

Shifting from Silos: Where Integration Can Create Value

July 2026



CAMBER
COLLECTIVE

Seattle • San Francisco • Washington D.C. •
Paris • Abuja

Authors

Caroline Carrasco, Ben Jenson, Madeleine Webb, Saira Zaidi

About Camber Collective

Camber is a strategic partner to the organizations and fields addressing the world's most urgent challenges. Our goal is simple: to accelerate progress toward an equitable and sustainable world. We work locally and globally across health, prosperity, climate, and gender equality to drive the strategies, action, and learning that our partners need to create lasting impact.

We are a global collective of empathic, purpose-driven leaders dedicated to impact. Our multidisciplinary team combines deep functional, sectoral, and systems expertise with diverse professional and lived experiences. By centering our work on the who, what and how of driving change, we place equitable project design, analytical rigor, and a bias for action at the core of everything we do.

Shifting from Silos: Where Integration Can Create Value



The eradication of smallpox, with the last natural case recorded in 1977, was transformative for global health in ways no one could have imagined at the time. This feat demonstrated that a single-disease focus, pursued at scale, could work, thus eradication became the frame through which donors concentrated a considerable portion of their investments. This architecture drove dramatic gains in areas like HIV treatment and coverage of critical vaccines such as polio and rotavirus. Since disease-specific programs produced visible, quantifiable results on timelines that matched political funding cycles, the vertical approach suited donors and was subsequently adopted by countries and implementers as the organizing logic of their own health systems.

An eradication agenda pursued through disease-specific programs presumes dedicated resources will be available and sustained, but over the last two years, the global health financing landscape has experienced [significant shocks](#). Bilateral and multilateral agencies have cut budgets, and fragile health systems in low- and middle-income countries must sustain services across a growing number of disease areas with fewer resources. Under funding pressures, the vertical disease silos that once enabled major health gains are proving difficult to sustain. The downstream effects are already visible, with some countries experiencing up to a [70% reduction in critical services](#).

Integration has long been discussed as an approach to improving the impact of services and the quality of the patient experience. Now, countries and implementers facing shrinking budgets and steady demand are turning to integration not as a design choice but as a financial necessity—even though the power to align siloed financing mechanisms sits with the funders above them.¹

The same environment that makes integration urgent is also making deliberate integration challenging.

Integration pursued as a cost-cutting reflex can produce fragile and ineffective systems. The outcome depends on whether there is genuine overlap in patients' needs, compatible delivery infrastructure, established clinical co-benefit, and aligned financing. These conditions, however, are not all within countries' power to create. Countries bear the burden of integrating delivery, but the donors and

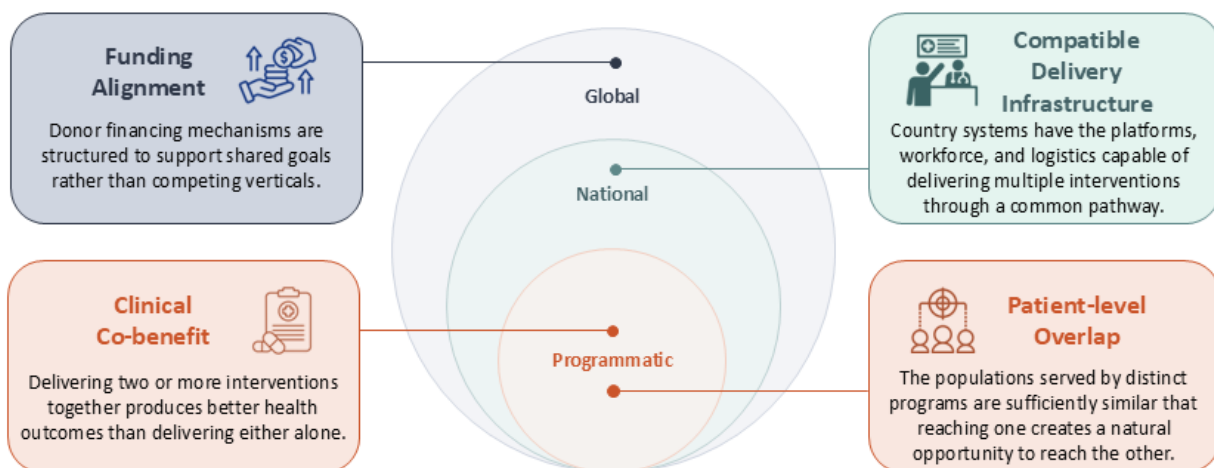
¹ Integration takes many forms; we are referring to combining disease-specific services, so they share common platforms, workforces, or supply chains rather than operating in parallel. This working definition draws on two reference points. The World Health Organization describes integrated health services as the management and delivery of services so that people receive a continuum of care matched to their needs across different levels of the health system (WHO, "[Integrated Health Services – What and Why?](#)", Technical Brief No. 1, 2008). Atun and colleagues deconstruct integration further as the extent, pattern, and rate at which targeted, disease-specific interventions are adopted and assimilated into a health system's critical functions, including governance, financing, planning, service delivery, and monitoring (Atun et al., "[Integration of targeted health interventions into health systems: a conceptual framework for analysis](#)," *Health Policy and Planning* 25(2): 104–111, 2010). We apply this lens to the operational dimension most salient in the current funding environment, which is whether disease-specific programs share common platforms, workforces, and supply chains rather than operating in parallel.



