# FINDINGS FROM A MULTI-COUNTRY ASSESSMENT OF INTEGRATED HEALTH PROGRAMS

*Global Health Initiative*

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MEASURE Evaluation

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## ACRONYMS

| | |
|---|---|
| ART | antiretroviral therapy |
| BCC | behavior change counseling |
| BHS | better health services |
| CCC | comprehensive care center |
| CDC | Centers for Disease Control and Prevention |
| DHIS | District Health Information System |
| HMIS | Health Management Information System |
| HPNSDP | Health, Population and Nutrition Sector Development Program |
| MCH | Maternal and Child Health |
| MOH | Ministry of Health |
| MSM | men who have sex with men |
| NCDs | non-communicable diseases |
| OGAC | Office of the Global AIDS Coordinator |
| PEPFAR | United States President's Emergency Plan for AIDS Relief |
| PMTCT | prevention of mother-to-child transmission |
| PRH | Office of Population and Reproductive Health |
| USAID | United States Agency for International Development |
| URC | University Research Corporation |
| USG | United States government |
| VCT | voluntary counseling and testing |
| SSDI | Support for Service Delivery Integration |
| STI | sexually transmitted infection |

# EXECUTIVE SUMMARY

Integration of health interventions is promoted to make better use of resources, meet health needs, and achieve sustained improvements in health. Many definitions of integration exist, and some converge on a concept of integrated health services within the context of a supportive health system that provides clients with a continuum of services according to their needs over time (Waddington & Egger, 2008). Studies of integrated health services have shown integration to be feasible, and that it can improve quality of care, increase service uptake, and improve outcomes such as contraceptive use and HIV testing uptake (Spaulding et al., 2009; Lindegren et al., 2012; Wilcher et al., 2013). Evidence is more limited regarding effects on health impacts and costs.

The United States government (USG) contributes to a worldwide effort to communicate, learn about, and promote integration by funding projects, issuing guidance, developing indicators, convening meetings and working groups, sponsoring literature reviews, and publishing. Specifically, a USG inter-agency group on integration published the *GHI Principle Paper on Integration in the Health Sector* in May 2012,[1] developed a related results framework for integration (Appendix 1), defined a list of indicators to measure the outputs and outcomes of integration (document forthcoming), and articulated a learning agenda.

To inform this broader learning agenda on integration of health services, this report presents the results of a multi-country assessment of integrated health programs conducted by MEASURE Evaluation. This multi-country assessment was intended to be a first step in gathering information to understand the types of services that are being integrated, rationale for the choice of integration model and interventions, perceived strengths, weaknesses, and gaps of M&E systems, and environment, policies and systems that facilitate service integration.

## I. SURVEY METHODOLOGY

Survey participants were identified based on recommendations from a USG inter-agency group on integration. Group members identified the appropriate mission personnel to contact and facilitated introductions for MEASURE Evaluation. MEASURE Evaluation followed-up via detailed email correspondence outlining the survey and its objectives and including the survey as an email attachment. The email requested that the mission staff or their designee determine who should participate in a phone interview. We conducted 10 phone interviews between 5/19/2013 and 12/12/2013. With a few exceptions, there was one call per country and each call lasted about one hour.

[1] Available at: http://www.ghi.gov/principles/docs/principlePaperIntegration.pdf

After a brief discussion of the integrated activities in each country, participants were asked to focus on just one integrated health program. Thus, the results generally focus on one program per county and are not meant to be exhaustive or representative of all integrated programs.

## II. Reasons for Choosing Integration

Survey respondents across participant countries identified numerous reasons for pursuing health integration in general and health service integration specifically. They identified integration as a means to extend services to underserved areas as well to add services to already existing service locations. Additional reasons for pursuing integration, such as cost-effectiveness, ease of providing a continuum of care, and potential improved service provision sustainability were also highlighted. The benefits of integration over vertical health service provision were widely acknowledged by participants and included reduced client drop-out, reduced stigma of health-seeking behavior, improved prospects for long-term health system sustainability, and synergy with behavior change counseling (BCC) activities.

## III. Deciding What Services to Integrate

All countries noted using similar decision-making criteria to identify and decide upon which services to integrate and how to best organize integration. Based on participant responses, the fact that these decisions are very context-specific in regard to national and sub-national conditions cannot be overstated. An early step in the decision-making process usually focuses on understanding rates of cause specific mortality and morbidity among the population, or a subset of the population, in-country. Once this is taken into consideration, evidence-based interventions to combat these causes and related health challenges are identified and considered. Another input in the decision-making process is often a consideration of the compatibility of the characteristics of the potential health services possible to integrate, of the clients seeking those services, and of their health needs. A focus is often placed on prioritizing areas where compatibility is the greatest.

## IV. Choosing an Integration Model

As a result of these considerations, choices of integration models were highly variable. While reasons given for pursing integration were fairly uniform across countries, integration models in-use varied notably. Variation was often present within the same health areas and same health interventions. Nonetheless, a guiding principle for essentially all participants was that providing as many services as possible at the same location and during a single visit was ideal. When this was not possible, aiming for co-located service provision and referral systems, as well as satellite and outreach activities to augment service provision, was common.

## V. Integration Inputs and Overcoming the Challenges of Integration

Challenges to integration noted by respondents included health system areas such as human resources (including both clinical and non-clinical staff, and considered in terms of both workforce quantity and workforce skill), infrastructure, coordination (with the government, amongst partners and stakeholders, between programs, etc.), and service quality. The most challenging elements from the point of view of participants are service provision, funding streams, information systems, and monitoring and evaluation (M&E) systems to support health services. In the future a key area of investigation will likely continue to be the consideration of challenges to integration, as well as to specific integration areas, and how to most appropriately overcome them.

## VI. Monitoring and Evaluation of Integrated Services

M&E is a formidable area of consideration unto itself. Survey results suggest that adapting M&E systems to integrated approaches is lagging behind program changes towards integration. M&E systems largely follow donor information demands, which were noted as overwhelmingly vertically aligned. Given both the structure of funding streams and program reporting requirements (as well as other more secondary factors), M&E systems generally do not measure integration per se. Although true at the level of program-specific oversight, this is especially relevant for governmental M&E efforts. There are limited instances where data collection forms in use contain information about multiple disease areas and some level of integration indicators, but in most cases indicators to measure integration simply do not exist. Many participants have a desire for change and for advances in the development and implementation of indicators that measure integration and the implementation of the integrated intervention package.

## VII. Environment, Policies and Systems that Facilitate Service Integration

The level of commitment to health integration present in the wider environment—particularly within the realm of public policy—varied among participant countries. All respondents noted some level of integration outlined implicitly within country policy documents, especially within community health strategy documents. Countries with the most development in this area, such as Senegal, Bangladesh, and Kenya, have aspects of integration in their national health sector strategic plans, health area specific strategic plans, and minimum packages of services. In the case of specific disease strategies, it is not uncommon to find reference to additional diseases (e.g., TB in an HIV strategy). Integrated packages of services at the national level focused on specific groups are not uncommon; for example in Nicaragua for key populations.

The idea of policy champions in the advancement of the legitimacy of integration in public policy was particularly relevant in regards to institutions. Policy champions—when noted—included exclusively donors and institutions, both from the government and other sectors. Certain actors promote integration in their specific areas of interest (the example

was given of Australian Aid promoting gender-based violence integration in Cambodia). The role of technical working groups (TWGs) appears very important to advocate for and inform integrated interventions. TWGs were often noted as having brought partners, donors, and governments together to gain consensus on integrated program strategies.

## VIII. Upcoming Country Case Studies & Going Forward

This activity was also completed to gain information as a basis to inform in the selection of two participant countries for in-depth case studies. These countries have since been identified as Malawi and Senegal, and results for these case studies are anticipated for late 2014. It is hoped that information from this assessment, the in-depth case studies, and the wider literature will combine to inform and aid missions and host countries in the planning, design, monitoring and evaluation of integrated health services. This will be accomplished by gaining an understanding of the factors facilitating the choice of integration models and interventions, intervention inputs and outputs and gaps in documentation of M&E, useful indicators to integrated programs, and by furthering the evidence and learning about integration.

# INTRODUCTION

## I. BACKGROUND AND PURPOSE

The rationale behind the push to coordinate and integrate the delivery of health interventions is that it may make better use of resources, meet the full range of health needs, and achieve sustained improvements in health. Several descriptions and definitions exist in an attempt to give a common language to what is meant by "integration." One oft cited definition of health service integration comes from the World Health Organization (Waddington & Egger, 2008): "The management and delivery of health services so that clients receive a continuum of preventive and curative services, according to their needs over time and across different levels of the health system."

Studies of integrated health services have shown integration to be feasible across a number of countries, service delivery interventions and settings, and target populations (Lindegren et al., 2012). Systematic reviews of integrated HIV; family planning; and/or maternal, neonatal, and child health services suggests that integration can improve quality of care, increase uptake of services, and result in positive effects on outcomes such as contraceptive use, pregnancy incidence, initiation of antiretroviral therapy (ART), reduced time to treatment initiative, and HIV testing uptake (Spaulding et al., 2009; Lindegren et al., 2012; Wilcher et al., 2013). Fewer positive effects have been found on outcomes further along the causal pathway, such as retention on treatment, unintended pregnancy, HIV or sexually transmitted infection (STI) incidence. In some cases these outcomes have not been studied; in others, a lack of positive results may be due to the relatively longer follow-up time and larger sample sizes needed to detect differences.

Few studies have included costing data, although of note is a recent study of the costs, cost-efficiency, and cost-effectiveness of integrated family planning and HIV services (Shade et al., 2013). Total costs in the integrated sites were more than twice the costs of the non-integrated sites due to training, refresher training, reorganization of patient flow and logistics; re-design of clinic space, and equipment costs. Results suggest lower cost per additional new user in the integrated compared with non-integrated sites and economies of scale (i.e., lower costs per additional user in larger sites compared with smaller sites).

The increasing attention to building an evidence base for integration compared with the preceding decades can be attributed to the infusion of funds to combat the HIV epidemic that has fueled, both directly and indirectly, investments in integrated approaches and available evidence. At the same time, endorsements of integration come from a number of international groups; among them are calls from USG initiatives including the Global Health Initiative (GHI), and the President's Emergency Plan for AIDS Relief (PEPFAR) (PEPFAR, 2009; USAID, 2010).

The USG has launched a variety of efforts that result in a comprehensive approach to communicate, learn about, and promote integration. Efforts include:

- Funding projects focused on integration[2]
- Issuing guidance (see for example PEPFAR, 2011)
- Developing indicators (on integration and family-planning/HIV integration, forthcoming)
- Convening meetings[3]
- Forming working groups and task forces[4]
- Sponsoring literature reviews (see Lindegren et al., 2012); and
- Publishing in peer reviewed literature (see for example Schuchat & De Cock, 2012 and Johnston et al., 2013)

One important landmark among these USG efforts was the development and publication of the *GHI Principle Paper on Integration in the Health Sector* in May 2012.[5] This document builds on the literature reviews on integration and experiences from the field. It provides an overview of the state of integration, definitions, examples of service delivery packages and integrated approaches, and contains a scoping tool that can be used to understand the scope and nature of integration in a country. The paper also includes a call for M&E processes to be included in integration programming so as to identify and find solutions to bottlenecks in integration and improve policies and programs.

Following publication of the paper, a USG inter-agency group on integration developed a results framework for integration (Appendix 1) and a list of indicators to measure the outputs and outcomes of integration (document forthcoming). This framework is a graphical and narrative representation of the theory of how implementation of the integration principle will improve health outcomes. It describes the main health system inputs necessary to result in coherent service integration (outputs) and measurable outputs and outcomes. The framework describes where to intervene and what key concepts to observe and measure. It will also assist in the interpretation of research results and facilitate a critical assessment of program suitability and completeness of implementation of activities.

