THE GLOBAL FUND

Accelerating Integration of HIV, TB and Malaria to Strengthen Health Outcomes

Technical Brief

Grant Cycle 8

Core Guidance

Date published: 15 December 2025

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Key messages

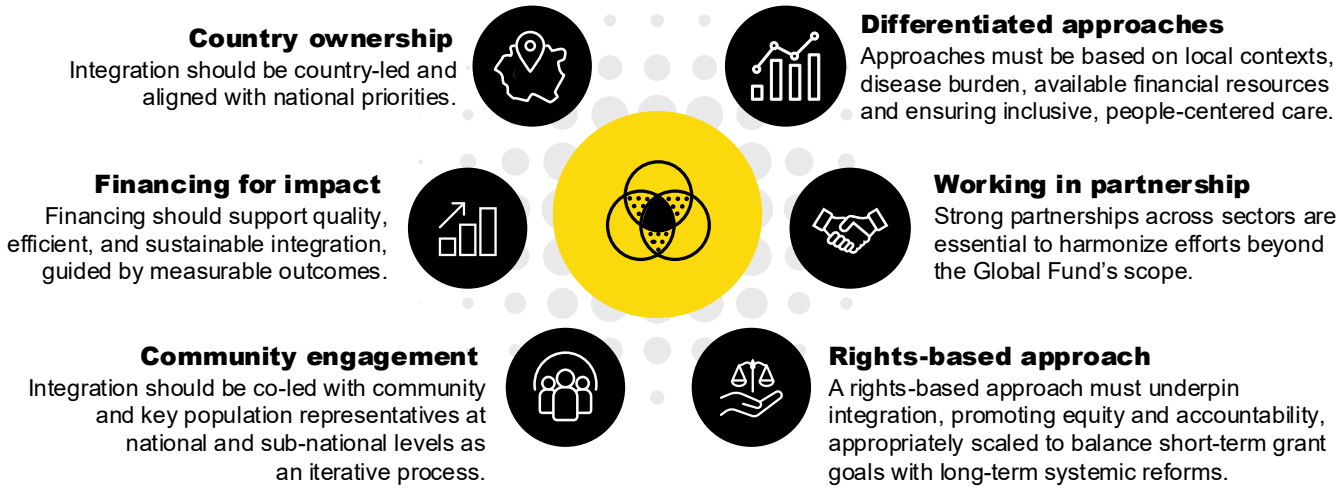
The result of the Global Fund Eighth Replenishment, while still partial, reflects the increasingly challenging global health landscape that the partnership must now navigate. Whereas the Global Fund's unique model remains strong, it is clear that **the approach to Grant Cycle 8 (GC8) must evolve**. With less funding, the partnership will need to work smarter and collaborate even more effectively.

Accelerating integration is essential to protect hard-won gains, build resilient health systems and discontinue siloed, vertical programs that are no longer sustainable.

Integration is a strategic process that supports sustainability, efficiency, and responsiveness to people's needs. It replaces fragmented approaches with a unified model that maximizes impact and promotes equity and accountability. It includes:

- **Service delivery integration**. Converging HIV, TB, and malaria interventions into PHC and other health services for patient-centered care.
- **Health systems integration**. Aligning and strengthening building blocks such as workforce, data, surveillance, supply chain, laboratories, community engagement, and financing—so they function cohesively across programs.

The Global Fund's support to integration in GC8 will be guided by six principles:



One way to optimize funding across the disease allocation is through integration, based on country context. To effectively advance integration, countries can:

- **Plan with key stakeholders under MOH's leadership and with the CCM** to identify integration priorities before disease-focused planning and before the allocation letter arrives, in coordination with relevant actors, including disease programs.

- **Submit a single integrated funding request or all funding requests in the same window, with earmarked investments for RSSH to support integrated services and systems**, to optimize and integrate resources across diseases.

- **Adjust implementation arrangements where appropriate**. Priority should be given to national PRs and SRs (and CSOs as needed) to ensure sustainability. Consider a **common Program Management Unit,** where possible, within the MOH.

- **Use financing levers.** Strategic purchasing or other output-based financing (e.g., social contracting to communities) can incentivize integrated service delivery.

Introduction

Integration of health services refers to delivering healthcare to ensure people receive coordinated, continuous, and comprehensive care across different programs, levels, and providers. Efforts to link services have existed for decades, but integration has evolved into a core strategy to ensure that patients receive holistic care that meets their needs across the life-course, strengthen health systems and to improve efficiency. The Global Fund has supported countries' integration efforts through its grants. However, today, with significantly reduced external funding and constrained domestic resources, accelerating integration becomes an imperative to protect hard-won gains and accelerate progress against the three diseases.

For Grant Cycle 8 (GC8) we need a **renewed commitment to integration**. This brief describes areas of integration that the Global Fund will support and how countries can use GC8 funding to accelerate integration. It should be read alongside other Global Fund "core guidance" for GC8, including Information Notes, Technical Briefs and the Modular Framework, which streamline the importance of integration.

Focus areas

The main focus will be on **integration of service delivery** and **integration of health systems.**

Integration of service delivery focuses on integrating HIV, TB and malaria into PHC. Integration means much more than delivering joint services (co-delivery). It includes coordinating service delivery with training, supervision, supply, reporting and analysis and legal services. It needs to enable access to the most vulnerable.

Integrating health systems (human resources for health, health product management, laboratory systems, surveillance and data systems, digital, community systems and health financing) can result in cost and implementation efficiencies and support broader health outcomes and sustainability. It requires engaging with the relevant departments in the Ministries of Health and others such as Ministries of Finance, Ministries of Social Justice and Ministries of IT, and sustaining community leadership to address the needs of populations at risk of being left out.

