

## A Survey of Country Campaign Manager Perspectives on Integration: A Snapshot in 2022

### Linksbridge SPC and the Health Campaign Effectiveness Program at The Task Force for Global Health

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#### Key Messages

Linksbridge SPC led a desk review of campaign integration data and solicited input from stakeholders through an online survey, key informant interviews, and a data validation exercise. The following lessons learned resulted from this study:

- Stakeholders report campaign integration taking place across all disease areas. Partial integration is more frequent than full integration, and the two types occur at both the national and subnational levels.
- Vitamin A and deworming are the campaigns most commonly integrated with other programs.
- Top facilitators for integration include (1) government buy-in; (2) donor, partner, and government coordination; and (3) identical target populations. Other facilitators include not requiring additional skills to deliver secondary interventions (e.g., deworming, vitamin A), and one intervention acting as an incentive for another (e.g., vaccination paired with a bed net).
- Top barriers to integration are different for full and partial integration but include issues related to (1) donor and partner coordination, (2) lack of government buy-in, (3) different target populations, and (4) human resource capacity. Notably, there are many contexts in which integration is not advised. Examples include in emergency or outbreak settings when there is a short planning timeline, when distrust of one intervention will impact the uptake of another, and when campaign logistics are too dissimilar.
- Most integrated campaigns use a campaign coordinating body or integration workgroup composed of many different actors, from the community to the government level. The closest collaboration was reported to occur in the training, engagement, and recognition of campaign staff. Over half of integrated campaigns also used digital tools, most commonly for data collection.

## Introduction

Health campaigns are activities that address specific epidemiological challenges and provide a means to deliver health interventions. These activities are often initiated in response to disease outbreaks, disease control, or to eliminate specific diseases in an effort to achieve context-specific health goals. High-priority health programs often use campaigns to distribute products, drugs, and vaccinations for a range of diseases. Campaigns are typically scheduled, planned, and implemented through vertical approaches with limited collaboration across programs.

Despite generally positive sentiments toward campaign integration, vertical approaches to funding, planning, and logistics tend to impede cross-program collaboration. However, interest in integration has increased in the post-COVID-19 landscape as global and country partners evaluate strategies to catch up on disrupted campaigns and plan new campaign activities to reach the same populations with lifesaving interventions, boost immunity toward vaccine-preventable diseases, reach disease elimination targets, and improve the nutritional status of children.

Integration may be partial or full. Partial integration (i.e., collaboration or coordination) involves the repurposing or sharing of common inputs, data, tools, and/or processes between vertical health programs without co-delivery of interventions at the same point of service. Full integration includes co-delivery: campaigns coordinate most or all components and provide two or more health interventions at the same point of service. Co-delivered campaigns typically share common inputs (e.g., enumeration, microplanning, data, tools) but also use a shared cohort of healthcare providers.

While fully integrated campaigns are tracked in the Linksbridge SPC [Campaign Calendar](#) and shared on the Health Campaign Effectiveness website, those using partial integration have been less visible. Integrated campaign delivery models likely offer opportunities for increased effectiveness and efficiency, but the data are scarce.

To learn more, Linksbridge SPC led a desk review of campaign integration data and solicited input from stakeholders through an online survey, key informant interviews, and a data validation exercise.

The research questions included:

1. What types of campaigns are most commonly integrated and to what degree (by type of intervention and country/region and campaign type)?
  - a. What are the characteristics of integrated campaigns?
  - b. In which geographies is integration occurring?
2. What factors support integration for planning, implementation, and follow-up?
  - a. What facilitators exist to promote integration?
  - b. What barriers are impeding integration?
3. What campaigns have partially integrated or plan to do so (including sharing of digital tools and collaboration in early- or post-campaign components)?
  - a. To what extent are there digitized elements in integrated campaigns?

## Methods

### *Survey Development*

Linksbridge SPC conducted a mixed-methods study with retrospective and prospective quantitative and qualitative data. Advised by health campaign and survey experts, the research team developed a 25-question (approximately 20-minute) survey. The survey was split into several sections, including demographics, defining

characteristics of campaign integration, integration facilitators and barriers, and optional questions. Questions were imported into SurveyMonkey and appropriate branching logic was applied. The research team and partners piloted the survey tool in several rounds, making final adjustments prior to wider distribution.

