Integrating HIV and HTN services: Opportunities and Challenges

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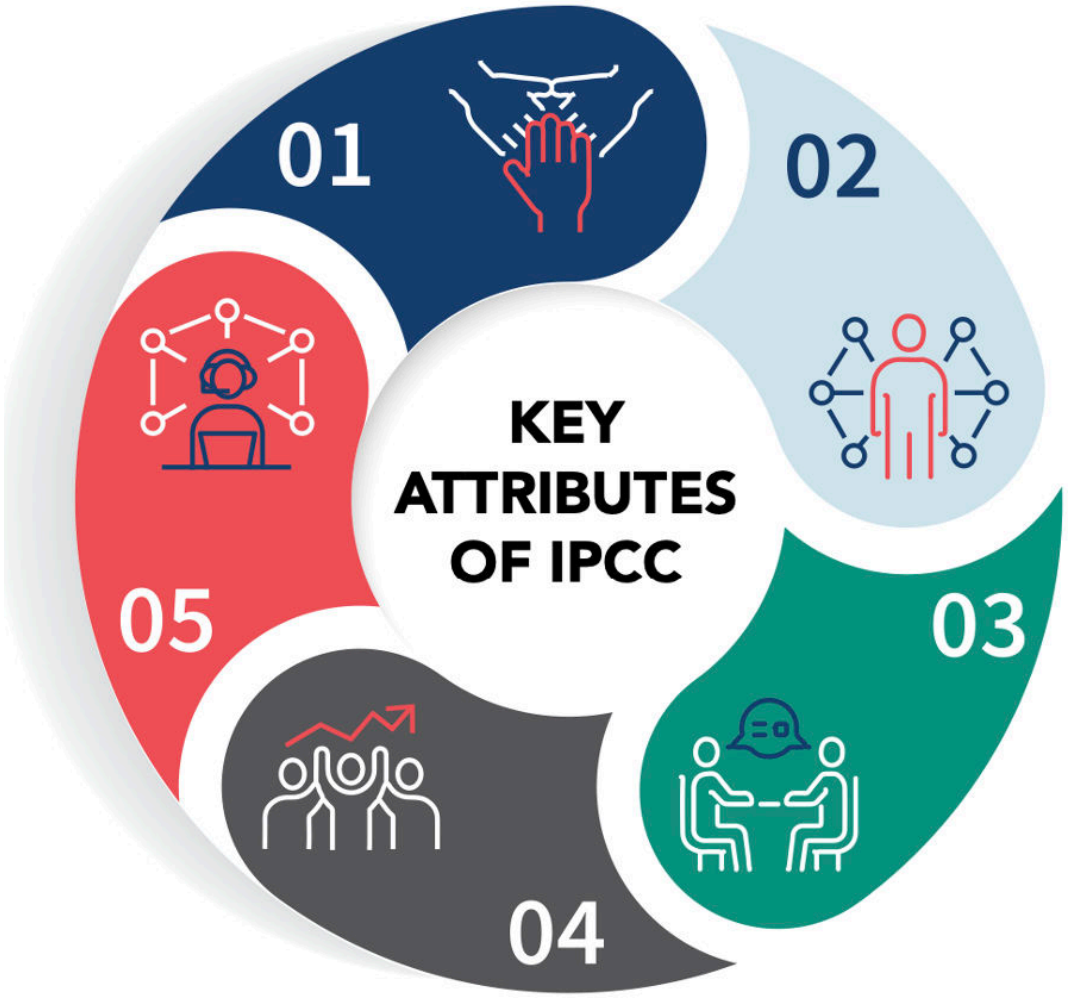
Outline

- **Introduction**
- Rationale for HIV/HTN integration
- Status of HIV/HTN integration in CQUIN partner countries
- What's next?

