



WHO 2025 HIV guideline: Integrating cardiometabolic care into HIV services

Guía de la OMS 2025 sobre el VIH: integración de la atención cardiometabólica en los servicios de VIH

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The World Health Organization (WHO)'s 2025 human immunodeficiency virus (HIV) service delivery guideline recognizes that the epidemic is entering a new era marked by ageing, multimorbidity, and limited resources.¹ Although global Antiretroviral Therapy (ART) coverage now reaches 31.6 million people, only 73% of People living with HIV (PLHIV) achieve viral suppression.² Increasing life expectancy increases vulnerability to chronic comorbidities. In sub-Saharan Africa, 5-10% of PLHIV have diabetes, and 20-25% have hypertension. A meta-analysis of 10,916 participants across East Africa found hypertension prevalence at 19.75%, with alcohol use, diabetes, and longer HIV duration as key predictors.³ Traditional HIV clinics, structured for infectious disease management, remain poorly equipped for lifelong chronic care. Without addressing hypertension and diabetes, cardiovascular risk will escalate, ultimately threatening viral suppression and the hard-won gains of the HIV response.

Evidence from sub-Saharan Africa demonstrates that integrating HIV and Non-Communicable Disease (NCD) care is both feasible and cost-effective. In South Africa, the Central Chronic Medicine Dispensing and Distribution program, launched in 2014, enables stable clients to collect ART, along with medicines for hypertension and diabetes, at community pick-up points.⁴ Patients benefit from reduced travel time, shorter queues, and less

stigma, while providers note decongested clinics and greater efficiency. In Uganda and Tanzania, the INTE-AFRICA pragmatic cluster-randomized trial followed more than 7,000 patients with HIV, diabetes, or hypertension.⁵ Integrated management achieved retention rates above 89% among NCD patients and maintained HIV viral suppression above 95%, demonstrating non-inferiority to vertical care. The economic evaluation confirmed significant cost savings, as single-clinic management of multiple conditions reduced staffing demands and overheads. Patients also valued the convenience of fewer clinic visits. Together, these findings highlight integrated care as an efficient, patient-centered strategy for resource-limited settings.

To scale integrated care, investments are needed in equipment, supply chains, and human resources. Policies enabling task sharing with nurses and community health workers must expand beyond HIV services to include blood pressure and glucose management. Economic analyses suggest that integration can improve efficiency and equity for clients and health systems. Yet HIV funding is shrinking: 2024 resources for the AIDS response were US\$18.7 billion, 17% below the US\$21.9 billion needed.² As donors retreat and national budgets dwindle, integrated chronic disease services can maximize impact per dollar spent. Now is the time for ministries, donors, and implementers to align HIV programs with universal health

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coverage and non-communicable disease strategies, thereby protecting the hard-won gains of the HIV response.

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