



Primary Health Care Integration Models for Universal Health Coverage: A Policy Brief for Global Health Decision Makers

Kyiv
2025

◀ Introduction:

Frontline AIDS, together with partners, undertook this comprehensive analysis, led by Alliance for Public Health, to address a critical challenge facing global health: how can community-based organisations successfully transform fragmented, disease-specific programs into integrated health services that meet the complex needs of the populations they serve? This question has become increasingly urgent as our partner organisations report that their clients, many living with HIV, now require care for tuberculosis, hepatitis, diabetes, and other conditions, yet must navigate disconnected services that waste resources, create barriers to access, and ultimately fail to deliver comprehensive care.

This analysis emerged from a practical imperative. Across our network of 17 partner organisations spanning Latin America, Asia, Africa, and Europe, we observed both inspiring innovations and persistent struggles in attempts to integrate services. Some partners had successfully co-located HIV and tuberculosis care, while others remained trapped in parallel systems despite serving the same communities. Digital health solutions transformed service delivery for some organisations, while others continued relying on paper-based systems that hindered coordination. These disparities demanded systematic investigation to understand what works, what doesn't, and why.

We designed this study to capture the reality of integration efforts on the ground—not as an academic exercise, but as a foundation for practical action. Using a mixed-methods approach grounded in WHO's Integrated People-Centred Health Services framework and other established models, we examined how our partners currently deliver services, what integration mechanisms they have implemented, what barriers they face, and what support they need to advance. The questionnaire deliberately balanced quantitative metrics with narrative responses, recognising that numbers alone cannot capture the complexity of health system transformation.

The timing of this analysis is deliberate. As countries work toward Universal Health Coverage by 2030, the window for meaningful health system reform is narrowing. The COVID-19 pandemic exposed the fragility of vertical programs and demonstrated that resilient health systems require integrated platforms capable of adapting to emerging threats while maintaining essential services. Moreover, the epidemiological landscape has shifted dramatically—people living with HIV are ageing, non-communicable diseases are rising across all regions, and the traditional boundaries between infectious and chronic disease management have become obsolete.

Primary Health Care has emerged as the logical platform for integration, yet our partners' experiences reveal that simply declaring PHC as the foundation is insufficient. Real integration requires fundamental changes in how services are organized, financed, and delivered. It demands new competencies from health workers, different approaches to community engagement, and technological infrastructure that many organizations lack. Most critically, it requires shifting from a mindset of disease control to one of comprehensive, lifelong care.

This analysis serves multiple purposes. For our partner organizations, it provides evidence to advocate for policy changes and resource mobilization. For Frontline AIDS, it informs how we provide technical assistance and allocate support. For the broader global health community, it contributes real-world evidence on integration implementation in diverse contexts. Ultimately, this work aims to accelerate the transformation from fragmented services to integrated systems that can deliver on the promise of health for all, ensuring no one is left behind in the pursuit of Universal Health Coverage.

Executive Summary

This policy brief presents findings from a comprehensive analysis of integrated health service delivery models across 17 Frontline AIDS partner organizations operating in Latin America, Asia, Africa, and Europe. The study employed a mixed-methods approach to assess current integration practices, identify barriers and enablers, and develop evidence-based recommendations for advancing Universal Health Coverage through strengthened Primary Health Care systems.

The analysis reveals significant progress alongside critical gaps in health service integration efforts. All participating organizations demonstrate strong HIV service platforms, with 100% coverage providing a solid foundation for expanded integration. Organizational maturity is notable, with most partners operating for over 15 years, bringing institutional stability crucial for sustainable integration. However, substantial challenges persist across regions.

Digital health adoption remains critically limited, with only 29% of organizations utilizing comprehensive digital tools for integrated service delivery. This digital divide severely constrains care coordination, patient tracking, and data-driven decision-making. Tuberculosis integration, despite high HIV-TB co-infection rates, remains incomplete—particularly in Latin America where zero organizations offer TB services despite universal HIV coverage. Financial constraints are universally reported as the primary barrier to integration, followed by inadequate infrastructure, weak coordination mechanisms, and persistent stigma.

Regional variations are striking. Asia emerges as the integration leader with 100% HIV-TB coverage, 83% offering non-communicable disease services, and universal community advisory board engagement. The region's digital maturity (50% comprehensive adoption) and strong government partnerships position it for accelerated progress. Africa demonstrates exceptional community engagement with 100% hospital partnerships and universal volunteer mobilization, yet faces a severe digital gap, with 71% lacking comprehensive digital tools. Latin America shows institutional strength but critical service gaps, particularly the complete absence of TB services and limited digital infrastructure (67% lack digital tools). Europe, represented by a single organization from Ukraine, offers unique insights into crisis-resilient integration but lacks clinical partnerships and a comprehensive service scope.

