GLOBAL INSTITUTE FOR DISEASE ELIMINATION

STAKEHOLDER ROUNDTABLE

PROTECTING PROGRESS: INTEGRATION FOR INFECTIOUS DISEASE ELIMINATION IN A SHIFTING GEOPOLITICAL LANDSCAPE

MEETING REPORT

19 MAY 2025 | 13:00 – 14:30

GRAND SALON, CAGI, GENEVA, SWITZERLAND

ACRONYMS

PHC	Primary Health Care
JBI	Joanna Briggs Institute
PRISMA	Preferred Reporting Items for Systematic Reviews and Meta-Analyses
TB	Tuberculosis
RSSH	Resilient and Sustainable Systems for Health
CHW	Community Health Worker
WASH	Water, Sanitation and Hygiene
eLMIS	Electronic Logistics Management Information System
ERP	Enterprise Resource Planning
CDC	Centres for Disease Control and Prevention
IWG	Integration Working Group
DNDi	Drugs for Neglected Diseases initiative
IAVI	International AIDS Vaccine Initiative
WHO	World Health Organization
NCD	Non-Communicable Diseases

EXECUTIVE SUMMARY

Amid shifting geopolitical dynamics, constrained funding, and ongoing global health emergencies, the integration of disease-specific programs into broader health systems has become essential to sustaining and accelerating progress in disease elimination. In response to this, the Global Institute for Disease Elimination (GLIDE) convened a high-level event during the 78th World Health Assembly, continuing its work on exploring integration as a means to accelerate disease elimination. Bringing together policymakers, donors, researchers, and implementing partners, the event explored how pragmatic, country-led, and performance-oriented integration can align programs, optimize resources, and adapt to local contexts. Drawing on global evidence, country case studies, and partner insights, participants emphasized integration as a strategic imperative to maintain momentum against diseases such as malaria, polio, and neglected tropical diseases (NTDs).

OBJECTIVES

The objectives of this session were to:

1. **Share best practices and lessons learned within and beyond health:** National programs and multilateral initiatives will share practical examples of past integration efforts, and critically examine how evolving geopolitical dynamics may necessitate strategic pivots to sustain and optimize progress towards infectious disease elimination.
2. **Highlight the role of cross-sector collaboration:** Highlight successful models of integration between sectors and discuss new opportunities for collaboration.

PARTICIPANTS AND FORMAT

The event convened 25 experts representing multilateral agencies, national disease control programs, global health partnerships, foundations, and research institutions. The format included a keynote presentation sharing insights from a global scoping study, followed by interventions from key partners such as the Global Polio Eradication Initiative (GPEI) and the Global Fund. A structured discussion, moderated by GLIDE, guided participants through a focused exchange on barriers, enablers, and strategic recommendations for advancing integration in disease elimination efforts.

KEY THEMES AND INSIGHTS

Evidence and Definitions of Integration

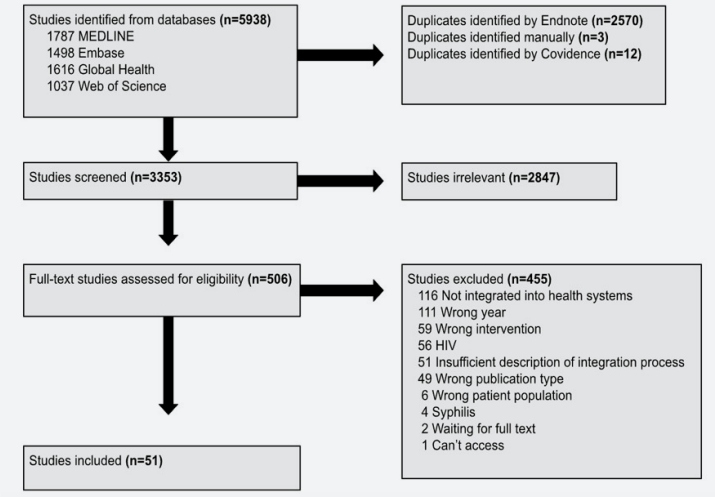
Margaret Baker, Associate Professor of Global Health at Georgetown University, opened the session by laying a foundational understanding of what integration means in the context of disease elimination. Drawing from a scoping review, supported by GLIDE, she emphasized that integration is best understood as a process, one that requires careful planning, contextual clarity, and specificity. Prof. Margret explained that integration involves combining two or more components and the use of this term in health has taken on different meanings - such integrating activities of two or more diseases (e.g. co-delivery of mass drug administration (MDA) for several NTDs or integrated vector control for lymphatic filariasis and malaria), or integrating a vertical disease program with the health system (e.g. tuberculosis treatment into primary health care), or to integrate a disease program with other sectors like education or water and sanitation. She underscored the importance of clearly defining the type of integration being pursued. Simply calling for integration, she noted, is not sufficient as the success and outcomes of integration ultimately depend on how the process is designed and implemented

