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Letter to the Editor

On the Effectiveness of Primary Health Care System in Controlling HIV/AIDS in Iran

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Dear Editor-in-Chief

We very much enjoyed reading a letter by Drs Joulaei and Motazedian published in an earlier issue of your journal (1). We are thankful to the authors for bringing this overlooked topic up and for opening a window of opportunity to discuss over the effectiveness of the Primary Health Care (PHC) system of Iran in controlling HIV/AIDS in the country. The conclusions of this letter concern us; they stated that "PHC oriented health network system of Iran could play a key role in reaching out to high-risk groups, accelerating case findings and harm reduction intervention, and reducing high-risk sexual behavior in the HIV program". We do agree with some of the ideas presented in the letter; however, we think this approach may not be that feasible and practical in Iran based on the socio-cultural context of the country as well as the barriers against PHC.

Although the PHC in Iran has a high level of political and medical commitment in the control and prevention of several diseases, its limitations cannot be ignored (2). The coverage of PHC in cities is not high enough, and has a passive approach towards reaching Most At-Risk Populations (MARPS); this limits the delivery of service and care to these target populations. Moreover, there is much workload on the shoulder of its staff; in recent years new responsibilities were added to the list of errands of the healthcare workforce. Therefore, it is not feasible to add a new and complex task to their tasks.

MARPS do not tend to be seen in public and are less likely to refer to public clinics which may reveal their HIV status to the general population. We believe the stigma surrounding HIV/AIDS is really profound and most people in the family-oriented context of Iran care deeply about the issues of "face" at both individual and family levels. Most People Living with HIV (PLHIV) worry that the disclosure of their HIV status to the community can negatively affect themselves and their families in the terms of employment and the level of social support they would receive. As a result, assuming that PLHIV would approach a PHC clinic is a little bit far-fetched (3).

On the other hand, the majority of MARPS live in cities; even those who may live in rural areas tend to migrate to cities where they can choose an isolated life and avoid the stigmatized look of those around them. In other words, the effectiveness of PHC in rural areas in reaching MARPS can be questioned. Therefore, we assume we should be more realistic when considering PHC for controlling HIV/AIDS. We doubt that we can put the burden of HIV/AIDS on the shoulders of PHC.

We think a partial vertical approach should still be taken into account. Despite the disadvantages of a vertical health program, we still believe their defined goals and objectives with measureable outcomes as well as high accountability and the rate of success in limited timeframe make them a better option in the context of

Iran. We do not recommend an entire isolated vertical care and treatment system. In our model, we suggest a vertical system in providing special care and treatment to those who are at a higher risk of infection, as well as PLHIV along with their families. This system should be compatible with the rules and regulations of a comprehensive PHC with appropriate links to formal components of the national health system in order to access its data and resources, benefit from its settings, and seek support from the personnel of the system.
All in all, considering that HIV is not only an infection, but a complex and multifaceted issue, reaching the MARPS through only the PHC system in Iran is not that achievable and despite its effectiveness, PHC cannot have a key role in this regard. We recommend the authors address such limitations to PHC in Iran, and suggest a more comprehensive scheme to approach this complicated issue.

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Reply

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Dear authors
Thanks so much for attention to our letter;
First of all PHC oriented health network system (HNS) of Iran has three levels so that health houses are a part of its first level, and we do believe all levels should be involved in both rural and urban areas.
The second issue is the proposed strategies to combat HIV/AIDS among population at national and international level, including health promotion and prevention activities among all different groups of the societies as well as full coverage of treatment among PLHIV.
We also highly recommended partial vertical program, obviously for improving health care services (PHC oriented). We need to involve our HNS; otherwise, we should waste a lot of resources to expand the existing vertical system and find hidden population of HIV^+ and provide health care for them which are nearly impossible. We agree that stigmatization is a very important issue in not only Iranian but also many other cultures, but we have to try to convince and educate our Family physician (FP) to take confidentiality into account as it is integrated of their responsibility. Although at the first step we don't expect to involve the FPs in the treatment process and it can be done very cautiously and gradually. Last but not the least, numerous articles reveal the effectiveness of integration of HIV/ AIDS preventive programs in PHC all around the world.