[2] See for example FHI 360's Prevention Technologies Agreement (PTA) project (http://www.fhi360.org/projects/preventive-technologies-agreement-pta) or CDC's work in Namibia (http://www.cdc.gov/globalhealth/countries/namibia/pdf/namibia.pdf)

[3] See for example the 2013 Meeting on Integrating family planning/HIV/MNCH Programs at http://www.aidstar-one.com/resources/technical_consultation_materials/meeting_integration_fphivmnch_programs

[4] For example, in 2013 a USG family planning/HIV Integration Task Force was created and made up of representatives from USAID, CDC, Department of Defense, and OGAC (Johnston et al., 2012)

[5] Available at: http://www.ghi.gov/principles/docs/principlePaperIntegration.pdf

The integration indicators that have been developed align with the results framework's main integration outcomes, coverage, access, and uptake. There are also illustrative indicators that align with framework elements of policy and governance, health systems functions, coherent service integration, demand creation, responsiveness and quality, and efficiency. Indicators are intended to be used by countries to strengthen their M&E of integration.

In-country PEPFAR teams are similarly encouraged to emphasize integration across several health areas as a strategy to achieve PEPFAR's goals and activities (PEPFAR, 2013). New in FY 2014 is an indicator related to family planning and HIV integration developed by the USG family planning/HIV Integration Task Force that appears in the Monitoring, Evaluation, and Reporting Strategy (MER) Operational Guidance and Indicator Reference Guide (available internally on PEPFARii.net). This indicator is a type of disaggregation of one of the indicators put forth by the USG inter-agency group on integration.

Finally, the USG inter-agency group also worked to define a learning agenda in order to further the learning around integration. The learning agenda is based on an analysis of the literature and the expressed needs of programmers in the field. Following the GHI Principle Paper and the development of the results framework, there remains a need to further understand the current experience of countries implementing integrated health services, the value added of integrated service delivery compared with community standards of care, and the health system changes needed to support integration, including M&E systems.

MEASURE Evaluation is working to inform this learning agenda and further define and articulate the learning questions through a series of activities. The goal of the activities is to assist missions and host countries to plan, design, monitor, and evaluate integrated health services by gaining an understanding of the factors facilitating the choice of integration model and interventions, intervention inputs and outputs, and gaps in documentation of M&E, indicators useful to integrated programs, and further the evidence and learning about integration. This includes adding to the body of knowledge used to identify activities that can be undertaken to support the highly country specific process of designing, implementing, and monitoring and evaluating the most appropriate integrated health interventions for their context.

To achieve these objectives, MEASURE Evaluation has carried out: 1) a multi-country assessment of integrated services and programs in order to achieve a broad, landscape perspective on how countries around the world are approaching integration; and is carrying out 2) in-depth country case studies in Senegal and Malawi in order to document needed changes to health system inputs in order to achieve successful health service integration and to document strengths and weaknesses of M&E systems to monitor and evaluate integration.

This paper presents the objectives, methods, and results from the first activity, the multi-country assessment.

## II. Activity Objective

The objective of this activity was to gain a better understanding of nationally supported integrated health programs in selected USG-supported countries, specifically in relation to:

- Types of services that are being integrated, reasons for choosing integration, and choice of integration model and interventions;
- Perceived strengths, weaknesses, and gaps of M&E systems; and
- Environment, policies and systems that facilitate service integration.

The information that follows has a dual-utility.

1) It provides an overview of selected integration activities being carried out in a subset of countries where there is a United States Agency for International Development (USAID) mission presence. The report describes characteristics of those integration activities and M&E systems. The findings should be of interest to participant countries as well as other countries and regions to learn more about integration as it is currently taking place.
2) It identifies areas of integrated services that might benefit from further study, either during the aforementioned case studies (pg. 10, above) or for more in-depth investigation in a different setting.

## III. Survey Methods

To identify participant countries for the survey, USG inter-agency group members first generated a preliminary list based on data from USAID missions' annual reports and staff knowledge of country programs. It ultimately included criteria such as 'being home to a nationally supported integration project', and considerations including 'achievement of geographic and programmatic variety'. All countries considered were home to programs that were scaled up to a regional or national level (or are being scaled up over a period of three to five years).

Group members identified the appropriate mission personnel in candidate countries and facilitated introductions to them for MEASURE Evaluation staff. MEASURE Evaluation staff then followed-up via detailed email correspondence outlining the survey and its objectives and requesting to arrange a time to hold the survey interview. The survey was included as an email attachment so that recipients could gain a better understanding of the kind of information that was being sought, gather information, and nominate additional key informant participants for the call. A number of missions declined to participate in the

survey due to a lack of suitable integration activities or other limiting factors, such as time and logistical constraints.

In total, MEASURE Evaluation conducted 10 country-focused survey interviews between 5/19/2013 and 12/12/2013 using a survey specifically designed for this activity (Appendix 3). The survey was reviewed by USAID, the Office of the U.S. Global AIDS Coordinator (OGAC), and Centers for Disease Control and Prevention (CDC) staff. It was pretested with individual USAID mission staff from Egypt, Bangladesh and Uganda. Two of the pre-tests took place via telephone and one was conducted in-person. Prior to conducting the survey, the University of North Carolina Institutional Review Board determined the survey to be exempt from board review. Survey participants included USG representatives, ministry of health (MOH) staff, implementing partner staff, and other key informants identified by the USAID mission or partner staff.

The ten participant countries included:

| | | |
|---|---|---|
| Bangladesh | Cambodia | Guatemala |
| Honduras | Kenya | Liberia |
| Malawi | Nepal | Nicaragua |
| Senegal | | |

There was variation in participation by country in terms of both the quantity and type of survey respondents. In some countries respondents participated from all of the above mentioned stakeholders (e.g., Bangladesh and Kenya). In others, a single survey respondent provided responses (e.g., Cambodia, Liberia, Nicaragua, and Guatemala).

A single telephone call was held with participants from each country, except in the cases of Kenya and Nicaragua, whose participants provided responses in writing, and in the case of Senegal, where two telephone calls were held with two participant groups. Calls, which lasted approximately one hour, were recorded in mp3 format and stored with password protection in order to verify and clarify written interview notes.

The interviewer provided background information on the activity and received participant consent prior to asking the first survey question. Participants were informed that they could choose not to respond to questions and could end their participation at any time. After a brief discussion of the integrated activities in each country, participants were asked to focus on just one program. Thus, the results focus on one program per county and are not meant to be exhaustive or representative of all integrated programs.

Participation on calls with more than one respondent was conversational, with participants openly offering their responses to survey questions in a group setting. Generally, the interviewer asked whether participants had anything more to add prior to moving on to the next question. At the end of the survey participants were asked about their willingness

to facilitate an in-depth case study in-country and if they saw value in such an exercise. Upon completion of the call participants were thanked for their participation.

## IV. METHODOLOGY OF SURVEY ANALYSIS

Qualitative data analysis was completed via an inductive approach, which is an approach frequently used in health and social science research.[6] This approach involved grouping data from the survey responses and then reviewing it for similarities and differences. Interview notes and recordings were reviewed and compared several times in an iterative fashion in order to identify themes and categories from the qualitative data. The primary purpose of using this approach was to facilitate the emergence of research findings from the most frequently cited, significant themes and issues within the data. These themes and specific country examples are presented in the report.

[6] Thomas, David R. A General Inductive Approach for Analyzing Qualitative Evaluation Data. *American Journal of Evaluation*, ISSN 1098-2140, 06/2006, Volume 27, Issue 2, pp. 237 – 246

# COUNTRY OVERVIEWS

This section provides a summary of each country's integrated program. As per the structure of the survey, respondents were asked to report on one integrated program that they knew of well. Thus responses were not inclusive of all integrated programs. Appendix 4 is comprised of a table that lists the country; the name of the program(s) discussed, and includes information about integrated services in-country.

## I. SENEGAL

USAID's health program in Senegal is divided into five components. Participants primarily provided responses in relation to the USAID Community Health Program (Programme Santé Santé Communautaire II, or PSSC II), implemented by ChildFund. PSSC II offers community-based service provision for HIV/AIDS, maternal and child health (MCH), reproductive health, family planning, and non-communicable diseases (NCDs).

The program uses a one-stop shop integration model based on the country's "health hut" system. Services are available from individual health care providers trained to provide all services that form part of the essential health package (in Senegal, Paquete POPAEN). The government of Senegal is currently harmonizing the service package and integrating the health-hut and community health system into the formal health system through the National Community Health Policy. In addition, a national protocol and norms document has been developed, also jointly with the MOH. They are also developing national standards of service delivery and care.

The goals of the program include: to improve the quality and availability of products and services, to impact policies of community health, to improve integration and collaboration within the health team, and to develop in their roles as partners and community actors. Improved ownership of community health by the Senegal MOH and harmonizing relations in community health with other national initiatives are also priorities.

Another project that was referenced was the Maternal, Neonatal, and Child Health/Family Planning/Malaria Project, which supports the MOH, and more specifically the MOH health package, and is currently being scaled up by IntraHealth International.

## II. NICARAGUA

Since 2010, Nicaragua and the Central American Region have been implementing the HIV combination prevention approach (see Guatemala, below). Forming a part of this approach, the PrevenSida project has been implemented in Nicaragua by University Research Corporation (URC). Also since 2010 (and across six countries in the region, excluding Honduras), the Combination Prevention Program (PSI-PASMO) is being implemented,

contributing to the general goal of the Central America Partnership Framework of reducing HIV and AIDS incidence and prevalence in the Central America region.

The focus of the project is on addressing HIV/AIDS at the local level via non-governmental organizations (NGOs) and private sector prevention service providers. The base service is HIV/AIDS (including both prevention of transmission among key populations, as well as care and treatment [including the promotion of treatment adherence] among HIV-positive individuals), and other services are added to that platform. This has been done via a mixed integrated model based on a hybrid between a one-stop shop and a referral system. The referral system includes referral to voluntary counseling and testing, treatment for people living with HIV, family planning services, STI services, and treatment of opportunistic infection. NCDs are also addressed via referral to alcohol/drug abuse centers for alcoholism and drug addiction, as well as referral to other chronic disease treatments and psychological services.

The PrevenSida project works to increase healthy behaviors in order to reduce HIV transmission among both key populations and the population at large, with an expected 50% increase from baseline in the consistent use of condoms among key populations in all sexual contacts, including those with long-term partners; a decrease of 30% from baseline in the number of multiple partners among key populations; and an increase of 60% from baseline in the use of HIV counseling and testing among key populations by the end of the program. Among key populations, the focus is on evidence-based interventions, including behavior change counseling (BCC), voluntary counseling and testing (VCT), and the provision of condoms and lubricants. For people testing HIV positive, there are also referrals for anti-retroviral treatment and the promotion of treatment adherence. In addition, other interventions are provided to address structural inequities, including education on gender-based violence, referrals to centers for gender violence, and education on stigma and discrimination.

These are all outlined in a combination prevention package for key populations; a nationally recognized health service package. To date, this package has been provided through community-based services and the private sector (through which it has been provided in work places with referral to other health services). Currently, 50 NGOs working with key populations and 10 private sector medical facilities at work places are implementing these services. There is potential for implementation by MOH facilities in the future.

