



Evaluation Report of the Collaborative Action Strategy Pilot Phase

2024 - Q1 2026

HEALTH CAMPAIGN
EFFECTIVENESS COALITION
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TABLE OF CONTENTS

2	<i>Acknowledgements</i>
3	<i>Acronyms & Glossary</i>
6	<i>Executive Summary</i>
12	<i>Introduction</i>
14	<i>Methodology</i>
19	<i>Country Level Findings</i>
42	<i>Global and Regional Findings</i>
46	<i>Lessons Learned</i>
50	<i>Recommendations</i>
54	<i>Appendices</i>
56	<i>References</i>

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ACRONYMS & GLOSSARY

Acronym	Definition
AEFI	Adverse Events Following Immunization
AFP	Acute Flaccid Paralysis
CAS	Collaborative Action Strategy
CDC	Centers for Disease Control and Prevention
CHW	Community Health Worker
DPH	Director of Public Health
E-CAS	Ethiopia Collaborative Action Strategy
ED	Executive Director
EFMoH	Ethiopia Federal Ministry of Health
EMRO	Eastern Mediterranean Regional Office
FMoHSW	Federal Ministry of Health and Social Welfare
GPEI	Global Polio Eradication Initiative
HCE	Health Campaign Effectiveness
HCM	Health Campaign Management
ITN	Insecticide-Treated Net
LGA	Local Government Area
LLIN	Long-lasting Insecticidal Nets
MCH	Maternal and Child Health
MDA	Mass Drug Administration

Acronym	Definition
MERLA	Monitoring, Evaluation, Research, Learning, and Adaptation
MR	Measles-Rubella
N-CAS	Nigeria Collaborative Action Strategy
NCD	Noncommunicable Disease
NPHCDA	National Primary Health Care Development Agency
NSC	National Steering Committee
NTD	Neglected Tropical Disease
ODK	Open Data Kit
PAHO	Pan American Health Organization
PHC	Primary Health Care
RBM	RBM Partnership to End Malaria
SIA	Supplemental Immunization Activities
SWAp	Sector-Wide Approach
ToC	Theory of Change
TOR	Terms of Reference
TWG	Technical Working Group
UHC	Universal Health Coverage
UNICEF	United Nations Children's Fund
WHO	World Health Organization

Term	Definition
Campaign Effectiveness	The ability of a campaign to achieve specific objectives related to coverage, equity, efficiency and impact.
Collaborative campaign	Health campaigns that plan and use coordinated and/or integrated approaches for campaign planning, implementation, evaluation and/or financing.
Co-financing arrangements	Involve two or more programs or stakeholders (e.g., disease programs, funders, government departments) agreeing to share the costs of specific campaign components—such as logistics, training, or data systems—to enable joint implementation across health areas.
Data visualization (integrated)	Integrated dashboards or reporting platforms combining multiple campaign indicators to support decision-making, performance tracking, and stakeholder communication.
Evaluation (joint)	Joint evaluations covering multiple health campaigns that are planned and conducted collaboratively across two or more health programs or disease areas.
Fair and equitable compensation	Compensation or payments that are standardized and reflect the workload, risk, and role of the implementer, regardless of the disease area, program, or campaign funder.
Harmonized payment	Aligning payment rates and terms (e.g., per diem, transport reimbursement) across different campaign programs to reduce fragmentation and inequity.
Integrated data collection form	A single data collection form used to capture information on multiple interventions (e.g., vaccinations, deworming, vitamin A supplementation) delivered during the same campaign.
Integrated data collection systems	Digital platforms, apps, or databases that are configured to collect, store, and manage data from multiple health campaign components in a unified way.
Integrated data system	A national or subnational digital or manual platform that enables two or more health campaign domains to share data, tools, or infrastructure to support campaign-related planning, monitoring, or evaluation.
Integrated health campaign	A campaign in which there is coordination between different programs, stakeholders and country health systems. These campaigns can be fully integrated, whereby there is a high level of coordination and interventions are co-delivered, or partially integrated when various functions (e.g., governance, health workforce, monitoring) or components (e.g., tools, guidelines, technologies) are integrated, even when fully integrated service delivery may not be feasible.
Joint budget	A single, consolidated financial plan developed collaboratively by two or more programs or campaign areas, which outlines shared resource needs and allocates funding across multiple health targets within one unified budget document.

Term	Definition
Joint warehousing	The shared use of storage facilities for commodities serving multiple health targets, with integrated inventory tracking or stock management systems.
Microplanning	A local-level planning function through which health teams understand their catchment populations, identify barriers to service access, define appropriate delivery strategies, and organize resources to reach all groups effectively. In campaign settings, microplanning includes detailed, site-specific decisions about target populations, delivery strategies, logistics, staffing, supervision, timelines, and monitoring. Microplanning is therefore relevant both to campaigns and to routine and continuous service delivery.
Monitoring and supervision (shared)	Shared supervisory structures or tools during campaign implementation, which typically involve collaboration between multiple health programs (e.g., immunization, malaria, NTDs) to jointly plan, manage, or carry out supervision activities using common approaches.
Pooled funding	The practice of combining financial contributions from different programs, funders, or sectors into a common fund. These resources are managed collectively and disbursed to support integrated campaign activities that address multiple health objectives.
Service delivery (integrated)	Co-delivery of interventions to the same target populations at the same time.
Under-immunized	Infants who have not received the third dose of diphtheria, tetanus, & pertussis-containing (DTP)-containing vaccines by the end of their first year of life. In the context of CAS implementation and campaign catch-up activities, the term may also be used more broadly to refer to children who have missed age-appropriate routine immunization doses, including children in the second year of life who have not received recommended vaccines such as measles- or measles-rubella-containing vaccine, depending on the national immunization schedule and programmatic context.
Zero-Dose	For operational routine immunization purposes, Gavi defines as infants who have not received the first dose of DTP-containing (DTP1) vaccine by the end of their first year of life.



N-CAS Core Task Team members and healthcare team with children who received interventions in Kano State, Nigeria, during the integrated campaign in October 2025. Photo Credit: NTD Team, Kano State, Nigeria

EXECUTIVE SUMMARY

The Collaborative Action Strategy (CAS) pilot in Ethiopia and Nigeria (2024–Q1 2026) demonstrates proof of concept: integrated campaigns delivered strong efficiency gains, maintained or improved coverage, and catalyzed governance and data-system reforms, while financing and institutionalization remain the primary constraints to scale.

The Collaborative Action Strategy was developed by the Health Campaign Effectiveness (HCE) Coalition to address persistent challenges in the delivery of large-scale health campaigns, including fragmentation across disease programs, inefficiencies in planning and implementation, and limited alignment with national health systems.

The CAS aims to support countries in transitioning from siloed, vertical campaigns toward more integrated, coordinated, and system-aligned delivery platforms that improve effectiveness, efficiency, equity, and sustainability. The CAS builds on longstanding country and program experience with integrated and coordinated campaigns, while providing a structured framework for advancing integration in ways that are country-led, context-specific, and better aligned with routine health systems and broader primary health care and universal health coverage objectives.

Between 2024 and early 2026, the CAS was piloted in Ethiopia and Nigeria as part of a proof-of-concept phase. These countries adapted the CAS framework to their national contexts and implemented integrated campaign models across multiple health domains, including immunization, neglected tropical diseases (NTDs), malaria, nutrition, and selected noncommunicable disease services. This report presents findings from the mid-term evaluation of CAS implementation, with a focus on understanding early progress, identifying key lessons, and informing future scale-up. As an interim assessment, the evaluation finds that the CAS is showing proof of concept in both Ethiopia and Nigeria, with the strongest early results in governance, coordination, operational efficiency, and the use of the integrated data systems, while longer-term reforms in financing, institutionalization, and sustained systems remain in progress.

Key Lessons Learned

Findings from Ethiopia and Nigeria, complemented by insights from global and regional partners, highlight several cross-cutting lessons:

1. INTEGRATED CAMPAIGNS ARE FEASIBLE AND DELIVER STRONG EFFICIENCY GAINS WHEN THEY ARE APPROPRIATELY DESIGNED, CONTEXT-SPECIFIC, AND LINKED TO ROUTINE SYSTEMS.

Integration reduced duplication, compressed timelines, and lowered delivery costs while maintaining or improving coverage. At the same time, these gains need to be assessed alongside considerations of service quality, operational complexity, workforce burden, and sustainability over time. The appropriate model of integration also varies by disease area, delivery strategy, and epidemiological context. Integration should therefore be designed around country priorities and program objectives, rather than applied as a uniform model across all campaigns.

- **COMPRESSED TIMELINES:** Ethiopia's integrated campaign compressed approximately 25 days of standalone campaign work into a 10-day window, resulting in a 60% savings in project time. Similarly, Nigeria successfully consolidated multiple vertical campaigns that would have otherwise spanned over months into a single 10-day delivery window plus a short mop-up period.
- **DIRECT COST SAVINGS:** Nigeria's integration of polio and non-polio campaign budgets generated over USD \$4.18 million in savings compared to standalone efforts. The cost per child vaccinated in Nigeria declined by 23% (from \$0.30 to \$0.23) through integrated delivery.
- **MAINTAINED OR IMPROVED COVERAGE:**
 - Ethiopia:** Vitamin A and deworming coverage increased by 27% and 25% respectively, while the zero-dose vaccination rate improved from 27% to 34%.
 - Nigeria:** Pilot areas achieved high admin coverage across multiple programs simultaneously, including 99% for measles-rubella (MR) and 116% for polio.

2. INTEGRATION CAN STRENGTHEN HEALTH SYSTEMS AND ADVANCE PHC AND UHC OBJECTIVES WHEN CAMPAIGN PLATFORMS ARE DELIBERATELY CONNECTED TO ROUTINE AND CONTINUOUS SERVICE DELIVERY.

Integrated campaigns improved linkages between outreach and routine care, enhanced surveillance, and expanded reach to underserved populations. These findings suggest that integrated campaigns can serve as an important bridge to routine systems, while reinforcing the central role of PHC platforms in sustaining coverage and continuity of care.

- **ZERO-DOSE CHILDREN:** Ethiopia's integrated campaigns identified and vaccinated more than 191,346 zero-dose children. Nigeria reached over 55,000 zero-dose and 50,000 under-immunized children across the four pilot states by integrating routine immunization catch-up into campaigns, due to acceptability and community trust from the other long-serving interventions, such as for NTDs.
- **DATA SYSTEM MODERNIZATION:** Both countries shifted from fragmented, paper-based reporting to unified digital ecosystems (such as DHIS2 and ODK), enabling real-time performance monitoring and adaptive management across campaign domains.

3. STRONG NATIONAL LEADERSHIP ENABLES PROGRESS, BUT INSTITUTIONALIZATION REMAINS INCOMPLETE. Governance structures were effective at national level, but uneven sub-national implementation and limited formalization constrained sustainability.

4. DATA INTEGRATION AND REAL-TIME USE ARE ESSENTIAL ENABLERS OF ADAPTIVE IMPLEMENTATION. Integrated digital systems improved visibility and supported real-time decision-making, though infrastructure and harmonization challenges persist.

5. FRAGMENTED FINANCING REMAINS THE PRIMARY BARRIER TO SCALE AND SUSTAINABILITY. Misaligned donor funding structures and limited domestic financing constrain deeper integration.

6. WORKFORCE CAPACITY AND OPERATIONAL COMPLEXITY, AND SUSTAINABILITY MUST BE ADDRESSED. Integrated delivery increases demand on frontline workers, requiring expanded training, supervision, and harmonized incentives. While integration can reduce duplication across campaigns, it can also concentrate multiple tasks into shorter implementation windows and increase the intensity of work for frontline teams. As countries move from pilot implementation toward scale-up, greater attention will be needed to how integrated delivery can be embedded within existing workforce systems, supported through routine supervision structures, and sustained in contexts where short-term external incentives may be limited or unavailable.

7. GLOBAL AND REGIONAL PARTNER ALIGNMENT IS CRITICAL TO ENABLING SYSTEMS TRANSFORMATION. Policies, financing mechanisms, and technical guidance from global partners can either enable or constrain country-led integration.



⚠ *While early findings point to improved coordination, efficiency, and service integration, additional outcome data from recent campaigns will be important to further assess effects on coverage, equity, quality, and cost-effectiveness.*

NTD and immunization team with supervisors in Dambatta LGA, Kano State, Nigeria, during the integrated campaign in October 2025. Photo Credit: NTD Team, Kano State, Nigeria

Key Recommendations

For Countries Already Implementing the CAS

- **FOCUS ON FULL IMPLEMENTATION, SCALE-UP, AND SUSTAINABILITY.** This will require scaling beyond pilots into routine delivery platforms, strengthening subnational ownership, aligning the CAS with PHC, UHC, and health sector reform agendas, and sustaining technical and financial support through institutionalization.
- **INSTITUTIONALIZE INTEGRATION WITHIN NATIONAL SYSTEMS.** Moving from pilot success to sustained impact requires embedding the CAS within governance and planning frameworks, including formalizing coordination structures, integrating the CAS into routine delivery platforms, and establishing unified financing and coordination approaches.
- **STRENGTHEN SUBNATIONAL INTEGRATION STRATEGIES.** Implementation depth will depend on regional and local adoption, requiring strengthened capacity, clear operational guidance, and cascading governance and accountability mechanisms.
- **ADVANCE FINANCING REFORM FOR SUSTAINABILITY.** This includes developing unified financing frameworks, expanding domestic financing, and aligning payment and incentive structures to support integrated delivery.
- **STRENGTHEN WORKFORCE AND LEARNING SYSTEMS.** Sustained integration requires investment in workforce capacity, integrated planning and compensation models, and embedding monitoring, evaluation, research, learning and adaptation (MERLA) and adaptive learning systems within implementation. This includes assessing workload implications, clarifying frontline roles, strengthening supervision, and ensuring that payment and incentive models are equitable, harmonized, and sustainable beyond short-term pilot financing.

For Countries Considering Future CAS Implementation

- **FRAME THE CAS AS A SYSTEM TRANSFORMATION APPROACH.** Positioning the CAS as a systems strategy increases political ownership and sustainability by aligning it with PHC, UHC, and national reform priorities, integrating the CAS into existing governance platforms early, and positioning integration as a systems strengthening strategy rather than solely an efficiency measure. This framing should also make clear that campaigns are complementary to routine and continuous service delivery and should be used strategically to address defined gaps, accelerate progress, or respond to specific epidemiological and programmatic needs.
- **START WITH PHASED INTEGRATION PATHWAYS.** Begin with high-feasibility integration opportunities and scale iteratively. Define clear progression milestones and readiness benchmarks. Use integration maturity staging models to guide scale-up. Integration pathways should be tailored to the purpose of each campaign, the disease and epidemiological context, the target population, and the maturity of routine service delivery systems. Countries should avoid assuming that all programs require the same model, timing, or depth of integration.
- **ESTABLISH GOVERNANCE AND STAKEHOLDER ALIGNMENT EARLY.** This includes creating or leveraging existing cross-program coordination bodies with clear mandates, roles, and accountability structures to support joint planning, implementation, and oversight.

- **IDENTIFY AND EMPOWER INTEGRATION CHAMPIONS.** This would require a) identifying dedicated integration champions within the Ministry of Health (MoH) who can work across programs; b) clearly defining roles and responsibilities to lead and sustain integration efforts; and c) ensuring these roles are supported with sufficient authority and resources to coordinate across stakeholders.
- **BUILD WORKFORCE AND LEARNING MODELS INTO PILOTS.** Early integration efforts are more sustainable when designed holistically. Key actions include integrating workforce planning into initial CAS adaptation and design, establishing learning systems early rather than retrofitting MERLA later, and using phased integration maturity pathways.
- **PLAN FINANCING AND WORKFORCE REALITIES FROM THE OUTSET.** Map funding streams early and identify pooling opportunities. Incorporate workforce planning into initial CAS adaptation or customization. Use pilots or early experiences to test financing and incentive alignment models.
- **BUILD LEARNING SYSTEMS INTO IMPLEMENTATION FROM THE START.** This can be accomplished by establishing MERLA platforms at the outset instead of retrofitting learning later, promoting real-time learning and adaptive implementation cycles, and developing country-specific integration roadmaps informed by pilots or early experiences.

