiene, vector reservoirs, poor access to clear water).

**Malaria:** Integration of interventions can contribute to expanding or sustaining coverage of insecticide-treated bednets (ITNs) achieved through campaigns. For example, household ITN ownership and use in children under 5 years of age is higher in countries integrating ITN services with antenatal care and expanded programs on immunization (service delivery element in PHCPI), in contrast to countries with no ITN integration (49).

**Vaccine preventable diseases:** Campaigns can deliver rapid results in increasing coverage and interrupting transmission. However, they may also be disruptive of ongoing (routine) activities, at least in the short term, and may also have longer-term effects on ongoing activities. They also may have longer-term effects on ongoing activities. For example, in Madagascar, the use of SIA and vaccination weeks closed the coverage gaps in measles vaccine; however, for unexplained reasons, there were decreases in routine vaccination in subsequent months, suggesting that the campaigns may have affected routine services (50). It is important to monitor delivery of ongoing services in the months following other campaigns to see if campaigns have longer-term effects.

**Polio:** The Global Polio Eradication Initiative (GPEI) has financed the global polio eradication program (9) for more than three decades. In several countries, GPEI's support goes beyond polio eradication activities to supporting other activities such as routine immunization, disease surveillance, and social mobilization. However, as several countries are reaching their polio eradication goals, GPEI resources are declining and will soon cease once polio is eradicated (9). To ensure that the transition from GPEI funding is smooth, countries need to support and sustain their disease prevention and control activities currently supported by GPEI through other mechanisms. One such mechanism could be integrating service delivery with routine or ongoing health services at the PHC level.

GPEI has identified 16 countries for active polio transition planning (i.e., countries that together receive over 90% of GPEI resources). These include Afghanistan, Angola, Bangladesh, Cameroon, Chad, Democratic Republic of the Congo, Ethiopia, India, Indonesia, Myanmar, Nepal, Nigeria, Pakistan, Somalia, South Sudan, and Sudan (9). Several of these countries are actively planning for the transition to minimize the effect of the GPEI wind down (9).

**Nutrition:** Depending on the local context, transitioning delivery of vitamin A supplementation from campaigns to PHC services and fully integrating with the system can be a sustainable and effective strategy for a nutrition program. For example, a study in Ethiopia demonstrated that integrating delivery of vitamin A supplementation with PHC can improve coverage and is also sustainable in the long run if the transition from the campaign approach to facility-based delivery is well planned, has enough resources, and is implemented carefully (51).

<sup>5</sup> Personal communication of Dr. Margaret Gyapong with the deputy Director General of the Ghana Health Service, October 16, 2020

TRANSITIONING DELIVERY OF HEALTH CAMPAIGN INTERVENTIONS TO THE PHC SYSTEM

**Table: Full or Partial Integration of Campaigns with Different Elements of the PHC System<sup>6</sup>**

	Partial Integration	Full Integration
<b>Systems Level</b>		
<b>Governance and Leadership</b>	Program responsibilities are shared between the primary health care system and the vertical structure specifically charged with the intervention.	Governance structures for the vertical program are the same as those for the general health services or national/local administrative structures.
<b>Planning</b>	Decision-making for planning-related tasks rests with those managing the health intervention and involves the other stakeholders, such as civil society groups, the PHC system, or local/regional/national government.	Planning function can include activities, processes, and systems for assessing needs, setting health priorities, and determining resource allocations. The same individuals who are involved in the decision-making tasks for the general health system are trained to undertake decisions for the different planning functions for the integrated program.
<b>Health Financing</b>	Earmarked funding is often provided by a donor and is channeled through the health system.	Integration is funded entirely through the national or regional health budget (or funded by external sources through the overall health budget).
<b>Monitoring, Evaluation, and Surveillance</b>	Monitoring and evaluation (M&E) and surveillance is carried out by both PHC and specific health campaign staff.	M&E and surveillance is the responsibility of the institutions that are also responsible for the overall M&E in the health system.
<b>Inputs Level</b>		
<b>Workforce</b>	Services are provided by both general or multi-purpose health workers and specific staff of the health intervention. Health campaigns may offer separate financial incentives to workers.	Services are provided by general or multi-purpose health workers. Services may fall under regular remuneration only.
<b>Drugs and supplies</b>	Procurement system for medicines and supplies may be partially separated for campaigns.	Supplies and medicines needed for all interventions are procured by the health system.
<b>Facility Infrastructure and Information Systems</b>	Certain components of a health campaign (e.g., screening) use the same PHC infrastructure. Parts of the PHC information systems are used by the campaign while campaign-specific systems are also maintained.	The PHC infrastructure is used for delivery of the entire service package, and the same information systems used by PHC for other health programs are also used by the campaign.
<b>Service Delivery Level</b>		
<b>Demand Generation, Community Acceptability, Health Needs, and Availability of and Access to Services</b>	Activities for generating demand, such as information, education, and communication (IEC) activities, are implemented by workers of the health campaign as well as staff from general health services.	IEC activities are provided through the PHC system.
<b>Service Delivery Point</b>	Certain components of a health campaign service (e.g., counseling, screening, immunization) are integrated with PHC, with other points of service delivery also available.	All interventions that are part of the health campaign are delivered through PHC at the same service delivery point (e.g., a caregiver bringing a child for immunizations also receives a bed net). Integration can also involve delivery of interventions via campaigns (e.g., PIRI) when campaigns are implemented by the PHC system.

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<sup>6</sup> Adapted from (4) and [The PHCPI Conceptual Framework](#).

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