Disease specific approaches and PHC: contradiction or alliance? *40 years after Alma-Ata*

Marie Laga

HIV and Sexual Health group

ITM

SPECIAL ARTICLE FREE PREVIEW ARCHIVE

Selective Primary Health Care — An Interim Strategy for Disease Control in Developing Countries

Julia A. Walsh, M.D., and Kenneth S. Warren, M.D.

Abstract

Priorities among the infectious diseases affecting the three billion people in the less developed world have been based on prevalence, morbidity, mortality and feasibility of control. With these priorities in mind a program of selective primary health care is compared with other approaches and suggested as the most cost-effective form of medical intervention in the least developed countries. A flexible program delivered by either fixed or mobile units might include measles and diphtheria–pertussis –tetanus vaccination, treatment for febrile malaria and oral rehydration for diarrhea in children, and tetanus toxoid and encouragement of breast feeding in mothers. Other interventions might be added on the basis of regional needs and new developments. For major diseases for which control measures are inadequate, research is an inexpensive approach on the basis of cost per infected person per year. (N Engl J Med 301:967–974, 1979)

November 1, 1979
N Engl J Med 1979; 301:967-974
DOI: 10.1056/NEJM197911013011804

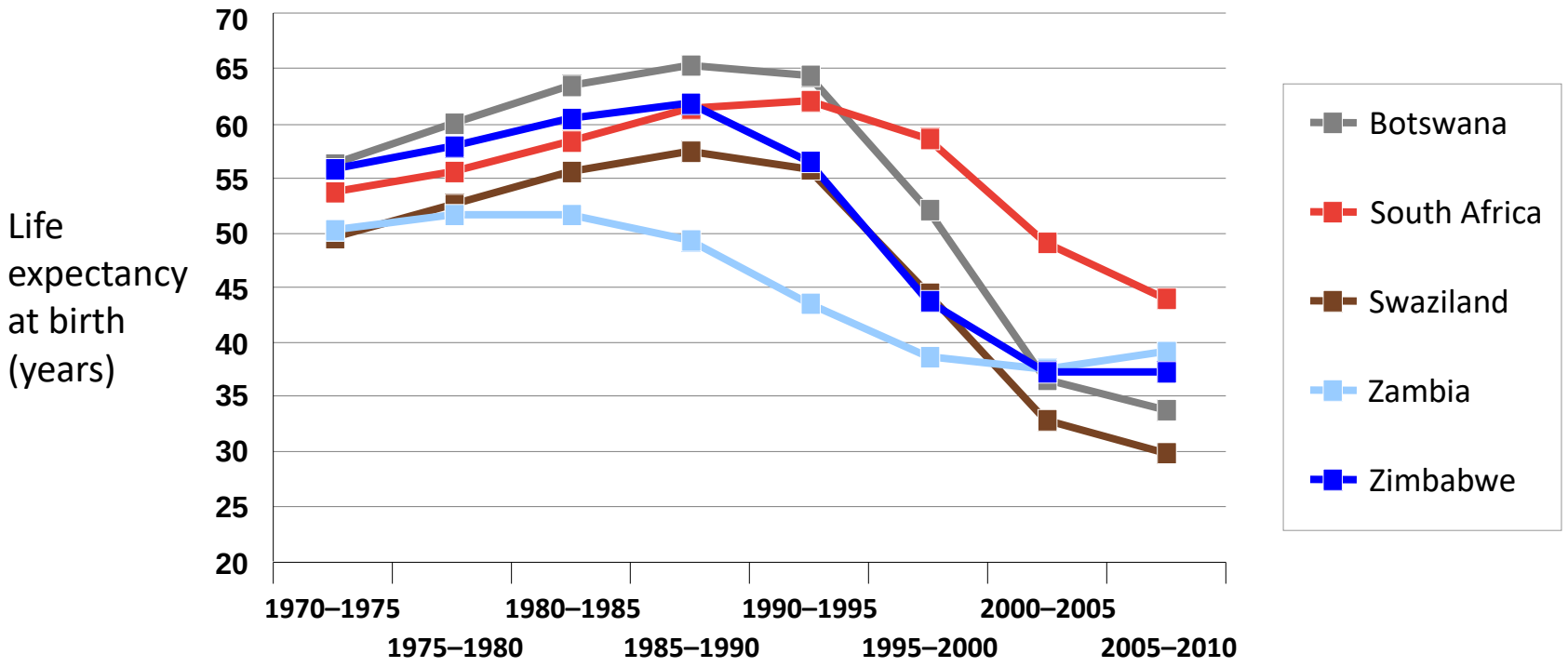
Related Articles

CORRESPONDENCE MAR 27, 1980
Selective Health Care for Developing Countries

CORRESPONDENCE JUN 14, 1984
Care within Reach: Appropriate Health-Care Delivery in the Developing World

