

# MOMENTUM

## Country and Global Leadership

**Integration Landscape Analysis –**  
Literature review findings

January 2023



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# Agenda

- **Background and objectives**

- Methodology

- Findings

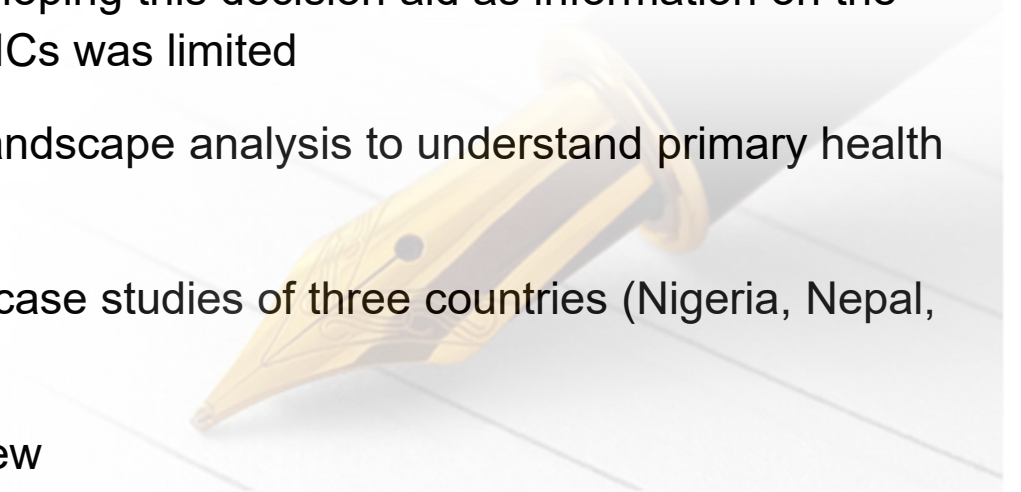
- Limitations

- Next steps

# Background

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- Health systems in low- and middle-income countries (LMICs) face several challenges, one of them being verticalization of programs and fragmented approaches to service delivery at the frontlines
- The need to integrate interventions and share resources between programs is becoming more evident and has been widely advocated
- To address gaps in provider's knowledge about integration, MOMENTUM proposed to develop a decision aid for integrating health care at primary level in LMICs
- However, there was an inadequate evidence base for developing this decision aid as information on the extent, benefits, barriers, and enablers of integration in LMICs was limited
- Therefore, MOMENTUM pivoted the project to conduct a landscape analysis to understand primary health care integration in LMICs
- The landscape analysis consists of a literature review and case studies of three countries (Nigeria, Nepal, and Madagascar)
- This document outlines the findings from the literature review



# The initial objective was to develop a decision aid for health workers; however, paucity of information on the extent of integration in LMICs led us to conduct a landscape analysis

Objective	Problem statement	Proposed solution
<p>Provide evidence on the extent, benefits, barriers, and enablers of primary health service integration in LMICs to inform efforts to improve integration</p>	<ul style="list-style-type: none"><li>▪ Less than holistic view of integration policies/guidelines and level of implementation of existing policies in LMICs with a focus on the three case studies countries of Madagascar, Nepal, and Nigeria**</li><li>▪ Lack of data on knowledge and capacity of health workers on health care integration</li></ul>	<ul style="list-style-type: none"><li>▪ Conduct a policy analysis on health service integration to achieve the following:<ul style="list-style-type: none"><li>– Describe the policy landscape on health care integration in LMICs</li><li>– Identify the policy gaps</li><li>– Describe the level of implementation of health care integration; the enablers of integration and challenges with integration policy implementation</li></ul></li><li>▪ Conduct a situational analysis to determine the following:<ul style="list-style-type: none"><li>– Knowledge and capacity of health workers and health managers to integrate health services</li><li>– Challenges facing health care integration at the facility levels</li></ul></li></ul>

\*\*Original countries were Indonesia, Nigeria, and Tanzania

# The landscape analysis seeks to achieve four research objectives

The overall aim of the research is to understand how primary health care can be integrated in LMICs

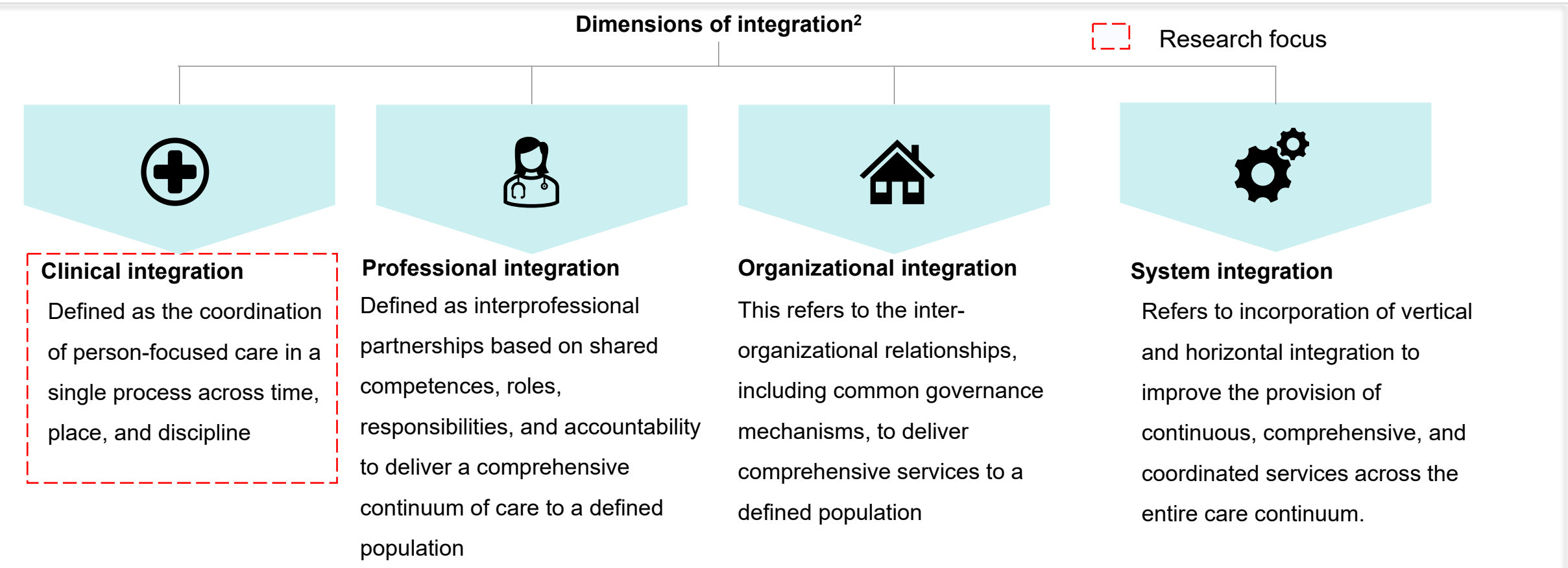
## The objectives are to:

- Understand the extent of clinical health care integration in LMICs
- Explore the benefits and risks to clinical integration
- Identify barriers and enabling factors for clinical integration in LMICs
- Identify possible solutions or approaches to solving challenges with clinical integration in LMICs



# To conduct the analysis, we first defined integration and our research scope within the established dimensions of integration

We adapted the World Health Organization's definition of integration<sup>1</sup> and defined integration as the management and delivery of health services so that people receive a continuum of health services coordinated across the different sites of care and according to their needs throughout the life course



- We examined clinical integration in terms of **place** (i.e., co-location of services), **discipline** and **systems** (utilization of policies, HMIS, equipment, etc., to provide integrated care)

# Agenda

- Background and objectives

- **Methodology**

- Findings

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# Methodology (1/2)

## Theme

## Description

1



### Study design

A systematic review of peer reviewed and grey literature was conducted. Materials selected for the systematic review included:

- Peer reviewed articles, e.g., literature reviews, systematic reviews, primary and secondary data analysis
- Grey literature, such as reports, policy documents, and guidelines

2



### Data sources

- The peer reviewed materials were sourced from four open-source databases:
  - Pubmed
  - JSTOR
  - Microsoft Academic
  - Hinari
- Grey literature materials were sourced through internet searches on Google and organization websites

3



### Study selection

We selected articles that discussed any of the following:

- Benefits or risks of integrating health care in LMICs
- Governance structures and policies for integration in LMICs (including implementation and monitoring of policies)
- The extent of clinical integration across location, professions, and systems
- Success factors and/or barriers to integration in LMICs