Key Points from Plenary Session

- **Integration is a means, not an end**
  - Our hypothesis is that integrated service delivery will help enhance the coverage and quality of health services
  - Integration is not a "one size fits all" approach – as with all DSD, services should be tailored to the needs and expectations of recipients of care and to national/local context
- **Defining integration is critical to shared understanding**
  - Important to differentiate integration of *services* from integration of *systems*
  - Essential to articulate how varied integration models are designed and implemented (one-stop shop *vs.* referrals *vs.* other approaches)
  - Necessary to track the extent to which integrated services are delivered (not just planned) and to track their impact on recipient of care satisfaction, health outcomes, and program efficiencies

Integrated, person-centered health services



1. Services must be comprehensive, holistic, and coordinated.
2. Services must prioritize individual convenience, making it as easy as possible for individuals to access the services they need and reducing disincentives to avoid needed health care.
3. Services must respect each individual's values and differences.
4. Services should empower clients and their households and communities to participate actively in their own care.
5. Service systems and sites should actively solicit clients' feedback and adapt service approaches in response.

Integrated, person-centered health services. Friends of the Global Fight, PATH, JSI October 2023

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Why focus on integration of HIV and Hypertension?

- Prevalence of HIV/HTN co-morbidity
  - Countries in the CQUIN network face dual epidemics of HIV and non-communicable diseases, including HTN
  - As people living with HIV age on treatment, their risk of NCDs, including HTN, rises markedly
- Programmatic feasibility
  - Similarities between HTN and HIV treatment facilitate integrated program design
  - Multiple successful pilot projects have demonstrated proof of concept
- Interest on the part of MOH, recipients of care, and donors
  - PEPFAR highlighted the importance of HIV/HTN programs in COP23 planning
  - Global Fund 2023 guidance note encourages countries to align HIV and NCD programming
  - However, funding for HTN services is still limited

HIV and HTN Comorbidity – 1

- HIV treatment scale-up has led to increased longevity for people living with HIV, who now have similar life expectancy as their HIV-negative peers
  - For example, 50% of people on ART supported by PEPFAR are > 40 years, and 22% are > 50 years
    (Godfrey C et al. Journal of the International AIDS Society 2022, 25(S4):e26002)
- Approximately 25% of people living with HIV are estimated to have HTN – including nearly 50% of people living with HIV aged 50 and older
  - In sub-Saharan Africa, an estimated 6 million people with HIV also have HTN
  - Evidence suggests that < 25% are receiving HTN treatment
    (Bigna et al. J Hypertens. 2020 Sep;38(9):1659-1668)

HIV and HTN Comorbidity – 2

- As they age, people living with HIV are at higher risk of cardiovascular disease (including heart disease and stroke) than HIV-negative adults
- Higher CVD risk persists even in people on ART with suppressed viral load
- Treating people living with HIV for HTN could prevent tens of thousands of CVD deaths

HIV and HTN Comorbidity – 3

Recent cross sectional and cohort studies from CQUIN member countries:

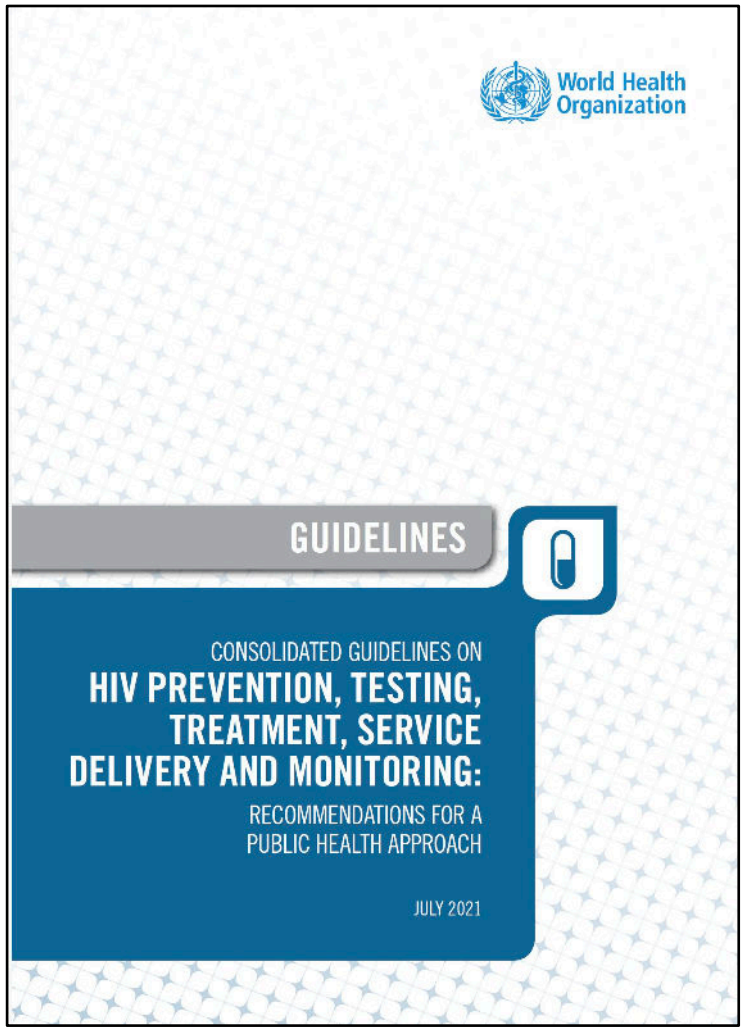
1. Uganda: HTN prevalence **24.4%** amongst adults with HIV (median age 45 years)
2. Uganda: HTN prevalence **27%** amongst adolescents and young people with HIV (13-25 years)
3. Burundi: HTN prevalence **17.4%** amongst adults with HIV (35-50 years)
4. South Africa: HTN prevalence **32%** amongst adults with HIV (median age 49 years)
5. Ethiopia: HTN prevalence **18.5%** amongst adults with HIV (mean age 40 years)
6. Tanzania: HTN prevalence **35%** amongst adults with HIV (mean age 43 years)

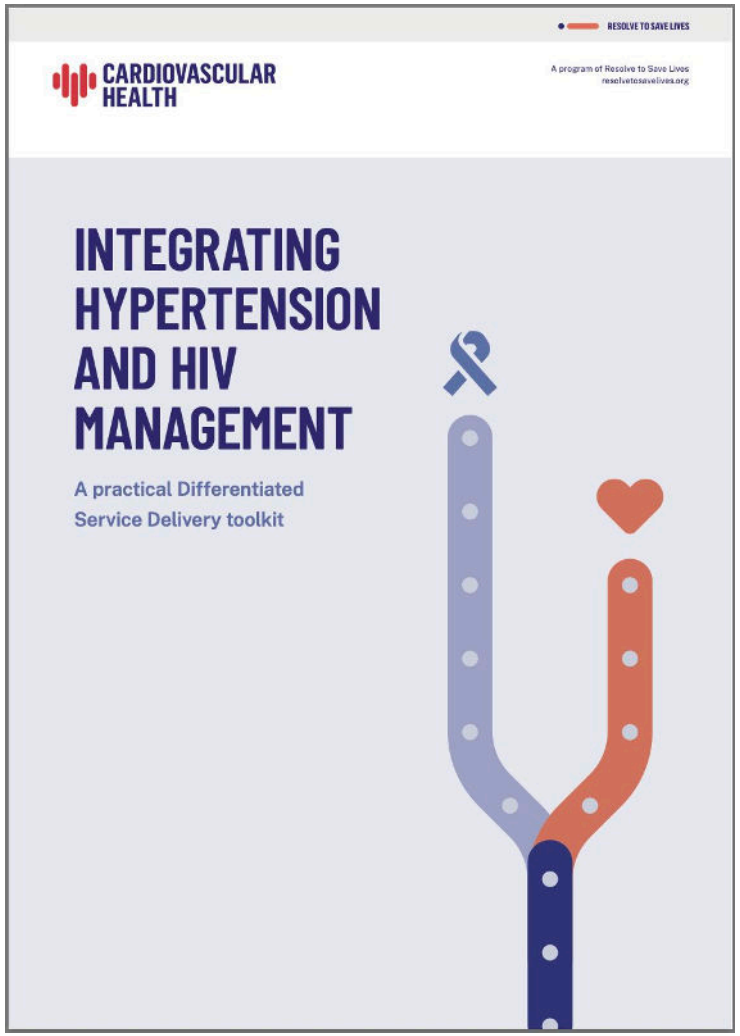
1. Byonanebye *et al*., PLoS ONE 2023
2. Migisha *et al*., Clin Hypertension 2023
3. Harimenshi *et al*., Sci Rep 2022
4. Lebina *et al*., South Afr J HIV Med 2023
5. Badacho *et al.,* Front Cardiovasc Med 2023
6. Sakita *et al.,* PLoS Global Public Health 2023

