THE AIDS RESPONSE AND PRIMARY HEALTH CARE: LINKAGES AND OPPORTUNITIES
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Acknowledgements

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First there was Alma-Ata and then there was AIDS …

In 1978, the Alma-Ata Declaration identified primary health care (PHC) as key to the achievement of the goal of health for all by the year 2000 (1). It defined PHC as “essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community”(1).

However, on the ground and in practice, governments were unable to realize the PHC ambition and meet “the health needs of individuals throughout their life”. By the turn of the century, it was clear that Alma-Ata’s health for all target was out of reach. The advent of the AIDS epidemic and the resurging rates of tuberculosis (TB) and malaria were certainly a cause and consequence of this failure to meet the goal (2). In the 1990s, the AIDS epidemic alone reversed 30 years of gains in life expectancy, particularly in sub-Saharan Africa (3).
Tremendous progress, but people still left behind …

Thanks to sustained access to antiretroviral therapy (ART), the number of AIDS-related deaths is the lowest this century with fewer than 1 million people dying each year from AIDS-related illnesses. Three out of four people living with human immunodeficiency virus (HIV) know their status—the first step to getting treatment. Four out of five pregnant women living with HIV globally received ART to prevent mother-to-child transmission (4). In addition, a record 21.7 million people are on treatment—a net increase of 2.3 million people since the end of 2016 (Fig. 1).

Fig. 1: Rising numbers of people living with HIV accessing ART

Aiming for the 2020 treatment target

Yet these gains are fragile and not distributed equally.
• While the percentage of pregnant women living with HIV who receive ART to prevent mother-to-child transmission of HIV is at an all-time high of 80%, the coverage in western and central Africa is 48% compared with 93% in eastern and southern Africa. Consequently, the mother-to-child transmission rate in western and central Africa is 20.2% compared with 9.9% in eastern and southern Africa (5).

• Children remain underserved in the HIV response. Only 52% of children living with HIV aged 0–15 years receive ART compared with 59% of adults (5).

• In sub-Saharan Africa, adolescent girls and young women (aged 15–24 years) accounted for one in four HIV infections in 2017, despite being only 10% of the population (6,7).

• HIV disproportionately affects populations already marginalized, stigmatized, discriminated against and criminalized across many societies. Critical to actualizing an effective AIDS response, these groups are often referred to as “key populations”.¹ In 2017, approximately 47% of new HIV infections globally were among key populations and their sexual partners (5). The risk of HIV acquisition among gay men and other men who have sex with men was 28 times higher in 2017 than it was among heterosexual men; 22 times higher for people who inject drugs than for people who do not inject drugs; 13 times higher for female sex workers than adult women aged 15–49 years and 13 times higher for transgender women than adults aged 15–49 years.

• While three-quarters of all people living with HIV knew their status globally at the end of 2017, young people and key populations are often underserved by HIV testing, and men across all geographic settings are less likely than women to take an HIV test (5). Men are also more likely than women to start treatment late, to interrupt treatment and to be lost to treatment follow-up (5).

¹ In addition to people living with HIV, key populations include gay men and other men who have sex with men, sex workers, transgender people and people who inject drugs. UNAIDS acknowledges that prisoners and other incarcerated people are also particularly vulnerable to HIV and frequently lack adequate access to services. UNAIDS encourages countries to “define the specific populations that are key to their epidemic and response, based on the epidemiological and social context.”

Challenges

Today, the global AIDS response is at a precarious point—partial success in saving lives and stopping new HIV infections is giving way to a faltering response. Funding is stagnant and 44 countries rely on international assistance for at least 75% of their national AIDS response. In this context, ensuring sustained access to ART for the tens of millions of people who will require treatment for the years to come constitutes an immense challenge (8). Recent estimates suggest that an additional 2.8 million people must access treatment each year (5). Overall, the global AIDS response is facing a 20% shortfall in resources compared to the 2020 target. Moreover, this aggregate figure masks even greater gaps in regions, such as in western and central Africa, the Eastern Mediterranean Region, eastern Europe and central Asia (Fig. 2) (5).

Fig. 2: Insufficient investment and impact in several regions: an example from the Middle East and North Africa

Epidemics of HIV, TB, viral hepatitis, and human papillomavirus persist, with similar modes of transmission, diagnostic difficulties and affected populations that are often marginalised, yet infectious disease programmes often operate in isolation in many countries (5). TB remains the leading cause of death among people living with HIV who are on average 21 times more likely to develop active TB than a person without HIV (9), and there were an estimated 71 million people living with hepatitis C infection in 2016 (10).