# Methodology (2/2)

## Theme

## Description

4

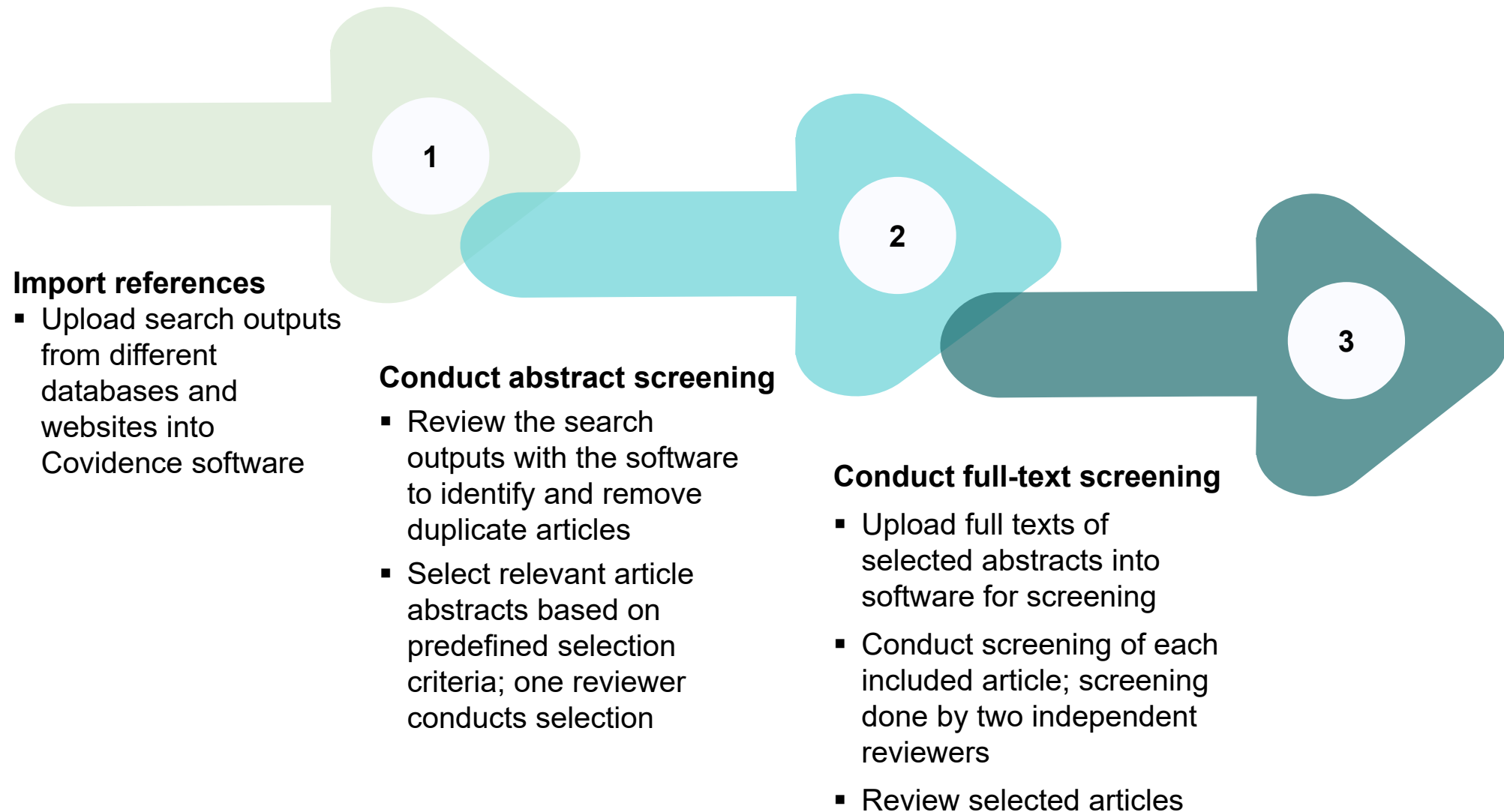


### Search strategy

Search terms\* from the research question were combined through Boolean operations “or” and “and”

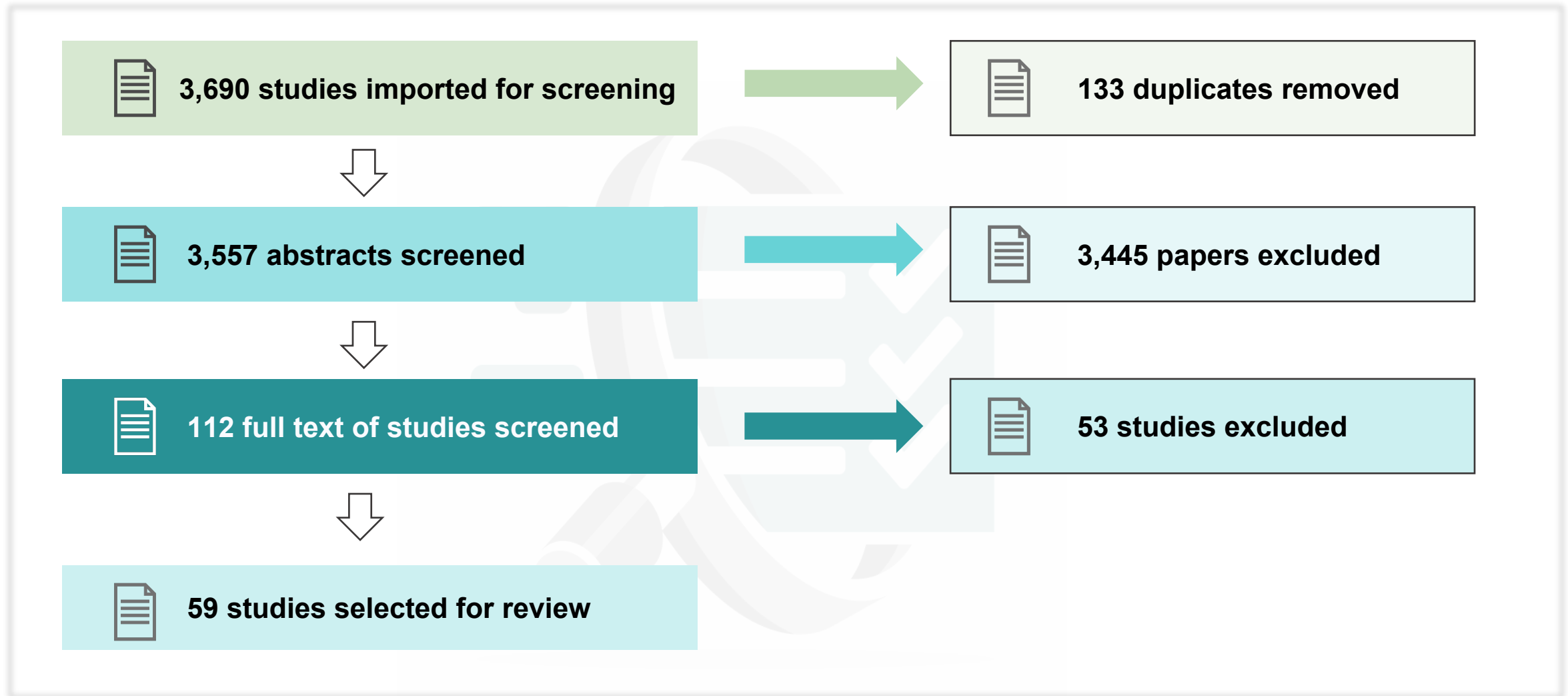
- Healthcare integration
  - Integration
  - Healthcare integration
  - Health coordination
  - Clinical integration
- Extent of integration
  - Extent
  - Level
  - Dimension
- Integration in LMICs
  - Low-income countries
  - Middle-income countries
  - Low- and middle-income countries

# The team adopted a three-step process to collect data for the systematic review



All conflicts on selection of articles were resolved during team meetings

**After applying the inclusion and exclusion criteria to the imported articles, 59 articles that answer our research questions were selected for the literature review**