1. Country Planning for Integration

This section aims to support GC8 applicants to include integration as a critical way to maintain HIV, TB and malaria services. It provides a non-exhaustive checklist of actions that enables integration of services and systems. Countries can use it based on country context.

1.1 Defining integration priorities

a. **Identify existing country efforts that enable integration of HIV, TB and malaria** to understand how GC8 funding can best support ongoing government and community-led efforts. The landscaping should include the National Health Sector and Integration Plan and National Strategic Plans, where available, and critically assess their adequacy to include integration strategies and address community needs. **Maturity models** can be used to assess integration progress and gaps including areas of fragmentation. Where applicable, leverage technical partners to support the development of sound situational analyses, including gaps and opportunities for integration, such as the WHO Cross-Programmatic Efficiency Analysis (CPEA)[1].

b. **Organize processes to promote an inclusive upfront country dialogue,** led by senior Ministry of Health and Ministry of Finance leadership. Active participation should be sought by the Country Coordinating Mechanism (CCM), relevant disease control programs and primary health care directorates/units, laboratory directorates, surveillance authorities, National Public Health Institutes (NPHIs), development partners, communities, civil society, representatives of key populations and other relevant stakeholders. Some countries set up a national **Integration Task Force**, which includes government, partners, community (including representatives of key and vulnerable populations) and private sector stakeholders to oversee and guide integration processes and can have subnational equivalents.

As programs define priorities, it will also be key to discuss and define areas which may be deprioritized to ensure maximum impact of the available resources. Decisions should be made with and for communities that need access to health services.

1.2 Planning for sustainable integration

c. **Establish policy-level decisions that formally institutionalize integration.** When integration objectives are embedded in national and subnational health policies, financing and accountability frameworks, and sector coordination mechanisms, countries create the necessary structural conditions for sustained and accountable, system-wide integration. For example, HRH policies that enable the delivery of integrated services, or policies on data governance, data privacy, digital rights, digital health standards, and internet availability across all digital health systems.

d. **Embed integration in sub-national planning processes** such as district health plans and annual implementation plans. District managers should have the capacity to plan across programs and mechanisms adapting the services to the specific population needs, with community platforms and civil society contributing to local decision-making and accountability. Modify governance structures as needed to accommodate shared decision making across health areas and performance monitoring. The Global Fund and partners can align to support this district-led model.

e. **Adapt service protocols** in a participatory manner. As part of health systems planning, countries can embed integration in policies and update and harmonize protocols and SOPs.

f. **Support sustainable financing.** Integrated services should be reflected in national and sub-national health financing strategies. They should be ideally costed, budgeted and funded from pooled domestic and external funding. Joint budgeting promotes sustainability and reduces duplication. In parallel, continue to strengthen public financial management (PFM) systems.

g. **Plan any digital or AI-related investments holistically** across disease programs, digital health data systems, digital health services (e.g., CAD for TB, social media for HIV, TB and malaria prevention messaging), and relevant ministries and stakeholders such as Ministry of IT, Ministry of Energy, and cross-sector eGov initiatives. Digital investments can be a strong enabler of integration (e.g., common dashboards for health data and health products) and contribute to quality and efficiency.

Mitigating risks of integration

While integration offers significant opportunities for sustaining health outcomes it is **not a one-size-fits-all solution**. The table below highlights common challenges, risks and suggested mitigation strategies to address them.

Challenges and risks	Mitigation strategies
Cost-effectiveness. Well integrated systems will mostly increase savings but may also have **increased initial costs** of planning, alignment and implementation. Similarly, co-location of service delivery may require added costs of training, supervision and staffing among others.	• Within integration priorities, ensure appropriate coordination across programs, health systems and levels of care. • While some efficiencies will be gained in the mid or long-term, ensure there is sufficient budget for initial integration investments. • Costing integrated activities can be challenging but can help decision-making in mid-long term.
Diluted quality. Integration can compromise quality. For example, if health workers are expected to deliver services across multiple areas without adequate number of workers, training, supervision, or caseloads to maintain clinical expertise. It can	• Integration strategies should be supported by task sharing reform and incorporate patient volumes that allow clinicians to maintain expertise, balancing accessibility with the need for critical caseloads. • Integration of service delivery can be implemented gradually, to provide the grounds for learning and adapting

Challenges and risks	Mitigation strategies
also dilute currently specialized services (e.g., HIV care) when integrating with broader PHC. **Integration and specialized care are not mutually exclusive, and both will be necessary to provide adequate care.**	• In some settings, some HIV or TB specialized services will need to be maintained in order to ensure quality and access, e.g., in harm reduction services • Implement targeted clinical mentoring and flexible capacity building approaches[2]. • Include integration in pre-service training, as a longer term strategy to maintain quality. • Leverage strategically located specialist expertise and blended learning approaches[3].(e.g. Hub and spoke models) • Use continuous quality improvement approaches for data driven tailoring of interventions as integration progresses.[4]
Fragmented financing and governance. Siloed budgets and vertical program structures can hinder joint planning and implementation. Integration requires alignment across all levels of domestic and external funding sources and governance mechanisms, which may not always be in place.	• Identify the existing integration opportunities that can serve as a catalyst for broader work. • Consider how subnational governance structures may need to adapt to reflect joint planning, shared accountability, and performance monitoring for integrated, people-centered quality services. • Look at “Financing as a lever” section below for other mitigation strategies.
Fragmented data systems and analytic platforms In many settings, Health Information Systems or analytic/intelligence platforms remain fragmented by disease programs limiting the ability to deliver and monitor integrated service delivery and outcomes. Many settings lack interoperability functionality for sharing specific digital data back and forth across systems For example, multiple patient-level or community-level data systems for specific diseases/programs, fragmentation between routine early warning surveillance and response monitoring systems, or between electronic medical record, lab and logistics digital data systems.	• Identify the existing needs to integrate data systems and/or analytic platforms across disease programs, PHC, and early warning surveillance. Prioritize and plan to address these according to national HIS and digital strategy, as well as ability to catalyze integrated service delivery, along with patient management, referral tracking, and follow up. • Identify the existing needs for digital data system interoperability functionality. Prioritize and plan to address these according to national HIS and digital strategy, digital maturity levels, and reflecting business processes that enable longitudinal patient management, referral tracking, and follow up.
Siloed planning and implementation of digital health services and systems; lack of interoperable digital systems. While digitization can be a strong efficiency measure, digital health services or systems planned in silos risk creating greater fragmentation or digital systems that are too burdensome to maintain. In addition, many settings lack interoperability functionality for sharing specific digital data back and forth across systems (e.g., between electronic medical record, lab and logistics digital data systems).	• Plan and align digital health investments towards shared digital services (power & internet availability and maintenance, data access, hosting, standards, interoperability functionality, etc.), according to national digital strategies, architecture, and governance mechanisms. Prioritize a shared Digital Public Infrastructure*[1]* approach across the Ministry of Health and across other ministries and eGov initiatives. • Identify the existing needs for digital health data system interoperability functionality. Prioritize and plan to address these according to national HIS and