## III. CAMBODIA

Cambodia was noted as having a very integrated platform, including three MCH initiatives that combine to compose a flagship MCH program. The Better Health Services (BHS) project, which is led by URC, works at the referral hospital and national level. BHS is a

health systems project with a focus on TB, health financing, quality improvement, and information systems. Surveillance training and reporting (on infectious diseases) also form a part of its mandate.

The other two projects in the MCH program are the Together for Good Health (ToGoH) project, led by Reproductive Health Alliance Cambodia, and the Reproductive and Child Health Alliance project. These projects operate at the community level and cover 11 provinces where the integration model is that of a one-stop shop, with a referral system for specific services. These programs include raising awareness on avian influenza, prevention of mother-to-child transmission (PMTCT) components, family planning, nutrition, and an HIV program focused on care and support for people living with HIV (which itself includes a family planning component, as well as TB referral and testing). Since the focus is on the health center level and below to the community, activities include training midwives, improving health center management and use of data, working with volunteers, promotion of the use of discretionary funds for health, and emergency transport.

## IV. GUATEMALA

Guatemala is home to the USAID HIV/AIDS Combination Prevention program for key populations in Central America and Mexico, which is part of the PEPFAR initiative in the Central American Region. It is operationalized through Population Service International (PSI) in Mexico, Guatemala, Belize, El Salvador, Nicaragua, Costa Rica and Panama.

The HIV epidemic in Guatemala is concentrated in towns and urban areas and among key populations. A minimum health package of services was formulated out of this reality, to be offered to most at-risk populations in the region. These populations include people living with HIV/AIDS, transgender women, female sex workers, and men who have sex with men. The minimum package includes but is not limited to access to condoms, VCT services and STI diagnosis and treatment centers, emphasizing the involvement of private health providers. The integration model that clients encounter in the program ultimately depends on how and where they enter the health system, but is generally focused on a one-stop shop or referral system.

The four basic components of the program are:

1. Reduced prevalence of high-risk behaviors among key populations and people living with HIV/AIDS.
2. Increased effective interventions implemented to decrease hostility in social environments that foment and tolerate homophobia and stigma and discrimination attitudes related to sexual orientation, occupation or status.
3. Increased access by key populations to a minimum package of essential prevention and health services.

4. Strategic information obtained through research and monitoring to design or modify prevention activities.

## V. MALAWI

Support for Service Delivery Integration (SSDI)-Services is Malawi's flagship program in service integration. There are two other programs under the SSDI banner: SSDI-Systems (led by Abt Associates), and SSDI-Communication (led by Johns Hopkins University). The goal of SSDI-Services is to extend the long-term outcomes of newborn and child wellbeing and mortality and to lower the risk of HIV, particularly via the concept of "no missed opportunities." In other words, anytime that a client comes into contact with the health system, that client should able to avail themselves of as many needed services as possible. It is an evidence-based intervention tailored to local conditions, currently in 253 facilities (with 307 forecasted for 2014). This 2014 forecast will account for 100% of the health facilities in the 15 districts where the program operates.

The program integrates family planning and nutrition into HIV, HIV into MCH, and nutrition into community-based programs. MCH is considered the base service platform onto which other services are integrated. The integration model depends on specific conditions (including the health system level, infrastructure, services offered, number of providers, and the national guidelines). In small facilities, a single provider may offer all available services. In larger facilities, services may be available from different providers in the same facility. Referrals are also available for cases where facilities do not offer a particular service. For example, permanent contraceptive methods may only be available at the district hospital or higher levels.

In addition to what is offered at the health facilities, a national community-based health worker program offers integrated services in an effort to improve household-to-health-facility continuum of care (linking households to the health center and, as needed, on to the district hospital). The program seeks to provide a variety of services that can be offered at the community level in an integrated fashion by trained community health workers known as Health Surveillance Assistants. Health Surveillance Assistants conduct health education, distribute mosquito nets, provide antenatal support and referral, and provide treatment and referral for a host of febrile and diarrheal illnesses. At the community level, community case management and family planning services are also provided.

## VI. NEPAL

An analysis by the Nepalese government to address nutrition in the country led to a multi-sector nutritional plan (MSNP) and an integrated nutrition project focused on MCH, family planning, nutrition (including 'backyard gardens,' small-scale chicken farming, etc.), and water and sanitation. The Suaahara project, implemented by Save the Children, focuses on

the 'first 1000 days' after birth, and is aimed at fighting stunting and malnutrition. The project is currently in 20 of Nepal's 75 districts and is expanding.

According to participants, the project is doing what Nepal has outlined in its multi-sectoral nutrition plan and is aligned with the latest Leveraging Agriculture for Nutrition in South Asia (LANSA) theories on addressing malnutrition. The project is unique, operating at the household level, and is focused primarily on communication and dissemination of health messages, services and commodities. The project has clinically measurable goals, such as reduced stunting.

## VII. KENYA

Kenyan participants noted that integration exists across Kenya, although there is variability in terms of how well integration is being operationalized among counties and facilities. Reproductive health/HIV Integration began in 2002 with rapid assessments, and developed into a family planning/HIV strategy, in part based on experience from various other integration models (family planning/VCT, cash transfer/family planning, family planning/ART, STI/ART/PMTCT). The minimum package for RH/HIV is a set of recommendations for different types of RH/HIV integration services that are feasible by level of care.

This RH/HIV minimum package seeks to provide guidance to implementers or service providers on the minimum requirements in terms of infrastructure, human resources, skill set and training materials, equipment, commodities and supplies, and M&E that are necessary at each service area or clinic to provide effective services. With limited resources and a high demand for quality services, implementers must consider the possible synergies in each particular context and plan services to reach as many of the target population as possible. The goal of the minimum package is to operationalize the National RH/HIV Integration Strategy.

At the community level, the package integrates HIV counseling and testing, family planning information & counseling, STI information, information on reproductive tract cancers (e.g. cervix, prostate, breast), information on post rape care service, and information on TB & maternal and newborn health. At the facility level, the package integrates an MCH/family planning unit which includes focused ANC and post-natal care. Outpatient includes family planning, HIV testing and counseling, cervical cancer screening, prostate and breast cancer screening and post-rape care. The comprehensive care unit integrates family planning, STI & cervical cancer screening and prostate and breast cancer screening. A youth friendly services model also includes family planning, HIV testing and counseling, STI, cervical cancer screening & post-rape care. Inpatient services include maternity and post-natal wards integrating HIV testing and counseling and family planning.

The programs that were mentioned by participants were designed to enhance access to comprehensive, high quality, effective, efficient, affordable, and sustainable reproductive health and HIV services. Community-based components include a basic care package delivered through home-based care and home visits to meet the needs of every member of the household. There are also support groups (e.g., mother-to-mother), HIV counseling and testing, family planning information and counseling, and community-based distribution of family planning commodities by community health workers in hard to reach areas.

Respondents from Kenya reported a greater context of policy documentation supporting integration, suggesting an important government recognition and potential promotion of an integrated approach. Key policy documents include the Kenya National Health Sector Strategic Plan II (which includes the Kenya Essential Package for Health), the Kenya National Health Sector Strategic & Investment Plan (2012-2017), the Kenya National Reproductive Health Policy (2007), the Kenya National HIV & AIDS Strategic plan, the National Reproductive Health-HIV integration strategy, and the Minimum Package for Reproductive Health and HIV Integrated Services.

## VIII. BANGLADESH

Participants noted that Bangladesh is home to many integration projects. Projects generally incorporate Bangladesh's Millennium Development Goals and the goals of the Government of Bangladesh's Health, Population and Nutrition Sector Development Program (HPNSDP). Where the government seeks to monitor the integration process they look into the higher level indicators via an annual program review. Aside from limited cross-cutting indicators there are no indicators that monitor how integration is being implemented.

The HPNSDP is a sector-wide program for overall improvement of health, population and nutrition, and the service delivery model is based on a mixture of one-stop shop and co-location. Its objective is to increase demand and improve access to and utilization of health, population and nutrition services.

The USAID NGO Health Service Delivery Project (Smiling Sun), is a network of partner NGO clinics built to support service delivery in population, health, and nutrition. The project supports the delivery of primary health care through the delivery of an essential service package via a nationwide network. The essential service package includes access to reproductive health, MCH, nutrition, BCC, communicable disease, and limited curative care. The project is designed to provide care via a one-stop shop model, although many activities that operate on this model in Bangladesh are complimented by satellite services and outreach activities.

MaMoni—Integrated Safe Motherhood, Newborn Care and Family Planning Project, was also mentioned by participants, as was MaMoni Health Systems Strengthening, whose goal

is to improve the utilization of integrated maternal, newborn and child health, family planning, and nutrition service.

## IX. LIBERIA

Liberia is home to a flagship Government to Government (G2G) program resultant of a bilateral agreement which incorporates or integrates malaria activities along with other activities such as family planning, immunization, HIV, etc. It operates at the national level and its goal is to prevent women from becoming infected with malaria during pregnancy. A major deliverable of the G2G mechanism is the integrated supportive supervision which is carried out by all key heath donors and the Ministry of Health and Social Welfare. The integrated supervision is conducted quarterly and all health interventions, ranging from community-based, to quality improvement, to data quality, are reviewed during these visits.

The program's base service was considered as maternal health, and malaria was incorporated into it (malaria and pregnancy are one intervention area under Liberia's National Malaria Control program). As such, the integration activity mainly incorporates malaria and pregnancy, and highlights the distribution and usage of bed nets for combating malaria (particularly in rural villages, defined as being located greater than five kilometers from a health post). It also includes promotion of delivery with skilled birth attendants, nutrition education and awareness, and HIV testing for pregnant women. The program includes weekly outreach to meet some of these responsibilities.

Integration was identified as an appropriate response in country in part because of timing issues; e.g., when a child receives vaccines on a set timetable, it is the perfect time to talk to mothers about family planning, the safe spacing of children and malnutrition. Thus, the immunization program and its specific timetable offer a platform to create awareness. M&E staff is able to count on sound government data and an effective health information system. Indicators, as in other countries, are not integration specific, and instead focus on clinical results. Nonetheless, the respondent noted that there is a strong belief that "integration works."

## X. HONDURAS

According to participants, health services in Honduras have been approached historically in the form of a framework of responding to specific health challenges via vertical programs. Around 2008, the country acknowledged that services were fragmented and began to consider how to make systems more integrated and more sustainable. In particular, HIV service provision has historically been vertical due to discrimination and stigma. A new strategy was defined around 2012, with the participation of USAID, called the Integrated Approach to HIV/AIDS (Abordaje Integral del VIH/SIDA), within the realm

of the reform. Its goal was to increase integration and to raise the level of responsibility at the regional level vis-à-vis the national level.

Honduras formulated a new health model in mid-2013 whose principal focus is on family and community health. The model is directed toward an integrated focus for health services from a strategic standpoint. It is based on a legal framework, including the National Health Model and a policy on reducing maternal and child mortality. A validation process was carried out in relation to the provision of services, integrated with three community-based strategies. One strategy focused on the provision of family planning methods in rural areas (via health volunteers), integrated with an individual, family and community strategy, which focuses on health promotion at the community level. A third strategy focused on maternity waiting homes (Hogares Maternos) was integrated as well, and involved institutional delivery — sites where pregnant women can be safe and well taken care of as they await giving birth.

## SYNTHESIS OF FINDINGS ACROSS SURVEY COUNTRIES

Survey findings are organized and presented below based on the dominant themes that emerged from participant responses across countries. As such, the organization of findings does not follow the same structure as the survey instrument itself.