For Global and Regional Partners

- **ACCELERATE STRUCTURAL ALIGNMENT TO ENABLE INTEGRATION.** This includes moving beyond strategic endorsement to structural reforms in financing, payment alignment, and reporting, establishing a shared framework among funders for harmonized funding approaches that support integrated campaigns, and simplifying application, budgeting, and reporting processes for countries to reduce fragmentation across programs.
- **REFRAME INTEGRATION AS SYSTEMS TRANSFORMATION.** Key actions to facilitate this transformation include: a) aligning global strategies to position the CAS within PHC and UHC agendas; b) strengthening linkages between campaigns and health system strengthening initiatives; and c) embedding integration within replenishment cycles and global strategies.
- **IDENTIFY AND EMPOWER INTEGRATION CHAMPIONS.** This would require a) identifying dedicated integration champions within organizations who can work across programs; b) clearly defining roles and responsibilities to lead and sustain integration efforts; and c) ensuring these roles are supported with sufficient authority and resources to coordinate across stakeholders.
- **UPDATE AND SIMPLIFY GLOBAL TECHNICAL GUIDANCE.** Outdated norms and fragmented guidance remain major barriers to integration. Key actions for mitigating such barriers include: a) updating normative guidance to explicitly promote joint microplanning and cross-disease delivery; b) developing adaptable frameworks that allow local policy flexibility (e.g., community health worker scope expansion); and c) simplifying technical requirements that create operational challenges and deterrents to integration.
- **TRANSITION TOWARD FLEXIBLE, POOLED FINANCING MECHANISMS.** This will require expanding pooled or harmonized funding models, supporting country-led financing alignment, and embedding integration incentives into funding architectures.
- **ACCELERATE FINANCING REFORMS TO ENABLE INTEGRATION.** This includes: a) aligning funding cycles and reducing siloed financing structures, b) transitioning toward flexible, multi-year joint applications and budgets, c) introducing incentives for cross-program collaboration, including funding joint planning and not penalizing efficiencies gained through integration, and learning from and scaling up models such as Gavi, the Vaccine Alliance's (Gavi) multi-year co-delivery applications.
- **INVEST IN CAS MERLA TO BUILD THE EVIDENCE BASE.** This includes supporting measurement of integrated campaign effectiveness and documenting outcomes to inform scale and decision-making.

For the HCE Leadership Team with support from the HCE Program Office

- **DEVELOP STRUCTURED CAS SCALE-UP PATHWAYS FOR NEW COUNTRIES.** As interest grows, a deliberate approach is needed to support expansion beyond early adopters. This will require developing a structured scale-up and support model for new countries, creating readiness assessments and phased adoption pathways, and providing peer learning opportunities from Ethiopia and Nigeria.
- **STRENGTHEN SUPPORT TO FOCUS COUNTRIES AS GLOBAL EXEMPLARS.** Early adopters are essential to building the evidence base and credibility of the CAS. Strengthening support to focus countries should entail providing sustained technical support to Ethiopia and Nigeria, supporting national scale-up and institutionalization, and documenting lessons and translating them into global public goods.
- **DESIGN THE CAS INTEGRATION MATURITY PATHWAYS.** Key activities would include: a) developing a CAS maturity model and progression framework; b) providing diagnostics and scaling tools for countries; and c) defining milestones for transitioning from pilot to institutionalization.
- **STRENGTHEN THE CATALYTIC ROLE OF THE COALITION AND PROGRAM OFFICE.** Clarify the role of the HCE Program Office as a systems integrator and convener across partners. Develop targeted advocacy focused on structural reforms (especially financing). Use the convening power of the HCE Program Office and the broader HCE Coalition to align partner timelines and incentives.
- **WIDELY DISSEMINATE THE CAS LESSONS AND INTEGRATION MODELS.** Lessons from Ethiopia and Nigeria are valuable global public goods and should be actively shared. This will require sharing of lessons with countries and via regional platforms, strategic dissemination within partner organizations and technical networks, and ensuring that the CAS learnings are embedded into global guidance, strategies, and technical documents.
- **INVEST IN MERLA TO BUILD THE EVIDENCE BASE.** A stronger evidence base is essential for scaling the CAS and validating theory of change (ToC) assumptions. This will require dedicated funding for MERLA aligned with the CAS ToC, strengthening measurement of integration outcomes and system effects, and longitudinal evaluation and implementation research.
- **SUPPORT PRACTICAL IMPLEMENTATION TOOLS AND LEARNING FORUMS.** Countries will continue to need actionable tools to operationalize integration. This will require activities such as: a) ongoing development of practical guidance and decision-support tools (e.g., integration design frameworks, microplanning tools, readiness assessments); b) creating toolkits and implementation guides for integrated campaigns; and c) supporting regional learning forums and peer exchange platforms.

The early experience of CAS implementation in Ethiopia and Nigeria demonstrates that integrated, country-led campaigns are both feasible and impactful, offering a pathway to improve efficiency, expand service delivery, and strengthen health systems. At the same time, these findings underscore that campaigns are most effective when they are strategically used, context-specific, and connected to routine and continuous service delivery.

However, achieving sustainable scale will require moving beyond pilots to institutionalized, system-level transformation, particularly in governance, financing, workforce capacity, and data systems. It will also require careful attention to workforce sustainability, disease-specific delivery requirements, denominator quality, the long-term interface between campaigns and routine systems and stronger alignment across global and regional partners to support country-led implementation.



Children hold up their vaccination cards during the integrated campaign in Akwa Ibom State, Nigeria in February 2026.
Photo Credit: Destiny Chukwu

INTRODUCTION

The delivery of large-scale health campaigns has been a cornerstone of global public health efforts, enabling countries to rapidly reach populations with life-saving interventions across immunization, neglected tropical diseases (NTDs), malaria, nutrition, and other priority areas.

However, these campaigns have historically been implemented through fragmented, disease-specific approaches, often resulting in inefficiencies, duplication of effort, and missed opportunities to strengthen national health systems.

Integrated and coordinated campaign approaches have been applied in different forms across countries and programs over many years. The CAS builds on this broader body of experience by offering a structured, country-led approach to improve collaboration across campaigns, strengthen alignment with national systems, and generate practical learning on how integration can be planned, implemented, financed, monitored, and adapted in diverse contexts.

In response to these challenges, the Health Campaign Effectiveness (HCE) Coalition developed the Collaborative Action Strategy (CAS) to support a shift from siloed, vertical campaigns toward more integrated, coordinated, and country-led delivery models. The CAS is designed

to improve the effectiveness, efficiency, equity, and sustainability of health campaigns while strengthening alignment with primary health care (PHC) systems and advancing broader Universal Health Coverage (UHC) goals.

Within this framing, campaigns are understood as complementary, time-bound strategies that serve different purposes depending on the disease area, epidemiological context, and programmatic objective. They may be used for outbreak response, catch-up vaccination, elimination acceleration, preventive chemotherapy, vector control, seasonal prevention, or targeted outreach to underserved populations. As a result, the appropriate level and depth of integration should be tailored to country priorities, target populations, delivery strategies, safety and quality requirements, and the strength of routine service delivery platforms.

Between 2024 and early 2026, the CAS was piloted in Ethiopia and Nigeria as part of a proof-of-concept phase. Both countries adapted the global CAS framework to their national contexts and implemented integrated campaign models across multiple health domains. These pilots were intentionally designed not only to test the operational feasibility of integration, but also to generate practical insights on governance, financing, service delivery, and data systems that could inform broader system transformation.

This report presents findings from an interim evaluation of the CAS pilot phase. The evaluation was conducted to assess early progress toward the outcomes outlined in the CAS Theory of Change (ToC), generate actionable lessons from implementation in the focus countries, and examine emerging shifts at the global and regional level. As a mid-term formative assessment, the evaluation is intended to support the HCE Leadership Team and partners in making evidence-informed decisions about how to refine, strengthen, and scale the CAS in future phases.

Specifically, the evaluation aims to:



ASSESS VALIDITY:

Examine progress toward mid-term outcomes and test key assumptions underlying the CAS Theory of Change



LEVERAGE LESSONS:

Identify early successes, challenges, and enabling factors from implementation in Ethiopia and Nigeria



GUIDE FUTURE STRATEGY:

Inform strategic adjustments and shape the expansion of the CAS to additional countries

The evaluation focuses on three interconnected levels of change: (1) country-level policy and system reform, including governance, integration, and early campaign outcomes; (2) global and regional alignment among funders and partners; and (3) cross-cutting learning and adaptation processes that support continuous improvement.

As an interim evaluation, the report emphasizes learning over attribution. It highlights early signals of progress, identifies areas requiring further attention, and documents emerging practices that may inform the evolution of integrated, system-aligned campaign delivery models. These findings contribute to a growing evidence base on how collaborative approaches can enhance campaign effectiveness while supporting long-term health systems strengthening.



The CAS is designed to improve the effectiveness, efficiency, equity, and sustainability of health campaigns while strengthening alignment with primary health care (PHC) systems and advancing broader Universal Health Coverage (UHC) goals.

Celebration and launch of the National Integrated Measles campaign, nutrition services and more under the Ethiopia Collaborative Action Strategy in May at the Babugaya Health Center, Oromia Region. Photo Credit: Ethiopia Federal Ministry of Health



Ethiopia Federal Ministry of Health leadership and healthcare teams carry out an integrated health campaign in the Oromia region, Ethiopia, providing essential health services for onchocerciasis, malaria, and non-communicable disease services and screenings for eye health and hypertension. Photo Credit: Ethiopia Federal Ministry of Health

METHODOLOGY

Evaluation Design

This interim evaluation employed a formative, mixed-methods design to assess early progress during the CAS pilot phase (2024–Q1 2026). The evaluation was grounded in the CAS ToC and aligned with the CAS monitoring, evaluation, research, learning and adaptation (MERLA) framework. The primary aim was to generate actionable insights on implementation processes, early outcomes, and emerging lessons to inform adaptive decision-making and future scale-up.

Evaluation questions were structured around the three primary CAS ToC domains: country-level policy and system reform, global and regional level change, and cross-cutting learning and adaptation. To ensure alignment with the CAS ToC, data collection was conducted at two levels: (1) the country level, focused on implementation experiences in Nigeria and Ethiopia, and (2) the global and regional levels, focused on changes in partner coordination, policy alignment, and funding practices. This structure enabled the evaluation to capture systemic shifts across the CAS ecosystem from country governance structures, campaign integration to global donor and partner dynamics, and applied learning.

Key thematic areas of inquiry included governance, integration, policy alignment, outcomes, and applied learning. For example, at the country level, the evaluation examined what national governance structures were established to support CAS implementation and how effectively they functioned. It also assessed how focus countries integrated multiple health campaigns and what implementation challenges or successes emerged. At the global and regional levels, the evaluation explored the extent to which funders and partners have aligned policies with CAS recommendations and adapted their approaches based on early CAS learning. Across domains, the evaluation examined how CAS learnings influenced policy or practice changes and early indications of improvements in campaign coverage, quality, efficiency, equity, and acceptance.

Evaluation Questions

The evaluation questions align with the three primary CAS Theory of Change domains: Country-Level Policy, Global/Regional Level Change and System Reform, and Cross-Cutting Learning and Adaptation. This structure ensures capture of systemic shifts at all levels, from high-level donor policy changes to on-the-ground improvements in campaign implementation and health outcomes.

CAS ToC Domains	Core Evaluation Questions	Key Sub-Questions
Country Level Policy and Reform	GOVERNANCE: What national governance structures were established to support CAS implementation, and how did they function?	• INSTITUTIONALIZATION: In what ways has the CAS been institutionalized within country health program policies and operational practices?
	INTEGRATION: How effectively are focus countries integrating multiple health campaigns, and what challenges or successes have emerged?	• ADAPTATION: To what extent have CAS strategies been adapted/customized to reflect country-specific health priorities, and what measurable changes have resulted? • WORKFORCE: How are health systems and frontline health workers supported during collaborative campaigns?
	OUTCOMES & DATA: What improvements in campaign coverage, quality, efficiency, equity, and/or acceptance have resulted from CAS implementation?	• RESILIENCE: What measurable improvements in health outcomes and system resilience have resulted from collaborative campaigns? • EQUITY: How fair and equitable are the methods for compensating field implementers and health workers? • RESOURCE ALLOCATION: How are domestic and donor funds allocated to support collaborative campaigns? • DATA SYSTEMS: To what extent have data systems and/or data use practices been modified to monitor the impact of collaborative campaigns?
	CROSS-CUTTING LEARNING & ADAPTATION: What specific changes in policies or practices have resulted from CAS learnings, and how have they improved program adaptation?	
	POLICY ALIGNMENT: To what extent have global health funders and partners updated their guidelines and policies to align with CAS recommendations?	• TRANSPARENCY: How are campaign funders sharing financial and investment data, and how is this information being used for planning and decision-making?

Data Collection

A mixed-methods approach was used to generate evidence on implementation processes and early results across both country and global/regional levels.

Country-Level Data Collection

Document and Data Review

A structured review of program documentation and monitoring data was conducted to assess progress against the CAS ToC. Materials reviewed included country customization documents, governance outputs, program reports, meeting reports, and case studies. A review of a situational analysis produced for the HCE program by Camber Collective was also reviewed. These sources provided insight into governance structures, implementation milestones, and early operational shifts.

Key Informant Interviews

Key Informant Interviews (KIIs) were conducted with ministry officials and campaign implementers in Nigeria. These discussions explored governance functionality, service continuity during campaigns, operational integration, and stakeholder buy-in. Qualitative insights were particularly important for understanding real-world implementation dynamics and contextual adaptations.

Global and Regional-Level Data Collection

Key Informant Interviews

To assess progress toward global and regional CAS outcomes, KIIs were conducted with global funders, technical partners, and members of the HCE Leadership Team. A total of 19 KIIs were conducted between May and August of 2025 with one or more representatives from each of the following organizations: The Centers for Disease Control and Prevention (CDC); The Carter Center; Gavi, the Vaccine Alliance (Gavi); Gates Foundation; The Global Fund; Global Polio Eradication Initiative (GPEI); RBM Partnership to End Malaria (RBM); UNICEF; World Health Organization (WHO) Headquarters: Immunizations, Vaccines, and Biologicals Department (IVB) and NTD Department; and WHO Regional Offices: Africa Regional Office (AFRO), Eastern Mediterranean Office (EMRO), and Pan American Health Organization (PAHO).

These interviews explored: a) alignment of global partner policies and guidance with CAS recommendations; b) changes in coordination across donors and technical agencies; c) progress toward financing transparency and harmonization; and d) use of CAS learning to inform organizational strategy and decision-making.

These perspectives provided insight into shifts in global norms, partner behavior, and institutional alignment that are not directly observable through country-level data alone.



N-CAS Task Team reviewing frontline team's data tools in Oyo State, Nigeria to strengthen real-time data quality during the integrated campaign in October 2025.
Photo Credit: Destiny Chukwu

Data Sources

The evaluation synthesized evidence from multiple data streams to support triangulation across levels. It is important to note that the specific data sources varied between the two focus countries (Nigeria and Ethiopia) based on availability, pilot scope, and reporting structures. Our data sources comprised:

PARTNER REPORTS: HCE dashboards and partner documentation (e.g., Clinton Health Access Initiative (CHAI), Solina Group, and UNICEF specifically for Nigeria), and related synthesis products.