Challenges and risks	Mitigation strategies
	digital strategies, digital maturity levels, and ability to catalyze longitudinal patient management, referral tracking, and follow up.
Limited measurement frameworks. There is no standardized approach to measuring integration across service delivery, systems, and organizational levels. This can make it difficult to assess impact and justify investments.	The Global Fund is developing a measurement framework that can contribute to measuring integration policy development and integrated service delivery. Beyond this framework, countries will need to develop measurement approaches that align to their integration priorities.
Equity risks. Integrated models may unintentionally exclude or underserve marginalized populations if not designed with inclusion in mind. In contexts where these populations are key drivers of disease burden, the impact of not addressing equity may have a disproportionate effect on the epidemics.	• Tailored approaches and continuous community and key population engagement including social contracting and monitoring and evaluation such as community-led monitoring (CLM) are essential to ensure inclusion. • Engaging KPs and PLHIV in planning, designing and monitoring service integration • Integrate legal mechanisms, services and safeguards across the continuum of care • Provide all-staff trainings to ensure understanding of complexities of KPs and other vulnerable populations and addressing stigma and confidentiality
Planning and implementation complexity. Integration requires coordinated updates to clinical guidelines, training curricula, supervision guidance, health workforce accreditation and registration, supply chains, and financing codes. These processes are resource-intensive and may take years to implement.	• Collaborate with partners and countries with similar contexts to capitalize on existing or ongoing work to address existing and emerging needs of planning and implementation • Adapt CCM composition to reflect and address the thinking around integration.

1.4 Using Global Fund grants to accelerate integration

- **Planning to apply for funding.** Coordinate across disease programs, technical partners, technical assistance availability, and civil society to ensure that people know where, when and how to participate in country dialogue and Global Fund funding request development process. Carefully consider the time needed to discuss priorities across disease programs, to develop requests for all components at the same time, and for stakeholders to have sufficient opportunity to review requests for all components at the same time.

- **Build on the outcomes of an inclusive country dialogue,** to define what elements of integrated service delivery or health systems will be funded through the GC8 grant before allocation letters are received.

- GC8 applicants are encouraged to **submit all funding requests in the same window**. This is an appropriate time to consider whether developing **a single funding request** for all

eligible components will allow greater visibility on how RSSH investments meet country priorities.

- **Earmark investments for RSSH to support integrated services and systems** in the Global Fund's "program split table" discussions (ideally from all three disease allocations equally), and **prioritize integrated investments across diseases**. Integrating HIV, TB, and malaria services into PHC requires upfront investment, which can be funded through RSSH. We discourage disease-specific health workforce investments unless strongly justified during the program split. Consider upfront investments which may not result in immediate efficiencies but increase sustainability.

- **Prioritization of Modules and Interventions.** Ensure that integration is reflected in the RSSH modules rather than a fragmented approach that addresses the needs of each disease separately. To support this, the GC8 Modular Framework includes some integrated activities such as joint data quality reviews, joint training and supervision for HIV, TB, malaria and PHC and beyond (aligned with other services), and data triangulation between different services (HIS and LMIS).

- **Implementation Arrangements.** Consider how Principal Recipient (PR) selection may advance Integration priorities in some contexts. For example, selection of **a single government PR** can help align with national systems and enable integration, such as PHC Departments, though applicants should also consider how this change may impact populations who may fall outside of the systems' reach. A single grant can include different Sub-recipients (SRs) for different functions such as National Lab Directorate for laboratory systems, Central Medical Stores for HPM. Generally, priority should be given to **national PRs and SRs** (including CSOs as needed) to ensure sustainability, with special considerations for Challenging Operating Environments.

- **In COE contexts or within the context of public health emergencies**, engage with the humanitarian health cluster or other relevant structures such as MoH Public Health Emergency response operations centers (PHEOC) and the incident management team to ensure a coordinated, specific approach amongst partners, avoid duplication and align the delivery of activities.

- **Grant-making.** PRs also need to coordinate during grant-making to ensure integration priorities defined in the funding request are captured in the resulting grants, in the narrative and in the budget.

- **Monitor integration process and outcomes.** The Global Fund is preparing a list of custom indicators that can help guide monitoring integration aligning them to country priorities. Costing integrated activities can help countries decide on most efficient models.

- **Project Management.** Consider implementation of **common Program Management Units** (where possible within the MoH), including with other partners that are supporting the health system (e.g. World Bank and other development banks, Gavi, bilateral partners).

