Integration as a Health Systems Strengthening Intervention: Case Studies from Senegal and Malawi

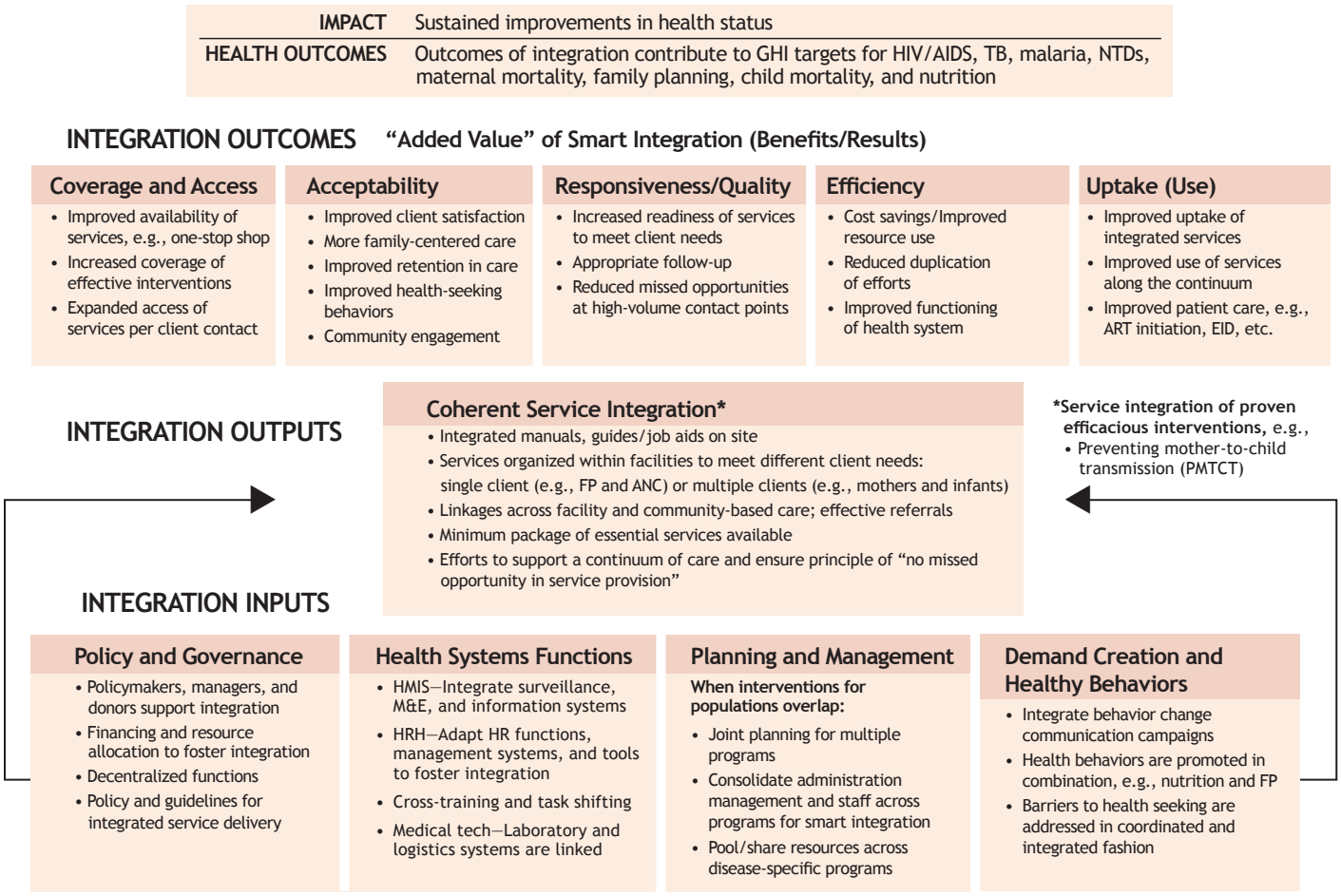
Integration of health services has been adopted in recent years as a strategy to improve the availability of and access to quality services for people.

Integration is defined here as the set of interdependent activities that contribute to improving the overall social and health conditions within a country or health system through the provision of quality services, qualified personnel delivering those services, and the availability of equipment, materials, medicines, and financial resources.

Integrated health services, in this context, refers to the suite of services that surround good care for child health, maternal and newborn health, reproductive health/family planning (RH/FP), HIV, malaria, tuberculosis, and non-communicable diseases such as diabetes, cardiovascular disease, and chronic respiratory diseases.

