CARDIOVASCULAR HEALTH

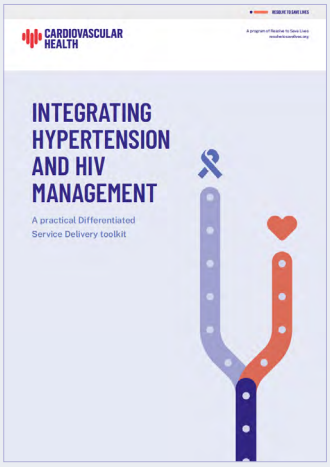
A project of Resolve to Save Lives
resolvetosavelives.org

INTEGRATING HYPERTENSION AND HIV MANAGEMENT

A Differentiated Service Delivery (DSD) approach

- Now that life-saving HIV treatments are widespread, people with HIV are living longer lives.
- One consequence is that people living with HIV (PLHIV) are more likely to die from uncontrolled high blood pressure (hypertension) than from their HIV disease.
- Better *hypertension* treatment for PLHIV could prevent more than 600,000 heart attacks and strokes and 87,000 deaths over the next 10 years[1]

NOW IS THE TIME TO SCALE UP INTEGRATED HIV AND HYPERTENSION CARE.



Integrating Hypertension and HIV Management — a practical Differentiated Service Delivery Toolkit can help HIV control programs incorporate a patient-centered approach to hypertension care, supporting PLHIV to keep their blood pressure under control and live longer, healthier lives.

The toolkit is a practical guide to implementing "Differentiated Service Delivery (DSD)" models for those with stably controlled HIV and hypertension, and includes patient-centered strategies such as less frequent clinic visits, longer, multi-month medication refills and community-based care.

Why integrate hypertension management into HIV services?

- It improves total health care services for PLHIV, especially for harder-to-reach populations, and improves retention in HIV care.
- It's recommended by the World Health Organization[2] as an important component of a comprehensive package of clinical care for PLHIV.
- Pilot projects in four countries have shown that HIV control can be maintained to a high standard while delivering effective hypertension services.
- Makerere University Joint AIDS Program's RTSL-funded pilot project in Uganda saw hypertension control increase from 5.1% to 73% after two years, with HIV control maintained at 98%.

INTEGRATING HYPERTENSION AND HIV MANAGEMENT

LEARN MORE

resolvetosavelives.org/app/uploads/2023/05/HIV-HTN-Toolkit.pdf

Program component	Challenges of parallel management systems for HIV and hypertension	Benefits of a patient-centered, integrated approach
Care delivery	• Follow-up of ART and hypertension may be planned at different frequencies. • Care delivered in different settings • Lack of consideration for medication interactions	• Alignment of follow-up schedules • Care adapted to be delivered in the service location • Medication interactions considered
Pharmacy and supply chain	• Forecasting and procurement not adapted to align medication refill supply • Duplication of supply chain resources	• Alignment of medication refills supported • Use of similar forecasting tools for both chronic diseases. • Efficient use of supply chain resources
Monitoring and evaluation (M&E)	• Separate paper-based tools or electronic medical records (EMR) for HIV and hypertension, resulting in duplication of work for health care workers (HCWs)	• Paper-based tools or EMR developed to include the same baseline demographics and key follow up indicators for HIV and hypertension • Integrated monitoring and Continuous Quality Improvement of both HIV and hypertension programs

Adapting standard DSD models for antiretroviral therapy to integrate hypertension management

The four common models of differentiated service delivery (DSD) currently implemented by Ministries of Health for antiretroviral therapy (ART) can all be adapted to integrate hypertension management. Crucially, all DSD models separate **clinical visits from medication refill visits, which can take place outside the clinic and/or without the involvement of a physician.** Moving services for stable patients out of the clinic can save patients time and money, and frees up physicians to manage more complex HIV and hypertension cases.

Four standard differentiated delivery models that can be adapted to integrate hypertension management

Group	**Group model managed by health care worker** Clients meet as a group (e.g., of 15-20 people) at the health facility or at a location in the community to receive their medication refills. The HCW facilitates a group discussion; patients then collect their medication and leave.	**Group model managed by clients** Peer-led groups (e.g., of 6-12 patients) meet in the community and nominate one member to collect medication refills from the facility for the other group members; this may be done on a rotating basis, so everyone takes a turn, or there may be a single designee.) Peer group leaders review and document medication adherence and complete a treatment checklist.
Individual	**Individual model based at facility** Clients make rapid visits to the health facility for medication refills by bypassing clinical consultation and presenting directly to pick up their medication from an arranged pick-up point in the facility (or pharmacy).	**Individual model not based at facility** Clients collect medication refills at a community outreach point, peer-led drop-in center, workplace site, community-based pharmacy or mobile outreach service; they may also receive home delivery.

To be eligible for an integrated HIV and hypertension management DSD model, clients must have both conditions controlled (as per WHO criteria, please refer to page 19 of the toolkit).

References

1 Authors own calculations based on PEPFAR-treated populations, hypertension prevalence in the general population, and clinical-trials based effectiveness of hypertension treatment.

2 Consolidated guidelines on HIV prevention, testing, treatment, service delivery and monitoring: recommendations for a public health approach. Geneva: World Health Organization; 2021.