- **Use financing as a lever**
    - **Use strategic purchasing, or other output-based financing models** to incentivize integrated service delivery such as joint HIV/TB screening or co-managed NCD-HIV patient retention. For example, by using bundled payments or capitation models[5] that encourage efficiency and coordination; or target providers capable of providing integrated services. This approach can extend to social contracting.
    - **Co-financing dialogue** can move domestic commitments towards integrated service delivery rather than disease-specific silos and do not have to be straightforward imported disease-specific inputs or services from donor-funded programs. For example, a government might commit to funding community health workers who deliver both malaria and maternal health services.
    - **Blended finance approaches** can use Global Fund grants to catalyze broad health system finance from multilateral development banks (MDBs) to incentivize integration of HIV, TB and malaria services into PHC, for example, by supporting the M&E framework to track integrated outcomes as disbursement linked indicators.
    - Technical assistance can help ministries of health to **develop financial tracking** systems that reflect integrated service delivery, removing a bottleneck to external funding of integrated service delivery.
    - Ensure that the Global Fund's Funding Landscape Table captures all funding streams for the health sector,
    - **Harmonize** planning and budgeting **in alignment with national planning and budgeting.**

- **Engage and leverage bilateral and multilateral partners** providing technical and/or financial support to countries' integration efforts, including WHO, Gavi, World Bank/GFF, bilateral partners and other relevant partners. Align with national planning processes, the design and timing of funding requests, coordination of requests for support to leverage complementarity, including engaging the same consultants, reporting and governance and implementation arrangements.

2. Prioritizing Integration through Global Fund Grants

Once countries have defined priorities for integration and planning based on country context and need, they can consider GC8 investments as per the list of activities for service delivery and health systems integration in this section.

The Global Fund encourages investments that support access and sustainability based on each country's unique situation. For example, countries with lower income could focus support from the Global Fund on ensuring access to essential, integrated HIV, TB and malaria services while countries with relatively higher income and high disease burden could focus their GC8 support on targeted, integrated HIV, TB and malaria investments that are critical to achieving domestic sustainability. Countries with higher income and lower disease burden may aim to use their allocation to catalyze progress in overcoming remaining barriers to HIV, TB and malaria responses that are fully domestically funded and integrated.

2.1 Service delivery and health systems integration

Service delivery integration of HIV, TB, and malaria within Primary Health Care

- **The Global Fund encourages activities that integrate HIV, TB and malaria services into PHC** in a differentiated and targeted manner, according to epidemiology, operational capacity including proximity to specialized services, economic capacity, community and equity needs, alongside the relevant comorbidities and conditions. Noting that integration may not be possible everywhere at the same time.

- **Activities that support integration alignment with national policies and country strategic plans**, and other instruments countries use to define care, such as essential packages of services, UHC roadmaps, PHC policies and plans, standard treatment guidelines, essential medicine and diagnostics lists (EMLs and EDLs) or health service norms and standards addressing people's needs along the continuum of care. While not an activity per se, **integrated program management**, across disease programs, including beyond HIV, TB and malaria, and systems can facilitate coordination and planning for integrated systems and services.

- **Activities that support comprehensive and integrated services that may have synergistic benefits on multiple programs.** A people-centered approach should include preventive and curative care for communicable and non-communicable diseases, sexual, reproductive, maternal, newborn, child and adolescent health, support for mental health, disability and legal services within healthcare packages. This will require more intentional alignment across disease control programs, leveraging PHC as a delivery platform beyond the Global Fund's scope by aligning domestic and external financing.[6]

- **Individual disease services should also be integrated.** While the focus of this brief is to address integration in a broader health context and not just disease-specific programs, integrating disease-specific components (such as diagnosis, treatment, and prevention) contributes to a patient-centered approach and reduces discontinuation of care, simplifies the management of comorbidities and ensures that care is coordinated across all levels of the health system.

2.2 Operational examples of integrating HIV, TB, and malaria into essential healthcare services

The table below illustrates examples of how integration can be operationalized across different levels of service delivery. The list is non-exhaustive and may refer to approaches that have already been implemented. Countries should consider reflecting these approaches in funding requests, according to country priorities and contexts.

Point of service delivery	Services
Primary Health Care settings	• In moderate and high malaria burden settings, malaria interventions are mostly already co-delivered with other acute febrile illnesses (AFI) into PHC. For low burden and elimination settings please refer to the Malaria Information Note and Modular Framework, as further efforts will be needed to fully integrate malaria prevention, care and surveillance and integrate with other conditions. • Where all HIV and TB services are not integrated into PHC refer to WHO guidance[7,8] to support their introduction according to epidemiological and operational context (including rural and urban settings, public or private provider). Define the elements of social and behavior change and communication (SBCC), prevention, screening, diagnosis, counselling and treatment (level of care, geographic scope). • Services within PHC clinics can be organized into adult and pediatric outpatient departments; acute care (for all acute conditions including malaria) and chronic care (includes HIV or TB patient follow-up care and other chronic conditions such as NCDs). Ensure that spaces are safe to provide access to all populations at risk. • Services for women and adolescents that are routinely offered at PHC level, such as ante-natal, labor and delivery and post-natal care, should be coordinated with MNCH / adolescent health programs to include all needed interventions to provide people-centered services (e.g., Co-delivery of HIV and malaria prevention and care including LLIN and IPTp and TB screening in ANC services). • Adapt services to key and vulnerable populations (KVP): to avoid risk of reduced coverage or continuation of care, adapt spaces to ensure safety and respect patient confidentiality needs, including training of all facility and community staff. • Define specific packages for humanitarian settings, including consultations with affected communities and/or organizations directly working with them and respecting existing standards (e.g. UNHCR, IOM – refugees, UNICEF, UNFPA, WHO, UNICEF and civil society organizations). SRMNCAH and gender-based violence services, as well as services for refugees and IDPs should be included in these settings. (MISP package) • Ensure that data quality assurance and data reviews take place at all levels of care, focused on data improvement across primary health care and that joint action plans are developed to address challenges.
Community-specific (refer to Human Resources for Health and Community Systems Strengthening in section 2 for more details)	• Integrate CHW into PHC teams that address the health needs of the community in a coordinated manner, including where CHWs are employed by CSOs. • Mobile brigades/outreach clinics/workers should also provide integrated services, addressing the specific population needs, including appropriate scheduling. • CHW can provide valuable links to communities and contribute to implementing activities such as campaigns, surveys, and social and behavior change and communications (SBCC), among others. • Define an integrated training package for community health workers and social mobilizers who will be engaging with the families and communities on regular basis. • Ensure recording and reporting tools for CHWs are integrated into the national health information system, either through integration with health facility reporting, or through software integration in the case of digital reporting. Health facilities should be able to see and track CHW data.