### ***Survey Deployment***

To broadly reach campaign managers and implementation experts around the world, the team used a snowball sampling method, initially sending the online survey link to 143 individuals, with the request that they pass it along to potential respondents. The original recipients represent organizations that are sources of data about campaigns to the Campaign Calendar in addition to people who interact with the Health Campaign Effectiveness Coalition and the authors of this report. The goal was to receive responses from 15 countries (preferably lower-middle-income countries) in five health domains within four World Health Organization regions. The survey opened on June 6, 2022, and closed after three weeks.

### ***Key Informant Interviews***

The research team asked all survey respondents whether they were willing to participate in a key informant interview. Of the 21 (43% of respondents) who expressed interest, the team approached 13 via email on June 14, 2022, and ultimately interviewed 7. The team conducted 30-minute semi-structured interviews via an online video platform. The interview questions were informed by survey responses and aimed to obtain details about certain questions where clarification was needed or where answers to survey questions presented nuances specific to the respondent's area(s) of expertise and geographies.

### ***Data Validation Exercise***

The data validation exercise was used to assess the accuracy of health campaign data reported at the global level, including on co-delivery. If a respondent indicated interest in supporting data validation efforts, Linksbridge sent spreadsheets with data obtained at the global level for respondents to review and edit. The country-validated data were then compared to the global-level data, and participants were encouraged to continue editing the online database in the future to increase knowledge about integrated campaigns and improve tracking of co-delivery.

## **Results**

At the end of the three-week data collection period, 49 respondents had initiated the survey and provided their information, 47 went on to answer at least the first question, and 35 answered most questions (but were allowed to skip questions as appropriate due to the survey design). Each question has a unique total number of responses. All respondents were included in the survey analysis. The 49 respondents represented 26 countries, four WHO regions (Africa, Europe, Southeast Asia, and the Americas), and several major health domains including malaria, polio, neglected tropical diseases, measles, and nutrition. Respondents represented a range of roles, including country representative, desk officer, monitoring and evaluation officer, and program analyst. To preserve respondents' anonymity, questions were grouped and analyzed by region.

The seven key informant interviewees work in sectors including community-based healthcare, vaccine-preventable disease, malaria, and neglected tropical diseases, and represent a range of roles (control program lead, health promotion manager, immunization specialist, ministry of health official, program director, surveillance agent, and vaccine management officer), five countries (Cameroon, Chad, Colombia, Nigeria, and Rwanda), and one global-level partner.

Results from the survey were thematically analyzed and are presented in four categories: (1) reasons for integration, (2) characteristics of integrated campaigns, (3) facilitators and barriers, and (4) collaboration and digitization. Respondents were grouped into six regions (West Africa, Central Africa, Eastern Africa, Europe, Southeast Asia, the Americas) and one global category. The regional differences between survey responses can be explored in the [online integration survey dashboard](#).

**Reasons for Integration**

In survey responses, the most frequently selected rationale for campaign integration (partial or full) was to reach coverage targets more efficiently (n=25). Streamlining of resources was the second most frequent reason given (n=21), followed by reaching zero-dose communities (n=17). Respondents also mentioned catching up partially immunized children, increasing impact in communities, leveraging one intervention to promote another, and accessing hard-to-reach areas and conflict zones.

Key informants echoed the importance of integration for accessing hard-to-reach and zero-dose communities. They noted that time and resources must be optimized to meet the many needs of the most remote populations and that integration planning must actively consider the requirements of zero-dose communities when tailoring services. One key informant noted that integration is “not something to be done ad hoc; it needs to be well-planned and well-organized, and if it is done at the last minute then everybody loses.”

**Characteristics of Integrated Campaigns**

A desk review of the Campaign Calendar and Campaign Effectiveness media monitoring newsletters found that integrated campaigns most commonly address polio and measles, frequently including vitamin A supplementation and/or deworming treatment as secondary interventions. The survey confirmed that vitamin A and deworming are commonly included in both fully and partially integrated campaigns.