The analysis proposes phased, region-specific integration models while identifying cross-cutting priorities. Immediate actions include establishing shared electronic health records across all organizations, completing TB-hepatitis integration where gaps exist, and deploying mobile health platforms to enhance patient engagement. Medium-term strategies focus on developing comprehensive one-stop-shop models, strengthening Primary Health Care treatment capacity, and building formal clinical partnership networks. Long-term sustainability requires diversified funding mechanisms, policy harmonization across countries, and the establishment of regional integration alliances for knowledge exchange and technical assistance.

Success requires coordinated action at multiple levels. Governments must align policies to support integration, remove bureaucratic barriers, and ensure sustainable financing. Donors should shift from disease-specific funding toward flexible, integrated program support. Implementing organizations need investment in digital infrastructure, workforce cross-training, and community engagement systems. Regional bodies should facilitate cross-border collaboration and harmonize integration standards.

While significant progress has been made, achieving truly integrated, people-centred health systems requires sustained commitment and investment. The experiences of these 17 organizations demonstrate that integration is not merely about co-locating services but fundamentally transforming how health systems organize, deliver, and monitor care. With appropriate support and strategic implementation of the recommendations presented, these organizations can lead the transformation toward resilient, equitable health systems that leave no one behind.

Global Policy Recommendations

DIGITAL HEALTH INFRASTRUCTURE:

Only 29% of organizations have comprehensive digital tools, with 67% in Latin America and 71% in Africa lacking digital infrastructure. This gap undermines care coordination and patient tracking. Organizations with shared EHRs demonstrate superior integration outcomes. Priorities include: interoperable EHR systems, mobile health applications for patient engagement, telemedicine platforms, and data analytics systems. The correlation between digital maturity and integration success, particularly Asia's 50% digital adoption, coinciding with regional leadership, demonstrates that digital infrastructure is fundamental for achieving Universal Health Coverage by 2030.

DISEASE-SPECIFIC INTEGRATION:

Critical service gaps persist: Latin America has zero TB services despite universal HIV coverage; Asia shows only 17% hepatitis coverage. This fragmentation forces patients through disconnected systems, causing treatment interruptions. Organizations with comprehensive disease integration report better adherence and resource efficiency. Asia's 100% HIV-TB coverage proves feasibility. Implementation requires unified screening protocols, integrated treatment guidelines, cross-trained healthcare workers, and single patient records. Given increased co-morbidity risks among people living with HIV, integrated disease management is essential for addressing complex health needs.

COMMUNITY GOVERNANCE:

Asia's 100% advisory board coverage correlates with integration leadership, while organizations without these structures show weaker outcomes. Community governance ensures cultural appropriateness, builds trust, and mobilizes resources. Organizations with comprehensive engagement achieve better service uptake and retention. Requirements include: formal advisory structures with decision-making authority, regular feedback collection, community health worker programs, and volunteer networks. These mechanisms transform top-down approaches into responsive, community-owned services essential for sustainable integration.

QUALITY ASSURANCE:

Widespread absence of Monitoring and Evaluation (M&E) frameworks prevents assessment of integration effectiveness and data-driven improvements. Organizations cannot track patients across services or measure long-term outcomes. Critical components: standardized integration indicators, real-time service utilization tracking, patient-reported outcomes, cost-effectiveness analyses, and longitudinal cohort studies. Without robust M&E systems, integration efforts cannot demonstrate impact or justify investments, perpetuating inefficient fragmentation and undermining evidence-based scale-up.

SUSTAINABLE FINANCING MECHANISMS:

Financial constraints are universally identified as the primary integration barrier. Disease-specific funding perpetuates fragmentation through competing priorities and duplicative systems. Restrictive donor requirements prevent resource pooling and flexible programming. Solutions require: pooled funding supporting integrated platforms, Global Fund/PEPFAR investments in integration infrastructure, government performance-based financing incentivising integration, and social impact bonds rewarding long-term outcomes. The transition from vertical to horizontal financing must ensure stable support during the transformation from fragmented to integrated services.