### I. REASONS FOR CHOOSING INTEGRATION

Respondents gave many reasons for pursuing health integration in general, and health service integration in particular. Participant responses indicated that the integration of health services is often used as a means either to extend access to services to unserved or underserved areas, and/or to increase access to additional services in existing service locations. This was not surprising given that respondents named access to care as a key challenge facing many them.

#### *EXTENDING SERVICES TO UNSERVED OR UNDERSERVED AREAS*

Respondents reported that integrated approaches were pursued as a means of increasing the geographic coverage of health services. As was noted by participants in Kenya, "the integration of services allows for expanded coverage," which in turn "increases service utilization, especially for underserved and vulnerable populations." This was especially true at the community level and in rural areas.

In some instances, such as in Senegal, integration was being utilized where no services had been provided previously, allowing multiple services to be provided via one provider. In others, integration increased access to services by adding new services to an already existing base service. For example:

- Liberia's respondent noted that mothers visiting immunization clinics in order to receive immunization services for their children are there able to obtain referrals to family planning services for themselves. Given the immunization schedule for children, timing dictates that these visits provide a great opportunity to raise awareness for family planning among mothers, as well as to provide them with services. A single point of entry for both mother and child is thus used to link mothers to services.

Although implementing integrated strategies was one way to increase access to services, respondents noted that not all services lend themselves to this ideal. Some services simply cannot be made available everywhere, especially at the community level in particular. This was noted to be particularly true in relation to certain family planning methods. For example:

- In Malawi, permanent family planning methods are only available at health centers in select districts, specifically through mobile services offered by Banja La Mtsogolo

and the Family Planning Association of Malawi. At the community level family planning methods are limited to temporary methods.

- Similarly, a one-stop shop integration model in Liberia was also faced with the challenge of providing permanent family planning methods. Unavailable at the community level, these services require a referral to higher-level facility or clinic. The Liberia respondent stated that referrals can also be required for certain other health concerns beyond family planning, and gave the example of complicated malaria cases involving pregnant women.

### *Increasing Long-Term Service Sustainability*

Respondent opinions referred to the idea that the integration of health services can be a key part of promoting long-term service provision sustainability. For example:

- A respondent highlighted a process that began in Honduras in 2008 to increase thinking about ways to create more sustainable health system service provision in the country. The process identified a significant dependence on donor funding for health service provision, particularly in relation to the provision of HIV services. This led to Honduras' reform towards health integration, also in part due to cost-effectiveness (which was noted as an underlying factor supporting sustainability.)
- A respondent in Cambodia also felt that integration helps to create greater sustainability within the wider public healthcare system. The respondent noted a belief that, from a systems standpoint, parallel donor-driven systems are less sustainable and less natural than integrated systems.

## II. Other Reasons for Choosing Integration

### *Cost-Effectiveness*

The cost-effectiveness of integration, particularly in relation to the alternative of vertical service provision, was often cited by participants as a reason for pursing integration. As noted above, cost-effectiveness was also noted as a contributor to long-term service provision sustainability. Some cost efficiencies are quite notable; for example:

- A Nicaraguan participant reported that with integration and organizational improvement, service provision costs fell by half (rom $10 per capita to $5 per capita). This was specifically in relation to the cost of service provision on a per capita basis for the provision of six HIV services. The number of client contacts in the provision of these six services fell from four contacts prior to integration to just two post-integration. Clients are receiving in two visits the same services they previously received in four.

Further exploring reasons for the cost-effectiveness of integration, Table 1 highlights selected responses from participant countries.

***Table 1: Selected Reasons Given for Cost-Effectiveness of Integration***

| Country | Kenya | Bangladesh | Nicaragua | Malawi |
|---|---|---|---|---|
| Area of Cost-Effectiveness | • Human Resources<br>• Infrastructure<br>• Time | • Human Resources | • Human Resources<br>• Time | • Human Resources<br>• Infrastructure<br>• Commodities |
| Details | Participants noted that integration reduces total client visits, leading to time savings for both the client and service provider.<br><br>Integration also limits the need for multiple rooms and the need for additional human resources. | Participants noted human resource savings in particular, especially under the one-stop shop integration model. | The participant stated that the number of client contacts required per service received reduced, thus creating greater efficiency with human resources. | Participants noted that integration can result in streamlined staffing and resources in comparison to vertical service provision.<br><br>Integration also reduces overlapping efforts, or what two participants referred to as 'the duplication of efforts'. |

### *Continuum of Care*

In Bangladesh, respondents reported that it was considered important for the health system to provide services that are consistent with a 'life-cycle approach', which refers to the objective of covering health needs of the population across the continuum of life at all of its stages. Integration was pursued in-part because it was believed that it can help ensure that clients in all cycles of life are positively affected (that no age segment of the population is left behind/left out of integrated service provision). Respondents reported that it is felt that integration helps to achieve this.

## III. Benefits of Integration

Participants reported having observed the following benefits of integrated services.

### *Reduced Client Drop-Out/ Increased Treatment Adherence*

Respondents noted that there is less client drop-out from the health system when services are integrated than under traditional vertical health service provision, particularly in cases in which clients can get most or all of their services from a single provider and/or during a

single visit. Respondents noted that this is not only true of one-stop shops but also of referral systems. A few examples included:

- In Kenya, respondents stated that the number of pregnant women living with HIV lost to follow-up has been reduced via an integrated model. There has also been increased treatment compliance.
    - This has been particularly true in Kenyan comprehensive care centers (CCC's), where the number of women receiving modern family planning methods has been increasing. A 2008/09 study conducted by FHI360 in the Rift Valley and coastal provinces showed that use of modern family planning methods differed significantly from baseline, after adjusting for province and facility size and controlling for clustering by individual, facility, and facility by time.
- Kenya highlighted an additional increase in testing for antenatal mothers in the ANC, maternity, labor ward & OBGYN ward due to service integration in these departments. The OBGYN ward offers an integrated Comprehensive Post Abortion Care Service.

Based on responses, this decline in client drop-out is mainly operationalized by increasing the number of health issues addressed per client visit and thereby avoiding potential barriers to a client returning to seek care. These barriers, which can be notable factors to client drop out in a vertical system, include cost to pay for a follow-up visit and a lack of transportation options. These barriers often disproportionately affect people living in hard to reach areas and members of key populations.

### *Increased Uptake*

According to respondents, client uptake of services increases under integration in part due to the anonymity attached to health-seeking behavior that integration provides. This is particularly true in relation to HIV care and treatment. A number of participants noted that, whereas an individual may not seek HIV testing or treatment services from an HIV-specific provider, the same individual often will do so at a facility where services are integrated. As one participant from Malawi noted, "When HIV services are sought out within the context of integrated services, the stigma is not there."

### *Opportunity to Maximize Behavior Change Activities*

As one Bangladeshi respondent explained, integrated services can be provided perfectly, yet this would be of doubtful utility without adequate health-seeking behavior towards these services on behalf of clients. Behavior change can result from integrating health services, as noted above, e.g. by reducing the stigma of health-seeking behavior. Yet focused efforts towards behavior change activities are also important in order to promote health

seeking and can be a vital component to improving service uptake (and strengthening integrated service provision).

Such behavior change activities often face challenging cultural norms, which can be pervasive. They can be broad, such as the role of the male in the eyes of health providers in Guatemala, or they can be more specific. Changing norms like these can help facilitate behavior change, and go hand in hand with integration in increasing service uptake.

***Table 2: Success in Challenging Norms and Behavior Change to Improve Integrated Services***

| Senegal's Grandmother Strategy | Nepal's Demonstrations |
|---|---|
| In Senegal, a 'grandmother strategy' has been used as an effective means of behavior change and promotion of health-seeking behavior.<br><br>Via this strategy, older women in communities receive education on family planning. They, in turn, are able to educate younger women about the family planning services available to them. Given the respect that these women hold in the community, and influence that they have - particularly with younger women - the strategy has proven effective. | In Nepal, demonstrations have taken a role alongside communication in the promotion of behavior change, and have been successful. Demonstrations have been given on topics such as cooking, gardening, and small-scale poultry farming.<br><br>Communication remains important; whereas the focus on nutrition used to be communicated in terms of how malnourished babies are physically smaller, research has given more credence to the message of the impact of malnutrition on cognitive abilities and motor skills. Giving families the message that improved nutrition will help their children perform better academically, for example, has improved Nepal project staff's ability to positively influence family nutrition. |

## IV. DECIDING WHAT SERVICES TO INTEGRATE

Key survey questions addressed why countries are choosing to integrate the specific services that they are integrating. Straightforward and consistent responses to this question were received from essentially all survey participants. Health service integration in particular was described as being evidence-based, resulting in minimum service packages, based on service compatibility, and resultant of country-specific epidemiology. We will now examine each of these aspects in detail.

### *RESULTANT OF COUNTRY-SPECIFIC EPIDEMIOLOGY*

In all cases respondents noted that epidemiological data, both at the national and local levels, informed decisions on service integration. For example:

- A Nepali integrated nutrition project used global scientific best practices to identify seemingly disparate activities as essential to addressing chronic malnutrition. These activities included water and sanitation, community gardening, small-scale poultry farming, and family planning.

Similarly, epidemiological data has played a key role in validating decisions on what services not to integrate.

- In Cambodia, the decision was made not to integrate HIV services into service provision in rural areas. This was because the epidemiology of HIV in-country was such that it would not be considered a cost-effective use of resources.

In addition, epidemiology can place significant constraints and demands on the potential of integrated efforts. For example, the HIV epidemic in Guatemala is concentrated among transgender women and MSM. Therefore, according to the respondent, integration of health services should be moving ahead in topics like harmonization and information systems on health status and health access for these groups. Yet efforts towards this goal in-country are considered very inadequate.

### *Evidence-Based, Resulting in Minimum Service Packages to Maximize Impact*

Respondents reported examining local, regional and global evidence to understand which potential interventions and integrated measures have the greatest potential benefit in terms of mortality and morbidity reduction per unit of investment. This evidence generally resulted in a package of services designed to have the greatest possible positive impact. For example:

- In Senegal, this process led to the community level essential package known as the POPAEN package (Plan opérationnel de passage à l'échelle nationale). This package is aimed at addressing health priorities at the local level, including the reduction of maternal and neonatal mortality and morbidity. POPAEN includes aspects of health education, counseling, and service provision related to nutrition, family planning, HIV testing, oral rehydration therapy, and other primary care interventions.
- In Nicaragua, an HIV-focused minimum package of services includes BCC, condom and lubricant provision, rapid HIV testing and counseling, STI counseling, family planning, and drug abuse counseling.

### *Service Package Compatibility*

Respondents reported attempts to recognize and exploit synergies available from integrating specific services together, especially at the community level. For example, services that are provided to the same target audience (such as in the cases of family planning, reproductive health, and HIV), were often integrated together.

- Cambodia's respondent shared the case of integrating reproductive health with cervical cancer screening, as the same women are generally at risk in both areas.
- Similarly, in Liberia, malaria is integrated with MCH and nutrition because the same women and children typically require these services.

- In Kenya, integration of family planning, reproductive health services and HIV services was the result of observed client needs. It is common for clients seeking these one of these services to be sexually active, and thus they may be at risk of HIV infection, unintended pregnancy, or other reproductive health problems.
- In Cambodia, where the HIV epidemic is fairly concentrated among key populations, the HIV program focuses on providing prevention, care, and treatment services to entertainment workers—female workers in entertainment establishments who may be engaged in sex work. This has opened the door to integration in the provision of family planning services, as a high unmet family planning need has been recognized within this target population.