Tables 1 and 2 list a sampling of campaigns reported as fully or partially integrated in respondents’ programs or countries. A wide variety of other combinations were also reported, with sometimes up to four programs involved in partially integrated campaigns.

**Table 1. In your country(s) and/or program(s), in which disease area(s) has full campaign integration taken place in the last 5 years? (n=21)**

Vitamin A + Deworming	Vitamin A + Malaria (SMC)	Various Neglected Tropical Diseases	Vitamin A + Polio	Covid-19 + Cholera
Polio + Measles	Vitamin A + Polio	Vitamin A + Malaria (ITN)	COVID-19 + HPV + Polio	Measles + COVID-19 + Malaria (ITN)

Abbreviations: SMC, seasonal malaria chemoprevention; HPV, human papillomavirus; ITN, insecticide-treated net.

**Table 2. In your country(s) and/or program(s), in which disease area(s) has *partial* campaign integration taken place in the last 5 years? (n=20)**

COVID-19 + Flu + Pneumonia	Vitamin A + Measles	Yellow Fever + Measles + COVID-19 + Vitamin A	Various Neglected Tropical Diseases	Polio + Vitamin A + Deworming
Vitamin A + Malaria (SMC)	Vitamin A + Polio + Measles	Vitamin A + COVID-19 + Deworming	Vitamin A + Deworming + Malaria (ITN)	COVID-19 + HPV

Additionally, survey respondents reported that their countries or programs used partial integration most often (n=15), followed by both full and partial integration (n=13), then full integration alone (n=11). On whether integrated campaigns were taking place at the national or subnational level, respondents were nearly evenly split; a few also reported that integration was merely being piloted in their countries or programs. Finally, respondents said integrated campaigns were sometimes implemented in conjunction with immunization weeks, national and subnational immunization days, national child health weeks, or other events.

**Facilitators and Barriers**

*Facilitators*

When asked what factors facilitate integrated health campaigns, survey respondents most frequently cited (1) government buy-in; (2) having donor, partner, and government coordination mechanisms in place; and (3) identical target populations. Moreover, for partially integrated campaigns, respondents added appropriate and achievable timelines and the presence of data management and collection systems to the above list.

Respondents shared several reasons why some campaigns are easier to integrate than others, including:

- Some secondary interventions (e.g., vitamin A or deworming) require no additional technical skills on the part of community health workers.
- In the case of vaccination campaigns paired with malaria (bed nets), the bed nets act as an incentive.

Respondents had a slight preference for integrating at the subnational (n=21) over the national level (n=16), and nearly everyone who participated in the survey agreed that health campaign integration should be part of national strategies given the numerous potential benefits to coverage, cost-effectiveness, and efficiency. Nearly all respondents confirmed that their program or national strategies promote opportunities for integration.

*Barriers*

Survey respondents ranked the top three barriers differently for full versus partial integration.

**Table 3. Respondent ranking of barriers to integration**

	Fully integrated campaigns	Partially integrated campaigns
1.	Poor communication or coordination between donors, governments, and other partners	Lack of human resources capacity, high turnover, or lack of incentives
2.	Lack of government buy-in	Poor communication or coordination

		between donors, governments, and other partners
<b>3.</b>	<b>Multiple and/or vertical funding sources</b>	<b>Different target populations</b>

Regarding poor communication or coordination between partners, one key informant interviewee noted that it “creates confusion for countries when donors and major actors say integration is a priority, only for country teams to prepare for campaign integration and it to not be adequately funded.”

Participants also noted that integration may not be advisable in some circumstances. These include:

- In conflict, emergency, or outbreak response settings
- When distrust of one intervention could harm uptake of another
- When campaign logistics are too dissimilar (e.g., different target populations or supply chains, inconsistent timing of funding delivery, healthcare workers’ skills not compatible)

### **Collaboration and Digitization**

#### *Collaboration*

Nearly all survey respondents confirmed that campaign coordinating bodies or an integration workgroup are in place when integrating activities. This collaboration involved different groups, including government actors, development partners, community leaders, and technical working groups. As one key informant interviewee shared, “there is diversity in campaign stakeholders, who all show up and actively participate in planning.” According to survey responses, the most collaboration occurs in training, engagement, and recognition of campaign staff (n=33); coordination and microplanning (n=32); and social mobilization and communication (n=31). The least collaboration occurs during the evaluation and surveillance processes (n=19).