Point of service delivery	Services
Primary-Secondary Care Integration	Address the needs of the continuum of care through: 1. Coordination between the different levels of care at national and subnational level: including continuous quality improvement approaches, driven by service delivery gaps along the patient pathway, supported by coordinated and integrated training and supervision. The hub and spoke models used in HIV care are a good example of leveraging specialized care to improve PHC outcomes and can be adapted other conditions. 2. Assisted referrals and counter-referrals including formal referral linkages between community platforms, primary care clinics and higher-level facilities, psychosocial support and peer-led patient navigation and peer-paralegal support to address access and rights related barriers; recognizing the critical role of integrated sample transport to increase access to quality-assured diagnostics. 3. Where possible, support interoperable patient and laboratory data systems, including shared medical records, with safeguards for data protection, informed consent, confidentiality and digital rights, in line with national standards and human rights obligations. 4. Collaborative reporting (including data quality and data validation) while safeguarding data privacy, informed consent and digital rights to ensure accountability, non-discrimination and trusted data sharing between levels of service.
Campaigns	• Integrate malaria campaigns (insecticide treated net (ITN) and Seasonal Malaria Chemoprevention) with other malaria services and/or with other activities targeting the same populations or communities (e.g., vitamin A, nutrition, Neglected Tropical Diseases, routine immunization), including in humanitarian settings. Integration of campaigns does not only mean co-delivery, it requires coordinated planning, financing, SBCC, health product management, training and supervision, digital systems, M&E and reporting. • Some examples and practical guidance can be accessed through the Collaborative Action Strategy for Campaign Effectiveness[9] (CAS.tools - Health Campaign Effectiveness Coalition). • Utilize existing community systems and platforms to deliver campaigns and community engagement interventions where possible • Utilize existing information on population, such as population denominators or microplans from different disease programs or partners, analyzing their discrepancies, and work with the broader MOH and statistics office to determine a way forward.

2.3 Optimizing integrated health systems

This section includes specific recommendations to enable integration through the different building blocks of health systems. Applicants are advised to consider their needs in adapting the systems' governance to move from a disease-specific approach to a patient/population-centered approach that focuses on overall health outcomes. Beyond the vertical integration within a system, applicants are encouraged to look for opportunities for integration across systems, such as data triangulation, coordinated transport and shared mapping of available resources.

Health System Component	Recommendation	Operationalization Examples
Human Resources for Health (HRH)	Consider optimal deployment of multiprofessional teams aligned with service integration models.	• Train clinical staff for TB treatment initiation at PHC level with specialist remote support; • Target CHW deployment to include community engagement, screening, referrals and counter-referrals.
	Develop/implement task sharing reform and optimize health worker roles.	• Implement nurse-led treatment initiation for TB or HIV; • Implement midwifery-led care for integrated services at ANC (refer to Table 1); • Review CHW scope of work to include as needed: repost-natal follow-up of HIV-exposed newborns, TB screening and referral; • Implement community-based surveillance.
	Accelerate planning processes for HRH-CHW sustainability and transition.	• Conduct labor-market analysis; • Develop costed national HRH and community health strategies; • Create HRH-CHW investment compacts[10].
	Ensure that sustainability efforts map HRH-CHW positions and plan transition to government resources.	• Redesign vertical management functions to support PHC integration; • Harmonize pay scales aligned to national standards; • Formalize CHW roles through harmonized job descriptions aligned with essential packages, and enabling policies; • Advance social contracting reform for community-led responses.
Laboratory Systems	Establish coordinated governance for laboratory systems strengthening (LSS).	Create Laboratory Technical Working Groups (with representation from disease programs, NPHI, laboratory directorate, surveillance authorities and others) recognized by ministerial decree with decision-making authority.

Health System Component	Recommendation	Operationalization Examples
	Support integrated management and oversight of LSS interventions.	• Implement unified governance for cross-cutting interventions (e.g. External Quality Assurance proficiency testing programs); • Remove distinctions between clinical diagnostic and public health functions.
	Optimize utilization of molecular diagnostic platforms.	• Use multi-disease testing platforms or multiplexed assays; • Strategically place relevant instruments based on data analysis.
	Integrate sample transport systems for HIV/TB referrals, malaria samples, and surveillance.	• Establish a single MoH unit to coordinate sample referral; • Enable co-financing from domestic resources and donors; • Include public and private sector within networks.
	Ensure facility-level supply chains provide essential diagnostics.	• Provide tier-based diagnostic packages aligned with National Laboratory Strategic Plans; • Strengthen basic clinical microbiology services aligned with AMR surveillance[11].
	Pursue pooled procurement mechanisms and pricing service level agreements (AIP SLAs) for molecular diagnostic platforms.	Negotiate pooled procurement for commodities and service agreements to reduce costs.
	Conduct integrated planning and budgeting for laboratory services.	Budget for reagents, power, and skilled operators alongside capital equipment to ensure functionality.
Health Information Systems and Strategic Data	Include all health information systems (HIS) systems and tools within national HIS, surveillance/M&E, digital strategies, and/or digital health (operational) roadmaps with emphasis on PHC.	Reflect Health Management Information Systems (HMIS), Community Health Information Systems (CHIS), Laboratory Information Systems (LIS), Logistics Management Information Systems (LMIS), Human Resources Information Systems (HRIS), Electronic Medical Records (EMR), notifiable disease surveillance (e.g. Integrated Disease Surveillance and Response (IDSR)), Community-Led Monitoring (CLM), financial administrative, grant & program management in national HIS and digital health roadmaps.
	Strengthen workforce capacity in data use and digital literacy.	• Provide pre- and in-service training reinforcing through supportive supervision and data quality assurance;