CAMPAIGN DATA: Available execution and performance data from pilot campaigns. For Nigeria, this included selected call-in data, daily situation reports (sitreps), where accessible. For Ethiopia, campaign execution data relied on post-campaign integration presentations.

COUNTRY MERLA ASSESSMENTS: Baseline and follow-up MERLA assessments. In Nigeria, this included KIIs, focus group discussions with ministry officials and implementers, and community surveys across the four pilot states. In Ethiopia, this included a mixed-methods national MERLA assessment incorporating data mining and KIIs at the national and regional levels.

QUALITATIVE ASSESSMENTS: Synthesized findings from Leadership Team KIIs and partner and country level reflections.

GLOBAL PARTNER INTERVIEWS: KIIs with global funders and partners to assess progress toward global and regional CAS outcomes.

Together, these sources enabled triangulation across policy, programmatic, and experiential perspectives to generate a comprehensive understanding of early CAS implementation.



Mother and child receiving interventions during the integrated campaign in Oyo State, Nigeria in October 2025.
Photo Credit: Destiny Chukwu

Analytic Approach and Validation

Analysis followed a theory-informed triangulation approach. Evidence was synthesized within each CAS ToC domain and then examined across domains to identify reinforcing patterns and cross-cutting insights. Particular attention was given to (1) functionality of governance and coordination structures, (2) degree of campaign integration across health domains, (3) policy alignment among global partners and funders, (4) early indications of campaign effectiveness and acceptability, and (5) evidence of applied learning and adaptation.

Given the early implementation stage, qualitative data were analyzed thematically, while quantitative indicators were interpreted directionally where available. The evaluation prioritized sense-making and learning over causal attribution, consistent with the formative intent of the pilot-phase assessment.

FOCUS COUNTRY REVIEW AND VALIDATION: To ensure accuracy, contextual fidelity, and alignment with country realities, the evaluation process included a dedicated validation mechanism. Representatives, ministry officials, and key stakeholders from each focus country were provided the opportunity to review draft findings and validate the data, insights, and lessons learned prior to their final inclusion in this report.

Limitations

The methods employed in this interim evaluation have several limitations that should be considered when interpreting findings, particularly given the formative stage of CAS implementation and evolving data systems.

LIMITED QUANTITATIVE COVERAGE DATA: Post-Campaign Coverage Survey (PCCS) data for pilot campaigns in Nigeria and Ethiopia were not available prior to reporting, limiting validation of reach to zero-dose or underserved populations.

ADMINISTRATIVE COVERAGE AND DENOMINATOR LIMITATIONS: Some reported administrative coverage results exceeded 100%, which may reflect challenges with target population estimates, outdated denominators, population movement, duplicate reporting, or other data quality issues. These figures were retained because they reflect the data available to implementation teams at the time of reporting, but they should be interpreted with caution. Coverage above 100% is an important signal for further review and has implications for microplanning, resource allocation, monitoring, and evaluation.

SPARSE BASELINE COMPARISONS: The absence of pre- and post-CAS quantitative datasets limits attribution of changes in coverage or quality directly to CAS implementation.

RELIANCE ON QUALITATIVE PROXIES: In the absence of validated coverage statistics, qualitative evidence (e.g., partner assessments and stakeholder interviews) was used to infer early shifts in reach and acceptance.

LIMITED SERVICE CONTINUITY DATA: Quantitative facility-level data on health system resilience (e.g., outpatient visits or routine immunization during campaigns) were not available; findings rely primarily on qualitative inputs.

LIMITED FINANCIAL DATA: Quantitative data on domestic versus donor financing were not consistently accessible; financing findings are descriptive rather than based on detailed cost or efficiency analysis.

VARIABLE USE OF THE CAS LEARNING AGENDA: In-country partners did not consistently apply the standardized CAS Learning Agenda, limiting cross-country comparability of learning data.

EVOLVING DOCUMENTATION: As implementation is still maturing, documentation of learning and adaptation processes varied across stakeholders.

FORMATIVE TIMING: Many CAS outcomes remain emergent, and measurement systems are still being operationalized.

ATTRIBUTION CONSTRAINTS: Given the complexity of multi-partner campaigns and concurrent reforms, findings should be interpreted as early signals rather than causal effects.



At the launch of the Oyo State integrated campaign in October 2025, the state healthcare team prepares supplies during the integrated campaign in October 2025, including vaccines, albendazole, and recordkeeping tools. Photo Credit: Destiny Chukwu

COUNTRY LEVEL EVALUATION FINDINGS:

Ethiopia



What is the “big picture” story of CAS implementation in Ethiopia across operations, impact, and systems?

1. Massive gains in operational efficiency:

Transitioning from standalone vertical campaigns to an integrated “one-stop-shop” model yielded substantial resource optimization. On average, campaign integration saved 60% of project time (compressing 25 days of standalone work into 10 days).^{1,2}

2. Coverage was maintained and expanded:

Integration did not compromise service quality, but expanded reach. Post-CAS adoption, in May 2025 national Vitamin A and deworming coverage increased by 27% and 25% respectively, and 191,346 zero-dose children were vaccinated, representing a 7% increase in identifying zero-dose children from the expected zero-dose children in 2025.^{1,2} The January 2026 campaign successfully reached approximately 24,902,365 people for onchocerciasis treatment, distributed 1.3 million insecticide-treated nets (ITNs) while simultaneously screening 4.4 million people for visual impairments and identifying 26,873 adults with elevated blood pressure.³

3. Strong national governance, but subnational coordination requires strengthening:

Top-down leadership via the National Steering Committee (NSC) and multi-sectoral Technical Working Groups (TWGs) successfully drove the pilot.^{1,4} However, formal institutionalization is yet to be fully realized; subnational coordination remains fragmented, and localized policy enforcement (cascading the harmonized plan to regional bureaus) is a critical gap.²

4. Data systems shifted from silos to digital harmonization:

Ethiopia’s implementation of the CAS catalyzed a shift from fragmented, paper-based tools to a unified digital ecosystem (e.g., DHIS2 Campaign Tracker, Open Data Kit [ODK], and Power BI dashboards), enabling real-time performance monitoring.² However, poor connectivity in remote kebeles (wards) and a lack of digital literacy among some frontline workers delayed real-time reporting.²

5. Campaigns supported routine Primary Health Care (PHC):

The campaigns bridged the gap between temporary outreach and routine PHC.³ By using referral protocols, patients identified with severe hypertension or cataracts were successfully linked to additional health care services.³

6. Financing remains a bottleneck:

While the introduction of direct digital payments (e.g., Hallo Cash, E-Birr) vastly improved the timeliness and transparency of health worker stipends, overall campaign financing remains highly fragmented and donor-dependent, highlighting the urgent need for a unified national financing policy and pooled funding mechanisms.²



Ethiopia Federal Ministry of Health colleagues attend integrated health campaign in the Oromia region of Ethiopia in January 2026, which provided essential health services for onchocerciasis, malaria, and non-communicable disease screenings for eye health and hypertension. Photo Credit: Ethiopia Federal Ministry of Health

Country Level Policy and System Reform in Ethiopia

How was the CAS implemented in Ethiopia?

In 2024, Ethiopia opted into the CAS, adapted the global framework to its local context and began implementation of the recommendations, producing the Ethiopia Collaborative Action Strategy, or E-CAS.^{1,2}

Approach

In 2025, Ethiopia implemented the E-CAS as a nationally led, reform-oriented initiative, positioning integration as part of broader health system strengthening rather than a standalone pilot.^{1,2} The country used integrated campaigns as proof-of-concept demonstrations to test a) Operational feasibility: whether multiple health domains could be delivered together at scale across diverse geographic contexts; b) Resource optimization: early testing of a “one plan, one budget” direction, including shared logistics, joint training, and consolidated delivery timelines³; c) System integration: whether integrated campaigns could catalyze improvements in governance, financing coordination, and links between outreach and routine care³; and d) Scalability: lessons from pilots were intended to inform national policy shifts and longer-term institutionalization of integration.^{1,2} This approach reflected a deliberate effort to move from vertical campaigns toward system-oriented integration aligned with national priorities.^{1,2}

Integration Models Tested

- May 2025 Campaign: Integrated immunization (measles/zero-dose/COVID-19), nutrition (Vitamin A/deworming/nutritional screening), and select maternal and child health (MCH) services.
- January 2026 Campaign: Integrated NTD (onchocerciasis mass drug administration [MDA]) + malaria (LLINs) + Noncommunicable disease (NCD) screening (hypertension + eye problems) using a “one-stop-shop” model designed to connect community services with facility care.



National Alignment

The E-CAS was explicitly positioned as a vehicle for advancing national health reform goals, including: a) PHC strengthening: using integrated campaigns to improve referrals, surveillance, and continuity of care between outreach and facilities^{1,3}; b) UHC: expanding equitable access to multiple services through bundled delivery models; c) Reduced fragmentation: gradually shifting away from siloed, donor-driven vertical campaigns toward more harmonized delivery approaches¹; and d) Policy coherence: aligning integration with existing national strategies (e.g., Health Sector Transformation Plans and disease-specific master plans).^{1,2}

Over time, E-CAS has been framed not only as an operational innovation but as a pathway toward institutionalizing integrated service delivery within Ethiopia's health system.



Children hold up their vaccination cards during Ethiopia's May 2025 integrated campaign guided by the Collaborative Action Strategy.
Photo Credit: Ethiopia Federal Ministry of Health

Figure 1: Implementation Status of CAS Recommendations in Ethiopia

Planning & Implementation		
Rec #1a	Establish a multi-sectoral, cross-campaign National Steering Committee	Implemented
Rec #1b	Identify campaigns and domains for collaboration and integration	In Progress
Rec #1c	Develop a multi-year, cross-campaign workplan and schedule for campaigns	In Progress
Rec #1d	Harmonize tools and operations (e.g., logistics, supply chain, microplanning) across campaigns	In Progress
Rec #1e	Develop a coordinated and effective approach to enable active community engagement at all levels and phases	In Progress
M&E/MERLA		
Rec #2a	Develop a coordinated and collaborative cross-campaign MERLA strategy in Ethiopia	In Progress
Rec #2b	Aligned with Ethiopia's MERLA strategy, improve the ability of campaign implementers and partners to identify, measure, utilize, and share data on campaign effectiveness	In Progress
Campaign Financing		
Rec #3a	Create a comprehensive view of campaign financing at the country level by combining detailed campaign financing information from major funders and government, to enable better planning and execution	In Progress
Rec #3b	Take incremental steps toward harmonizing and aligning campaign financing	Not Yet Started
Rec #3c	Harmonize and align incentive payment modalities and rates across campaigns	In Progress
Rec #3d	Advance government role in campaign financing	In Progress



To what extent are national governance structures effectively facilitating CAS implementation in Ethiopia?

National governance structures have been a major enabling factor for CAS implementation in Ethiopia, particularly in securing political commitment and fostering cross-program collaboration. However, effectiveness declines at subnational levels due to uneven policy cascading.

✔ What's working?

- 1. MULTI-TIER GOVERNANCE ARCHITECTURE ESTABLISHED EARLY.** Ethiopia created a structured governance model to oversee CAS implementation, including a) National Steering Committee (NSC): comprised of Ministry of Health (MoH) leadership, development partners, and key implementing agencies, the NSC provides high-level strategic direction and legitimacy for integration efforts; and b) Technical Working Groups (TWGs): multi-disciplinary TWGs coordinated operational planning and implementation, with dedicated sub-groups focused on planning and delivery, MERLA, and campaign financing. These groups enabled cross-program problem-solving and helped translate strategic intent into operational plans.^{1,2}
- 2. STRONG POLITICAL LEADERSHIP AND VISIBILITY.** Governance structures successfully mobilized high-level political support for integration. Senior MoH leadership actively championed the CAS and maintained regular engagement with regional stakeholders (e.g., through quarterly reviews). High-level endorsement helped legitimize integration and encouraged historically vertical programs to collaborate.^{1,4}
- 3. IMPROVED CROSS-PROGRAM COORDINATION.** Governance mechanisms created structured forums for joint planning and alignment. These structures a) enabled joint microplanning, shared readiness reviews, and integrated supervision⁴; b) helped break down long-standing silos between disease programs and partners; and c) co-facilitated partner alignment around shared objectives, even in the absence of fully pooled funding.^{1,2}

✘ What's limiting effectiveness?

- 1. WEAK CASCADING TO SUBNATIONAL LEVELS.** While governance is strong at the national level, effectiveness diminishes downstream. Regional and subnational actors reported limited clarity on how integration should be operationalized locally. As a result, interpretation and implementation of integration guidance have varied across regions.²
- 2. EVOLVING GOVERNANCE STRUCTURES.** Governance structures on integration are still maturing. Coordination in some instances continues to rely on established relationships and informal mechanisms while formal policies, Terms of Reference (TORs), and standard operating procedures are being developed and institutionalized to support consistent implementation across levels.²
- 3. PERSISTENT STRUCTURAL FRAGMENTATION.** Despite governance advances, structural differences across programs, including planning cycles, funding rules, and implementation norms, continue to shape coordination dynamics and can complicate seamless integration. These variations are particularly visible at subnational levels, where departments often continue developing program-specific operational plans while integration is primarily guided through national directives.²
- 4. NEED FOR STRONGER FORMALIZATION FOR SUSTAINABILITY.** Evaluations consistently highlight the need to transition from pilot governance to institutional governance, including: a) formalizing cross-campaign coordination bodies within national policy; b) developing clear TORs across levels of the system; and c) embedding integration into standard planning and accountability processes such as multi-year integrated workplans.² Without these shifts, there is a risk that governance gains remain pilot-bound rather than system-wide.

❗ BOTTOM LINE ASSESSMENT

Ethiopia demonstrates strong governance readiness for the CAS, particularly in political commitment and national coordination. The next phase of progress depends on institutionalizing governance structures and strengthening subnational cascading to ensure integration becomes routine rather than pilot-driven.^{1,2}



How effectively are focus countries integrating multiple health campaigns, and what challenges or successes have emerged?

Ethiopia's recent experience with integration suggests that campaign integration is feasible and increasingly mature, with progression from moderate operational integration toward deeper multi-domain service bundling. The transition between the May 2025 and January 2026 campaigns reflects a shift in how integration was implemented: the earlier campaign emphasized coordination mechanisms, while the later campaign incorporated more instances of co-delivery across diverse interventions.

MAY 2025 CAMPAIGN — MODERATE OPERATIONAL INTEGRATION

The May 2025 integrated campaign combined immunization, nutrition, and selected MCH services at national scale.^{1,2,4} Integration during this phase was strongest in operational coordination mechanisms, including joint scheduling across program areas, coordinated logistics and supply chain alignment, harmonized readiness assessments, and shared supervision and joint monitoring visits. These features demonstrate that integration was operationally functional and scalable, confirming the feasibility of coordinated multi-domain campaigns.²

However, evaluation findings indicate that integration during this phase remained moderate in depth. For example, there was limited granular documentation on fidelity of integrated frontline service delivery, inconsistent use of integrated tools across regions, and variability in how integrated delivery was implemented locally.² Taken together, the evidence suggests that while coordination structures were well established, integration was more structural than deeply service-integrated, reflecting moderate operational maturity at this stage.