Feasibility – 1

- As chronic conditions, HIV and HTN share many commonalities, both from the individual and health system perspectives
- Examples include:
  - Need for screening and case-finding, including amongst asymptomatic people
  - Importance of linkage to treatment, adherence support, empowerment of recipients of care, and self-management
  - Use of daily medication and regular clinical and laboratory checkups
  - Need to deliver continuity services requires highly functional appointment systems, tailored medical records and M&E systems, ongoing access to laboratory and pharmacy services, and other approaches not required for acute or episodic care
- The public health approach so critical to HIV is also critical for HTN

Feasibility – 2

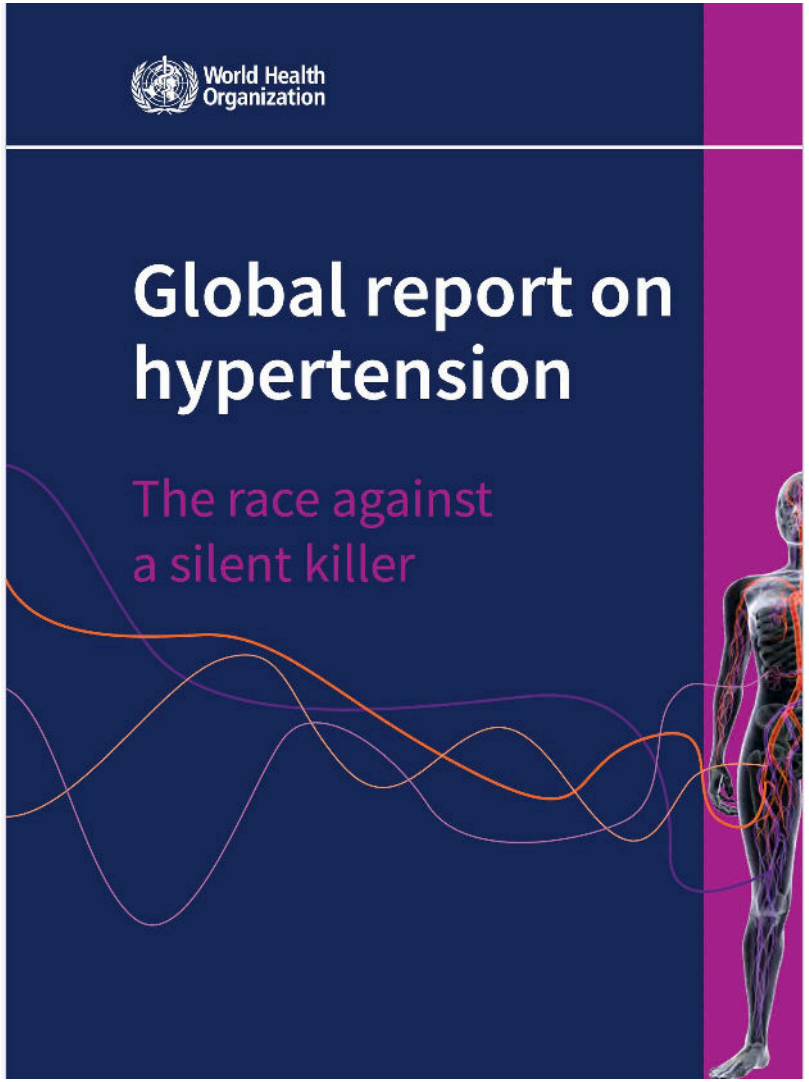




Feasibility – 3

"There are some health issues for which we lack knowledge or effective tools. Hypertension is not one of them."