- 48 articles were peer-reviewed, 11 were grey literature
- 19 articles selected were systematic or literature reviews, 5 were policy documents, 32 were reports of primary or secondary data analysis, 3 were WHO or country reports

# A four-step approach was adopted to tease out relevant data from selected articles



## Develop data extraction template

Data extraction template was developed on Microsoft Excel, primarily from the research questions on Microsoft Excel



## Import template to Covidence

Data extraction template was then uploaded on Covidence



## Extract data from articles

- Each article was extracted twice by two independent reviewers
- Consensus was reached on articles by comparing each reviewers' extraction sheet and arriving at a resolution during team meetings



## Export data extraction report

- Covidence generated an extraction report from the consensus sheet
- The report was then exported to Microsoft Excel

# Agenda

- Background and objectives
- Methodology
- **Findings**
- Limitations
- Next steps

## Findings from the research across the four research questions

1

What is the extent of clinical health care integration in LMICs?

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2

What are the benefits and risks to integration of health care service?

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3

What are the barriers/challenges to integration?

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4

What solutions/enablers were described for solving integration challenges?

## The focus of integration strategies in the literature is narrowed to specific vertical programs

### Summary of findings

- All literature reviewed discussed integration across 2 or 3 verticalized programs
- No comprehensive integration approach or intervention was described
- 49% of the papers reviewed focused on some form of HIV integration with other services

### Types of integration

### Description

#### 1. HIV/RMNCH

- 29 articles describe integration of HIV treatment and counselling into different forms of reproductive, maternal, newborn, and child health services (RMNCH) including sexual and reproductive health, family planning (FP), antenatal and postnatal care

#### 2. Immunization/other services

- 16 articles described integration of other services such as nutrition, FP, insecticide-treated net (ITN) distribution, and control of neglected tropical diseases into existing immunization programs, either as campaigns or fixed post sessions.

#### 3. RMNCH

- 6 articles described integration between different components of RMNCH services, aside from immunization such as:
  - FP and postnatal care; integrated child health days; integration of antenatal care and postnatal care with other services for pregnant women, such as ITNs

#### 4. NCD/primary health care

- 3 articles described the effects of integrating primary chronic care of non-communicable diseases (NCDs) with general primary health care (PHC) services, such as diabetes and hypertension screening in PHC, mental health counselling and screening at PHC level

## Policies on PHC integration exist in Nigeria but information on implementation and monitoring of these policies are limited

### Summary of findings

- Available policies focus on integrating specific vertical services
- No information was found on the implementation and monitoring of these policies

Country	Service type/level	Policy/guideline	Summary	Limitations*
1. Nigeria	PHC management	<ul style="list-style-type: none"> <li>• PHC under one roof</li> </ul>	<ul style="list-style-type: none"> <li>• Policy initiative of the federal government approved in 2011 that focuses on integrating <b>the management</b> of Nigeria's PHC to reduce fragmentation in the delivery of PHC services.</li> </ul>	<ul style="list-style-type: none"> <li>• High-level and does not provide operational guidance on how the services should be integrated</li> </ul>
	TB and HIV services	<ul style="list-style-type: none"> <li>• Guideline for clinical management of HIV/TB co-infection</li> </ul>	<ul style="list-style-type: none"> <li>• Outlines steps that health workers should take in managing HIV/TB co-infection</li> </ul>	<ul style="list-style-type: none"> <li>• Does not state the process nor requirements for integration</li> </ul>
	RMNCH services	<ul style="list-style-type: none"> <li>• Integrated MNCH strategy, 2007</li> <li>• National framework for iCCM implementation, 2015</li> <li>• National FP/RH policy guidelines and standards of practice</li> </ul>	<ul style="list-style-type: none"> <li>• National strategy for MNCH implementation across the continuum of care, bridging FP, nutrition, and child health services</li> <li>• Framework outlines clear roles and responsibilities at national, state, facility, and community level for integrated community case management (iCCM) implementation</li> <li>• Policy document highlights key FP methods and other related RH component services, as well as services that can be rendered at every level and location, to specify roles and responsibilities for the different cadres of service provider and defines their limitations.</li> </ul>	<ul style="list-style-type: none"> <li>• Does not state the process nor requirements for integration</li> <li>• Does not state the economic and budgetary impacts for implementation</li> <li>• Does not state the economic and budgetary impacts for implementation</li> </ul>
	Adolescent services	National guidelines for integrating adolescent and youth-friendly health services, 2013	<ul style="list-style-type: none"> <li>• Guidelines for integrating sexual and reproductive health care services for adolescent groups into PHC services. Outlines a 3-year implementation plan for integration.</li> </ul>	<ul style="list-style-type: none"> <li>• Does not completely describe the political and operational feasibility of the policy</li> </ul>
	RI and other services	<ul style="list-style-type: none"> <li>• OIRIS</li> </ul>	<ul style="list-style-type: none"> <li>• Intervention by National Emergency Routine Immunization Coordination Centre with clear guidelines for integration of routine immunization (RI) and other child health services</li> </ul>	<ul style="list-style-type: none"> <li>• Does not state the economic and budgetary implications for the implementation</li> </ul>

Key informant interviews with national focal persons at the health policy departments, PHC coordinating agencies, and partners will provide insights on implementation of these policies in Nigeria as well as barriers to implementation

\* Limitations identified using the CDC Policy Analysis Framework. <https://www.cdc.gov/policy/analysis/process/docs/cdcpolicyanalyticalframework.pdf>