multilaterals above them control the financing architecture that plays a major role in determining whether integration can hold.

Four Conditions Distinguish Where Integration Can Create Value

Integration is most valuable when conditions are reinforced across all levels of delivery & coordination



Silos Exist by Design

Donors intentionally developed the existing global health architecture around narrowly focused disease verticals. Smallpox eradication was the proof of concept that a concerted, single-disease effort could erase a disease entirely, and it is the precedent the modern vertical era was built to emulate. Polio followed the same playbook to the brink of the same outcome, with wild poliovirus cases falling from an estimated 350,000 a year across more than 125 countries to a virus now endemic in just two. Vertical programming measured specific outcomes, moved money quickly, and created clear lines of responsibility but it also created a disjointed system.

The vertical model reflected alignment between what donors could politically leverage and what programs could deliver operationally. Concentrating on a named disease, a defined target, and measurable results made disease-specific funding motivating and justifiable to legislatures and philanthropists. Short funding cycles reinforced this logic, as counting vaccinated children within a grant period is far more measurable than showing progress on a health system that can take decades to strengthen. Vertical programs also created clear lines of ownership over outcomes, making them easier to manage and audit. Global initiatives like those funded by PEPFAR and the Global Fund leveraged dedicated funding, staff, and clear chains of accountability to address defined health problems, resulting in some of the most significant health gains in modern history. The architecture, in short, was rationally designed for the incentive environment it operated in.



Conversely, this focused approach produced deeply fragmented systems. As funding concentrated on narrow disease verticals, parallel structures formed around each one, with funders and health systems building their own data requirements, supervision processes, and supply chains. In many countries, vertical programs run reporting systems entirely separate from the national one. An [analysis](#) of Tanzania's health information system found multiple such systems operating independently, overburdening the frontline providers who must input into several data systems at once. Duplicative, parallel systems are at best inefficient and at worst placing undue burden on the health systems they are meant to strengthen.

The fragmentation extends to how funding flows within systems. Since donors set their own funding cycles and reporting requirements, disbursements rarely align with each other or with a country's planning calendar. The thinner a country's fiscal space, the more [unpredictable flows disrupt national budgeting](#) and planning. The structures that enabled major health gains also made those gains dependent on a steady, earmarked flow of disease-specific funding, which is now contracting. This same misalignment, between how funders organize themselves and what countries are asked to deliver, will resurface as a recurring constraint on what integration can realistically achieve.

The Funding Environment Has Changed

Over the past two years, several forces have converged on global health financing at once. The dissolution of USAID and a broader US-led bilateral pullback have created an acute resource shock, pulling money out of the system faster than anyone planned for or predicted.

The multilateral institutions that might have been expected to absorb some of these shocks are also facing their own shortfalls. At its [Eighth Replenishment Summit](#) in November 2025, the Global Fund raised roughly \$12 billion in pledges against an \$18 billion target, a gap of about 33%. [Gavi](#) tells a similar story, falling \$2.9 billion short of its goal at its mid-2025 replenishment. Gaps of this scale have direct programmatic consequences. The Global Fund's [projections](#) estimated that reaching its full target would have prevented roughly 400 million new AIDS, tuberculosis, and malaria infections between 2027 and 2029. On the Gavi side, [analysts estimated](#) that US funding withdrawal alone could leave 75 million children without routine immunizations.

The vertical model was built on an assumption that long-standing financing commitments would hold stable. Programs were designed, staffed, and scaled around resources that are no longer guaranteed and may never return to prior levels. When the funding that held these structures in place recedes, the structures themselves begin to give way. The question is not whether the system needs to change, but whether the change will be designed deliberately or absorbed by default.



Integration Is Not a Panacea

As resources contract, integration has surfaced as one of the global health sector's prominent responses. It is increasingly central to donor strategy for stretching scarce resources further, visible in the [Lusaka Agenda](#) and [Gavi 6.0's efficiency commitments](#) on country planning. The logic is straightforward: if programs serving overlapping populations share platforms, workforces, and supply chains, they can use scarce resources more efficiently, reduce duplication, and improve outcomes. [Integrated campaigns in Nigeria, for example](#), delivered the same services at 23% lower cost per child than stand-alone campaigns, but results like this depend on the right conditions for integration being in place and whether integration is well-executed.