Alongside these challenges, the growing threat of non-communicable diseases (NCDs) increasingly affects people living in poverty and facing marginalization, including most people living with HIV, and is now also associated with long-term ART use (11).

A wider set of challenges affects the ability to deliver HIV services effectively, in particular to those who need them most. Violent conflict is on the rise, with the number of violent situations that can be qualified as war (according to number of casualties) tripling compared to 2007 (12). In 2017, 335 natural disasters affecting more than 95 million people occurred (13). The combined impact of violent conflict and natural disasters have forced millions of people from their homes. In 2017, the global population of displaced people was at a record high of 68.5 million, up by 2.9 million since 2016 (14).
Migrants and refugees face marginalization in many contexts where a lack of migrant-inclusive health policies, irregular immigration status, user fees, language and cultural barriers, and inaccessible health services prevent them from accessing the health services they need and thus expose them to poorer health outcomes (5). For example, studies from Europe have demonstrated that migrants diagnosed with HIV are more likely to present late for treatment or care than nationals (15). However, these challenges are not insurmountable. In northern Thailand, for instance, the removal of legal and policy barriers for Shan migrants and the introduction of measures to reduce discrimination in health care settings and provide appropriate services led to 1.4 million new enrolments in Thailand’s Migrant Health Insurance plan in just one year (16).

Gapping inequalities within and between countries are embedded in national health systems and global health governance structures. Communities are often unable to have their voices heard effectively, challenge injustice and hold decision-makers to account (17). While most of the determinants of health lie outside the health sector, ministries of health often lack leverage and power to influence other government sectors or key stakeholders, including large transnational corporations (18).

Priorities within the health sector are often skewed toward biomedical interventions, with services being vertical and fragmented (for example, three of five people started on ART are not screened, tested or treated for TB) (5). Insufficient integration of services at primary health care level and sub-optimal linkages and referral systems between service points are also contributing factors to the high mortality among children living with HIV (19).²

Other challenges that affect the ability to deliver services include out-of-pocket spending, which remains high in many countries, corruption and acute health workforce shortages. Even when services are available, they may not be accessible due to punitive laws and policies or pervasive stigma and discrimination.

Surveys of people living with HIV conducted across 19 countries in the previous 12 months show the following: approximately one in five people living with HIV reported having been denied health care due to their HIV status; one in five people living with HIV reported having avoided visiting a health facility for fear of stigma or discrimination related to their HIV status; one in four people living with HIV reported experiencing some form of discrimination when using health care services; and approximately one in three women living with HIV reported discrimination related to their sexual and reproductive health.³

² Additional factors outlined by UNICEF (2018) include insufficient access to simplified diagnostic technologies (that is, at the point of care), unpalatable and difficult to administer child drug formulations, and children’s lack of agency putting decisions regarding their health in the hands of others, who may be facing their own challenges.

³ These women reported that a health care professional had advised them not to have a child due to their HIV-positive status, that they had been told that access to ART was conditional on the use of certain forms of contraception, or that they had been denied sexual and reproductive health services in the previous 12 months due to their HIV status.
Opportunities

Agenda 2030 for Sustainable Development is fundamentally about generating profound structural change and societal transformation. It represents much of what has been practiced in the AIDS response—inclusive partnerships, working across sectors, addressing inequalities, empowering communities and enhancing access to justice.

Universal health coverage (UHC), of which PHC is the foundation, is a target alongside “ending AIDS as a public health threat” and others under Sustainable Development Goal 3 (20). UHC also serves as an organizing framework and, as such, as a springboard for enhanced cooperation within, across and beyond the global health community.

UNAIDS 2016-2021 strategy: On the fast-track to end AIDS calls for expanding HIV-sensitive UHC and social protection and urges countries to address three UHC dimensions in planning HIV responses: 1. define the essential, high-impact HIV interventions that should be integrated into the national health benefit package; 2. Ensure that this package is adapted and equitably delivered to populations in need; and 3. Ensure that the national health financing system covers the costs of HIV services to minimize out-of-pocket expenditure and the risk of financial hardship (21).