WORKFORCE DEVELOPMENT AND TASK-SHIFTING:

While 71% of African and 67% of Asian organizations provide cross-training, program standardization varies significantly. Critical gaps exist in mentorship, interdisciplinary coordination, and psychological support. Requirements include: comprehensive pre-service education for multi-disease management, standardized integration protocols training, formal task-shifting frameworks, and staff wellbeing programs. Organizations with comprehensive workforce development show superior outcomes. Investment in human resources proves equally critical as infrastructure for sustainable integration, requiring regional training centres and structured mentorship programs.

While global recommendations provide a universal framework, the analysis reveals distinct regional contexts requiring tailored approaches. Each region demonstrates unique strengths. Asia's exceptional HIV-TB integration and digital progress, Africa's unparalleled community mobilization, Latin America's organizational maturity, and Europe's crisis-resilient operations, alongside critical gaps that demand targeted interventions. This heterogeneity necessitates differentiated policy priorities that respect local realities while maintaining alignment with global integration goals. The following regional recommendations build upon existing strengths, address urgent gaps, and recognise diverse health system contexts, resource availability, and epidemiological profiles, enabling cross-regional learning while respecting each region's unique journey toward Universal Health Coverage.

Key Strengths by Region

LATIN AMERICA:

Latin America's universal HIV platform (100% coverage) provides a robust integration foundation, reinforced by exceptional institutional maturity. All three organizations have 25+ years of experience. Complete government collaboration and strong civil society networks enable policy alignment and community mobilization. Digital capabilities are emerging, with 67% utilizing telemedicine and data analytics. Despite spanning different countries and languages (Ecuador, Bolivia, Brazil), organizations maintain similar models facilitating cross-national learning. This combination of established HIV infrastructure, institutional stability, government partnerships, and emerging digital adoption positions the region for accelerated integration progress.

ASIA:

Asia leads globally with 100% HIV-TB coverage, addressing critical co-infection rates and creating the strongest integration foundation worldwide. Universal community advisory boards ensure responsive, culturally appropriate services. Primary Health Care integration is exceptional with 100% screening and treatment capacity aligns with WHO's UHC vision. Government partnerships are universal, providing policy support across all six organizations. Digital adoption is advanced with 67% using adherence platforms and 83% employing data analytics.

AFRICA:

Africa's strength lies in unparalleled partnerships, 100% hospital partnerships and 86% collaboration with clinics, providers, and NGOs create comprehensive referral networks. Universal mentorship programs with 71% cross-training and 86% providing learning materials build essential workforce capacity. Community mobilization is exceptional with 100% volunteer engagement, 100% outreach programs, and 71% deploying community health workers. Universal SRHR integration addresses critical linkages often missed in vertical programs. Advocacy capacity is strong, 86% engage policymakers and 71% build coalitions. Organizations like LVCT Health and Alive Medical Services serve as regional champions capable of providing technical assistance across the continent.

EUROPE:

Ukraine demonstrates exceptional crisis resilience, maintaining services through 24 years of conflicts, transitions, and active warfare, providing unique insights for fragile settings. Backend digital capabilities are robust, 100% telemedicine and data analytics implementation proves sophisticated technologies can function in crisis contexts. The organization operates without policy barriers, benefiting from Ukraine's supportive governance framework. A comprehensive infectious disease platform (HIV, TB, Hepatitis) plus primary care creates expansion foundations. Despite extreme challenges, strong government and NGO partnerships persist. This crisis-tested model offers invaluable lessons for health system resilience applicable to other unstable contexts globally.

Critical Gaps by Region

LATIN AMERICA:

Latin America faces a critical TB integration deficit despite high HIV-TB co-infection rates and universal HIV coverage, forcing patients to seek fragmented care. Digital health adoption is severely limited with 0% utilizing mobile health apps or digital adherence tools, undermining patient engagement and treatment monitoring. Primary health care treatment capacity is entirely absent with 0% providing treatment in PHC settings, only screening and referrals, contradicting WHO's vision of PHC-based integrated care. Only 33% have shared EHRs, fragmenting patient records across services. These gaps create systematic barriers where patients must navigate multiple disconnected service points, increasing dropout rates and compromising outcomes.

ASIA:

Despite regional leadership, Asia faces a hepatitis integration crisis, only 17% (one organization) provides hepatitis services despite high co-infection rates with HIV, leaving critical gaps in comprehensive viral disease management. Digital inequity persists with 50% of organizations lacking comprehensive digital tools, creating a two-tier system where certain organizations operate manually while others advance digitally. Paradoxically, 83% report policy gaps, absent frameworks, and conflicting guidelines despite operating in supportive environments, indicating severe implementation challenges between policy intent and operational reality. The heterogeneity between India's organizations reveals uneven integration progress even within countries, requiring targeted support for lagging organizations.