Prof. Margaret then presented early insights from a review of over 50 articles, which sought to fill a critical gap in the literature: how integration of disease-specific programs into broader health

systems has been studied, implemented, and evaluated. The review focused on all infectious disease programs with an elimination or eradication goal, often delivered in a vertical manner, and examined how treatment and surveillance activities have been integrated with primary health care and routine health system functions. Guided by two main research questions, the scoping review examined how have infectious disease eradication/elimination programs integrated treatment or surveillance functions into routine health systems/PHC and what methods and approaches have been used to study and assess the impact of integrating infectious disease interventions into health systems?

The screening and selection process followed JBI guidelines and is illustrated in Figure 1, which presents the PRISMA flow diagram used to identify and refine the final set of included studies. From an initial pool of nearly 6,000 articles, a rigorous screening process resulted in 51 studies that met the eligibility criteria and directly informed the findings of the review. Most of these studies focused on a single disease, with only five examining efforts to integrate multiple diseases into health systems. Of the total, 30 studies addressed treatment integration, 17 focused on surveillance, and just four covered both areas.

Figure 1. PRISMA flow diagram outlining paper review process



It was noted that most articles reported outcomes related to program-level performance—such as patient numbers, treatment adherence, cure rates, early case identification, and health worker capacity. However, there was a lack of measurement around the broader impact on health systems themselves. This gap highlighted a critical need for more robust evidence on how integration affects PHC functions over time.

Several factors emerged as key to successful integration. These included the quality and continuity of training, reinforcement by supervisors, incentives, access to essential supplies (such as diagnostics), political support, and strong collaboration among stakeholders. Community knowledge of services and the cost burden on patients also shaped outcomes.

In terms of research methodology, many studies used case study approaches—often with qualitative, quantitative, or mixed methods. A few included before-and-after comparisons or cost analyses,many lacked detailed descriptions of the integration process or the context in which it occurred. Despite their limitations, well-designed case studies were seen as valuable tools to explore the complexity of integration and to surface local innovations and solutions.

Prof. Baker concluded by emphasizing that effective integration requires more than merging services—it demands coordinated human resources strategies and a holistic health systems approach, including supply chains, information systems, and policy alignment. While such efforts still require funding, they

may offer opportunities for more efficient resource use and alternative financing models.

She underscored the importance of documentation, particularly given the scale of integration now occurring in real-world settings.

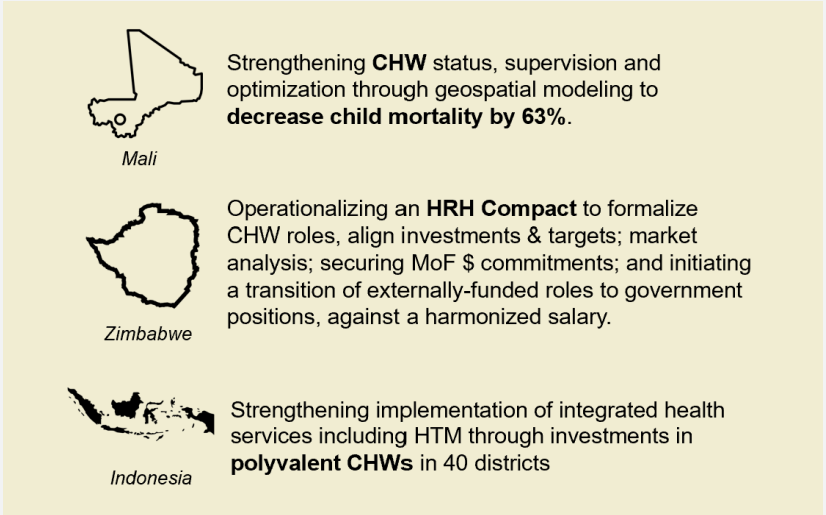
Interventions/Strategic Reflections from Partners

Michael Bryne, Head of the Technical Advice & Partnerships Department, Global Fund presented how the Global Fund supports the integration of HIV, tuberculosis (TB), and malaria programs into national primary health care systems through investments in Resilient and Sustainable Systems for Health (RSSH). He described integration as the alignment of disease-specific programs with broader health services, encompassing areas such as governance, human resources for health, supply chains, and data systems. The overarching goal, he noted, is to enhance health outcomes by fostering people-centred care, reducing duplication, improving cost-effectiveness, and strengthening domestic ownership of programs. RSSH initiatives focus on workforce development, diagnostics, service delivery, digital health systems, and sustainable financing.