To better understand the reasons to adopt integration approaches and the various changes to services, policies, and systems that would support integration, MEASURE

Results Framework for the Integration Principle



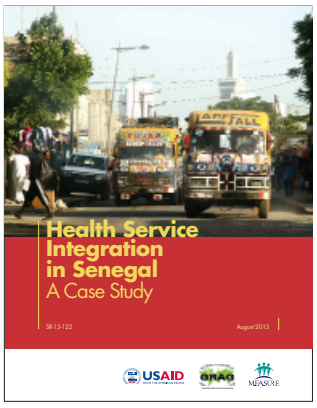
Evaluation, with the support of the U.S. Agency for International Development (USAID), conducted an assessment involving 10 countries (http://www.cpc.unc.edu/measure/publications/tr-14-115). Following the results of this assessment, MEASURE Evaluation initiated case studies in Senegal and Malawi to conduct more in-depth assessments of the integration process and to synthesize learning that will help host countries, USAID missions, and implementing partners, in the planning, implementation, and monitoring and evaluation (M&E) of integrated health services.[1]

Senegal and Malawi for the case studies on integrated service delivery because they were willing to participate, and were at the time (fall 2014) scaling up an integrated service delivery model. Further criteria included that they had been among the 10 countries previously assessed and that they each represent a low-resource setting.

The framework for considering integration and integrated service delivery was developed by an interagency working group of the U.S. Government's Global Health Initiative (GHI).[2] Their thinking, represented on the first page, provides an overview of what we know about integration in the health sector: i.e., (reading from bottom to top) what inputs are required, what outputs should occur, and what the improved health outcomes should be.

Senegal

Senegal faces significant challenges that affect the healthcare system, including gaps and weaknesses in human resource supply, and capacity, equipment, quality services, information systems, and management of infectious and chronic diseases. The Ministry of Health and Social Action (MSAS) and its partners have introduced a package of essential services referred to as the operational plan to transition high-impact interventions on child mortality to national scale, or POPAEN (plan opérationnel de passage à l'échelle national des interventions à haut impact sur la mortalité infanto juvenile au Sénégal), 2010–2014.



The design of the essential package of services responds to the health priorities identified at the local level, including the reduction of maternal, newborn, and child morbidity and mortality. Community health is at the heart of this strategy, and the government of Senegal has developed a national strategic Community Health Plan (2014–2018). Programme Santé/Santé Communautaire II (PSSC II) is a USAID program working with MSAS to develop a package of interventions that includes the renovation of health huts (cases de santé) and the provision of a minimum package of high-impact health services in the health huts and in the community.

Our case study used a mixed-methods methodology combining quantitative and qualitative inquiry in the regions of Kaolack and Louga to investigate the implementation of a minimum package of services offered by community health workers. We randomly selected four health districts, comprising 48 health posts and 48 health huts (the most basic service-provision level in Senegal). Our data collection targeted women of childbearing age

	Senegal	Malawi
Sites	8 health districts in 2 regions (Kaolack and Louga)	10 randomly chosen MOH facilities with ANC and under-5 clinics in Central Region, Malawi
Methods	Document review Qualitative and quantitative primary data collection Secondary analysis of Service Provision Assessment	Document review Qualitative and quantitative primary data collection
Respondents	23 principle actors at the national, regional, and district levels 13 district- and regional-level M&E officers 48 providers at health posts 96 providers at the health hut level and in the community 1,050 female clients ages 18-49 attending health activities and community sites	16 principal actors at the national, district, and zonal levels 11 M&E staff from MOH and IPs 75 facility-based provider interviews 3 focus group discussions with health surveillance assistants in the community 383 under-5 clinic clients (all female, ages 18-49) 379 antenatal care clinic clients (all female, ages 18-49)
Result Themes	• Health systems changes necessary to facilitate integration • Observed changes, strengths, weaknesses, recommendations • Services available, received, and needed • M&E systems • Pilot test results of proposed indicators	

[1] http://www.cpc.unc.edu/measure/publications/sr-15-122
http://www.cpc.unc.edu/measure/publications/sr-15-122-fr
http://www.cpc.unc.edu/measure/publications/sr-15-123

[2] http://www.cpc.unc.edu/measure/publications/ms-14-85

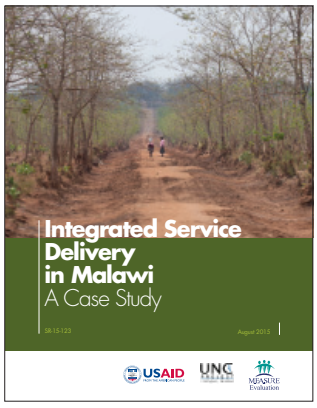
(18 to 49), district medical officers, primary health care supervisors, implementing partners, and others who play a role in service integration. Our aim was to document the health system changes necessary in order to make health service integration a reality, including how M&E systems have been or could be strengthened to document outcomes and describe sources of information.