In 2016, at the United Nations General Assembly, Member States adopted the Political Declaration on HIV and AIDS: On the Fast-Track to Accelerate the Fight against HIV and to End the AIDS Epidemic by 2030, which includes an important overarching theme of “taking AIDS out of isolation” (22). Among the commitments undertaken by Member States is the “delivery of more integrated services for HIV, TB, viral hepatitis, sexually transmitted infections, NCDs, including cervical cancer, drug dependence, food and nutrition support, maternal, child and adolescent health, men’s health, mental health and sexual and reproductive health, and to address gender-based and sexual violence...” (22).

This integration presents ample win-win scenarios. For example, HIV early infant diagnosis and immunization, HIV testing of children receiving care for severe acute malnutrition, HIV and early childhood development, HIV and TB, co-infections like HIV-TB and HIV-viral hepatitis, co-morbidities such as HIV and NCDs, as well as HIV and mental health, and child and adolescent health. In many of the countries most severely affected by HIV, health systems have traditionally focused on providing acute care and maternal and child health services.

When well resourced, primary care, with its emphasis on comprehensive, coordinated, continuous and people-centred care, is particularly well suited among service delivery platforms to provide care for people facing chronic illness and multi-morbidity. In some countries, the AIDS response has charted a new path, representing the first large-scale, chronic care programmes to support HIV as a chronic communicable disease and thus, potentially able to support large scale-up of NCD programmes (23). Given ART scale-up, HIV services are increasingly being tailored to ensure long-term, sustainable and comprehensive services centred around a life-course approach, which requires increased efforts to address the double burden of NCDs. In addition, several countries transitioning from donor financial support are putting in place the policy, health workforce, medicines and service delivery requirements to ensure that comprehensive services for people living with HIV are available through routine primary care.

These delivery requirements include a competent health workforce that respects and protects the sexual and reproductive health and rights of every person. Women living with HIV often experience violence in health care settings as well as in social and family settings, therefore, providers need to be competent and provide care without enacting further violence or putting them at risk for further violence (for example, by forcing them to disclose their HIV status to violent partners, sterilizing them without consent or forcing them to follow specific birth control regimens or infant feeding practices as a condition for receiving HIV treatment) (24).
Women living with HIV face up to a five-fold higher risk of invasive cervical cancer. About 80% of all cervical cancers occur in low- and middle-income countries (25). Linking cervical cancer screening and HIV services can be a cost-effective way of improving cervical cancer screening and treatment. For example, in Zambia, a national cervical cancer prevention programme was integrated into an existing HIV programme and led to an expansion of cervical cancer screening to more than 100,000 women (28% of whom were living with HIV) over a period of five years (26).

Many barriers to PHC and HIV services overlap. They are often anchored in existing power structures and inequities prevailing in our societies and relate to marginalized and underserved population groups. HIV raises questions that are considered sensitive or taboo in many societies, that is, issues around gender, sexuality, identity, exclusion and power. Building on the experience and strategies developed by the HIV community and using the entry point of PHC, challenges can be overcome.

It will be essential to ensure that PHC is responsive to the needs and rights of young people including adolescents. The world has now more young people than ever before – of the 7.2 billion people worldwide, over 3 billion are younger than 25 years, representing 42% of the world population. Empowering young people to protect themselves from health risks during this time in their lives is an investment and can help prevent health problems in adulthood (27).

PHC can provide a platform to engage young people in decision making in the development and implementation of more integrated health programming that serves their unique needs (28,29). Barriers to health services will need to be overcome. For instance, among 110 countries reporting, 71% (78 countries) require adolescents to have parental consent to access HIV testing services (Fig. 3). The emphasis on education in PHC provides a critical entry point to scale up comprehensive sexuality education among young people.

**Fig. 3: Discouraging adolescents from accessing services**

<table>
<thead>
<tr>
<th>Region</th>
<th>Percentage</th>
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<tbody>
<tr>
<td>Asia and the Pacific</td>
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<tr>
<td>Eastern and southern Africa</td>
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<td>61%</td>
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<tr>
<td>Western and central Europe and North America</td>
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Alma-Ata more relevant than ever

The AIDS response has operationalized many aspects of the Declaration of Alma-Ata and the current revival of PHC as part of the effort to reach UHC provides a welcome and timely opportunity to enhance the synergies with the AIDS response and to build on lessons learned.

From the outset of the AIDS response, HIV was conceptualized as much more than a health issue (30). Framing AIDS as a rights issue not only helped to generate action and accountability, but also helped to demonstrate how the ability of affected communities to protect themselves from (and to survive) HIV largely depends on their ability to exercise their rights.