In addition, participants reported that there were often benefits gained from an interaction between health areas, and among clients. For example:

- Kenyan respondents noted that women living with HIV benefit from understanding how their HIV status impacts their contraceptive options and usage. Therefore family planning and HIV services are beneficial to integrate together.
- Respondents from Senegal noted that childhood immunizations and their scheduling timeline offer an excellent and natural opportunity to provide mothers with other services, such as family planning.

## V. CHOOSING AN INTEGRATION MODEL: A QUESTION OF CONDITIONS

The survey instrument defined four categorical models of service integration, noted below in Table 3. What service integration models are countries utilizing? What are participants' thoughts in terms of how to optimally select an integration model for a specific context or intervention? By what criteria are these models selected?

***Table 3: Integration Models Identified***

| Model | Description |
|---|---|
| One-stop shop | All services are provided from the same provider in the same location. |
| Co-location of services | Services are located at the same facility, usually offered by different providers. |
| Referral system | Clients are referred from one service delivery point to a second service delivery point. A referral can be made within the same facility or to a different facility, and include the same provider or a different provider. |
| Other | A health integration model not encompassed by one of the above models. |

Respondents noted that multiple integration models are being used effectively and in a mixed fashion as a means to implement and operationalize integrated service delivery. Thus, according to almost all responses, the question can be framed not as a matter of

choosing one model over another; instead, different models are often implemented simultaneously to pursue a larger integration strategy. This variation in applied models was reported as dependent upon varying geographical contexts, health system levels, infrastructure availability, and target populations, among other factors.

Yet Kenyan participants did note that a mixed one-stop shop/referral system integration model is generally the most appropriate in most cases. This is due to its ability to successfully maneuver the inadequacies in human resource, skills, infrastructure, and equipment that integration must face. Therefore, Kenyan facilities generally use such a model to integrate family planning into CCC's, HIV testing and counseling into family planning, and HIV testing and counseling and PMTCT into ANC and cervical cancer screening (at the CCC's).

Kenya also provided a comprehensive overview in terms of service integration models operating in-country. The examples given were illustrative of the variety that exists in service integration. In terms of on-site integration (one-stop shop and intra-facility referrals), services reported included:

- HIV treatment and care services which include family planning and linkages to CCC's.
- MCH models with integrated HIV counseling and testing, PMTCT, early infant diagnosis, cervical cancer screening and TB screening, with linkages to care and treatment for clients living with HIV.
- Additional models with a focus on comprehensive care, family planning, and adolescent sexual and reproductive health.

Off-site referrals between facilities, outreach sites, and care units were also noted as being available for family planning counseling, HIV treatment and care, TB screening, uterine cancer, and cervical cancer screening.

### *Innovation at the Community Level*

Many programs have integrated services in rural areas, where few providers (or a single provider) must be capable of providing all available services. Respondents often emphasized the importance of innovation as a way to meet service provision demands at the community level, especially in hard to reach areas, and offered various examples of this. Outreach activities generally formed a part of this strategy, and were often noted as vital to augmenting service delivery integration at the community level. For example:

- Respondents noted that all health facilities participating within a Kenyan malaria program complete weekly outreach activities in accordance with an established outreach schedule. The schedule guides the provision of comprehensive service

delivery at each facility, including mosquito net provision and installation in communities that are greater than 5 km in distance away.

- Kenya also utilizes 'motorbike model outreach,' which is a facility-based outreach service that addresses geographic barriers to access with cost-effective outreach services. Services include areas such as ANC, immunization, HIV testing/prevention, TB, and malnutrition screening for hard to reach and/or underserved communities.
- In Honduras, the Individual, Family, Community Strategy is focused towards the community level and operationalized via a community health committee. These community health committees are charged with identifying pregnant women in the community with medical needs and facilitating their entrance into the health system so as to avoid undue delays in care.
- Kenya is also home to nomadic clinics, which enable the provision of integrated maternal, neonatal and child health, reproductive health, family planning, HIV services, and TB services. The clinics are designed to meet the needs of nomadic pastoralist communities.
- In other countries, such as Bangladesh, satellite services and outreach activities are also part of integration model designs.

## VI. M&E OF INTEGRATED SERVICES

Kenya summarized sentiment well by noting that "monitoring of integrated services is so far a major challenge." Government-collected indicators and project-specific cross-cutting indicators as they presently exist were viewed as insufficient. A majority among participants that were vocal about the subject voiced their desire to do more than what they are currently doing.

### *HOW ARE DATA COLLECTED?*

Based on participant responses, data collected for integrated health service programs generally do not differ from data collected for vertical service provision activities, and oftentimes is based on patient health records. Data are collected in different ways and at different levels; by programs themselves, through MOH routine systems, such as registers, and by USAID or partner organizations (e.g., through program evaluations). Most respondents that provided input to the "M&E of Integration Activities" section of the survey reported using data collection tools (registers, summary reports, etc.) that were completed as a part of the country's MOH routine health management information system (HMIS).

- In Kenya, indicators at the health facility level are collected in different registers; for example the CCC registers capture modern family planning method provision. Likewise the family planning register captures HIV testing and counseling provision. Challenges include:

- Not all registers are currently integrated
- The use of multiple registers leads to data loss
- Data is also lost as it moves upwards from the District Health Information System (DHIS), to the national HMIS
- Improvised books have sometimes been used to collect data, unfortunately leading to the inappropriate collection of some indicators
- There is no summary sheet capturing integrated services, which are thus not adequately reported. This can have a demoralizing impact on providers, as efforts may seem to go unreported.

- Participants from Malawi noted that MOH information system registers are used for data collection, although they are organized vertically, with limited integration aspects (e.g. the HIV register has family planning methods [with a focus on Depo-Provera], and it is now in the process of being reviewed to include referral for other family planning methods). These data are then entered into the integrated DHIS database, which stores it in a web-based format.
- In Bangladesh, the government HMIS is not integrated, and in addition systems are segregated between two separate directorates. A further challenge in Bangladesh is that private sector facilities, which are a large component of the country's health system, do not supply data into the government HMIS.

Typically the implementing partner, which is a USAID or a donor-funded project, is also collecting data and feeding them into their own monitoring systems as well as government information systems. For example:

- In Cambodia, data are collected from a combination of the HMIS and annual surveys, depending on the specific project. Yet the extent to which these databases allow for combined analyses across surveys, or can be investigated at the individual level to understand what services an individual has received, requires deeper investigation.
- Kenya is utilizing project performance reports and information from supervision, mentorship, and both small and large surveys. Like Malawi's participants, Kenya's felt that standard MOH data collection tools - which they use in addition to on-site supervision reports, technical quality assessment reports, referral forms, and facility custom-made registers - are useful.
- In Guatemala, the regional HIV program collects information from each activity in the field, in each country in the region. This information then enters into an electronic platform from which monthly reports are created on number of interventions, people reached, topics discussed, etc.

In addition to the above-referenced data collection tools and methods, some specific projects have also incorporated evaluations into their data collection repertoire. For example:

- A Nepali community-based project included a baseline evaluation (and will include an end line evaluation, both of which will have measured stunting as the main outcome). Interim monitoring for the community-based project is done via an annual Lot Quality Assessment Survey, which monitors implementation of program components such as breastfeeding, hand-washing, and back-yard farming.

Result and reporting requirements were noted as being strongly linked to program funding streams and respondents stated that these streams do not place importance on reporting on integration, the strength of integration, or integrated service provision. Therefore, based on participant responses - especially those of technical M&E staff - data measuring the strength of integration are simply not necessary in order for the projects discussed to report on their results. Given that this is the case, respondents noted that the data used to monitor integrated programs is therefore generally available; yet, this is not because data on integration is collected, but instead due to its absence as a requirement for reporting and M&E of integrated programs.

The benefits of the current M&E systems of the integrated programs described, which do not measure integration in-depth, are straightforward. The current systems:

- Are generally well-understood and well-used by their participants; and
- Provide the information required of them in order to complete reporting; and
- Face no significant reported challenges in terms of data collection or analysis

Respondents did note challenges in terms of capacity and HMIS':

- The capacity of local implementing organizations in effectively undertaking M&E activities is oftentimes limited.
- Health information systems may not be comprehensive; for example, in Bangladesh, the government-run management information system is not integrated and does not include private sector data. This limits the strength of the system.

### *A Disconnect Between Funding Streams, Reporting, and Integration*

As noted above, participants brought attention to the link between program reporting requirements and program funding streams. The clear message given was that donors and funding streams do not currently require any measurement of integration, the strength of integration, or the availability of integrated service provision in general.

Perhaps like the M&E systems for vertical service provision activities, those of integrated activities are considered somewhat top-down driven entities focused on reporting on given sets of indicators. These include indicators such as those on or related to the Millennium Development Goals, the State Department List of Standard Foreign Assistance Indicators, other USG initiatives such as PEPFAR, and the United Nations.

### *MEASURING THE STRENGTH OF INTEGRATION: 'INTEGRATION INDICATORS'*

One participant from Bangladesh summed up the current challenge clearly: "There are no indicators to measure integration yet, and there is no agreement [as to] how." Big questions stand out in terms of indicator development; should the focus be on indicators of service delivery? Should indicators measure quality? Should they measure outcomes? Identifying useful indicators to measure and document integration is a considerable task. To further complicate things, these could vary at various levels of a health system.

Yet there is a clear interest on the part of participants in moving in this direction. Developing a unified M&E system is in fact an ideal goal in Bangladesh. Similar is true in Kenya, about which respondents noted that "there is need to have an integrated reporting tool that would capture the integration services at the level where the country has reached with integration", (e.g. the facility level). Kenyan respondents felt that such information would be useful at all levels of the health system.

Respondents did report limited elements of integration within country MOH registers used for data collection. For example:

- Elements of HIV and malaria can be found within Malawi's maternity register
- Elements of TB can be found within the M&E of HIV in Bangladesh
- Kenya's family planning/HIV strategy developed selected RH/HIV integration indicators, such as *'number of (women) that came for MCH services that were also counseled on family planning'*

Despite the existence of these kinds of integrated data collection forms and indicators, the overwhelming majority of participants felt that current M&E systems for integrated health programs do not have appropriate indicators to measure integration itself. The only country that explicitly reported finding such current indicators of great utility was Nicaragua, whose participant noted that they allow for the documentation of efficiency gains. In this discussion the utility of measures of integration may be impacted by the maturity of the integrated program and program environment.

Of course, many participants noted a complete absence of integration indicators altogether within government systems, although attitudes toward the significance and relevance of this varied. For example, there are no specific indicators used by the MOH to measure integration in Bangladesh, and very few exist within program-specific M&E. As the indicators do not presently exist, the strength of integration has not been measured, and participants felt that promoting standard integration indicators is thus very important.

A different perspective was noted in Nepal, where there are also no indicators collected to measure integration (for a Nepali community-based project.) However, the attitude towards this issue in Nepal was different; there was a belief that best practices have proven

that the only effective intervention response to address malnutrition successfully is an integrated one. Therefore it was reported that measuring the implementation of the package of effective interventions, and not the measurement of integration itself, is what is important.

### *A Note on Data Analysis*

Aside from integration indicators, how data is actively analyzed was raised as an issue. It is difficult to discuss the success of service integration without first knowing what groups are gaining access to integrated health services. In Guatemala, information systems disaggregate information by sex, but do not have any consideration of gender identity or sexual orientation. Therefore it is difficult to reach a conclusion regarding provision of integrated services to transgender and MSM clients, although one of the common service-related complaints is precisely that there is a lack of access to health services for these groups. In a concrete sense, if a transgender woman visits a health center, although she will be immediately be referred to receive HIV test or visit the STI clinic, it is very unlikely that she will be referred to general health services.