JANUARY 2026 CAMPAIGN — EXPANDED INTEGRATION

The January 2026 campaign expanded integration by co-delivering onchocerciasis MDA, malaria LLIN distribution, and screening for hypertension and eye conditions.^{3,5} This campaign introduced a “one-stop-shop” outreach model, bundling communicable and non-communicable interventions within a single platform and demonstrating the operational feasibility of integrating services with different delivery requirements.³



Key Successes

- 1. HIGH COMMUNITY ACCEPTANCE AND DEMAND.** The bundled service model significantly strengthened community engagement. Communities valued receiving multiple services in a single visit, reducing fatigue associated with repeated campaigns.^{2,3}
- 2. OPERATIONAL EFFICIENCIES AND ECONOMIES OF SCALE.** Integration produced measurable delivery efficiencies. For example, integration was reported to reduce duplication across planning and supervision structures and shared supply chains reduced redundant logistics and vehicle trips.^{2,3}



Key Challenges

- 1. FRONTLINE WORKLOAD AND CLINICAL FATIGUE.** Delivering multiple interventions simultaneously increased operational intensity for frontline workers.^{2,3}
- 2. SKILLS GAPS FOR EXPANDED SERVICE PACKAGES.** Integration exposed gaps in specialized competencies.^{2,3}
- 3. DATA QUALITY CHALLENGES.** While progress was made toward integrated monitoring, data quality remains incomplete. For example, health extension professionals in remote and hard-to-reach kebeles continue to face persistent connectivity and power challenges affecting data accuracy.^{2,3}



BOTTOM LINE ASSESSMENT

Ethiopia demonstrates clear and accelerating progress in campaign integration, evolving from coordination-driven integration toward deeper service bundling. While operational feasibility is now well established, sustaining and scaling integration will require continued workforce optimization, stronger logistics systems, further data harmonization, and institutionalization of integrated delivery models. These findings suggest that Ethiopia is transitioning from proof-of-concept integration toward systems-level integration, with remaining challenges primarily related to depth, standardization, and sustainability.



What improvements in campaign coverage, quality, efficiency, equity, and/or acceptance resulted from CAS implementation?

Across both the May 2025 and January 2026 integrated campaigns, Ethiopia generated early but substantial gains across multiple dimensions of campaign effectiveness.^{1,3} Evidence suggests that the shift from vertical to integrated delivery produced improvements not only in coverage and efficiency, but also in surveillance quality, health system linkages, equity of access, and community acceptance.² While some outcomes remain preliminary, the slides consistently highlight measurable operational gains and strong signals of system strengthening.²

Coverage

SUSTAINED OR IMPROVED PERFORMANCE ACROSS MULTIPLE

DOMAINS. Measles vaccination coverage remained extremely high (99%), demonstrating that integration did not compromise core immunization performance.^{1,2} Nutrition outcomes improved substantially compared to pre-CAS baselines, with Vitamin A supplementation coverage increasing by 27% and deworming coverage increasing by 25%.^{1,2} The January 2026 campaign achieved strong results across multiple domains simultaneously, including surpassing its 80% target by reaching approximately 24,902,365 individuals (82%) with onchocerciasis therapeutic coverage and 1.3 million LLIN distribution achievement.^{3,5}

These coverage results provide encouraging early signals of campaign performance and reach. However, as with all administrative campaign data, they should be interpreted in light of known challenges related to target population estimates, reporting completeness, and denominator accuracy. Continued validation through post-campaign coverage surveys, routine data review, and strengthened microplanning will be important to confirm reach and guide future planning.

EXPANDED REACH INTO NEW SERVICE AREAS. Integrated delivery enabled large-scale screening for previously under-addressed conditions, including screening over 4.4 million people for visual impairments and identifying 26,873 adults with elevated blood pressure.^{3,5}

Efficiency

SIGNIFICANT TIME COMPRESSION. Delivering multiple services in a single deployment window reduced campaign duration by roughly 60%, shrinking implementation timelines from approximately 25 days to approximately 10 days in some cases.^{1,2}

OPERATIONAL AND LOGISTICAL EFFICIENCIES. Unified logistics systems reduced redundant vehicle trips. Consolidated campaign windows reduced duplicated per diems and operational expenditures.^{3,5}



Ethiopia Federal Ministry of Health healthcare teams carry out an integrated health campaign in the Oromia region, Ethiopia, providing essential health services for onchocerciasis, malaria, and non-communicable disease screenings for eye health and hypertension in January 2026. Photo Credit: Ethiopia Federal Ministry of Health



Equity

EXPANDED REACH TO UNDERSERVED POPULATIONS.

Integrated campaigns successfully identified and vaccinated 191,346 zero-dose children.^{1,2}

MORE TRANSPARENT AND EQUITABLE FRONTLINE COMPENSATION SYSTEMS.

The shift toward digital payment platforms (e.g., Hallo Cash and E-Birr) improved transparency, traceability, and accountability of payments to frontline workers.² Consolidated per diem models piloted during integrated campaigns simplified payment processes and reduced fragmentation associated with multiple vertical deployments. Combining up to five campaigns into a 10–12 day period replaced roughly 25 separate deployment days, enabling one shared per diem for frontline workers and supervisors.²

PERSISTENT EQUITY GAPS IN RESOURCE FLOW AND COMPENSATION RELIABILITY.

Despite digital advances, delayed donor disbursements and bureaucratic bottlenecks continue to result in late payments, disproportionately affecting frontline workers in remote areas.^{2,6} Infrastructure and capacity constraints at subnational levels highlight the need for more context-adapted compensation and resource flow models to ensure equitable implementation across regions.⁶

Community Acceptance

REDUCED CAMPAIGN FATIGUE. Delivering multiple services in a single visit minimized repeated disruptions to communities and increased overall satisfaction.^{2,3}

STRONG COMMUNITY SATISFACTION AND

CONVENIENCE EFFECTS. Communities valued receiving bundled services (vaccines, deworming, nets, screening) in one touchpoint.¹

Quality and Health System Outcomes

STRONGER LINKS BETWEEN OUTREACH AND

ROUTINE CARE. Campaigns used structured referral mechanisms to connect screened patients with facility-based services. This helped reduce referral leakage and strengthened continuity of care, especially for NCDs and eye conditions.³

EARLY SIGNALS OF SYSTEM RESILIENCE. Consolidated campaigns reduced disruption to routine services and strengthened the continuum between community outreach and primary care.³



Ethiopia Federal Ministry of Health National Steering Committee who oversees the Ethiopia Collaborative Action Strategy. Photo Credit: Ethiopia Federal Ministry of Health

! BOTTOM LINE ASSESSMENT

Taken together, the Ethiopia experience suggests that integrated campaigns can simultaneously improve multiple dimensions of effectiveness, including efficiency, equity, and community acceptance, without sacrificing coverage. While longer-term health outcomes and system resilience require continued monitoring, the available evidence points to meaningful early gains and strong proof-of-concept for integrated delivery models.



How are domestic and donor funds allocated to support collaborative campaigns?

Ethiopia's collaborative campaigns are financed through a blended funding model that combines donor financing, and government contributions, with integrated delivery enabling pooling of resources across historically vertical programs.² While financial integration has improved efficiency and transparency, the overall funding structure remains externally dominated, with domestic financing still representing a smaller share of total campaign resources.^{2,6} The key patterns emerging from the Ethiopia experience are summarized below.

- 1. BLENDED FINANCING WITH POOLED FUNDING ACROSS STAKEHOLDERS.** Integrated campaigns draw on multiple funding sources, including global donors, implementing partners, and government contributions. The May 2025 national campaign pooled approximately 1.5 billion birr (USD \$9.6 million equivalent) across stakeholders to jointly finance cross-cutting costs such as logistics, training, coordination, and monitoring. This figure includes donor and partner funding but excludes government in-kind contributions unless otherwise noted.²
- 2. INCREASING FINANCIAL INTEGRATION AND POOLING AT IMPLEMENTATION LEVEL.** Integration enabled shared financing of delivery platforms, reducing fragmentation associated with vertical campaigns.²
- 3. IMPROVED EFFICIENCY AND VALUE FOR MONEY.** Bundling interventions created economies of scale, including shared logistics, joint trainings, and unified deployment windows.² Consolidated per diem payments and shared transport fleets generated substantial cost savings compared to multiple standalone campaigns. Despite declining overall funding between 2024 and 2025, integrated campaigns enabled greater reach, suggesting improved efficiency through collaborative financing.²
- 4. CONTINUED HEAVY RELIANCE ON DONOR FUNDING.** External donors continue to finance the majority of campaign costs, with domestic allocations accounting for a smaller share of the total budget.^{2,6} Stakeholders highlighted concerns about sustainability and emphasized the need for stronger domestic co-financing models.²
- 5. STRUCTURAL BARRIERS TO DEEPER FINANCIAL INTEGRATION.** Fragmented donor earmarking and rigid funding requirements limit full pooling of resources.² The absence of a unified national campaign financing framework impedes systematic financial integration.⁶ Bureaucratic bottlenecks and delayed donor disbursements continue to affect implementation timelines and frontline payment reliability.^{2,6}
- 6. SUBNATIONAL FUNDING GAPS PERSIST.** Subnational actors often face resource constraints, particularly in remote or hard-to-reach areas where integrated campaigns require higher logistical investment.² These gaps highlight the need for more flexible and context-sensitive financing approaches.²

! BOTTOM LINE ASSESSMENT

Ethiopia's collaborative campaigns demonstrate growing financial pooling and improved efficiency, but the financing model remains donor-heavy and structurally fragmented. While integration has optimized resource use, long-term sustainability will depend on strengthening domestic financing and improving alignment across funding streams.



To what extent have data systems and/or data use practices been modified to monitor the impact of collaborative campaigns?

Data systems and data use practices in Ethiopia have undergone a substantial transformation under the CAS, shifting from fragmented, program-specific reporting toward more integrated, digital, and real-time monitoring systems. These changes have not only modernized data infrastructure but also fundamentally altered how data is used by moving from retrospective reporting to adaptive, real-time decision-making during campaign implementation.

- 1. SHIFT FROM FRAGMENTED PAPER SYSTEMS TO INTEGRATED DIGITAL PLATFORMS.** Prior to the CAS, campaign data was largely siloed by disease program and captured through manual, paper-based tools with limited interoperability.² Post-CAS, Ethiopia institutionalized digital data collection and integration, including deployment of the DHIS2 Campaign Tracker as a unified monitoring backbone and transition to ODK for house-to-house digital data entry.²
- 2. EMERGENCE OF UNIFIED REPORTING AND VISUALIZATION PLATFORMS.** Integration extended beyond data capture to harmonized reporting and visualization.² Multi-program dashboards were developed using tools such as harmonized Google Sheets trackers and Power BI dashboards for real-time monitoring.²
- 3. SHIFT FROM RETROSPECTIVE REPORTING TO REAL-TIME ADAPTIVE DATA USE.** Perhaps the most significant shift has been in how data is used, not just how it is collected.² Data practices evolved from end-of-campaign reporting to real-time operational decision-making, including daily meetings where regional leaders reviewed evening data snapshots for the next day, as well as field-level data validation huddles, where supervisors reconciled data across programs before digital upload.² These practices reflect a shift toward adaptive management, enabled by integrated data flows.
- 4. IMPROVEMENTS IN CROSS-PROGRAM MONITORING AND LEARNING.** Integrated tools enabled simultaneous tracking of multiple interventions, improving visibility into campaign performance across domains.² Harmonized dashboards supported cross-program comparisons and more holistic performance monitoring.² These changes strengthened real-time troubleshooting and supported learning across integrated delivery platforms.²
- 5. PERSISTENT CHALLENGES AND LIMITATIONS.** Despite clear progress, several constraints remain, including a) digital infrastructure gaps where connectivity and power limitations in remote kebeles delay real-time reporting and dashboard updates²; b) discrepancies between DHIS2 and parallel reporting platforms^{1,2}; and c) system harmonization gaps resulting from the continued use of multiple tools and population estimates that limit full integration.^{1,2}

! BOTTOM LINE ASSESSMENT

Overall, Ethiopia has made substantial progress in transforming both data systems and data use practices to support collaborative campaigns. The shift toward integrated digital tools and real-time decision-making represents a meaningful step toward more adaptive and coordinated campaign management. However, the full potential of these advances will depend on addressing infrastructure constraints in remote areas and further harmonizing population denominators and reporting platforms to ensure consistent, fully integrated monitoring across programs.



What specific changes in policies or practices have resulted from CAS learnings, and how have they improved program adaptation?

Ethiopia’s implementation of the E-CAS has generated clear policy and operational adaptations, with learnings from the 2025–2026 integrated campaigns actively shaping governance, delivery models, workforce practices, data systems, and financing approaches.^{1,2} While full institutionalization remains in progress, CAS learnings are already influencing how campaigns are designed, coordinated, and embedded within the national health system.²

Policy-level changes and institutional shifts

ALIGNMENT WITH NATIONAL HEALTH STRATEGIES. E-CAS was intentionally designed to align with major national frameworks, including the Health Sector Transformation Plans, national NTD and malaria strategies, and UHC goals.¹ This positioned integration as a vehicle for health system reform rather than a standalone campaign innovation.²

FORMAL NATIONAL ENDORSEMENT WITH EVOLVING INSTITUTIONALIZATION. The MoH has formally adopted E-CAS at national level.¹ A national campaign financing policy brief was drafted to guide pooled and equitable campaign financing.⁶

Governance and coordination practice changes

CREATION OF MULTI-TIER GOVERNANCE STRUCTURES. Establishment of a NSC and TWGs formalized cross-program coordination.¹ These structures enabled joint planning across historically siloed programs.²

STRONGER CROSS-PROGRAM DECISION-MAKING PLATFORMS. Joint TWGs fostered integrated microplanning, financing discussions, and MERLA coordination.¹ Governance structures strengthened political ownership and cross-sector collaboration.^{1,2}

MOVEMENT TOWARD FORMALIZED COORDINATION BODIES. Post-pilot learning emphasized formalizing cross-campaign coordination bodies and TORs to sustain integration.²

Operational and delivery model adaptations

SHIFT TOWARD BUNDLED SERVICE DELIVERY MODELS. Campaigns transitioned from vertical delivery to integrated “one-stop-shop” models delivering multiple interventions in a single visit.^{1,3}

INTEGRATION ACROSS THE CAMPAIGN LIFECYCLE. Adaptations included joint scheduling, shared logistics, harmonized readiness assessments, and integrated supervision²



Banner at the launch event for the Ethiopia Federal Ministry of Health integrated campaign in May 2025. Photo Credit: Ethiopia Federal Ministry of Health



Health system and workforce practice changes

STRONGER REFERRAL INTEGRATION WITH ROUTINE CARE. Campaigns introduced structured referral mechanisms to link outreach with facility-based care.³

DIGITAL PAYMENTS AND WORKFORCE MANAGEMENT IMPROVEMENTS. Transition to digital payment systems and consolidated campaign windows improved transparency and efficiency of frontline compensation.²

MULTI-SKILLING AND TASK-SHIFTING MODELS. Health Extension Professionals and Community Drug Distributors received cross-program training and on-the-job mentorship.^{1,2} Task-shifting strategies (e.g., community volunteers) were introduced to manage workload intensity.^{1,2}

Financing and implementation practice changes

MOVEMENT TOWARD POOLED AND INTEGRATED FINANCING. Integrated campaigns pooled donor, government, and partner resources into shared delivery platforms.^{2,6}

OPERATIONAL EFFICIENCY GAINS FROM BUNDLED DELIVERY. Joint logistics, unified deployment windows, and consolidated per diem models demonstrated strong economies of scale.¹

INCREASED FOCUS ON FINANCING REFORM. CAS implementation surfaced the need for unified financing frameworks and stronger domestic co-financing.^{2,6}

! BOTTOM LINE ASSESSMENT

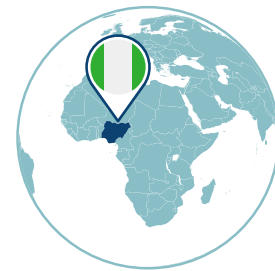
In Ethiopia, CAS implementation has catalyzed substantive shifts in both policy direction and operational practice, even as full institutionalization remains underway. The most significant adaptations include alignment with national reform agendas, establishment of cross-program governance structures, adoption of integrated delivery and data systems, and increased linkage between campaigns and routine care. Collectively, these changes demonstrate that the CAS is already reshaping campaigns into more adaptive, integrated, and system-oriented platforms.