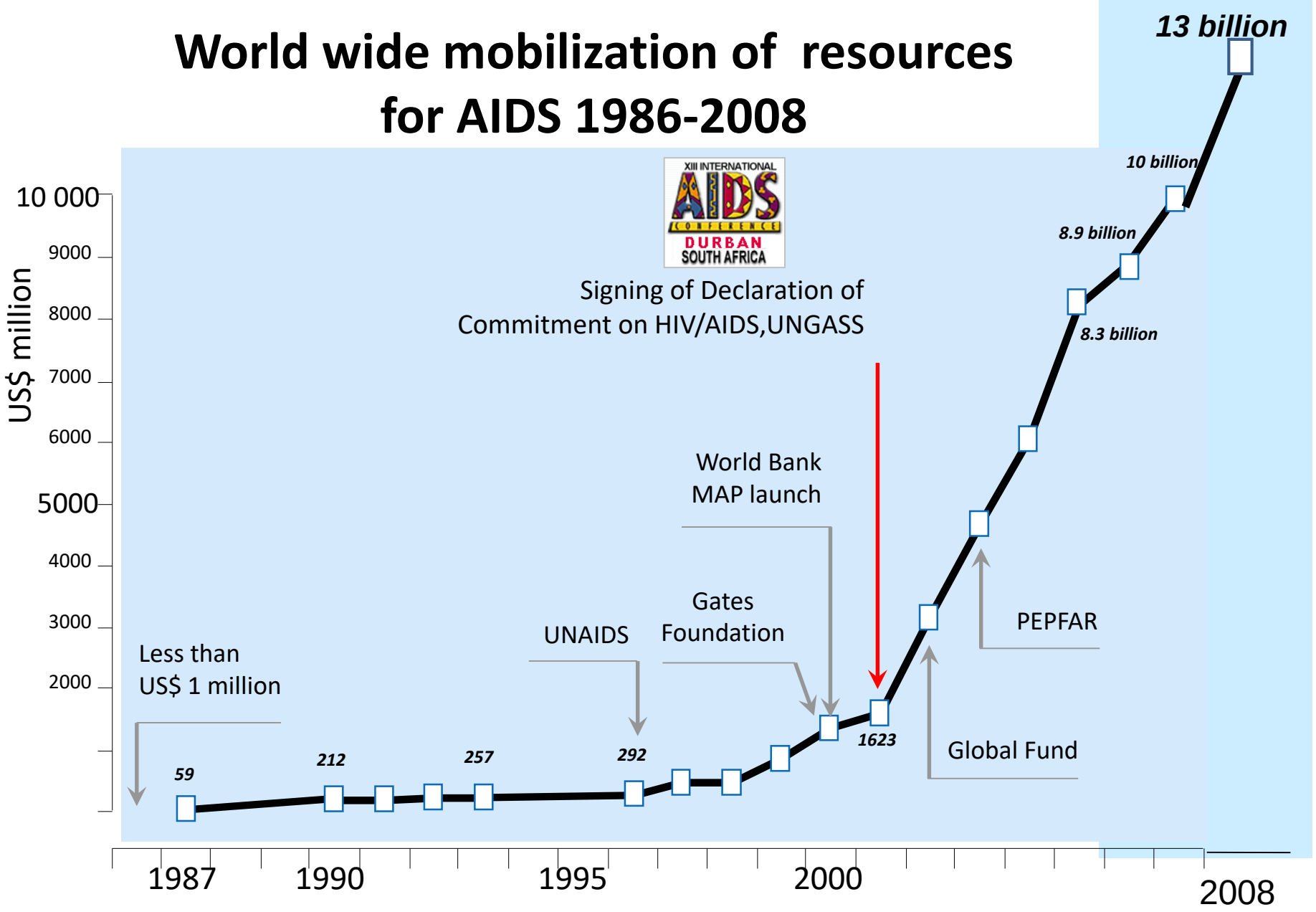
A disaster unfolding…

Impact of AIDS on life expectancy in five African countries, 1970–2010



Source: United Nations Population Division (2004). World Population Prospects: The 2004 Revision, database.

World wide mobilization of resources for AIDS 1986-2008



« AIDS and Health systems »
used to be a polarizing debate…

HIV/AIDS epidemic:

health system &
health staff under stress

AIDS response:

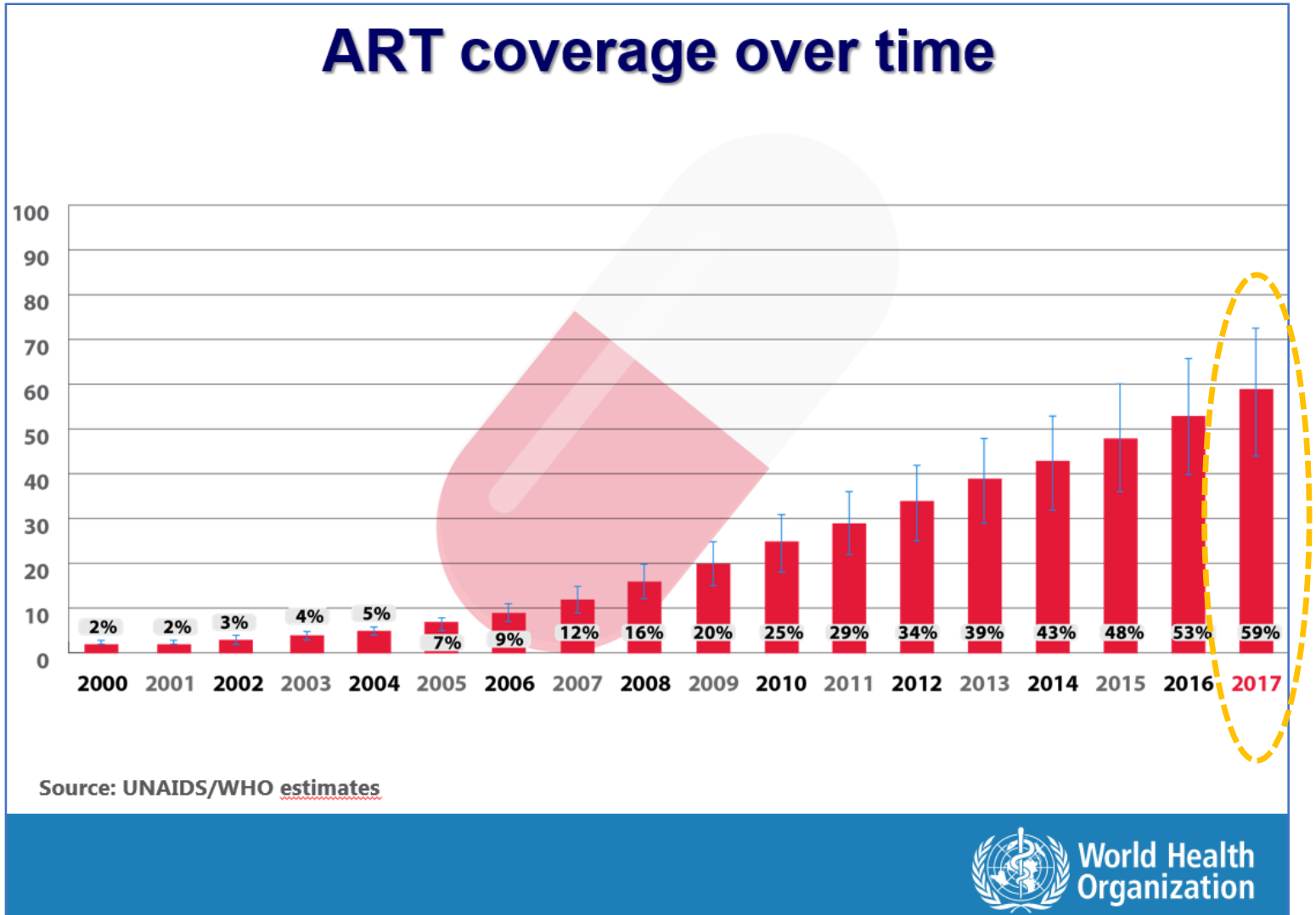
exceptional measures for
an emergency

Allegations:

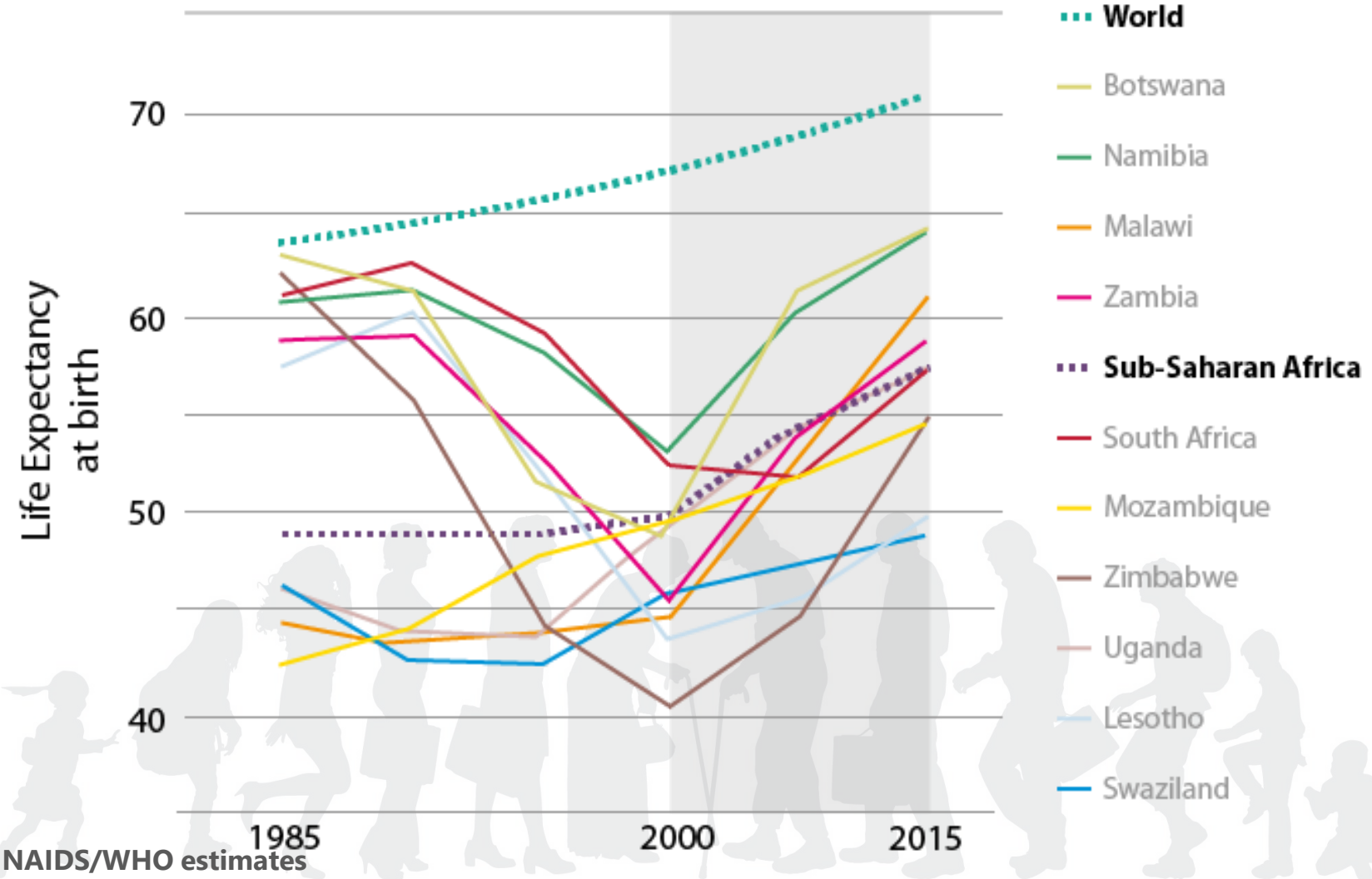
AIDS response
disproportionate &
undermining health systems?