## In Tanzania and Indonesia, we found limited number of policies on health care integration



### Summary of findings

- Very few policies were available for review from the countries
- Available policies focus on integrating specific vertical services



Country	Service type	Policy/guideline	Summary	Limitations*
2. Tanzania	Integration of MNCH services	<ul style="list-style-type: none"> <li>• The National Road Map Strategic Plan To Accelerate Reduction of Maternal, Newborn and Child Deaths in Tanzania 2008-2015</li> </ul>	<ul style="list-style-type: none"> <li>• A plan to guide coordination of integrated MNCH services across operational levels of the different levels of care at district and community levels</li> </ul>	<ul style="list-style-type: none"> <li>• Policy does not discuss budgetary costs for implementation</li> </ul>
	TB and HIV services	<ul style="list-style-type: none"> <li>• National policy guideline for collaborative TB/HIV services, 2016</li> </ul>	<ul style="list-style-type: none"> <li>• A policy to facilitate synergy of key stakeholder groups towards implementation of collaborative TB/HIV activities</li> </ul>	<ul style="list-style-type: none"> <li>• Policy does not discuss budgetary impact</li> </ul>
3. Indonesia	Integration of MNCH services	<ul style="list-style-type: none"> <li>• The National Mid-term Development Plan 2020-2024</li> </ul>	<ul style="list-style-type: none"> <li>• A plan to improve the country's health outcomes while strengthening delivery of RMNCH services in PHC centers</li> </ul>	<ul style="list-style-type: none"> <li>• Policy does not provide clear information on how to integrate services for program planners and health workers</li> </ul>

- Implementation budgets and operational guidelines for most of the policies were unavailable online at the time of review
- Limited information available online on existing policies in Tanzania and Indonesia

## Four major benefits from integrating health services were highlighted (2/2)

Benefits	Findings	Frequency of finding*	Examples
<p><b>1. Increased uptake of services</b></p> 	<ul style="list-style-type: none"> <li>Delivering multiple services together during outreaches improves convenience for patients and leads to increased uptake of preventive and curative services.</li> <li>However, in a few instances where health workers were not adequately supported, no change was reported in service uptake.</li> </ul>	<p>46%</p>	<ul style="list-style-type: none"> <li>5 papers discussed improved uptake of other services integrated with immunization such as FP, deworming, ITN, and vitamin A supplementation in areas where immunization coverage was high. It also led to reduced missed opportunities for vulnerable groups.</li> <li>Integration has been proposed as a strategy to improve coverage and/or efficiency of immunization and other health programs. While the other programs may benefit from adding their interventions on to immunization programs, immunization may also benefit from increased integration by cost sharing and by reducing missed opportunities for vaccination.</li> <li>11 studies conducted across LMICs in Asia and Africa described an increase in uptake of HIV services delivered alongside TB, antenatal care, and FP services. Integration was also shown to increase HIV testing for men.</li> </ul>
<p><b>2. Resource efficiency</b></p> 	<ul style="list-style-type: none"> <li>Integrating services can potentially improve efficiency of human, material, and financial resources.</li> <li>Findings on cost effectiveness were limited and mixed; one study described integrated services as being cost effective for reducing disease burden of cervical cancer, another study found integration of vaccination campaigns with neglected tropical diseases not to be cost effective.</li> </ul>	<p>31%</p>	<ul style="list-style-type: none"> <li>Integration of HIV with the outpatient department in Zambia was perceived to result in better distribution of resources that may not have been fully utilized for outpatient department patients before integration.</li> <li>Health workers perceived integration of RI services and other RMNCH services to be highly resource efficient in a qualitative study conducted in Kenya, Malawi, Ethiopia, and Cameroon.</li> <li>In a study conducted in Tanzania and Mozambique, researchers found that intermittent preventive treatment of infants for malaria was classified as highly cost effective when delivered through RI visits in these countries</li> </ul>





## Four major benefits from integrating health services were highlighted (2/2)

Benefits	Findings	Frequency of finding*	Examples
<b>3. Increased capacity of health workers</b> 	<ul style="list-style-type: none"> <li>If health workers are trained to provide integrated care, it increases their capacity and motivation to provide care and improve health outcomes.</li> </ul>	13%	<ul style="list-style-type: none"> <li>5 papers described how increasing the capacity of health workers via training improved their capacity to provide HIV counselling services, RI, and FP services.</li> <li>Training also helped to increase the motivation of the health workers.</li> <li>No job-aids or tools were found from the literature review.</li> </ul>
<b>4. Prevention/early detection of diseases</b> 	<ul style="list-style-type: none"> <li>Early detection of diseases through integration can help to prevent associated morbidity and mortality.</li> </ul>	10%	<ul style="list-style-type: none"> <li>Integrated child health days improved the profile of child survival across 6 countries in East and South Africa.</li> <li>4 paper reported integration of HIV/TB services created an opportunity for prompt commencement of antiretroviral therapy (ART) among individuals with HIV-associated TB and also the prevention of TB among HIV infected individuals in LMICs.</li> <li>In Tanzania, prevention of mother-to-child transmission (PMTCT)/ antenatal care integration led to reduction of pediatric HIV.</li> </ul>

While these benefits have been documented in the literature, it will be useful to understand these benefits within the case country contexts, which the key informant interviews can help to achieve

\* This was calculated as the total number of papers that discussed a particular benefit by the total number of papers that discussed benefits of integration

# Integration has the potential risks of increasing provider workload, reducing quality of care, and increasing stigmatization and disease transmission