Healthcare workers collaborating on campaign delivery during Ethiopia's integrated campaign in May 2025. Photo Credit: Ethiopia Federal Ministry of Health

COUNTRY LEVEL EVALUATION FINDINGS:

Nigeria



What is the “big picture” story of CAS implementation in Nigeria across operations, impact, and systems?

1. Integration is operationally feasible & highly effective.

The pilot proved that cross-domain integration can be executed without compromising campaign performance.^{7,8} Preliminary coverage targets were largely met or exceeded across all domains: MR (113%), polio (116%), NTDs (>80%), and seasonal malaria chemoprevention (SMC) (87%).⁹ Bundling services also expanded reach to adults and older children, significantly boosting community acceptance.¹⁰

2. Measurable cost savings and efficiency gains.

Delivering multiple interventions simultaneously resulted in tangible financial efficiency.^{7,8} Preliminary data indicates the integration of polio and non-polio Supplemental Immunization Activity (SIA) budgets generated over USD\$4.18 million in savings compared to standalone efforts, reducing the delivery cost per child by 23% (from \$0.30 to \$0.23).^{7,9,11}

3. Strong political leadership & SWAp alignment.

A major driver of success was the unprecedented commitment from top leadership.^{4,10} The Nigeria Collaborative Action Strategy (N-CAS) was effectively anchored to Nigeria’s Health Sector Renewal Investment Initiative, being delivered through of the Sector-Wide Approach (SWAp). This allowed the Federal Ministry of Health and Social Welfare (FMOHSW) and the National Primary Health Care Development Agency (NPHCDA) to enforce traditionally siloed departments to collaborate, thereby strengthening and institutionalizing systems towards effective and efficient delivery of campaigns.^{4,9}

4. Navigating differing delivery strategies.

Integrating with the pre-planned polio/MR campaign meant NTD and malaria programs navigated compressed timelines for joint microplanning.⁸ While this initially surfaced operational differences, such as fixed-post versus house-to-house delivery, field teams demonstrated strong adaptive management, making real-time adjustments to team structures to successfully hit NTD coverage goals.¹⁰

5. Integration is a systems challenge, not just technical.

Field-level coordination demonstrated immense potential, but the pilots highlighted the need for deep structural harmonization.⁸ Addressing fragmented financing streams, reconciling disparate data tools (e.g., digital checklists vs. paper biodata registers), and aligning conflicting population denominators (e.g., a 3.3% immunization growth rate vs. 2.5% for NTDs) are essential steps to reduce administrative burdens before scaling nationally.^{8,10}

6. Pooled financing shows promise, but incentives require better alignment.

While pooled national funding reduced administrative duplication, fragmented donor streams created friction at community level.^{8,10} Within house-to-house sweep teams, NTD Community Drug Deliverers carried heavier workloads (broader population targets and extensive documentation) compared to polio vaccinators using rapid tallies, yet stipends and transport allowances remained disease-specific and unaligned.⁸



How was the CAS implemented in Nigeria?

The Nigeria Collaborative Action Strategy (N-CAS) was implemented through a phased, highly contextualized national approach that combined strong federal leadership with state-level customization. Their approach demonstrated strong feasibility and political ownership, though institutionalization remains in transition, with deeper policy embedding and subnational adoption still evolving.

- 1. PHASED NATIONAL ROLLOUT ANCHORED IN STRONG GOVERNANCE.** CAS implementation in Nigeria followed a stepwise institutional pathway. During the conceptualization phase (2024), FMoHSW and NPHCDA established an N-CAS Core Task Team to co-create the national implementation framework and design the pilot strategy across disease programs.⁸ During the institutionalization phase (2025), a formal National TWG was launched, co-chaired by the Director of Public Health (DPH) of FMoHSW and the Executive Director (ED) of the NPHCDA.^{8,9} This phased approach enabled the CAS to transition from concept to operational pilot while maintaining strong political ownership.
- 2. INTEGRATION EMBEDDED WITHIN NATIONAL HEALTH REFORM PRIORITIES.** Nigeria did not treat the CAS as a standalone initiative but aligned it with broader national strategies, including SWAp's delivery of the Nigeria Health Sector Renewal Investment Initiative.^{4,9} Positioning the CAS within these frameworks helped legitimize integration as a system-strengthening reform and provided a platform for resource pooling and cross-program collaboration.^{4,9}
- 3. STATE-LEVEL PILOT IMPLEMENTATION USING EXISTING CAMPAIGN PLATFORMS.** The CAS was operationalized through multi-state pilots integrated into existing campaigns rather than launching entirely new delivery platforms. The pilots integrated up to five health domains: MR, polio, routine immunization, NTDs, and malaria.⁸ Implementation occurred across four pilot states: Kano, Oyo, Yobe, and Akwa Ibom.⁸ Integration spanned multiple stages of the campaign lifecycle, including joint microplanning, shared training and supervision, integrated delivery teams, and unified daily monitoring systems.^{8,10} This approach allowed Nigeria to test CAS feasibility within real delivery environments.¹⁰
- 4. CONTEXTUAL ADAPTATION AND STATE CUSTOMIZATION.** A defining feature of Nigeria's implementation was intentional customization to local contexts. Each state tailored integrated packages based on disease burden and operational realities (e.g., onchocerciasis integration in Kano, school-based delivery models in Akwa Ibom).⁸ Operational models were adapted, including expanded integrated teams and context-specific delivery approaches.⁸ This flexible approach reflected recognition that a single integration model would not work across Nigeria's diverse settings.¹⁰
- 5. INCREMENTAL INSTITUTIONALIZATION WITHIN POLICIES AND SYSTEMS.** CAS institutionalization is ongoing but incomplete. Elements of the CAS have been incorporated into national operational plans and NPHCDA systems, and policy integration is occurring gradually as existing guidelines are revised.¹² However, subnational policy adoption remains nascent, with many states noting it is too early to see the CAS reflected in formal policies.¹²
- 6. REAL-TIME COORDINATION AND ADAPTIVE IMPLEMENTATION.** Implementation was supported by strong accountability and adaptive management mechanisms, including daily review meetings across national, state, and local government area (LGA) levels, real-time monitoring and rapid course correction using integrated data tools, and non-compliance resolution teams to address community resistance.^{11,13} These mechanisms enabled iterative refinement during implementation.



Healthcare workers in Kano State, Nigeria, co-deliver polio vaccine and ivermectin during the integrated campaign in October 2025. Photo Credit: Prof. Yahaya Mohammed



Figure 2: Implementation Status of CAS Recommendations in Nigeria

Planning & Implementation		
Rec #1a	Establish multi-sectoral, cross-campaign National Coordination Body to oversee CAS activities	Implemented
Rec #1b	Identify campaigns for collaboration and integration (including plan to transition them to the PHC system)	Implemented
Rec #1c	Develop a multi-year, cross-campaign workplan and schedule for campaigns	In Progress
Rec #1d	Harmonize tools and operations (e.g., logistics, supply chain, microplanning) across campaigns	In Progress
Rec #1e	Develop a coordinated and effective approach to enable active community engagement at all levels and phases	Not Yet Started
M&E/MERLA		
Rec #2a	Develop a coordinated and collaborative cross-campaign MERLA strategy in Nigeria	In Progress
Rec #2b	Aligned with the coordinated country MERLA strategy, improve the ability of campaign implementers and partners to identify, measure, utilize and share data on campaign effectiveness	In Progress
Campaign Financing		
Rec #3a	Create a comprehensive view of campaign financing at the country level	Implemented
Rec #3b	Take incremental steps toward harmonizing and aligning campaign financing	In Progress
Rec #3c	Harmonize and align incentive payment modalities and rates across campaigns	Not Yet Started
Rec #3d	Advance government role in campaign financing – gradually transition campaigns into the PHC system	Not Yet Started



To what extent are national governance structures effectively facilitating CAS implementation in Nigeria?

Nigeria's national governance structures have been highly effective in driving high-level political commitment and establishing the institutional framework for N-CAS implementation, supported by strong federal leadership and structured coordination mechanisms.^{4,8} At the same time, governance effectiveness has been uneven, with limitations related to late engagement of some programs, inconsistent coordination, and variable subnational cascading.⁸

✓ What's working?

1. PHASED GOVERNANCE AND STRONG

INSTITUTIONAL LEADERSHIP. Nigeria adopted a phased governance model, beginning with the establishment of a Core Task Team in 2024 to co-create the national CAS framework and operationalize the pilot approach across programs. Subsequently, a formal National TWG launched in December 2025 and co-chaired by senior federal leaders (DPH FMOHSW and ED NPHCDA), reinforcing political ownership and institutional legitimacy.^{8,9} The Core Task Team functioned with clear TORs and frequent coordination meetings, increasing intensity as campaigns approached.^{7,8}

2. CLEAR LEADERSHIP AND POLITICAL COMMITMENT.

Strong endorsement from federal leadership (including the Ministry of Health and NPHCDA leadership) helped drive cross-program collaboration.⁴ Stakeholders highlighted cascading commitment from national to community levels as a key enabler of integration.

3. STRATEGIC ALIGNMENT WITH NATIONAL HEALTH

REFORMS. Governance structures embedded the N-CAS within broader national priorities, including the Nigeria Health Sector Renewal Investment Initiative being implemented through the SWAp.^{4,9} This alignment positioned the N-CAS as a system reform and provided a vehicle for cross-program collaboration and resource pooling.⁴

4. CROSS-PROGRAM COORDINATION AND ACCOUNTABILITY MECHANISMS.

Governance platforms successfully brought together historically siloed programs (immunization, NTDs, malaria) for joint planning and coordination.⁸ Daily multi-level review meetings created strong accountability loops and enabled rapid problem-solving during implementation.^{9,11} Governance structures also enabled innovations such as non-compliance resolution teams involving traditional and community leaders.^{9,14}

5. INSTITUTIONAL MOMENTUM TOWARD

INTEGRATION. CAS principles are beginning to be incorporated into national operational plans and policy cycles, with gradual institutionalization underway.¹²



Samira Muhammad, a teacher from Madobi LGA, Kano State, Nigeria, with her child. She described how she and her family benefited from the integrated health campaign in October 2025, and encourages continued integration in future campaigns. Photo Credit: Destiny Chukwu



✕ What's limiting effectiveness?

- 1. SUBNATIONAL READINESS CHALLENGES.** While the decision to leverage the polio/MR campaign as the N-CAS pilot was jointly agreed at the national level, in some states, delayed responsiveness from non-immunization partners limited early input into microplanning, contributing to target misalignment and constraining full integration.^{7,8}
- 2. INCONSISTENT ATTENDANCE, MITIGATED BY STRONG INFORMAL COMMUNICATION.** Although weekly N-CAS coordination meetings experienced inconsistent attendance from some focal persons and partners, the creation and active use of N-CAS Task Team WhatsApp groups proved vital in closing communication gaps.^{7,8} These daily exchanges helped maintain alignment, accelerate decision-making, and address bottlenecks at both national and state levels.⁸
- 3. SUBNATIONAL COORDINATION GAPS, ADDRESSED DURING IMPLEMENTATION.** In states such as Oyo and Yobe, early coordination gaps between state and LGA teams led to inconsistent messaging and parallel engagement.⁸ Daily review meetings and active support from national N-CAS leads helped restore alignment and reinforce collaborative implementation.⁸
- 4. EARLY-STAGE INSTITUTIONALIZATION.** While strategically aligned at national level, formal policy embedding is still evolving.¹² State-level respondents noted limited evidence of the CAS reflected in formal policies at subnational levels.¹²



Students in a school in Dambatta LGA, Kano State, Nigeria, proudly display their vaccination cards after participating in the integrated campaign in October 2025. Photo Credit: Zaiyanatu Abubakar Umar

! BOTTOM LINE ASSESSMENT

Nigeria's governance structures have been highly effective in catalyzing and legitimizing CAS implementation at the national level, particularly through strong leadership, phased institutional development, and robust accountability mechanisms. However, governance effectiveness remains uneven across programs and levels of the system, with late stakeholder engagement and incomplete subnational cascading limiting full realization of integration. Continued progress will likely depend on earlier multi-program alignment and deeper institutionalization of governance structures across federal and state levels.



How effectively are focus countries integrating multiple health campaigns, and what challenges or successes have emerged?

Nigeria's pilot implementation demonstrates that multi-domain campaign integration is operationally feasible and moderately strong, with evidence of high coverage, efficiency gains, and operational learning across diverse contexts.⁸ Integration was implemented across multiple stages of the campaign lifecycle (e.g., joint microplanning, shared supervision structures, integrated delivery teams, and unified monitoring platforms) reflecting a deliberate effort to move beyond co-scheduling toward more functional integration.^{7,8} The pilots successfully demonstrated that multiple interventions (e.g., immunization, NTDs, malaria) could be delivered simultaneously without compromising performance outcomes.⁸

However, the depth of integration varied across domains and locations. In several cases, harmonization remained stronger at the coordination and monitoring levels than at the point of service delivery, where differences in delivery models, documentation requirements, and pacing created operational friction.⁸ Delayed responsiveness of some state non-immunization partners also limited early alignment around microplanning and denominators.^{7,11} As a result, while Nigeria's experience provides strong proof of feasibility and value, it also highlights that integration maturity remains uneven and continues to evolve through iterative implementation and learning.⁸

Key Successes

- 1. HIGH COVERAGE ACROSS MULTIPLE HEALTH DOMAINS.** Integrated campaigns achieved strong performance across programs, including high MR and polio coverage and >80% NTD coverage across pilot states.⁹ Integration did not compromise performance and enabled simultaneous delivery of multiple services.⁸
- 2. COST SAVINGS AND EFFICIENCY GAINS.** Integration of polio and non-polio campaign activities generated significant financial savings (e.g., approximately \$4.2M USD compared to standalone campaigns).^{7,9} Cost per child vaccinated declined, and delivery windows were compressed into shorter integrated campaigns.⁷
- 3. IMPROVED COMMUNITY ACCEPTANCE AND DEMAND.** The “one-stop-shop” model reduced community fatigue and increased satisfaction.⁸ Highly valued interventions (e.g., NTD medicines) created a spillover effect that boosted vaccine acceptance.⁸
- 4. DIGITAL INTEGRATION, SHARED LEARNING AND ADAPTIVE MANAGEMENT.** Learning across programs also supported adaptive management. NTD programs adopted daily implementation plans (DIPs) from immunization programs to guide adjustments during campaign implementation and began institutionalizing their use, including in standalone campaigns.^{7,11}
- 5. CUSTOMIZATION TO LOCAL CONTEXTS.** Integration packages were tailored by state based on disease burden and delivery models (e.g., school-based models, security adaptations).⁸ This flexibility helped demonstrate feasibility across diverse contexts.