### *Measuring Integration: The Next Step Forward?*

The next frontier in both integrated services and M&E may very well be advancing understanding of how to measure the strength of integration, what additional measures of integration are needed and what information gap they may fill, and to put it into practice at a higher level. 'Next steps' in terms of deeper investigation will include better understanding about what people need to know about integration and its association with outcomes. People also need to know about the implementation of integrated interventions and service packages or for what use may warrant other indicators and measures. A starting point for this may lie in something similar to the Nicaraguan Unique Registry System, which shows how M&E systems can be developed to report on integrated services. The system registers and reports on the type and quantity of services that are provided during any HIV patient visit. Services include BCC, condom and lubricant provision, rapid HIV testing and counseling, STI counseling, family planning, and drug use counseling. The system software was created specifically for this purpose, and currently includes data from not only programs funded by USAID and the International Monetary Fund, Nicaragua's two largest donors, but also Nicaragua's public sector and roughly 50 NGOs.

## VII. External Environment, Policies, and Systems

The level of commitment to health integration present in the external environment—particularly within the realm of public policy—varied notably among participant countries. All respondents noted a certain level of integration outlined implicitly, if not explicitly, within country policy documents. This was especially true for community health strategies. Countries most advanced in this area, such as Senegal, Bangladesh, and Kenya, have aspects

of integration in their national health sector strategic plans, health area specific strategic plans, and minimum packages of services. In other countries with less development in this area, such as in Guatemala, the intention of integration, some principles and some actions are included in a national strategic plan document. Among the least advanced in this area, based on participant responses, was Cambodia, where explicit reference to integration in the national policy environment was noted as non-existent.

In the case of specific disease strategies, it is not uncommon to find reference to additional diseases (e.g., TB in an HIV strategy). Integrated packages of services at the national level focused on specific groups are not uncommon; for example for key populations in Nicaragua.

The idea of policy champions[7] in the advancement of the legitimacy of integration in public policy was particularly relevant in regards to institutions. Policy champions—when noted—included exclusively donors and institutions, both from the government and other sectors. Certain actors are seen as promoting integration in their specific areas of interest and/or operation (the example was given of Australian Aid promoting gender-based violence integration in Cambodia).

What appears to be very important to advocate for and inform integrated intervention, based on responses, is the role of technical working groups (TWGs). TWGs were noted as having brought partners, donors, and governments together to reach consensus on integrated program strategies. For example, Kenyan participants noted that stakeholders held consultative meetings through MOH–led TWG's, specifically in relation to the reproductive health/HIV strategy.

Few programs, however, were charged with actively working to engage in policy or involved in the policy formulation dialogue. Pursuing public policy goals was noted as very important, however, by a minority of participants, perhaps most notably Bangladesh.

- Respondents from Bangladesh reported that a platform to provide integrated services, one consisting of excellent capacity directed to the challenge of delivering services, is vital for success. They felt that in many countries this would require a strategic partnership to leverage resources, which is not considered a common opportunity in Bangladesh. Therefore, the clear way forward was enabling policy, thus making the policy environment extremely important. It is no surprise, then, that participants in Bangladesh were working with the government at both the district and national level to ensure optimal functional integration between government structures.

[7] People or organizations that voluntarily take an extraordinary interest and/or make a great effort in the pursuit of the adoption and/or implementation of integration

- In Nepal, a nutrition project utilized committees led by key political figures at the local level. Participants felt that since successfully combating malnutrition is based on so many different factors, it is very important to have the district governor chair involved and using political will in order to address them.

## VIII. Integration Inputs and Overcoming the Challenges of Integration

Responses to questions on integration inputs generally overlapped significantly with responses regarding the challenges of integration. These responses focused on the challenges that must be overcome in many areas in order to improve the function of integrated service provision. Many challenges are not unique to integration but instead affect the overall health system and its functioning.

### *Coordination*

Coordination challenges noted by respondents were not limited to working with governments, or even to the uptake of integration by NGOs and the private sector, among other actors (as was the case in Senegal and Kenya). Acceptability and ownership of the integration process by facility managers and service providers themselves was also considered a key coordination challenge. As many of the interventions have focused for decades exclusively on the public sector, this is where coordination challenges have been the most significant. Coordination between different health programs is also a problem, especially when they are organized vertically to respond individually to specific health challenges.

- Coordination between health programs in Senegal has an impact at the local level, where certain facilities and property (e.g., diagnostic equipment, such as microscopes) may be considered program specific and therefore only be available for use in their own program or for its main health concern (e.g. testing for malaria).
- Scheduling coordination in integrated programs can also be a challenge. Theoretical integration may be trumped by practical matters regarding how and when services are organized. For example, a mother may come in for a child's vaccinations on a day when additional, integrated services may not be offered, as all services may not be offered all of the time.

Respondents felt that including all sectors involved in health service provision (including the public, private, and NGO sectors) would help to eliminate many coordination challenges from developing, both in the short and long-term.

- In Senegal, successful coordination across partners, donors, and government departments has resulted in significant advances in the policy arena. This has included participation in the development of documentation such as the National

Standards of Service Delivery and Care and the Community Health Strategy, to guide and standardize integrated service delivery.

### *Integration of Funding Streams*

Participant responses indicated that funding streams for service provision are still overwhelmingly vertical. For example:

- In Malawi, it was noted that earmarked funding limits flexibility to pursue integration. Funding streams - whether specific to HIV, TB, or any other health concern - are each focused on their own results. As such, funders are much less concerned about the 'integration piece,' if applicable.
- A Nepali nutrition project encountered difficulty in attracting partners given nutrition's lack of short-term results on other health areas (for example, spending HIV funding on nutrition provides a benefit that must be measured on a much longer timeline than if the same funding is invested in HIV testing.)

Of course, vertical program funding does make its way into integrated programs, but participants felt that spending vertical funding on integration is not an easy achievement. Based on participant responses it would appear that there is no real incentive (and, actually, a disincentive) for a specific program area to share funds in an integrated project.

### *Service Quality*

Respondents were concerned about the impact of integration on service quality, and felt that vertical programs were unquestionably more adept at offering higher quality clinical services. Reasons identified for this included greater provider and infrastructure specialization under vertical service provision as well as more streamlined direction of resources towards specific health goals. Raising the level of service quality under an integrated system to that accustomed to under a vertical system was often considered a challenge and goal.

### *Infrastructure*

Infrastructure challenges, such as those involving space and equipment, were oftentimes noted alongside supply chain and human resource inadequacies. For example:

- In Malawi, a lack of sufficient infrastructure was considered a main challenge under integration, particularly because of increased health services demand post-integration.
- Some countries noted having to create or renovate entire facilities to meet infrastructure needs, such as in the case of the health hut system that comprises a part of Senegal's community health system.

- Participants in Kenya felt that integration is much more resource-efficient than vertical service provision, as the demand for infrastructure, including rooms and equipment, is thereby minimalized. Yet as in Malawi, increased health services demand has been recognized post-integration, which mitigates this benefit.

The relationship with provider attitudes has an impact here, as although Kenya reported positive benefits, participants also noted staff 'ownership' of certain space/areas. This leads to sub-optimal infrastructure usage.

### *Supply Chain/Commodities*

As was noted by one participant from Honduras, without supply and commodity inputs, programs wouldn't exist even with the best systems in place. Yet the supply chain is frequently inadequate in developing countries. This was labeled as 'commodity insecurity' by participants from Kenya, and is especially notable in the Kenyan context in relation to contraceptives, HIV test kits, and intrauterine devices, at all health levels. Integration may not have a big impact on improving commodity availability; in fact, it may exacerbate the problem due to increased commodity demands post-integration.

Supply chain challenges also reach to the level of organizational design. In Kenya, there are separate supply chain systems between reproductive health and HIV/AIDS programs. Pharmacists have had to realign themselves into the integrated system, while at the same time commodities continue to be supplied through these vertical pipelines. Multiple respondents noted that integrated programs continued to request commodities via vertical supply chains.

### *Human Resources Gaps*

Human resource shortages in absolute numbers were frequently noted, although they are common in many developing country contexts. Similar to commodities and infrastructure, participants felt that this challenge is exacerbated by increased health services demand post-integration. In one country the human resource gap was at least partly ascribed to sub-optimal human resource deployment, as opposed to a lack of total supply.

Attitudes towards the impact of integration on human resource gaps, whether positive or negative, varied:

- In Malawi, this challenge presents itself in single-provider facilities, where providers are often confronted by lengthy lines of clients awaiting service. This was partly ascribed to great health-seeking behavior post-integration.
- Alternatively, in Senegal, integration is seen as a means to overcome what was described as a 'critical' human resource shortage, as having one provider looking after all of a client's needs allows for greater coverage.

Respondents also felt that training demands can play a contributory role:

- In Kenya, extra training for health workers, considered key to integrated service provision and quality services, was noted as also being contributory to human resource overloads and gaps.

### *PROVIDER EXPERTISE/SKILL GAP*

A related human resource shortage exists in terms of skills, referred to as 'skill gaps.' Participants noted a lack of adequate training; high provider turnover and less than ideal provider attitude and morale were also challenges. High staff turnover at the facility level in Kenya was noted as due in part to staff rotations to other units in which they have not had adequate experience. This was mainly influenced by the introduction of new services via providers with no history of providing them. In terms of attitude, staff can unfortunately sometimes be considered by themselves (as well as by colleagues) as 'owning' certain specific procedures (such as intrauterine device insertion). Therefore other staff may avoid learning such a new skill due to an attitude that another provider should continue to do it simply because they have always done it.

Provider expertise/skill gaps were not a challenge noted in all countries. A skill gap was not noted as a challenge in Nicaragua, and in fact training was stated as the reason for overcoming it. Training of providers in Nicaragua has been integrated into the university curricula, although at present the demand for training is limited due to the lack of participation of the public health sector in the Nicaraguan program.

Challenges specific to training include:

#### MANAGING TRAINING DEMANDS

Based on participant responses, there is a clear balance to be found between training to improve provider expertise, yet limiting training enough so as to not negatively exacerbate provider shortages.

- In Cambodia, a common complaint is that providers are too often 'out for training'. A provider may attend infection control training one week, active management of the third stage of labor the next, and so on, which can limit their ability to fulfill their clinical role. Even if providers can remain sufficiently present to meet client demands, the time demands of continual training can be detrimental to provider morale.
- Malawi reported a similar experience, as participants felt strongly that training can be draining to the staff and staff morale, especially when providers need to receive training consistently in many different thematic areas.

Despite the challenges, successes were also noted.

- Nicaragua's HIV program saw success by integrating training programs into university curricula, thus bypassing to a degree the need to undergo on-the-job training by full-time providers. This has included personnel being trained in basic components of logistics as well as laboratory (including rapid tests performed in field), the development of educational material and technical guidelines, and standardizing training and materials across vertical areas.
- Other participants saw success with joint trainings within the public sector, although NGOs and private sector personnel may also need to be trained to support integrated services.

#### DEVELOPING TRAINING TOOLS

The development of training tools has also been a challenge.

- In Senegal there is an annual joint training completed with the MOH to implement activities and to carry out M&E together. Yet training and communication tools that address all of the integrated services as one have not yet been developed; instead they rely on existing training tools to train in specific health areas. This remains an area for future improvement.

### *NON-PROVIDER EXPERTISE/SKILL GAPS*

Respondents also noted a general lack of non-provider staff expertise regarding certain areas of integrated services, especially in areas that are not their specialization. In a program with a MCH based-service, additional health areas integrated into the project (e.g., HIV, TB, etc.) are likely not to be the area of expertise of the management staff (who in all likelihood will have a MCH background, given the focus of the program). For one country's respondents, more than one manager is thus often required so as to ensure that expertise in each project area is held by the management staff. This numerical increase in management staff can, in turn, have negative effects on leadership and accountability. Project direction may be divided amongst multiple staff, with no single individual accountable for project performance or leadership.