Are we spending too much on HIV?
Roger England, BMJ 2007;334;344

Disease Specific outcomes
21,7 million (60%) of HIV+ people on ART



Impact of AIDS (1985-2000) and Response (2000-15) on life expectancy



Source: UNAIDS/WHO estimates

Reported negative effects of AIDS response on local HS

Brainstorm MPH students, ITM 2008

Human Resources	Resources, Infrastructure, M&E	Service Delivery
VIETNAM, CAMBODIA: AIDS specific Incentives	MOZAMBIQUE: Parallel supply systems	UGANDA, VIETNAM, CAMBODIA, INDIA: Disharmony Focus on 1 problem (HIV)
TANZANIA, THAILAND: Different salary scales & working conditions > demotivation of staff	UGANDA: Competition for space (offices, consultation)	THAILAND: Distortion of team work (referral to HIV staff)
MOZAMBIQUE: Increased workload	MOZAMBIQUE: Parallel M&E	MOZAMBIQUE: Integration without allowances > refusal by general staff
ETHIOPIA: Shift clinicians to HIV org		ETHIOPIA: Clinical services closed, HC without doctors
MALAWI: CHW diverted to AIDS services		MALAWI: ↓ EPI coverage ?
UGANDA, INDIA: HIV training consuming HW time		

Debate MPH 2008 & Workshop ITM in Geneva…

Evidence of HS strengthening effects

The AIDS emergency was a wake-up call:
Years of under-investing in HS lead to
HS too weak to tackle a new epidemic.

All 'building blocks' of health systems received
financial injections from the global AIDS response.

This renewed attention and financial injections have
generated wider HS benefits in several settings.

AIDS response: a boost for PHC

Improved counselling skills
strengthened **patient centredness**

Models of care for AIDS patients:
helpful to respond to other **chronic diseases**

Involvement of people living with HIV in ART programmes
enhanced **community participation** in general

A **rights based approach** employed by AIDS activists
could be expanded to general health care

Comprehensive PHC: a uniting concept

Comprehensive PHC **includes** AIDS prevention and treatment

Health and access to care (including ARV treatment) are
a **human right** and an **entitlement**

The **new concept of sustainability** adopted for AIDS treatment

- based on domestic resources and sustained international funding - should be expanded to general health care

The **global aid architecture** must be **reorganised** in a way:

- To support national priorities and planning
- To support comprehensive PHC for all,
  not one part of comprehensive PHC at the expense of another

Universal Access to AIDS Treatment &Prevention and Primary Health Care for All
One fight….

