



At the frontline: Joint community-level service delivery for prevention, outreach and uptake

Routine services and time-bound campaigns – such as vaccination or outreach – can improve reach, efficiency and uptake when delivered jointly across sectors, particularly in underserved populations facing overlapping risks

One Health in context

For those working in global health, community-level service delivery is a critical entry point for One Health. Many underserved populations – including pastoralist, remote and low-access communities – experience health risks that cut across human, animal and environmental systems. Zoonotic disease, food safety, antimicrobial use, environmental exposure and livelihood risks are often encountered together at household level, yet services remain largely organized by sector.

Joint delivery – where services from human health, animal health and (where relevant) environmental or agricultural sectors are delivered together – provides an opportunity to respond more effectively to these overlapping risks. This can take different forms:

- **routine service delivery**, where community health workers, animal health workers and agricultural extension agents engage regularly with households in a co-ordinated manner, supporting prevention, early detection and referral
- **time-bound campaigns and outreach**, such as vaccination or integrated service days, where sectors align temporarily to expand coverage and reach underserved populations

These approaches are complementary. Routine systems build trust, continuity and early warning over time, while campaigns can extend reach, improve uptake and test co-ordination under operational pressure.

In pastoralist, remote and fragile environments, where access to services is limited and mobility is high, joint delivery can improve efficiency and, in some contexts, increase uptake by aligning incentives for communities (for example, combining human and livestock services). Importantly, for either of these approaches (routine or time-bound) to work, there needs to be good co-ordination, to enable planning, logistics, communication and service delivery.

Why it matters

- **Underserved communities often face overlapping risks across human, animal and ecosystem health**, but they often interact with fragmented systems.
- **Many risks are preventable through early advice, behaviour change and referral** – not only clinical care.
- **Joint delivery can improve efficiency and, in some contexts, it can increase uptake** by aligning services with community priorities.
- **Routine frontline actors are often the first to detect emerging risks and may be among the most trusted points of contact for communities**, but impact depends on adequate support, mentorship, co-ordination and referral pathways.
- **Campaigns and outreach can extend coverage rapidly**, but can also expose co-ordination gaps in planning, logistics and reporting.
- **These issues intersect directly with health equity, resilience, food security, AMR, and health security priorities.**

Practical examples

- **'Joint Human and Animal Health Campaigns in Chad'**. This case study documents co-ordinated outreach delivering human and animal vaccination services together to remote pastoralist communities. Shared microplanning, synchronized outreach schedules and integrated logistics improved access to mobile populations that were often missed by routine services. The combined delivery also strengthened community engagement and, in some cases, increased uptake by aligning services with community priorities. At the same time, the case highlights co-ordination challenges, including aligning sectoral mandates, managing separate reporting systems, and sustaining joint delivery beyond campaign periods.
- **Integrated human and animal health services for pastoralist communities (sub-Saharan Africa)**. This synthesis examines routine integrated service delivery models in pastoralist settings. Rather than relying on time-bound campaigns, these approaches embed co-ordination within ongoing community-level interactions. The evidence suggests that

integration can improve service acceptability, continuity of care and trust in services, particularly in contexts where access is limited. However, sustainability depends on institutional alignment, workforce stability and financing mechanisms that support routine collaboration across sectors. In remote or mobile settings, integration also requires realistic workforce models, including appropriate financial or non-financial incentives and, where possible, the recruitment and training of workers from the communities they serve.