### *OVERCOMING PRECONCEPTIONS OF CLIENT POPULATIONS*

In addition to addressing provider knowledge and skills, as noted above, integration requires addressing provider attitudes and biases as well. This is because integrated health services rely to a greater extent on successfully identifying client needs in a more challenging environment than within vertical health service provision.

- In Guatemala, a respondent noted that when providers think of family planning, they immediately think not only of women, but of a certain preconceived notion of a particular 'type' of woman. If a client does not fit such a stereotype of 'mother'

within an integrated service package, it is possible that a clinician will underestimate potential MCH (or HIV, etc.) health needs of the client.

- Similarly, The HIV epidemic in Guatemala (urbanized, concentrated among MSM and sex workers) has a completely different epidemiological profile from the family planning target audience (which is rural, mainly indigenous, and focused in the country's Western Highlands). With such a distinct difference between the two, the HIV epidemic target population may be completely removed from family planning services in the minds of some providers.
- In Senegal, it was noted that the systemic identification of client needs is an approach used as a way of ensuring that all of a client's healthcare needs are met.

## CONCLUSION

This report is the result of a USG health integration survey that focused on select integration programs in select countries. This survey sought to identify types of services being integrated; reasons for choosing integration; choices of integration models; perceived strengths, weaknesses, and gaps of M&E systems; and environment, policies and systems that facilitate service integration.

There are a number of limitations inherent with a convenience-based sample, such as that which was used in this research. Insight across various programs and into some survey domains (particularly in specialized survey areas such as M&E systems, finance, and reporting) was limited in certain cases. Cases where there were few participants, or in which participants lacked specialized knowledge, are the most notable among these. Thus, survey responses do not necessarily reflect a consensus across country participants. Further, in order not to impose an undue burden on participants, an attempt was made to limit survey interviews to one hour. As a result, follow-up questions for in-depth details were often limited by time constraints. In addition, not all integration programs in each country were discussed in the survey or in this report. Participants were asked to focus on one integrated program.

Through the participation of staff from USAID missions, ministries of health, and implementing partners, the result of the survey was an improved understanding of nationally supported integrated health programs. This is true specifically in terms of the types of services that are being integrated, reasons for choosing integration, challenges of and changes required to integration inputs, and choices of integration models and interventions. Insight was also obtained in relation to M&E systems for integration programs and integration working environments.

In addition to forming the basis of this report, the survey findings were also used to inform the country selection of Senegal and Malawi for case studies, as well as the implementation of these studies. This is because the results suggest themes that can be explored more in-depth in a case study format.

The survey findings highlight:

- The need for, and decision-making process regarding, health service integration is informed by the countries' specific epidemiology, and the organization of services is specific to their health system.
- Minimum packages of services from different program areas are designed to better target the health needs of specific populations, with the choice of components often being informed by internationally generated evidence of intervention efficacy.

- Integration is being pursued as a strategy to improve coverage and access to health services.
- Positive externalities due to integration, including cost-efficiencies, potential improved sustainability, improved continuity of care, reduced client drop out, reduced stigma to health-seeking behavior, and reinforcing behavior change interventions in a synergetic relationship.

Service integration—even in it's more complex and challenging forms—appears to be achieving successful implementation of service provision. Yet, respondents noted that successful implementation of integration in other complementary areas, such as the integration of M&E systems, funding streams, and information systems, is lagging behind. A focus has not been placed on adapting M&E systems to measure integration, or on leveraging information to improve planning, implementation, and monitoring and evaluation of integrated programs. Across all countries surveyed there was a noted lack of indicators to measure integration, especially by the government, and more work is needed to understand what information should be collected on integration or integrated packages and about what indicators may be feasible to achieve this. Participants noted an interest in moving in these directions.

Many integrated programs included in this survey have been implemented in rural areas. This does not appear to be a qualitative shift from what has already been occurring in rural areas in the past. The notion of primary care services has been a reality at this level of the health system, and in this sense integration may be something of a rebranding of service provision in the rural environment at the community level. Although integration in this environment may not be new, labeling it integration as a point from which to pursue best practices is of value.

Integration is giving community-based services a legitimacy to operate in the way they often have, while also recognizing the health service challenges that must be overcome to improve service delivery. Community-level integration is in a sense thus put on par with integration at the district level, and recognized as facing similar challenges and requiring similar changes in the health system in order to function. In this research, these changes were generally considered challenges—in areas such as infrastructure, human resources, training, commodities, information systems, etc.—which must be managed in order to support integration effectively.

These results are intended to provide a broad picture of how integration is being operationalized across several countries and various contexts. The forthcoming in-depth case studies in Senegal and Malawi will allow us to go into detail on the national and government roles in management, planning, and institutionalization, and also help expand the understanding of issues raised in the survey activity. The results of these studies are being anticipated and will be available in late 2014.

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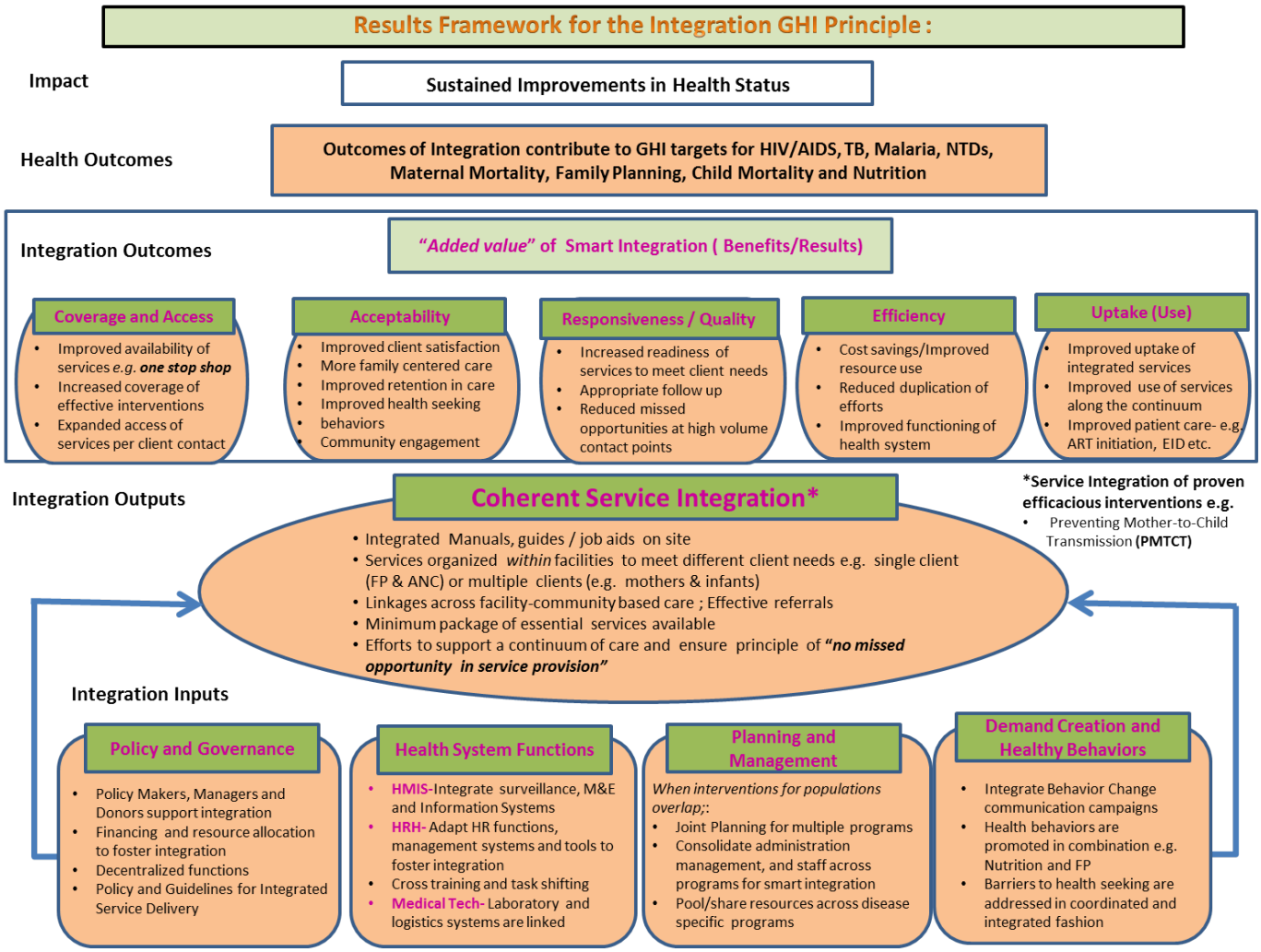
# APPENDIX 1: INTEGRATION RESULTS FRAMEWORK



## APPENDIX 2: COUNTRY AND PARTICIPANT LIST

| | | | |
|---|---|---|---|
| **Malawi** | – Deputy Health Team Leader<br>– Family Health Cluster Lead<br>– Agreement Officers Representative for SSDI Services<br>– SI Advisor, PEPFAR<br>– M&E Officer HPN<br>– Deputy Chief of Party - SSDI services<br>– M&E Advisor - SSDI services | **Bangladesh** | – Chief of Party, NGO Service Delivery Project<br>– Senior Technical and Policy Advisor, USAID/Bangladesh<br>– Senior Monitoring, Evaluation and Research Advisor, USAID/Bangladesh<br>– Chief of Party, Maher Hashi Project, Bangladesh<br>– M&E Advisor to the Program Management and Monitoring Unit, Planning Wing, Ministry of Health and Family Welfare<br>– Program Management Specialist, USAID/Bangladesh<br>– Chief of Party, MaMoni Project, Bangladesh |
| **Kenya** | – Senior Health Manager<br>– HIV/AIDS Team Leader<br>– Senior Health Advisor<br>– Director, Office of Population & Health<br>– Deputy Team Leader for HIV, USAID Kenya<br>- Project Management Specialist, Pediatric HIV/AIDS, Office of Population and Health, USAID/Kenya<br>– Program Specialist at USAID/Kenya<br>– MCH/RH/family planning Program Specialist<br>– Project Management Specialist | **Nicaragua** | – HIV Strategic Information Advisor for Central America & Project Development Specialist for Nicaragua, USAID Nicaragua |
| **Nepal** | – Sr. Health Officer, USAID Nepal<br>– Deputy Director, Office of Health and Family Planning | **Cambodia** | – Office Director, Office of Public Health and Education, USAID Cambodia |
| **Senegal** | – Deputy Health Team Leader<br>– PMI Health Team<br>– PMI Advisor<br>– Health Team Leader<br>– Malaria Technical Advisor, PMI | **Honduras** | – Director, Health Office USAID/Honduras<br>– HIV Advisor<br>– MCH/family planning/Reform Advisor<br>– AIDSTAR Plus Chief of Party<br>– ULAT Chief of Party |

| | | | |
|---|---|---|---|
| **Senegal** | – PMI Health Team<br>– Alternate Agreement Officer's Representative for ChildFund Community Health Project<br>– Chief of Party, ChildFund<br>– Director of Operations and Finance, ChildFund<br>– Health officer | **Guatemala** | – HIV Prevention Specialist<br>Health and Education Office<br>Central America HIV/AIDS Regional Program, USAID |
| **Liberia** | – Deputy Health Team Leader, USAID Liberia | | |

# APPENDIX 3: COUNTRY HEALTH INTEGRATION SURVEY

## SURVEY:

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Please keep in mind that in this survey we are looking to identify models of integrated health services that are being implemented in the country that support and follow the strategic direction of the Ministry of Health and have potential for scale-up if the program is not already implemented nationally. Integrated health services may be one of the objectives or activities within a larger program or project.