Investing in our future
The Global Fund
To Fight AIDS, Tuberculosis and Malaria

THE GLOBAL FUND'S APPROACH TO HEALTH SYSTEMS STRENGTHENING (HSS)

INFORMATION NOTE

malaria consortium
disease control, better health

Advocacy Brief . May 2016

Alma-Ata : a philosophy of thinking about health and health care http://www.who.int/hpr/archive/docs/almaata.html

- Importance of equity as a component of health
- Need for community participation in decision-making
- Need for multi-sectoral approach to health problems
- Ensure the adoption and use of appropriate technology
- Emphasis on health-promotional activities

THE END TB STRATEGY

World Health Organization

Global strategy and targets for tuberculosis prevention, care and control after 2015

1. *Government stewardship and accountability, with monitoring and evaluation*
2. *Strong coalition with civil society organizations and communities*
3. *Protection and promotion of human rights, ethics and equity*
4. *Adaptation of the strategy and targets at country level, with global collaboration*

PILLARS AND COMPONENTS

1. INTEGRATED, PATIENT-CENTRED CARE AND PREVENTION

A. Early diagnosis of tuberculosis including universal drug-susceptibility testing, and systematic screening of contacts and high-risk groups

B. Treatment of all people with tuberculosis including drug-resistant tuberculosis, and patient support

C. Collaborative tuberculosis/HIV activities, and management of co-morbidities

D. Preventive treatment of persons at high risk, and vaccination against tuberculosis

2. BOLD POLICIES AND SUPPORTIVE SYSTEMS

A. Political commitment with adequate resources for tuberculosis care and prevention

B. Engagement of communities, civil society organizations, and public and private care providers

C. Universal health coverage policy, and regulatory frameworks for case notification, vital registration, quality and rational use of medicines, and infection control

D. Social protection, poverty alleviation and actions on other determinants of tuberculosis

PRINCIPLES

- All countries can accelerate efforts towards elimination through combinations of interventions tailored to local contexts.
- Country ownership and leadership, with involvement and participation of communities, are essential to accelerating progress through a multisectoral approach.
- Improved surveillance, monitoring and evaluation, as well as stratification by malaria disease burden, are required to optimize the implementation of malaria interventions.
- Equity in access to health services especially for the most vulnerable and hard-to-reach populations is essential.
- Innovation in tools and implementation approaches will enable countries to maximize their progression along the path to elimination.

GLOBAL TECHNICAL STRATEGY FOR MALARIA 2016–2030

VISION – A WORLD FREE OF MALARIA

GOALS	MILESTONES		TARGETS
	2020	2025	2030
1. Reduce malaria mortality rates globally compared with 2015	At least 40%	At least 75%	At least 90%
2. Reduce malaria case incidence globally compared with 2015	At least 40%	At least 75%	At least 90%
3. Eliminate malaria from countries in which malaria was transmitted in 2015	At least 10 countries	At least 20 countries	At least 35 countries
4. Prevent re-establishment of malaria in all countries that are malaria-free	Re-establishment prevented	Re-establishment prevented	Re-establishment prevented

UNAIDS 2012 strategy

6. Close the global AIDS resource gap by 2015 and reach annual global investment of US$22-24 billion in low- and middle-income countries

7. Eliminate gender inequalities and gender-based abuse and violence and increase the capacity of women and girls to protect themselves from HIV

8. Eliminate stigma and discrimination against people living with and affected by HIV through promotion of laws and policies that ensure the full realization of all human rights and fundamental freedoms

9. Eliminate HIV-related restrictions on entry, stay and residence

10. Eliminate parallel systems for HIV-related services to strengthen integration of the AIDS response in global health and development efforts

Beyond the silos: integrating HIV and global health

The Lancet, July 2018

Advancing global health and strengthening the HIV response in the era of the Sustainable Development Goals: the International AIDS Society—*Lancet* Commission

How can the Global/International go beyond silos?

in the words of the Commission, to "make common cause with the global health field".[1] That conclusion raises many questions about the existing instruments to address the AIDS epidemic—namely, UNAIDS, the Global Fund to Fight AIDS, Tuberculosis and Malaria, and the US President's Emergency Plan for AIDS Relief (PEPFAR). We invite these major institutions that are instrumental in driving the AIDS response to reconsider their purpose and their future. We encourage their respective leaderships to reassess their missions and to move towards a broader global health purpose, while at the same time sharpening their commitments to HIV/AIDS. With an upcoming replenishment in 2019,

Discussion : Propose strategies to overcome silos and maximize synergies for health for all

- At international level: institutions and donors?
- The role of the countries?
- At level of implementation and role of communities?