Health System Component	Recommendation	Operationalization Examples
		• Apply 7-1-7 approach[12],[13]. for outbreak response.
	Consolidate core data functions for public health action.	Improve collection, analysis, interpretation, and triangulation for routine monitoring and outbreak detection, for example aligning surveillance and laboratory data
	Integrate and ensure interoperability of data systems.	• Create interoperable data hubs housing multiple sources; • Apply Health Level Seven International Fast Healthcare Interoperability Resources (HL7 FHIR),[14] standards.
	Strengthen national digital enterprise architecture.	• Ensure compliance with national data standards (e.g. HL7 FHIR); • Leverage governance structures; • Establish data sharing agreements.
	Treat digital rights as critical in system design.	• Safeguard personally identifiable information with encryption and access controls; • Involve communities in design and accountability.
Supply Chain Systems	Use interoperable, standards-compliant supply chain information systems, that are not limited to specific product types.	• Implement ERP, LMIS, WMS, TMS systems; • Adopt a whole market approach incorporating public and private sector data.
	Adopt innovative, integrated and patient-centric multi-channel approaches to supply chain design.	• Ensure last-mile delivery beyond health facilities; • Include commodities funded through different sources, including public, donor and private sector; • Promote integrated forecasting, planning and analytics at health facilities and at district level; • Improve health-worker capacity and incentives.
	Include considerations on safe-waste management, reduced emissions, access and availability;	• Include considerations on safe-waste management, reduced emissions, access and availability; • Ensure coordination/convergence with other transportation networks (sample, supervision); • Engage with Logistics Cluster[15] in COE contexts or where activated.

Health System Component	Recommendation	Operationalization Examples
	Support coordinated, comprehensive national supply chain governance.	• Establish governance structures for accountability and oversight; • Develop holistic costed national strategies for coordinated financing.
Community Systems	Recognize, formalize, and invest in community systems as part of national/subnational health systems.	• Expand reach and equity of integrated PHC services; • Ensure access to key and underserved populations; • Ensure sustainable financing and fair remuneration for community-led services.
	Institutionalize community service delivery through formal mechanisms.	Use social contracting or performance-based financing to integrate community providers and peer-led services into PHC systems.
	Collect, analyze and use social and behavioral data with surveillance data.	Use data to tailor community outreach and engagement to local drivers of vulnerability, health-seeking behavior and access barriers.
	Expand the role of community health workers to deliver integrated care.	• Include integrated parenting package[16]; • Embed peers and treatment supporters for psychosocial, legal and adherence support.
	Train and equip the community workforce.	• Provide skills, supervision, and linkages to uphold rights and responsibilities in service delivery. • Include peers and paralegal within the workforce
	Integrate Community Led Monitoring (CLM) into health systems to understand integrated service delivery, quality, compliance and barriers to accessing services	• Embed CLM in health information and quality systems strengthening accountability and real-time insight on service quality, rights, safety, accessibility and patient experience across HIV, TB, malaria, RMNCAH, NCDs, WASH, PPR, gender and human rights; • Integrate CLM data (quantitative and qualitative as possible) into HMIS, CHIS, and surveillance to strengthen quality assurance, program performance and coordinated referrals and care pathways; • Establish community social listening mechanisms; • Monitor integration processes and their contribution to health outcomes.

Health System Component	Recommendation	Operationalization Examples
Health Financing Systems	Strengthen financing systems and integrate HTM services into domestic financing.	• Partner with MoH, MoF and relevant ministries to integrate HTM into domestic financing (funding for TA can be provided through the grants); • Develop co-financing commitments linked to transition/sustainability; • Provide technical assistance for health technology assessments and budget impact assessments; • Promote joint planning and budgeting using PFM systems.
	Support health financing strategies for UHC ensuring equitable access to expanded package of essential services.	• Pool funds with development partners; • Harmonize funds and budgeting with other development partners to increase efficiency and reduce fragmentation; • Align Global Fund financing with PFM systems (e.g. payment for results, joint strategies or planning, budgeting and budget execution across funding sources); • Subsidize national health insurance schemes; • Support unified strategic purchasing or payment mechanisms; • Use social contracting for CSOs and CBOs.
	Scale up blended finance approaches.	Leverage multilateral development bank credit packages to incentivize HTM service delivery within broader health systems.
	Support costing and efficiency analysis.	Map service coverage, funding flows, and resource gaps across all health system domains to inform allocation of resources to enhance integration and sustainability.