Key Challenges

- 1. OPERATIONAL AND PACING INCOMPATIBILITIES ACROSS PROGRAMS.** Differences in delivery models created friction (e.g., rapid immunization workflows vs. slower NTD biodata documentation).⁸ This pacing mismatch often caused teams to split up or leave the NTD workers trailing far behind.¹⁰ Timing mismatches sometimes reduced coverage or required mop-up activities.⁸
- 2. SUBNATIONAL RESPONSIVENESS CHALLENGES.** Despite national alignment, delayed response from some state non-immunization partners, who did not initially see N-CAS as applicable, limited early microplanning input and contributed to target misalignment and constrained integration.⁸
- 3. FRAGMENTED FINANCING AND INCENTIVE MISALIGNMENT.** Incomplete pooling of funding streams resulted in uneven incentives and compensation across programs.⁸ This created friction and trust challenges among frontline teams.
- 4. FRONTLINE WORKFORCE STRAIN.** Expanded integrated teams faced heavy workloads, clinical fatigue, and role confusion.^{8,10} Pacing differences and expanded responsibilities added operational pressure.^{8,10}
- 5. COORDINATION CHALLENGES IN SPECIFIC DELIVERY MODELS.** School-based delivery models exposed coordination gaps between teachers and health workers.¹⁰ Because communication was unclear, teachers frequently administered the NTD drugs before the vaccination teams arrived, breaking the synchronized “one-stop-shop” delivery model.^{8,10} Data reporting inconsistencies and synchronization issues emerged in some contexts.¹⁰

BOTTOM LINE ASSESSMENT

Nigeria demonstrates moderate-to-strong integration effectiveness, with clear evidence that multi-domain campaigns can achieve high coverage and efficiency gains without compromising performance. However, integration depth remains uneven, with operational complexity, financing fragmentation, and late cross-program alignment limiting full harmonization. Continued progress will depend on earlier stakeholder engagement, deeper financing integration, and stronger frontline coordination mechanisms.



What improvements in campaign coverage, quality, efficiency, equity, and/or acceptance resulted from CAS implementation?

Evidence from Nigeria's implementation of the N-CAS indicates substantial early gains across multiple dimensions of campaign effectiveness, including coverage, operational efficiency, real-time performance management, equity of reach, and community acceptance.⁸ However, while population-level gains were clear, findings related to the campaign workforce experience reveal a more mixed picture, particularly regarding fairness and equity of compensation across integrated delivery platforms.^{8,12}

Coverage

STRONG MULTI-DOMAIN COVERAGE OUTCOMES.

N-CAS pilot LGAs achieved high coverage across multiple programs simultaneously, including approximately 99% MR coverage and 116% polio coverage.^{7,16} Three of the four pilot states met >80% coverage targets for NTDs (e.g., 106% onchocerciasis in Kano; 108% trachoma in Yobe; 84% lymphatic filariasis in Oyo; 60% soil-transmitted helminths [STH] in Akwa Ibom*).^{9,16} SMC targets were also achieved (e.g., 87% coverage in Yobe).⁹

The coverage results demonstrate strong implementation performance across multiple domains; however, figures exceeding 100% should be interpreted cautiously. These results may reflect denominator limitations or differences in population estimates across programs, reinforcing the importance of harmonizing target populations during joint microplanning and strengthening data validation during and after implementation.

ROUTINE IMMUNIZATION BOOST. Collaborative campaigns supported routine health service delivery rather than bypassing it. By integrating RI catch-up into the campaign, Nigeria reached over 55,000 zero-dose children, over 50,000 under-immunized children, and vaccinated over 116,000 girls against human papilloma virus across the four CAS pilot states.^{7,9,16}

Efficiency

SIGNIFICANT FINANCIAL SAVINGS. Integrated MR-polio delivery generated more than \$4.18M USD in savings compared to standalone campaigns.^{7,9} Cost per child vaccinated declined by approximately 23%.^{7,9}

OPERATIONAL EFFICIENCIES AND TIME SAVINGS.

Multiple campaigns were consolidated into an approximately 10-day delivery window (plus short mop-up periods), replacing months of vertical campaigns.¹⁰ Shared teams and logistics improved cost-efficiency and reduced duplication.⁸

Equity

EXPANDED REACH TO UNDERSERVED POPULATIONS.

Integration extended services beyond children to adolescents and adults through NTD interventions.¹⁰ Joint microplanning helped identify previously unmapped populations (e.g., newly identified schools in Akwa Ibom).¹⁰

IMPROVED SYSTEM VISIBILITY. Cross-program data sharing improved understanding of population coverage gaps and expanded the health system's known reach.⁸

GEOGRAPHIC REACH OF SETTLEMENTS. The settlement coverage achieved in the N-CAS pilot states suggests meaningful progress toward equitable reach, while also underscoring the continued need to strengthen microplanning, settlement mapping, and last-mile delivery to fully realize the "leave no one behind" principle of integrated campaigns. Across the four N-CAS pilot states, campaigns reached a large proportion of known settlements: 75% of settlements in Kano (28,735 total), 91% in Yobe (5,923 total), 85% in Oyo (11,259 total), and 93% in Akwa Ibom (3,163 total).¹⁶ While these results demonstrate substantial geographic reach and reflect improvements in joint planning and mapping across programs, they also highlight a remaining equity gap.

*The WHO has established a target to achieve and sustain a minimum of 75% coverage with preventive chemotherapy for STH in preschool children and school-aged children in all endemic countries, such as Nigeria.





Community Acceptance

REDUCED CAMPAIGN FATIGUE. The “one-stop-shop” model reduced the burden of repeated health worker visits and disruptions to schools and communities.^{8,10}

POSITIVE SPILLOVER EFFECTS ON VACCINE ACCEPTANCE. Highly valued NTD medicines acted as a “pull factor,” increasing acceptance of MR and polio vaccines in previously hesitant communities.^{8,10}

Health Campaign Worker Experience

IMPROVED PAYMENT TRANSPARENCY. Digital transfers improved traceability, accountability, and clarity around compensation processes.¹²

GREATER WITHIN-PROGRAM HARMONIZATION. The immunization program introduced more standardized compensation across platforms (e.g., alignment of polio and MR payment structures), reducing inconsistencies within programs.^{8,12}

CLEARER COMMUNICATION OF COMPENSATION EXPECTATIONS. Campaign workers were more consistently informed of payment benchmarks and modalities prior to implementation, improving predictability and transparency.^{8,12}

Quality and Health System Outcomes

STRONGER REAL-TIME PERFORMANCE MANAGEMENT. Daily review mechanisms enabled rapid stock redistribution and operational course correction.⁸ Integrated campaigns demonstrated agile logistics management (e.g., rapid redistribution of MR vaccines during stockouts).⁷

ENHANCED SURVEILLANCE AND ACCOUNTABILITY. Integrated outreach enabled active surveillance, including identification of acute flaccid paralysis (AFP) cases and tracking of adverse events following immunization (AEFIs).^{7,13} non-compliance resolution teams resolved approximately 85% of non-compliance cases, improving accountability and responsiveness in Phase One.⁷

IMPROVED SYSTEM ADAPTABILITY AND COORDINATION. Integration supported routine immunization, enhanced surveillance, and expanded population registries.^{14,15} Consolidating campaigns reduced cumulative workforce disruptions and improved system resilience.^{14,15}



Zaiyanatu Abubakar Umar, N-CAS Focal Point, Federal Ministry of Health and Social Welfare at the Joint Annual Review in November 2025 holds a printed copy of the N-CAS following its launch. Photo Credit: Kris Saarlus

! BOTTOM LINE ASSESSMENT

Nigeria’s experience suggests that CAS implementation has delivered clear early improvements in coverage, efficiency, operational coordination, equity of reach, and community acceptance. However, these gains are not uniformly distributed across stakeholders. While population-level outcomes are strongly positive, the campaign workforce experience reveals persistent inequities in compensation, delayed payments, and fragmented incentive structures. Sustaining integrated campaigns will require not only continued operational alignment, but also harmonized and equitable compensation frameworks to ensure fairness, morale, and long-term sustainability of collaborative delivery models.



How are domestic and donor funds allocated to support collaborative campaigns?

Nigeria's experience suggests that resource allocation for collaborative campaigns is in a transitional phase, with early progress toward pooled financing at national level but continued fragmentation across donor streams and programs.⁸ While some national co-financing and pooling mechanisms are emerging, funding flows remain partially siloed and inconsistently integrated at subnational levels.¹²

Emerging Strengths in Resource Pooling

INITIAL NATIONAL-LEVEL POOLING MECHANISMS.

The NPHCDA successfully pooled funding across major campaigns (e.g., polio and MR), creating integrated budgets and reducing duplication.^{7,8}

DOMESTIC COUNTERPART FUNDING CONTRIBUTIONS.

Both national and state governments contributed counterpart funding, indicating shared ownership of collaborative campaigns.⁷ Stakeholders reported growing expectations for domestic co-financing, even though visibility into proportions remains limited.¹²

MOMENTUM TOWARD UNIFIED FINANCING

APPROACHES. Stakeholders increasingly advocate for a single “basket of funding” model to streamline funding requests and reduce campaign fragmentation.^{8,12}

Persistent Fragmentation Across Funding Streams

SILOED DONOR FINANCING STRUCTURES. Donor funding remains largely program-specific, with separate stewardship across disease domains.¹² This fragmentation creates operational inconsistencies (e.g., uneven allowances, differing training provisions across programs).^{10,12}

INCOMPLETE FINANCIAL INTEGRATION AT

IMPLEMENTATION LEVEL. Even where national pooling exists, financing is not fully integrated at the community level, leading to unequal resource distribution across teams.⁸

LOGISTICS FUNDING IMBALANCES. In some states, logistics funding was skewed toward immunization, limiting resources available to other programs (e.g., NTD supervision and reporting).¹⁰

Operational Constraints and Financing Bottlenecks

DELAYED BUDGET HARMONIZATION AND APPROVALS.

Integrating budgets exposed coordination challenges, with late approvals compressing timelines and affecting subnational readiness.^{7,11}

WEAK OR DELAYED COUNTERPART FUNDING. In some states, delayed or incomplete domestic contributions limited local ownership and readiness.⁷

IMPLEMENTATION STRAIN FROM FRAGMENTED FINANCING. Misaligned donor policies and delayed disbursements contributed to frontline operational challenges and inequities.^{7,10,11}

BOTTOM LINE ASSESSMENT

Nigeria demonstrates early but incomplete progress toward pooled financing for collaborative campaigns. While national-level pooling (particularly across immunization platforms) has shown clear efficiency gains, deeper financial integration across all programs and donors remains limited. Achieving sustainable collaborative financing will likely require multi-donor pooled funding mechanisms, stronger domestic co-financing, and earlier alignment across federal and state financing actors.



To what extent have data systems and/or data use practices been modified to monitor the impact of collaborative campaigns?

Nigeria has made substantial progress in modifying both data systems and data use practices to support collaborative campaigns. The transition reflects a shift from historically siloed reporting toward more harmonized, digital, and real-time monitoring platforms.⁸ While integration is strong at the dashboard and management levels, harmonization remains incomplete at the frontline data collection level.⁸

Modifications to data systems and tools

HARMONIZED MONITORING TOOLS ACROSS PROGRAMS. Existing monitoring and evaluation (M&E) tools (e.g., readiness dashboards and supervisory checklists) were modified to include components from multiple integrated programs.^{7,8}

INTEGRATED CALL-IN DATA SYSTEMS. Daily call-in templates were harmonized to capture performance across multiple domains (e.g., MR, polio, NTDs) in a single reporting structure.¹⁰ This multi-domain reporting format was noted as a first-of-its-kind achievement.¹⁰

PILOTING INTEGRATED DIGITAL PLATFORMS. Kano piloted the DIGIT HCM platform, creating a reusable population registry, an agreed-upon dataset that everyone could use to decide who to reach and where, and unified real-time dashboards across programs.^{8,15}

Modifications to data use practices

REAL-TIME ADAPTIVE DATA USE. Integrated dashboards supported daily Evening Review Meetings (ERMs) at national and state levels.⁷ Supervisors used real-time data to identify discrepancies (e.g., under-reporting or data anomalies) and rapidly reallocate resources.^{11,14}

SHIFT FROM RETROSPECTIVE REPORTING TO ACTIVE PERFORMANCE MANAGEMENT. NTD data was increasingly used during implementation for course correction rather than solely for post-campaign reporting.^{8,15}

Persistent challenges and limitations

CONFLICTING DENOMINATORS ACROSS PROGRAMS. Differences in population estimates (e.g., NTD vs immunization growth rates) complicated joint planning and coverage interpretation.^{8,10}

FRONTLINE DATA COLLECTION INCOMPATIBILITIES. NTD programs required detailed biodata registers, while immunization teams used rapid tally sheets, creating reporting friction.^{8,10}

REPORTING FREQUENCY MISMATCHES. In school-based delivery models, teachers reported data at campaign end, conflicting with daily reporting expectations.¹⁰

REFERRAL TRACKING LIMITATIONS. Integrated tools lacked built-in mechanisms to track referral coupons, requiring manual triangulation.¹⁰

! BOTTOM LINE ASSESSMENT

Nigeria has made meaningful progress in modernizing data systems and data use practices to support collaborative campaigns, particularly through harmonized dashboards, integrated reporting templates, and real-time decision-making platforms. However, integration remains uneven across levels of the system. While management-level data integration is strong, frontline tool incompatibilities and denominator inconsistencies continue to limit full harmonization. Future gains will depend on aligning frontline data tools, standardizing denominators, and embedding integrated reporting workflows across all programs.



What specific changes in policies or practices have resulted from CAS learnings, and how have they improved program adaptation?

Ethiopia's implementation of the E-CAS has generated clear policy and operational adaptations, with learnings from the 2025–2026 integrated campaigns actively shaping governance, delivery models, workforce practices, data systems, and financing approaches.^{1,2} While full institutionalization remains in progress, CAS learnings are already influencing how campaigns are designed, coordinated, and embedded within the national health system.²

Operational and delivery model adaptations

STATE-SPECIFIC CUSTOMIZATION OF INTEGRATION MODELS. Campaign packages were tailored by state based on disease burden and context (e.g., school-based delivery in Akwa Ibom, security-adapted microplans in Yobe).⁸

ADAPTIVE MOP-UPS: Differing operational speeds across interventions required flexible mop-up strategies. In Kano, a 5-day NTD mop-up followed the main campaign due to slower NTD biodata capture, while in Akwa Ibom, a 2-day NTD-specific mop-up addressed low coverage where NTD activities outpaced MR teams.^{8,15} These adjustments enabled programs to meet targets without slowing parallel interventions.^{8,15}

EXPANDED AND RESTRUCTURED FRONTLINE TEAMS. Integrated teams were scaled up and reconfigured to handle multiple interventions simultaneously.^{8,10}

JOINT TRAINING AND DAILY REFRESHERS: Frontline workers received joint training on multiple antigens and NTD protocols; where large class sizes limited retention, supervisors provided early-morning refreshers and on-the-job coaching.^{8,14} In Akwa Ibom, a tailored standard operating procedure was developed to strengthen ward-level integrated coordination.¹⁰

Data and learning practice changes

TRANSITION TO INTEGRATED DATA PLATFORMS. Monitoring tools (ODK, dashboards) were modified to capture multi-program performance.^{7,8} Pilots like DIGIT HCM introduced unified population registries and shared dashboards.^{8,15}

SHIFT TOWARD REAL-TIME ADAPTIVE MANAGEMENT. Data began to be used actively during campaigns to guide rapid decision-making and logistics adjustments.^{8,15}

Financing and implementation practice changes

EARLY MOVES TOWARD POOLED FINANCING APPROACHES. Initial examples of budget pooling (e.g., MR and polio) demonstrated feasibility of integrated financing models.^{7,8}

INCREASED ATTENTION TO FINANCING HARMONIZATION. CAS implementation surfaced the need for unified funding baskets and harmonized payment structures.⁸

! BOTTOM LINE ASSESSMENT

CAS implementation in Nigeria has catalyzed meaningful shifts in both policy direction and operational practice, even while formal institutionalization remains in progress. The most significant adaptations include integration of campaigns into national reform agendas, creation of cross-program governance structures, adoption of real-time learning mechanisms, and increasing customization of delivery models. Together, these changes demonstrate that CAS has begun to reshape campaigns into more adaptive, data-driven, and context-responsive platforms.