The broader evidence base reflects inconsistency in added benefits of health services integration. A [review](#) of more than a hundred studies found that health outcomes were generally better when HIV services were integrated with others rather than delivered separately. However, integration does not reliably produce these gains across all program combinations. A [trial](#) integrating family planning counselling into routine immunization visits found no measurable increase in contraceptive uptake, with weak implementation identified as the probable cause. Integration falters when the delivery requirements of the added service do not match the host platform's timing, target population, or workforce capacity.

Applied without appropriate diagnosis, integration can blur accountability, dilute specialized expertise, and add complexity when systems designed independently are forced together. The risk is not that integration is wrong, but that it is being pursued as a financial reflex rather than a design decision, one shaped by the same funding misalignment described above. Donors, implementers, and countries need to understand where integration reliably creates value and what conditions make that possible.

Where Integration Can Create Value

[Results for Development's 2019 decision-making approach](#) offers a process for country policymakers weighing whether and how to integrate specific vertical programs into primary health care. The [Wallace systematic review](#) catalogues empirical outcomes across 34 integration efforts. Earlier work by [Atun and colleagues](#) and a [2017 systematic review by Topp and colleagues](#) identifies recurring features of effective service integration. More recently, the Health Campaign Effectiveness Coalition's [Collaborative Action Strategy](#), co-developed in 2023 by more than fifty global, regional, and country partners, distills a body of implementation research into a practical framework for planning, evaluating, and financing health campaigns in concert with routine services.

Four conditions, drawn from this growing body of integration research, distinguish opportunities where integration has the potential to create value:

1. **Patient-level overlap:** When patients need multiple services at the same point in their lives, integration becomes a potential solution. Separate delivery systems impose genuine costs:



repeated trips, lost wages, redundant intake, and the risk of falling out of care between visits. Where populations and clinical pathways do not naturally intersect, the case for integration weakens regardless of how convenient the platform may be.

2. **Evidence of clinical co-benefit:** Patient overlap tells us integration has potential; co-benefit tells us where integration can achieve outcomes that neither service could produce alone. The strongest integration cases are those where the services measurably reinforce each other rather than simply sharing a target population.²
3. **Compatible delivery infrastructure:** Even where target populations overlap and clinical co-benefit reinforces outcomes, integration works best when underlying systems can operate jointly without degrading either service. Where services share compatible timing, target age ranges, supply chains, training requirements, and workforce capacity, integration can strengthen both. Where they do not align, forcing integration risks inheriting the constraints of the weaker platform.
4. **Funding alignment:** Most global health financing still flows through disease-specific channels with disease-specific accountability requirements. This creates structural friction where implementers must integrate delivery at the country level while still being evaluated and funded based on disease-specific metrics by donors. Even where the first three conditions are met, financial architecture can pull integration apart.³

² Evidence of clinical co-benefit condition example: Diabetes triples the risk of developing active TB and doubles the risk of death during treatment, while TB simultaneously worsens glycemic control. [Evidence from Malawi](#) found that people with diabetes were retained in care at a rate 20 percentage points higher in integrated facilities than in non-integrated ones, and TB patients in the same integrated facility had no recorded loss to follow-up compared with 15 percent in non-integrated settings.

³ Funding alignment condition example: Efforts to close this gap are increasingly a joint endeavor among [Gavi, the Global Fund, and the Global Financing Facility \(GFF\)](#). Gavi 6.0's commitments to align grant cycles with partners, joint guidance on country planning, and the one-year Joint Committee Working Group the three institutions' boards convened in September 2024 to operationalize the Lusaka Agenda are early attempts to harmonize grant cycles and joint planning. In practice, these are being tested in a handful of pathfinder countries, while most countries continue to navigate separate funding streams, separate reporting requirements, and separate planning calendars. [Progress to date](#) remains early-stage and uneven, with the extent of collaboration varying by country.



Case Studies

Three examples show how these conditions align, fall short, and what separates value-creating integration from added complexity



Routine Immunization & MCH Services

Integrating maternal health services into existing immunization visits improved MCH outcomes in most reviewed studies while leaving immunization coverage largely unchanged.

Conditions applied:



Patient-level overlap



Compatible delivery infrastructure

Routine immunization contacts offer one of the most natural integration platforms available.