– Tedros Adhanom Ghebreyesus, WHO Director General, September 2023



Box 9: HIV and hypertension

The integration of HIV and hypertension care, based on the WHO HEARTS technical package, has demonstrated that high levels of HIV viral suppression can be maintained while simultaneously achieving high blood pressure control.

A HIV–hypertension integration pilot in Uganda resulted in control of 73% at 24 months, up from 5.1% at baseline, while maintaining an HIV viral load suppression rate of 98%. Ninety-six percent of the patients were also retained in care while receiving integrated multi-month dispensing for both hypertension and HIV medications within a differentiated service delivery model *(155)*.

Feasibility – 4

Experience sharing within the CQUIN HIV/NCD community of practice over the past few years:

- Integrated HIV and HTN services in Kenya
- Scaling up integrated HIV and NCD services in Eswatini
- Out of pocket expenditures for NCD services by PLHIV in Cote d'Ivoire
- Integrating HIV and NCD services in Rwanda
- DSD for people with both HIV and NCDs in Uganda
- Integrated Chronic Care Clinics in Malawi
- Accelerating HIV and HTN services in Nigeria

Evolving Donor Interest – PEPFAR COP23

- "In alignment with PEPFAR's strategic pillar of sustaining the response and recognition of the life-threatening unmet need of uncontrolled hypertension among adults living with HIV, countries where there is a high burden of HIV and PLHIVs with hypertension are encouraged to work with partners to implement proven solutions that advance person-centered care for hypertension control.
- It will be important for such programs to (1) screen for hypertension among all adult PLHIV at least annually; (2) implement standard hypertension treatment protocols in primary care; (3) ensure access to essential HTN medicines for PLHIV; and (4) track patient outcomes and program performance over time using an information system. Such integrated programs will further PEPFAR's goal of utilizing its platform for broader public health programming."

Evolving Donor Interest – Global Fund

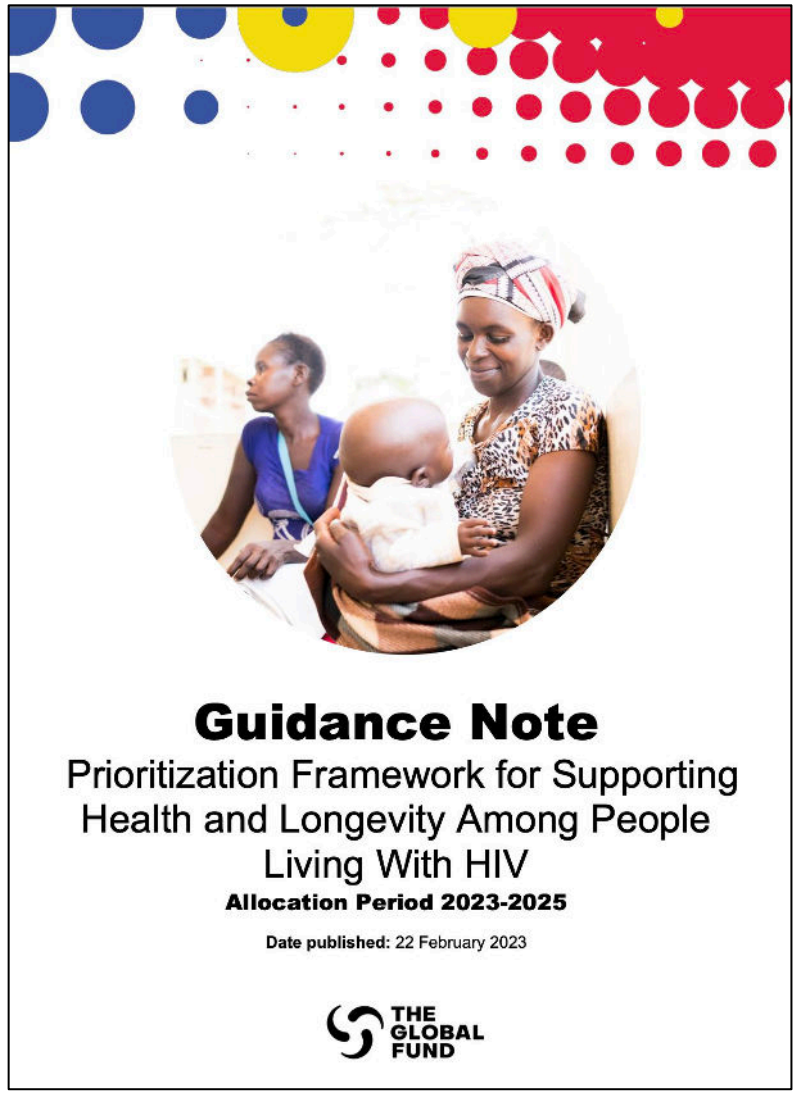
Priority 5: Non-communicable diseases associated with ageing