- **'Community-Designed One Health Units as a Model for Integrated Service Delivery in Pastoralist Areas of Africa'**. This case study describes multidisciplinary teams delivering integrated human, animal and environmental services through mobile and fixed platforms, supported by community groups and local government co-ordination structures. The model embeds co-ordination within routine service delivery and enables communities to shape priorities and service provision. Early results suggest improved access, high levels of satisfaction and repeated use of services among hard-to-reach populations. However, the comprehensiveness and mobility that make the model attractive also raise sustainability questions, particularly around recurrent costs, the reliability of supply chains and long-term financing.
- **Crop–livestock clinics**. This case study illustrates how shared service platforms can provide integrated advice to farmers on crop and livestock health within a single setting. Although primarily agricultural, the clinics increasingly surface cross-sector risks, including zoonotic diseases, pesticide misuse and antimicrobial use. By bringing services together, these platforms create opportunities for prevention, behaviour change and referral that would otherwise be missed. The case study also highlights limitations: frontline workers are expected to recognize and respond to cross-sector risks without clear mandates, manageable workloads, supervision or structured referral pathways.

Common challenges in practice

- **Siloed mandates**, limiting what frontline workers can address.
- **Misaligned planning, budgeting and reporting systems across sectors.**
- **Overburdened frontline workers with competing responsibilities.**
- **Inconsistent messaging** across human, animal and agricultural services.
- **Weak referral and communication pathways** between sectors.
- **Logistical challenges** in reaching mobile or remote populations.
- **Sustainability risks** once project or campaign funding ends.

Factors that make these approaches work

- **Clear role definition** across frontline actors.
- **Structured referral and communication pathways.**
- **Joint planning and aligned messaging** across sectors.
- **Trusted community engagement and participation.**
- **Institutional support** for co-ordination beyond individual projects.
- **Workforce continuity and practical, context-appropriate collaboration.**

Possible entry points for those working in global health

- **Recognizing opportunities for joint delivery.** Routine services or outreach activities may provide entry points for co-ordination with veterinary or environmental actors, including where this could improve access and uptake.
- **Encouraging alignment among partners.** Where multiple actors support community-level programmes, there may be opportunities to align approaches, including joint training or consistent messaging on cross-sectoral risks.
- **Advocating for consistent messaging and integration.** Preventive guidance on issues such as food safety, zoonoses or environmental health may benefit from alignment across sectors.
- **Supporting cross-sectoral training approaches.** Integrating One Health perspectives into in-service training for community-based workers may strengthen collaboration and shared understanding.
- **Linking frontline observations to surveillance systems.** Routine and outreach interactions can provide early signals of risk when communication pathways to higher levels are clear.
- **Supporting local co-ordination where relevant.** Co-ordination challenges often emerge at district or community levels, where there are interactions between the operations of different actors.
- **Reflecting on operational lessons.** Both routine delivery and campaigns can provide insights into co-ordination gaps, including factors affecting uptake and service effectiveness.

Want to know more?

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Key resources:

- 'One Health Explainer' – <https://www.cabi.org/cabi-publications/one-health-explainer/>
- 'Joint Human and Animal Health Campaigns in Chad' – <https://www.cabidigitallibrary.org/doi/10.1079/onehealthcases.2024.0026>
<https://pmc.ncbi.nlm.nih.gov/articles/PMC2725911/>
<https://link.springer.com/article/10.1186/s12961-021-00688-z> (Longitudinal implementation case study / practice-based evidence)
- 'Integrated (One) Health service delivery in pastoralist settings in sub-Saharan Africa', in *One Health Atlas* (p. 102) – <https://www.quae-open.com/produit/336/9782759240265/one-health-atlas> (Literature review / evidence synthesis)
- 'Community-Designed One Health Units as a Model for Integrated Service Delivery in Pastoralist Areas of Africa' – <https://www.cabidigitallibrary.org/doi/10.1079/onehealthcases.2024.0004> (Implementation case study / programme case)
- 'Integrated crop–livestock clinics in East Africa', in *One Health Atlas* (p. 104) – <https://www.quae-open.com/produit/336/9782759240265/one-health-atlas>
- 'How Crop–Livestock Clinics Are Advancing One Health: A Pilot Case from Uganda' <https://www.cabidigitallibrary.org/doi/10.1079/onehealthcases.2022.0002> (Practice-based case example)

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