Integrated care for people living with HIV, diabetes and hypertension in sub-Saharan Africa

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In Africa, health care services for non-communicable diseases (NCDs) are fragmented and provision of care is often less accessible and of lower quality than chronic care services for HIV. Only about half of the people who start treatment for diabetes or hypertension in good clinical care settings on the continent remain in care one year later and about two million premature deaths are attributed annually to the effects of these conditions. In contrast, the vast majority of people living with HIV are in regular care and virally suppressed, and mortality rates have fallen five-fold since their peak in the early 2000s.

There has been growing interest to establish integrated chronic care clinics using the platforms developed for and the learning acquired by HIV programmes to improve outcomes for people living with NCDs. However, high quality evidence on the feasibility of such clinics, their potential effect on HIV outcomes, and their costs was lacking.

To add to the evidence base, we conducted a large cluster-randomised trial [1] in partnership with policy-makers, health care providers, patient representatives, and civil society members to compare integrated care for HIV, diabetes or hypertension with standard vertical standalone care for these conditions.

A study across two countries and 32 health facilities

Thirty-two health facilities in Uganda and Tanzania providing primary care were randomised to either integrated care or to standard vertical care. Approximately 7,000 participants were enrolled and followed up for 12 months. In the integrated care clinics, participants were managed by the same healthcare workers, shared the same registration and waiting area, used the same pharmacy, had similarly designed medical records and used an integrated laboratory service. Standard care involved vertically separated provision of HIV and hypertension or diabetes care.

Services were provided by trained healthcare workers for all the trial participants. Many of the procedures available for participants with HIV were implemented for those with diabetes or hypertension, such as medicine adherence

counselling and tracking and tracing of those who missed appointments to encourage them to attend clinic.

Participants were free to refuse joining the trial or withdraw at anytime, but very few declined to join or withdrew over the 12 months. A social science sub-study showed that integration of services were, on the whole, welcomed by participants through a reduction in stigma.

Findings: cost savings and improved control through integrated care

By the end of the trial, the rates of retention in care in both the integrated and the vertical care models of care were close to 90%, the highest ever recorded in primary care settings in Africa. Integration did not adversely affect the rates of viral suppression among people with HIV – these exceeded 90% in both arms. Integrated care was cost-saving for health services because of reduced duplication when managing people with multiple conditions.

Although we strengthened hypertension and diabetes management in both tracks equally, some markers of blood pressure and glycaemic control were superior in the integration arm compared to the vertical care one. However, the proportion of individuals with adequate control was low, consistent with the general challenge of managing these conditions worldwide.

Our research shows that integrated care is feasible and cost-effective for African health services to deliver high-quality services compared to the current approach of vertical care.

About the authors:

Shabbar Jaffar is Professor of Epidemiology and Director of the UCL Institute for Global Health.

Moffat Nyirenda is the Professor of Medicine (Global NCDs) at LSHTM and the NCD Theme Lead at the MRC/UVRI/LSHTM Uganda Research Unit.

Kaushik Ramaiya is Professor of Medicine, Secretary of the NCD Alliance and CEO of the Shree Hindu-Mandal Hospital in Tanzania.

Dr Josephine Birungi is a Senior Research Scientists at the MRC/UVRI/LSHTM Uganda Research Unit and one of the lead authors of the research paper.

Sayoki Mfinanga is a Professor of Global Health and Chief Research Scientific Fellow at the National Institute for Medical Research in Tanzania.

Nelson Sewankambo is Professor Emeritus at Makerere University, Uganda. He is an HIV and NCD researcher and passionate about using evidence to inform policy and practice

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