Practical examples

A country in East Africa conducted a WHO Cross-Programmatic Efficiency Analysis (CPEA) and identified fragmentation within most Health system building blocks and at health service delivery. This assessment prompted a strategic shift toward integrated service delivery to enhance patient-centered care, and optimize use of resources for improved efficiency and sustainability. A National Integration Task Force was set up under the Minister of Health, and with District level equivalent task forces, to oversee and monitor integration of chronic care services into PHC and health systems levels. The Task force includes representatives from various disease programs in the MoH, MoF, Min of Social Justice, Ministry of ICT, civil society and academia. The task force has also defined the different domains for integration, and commissioned the development of a tool to mentor the regional, district and health facility levels on the processes involved. Stakeholders involved in monitoring include health officials at district level, health facility staff and patients, who provide regular feedback on the roll-out of activities. In the future, decision-makers at different levels of the health system can use the outcomes of the tool to triangulate the data with HMIS data to assess potential correlation between changes made through integration and health outcomes.

A West African country adopted an integrated CLM approach, starting in 2015 with the development of an integrated CSS Framework to address community needs across multiple diseases. This framework was later reviewed in 2018 and further revised in 2024/2025 which informed the creation of an integrated CLM framework in 2024/2025, establishing the foundation for more streamlined and harmonized monitoring mechanisms across HIV, TB, and Malaria, and later expanded to include Pandemic Preparedness and Response (PPR) components.

The Global Fund reinforced the integration effort by consolidating CLM financing into a single grant for 2026.

The integrated CLM monitors healthcare services and system elements - such as commodity availability, human resources, and domestic resource commitments. The data generated is leveraged to expand services, enhance quality, and ensure accountability at all levels.

The CLM framework allowed for coordination of data collection, analysis, stakeholder engagement and advocacy efforts across different CSOs representing communities affected by HIV, TB and/or malaria. It includes

- A multistakeholder plan and forums at national and district level.
- Shared paper-based and electronic tools enabling data harmonization
- A data triangulation plan
- Shared leadership and coordination structures
- A unified advocacy strategy

The Integrated CLM has streamlined processes by eliminating parallel activities, fostering a unified stakeholder engagement and approach. This integrated model is designed to ensure optimal implementation of CLM, particularly in the current context of constrained financial resources.

A country in Southeast Asia transitioned malaria-specific volunteer health workers, to community workers delivering the full iCCM package, diagnosis and referral of HIV and referrals for TB. The initial trigger for the expansion to the iCCM package was ensuring a sustainable approach to continued malaria surveillance in an elimination context and respond to the needs of a population with limited access to care. The role of the CHWs was then expanded to integrate HIV and TB care, in a differentiated manner, adapting the package of tasks according to the proximity to health facilities, and limitations of access to care. Funding for HIV, TB and malaria commodities as well as Amoxicillin and Zinc was provided through the grant. Reporting tools (paper-based) were adapted to include the package offered, and digitalization of the tools is planned for later. This change helped improve access to HIV care, increased TB diagnosis by and sustain access to malaria care including in conflict settings.

Annex 1: Definitions

Box 1. **Definitions**: Multiple definitions are used by different actors to define integration and the different building blocks of health systems. For the purpose of this brief we will be using the following:

Universal health coverage (UHC): means that all people have access to the full range of quality health services they need, when and where they need them, without financial hardship. It covers the full continuum of essential health services, from health promotion to prevention, treatment, rehabilitation and palliative care[17].
Primary Care (PC): Refers to the clinical care process within the health system, focused on personal health needs and service delivery by professionals such as general practitioners, nurses, and allied health, who provide first-contact and continuing care[18].
Primary Health Care (PHC): Is a broader concept that includes primary care plus essential public health functions, multisectoral action, and community empowerment, as defined by the World Health Organization. Throughout this brief, we will be referring to PHC, in order to capture clinical care provided in primary care, as well as the multidimensional aspects of services offered through the PHC approach.

Integration refers to health services which are managed and delivered so that people receive a continuum of health promotion, disease prevention, diagnosis, treatment, disease-management, rehabilitation and palliative care services, coordinated across the different levels and sites of care within and beyond the health sector, and according to their needs throughout the life course.[19].

Types or dimensions of integration: this brief will refer mainly to 2 dimensions

- ***Horizontal integration****.* Integrated care between health services, social services and other care providers that is usually based on the development of multi-disciplinary teams and/or care networks that support a specific population group (e.g. HTM integration within primary care facilities)
- ***Vertical integration****.* Integrated care across primary, community, hospital and tertiary care services manifest in protocol-driven care pathways for people with specific diseases (such as HTM) and/or care transitions between hospitals to intermediate and community-based care providers

Degrees of integration[20]
Coordination: Communication and information exchange among distinct programs for the purpose of simplifying the implementation of the respective programs. For example, programs could work together at the national level to develop an annual plan for implementation (i.e., in the activity domain and at the national level).
Collaboration: Increased cooperation among disease-specific programs, which, in addition to increased coordination, could include the sharing of resources or personnel. For example, multiple programs can join to purchase vehicles and other equipment that could then be used by all of the programs (i.e., in the activity domain and at the national and regional levels).
Consolidation: Implementation of a portion or an entire program by another program. Consolidation implies the replacement of either a portion or the entire program by a new effort or entity. For example, instead of conducting multiple single disease training sessions for district level health workers, regional-level health workers could instead offer a single once-a-year training session for multiple-disease programs (i.e., in the activity domain and at the implementation level).