#### *Digitization*

For integrated campaign activities, over half of the respondents reported some elements of digitization (Table 4). The most frequently cited uses were data collection and reporting. Lack of infrastructure and poor resourcing were identified as digitization barriers. In addition, as mentioned by a key informant, digitization efforts can be hampered by unsupportive policies (e.g., when ministries restrict the use of specific applications, software, or platforms that have servers in other countries). Of the 19 respondents who indicated that campaigns were digitized, 68% (n=13) were in Africa—7 in West Africa, 3 in Central Africa, and 3 in East Africa (Table 4).

**Table 4. For integrated campaign activities in your country or geographic area of focus, are any elements of the campaigns digitized? (n=27)**

	Central Africa	East Africa	West Africa	Europe	Southeast Asia	The Americas	Global	Total
<b>Yes</b>	3	3	7	1	2	1	2	19
<b>No</b>	2	3	0	0	0	1	0	6
<b>Unsure</b>	0	1	0	0	0	0	1	2

### **Promising Practices**

Based on results from the survey, two promising practices were identified that may help campaign planners successfully implement and track integrated campaigns.

### ***Support the Development of National Health Policies and Health Strategies for Integration***

As shown in other findings, government buy-in and coordination is very important for integration. Respondents viewed the inclusion of integration in a country's national health policy or strategy as a key opportunity for success. By institutionalizing integration opportunities, programs are set up to reach country, disease, and global goals more efficiently while maximizing resources. Several key informants noted that the government determines when to integrate campaign activities. In instances where the government has committed to integration as part of its national health strategic plan, integration tends to be more successful, in part because determinations, assessed at a regular cadence, are built into programming and planning processes.

### ***Use Data from Country-Level Partners***

While some global systems collect data on upcoming campaigns, the most robust information about what is occurring and how it is being planned can be found at the national level. Data collected from country-level partners should therefore be used whenever possible. By engaging country-level partners in campaign data sharing, campaign planners across sectors will have timely information on what campaigns are being planned and can create opportunities for improved coordination and integration of campaigns.

## **Lessons Learned**

When asked what three things they would do to promote integration, survey respondents emphasized the importance of:

- Coordination or coordinating bodies (n=15) for defining roles or harmonizing plans
- Tools (n=13) to harmonize microplans, macroplans, social media strategies, and data collection
- Resources (n=10) that can be shared as common inputs (e.g., population enumeration, waste management, financing)
- Advocacy (n=8), community benefits (n=5), and policies (n=3)

Additionally, key informants echoed the importance of considerations such as: (1) ensuring that key agencies at the government and national levels are aligned with local entities to promote integration; (2) utilizing service programs to increase the acceptability and frequency of integrated activities; and (3) implementing human-centered design approaches to integration, which promotes people-centered principles in campaign planning, program design, promotion, and evaluation.

## **Implications for Policy, Practice, and Future Research**

When considering future iterations of this research, there are several activities the team could modify:

1. *Deployment strategy*: This survey's deployment list could serve as the foundation for future surveys.
2. *Scope*: As uncovered in this introductory survey, there are several areas that may be of further interest to the global health campaign community (e.g., which components of campaigns were partially integrated, examples of digitization, how campaign staff is recognized or rewarded, and why there are preferences for integrating at certain levels). The team recommends adjusting the survey to more comprehensively assess these areas of additional research.
3. *Logistics*: The team suggests extending the survey open window to one month to encourage a larger response. Also, offering the survey in languages other than English and Spanish (e.g., French and Arabic) could enable broader participation.

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The Task Force for Global Health's Human Subjects Administrator determined that the project is non-human subjects research focused on improving public health practice and does not constitute human subjects research as defined by 45 CFR 46.102(I).

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