Mothers and infants need both immunization and maternal health services during the same critical window in the first two years of life. Routine childhood immunization, delivered through the WHO's Expanded Programme on Immunization, already reaches most children in low- and middle-income countries, making it one of the most reliable delivery infrastructures available. The [Wallace review of thirty-four studies](#) found that integrating Maternal and Child Health (MCH) services with childhood immunization programs in LMICs improved MCH outcomes in most cases.

Among the twenty studies that measured an

immunization outcome, coverage was better or unchanged in nine in ten. The cases where integration underperformed concentrated in family planning, malaria, and HIV, which are prevention services that require different timing than routine immunization, pointing to the importance of delivery infrastructure compatibility.

HIV and tuberculosis are perhaps the clearest clinical case for integration since co-infected patients fare dramatically better when both diseases are managed together. A [retrospective evaluation in Eswatini](#) found high rates of antiretroviral uptake among co-infected patients in integrated programs, and a [systematic review](#) found that integration was associated with lower mortality and improved treatment retention. Yet funding alignment remains the persistent structural gap. Even the Global Fund, which finances both diseases, allocates and tracks resources by disease component, so a country can draw from the same institution while still being budgeted and evaluated separately for HIV and TB. Recent grant cycles have encouraged countries to submit combined funding requests and to plan for integrated delivery, but the underlying accountability structure, separate allocations and separate



HIV & Tuberculosis Treatment

Co-infected HIV and TB patients need both treatments at once and see better treatment outcomes when both diseases are managed together, but separate funding tracks continue to undercut integrated delivery.

Conditions applied:



Clinical co-benefit



Patient-level overlap



indicators for each disease, persists. The result is that one of the most clinically compelling cases for integration in global health remains structurally undermined, not by the absence of a coordinating funder, but by accountability structures that continue to track HIV and TB as separate programs even when they are delivered jointly.



Measles & Oral Polio Vaccines

Shared conditions create the opportunity for high-value integration, but design and execution still determine whether that potential is realized.

Conditions applied:



Compatible delivery infrastructure



Patient-level overlap

The infrastructural conditions for measles and oral polio vaccine campaigns indicate integration compatibility since both vaccines target children under five in the same communities through overlapping delivery infrastructure (e.g., trained vaccinators, cold chain logistics, and community mobilization networks). Camber's analysis of integrated measles-polio campaigns in Chad and Nigeria shows what determines whether those conditions translate into value. In Nigeria, where the decision to integrate was made early in planning and governance was aligned across programs, polio's planning systems, data tools, and

field workforce actively strengthened measles delivery. In Chad, the campaign was nominally considered integrated because both programs operated in the same areas under a shared structure, but the decision to integrate was made only four to five weeks before the launch of the campaign and delivery modalities were never reconciled. While measles used fixed sites, polio relied on house-to-house outreach, so door-to-door polio teams drew families away from fixed measles sites rather than toward them. The conditions were present in both countries, but what differed was whether the integration design honored them.

As seen from the examples above, meeting these conditions is not a substitute for implementation quality, which does much to determine outcomes, but a guide to identify conditions in which high-value opportunity exists. Realizing the value of integration still requires deliberate design and planning at the country level. As the fourth condition (funding alignment) makes clear, whether these conditions can be met is not fully in countries' hands. Much of it depends on decisions made above the country level, by the donors and multilaterals whose architecture countries must work within.

The Unresolved Challenge

The conditions that justified vertical programming have changed, and the pressure to adapt is mounting. A growing body of evidence is shedding light on where integration creates true, sustainable value: when patients' needs overlap, when delivery infrastructure is compatible, when clinical co-benefit is established, and when financing is aligned. Where these conditions hold, integration produces outcomes that vertical delivery cannot. Where they do not, it can compound the fragmentation it was meant to solve, with the added cost of disrupted systems and diluted expertise built over decades.



The temptation to treat integration as a universal solution is greatest precisely when resources are most constrained. Funders facing replenishment shortfalls, implementers absorbing programmatic cuts, and policymakers managing competing demands all share an incentive to integrate quickly rather than deliberately. That incentive is understandable; however, acting on it without the diagnostic work can produce systems weaker than the silos they replace, in an environment that cannot absorb further setbacks.

The urgency driving that temptation is not something countries set for themselves. What makes this moment different is that the pressure driving integration originates at the top of the financing architecture, while country leadership works to deliver services in an environment that has become far more turbulent and unpredictable. The conditions that make integration work at the country level, like compatible delivery systems, aligned workforces, and coherent planning calendars, cannot hold when the funding structures above them remain fragmented.

The gap between what integrated delivery requires on the ground and the structure of donor financing is the central unresolved challenge in the integration agenda.

Closing this gap requires a different conversation about what integration means above the country level, among the funders and multilaterals whose ability to work better together improves country leadership's ability to deliver high-quality integrated health services.