Do you have any questions before we begin?

**Integrated Programs**

1. What are the major programs or projects that have integrated health services as an objective or activity in the country?
   *Probe about implementing partners and level of targeting*

| Program Name (with integrated health services) | Implementing Partner | Health System Level targeted for integration interventions |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

****After identifying these integration programs, the following questions will be asked of one major program. Where feasible, these questions could be asked of two or more programs.***

2. I would like to talk more about (*program name).* In this program, what are the base services (or the platform) for integration, and what services are being integrated into that platform?

| | **Base Service/Platform** | | | | |
|---|---|---|---|---|---|
| Base service category: | HIV/AIDS | MCH | RH/family planning | Other communicable disease (CD) | NCD |
| Specific base services (*List*): | | | | | |
| Services being integrated to base service(*List*): | | | | | |

3. Can you describe the goals and related objectives of the program, specifically those related to integration?

4. Why were these specific services integrated and not others?
*Probe why these specific services were a priority for integration*
*Is there a community-based component?*

5. What districts are currently implementing or planning to implement the integrated health program and in approximately how many facilities in each district?
*Probe how and when the implementation was rolled-out and the scale (i.e. how many and which districts, how many sites in each districts, etc.)*

**Model of Integration**

6. How are services organized and delivered to facilitate integration[8]?
*Probe whether services are available at the same site by a different provider or the same provider, or if referrals are within the same facility or a different one*

7. What have been the major benefits and challenges to implementing integrated services?
*Probe on:*
- *In what areas have there been demonstrable improvements?*
- *Have there been any unintended consequences of integration?*
- *Positive or negative consequences, and if they led to any change of course (In terms of commodities, supplies, laboratory, logistics or health workforce / training.)*

8. What do you envision as a good model or as a recommendation of integration of specific programs? What can you identify as "best bets, best buys", and under what circumstances they seem to be the most efficient, vs. what services are better left not integrated?

**M&E and Other Systems to Support Integration**

9. How are integration efforts as a whole being monitored and evaluated? How are the specific services that have been integrated being monitored and evaluated (in terms of changes in coverage, use, access, etc.)?
*Probe on the main sources of data used to collect information on integrated service, indicators, M&E plans, M&E tools and data collection forms, data entry and reporting systems and other data collection efforts to document and track integrated health services.*
*Probe on whether indicators capture integration (E.g., 2 or more services in same service) or whether they are still disease related.*
*Probe on whether maps are produced or used in reporting and data collection efforts?*

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[8] **One-stop Shop**: All services are provided from the same provider
**Referral System**: Patients are referred from one service delivery point (SDP) to a second SDP. A referral can be made within the same facility or to a different facility, and include the same provider or a different provider.
**Co-location of Services**: A co-location model is one where services are located close together at the same facility, usually provided by different providers.
**Other**: A health integration model not included in one of the above models.

10. What are the main sources of data being used to collect information on the integrated services? What are the main sources of data being used to collect information for the specific program or project?
*Probe on whether any data gaps have been identified.*
*Probe on whether any of these main sources of data include spatial data or a geographic identifier?*

11. What changes in human resource allocation and training, in commodity and logistics systems, and in laboratory have been required in order to support the integrated services?
*Probe how they have been modified and how difficult their modification was to achieve.*

**National Policies and Strategies**

*12.* Does the country have an official policy or position on integration or integrated health services? What are the documents that we should look at (policies, guidelines, websites, etc.) that address integration?
*Probe on Implementation; If:*
- *An integration clause exists in the national (health) strategic plan or other strategic and policy documents,*
- *National guidelines or standard operating procedures exist to support/guide this project (either Ministry of Health, NGO, etc., including titles and publication dates where possible)*

*Probe on Process; What:*
- *Were the key steps to having integration as a key policy or strategy*
- *Were the key steps to getting that policy translated into service delivery?*
- *National technical working groups were tasked with addressing integration? If these existed, who is included (organizational representatives), how often do they meet, and who chairs the meetings?*

13. Is there an integrated package of services that is defined at the national level, and what is included in that package?

14. *(In terms of our deliverable)* What kinds of information would help you plan, implement or monitor and evaluate integrated services? What format should this information take?
*Probe at what phase this information would be useful (Design, Implementation, Monitoring and Evaluation, etc.).*
*Probe: Do you think that this country is a good candidate for the in-depth case study? And if so, are you/is the country interested in participating?*

*Final questions if time permits:*

15. What would you like to know about integration and integrated services that you don't already know?
*Probe: Have any process or impact evaluations been done, or are any planned to happen soon?*

16. Please name any champions[9] of integration within the government or the wider health care community, e.g. NGOs, CBOs, private sector actors, donor representatives, working groups, etc.?

17. Are there any other donors promoting and investing in service integration? If so, do you have some contact information?

18. What types of models of integrated services (e.g. one-stop shop model; co-location of services; referral models) seem most appropriate in various contexts and for different types of service delivery platforms (e.g. community-based services; clinic services)? Is there a "tipping point" where adding extra services might actually be more harmful than beneficial?

***END***----------

That completes the interview questions. Your feedback and thoughts have been very important, and we appreciate your assistance. Before we end, do you have anything else you would like to add?

Is there anyone else that you recommend that I be in contact with, given the focus of this survey?
Thank you for cooperation!

[9] Person who voluntarily takes extraordinary interest in the adoption, implementation, and success of integration policy or practice

## APPENDIX 4: SELECTED PROGRAMS AND INTEGRATED SERVICES

| Country | Selected country programs and projects that have integrated health services as an objective or activity | Base services (the platform) for integration, and services integrated into that platform |
|---|---|---|
| Guatemala | Nutri-Salud: Community Nutrition and Health Project (led by URC) | |
| | USAID Health Care Improvement Project (PSI/PASMO and HCI) | |
| | Combination Prevention project (Regional) | HIV/ AIDS are the base service; family planning, reproductive health, other communicable diseases, and non-communicable diseases are all integrated into HIV/AIDS via a referral system. |
| Kenya | APHIAPlus Kamili (led by Jhpiego) | Targeted integrated outreach includes MCH services such as immunization, antenatal care, nutrition screening, RH/family planning services (including family planning information), CECAP services (for cervical cancer) and long-acting permanent methods of family planning as well as HIV testing and counseling services.<br><br>Comprehensive care centers provide HIV care, support and treatment services, family planning services (including counseling and basic methods, including long-acting reversible contraception). Family planning services also include cervical cancer screening, counseling and referral. Family planning, cervical cancer prevention, MCH and Nutrition services have also been integrated into community action days. |
| | APHIAPlus Nuru Ya Bonde (led by FHI 360) | RH/family planning services are integrated with HIV testing and counseling, screening and treatment of STIs, TB, and cervical cancer screening and treatment. TB is integrated with HIV testing and counseling and linkage to care, provision of ARVs to co-infected patients, counseling for family planning, and nutrition counseling. Youth friendly service sites in particular integrate family planning services (information, counseling and provision of family planning methods), HIV testing and counseling, STI screening services, and reproductive organ cancer screening. |

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| | APHIAPlus IMARISHA (led by African Medical Research Foundation) | Outpatient and inpatient services include HIV testing and counseling, post-exposure prophylaxis, post-rape care, STI screening MCH/family planning focused antenatal care, prenatal care, cervical cancer screening and STI screening. ARV prophylaxis/ HAART, TB screening, early infant diagnosis, HIV testing and counseling, Immunization, maternity care, and family planning are also included.<br><br>Comprehensive care centers integrate TB screening, post-rape care, family planning, STI screening, post-exposure prophylaxis, cervical cancer screening, and prevention with positives. TB Clinics integrate HIV testing and counseling, family planning, ART, VCT, family planning, STI screening, TB screening, Integrated outreach activities include focused antenatal care, prenatal care, cervical cancer screening, STI screening, ARV prophylaxis/HAART, TB screening, early infant diagnosis, HIV testing, immunization, and PMTCT. |
| | APHIAPlus Nairobi Coast (led by Pathfinder International) | Integrated services include maternal, newborn, and child health, nutrition, water, and sanitation. |
| | APHIAPlus Nyanza Western (led by Path) | Services include HIV /AIDS, malaria, family planning, TB and maternal, neonatal and child health services, water and improved sanitation. |
| | AMPATHPlus (led by MTRH) | PMTCT, family planning and MCH are provided as an integrated package. Provision of family planning to HIV Positive clients in CCCs by the same clinician prescribing the ART. Integrated outreach activities providing integrated services to communities including antenatal care, post-natal care, immunization, HIV testing and counseling, PMTCT and nutrition monitoring. |
| | MCHIP (led by Jhpiego) | Integrated services include child and adolescent Health, reproductive health and nutrition. |
| **Cambodia** | Maternal Child Health Program (Together for Good Health, or ToGoH, project) (led by RACH) | Integrated activities include TB, HIV/AIDS, key populations, avian influenza, family planning, maternal and child health, nutrition. |
| | Reproductive and Child Health Alliance project (led by RACHA) | Integration includes TB, HIV/AIDS, avian influenza, family planning, maternal and child |

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| | | health and nutrition. |
| | Health systems (The Better Health Services (BHS) Project) (led by URC) | Integration includes financing, quality improvement, HMIS, TB infection control, surveillance training. |
| **Nepal** | Suaahara Project (led by Save the Children) | Integrated areas include health, nutrition, agriculture and food security activities. |
| **Malawi** | SSDI-Services | Integrated services include HIV/AIDS, maternal and child health, family planning, nutrition, malaria and water and sanitation. |
| | SSDI-Systems | |
| | SSDI-Communication | |
| **Bangladesh** | NGO Health Service Delivery Project (Smiling Sun) | Services include reproductive health, maternal and child health, nutrition, behavior change communication, communicable disease, and limited curative care. |
| | MaMoni Integrated Safe Motherhood, Newborn Care and Family Planning Project | Services focus on maternal, newborn, and child health and family planning. |
| | The Health, Population and Nutrition Sector Program (HPNSP) | A sector-wide approach that integrates maternal and child health, family planning, nutrition, communicable diseases, non-communicable diseases, health systems, etc. |
| **Senegal** | USAID/Senegal Maternal, Neonatal, and Child Health/Family Planning/Malaria Project | Technical assistance is being provided to ensure the successful scale-up of the MOH designated integrated package of services at the local level. The MOH package includes malaria, family planning, antenatal care and vaccinations, among other services. |
| | Community Health Component (1 of 5 Health Program components) | HIV/AIDS, reproductive health, family planning, other communicable and non-communicable disease. |
| **Liberia** | Maternal and Child Health Integrated Program (MCHIP) | This program integrates family planning and immunization. |
| | Presidents Malaria Initiative (via the National Malaria Control Program) | Malaria and pregnancy were incorporated into the base service of maternal and child health. |
| **Honduras** | AIDSTAR | HIV/AIDS and is integrated with policy (health sector reform). |
| | Local Technical Assistance Unit for Health Project (ULAT) | Family planning, maternal and child health, health systems strengthening, policy (health sector reform). |

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| **Nicaragua** | PrevenSida (Nicaragua) | HIV/AIDS is the base service with family planning, reproductive health, other communicable diseases, and non-communicable diseases are all integrated into it via a referral system. |