Child receives vaccination in Akwa Ibom State, Nigeria, during the integrated campaign in February 2026. Photo Credit: Destiny Chukwu

GLOBAL AND REGIONAL FINDINGS

To what extent have global health funders and partners updated their guidelines and policies for countries to align with CAS recommendations?

At the global and regional level, the CAS aims to catalyze shifts in how global health funders and partners design campaigns, allocate resources, and support countries, particularly by promoting integration, flexibility, and coordinated planning. Evidence from key informant interviews (KIIs) and situational analysis suggests meaningful directional progress, though structural alignment remains incomplete.

1. Recognition that current funding and campaign models reinforce silos.

Interviewees widely acknowledged that traditional donor funding structures reinforce vertical program implementation, limiting opportunities for collaboration.¹⁷ At the same time, shrinking global health financing and rising campaign costs are creating stronger incentives for efficiency and integration. The broader situational analysis reinforces this trend, highlighting continued fragmentation across hundreds of campaigns annually, and growing urgency to optimize delivery in a contracting financing environment.¹⁸

2. Movement toward more flexible and integration-oriented funding guidance.

Several major funders have begun introducing policies and guidance that enable more integrated approaches.¹⁷ For example, Gavi 6.0, the organization's current five-year strategy from 2026-2030, has introduced co-delivery models (e.g., MR + yellow fever) and encourages single, multi-year applications that support bundled delivery and country-led prioritization and their guidance increasingly promotes integration as a planning norm rather than an exception. In addition, The Global Fund's GC8 guidance similarly encourages optimization of available resources, including integration and coordination across disease platforms. These shifts reflect a broader ecosystem trend toward country ownership, integration, and optimized use

 of funds.

3. Expansion of integration-oriented technical guidance and norms.

Technical agencies are also adapting guidance to reflect integration principles.¹⁷ For example, WHO has issued new guidance on integrated health campaigns and established task forces and working groups focused on integration and coordination. WHO and UNICEF are advancing implementation guidance that supports harmonized monitoring and planning approaches. These efforts reflect a broader shift toward positioning campaigns within PHC

 and systems-strengthening agendas.

4. Regional and ecosystem-level guidance adaptations.

Regional actors are also evolving their approaches.¹⁷ PAHO's Disease Elimination Initiative is promoting integration tailored to regional epidemiology and emphasizing cost-effectiveness and holistic planning. Africa CDC and other regional bodies are advancing integration through continental strategies and task forces focused on coordination and domestic ownership.¹⁸ These regional initiatives demonstrate growing alignment with CAS principles, particularly around country ownership and

 system integration.

5. Persistent demand for simplified norms and operational alignment.

Despite progress, interviewees emphasized that technical norms and operational processes still lag behind integration ambitions.¹⁷ Key challenges include complex and outdated technical guidance, parallel application and reporting processes, and limited harmonization across financing and data requirements. Taken together, findings suggest that global health funders and partners have made meaningful progress in aligning strategies and guidance with CAS principles, particularly around integration and country ownership. However, most changes remain at the level of strategic intent rather than fully embedded policy or operational practice, and country-level implementation remains uneven. Structural barriers, including fragmented financing, parallel data systems, and complex institutional processes, continue to constrain integration. Sustained progress will depend on translating alignment into structural reforms that enable scalable, country-led integration.

“ Through the holistic five-year application, countries will have the opportunity to do a more strategic planning process, identify synergies and integration opportunities and optimize their portfolio overall. ”

— Gavi, the Vaccine Alliance

During the KIIs, interviewees were asked whether their organizations have identified internal policies, structures, or operating norms that are being aligned with CAS recommendations. Insights from the interviews, reinforced by ecosystem analysis, suggest growing internal alignment in strategic direction and organizational priorities, though deeper institutional embedding remains uneven.

1. CAS PRINCIPLES ARE INFLUENCING INTERNAL STRATEGIC DIRECTION ACROSS MULTIPLE ORGANIZATIONS.

Several organizations reported that the CAS is shaping internal strategy, particularly around integration, coordination, and flexibility.¹⁷ Major global actors (e.g., Gavi, WHO, UNICEF, RBM) described increasing alignment between CAS principles and their strategic agendas. Gavi has incorporated an “integration view” into internal planning tools such as vaccine forecasting to support cross-program decision-making. GPEI has elevated campaign integration as a strategic priority in forward planning (e.g., 2026 Action Plan). These findings align with broader ecosystem trends showing growing recognition of integration as a strategic imperative in the face of rising campaign complexity and constrained resources.¹⁸

2. INTERNAL ALIGNMENT IS INCREASINGLY REFLECTED IN TECHNICAL GUIDANCE AND PLANNING TOOLS.

In several organizations, CAS alignment is being operationalized through internal technical norms and programmatic tools.¹⁷ WHO and UNICEF are updating internal guidance to promote joint planning, integrated surveillance, and cross-disease delivery models. Gavi and the Global Fund have established a joint task force to streamline country support and promote coordinated approaches. UNICEF is adapting tools for joint microplanning and integration, particularly in fragile and emergency settings.¹⁸ These shifts reflect early internalization of CAS principles within operational guidance and technical architecture, not just external positioning.

3. INTERNAL POLICIES ARE EVOLVING TO SUPPORT MORE FLEXIBLE, COUNTRY-CENTERED IMPLEMENTATION.

Some organizations reported internal adjustments that enable more flexible, country-led integration.¹⁷ WHO and partners are facilitating country dialogues to align national strategies with integrated delivery approaches. In some contexts, internal policies are being interpreted or adapted to allow flexibility in workforce roles or delivery models (e.g., Community Health Worker [CHW] scope adjustments in hard-to-reach settings).¹⁸ Regional offices (e.g., EMRO and others) are embedding flexibility into campaign design to better reflect operational realities.¹⁷ These examples suggest that internal policy interpretation is evolving, even where formal policy changes are still limited.

4. ORGANIZATIONAL ROLES AND STRUCTURES INCREASINGLY REFLECT INTEGRATION PRIORITIES.

Several structural changes point to growing institutional commitment. These changes include the creation of dedicated integration-focused roles (e.g., a Senior Integration Specialist position at the Global Fund) and establishment of internal mechanisms such as WHO’s Campaign Integration Taskforce.¹⁷ Although organizations such as RBM and PAHO are not direct policy-setters, they are among those organizations facilitating alignment through convening power, coordination platforms, and consensus-building mechanisms.¹⁷ These developments indicate that integration is becoming embedded in organizational structures, not just strategies.

5. EVIDENCE OF ALIGNMENT REMAINS STRONGER IN STRATEGY THAN IN FORMAL POLICY REFORM.

Despite clear progress, the situational analysis suggests that most alignment remains at the level of strategic direction, guidance and tools, and organizational signaling.¹⁸ Formal internal policy reform, particularly in areas such as financing models, incentive structures, and accountability frameworks, appears more limited and uneven across institutions. The broader ecosystem analysis highlights that institutional learning and policy embedding remain nascent and often ad hoc, reinforcing this finding.

Overall, global health funders and partners are making meaningful progress in aligning strategies, structures, and technical guidance with CAS principles. However, most alignment remains directional rather than fully institutionalized, with deeper changes to formal policies, particularly financing, incentives, and accountability, still uneven. The next phase will require translating strategic alignment into concrete policy reforms that enable country-led integration at scale.

“ Having a dedicated position of Senior Integration Specialist is a direction that the organization is taking to promote integrated service delivery. Having this position is a sign of commitment that is an important function that should promote integration work. ”

— The Global Fund



Healthcare workers in Kano State, Nigeria, co-deliver polio vaccine and ivermectin during the integrated campaign in October 2025. Photo Credit: Prof. Yahaya Mohammed

LESSONS LEARNED

Lessons from Focus Countries: Ethiopia & Nigeria

The experiences of Ethiopia and Nigeria provide early but actionable lessons for countries exploring integrated campaign models. Together, they illustrate the opportunities integration creates, the systems changes required to sustain it, and the key factors that shape successful adaptation across different contexts.

1. Integration is feasible and delivers multi-dimensional gains.

Both countries demonstrated that multi-domain integration can maintain or improve coverage while generating efficiency gains. Integrated campaigns produced measurable cost savings, time compression, and expanded reach without compromising core outcomes.

2. Strong national leadership is essential but insufficient alone.

High-level political commitment enabled pilots and cross-program coordination. Without effective translation of these mandates subnationally, localized coordination in some contexts remained fragmented, preventing the full realization of integration benefits.

3. Integration maturity evolves through phases.

Early integration typically begins with coordination-level alignment (planning, logistics, supervision). Deeper integration emerges over time through bundled service delivery and shared platforms.

4. Integration requires both systems reform and delivery innovation.

Successful integration required changes across governance, financing, data, workforce, and incentives. Structural misalignment across systems continues to limit integration depth.

5. Integrated campaigns can strengthen primary health care.

Integrated delivery can support referrals, surveillance, and continuity between outreach and routine services. Evidence suggests integration can act as a bridge between campaigns and PHC systems.

6. Workforce realities must be addressed early.

Integration increased frontline workload and exposed skill gaps. Compensation inequities and workload intensity risk undermining sustainability if not addressed.

7. Integration improves equity and community experience.

Bundled services reduced community fatigue and increased trust and demand. Integrated outreach expanded reach to underserved populations and new demographic groups.

Overall, Ethiopia and Nigeria have demonstrated that integrated campaigns are both feasible and beneficial, delivering clear gains in efficiency, equity, and system responsiveness. However, sustaining these gains will require moving beyond pilot integration toward deeper institutionalization, particularly through stronger subnational ownership, workforce support, and alignment across governance, financing, and data systems.

Lessons from Global and Regional Partners

Experiences from Ethiopia and Nigeria underscore that successful integration is not driven by countries alone. The following lessons highlight how global and regional partners play a critical role in shaping the enabling environment for the CAS through financing approaches, technical systems, and long-term institutional alignment.

1. Integration requires structural alignment across the ecosystem.

Fragmented donor funding, data tools, and incentive models constrain integration. Countries cannot fully integrate campaigns without aligned partner policies and funding structures.

2. Financing reform is critical for scale.

Integrated delivery generated efficiencies, but financing remains donor-heavy and fragmented. Pooled financing models and stronger domestic co-financing are essential for sustainability.

3. Harmonization of tools and data systems is essential.

Integrated dashboards enabled real-time adaptive management. However, parallel systems and conflicting denominators remain major barriers.

4. Support should shift from pilots to institutionalization.

Both countries demonstrated proof-of-concept. The next phase requires policy embedding, systems harmonization, and long-term institutional support.

5. Integration should be framed as system strengthening.

Positioning CAS within national reforms helped build legitimacy and ownership. Integration should be advanced as a health system transformation strategy, not only an efficiency agenda.

Overall, findings suggest that while countries have demonstrated the feasibility of integrated campaigns, the pace and sustainability of the CAS will depend heavily on global and regional partner alignment. Fragmented financing, data systems, and institutional incentives continue to constrain integration depth, indicating that the next phase must focus on structural reforms, particularly pooled financing, data harmonization, and long-term institutional support, to move from proof of concept to scalable, systems-level transformation.

Cross-Cutting Lessons at the Systems Level

Taken together, the Ethiopia and Nigeria experiences reveal a set of cross-cutting lessons that extend beyond individual country contexts. These findings highlight broader systems-level dynamics shaping CAS implementation, including the interplay between political will and structural reform, the importance of adaptive learning, and the realities of transitioning from pilot integration to institutionalized practice. The lessons below synthesize patterns that are likely relevant across diverse settings and phases of CAS implementation.

1. Integration generates value but exposes system fragmentation.

CAS pilots revealed both efficiency gains and structural misalignments across financing, governance, and data systems. These experiences show that integration can unlock operational benefits quickly, but also surfaces underlying system fragmentation that must be addressed for sustainable scale.

2. Political will is ahead of structural reform.

National leadership and global endorsement for integration are strong, but structural reforms—particularly in financing and payment harmonization across programs—are progressing more slowly. This gap suggests that while the vision for integration is widely shared, institutional systems and funding architectures have not yet fully evolved to support it.

3. Learning and adaptation are central to integration success.

Daily review mechanisms during campaigns and real-time data use enabled iterative improvements and adaptive implementation models. These learning-oriented approaches allowed countries to refine integration in real time and highlight the importance of embedding continuous learning into future CAS phases.

4. Integration is iterative and path-dependent.

Countries progressed through phased integration maturity, reinforcing the need for adaptive scaling strategies. Early coordination gains laid the foundation for deeper integration over time, underscoring that integration should be viewed as a gradual evolution rather than a one-time shift.

5. Institutionalization is the next frontier.

Both countries demonstrated proof-of-concept but remain in transition toward policy and systems embedding. Moving forward, sustained impact will depend on formalizing integration within national policies, financing frameworks, and routine operating practices.

Overall, cross-country evidence suggests that the CAS has successfully demonstrated a strong proof of concept but remains in a transitional phase toward full institutionalization. Integration is generating clear value in efficiency, learning, and coordination; however, structural barriers—particularly in financing alignment, equitable payment structures for frontline workers, and broader systems alignment—continue to constrain depth and sustainability. The central takeaway is that the CAS represents less an operational innovation than a pathway for systems transformation, and the next phase will depend on translating early momentum into durable institutional reforms.

Lessons on CAS Theory of Change Assumptions

Implementation of the CAS in Ethiopia and Nigeria provides early validation of several core ToC assumptions, while also highlighting areas where assumptions remain only partially realized. Overall, findings suggest that CAS assumptions are directionally valid but constrained by structural barriers, particularly in financing, institutionalization, and learning investment.

Assumptions most strongly validated

NATIONAL LEADERSHIP AND VALUE PROPOSITION OF THE CAS. In both countries, senior MoH leadership clearly endorsed the CAS and used governance structures to drive integration. The CAS is widely perceived as valuable at national levels and aligned with broader health reform priorities.

THE CAS AS A CATALYST FOR SYSTEMS STRENGTHENING. Early signals suggest the CAS supports referrals, surveillance, and adaptive management. Integrated delivery appears to support broader health system goals, including elimination agendas.

Assumptions partially validated

IMPLEMENTATION INTENSITY SUFFICIENT TO DRIVE CHANGE. CAS PILOTS DEMONSTRATED FEASIBILITY AND MEANINGFUL RESULTS. However, neither country's health system is structurally robust to sustainably scale nationally without catalytic investment in governance and institutional capacity and fundamental reforms in global financing.

GLOBAL PARTNER WILLINGNESS TO ADAPT PRACTICES. Partners have actively engaged in pilots and governance platforms. Yet financing mechanisms remain largely vertical and earmarked, limiting structural transformation.

HCE COALITION LEADERSHIP COMMITMENT. Leadership engagement has been strong and constructive. Translation into institutional reforms within large organizations has been uneven.

Assumptions at risk or requiring reinforcement

SUSTAINED RESOURCING FOR LEARNING AND ADAPTATION. CAS learning has been widely valued but insufficiently funded. MERLA functions and structured learning have relied heavily on ad hoc resources.

SUBNATIONAL INSTITUTIONALIZATION OF COLLABORATION. While national commitment is strong, subnational alignment continues to evolve. Operational decisions at regional and state levels will ultimately determine sustainability.