Risks	Findings	Frequency of finding*	Examples
<b>1. Increased health worker workload</b> 	<ul style="list-style-type: none"> <li>Increasing service provision in one location with pre-existing number of health workers can cause increased workload and waiting times for clients.</li> <li>Increased workload can lead to reduced coverage of immunization services.</li> </ul>	56%	<ul style="list-style-type: none"> <li>14 papers described increased workload as a risk of health care integration, especially when time-intensive interventions such as HIV testing and counselling, FP, and immunization are integrated.</li> <li>A systematic review on integration of immunization by Partapuri et al. described increased health worker workload as one of the biggest risk that must be circumvented in the design of integrated interventions.</li> <li>During RI campaigns that integrate time-intensive services with unique requirements such as HIV services (private room) will limit simultaneous delivery of vaccines, which may lead to reduced RI coverage.</li> </ul>
<b>2. Inadvertent disclosure and stigma</b> 	<ul style="list-style-type: none"> <li>The mode of operation of integrated clinics for HIV and other services have been showed to inadvertently disclose HIV status and cause stigmatization.</li> </ul>	16%	<ul style="list-style-type: none"> <li>4 studies described that clients perceived increased risk of disclosure of their HIV status in integrated clinics, because they had longer appointments.</li> <li>In Tanzania, fear of stigma and or positive results when PMTCT was integrated with ANC deterred some women from attending ANC at all</li> </ul>
<b>3. Poor quality of care</b> 	<ul style="list-style-type: none"> <li>Poor quality of care (QOC) can occur with integrated care as a result of:                             <ul style="list-style-type: none"> <li>Overburdened health workers</li> <li>Poor monitoring and supervision</li> </ul> </li> <li>Poor QOC can increase drop-out rates of clients, if not properly managed</li> </ul>	22%	<ul style="list-style-type: none"> <li>5 studies discuss poor QOC as a risk of health care integration. For instance in one study, integrated clinics were perceived by clients to deliver poor quality services because the health workers have higher workload.</li> <li>This finding was, however, not corroborated by qualitative evidence from clients.</li> </ul>
<b>4. Disease transmission</b> 	<ul style="list-style-type: none"> <li>In integrated HIV/TB clinics, there is a risk of TB transmission to immuno-suppressed individuals.</li> </ul>	8%	<ul style="list-style-type: none"> <li>2 studies described a risk of TB transmission in integrated HIV/TB clinics if individuals with HIV-associated immunosuppression are increasingly exposed to infectious TB patients.</li> </ul>

## Inadequate supply of resources, poor capacity, and lack of policies to support integration were cited as major barriers to integration (1/2)

Themes	Barriers	Frequency of findings	Findings	Examples
1. Human Resource for Health	<b>Inadequate number and skill of health workers</b>	<ul style="list-style-type: none"> <li>• 32%</li> </ul>	<ul style="list-style-type: none"> <li>• Integrated care often increased patient load, overburdening the existing staff available to provide services</li> <li>• In some instances, health workers were not skilled to provide the required services</li> </ul>	<ul style="list-style-type: none"> <li>• Staff shortages and /or staff with inadequate skills were cited as major challenges for health workers in a large qualitative study conducted in four African countries</li> <li>• Three systematic reviews highlighted paucity of sufficiently skilled health workers to provide integrated care as a barrier to adequate FP service integration in integrated settings</li> </ul>
2. Financing	<b>Poor financing</b>	<ul style="list-style-type: none"> <li>• 28%</li> </ul>	<ul style="list-style-type: none"> <li>• Inadequate financing and poor coordination among funding streams have led to poor infrastructure in some settings and discontinuation of certain programs in other settings</li> </ul>	<ul style="list-style-type: none"> <li>• In Bangladesh, poor financing led to discontinuation of a nutrition service while in sub-Saharan Africa and India, this led to shortages of drugs and essential supplies for nutrition service integration</li> <li>• In a study in Kenya, the lack of private space for HIV counselling and testing was highlighted as a barrier to integration</li> </ul>
3. Poor quality of care	<b>Inadequate supply of essential drugs and vaccines</b>	<ul style="list-style-type: none"> <li>• 22%</li> </ul>	<ul style="list-style-type: none"> <li>• Inadequate supply of medicines and equipment significantly hinders implementation and intervention delivery</li> </ul>	<ul style="list-style-type: none"> <li>• Inadequate supply of essential drugs and vaccines were highlighted in several systematic reviews as a barrier to integration: <ul style="list-style-type: none"> <li>• Vaccine stockouts due to poor supply chain systems described in Wallace et al. 2012</li> <li>• Regular supply of drugs and commodities for treatment of NCDs caused by bottlenecks in supply chain described in Pati et al. 2020</li> </ul> </li> </ul>

## Inadequate supply of resources, poor capacity and lack of policies to support integration were cited as major barriers to integration (2/2)