AFRICA:

Africa's digital divide is severe, with 71% of organizations lacking comprehensive digital tools, with only a few organizations achieving digital integration, creating massive disparities in care coordination and monitoring capabilities. Universal financial constraints affect 100% of organizations, identified as the primary barrier limiting infrastructure development, staff training, and service expansion. TB integration remains incomplete, with 43% lacking TB services despite high HIV-TB co-infection burdens. Chronic care monitoring is critically weak, only 29% provide systematic monitoring for NCDs despite rising diabetes and hypertension prevalence. These gaps are compounded by medication supply inconsistencies and inadequate facilities, creating cascading failures in integration efforts across the region.

EUROPE:

Ukraine faces complete clinical system isolation with 0% partnerships with hospitals or clinics severely limiting referral pathways and care continuity for complex patients. No service co-location exists, with HIV, TB, and hepatitis delivered through separate programs rather than one-stop-shop models, forcing patients through fragmented systems. Critical service gaps include 0% NCD coverage despite Eastern Europe's high cardiovascular disease burden, and 0% SRHR services missing essential HIV-reproductive health linkages. Community engagement infrastructure is absent with no advisory boards, community health workers, or volunteer networks, relying solely on surveys for feedback. These gaps are particularly concerning given the organization's crisis context requiring streamlined, accessible services.

Policy Priorities by Region

LATIN AMERICA:

Mandatory TB integration at all HIV service points addresses the critical gap where zero organizations provide TB services despite high co-infection rates, requiring immediate policy mandates with implementation timelines and resources. Regional digital infrastructure investment must establish shared EHR systems and mobile health platforms, addressing the complete absence of digital adherence tools. PHC strengthening policies must enable treatment delivery at the primary care level; currently 0% provide treatment, only screening. A formal Latin America Integration Alliance spanning Ecuador, Bolivia, and Brazil would facilitate knowledge sharing, leveraging the region's similar organizational models and 25+ years of institutional experience for accelerated cross-national learning.

ASIA:

Hepatitis integration must rapidly expand from the current 17% to universal coverage, addressing the critical gap in comprehensive viral disease management despite high co-infection prevalence. A digital equity program targeting organizations currently operating without digital tools would address the 50% digital divide preventing coordinated care. Asia's exceptional integration performance positions it to become a global technical assistance hub, with leaders within Asia providing South-South support. Policy implementation support must bridge the paradox where 83% report policy gaps despite supportive frameworks, requiring operational guidelines, training, and monitoring systems to translate policy intent into practice.

AFRICA:

An Africa-wide digital transformation initiative must address the 71% digital gap through a unified platform with mobile health scale-up, building on successful models from existing organizations. Resource sustainability requires diversified funding with mandatory government co-financing, addressing the universal financial constraints affecting 100% of organizations. TB integration completion from the current 57% to universal coverage is essential, given high co-infection burdens. The Africa Health Integration Alliance would formalize South-South collaboration, leveraging the region's exceptional mentorship culture (100% offer coaching) and strong advocacy capacity (86% engage policymakers) to drive continental transformation and position Africa as a global leader in community-anchored integration.

EUROPE:

Clinical integration policy must mandate hospital and clinic partnerships, addressing organizations complete isolation from clinical systems, which severely limits referral pathways and continuity. Service expansion requirements should include NCD integration (currently 0%) given Eastern Europe's cardiovascular disease burden, and SRHR services for essential HIV-reproductive health linkages. An Eastern European Health Alliance would break the organization's regional isolation, enabling cross-border collaboration and knowledge exchange with neighboring countries facing similar challenges. Ukraine's unique crisis-resilience experience positions it for global leadership in health integration for conflict-affected settings, offering invaluable expertise for fragile contexts worldwide through technical assistance and policy guidance development.

◀ Conclusion

The path to Universal Health Coverage requires bold transformation from fragmented vertical programs to integrated, people-centered care networks. This analysis provides actionable regional roadmaps that leverage distinct strengths while addressing critical gaps. Success demands coordinated investment, policy alignment, and sustained commitment to comprehensive integration models.

The evidence is clear: regions with stronger integration foundations achieve better health outcomes, enhanced efficiency, and improved patient satisfaction. The time for incremental change has passed, and achieving UHC requires the transformative integration approaches outlined in these regional models.

* *This policy brief is based on comprehensive analysis of 17 organizations across four regions conducted in partnership with Frontline AIDS and aligned with WHO IPCHS, Global Fund RSSH, and CDC PCSI frameworks.*





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