Up to a quarter of all people with HIV are over age 50.[23] Associated with the aging cohort is a large and growing burden of NCDs. Where NCD integration is proposed, countries are encouraged to align services with epidemiological contexts and the WHO package of essential NCD disease interventions for primary health care,[24] focusing on cardiovascular and chronic respiratory diseases, diabetes, and early diagnosis of cancer.

i. Early detection for NCDs is an HIV integration priority. Applicants are encouraged to integrate early detection for NCDs as part of integrated packages delivered within HIV platforms as an integration priority aligned with WHO consolidated guidelines on HIV prevention, testing, treatment, service delivery and monitoring: recommendations for a public health approach.[2]

ii. Primary and secondary prevention of NCDs: Applicants are encouraged to provide behavioral advice and support as a part of integrated packages delivered within HIV platforms, addressing modifiable disease risk factors including blood pressure, smoking, obesity, unhealthy diet and lack of physical activity, as recommended by the WHO guidance.[2]

iii. Treatment: Integration of nationally available and procured treatment within HIV service delivery platforms is supported by the Global Fund. Where there is a strong investment case to address gaps in NCD management for people living with HIV, it will be considered on a case-by-case basis. Applicants are encouraged to align NCD follow-up visits with those for HIV care and integrate multimonth dispensing of NCD medicines with ART.



Why integrate HIV and hypertension care?

Adapted from Resolve to Save Lives

Management of HIV and hypertension both require daily medication and may have a similar schedule for clinical check-ups

Integration may reduce inefficiencies for health care providers and makes attending clinic visits, collecting prescriptions and adhering to treatment easier for recipients of care

Including hypertension care improves demand for HIV services, especially for harder-to-reach populations

It's preferred by recipients of care and recommended by Ministries of Health, WHO, PEPFAR and the Global Fund

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In 2023, CQUIN added a HIV/HTN domain to the treatment CMM

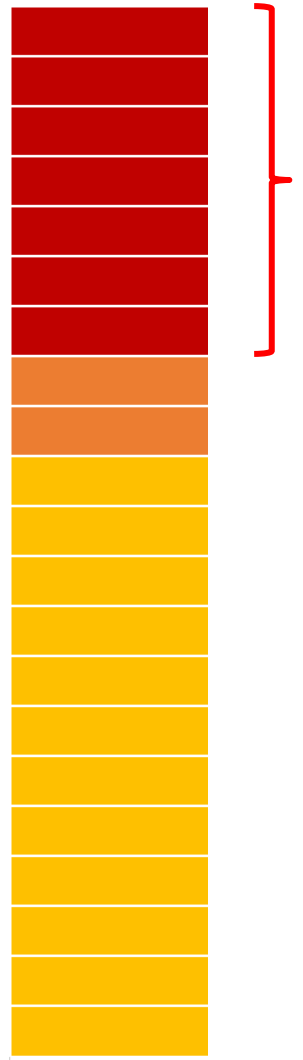
- 14/21 countries had policies and/or guidelines recommending HIV/HTN integration
- 12/21 countries recommended co-scheduled, co-located HIV/HTN services for people established on treatment
- 0/21 countries had data to describe the proportion of people in less-intensive DART models who receive the minimum package of HTN services
- 0/21 countries had targets for the proportion of people in less-intensive DART models receiving a minimum package of HTN services