Themes	Barriers	Frequency of findings	Findings	Examples
4. Policies and Guidelines	Lack of policies and guidelines	<ul style="list-style-type: none"> <li>19%</li> </ul>	<ul style="list-style-type: none"> <li>Absence of integration guidelines/protocols was a key barrier that prevented coordinated effort</li> <li>Lack of policies and guidelines may also facilitate vertical systems and hinder the successful implementation of integration of services.</li> </ul>	<ul style="list-style-type: none"> <li>6 studies mentioned availability of national policies that support integration of services in Malawi, Kenya, South Africa, Swaziland, India, and Tanzania. However, planning at the lower levels were insufficient due to absence of clear guidelines.</li> <li>The policies/guidelines were specific to the services being integrated and there was no mention on how and if these policies/guidelines were implemented.</li> </ul>
5. Monitoring & Evaluation (M&E) Systems	Poor supervision and M&E systems	<ul style="list-style-type: none"> <li>12%</li> </ul>	<ul style="list-style-type: none"> <li>Poor coordination among health agencies, and poor supportive supervisory and M&amp;E systems for integrated interventions may affect the implementation and quality of care provided</li> </ul>	<ul style="list-style-type: none"> <li>In a study evaluating NCDs into PHC, robust M&amp;E systems for coordinated care were unavailable or poorly designed, preventing program managers from receiving timely information to correct errors.</li> <li>Two systematic reviews described poor supportive supervision systems or the total lack thereof as a major challenge as it affected service coordination and QOC of integrated services in LMICs.</li> </ul>
6. Community Engagement	Poor community engagement	<ul style="list-style-type: none"> <li>8%</li> </ul>	<ul style="list-style-type: none"> <li>Poor community engagement was highlighted as a barrier to implementation and uptake of services in a few</li> </ul>	<ul style="list-style-type: none"> <li>Two systematic reviews highlighted inadequate community sensitization that led to poor uptake of integrated FP/RI services by community members.</li> </ul>

**We identified six solutions to integration implementation challenges from the literature (1/2)**

Themes	Barriers	Frequency of findings	Findings	Examples
<b>1. Human Resource for Health</b>	<b>Capacity building</b>	<ul style="list-style-type: none"> <li>• 53%</li> </ul>	<ul style="list-style-type: none"> <li>• Training health workers before implementing integrated interventions have been shown to improve quality of service delivery and staff satisfaction</li> </ul>	<ul style="list-style-type: none"> <li>• Provider skills, attitudes and motivation were highly influential in the success of integration programs in Swaziland and was highlighted as an enabler to integration in 7 other articles across LMICs</li> <li>• Continuous capacity building for health care teams through refresher courses and trainings were cited as success factors for health care integration in the Philippines</li> </ul>
<b>2. Policies and Guidelines</b>	<b>Formulation of policies and guidelines</b>	<ul style="list-style-type: none"> <li>• 25%</li> </ul>	<ul style="list-style-type: none"> <li>• Most policies are around HIV and RMNCH Integration. These policies, guidelines and protocols may facilitate the successful implementation of integration of these services.</li> </ul>	<ul style="list-style-type: none"> <li>• A cross sectional survey in Tanzania stated that at the policy level, integration of PMTCT of HIV and syphilis screening may be achieved through policies formulated to guide the delivery of services</li> <li>• Two studies discuss the how policies to integrate immunization with other services have served as a binding factor for implementation</li> </ul>
<b>3. Essential Medical Resources</b>	<b>Ensuring adequate supply of essential drugs and equipment</b>	<ul style="list-style-type: none"> <li>• 15%</li> </ul>	<ul style="list-style-type: none"> <li>• Providing adequate drugs and supplies are very vital to providing essential services</li> </ul>	<ul style="list-style-type: none"> <li>• Strengthening supply chain support through investments in supplies, equipment, diagnostics, human resources, medicines and commodities to support the provision of integrated services was highlighted as a solution to integration challenges in sub-Saharan Africa</li> </ul>






**We identified six solutions to integration implementation challenges from the literature (1/2)**

Themes	Barriers	Frequency of findings	Findings	Examples
<b>4. Financing</b>	<b>Adequate financing</b>	<ul style="list-style-type: none"> <li>• 13%</li> </ul>	<ul style="list-style-type: none"> <li>• For successful implementation of integration, adequate and sustainable financing is important for infrastructure, drugs, and supplies</li> </ul>	<ul style="list-style-type: none"> <li>• In sub-Saharan Africa, where a substantial number of patients are expected to receive HIV care and other services, further investments in lower-level facilities are needed to create room for private HIV consultations</li> <li>• 1 study in Tanzania suggested expanding service delivery points to improve access to services for people in remote and difficult geographic terrains.</li> </ul>
<b>5. M&amp;E Systems</b>	<b>Development of strong M&amp;E Systems</b>	<ul style="list-style-type: none"> <li>• 13%</li> </ul>	<ul style="list-style-type: none"> <li>• Development of strong M&amp;E systems for integrated interventions helps to improve assessment of health care quality and referral systems</li> </ul>	<ul style="list-style-type: none"> <li>• 5 articles recommended supervision and support of health service providers in India, Tanzania, Swaziland, and Philippines. In India, it was seen to strengthen referral networking systems.</li> <li>• In Africa, a study highlighted that developing quality indicators for NCD and HIV outcomes would assist in programmatic feedback and assessment of program quality.</li> <li>• In Tanzania, stakeholders and health workers advocated for the need to develop strong M&amp;E systems and building on existing national tools to harmonize the data tracking and reporting process</li> </ul>
<b>6. Community Engagement</b>	<b>Proper community engagement</b>	<ul style="list-style-type: none"> <li>• 3%</li> </ul>	<ul style="list-style-type: none"> <li>• Community engagement is a key success factor for implementation of integrated services. A human centered approach should be adopted from the start of implementation</li> </ul>	<ul style="list-style-type: none"> <li>• 2 systematic reviews highlighted inadequate community sensitization led to poor uptake of integrated services by community members</li> </ul>



# What are the key considerations for integration of health programs?

Evidence from this review demonstrates that integrating all essential PHC services may not be feasible in low-resource settings. However, these are key elements program planners need to focus on before integrating services:

Consideration	Description
<b>1</b> Context	 <b>Integration should be contextualized to settings</b> <ul style="list-style-type: none"><li>Factors to consider include financial and logistical support available to program planners to ensure integration meets its objectives</li></ul>
<b>2</b> Feasibility	 <b>Finding a balance between what is ideal and what is feasible is key</b> <ul style="list-style-type: none"><li>Planners need to consider what level of integration can be achieved with the available human resources and existing PHC and data management structures</li></ul>
<b>3</b> Compatibility	 <b>Ensuring compatibility of health interventions</b> <ul style="list-style-type: none"><li>Evidence shows that when health interventions that are compatible with each other and with the health system are integrated, there's a higher chance of success</li></ul>
<b>4</b> Acceptability	 <b>Integrated services need to be acceptable</b> <ul style="list-style-type: none"><li>Acceptability of the interventions to community members and health workers is paramount to for successful integration</li></ul>
<b>5</b> Accountability	 <b>Governance and monitoring mechanisms need to be clearly defined</b> <ul style="list-style-type: none"><li>This includes provision of policies and guidelines for integration and supervision to ensure integration meets its objectives</li><li>Adopting a unified or standard measurement framework for integration will also help to objectively measure progress towards its achievement</li></ul>

# Agenda

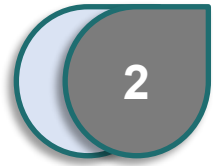
- Background and objectives
- Methodology
- Findings
- **Limitations**
- Next steps

# The team highlighted the limitations of this study

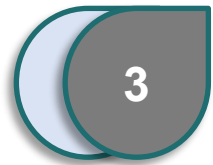
## Limitations



Review was limited to literature written in English; thus, insights documented in papers in other languages were not harnessed.



Policy analysis was only conducted on documents with full texts online; thus, documents that are not online may have useful information that was not analyzed.

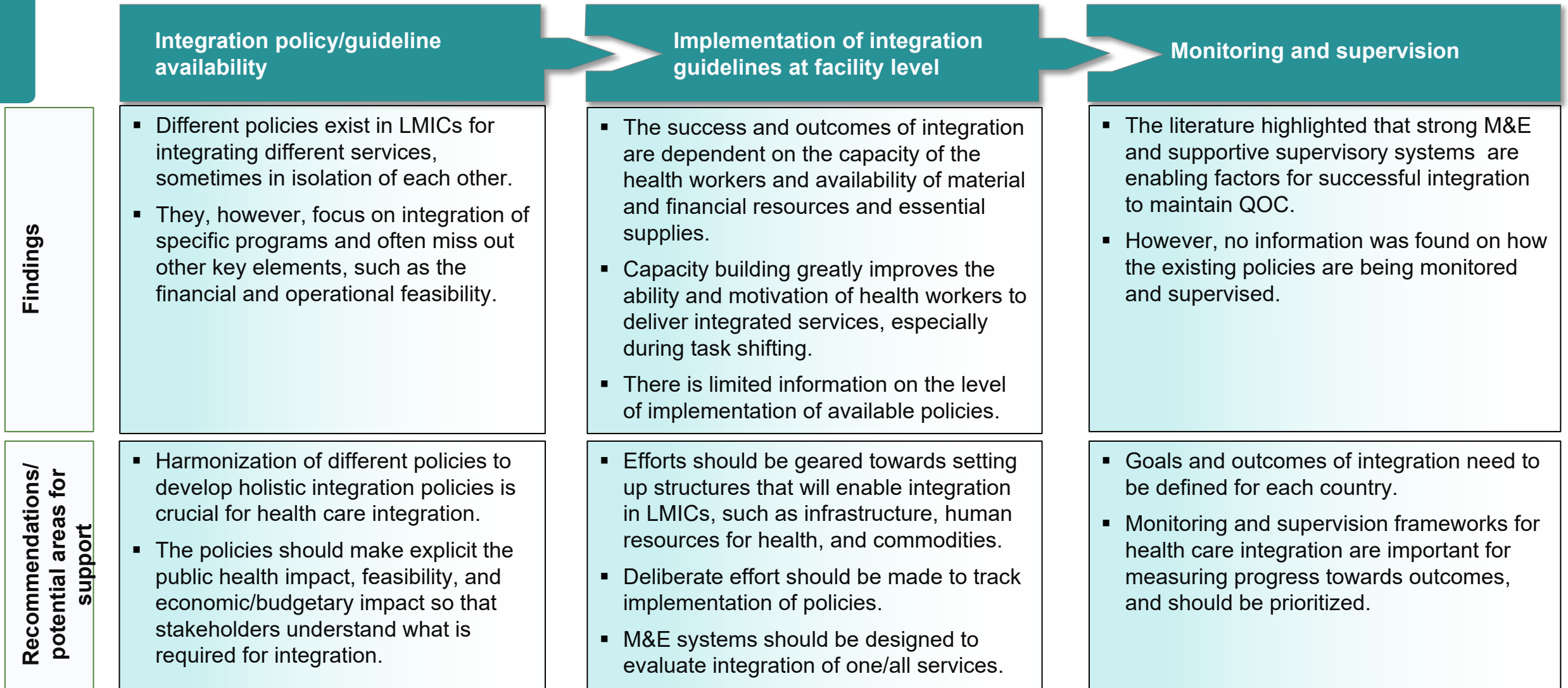


Online information on the implementation of the identified policies was lacking.

# Agenda

- Background and objectives
- Methodology
- Findings
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# This review highlights key gaps and opportunities for further work on integration in LMICs



Information gathered at the end of the analysis can help guide the development of strategies for successful Integration in LMICs

# THANK YOU

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