Results showed that the package of integrated services aligned with MSAS goals; were appreciated by the communities; and expanded coverage of an evidenced-based package of services. The response led to clearer roles and responsibilities from the community to national level, better management of resources, increased availability of data, and improved planning and collaboration between regional and district health teams. But, challenges remain to further expand services and promote sustainability of the community interventions. Three priority areas would further these goals:

1. Overcome clients' geographic and financial barriers to accessing services, particularly at higher levels.
2. In a low-resource setting, devise strategies to overcome competing demands among the need to continue to improve coverage of services, supervision, and human resource retention.
3. Continue to promote community ownership and improved relationships and collaboration between regional and district health teams, development partners, and community actors.
4. Continue to promote ownership of community health by MSAS and other sectors and harmonize linkages with national polices.

Malawi

Support for Service Delivery Integration (SSDI-Services) is Malawi's flagship USAID-funded service integration project. While there are other health service integration projects in Malawi, SSDI-Services is the largest. Its goal is to assist Malawi to reduce fertility and manage population growth, lower the risk of HIV, and reduce maternal, infant, and under-five mortality by scaling up access at the community level to an essential package of services, by providing training, clinical mentoring, supervision, and facility improvements to improve the quality of care, and by increasing community participation to improve health outcomes. SSDI-Services is working with the Ministry of Health (MOH) to integrate family planning and nutrition into HIV care, HIV care into maternal and child health (MCH) services, and nutrition into community-based programs. These efforts would help to address needs of the estimated 17 percent of the population who are under age five and the additional 22 percent who are women of childbearing age (15 to 49), which—combined—represent fully one-third of the population of Malawi.



The health facilities in the Central Region are similar to those found nationwide, and due to budget limitations we limited our study to this region. We used mixed methods of primary quantitative and qualitative data collection and a desk review of secondary data. We interviewed national, zonal, and district-level program staff, including MOH staff, plus donors and implementing partners. We also interviewed M&E officials to gather information on needs specific to integration. We interviewed providers and clients of under-five services and antenatal care (ANC) services and held focus groups to gather insight from health surveillance assistants (HSAs). Our desk review sought to understand how integration is captured in national policies, national M&E plans, guidance, standard operating procedures, and other norms.

The major human resource problem was a dominant theme for most respondents when discussing how well the health system functioned, the benefits of integration, and how well integration could be implemented. These concerns resonated with participants at all levels of the health system. Participants explained how the "under one roof" concept for services was problematic in small sites with only one worker. However, others at the national level and with implementing partners believed the resources expended for training, planning, and, at times, physical restructuring of facilities, would be worth the effort to maximize the impact of limited human resources.

Our findings indicate that Malawi has made great strides in the conceptualization and delivery of integrated health services, attributable to a strong, coordinated, national vision for integration, informed by key stakeholders and focusing on maternal and child health outcomes as their public health priority. Other positive attributes of Malawi's approach include:

- Choosing to improve outcomes through integrated service delivery at all levels of the health system;
- Defining an essential health package of services and mandating that it be available to women and children; and
- Improving training of staff, infrastructure (for example, space to provide privacy during HIV treatment and care), and technology (including commodities and supplies).

However, although the national level has done a great job of conceptualizing and delivering integrated services at the service delivery level, there is incomplete integration at the national and subnational levels, where planning, budgeting, and M&E take place.

The team's research also indicates that there are areas of implementation that remain challenging and could use additional operations research studies to clarify.

For example, nutrition services were frequently noted as "unavailable" in the facilities that the team visited. Additionally, very few women in under-age-five clinics were also accessing family planning services. Finally, almost no referrals were obtained by the clients interviewed, despite a sizeable minority reporting that they left the clinic with at least one unmet health need. Additional research to understand what might be driving these failures to deliver the essential health package, and to assure "no missed opportunities," could be of value in helping the Malawi public health facilities to improve the implementation of integration of these services.

Conclusion

Both cases highlight examples in which government, donor, and partners identified and agreed on priority health concerns to address with evidence-based packages of integrated services and delivery strategies, resulting in improved access to care for populations. Improved policies, strong leadership and governance, planning, and management functions all supported the coordination and collaboration among partners to provide integrated services. Health information systems and M&E data collection and reporting improved. However, data to support the contribution that integrated interventions can have on improved service coverage and other outcomes are limited. The aspects of human resources, supervision, and commodities and supplies remain challenges.

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Jim Thomas, PhD
Project Director
jim.thomas@unc.edu

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