CQUIN self-staging results – 1

7/21 countries staged themselves as being in the red (least mature) stage:

National policies and/or guidelines do not:

- Define a minimum package of HTN screening, diagnosis, and treatment services that should be integrated into HIV treatment models
- Include people in less-intensive DART models in plans for HIV/HTN services
- Provide guidance regarding *where* HTN services should be provided for people on ART (e.g., at the point of HIV treatment or elsewhere)
- Provide guidance re: *who* should provide HTN services for people on ART (e.g., the HIV service provider or other)
- Provide guidance re: *when* HTN and HIV appointments, lab testing, and drug pick-ups should be scheduled



CQUIN self-staging results – 2

2 countries described themselves as in the orange stage:

National policies and/or guidelines do:

- Define a minimum package of HTN screening, diagnosis, and treatment services that should be integrated into HIV treatment models
- Include people in less-intensive DART models in plans for HIV/HTN services
- Provide guidance regarding *where* HTN services should be provided for people on ART (e.g., at the point of HIV treatment or elsewhere)
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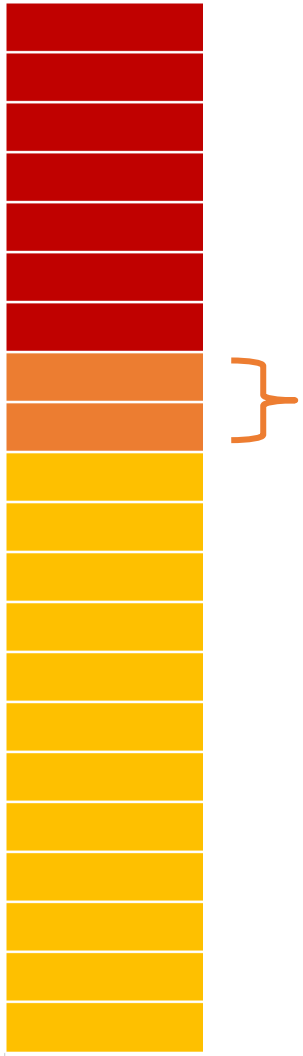


CQUIN self-staging results – 3

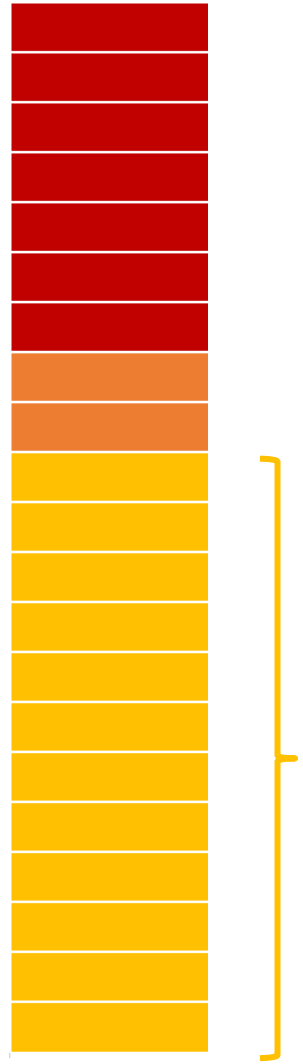
12 countries described themselves as in the yellow stage:

In addition to meeting the criteria for orange, national policies and/or guidelines recommend all of the following for people established on ART ("stable clients"):

- Routine HTN and HIV services are *co-located*
- Routine HTN and HIV services are *co-scheduled* (e.g., provided at the same visit)
- HTN and HIV *medication refills are coordinated* to maximize client convenience and minimize visits to health facilities/pharmacies

No countries achieved **light green** or **dark green** staging, which require:

- National M&E systems can report the proportion of people in less-intensive DART models who receive the minimum package of HTN services
- There are national coverage targets for the above
- The country is achieving at least 50% (light green) or 75% (dark green) of these coverage targets using data from the past 12 months



Challenges

- Broad interest and relatively high levels of policy support for HIV/HTN integration but implementation is limited to pilot projects in most countries due to lack of HTN funding
- Limited coordination between HIV and NCD programs due to funding and administrative silos
- Lack of training and detailed SOPs to support implementation of integrated HIV/HTN services
- Lack of data on HTN service delivery for people living with HIV
- **Limited (or no) funding for HTN services, commodities, or medication**

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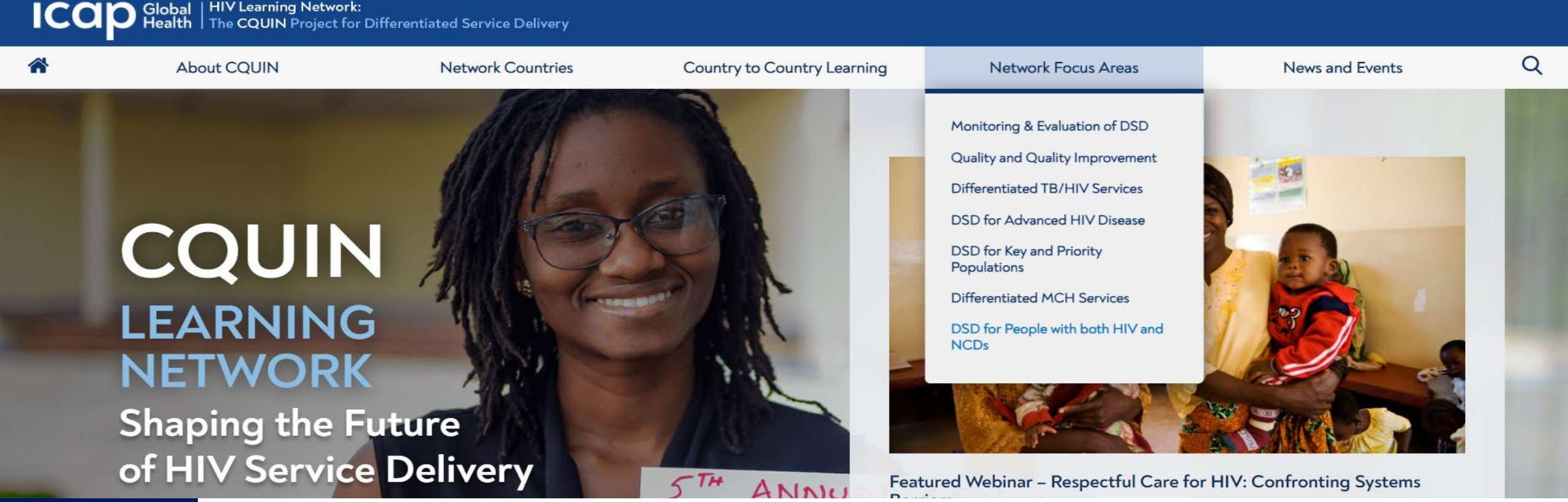
Next Steps and Plans for 2024

- Exchange of best practices, case studies, resources and tools
  - Quarterly COP meetings (virtual) focused on priority topics
  - Country-to-country exchange – virtual and possibly in-person
  - Sharing of successful Global Fund ‘business case’ documents for HIV/NCD services
- Engagement of recipients of care, including education, empowerment, demand generation (“nothing about us without us”)
- CQUIN integration meeting (April 2024)



DSD for People with both HIV and NCDs

- The CQUIN NCD Community of Practice was launched in March 2021
- Primary objectives include:
  - Identifying priority gaps and challenges related to incorporating NCD screening, prevention and treatment services into HIV programs.
  - Exchanging relevant best practices and resources.
  - Working together to co-create needed frameworks, tools and resources.

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CQUIN HIV/NCD community of practice

CQUIN Community Advocacy Network

Thank you!