Practical country examples were illustrated - In Mali, community health workers (CHWs) have been formally recognized as part of the national health system, with over 3,700 CHWs strategically deployed using geospatial modeling in high-risk areas. These workers provide a range of services, including maternal and child health, malaria and neglected tropical disease management, tuberculosis referrals, immunization support, and water, sanitation, and hygiene (WASH) promotion. The impact has been substantial, with improved service quality, a 63% reduction in child mortality, and more timely treatment at the community level. In Zimbabwe, a national compact formalized the roles of CHWs, aligning them with financing structures and standardizing salaries. Indonesia showcased strategic integration of HIV, TB, and malaria staff into the broader human resources for health framework, with program staff gradually transitioning into the national workforce under domestic financing. Country examples are summarized in figure 2 below.

At the systems level, Bryne highlighted several integrated approaches in diagnostics, accelerated system digitalization and broader rights-based. Diagnostics have seen improved access and turnaround times through integrated sample transport systems and digital tools such as electronic logistics management information systems (eLMIS) and enterprise resource planning (ERP). Digitalization efforts include the development of national disease-agnostic health information platforms. A rights-based approach to integration has also been adopted, with legal services embedded within HIV programs to support key populations, underscoring the importance of human rights and gender perspectives. In terms of health financing, strategies such as strategic purchasing, government-supported social contracting, and pooled resources for HIV, TB, and malaria within national health benefit packages have been implemented to ensure sustainability and efficiency.

Figure 2. Country examples on Resilient & Sustainable Systems for Health (RSSH)



Landry Dongmo Tsague, Africa CDC, emphasized that integration is not just a strategic option but a necessity in the face of resource constraints. He framed this moment as a pivotal turning point for public health globally, urging a shift in the narrative - from scarcity to creative efficiency. He also mentioned that integration is about making the most of available resources. He reaffirmed Africa CDC's commitment to disease prevention, control, and elimination, aligning closely with GLIDE's mission, symbolized by the 'crossed-out disease' on GLIDE's logo. Landry highlighted the need to reimagine the architecture of global health, which remains dominated by vertical programs driven by siloed initiatives. He advocated for stronger partnerships with the private sector, noting their systems-thinking approach and capacity to challenge existing models to enhance optimization and integration. Lastly, he referenced Africa CDC's recent work on community health workforce development as a foundation for innovative integration strategies.

Jamal Ahmed from the Global Polio Eradication Initiative (GPEI) emphasized the importance of avoiding integration 'for its own sake', underscoring the need for performance-based planning. He shared concrete examples from Angola and Madagascar where existing polio infrastructure successfully supported responses to cholera and lymphatic filariasis outbreaks, illustrating the utility of disease-specific platforms for broader public health functions. However, he cautioned that poorly planned integration can dilute program performance, particularly in the context of vertical funding structures. Shah noted that while donors may be hesitant to shift focus, integration remains possible where there is shared intent and goodwill. A key barrier, he highlighted, is the lack of global policy guidance that clearly defines roles and responsibilities in integrated performance frameworks. Finally, he stressed the importance of addressing financing risks and ensuring that integration does not compromise program feasibility.

Key insights from participants

Balancing long-term system building with immediate needs

While strengthening primary health care systems is recognized as critical, participants emphasized that certain disease programs, such as polio, cannot afford to delay action. Integration efforts must therefore balance urgency with sustainability, acting on short-term opportunities without compromising broader health system goals.

Moving from concept to practice

A central concern was how to move beyond theoretical discussions of integration and implement practical, effective solutions. In regions such as sub-Saharan Africa, this means developing both short-term and sustainable approaches that reflect existing resource constraints and political realities. Questions of cost-efficiency inevitably arise when more funding is requested, making results-oriented planning essential.

Challenges of coordinated delivery and unintended consequences

Well-intended integration can backfire if not thoughtfully planned. Overlapping campaigns risk overburdening health workers, while communities may resist unfamiliar changes, particularly if job roles or trusted disease-specific services are disrupted. Flexibility and context sensitivity are crucial. Coordinated delivery must consider community workforce fatigue, scheduling conflicts, and potential loss of focus.

Importance of planning

Effective integration depends on disciplined planning and clearly defined, measurable goals. Broad, unfocused agendas, especially when driven by multiple external partners, can stall progress. A

streamlined approach, aligned with national priorities, was seen as key to converting opportunity into measurable impact.

