Commentary – Alma Ata

'The best is the enemy of the good': delivering health care in sub-Saharan Africa

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I was taught this old adage 'the best is the enemy of the good' by my late friend and colleague Professor Tim Cullinan, at the time that we were leaving the shores of England in 1991 to set up a new medical school in Malawi, a very poor land-locked country in southern Africa. Having now spent over 20 years of my professional life working in different parts of Africa first as a clinician and latterly in a public health capacity, the adage is never truer today than it was then. It is also immensely relevant for global health. At the 61st World Health Assembly in May 2008, Dr Margaret Chan (the Director General of the World Health Organization) put primary healthcare at the centre stage of her vision for global health.¹ She emphasised to the delegates the crucial importance of primary healthcare in reaching the health-related Millennium Goals and called on governments to revitalise the vision laid out 30 years ago in the 1978 Alma-Ata Declaration.

What does this adage mean to health practitioners? In brief, it is about the widespread delivery of a good quality service to as many people as possible rather than a focus on a top-class excellent quality of service for a few. Let me give you an example from Malawi of how this works out in practice.

In the last five years in Malawi I was involved in assisting the country in scaling up antiretroviral therapy (ART) to patients with AIDS. Malawi has a population of 12.5 million and a staggering HIV/AIDS epidemic. There are almost 1 million people infected with HIV, 100 000 new infections per year and about 90 000 AIDS related deaths each year.² In 2004, we estimated that there were 170 000 patients in immediate need of ART and at that time about 3000 people receiving the medication on a fee-paying basis from nine health facilities across the country. Funds for scaling up ART were forthcoming from the newly created United Nations Global Fund against AIDS, tuberculosis and malaria (GFATM), but the question was how to scale up services in a country that only had 200 doctors, a gross domestic product of US\$200 per capita per annum and about US\$15 per capita per annum for health

(contrast the United Kingdom which allocates over US\$2000 per capita on health).

We realised right from the start that we could not scale up therapy based on the individualised medical model of care used in industrialised countries such as Britain, where treatment is provided by skilled doctors, where a variety of different regimens are tailored to individual patients based on professional expertise and where follow-up is strongly linked to sophisticated laboratory investigations such as CD4-lymphocyte counts, viral load and viral genotype resistance testing. We did not have the necessary skilled human resource base, and laboratory capacity even in tertiary care centres was weak and fragile, as it is all over sub-Saharan Africa. Borrowing strongly from the World Health Organization's DOTS model for delivering treatment to tuberculosis patients in some of the poorest countries of the world,³ we made the decision to scale up therapy using a public health model. Here, treatment is provided by a mix of paramedical clinical officers and nurses, eligibility for ART is based largely on clinical assessment, there is a standardised approach to treatment using non-expensive, generic fixed-dose combination tablets, there is a limited choice of regimens, and follow-up is clinical with little or no laboratory monitoring. We also believed in free treatment at the point of delivery, based very much on Britain's National Health Service.

The medical model provides the best standard of care for the individual patient, with rapid substitution to alternative regimens when adverse effects occur and to second line regimens when HIV drug resistance is identified. However, it requires skilled staff, it is costly and it is demanding of infrastructure and logistics. The public health model, focusing on service delivery to all who need it, has the advantage that it can be rolled out to district hospitals, health centres, health posts and community centres.⁴ Patient access to ART is easier, both for initiating therapy and for continued life-long follow-up, and defaulter tracing is more feasible. The disadvantage is that clinical assessment

of patients for eligibility to ART is prone to error, dangerous toxicity such as lactic acidosis may be missed if there are no laboratory assessments, and virological or immunological failure is only identified when clinical illness appears thus compromising the benefits of second line treatment.

Between 2004 and the end of 2007 Malawi made sterling progress with its public health model. Scale up occurred in all central, district and mission hospitals and included health centres and clinics. The private sector was brought on board with the incentive that private practitioners could receive drugs free of cost and charge patients a small nominal fee, but in return they had to follow national guidelines,⁵ use the ART Treatment Cards and ART Registers for registering patients and recording monthly outcomes, and every three months, in line with the public sector, carry out cohort analysis of case burden and treatment outcome. By 31 December 2007, there were 118 facilities in the public sector and 45 in the private sector that had started 146 856 patients on ART.⁶ Of these, 100 649 were alive and retained on therapy in the clinic where they had first registered. Without this treatment, the majority of these patients would be dead. Of course the scale up is not without its problems. There has been high mortality in the early stages of treatment – 65% of the known 16 375 deaths have occurred within three months of starting ART. Cumulatively, 14 078 patients have been lost to follow-up, and with rural communities having poor roads and no phone lines, the active tracing of patients who fail to attend the clinics is a major challenge.

The model of scale up of ART in Malawi has not been without criticism, both from outside the country and from within, with cries that it needs to be more sophisticated and laboratory based. These cries ignore the simple fact that if ART provision is tied to laboratory assessment, the treatment in a country like Malawi will only be available to those few patients who can access well-equipped health facilities. The debate over the optimal use of resources is not confined to poor countries in Africa. Even in the UK, there are frequent arguments and discussions about whether

the NHS can and should provide the most sophisticated treatment for diseases such as cancer or multiple sclerosis. The pot of money, even in rich countries, is not limitless, and unfortunately difficult choices have to be made. My long years in Africa have convinced me about trying to keep things simple and defending the stance of providing a good quality service to as many people as possible rather than excellence to the few.

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