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Taking Acute Care Worldwide: Pragmatic lessons from the HIV pandemic

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The first cases of what we now call HIV/AIDS were recognized just over 30 years ago. The ensuing epidemic brought massive suffering and death, and dramatically underscored global economic and health inequities. The magnitude of the epidemic was so great that it even threatened the political stability in communities around the globe. In the early years, when AIDS' aetiology and prognosis were not understood and, worse, later when they were, the picture was grim – a blood borne or sexually transmitted retrovirus was causing a near universally fatal disease occurring in socially excluded or impoverished communities at a time when there had never been an effective treatment, let alone cure, for any viral disease in humans.

It is markedly different today. For a great many people now living with HIV, including millions living on the continent of Africa, the combined efforts of government, science, the healing professions, and industry have produced HIV treatments that now can give a near-normal life span and even offer a glimmer of hope for a cure. Additionally, enormous efforts were made to build systems of care in Africa and around the world to make these life-sustaining treatments available. The President's Emergency Plan for AIDS Relief (PEPFAR) program, instituted by the U.S. government in 2003 has enabled the number of HIV infected people in sub-Saharan Africa receiving highly active antiretroviral therapy (HAART) to rise from 50,000 to 3,500,000 in less than a decade.

Examination of the multinational, multidisciplinary response to the HIV/AIDS epidemic reveals a framework that is applicable to the development of systems for the delivery of acute care in regions and countries where they do not yet exist. Strategies that proved to be successful in the provision of HAART to communities around the world, and significantly in Africa, are summarized below:

1. Use a multi-disciplinary/multi-faceted approach

Perhaps because in the earliest years of the HIV/AIDS epidemic most everyone involved, whatever their role, felt to

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one degree or another the fear and stigma associated with HIV/AIDS, the movement that arose was a broad-based coalition of stakeholders capable of being effective advocates at many levels of society and sectors of the economy. This multi-faceted (as opposed to just professional) advocacy must also happen if rapid progress is to be made in acute or emergency care development.

2. Incorporate proven solutions into resource-constrained environments

As long standing, massive and devastating as the HIV/AIDS problem was, it was only when HAART therapy was shown to be effective *and* when models of HAART therapy delivery were proven to be workable in resource constrained settings that meaningful public action was finally taken on sufficient scale in Africa to have lasting impact. Measuring the scope of the problem was not enough; it was necessary to have proof that the intervention could be successful in the crucible of an African health care system. Similarly, in the case for acute care, a much broader and deeper public awareness that timely access to excellent emergency care can make a profound difference is still needed. While proofs of concept of acute care interventions exist across the African continent, their impact, benefit, cost, comparative value to other health investments and contribution to overall population health remains opaque to many important decision makers.

3. Strengthen local health care systems and support local solutions

One essential outgrowth of the last decade of the global HIV/AIDS effort has been an understanding of the critical importance of strengthening local health systems and prioritizing funding for *locally led* solutions. This is a significant and welcome step forward from earlier more donor-centric, disease specific, ''vertical'' initiatives. A health systems approach fits naturally with the specialty of Emergency Medicine; emergency care is fundamentally based on **systems** that seek to maximize patient outcomes. Thus, emphasizing that emergency care is a neglected yet critical component of a health care *system* rather than merely another specialty interest is essential to any long-term success. (In this regard the term ''acute care'' can be contrasted to chronic care and therefore works better as an advocacy tool than ''emergency care''.)

4. Change the way leaders think about the health issue

Shifting the ways that problems are conceptualized and categorized in the minds of governments and donors is essential for success. For example, in the United States, the global HIV budget line was significantly boosted when political leadership began to openly conceptualize HIV/AIDS as an issue of national security. A disease process that was once thought of as strictly a charitable concern quickly garnered a much larger and more powerful set of stakeholders.

5. Engage the private sector

The fight against HIV/AIDS has always had strong private sector involvement. Many of the early ''proof of concept'' HAART initiatives in Africa arose from private sector efforts and countless industries have added to their bottom line by engaging the pandemic. Acute care would also do well to develop partnerships with private sector interests. Between 2000 and 2008, Africa was the world's third fastest growing economic region and the IMF estimates that 60% of health care in sub-Saharan Africa is delivered through private mechanisms. The perceived self-interest for business and political leaders in developing acute care systems as well as the impact on economic development of having emergency care available can be powerful means of attracting political and financial support. In this light, it is time to cease and desist referring to sub-Saharan Africa as consisting of ''developing countries'' and to start underscoring their economic potential as ''emerging economies''.

6. Involve leaders with a genuine concern for humanity

Finally, when thinking about expanding quality acute care in emerging economies the most important lesson to draw from the global HIV/AIDS epidemic is the importance of leadership that brings vision, knowledge, drive and, above all, love of humanity to the effort. Emergency medicine practitioners find amongst themselves an abundance of these qualities and, hence, great cause for hope and optimism. St. Francis of Assisi got it right so many years ago when he noted, ''Start by doing what's necessary, then what's possible and suddenly you are doing the impossible''.

In this issue, we feature research on interrater agreement between doctors and enrolled nursing auxiliaries (ENA) using the South African Triage Scale (SATS). The benefit of using ENAs appears safe, practical, financially appropriate for an emerging economy environment and on top of that, it makes a huge impact on prioritising acute patient care. Ujuzi/Practical Pearl features a smart weight estimation measuring tape that can compensate for different body habitus. Cliff Mann has written an excellent paper on observational research for AfJEM – basically a how to guide should randomised controlled trials prove impractical or just logistically impossible (the case in many African settings). It is based on a previous paper on the same topic penned by Cliff for the Emergency Medicine Journal in 2003, but with some Africa appropriate examples and the addition of newer material. This is an essential piece of work and should go into every serious researcher's permanent collection. We hope it all adds value to your enthusiasm and passion for what you do and inspire you to follow St. Francis' dictum.

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