Efficiency through innovation

Multiplex diagnostics and digital platforms, were highlighted as promising avenues for improving efficiency and reducing operational costs. However, these must be coupled with clear success metrics.

Country ownership and system alignment

There was strong consensus that national Ministries of Health must lead, with support aligned to their existing policies and systems. Integration efforts should reflect their priorities and implementation capacity. While many national policies speak to integration in principle, implementation is often hindered by fragmented funding streams and structural misalignments at the district level. There is a need to assess and strengthen existing systems rather than assume new structures are needed.

Defining success and measuring impact

A consistent theme was the absence of a shared definition for what successful integration looks like. A key issue raised was the lack of a shared definition of successful integration. Disease elimination goals must be balanced with broader system performance, and donors and governments must align on how progress is measured. Structural inefficiencies, rather than resource shortages, were often cited as key barriers.

Operational guidance and practical support

Despite widespread support for integration, participants agreed that more operational tools, case studies, and implementation frameworks are needed. Countries require support in planning, financing, and executing integrated strategies without compromising program focus or feasibility. There is a clear need for global frameworks that provide practical direction on planning, financing, measuring, and executing integrated approaches—without sacrificing program effectiveness.

RECOMMENDATIONS

We call on the wider global health community, including national governments, ministries of health, implementing partners, donors, and technical agencies, to take coordinated and collective action on the following recommendations to advance integration efforts.

1. **Develop operational/global guidance:** Develop global and operational guidance that supports countries in translating integration concepts into practice. This should include case studies, implementation frameworks, and adaptable tools that help navigate integration in varying contexts—particularly in resource-limited settings.
2. **Invest in evidence-to-action:** Expand use and support development of scoping studies, cost-effectiveness data, and operational research to support integration decision-making.
3. **Prioritize country-led integration:** Align with national health plans and structures, particularly at district level. Leverage existing health architecture to avoid redundancy. Emphasis should be placed on reinforcing current systems and structures rather than introducing parallel mechanisms.
4. **Purposeful planning for integration:** Support countries in identifying and mitigating risks of integration, including workforce burnout, loss of disease program momentum, or community disengagement. Emphasize context-specific planning and include contingency approaches in all integration strategies.
5. **Foster cross-sector partnerships and innovation:** Promote collaboration across sectors—including education, WASH, and the private sector—to identify shared delivery platforms and innovative technologies (e.g., digital systems, diagnostics) that can increase reach and operational efficiency.
6. **Facilitate sustainable financing and reduce fragmentation:** Encourage donors to support flexible financing mechanisms within national systems, avoiding vertical funding silos. Strategic purchasing and pooled resources should be explored to promote efficiency and domestic ownership.

CONCLUSION

In conclusion, the discussion underscored that while integration is not a new concept, the urgency to act has never been greater. The challenge is no longer about defining integration, but about enabling countries to implement it effectively and sustainably. Coordination, clarity, and country leadership are essential to realizing the full potential of integration for disease elimination.

GLIDE remains committed to supporting this agenda by facilitating knowledge exchange, investing in evidence, and fostering alignment between national priorities and global frameworks. One platform for continuing this work is GLIDE's Integration Working Group (IWG), which convenes 20 partners from countries and entities focused on infectious disease elimination. The IWG will produce several papers over the course of the next year, and the recommendations from this event will feed into their discussions.

Organized by: Global Institute for Disease Elimination (GLIDE)

For further information please contact: info@glideae.org

APPENDIX

AGENDA

Segment	Time	Description	Lead
Opening remarks	5 mins	Welcome remarks	Mr. Simon Bland (GLIDE)
Presentation on examples of integration	10 min	Presentation on the early findings from a scoping study on integration examples within and beyond health	Dr. Margaret Baker (Georgetown University)
Interventions from experts	25 min	Presentation and interventions from multilateral initiatives sharing practical integration examples, key lessons and outcomes	Mr. Michael Byrne (Global Fund)
Structured discussion	45 mins	Open dialogue and participant responses to the expert presentations	Participants
Wrap up	5 mins	Summary of key takeaways	Dr. Farida Al Hosani (GLIDE)

List of participating organizations

Georgetown University

WHO

Global Fund

Geneva Health Forum

H3D Foundation

Task Force for Global Health

Mohamed bin Zayed Foundation for Humanity

NCD Alliance

Resolve to Save Lives

The Carter Center

International Society for Neglected Tropical Diseases

DNDi

FIND

IAVI

Africa CDC

Gates Foundation

Malaria No More UK

Gavi

Uniting to Combat NTDs

Linksbridge

Helen Keller International

END Fund

RLM Fund Secretariat

GLIDE