“Health, which is a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity, is a fundamental human right… whose realization requires the action of many other social and economic sectors in addition to the health sector….“ (Article 1 of the Declaration of Alma-Ata)

Population health and well-being depend on an enabling social, legal, political and economic environment. Governments and other powerful actors have obligations and responsibilities to generate such environments by adopting laws, policies and practices that empower individuals and communities to claim and exercise their rights. These rights include freedom from discrimination and from violence, as well as rights to participation, information, education and health. In turn, the right to health encompasses, inter alia, sexual and reproductive health and safe and healthy working conditions (31).

To ensure an effective HIV response, enabling and protective legal environments are critical. Nevertheless, sex workers across approximately 100 countries face punitive laws that criminalize sex work or activities associated with it. Following the decriminalization of sex work in New Zealand, some 90% of sex workers reported that their legal rights were protected under the law and that the level of condom use among sex workers has increased (31).

Affected communities have been at the front line from the early days of the AIDS epidemic over 30 years ago, calling for urgent action while caring for loved ones who were dying in the midst of denial, stigma and neglect. Over the years, they have helped to maintain a sense of urgency and global solidarity which, in turn, has helped garner attention and resources around AIDS from the creation of institutions such as the Global Fund to Fight AIDS, TB and Malaria and the United States President’s Emergency Plan for AIDS Relief to leveraging the attention of the United Nations Security Council (30, 31).

Today, communities continue to lead efforts to break down barriers that hamper an effective AIDS response. For example, The People Living with HIV Stigma Index is a community-based information management system led by networks of people living with HIV. By collecting data on HIV-related stigma and discrimination, communities are able to report how this acts as a key obstacle to ensuring access to HIV prevention, treatment, care and support (33).

Primary health care “requires and promotes maximum community and individual self-reliance and participation…. and to this end develops…the ability of communities to participate….“ (Article VII, paragraph 5, of the Declaration of Alma-Ata)

The AIDS response has been effective in operationalizing community-based or community-supported models of care as one of the most effective ways of improving retention in care and adherence to ART (5). Overall, we have the evidence in the context of HIV (and as recently demonstrated by Ebola) that community-based organizations in many countries can reach people being left behind due to prejudice, poverty, punitive laws or simply because they live in remote areas (5).

Primary health care is “… the first level of contact …with the health system bringing health care as close as possible….“ It “relies…on health workers, including… community workers…“ (Articles VI and VII of the Declaration of Alma-Ata)

Community health workers are vital for managing the increasing numbers of people on ART in low-resource settings (5). For example, in KwaZulu-Natal, South Africa, community health workers contributed to improved retention in care, viral suppression and immunological restoration by providing clinic-linked home-based adherence and psychosocial support to people accessing ART (34).
Reflections as we move ahead…

The AIDS response has generated many valuable lessons relevant to scaling-up and operationalizing PHC. Today, it is being ambitiously redefined as a “whole-of-society approach to promote health that aims to equitably maximize the level and distribution of health and well-being by focusing on people’s needs and preferences (both as individuals and communities) as early as appropriate along the continuum from promotion and prevention to treatment, rehabilitation and palliative care, and as close as feasible to people’s everyday environment” (35). The AIDS response can serve as a pathfinder for further progress on PHC, while helping to ensure that PHC holds true to its values of human rights and social justice and lives up to Agenda 2030 in which the UN Member States pledged to “endeavour to reach the furthest behind first…” (20).

At the same time, the integration of HIV services into PHC,⁴ where feasible and appropriate will be critical to ensure continuum of both HIV prevention and care, optimal access to ART and ongoing chronic care that is properly coordinated with the other primary care needs of people living with HIV. To sustain long-term quality care for people living with HIV and all members of communities most left behind, in all of their diverse health care needs at all points in the lifecycle, traditional funding and professional silos need to be broken down and additional resources urgently raised (36).

“Our goal must be to save lives holistically, not disease by disease, issue by issue, in isolation.” Michel Sidibé, UNAIDS

To conclude, with the revival of PHC, the AIDS and the wider global health movements around UHC are presented with a unique opportunity to join forces and better address the structural and root causes of ill-health—many of which relate to poverty and social inequalities. We urgently need to seize this opportunity to bring together HIV, PHC, UHC, integration for health, and other movements to form a broader coalition demanding health as a fundamental, universal human right.

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⁴ WHO and UNICEF differentiate primary health care, a whole-of-society approach to health, from primary care, the first contact for continuous, comprehensive and coordinated health services.
Bagaimana HIV Menular? perpindahan cairan tubuh
References