Annex 2: Key References on Integration of HIV, TB, and Malaria and Health Systems Strengthening

[1] https://www.who.int/teams/health-financing-and-economics/health-financing/diagnostics/cross-programmatic-efficiency-analysis

[2] A blended learning approach for capacity strengthening to improve the quality of integrated HIV, TB, and malaria services during antenatal and postnatal care in LMICs: a feasibility study https://bmcmededuc.biomedcentral.com/articles/10.1186/s12909-024-06633-2

[3] Integration of tuberculosis services with primary healthcare: converting challenges into opportunities https://www.thelancet.com/journals/lanprc/article/PIIS3050-5143(25)00056-1/fulltext

[4] Effectiveness of strategies to improve health-care provider practices in low-income and middle-income countries: a systematic review https://pmc.ncbi.nlm.nih.gov/articles/PMC6185992/

[5] https://www.who.int/activities/promoting-strategic-purchasing

[6] Global Fund Modular Framework

[7] Primary health care and HIV: convergent actions: policy considerations for decision-makers

[8] https://www.who.int/publications/i/item/9789240111295

[9] CAS.tools - Health Campaign Effectiveness Coalition https://campaigneffectiveness.org/cas-tools/

[10] Principles of the Africa health workforce investment charter to stimulate sustainable health workforce investments DOI:10.1007/s44250-025-00297-5

[11] WHO guidance AMR surveillance

[12] Mayigane LN, Vedrasco L, Chungong S. 7-1-7: the promise of tangible results through agility and accountability. Lancet Glob Health. 2023 Jun;11(6):e805-e806. doi: 10.1016/S2214-109X(23)00167-5

[13] Guidance for conducting a country early action review (EAR): rapid performance improvement for outbreak detection and response, 31 August 2023. Geneva: World Health Organization; 2023 (WHO/WPE/HSP/CER/2023.1)

[14] See: https://www.hl7.org/fhir/overview.html and WHO's SMART Guidelines https://www.who.int/teams/digital-health-and-innovation/smart-guidelines

[15] Logistics Cluster https://logcluster.org/en

[16] Parenting and family interventions in lower and middle-income countries for child and adolescent mental health: A systematic review https://doi.org/10.1016/j.comppsych.2024.152483

[17] https://www.who.int/health-topics/universal-health-coverage#tab=tab_1

[18] https://www.who.int/teams/integrated-health-services/clinical-services-and-systems/primary-care

[19] Contandriapoulos AP, Denis JL, Touati N, Rodriguez C. Montréal: Université de Montréal; 2003. Jun, Groupe de recherche interdisciplinaire en santé. Working Paper N04–01. The integration of health care: dimensions and implementation. [cited 2014 24 Oct] Available from: http://nelhin.on.ca/assets/0/16/2100/3734/3736/6cab135d-87c1–45bd-88cd-2c1d5404ec9b.pdf

[20] Grépin KA, Reich MR (2008) Conceptualizing Integration: A Framework for Analysis Applied to Neglected Tropical Disease Control Partnerships. PLoS Negl Trop Dis 2(4): e174. doi:10.1371/journal. pntd.0000174

Other useful references

General:

- America First Global Health Strategy September 2025 America First Global Health Strategy
- PATH integration Primer

RSSH:

- WHO Global strategy on human resources for health: Workforce 2030 (2020) Global strategy on human resources for health: Workforce 2030
- WHO Optimizing community health worker programmes for HIV services (2021)
- WHO Implementation guidance on transitioning to midwifery models of care (2025) https://iris.who.int/handle/10665/381641
- WHO recommendations on antenatal care for a positive pregnancy experience (2016)
- Humanitarian Interagency Working group Minimum Initial Service Package in Crisis Situation (2022) Minimum Initial Service Package (MISP) for SRH in Crisis Situations | United Nations Population Fund
- WHO Digital Implementation Investment Guide (DIIG): Integrating Digital Interventions into Health Programmes (2020) https://www.who.int/publications/i/item/9789240010567
- ITU and WHO Health Platform Handbook: Building a Digital Information Infrastructure (Infostructure) for Health (2020) https://www.who.int/publications/i/item/9789240013728
- WHO Ethics and governance of artificial intelligence for health (2021) https://www.who.int/publications/i/item/9789240029200

HIV:

- Primary health care and HIV: convergent actions: policy considerations for decision-makers (2023): www.who.int/publications/i/item/9789240077065
- Integration of HIV testing and linkage in family planning and contraception services: implementation brief (2021)
- Integrating the prevention and control of noncommunicable diseases in HIV/AIDS, tuberculosis, and sexual and reproductive health programmes: implementation guidance (2023)
- WHO Consolidated guidelines on HIV prevention, testing, treatment, service delivery and monitoring: recommendations for a public health approach (2021): https://www.who.int/publications/i/item/9789240031593
- Consolidated guidelines on HIV, viral hepatitis and STI prevention, diagnosis, treatment and care for key populations (2022) https://www.who.int/publications/i/item/9789240052390
- WHO Country guidance for planning triple elimination of mother-to-child transmission of HIV, syphilis and hepatitis B virus programmes (2025)
- Longevity Brief GF (Link)

TB:

- WHO recommendations on https://www.who.int/publications/i/item/9789240057562
- WHO consolidated guidelines on tuberculosis:
- Module 2: screening – systematic screening for tuberculosis disease (2021): https://www.who.int/publications/i/item/9789240022676;
- Module 5: management of tuberculosis in children and adolescents (2022) https://www.who.int/publications/i/item/9789240046764;
- Module 6: tuberculosis and comorbidities (2024) https://www.who.int/publications/i/item/9789240087002

Malaria:

- WHO Consolidated guidelines for malaria (2024): https://www.who.int/teams/global-malaria-programme/guidelines-for-malaria
- WHO Global strategy on human resources for health: Workforce 2030 (2020)
- Global strategy on human resources for health: Workforce 2030
- WHO Optimizing community health worker programmes for HIV services 2021
- WHO Implementation guidance on transitioning to midwifery models of care (2025)
- https://iris.who.int/handle/10665/381641
- WHO recommendations on antenatal care for a positive pregnancy experience (2016)
- Humanitarian Interagency Working group Minimum Initial Service Package in Crisis Situation (2022) Minimum Initial Service Package (MISP) for SRH in Crisis Situations | United Nations Population Fund