Lelisa Amanuel Jira, Senior Disease Prevention and Control Advisor at Ethiopia's Federal Ministry of Health and National CAS Coordinator. Photo Credit: Ethiopia Federal Ministry of Health

RECOMMENDATIONS

Findings from Ethiopia and Nigeria demonstrate that the CAS is delivering strong early results across efficiency, coverage, coordination, and learning.

However, sustaining and scaling these gains will require coordinated action across countries, global partners, and the broader HCE ecosystem. While early adopters have demonstrated proof of concept, achieving the CAS's 2030 outcomes will depend on deepening implementation in focus countries, enabling new adopters, aligning global systems that shape country behavior, and evolving the CAS into a durable systems transformation platform.

The recommendations below reflect lessons from implementation and identify priorities for accelerating progress across countries, partners, and the HCE ecosystem.

For Leadership Team members and Coalition institutions, these recommendations are intended to identify areas for contribution, alignment, advocacy, technical support, resource mobilization, and learning exchange within each organization's mandate, governance structure, and accountability framework. They are not intended to assign direct implementation responsibility to individual Leadership Team members or institutions. This is especially relevant for institutions whose priorities are advanced through existing frameworks. CAS-related contributions should therefore build on, complement, and align with existing institutional mandates, strategies, and regional priorities.

For Countries Already Implementing the CAS (e.g., Focus Countries)

FOCUS ON FULL IMPLEMENTATION, SCALE-UP, AND SUSTAINABILITY. This will require: a) supporting national scale-up beyond pilots and embedding the CAS into routine delivery platforms; b) strengthening subnational ownership; c) embedding the CAS within PHC, UHC, and health sector reform agendas; and d) providing sustained technical and financial support during the transition from pilots to institutionalization.

INSTITUTIONALIZE INTEGRATION WITHIN NATIONAL SYSTEMS. Moving from pilot success to sustained impact requires embedding the CAS within national governance and planning frameworks. Key actions should include: a) formalizing the CAS governance structures in national policies and planning cycles; b) integrating the CAS into routine campaign calendars and PHC delivery models; and c) developing unified campaign financing and coordination frameworks.

STRENGTHEN SUBNATIONAL INTEGRATION STRATEGIES. Implementation depth will ultimately depend on regional/state-level adoption. This could be achieved by developing subnational integration roadmaps and readiness tools, building regional capacity for integrated microplanning and budgeting, and cascading governance authority and accountability mechanisms from national to subnational levels.

ADVANCE FINANCING REFORM FOR SUSTAINABILITY. This should include: a) developing unified campaign financing frameworks that enable pooled budgeting across programs; b) expanding domestic financing and embedding campaigns within broader health financing pathways; and c) piloting harmonized payment and incentive models that support integrated teams.

STRENGTHEN WORKFORCE AND LEARNING SYSTEMS. Sustained integration requires capable frontline systems and continuous learning. Key actions should include: a) developing integrated workforce planning and compensation models; b) embedding MERLA activities within national CAS implementation structures; and c) institutionalizing adaptive learning cycles and integration maturity pathways.

For Countries Considering CAS Implementation

FRAME THE CAS AS A SYSTEMS TRANSFORMATION

APPROACH. Positioning the CAS as a systems strategy increases political ownership and sustainability. This will entail: a) aligning the CAS with PHC, UHC, and national reform priorities; b) integrating the CAS into existing governance platforms early; and c) positioning integration as a systems strengthening strategy, not just an efficiency measure.

START WITH PHASED INTEGRATION PATHWAYS.

Begin with high-feasibility integration opportunities and scale iteratively. Define clear progression milestones and readiness benchmarks. Use integration maturity staging models to guide scale-up.

ESTABLISH GOVERNANCE AND STAKEHOLDER

ALIGNMENT EARLY. This can be accomplished by: a) creating or leveraging existing multi-sectoral coordination bodies to plan and coordinate stakeholders before launching pilots; b) ensuring early inclusion of all major programs to avoid late alignment challenges; and c) defining integration decision rules and accountability structures up front.

RESOURCE COORDINATION FUNCTIONS. Leverage existing resources where possible to initiate coordination and planning (e.g., existing staff time, partner support, or standing meetings). As integration matures, countries can progressively allocate dedicated funding and staff time for coordination functions such as a program management unit, integration coordinator, or structured planning mechanisms rather than relying on ad hoc partner contributions.

SECURE PARTNER SUPPORT FOR COORDINATION.

Regional and global partners should provide catalytic funding and technical support to help countries convene stakeholders and operationalize coordination mechanisms.

IDENTIFY AND EMPOWER INTEGRATION CHAMPIONS.

This would require a) identifying dedicated integration champions within the MoH who can work across programs; b) clearly defining roles and responsibilities to lead and sustain integration efforts; and c) ensuring these roles are supported with sufficient authority and resources to coordinate across stakeholders.

BUILD WORKFORCE AND LEARNING MODELS INTO

PILOTS. Early integration efforts are more sustainable when designed holistically. Key actions include integrating workforce planning into initial CAS adaptation and design, establishing learning systems early rather than retrofitting MERLA later, and using phased integration maturity pathways.

PLAN FINANCING AND WORKFORCE REALITIES FROM

THE OUTSET. Map funding streams early and identify pooling opportunities. Incorporate workforce planning into initial CAS adaptation or customization. Use pilots or early experiences to test financing and incentive alignment models.

BUILD LEARNING SYSTEMS INTO IMPLEMENTATION

FROM THE START. This can be accomplished by establishing MERLA platforms at the outset instead of retrofitting learning later, promoting real-time learning and adaptive implementation cycles, and developing country-specific integration roadmaps informed by pilots or early experiences.

For Global and Regional Partners

ACCELERATE STRUCTURAL ALIGNMENT TO ENABLE INTEGRATION. This can be facilitated by: a) moving beyond strategic endorsement to structural reforms in financing, payment alignment, and reporting; b) establishing a shared framework among funders for harmonized funding approaches that support integrated campaigns; and c) simplifying application, budgeting, and reporting processes for countries to reduce fragmentation across programs.

REFRAME INTEGRATION AS SYSTEMS

TRANSFORMATION. Key actions to facilitate this transformation include: a) aligning global strategies to position the CAS within PHC and UHC agendas; b) strengthening linkages between campaigns and health systems strengthening initiatives; and c) embedding integration within replenishment cycles and global strategies.

IDENTIFY AND EMPOWER INTEGRATION CHAMPIONS.

This would require a) identifying dedicated integration champions within organizations who can work across programs; b) clearly defining roles and responsibilities to lead and sustain integration efforts; and c) ensuring these roles are supported with sufficient authority and resources to coordinate across stakeholders.

UPDATE AND SIMPLIFY GLOBAL TECHNICAL

GUIDANCE. Outdated norms and fragmented guidance remain major barriers to integration. Key actions for mitigating such barriers include: a) updating normative guidance to explicitly promote joint microplanning and cross-disease delivery; b) developing adaptable frameworks that allow local policy flexibility (e.g., CHW scope expansion); and c) simplifying technical requirements that create operational challenges and deterrents to integration.

TRANSITION TOWARD FLEXIBLE, POOLED FINANCING MECHANISMS. Structural financing reform is essential for sustainable integration. This will require expanding pooled or harmonized funding models, supporting country-led financing alignment, and embedding integration incentives into funding architectures.

ACCELERATE FINANCING REFORMS TO ENABLE INTEGRATION.

Financing fragmentation remains one of the largest barriers to CAS implementation. The following actions should be taken by all global funders and partners to help mitigate these barriers: a) align funding cycles and reduce siloed financing structures; b) transition toward flexible, multi-year joint applications and budgets; c) introduce incentives for cross-program collaboration, including funding joint planning and not penalizing efficiencies gained through integration; and d) learn from and scale-up models such as Gavi's multi-year co-delivery applications.

INVEST IN CAS MERLA TO BUILD THE EVIDENCE BASE.

A stronger evidence base is essential for scaling the CAS and validating ToC assumptions. This will require dedicated funding for MERLA aligned with the CAS ToC, strengthening measurement of integration outcomes and system effects, and longitudinal evaluation and implementation research. Future MERLA efforts should also strengthen interpretation of administrative coverage data, improve the quality and harmonization of target population denominators, and assess the contribution of integrated campaigns to both campaign-specific outcomes and routine service delivery objectives.

For the HCE Leadership Team with support from the HCE Program Office

STRENGTHEN THE CATALYTIC ROLE OF THE HCE COALITION. Reinforce the HCE Coalition as a systems integrator and convener across partners. Develop targeted advocacy focused on structural reforms, especially financing that incentivizes campaign collaboration and integration.

DEVELOP STRUCTURED CAS SCALE-UP PATHWAYS FOR NEW COUNTRIES. As interest grows, a deliberate approach is needed to support expansion beyond early adopters. This will require developing a structured scale-up and support model for new countries, creating readiness assessments and phased adoption pathways, and providing peer learning opportunities from Ethiopia and Nigeria.

STRENGTHEN SUPPORT TO FOCUS COUNTRIES AS GLOBAL EXEMPLARS. Early adopters are essential to building the evidence base and credibility of the CAS. Strengthening support to focus countries should entail providing sustained technical support to Ethiopia and Nigeria, supporting national scale-up and institutionalization, and documenting lessons and translating them into global public goods.

SUPPORT AND ENABLE THE SUSTAINABILITY OF INTEGRATED AND COLLABORATIVE APPROACHES. Key activities would include: a) developing a CAS maturity model and progression framework; b) providing diagnostics and scaling tools for countries; and c) defining milestones for transitioning from pilot to institutionalization.

WIDELY DISSEMINATE THE CAS LESSONS AND INTEGRATION MODELS. Lessons from Ethiopia and Nigeria are valuable global public goods and should be actively shared. This will require sharing of lessons with countries and via regional platforms, strategic dissemination within partner organizations and technical networks, and ensuring that the CAS learnings are embedded into global guidance, strategies, and technical documents.

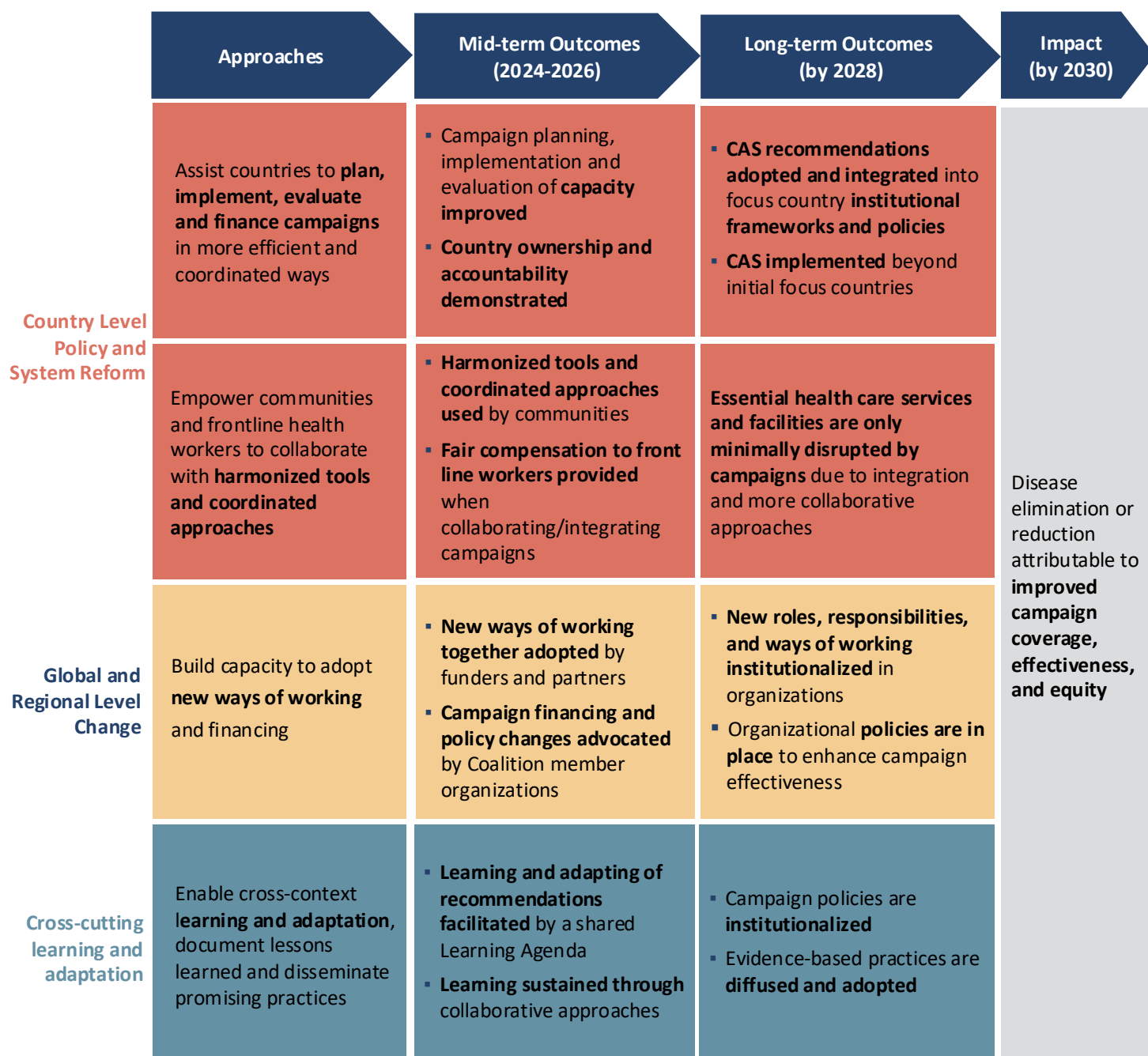
SUPPORT PRACTICAL IMPLEMENTATION TOOLS AND LEARNING FORUMS. Countries will continue to need actionable tools to operationalize integration. This will require activities such as: a) ongoing development of practical guidance and decision-support tools (e.g., integration design frameworks, microplanning tools, readiness assessments); b) creating toolkits and implementation guides for integrated campaigns; and c) supporting regional learning forums and peer exchange platforms.



Child receives vaccination from healthcare team during Ethiopia's integrated campaign in May 2026.
Photo Credit: Ethiopia Federal Ministry of Health

APPENDICES

Collaborative Action Strategy: Theory of Change



CAS Theory of Change: Key Assumptions

Assumptions		
Country level policy and system reform	 Country MOH leadership , health campaign managers/implementers and other partners see value in the CAS , commit to implementing it, and have sufficient incentives for collaboration and coordination	 Within countries , implementation of the CAS is of sufficient intensity to drive change
	 Countries that implement the CAS will customize it and create their own theories of change to reflect their needs and context	 Implementation of the CAS does not compromise ongoing campaigns and activities
	 Frontline workers are comprised of all types of health workers—including nurses , midwives , community health workers , doctors , pharmacists , and more —who provide care directly to their communities	 Implementing the CAS at scale will lead to sustainable changes in campaign practices and impact
	 Achieving CAS intended impacts will contribute to countries their efforts to strengthen their health systems and support their achievement of disease elimination/eradication and other goals	
Global and regional level change	 Global partners and funders are willing and able to change their practices (e.g., financing approaches) to support CAS recommendations	 Implementation of the CAS will surface promising and evidence-based practices that are adopted by and beyond focus countries
	 The HCE Coalition LT is deeply committed to advocating and advancing necessary changes within their respective organizations	 CAS implementation, monitoring and learning will be valued by global partners and appropriately resourced through at least 2028
Cross-cutting learning and adaptation	 Strategies proposed in the CAS are connected , interdependent , and intended to be implemented together	 Unanticipated events (e.g., political disruption, competing priorities) are sufficiently mitigated that they do not cause significant impact on CAS implementation

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