

This work is licensed under a [Creative Commons Attribution-NonCommercial-ShareAlike License](https://creativecommons.org/licenses/by-nc-sa/4.0/). Your use of this material constitutes acceptance of that license and the conditions of use of materials on this site.



Copyright 2006, The Johns Hopkins University and William Brieger. All rights reserved. Use of these materials permitted only in accordance with license rights granted. Materials provided "AS IS"; no representations or warranties provided. User assumes all responsibility for use, and all liability related thereto, and must independently review all materials for accuracy and efficacy. May contain materials owned by others. User is responsible for obtaining permissions for use from third parties as needed.



JOHNS HOPKINS
BLOOMBERG
SCHOOL *of* PUBLIC HEALTH

What Happened to Health for All?

**William R. Brieger, MPH, CHES, DrPh
Johns Hopkins University**

Health for All—2000

- ✦ What has happened to the 1979 World Health Assembly Resolution 32.30 to promote Primary Health Care?
- ✦ A question of policy implementation

The WHA

- ✦ **Decides** that the development of the Organization's programs and the allocation of its resources at global, regional, and country levels should reflect the commitment of the WHO to the overriding priority of the achievement of health for all by the year 2000

The WHA

- ✦ **Endorses** the report of the International Conference on Primary Health Care, including the Declaration of Alma Ata

The WHA

- ✦ **Invites** Member States to consider the immediate use of the document entitled *Formulating Strategies for Health for All by the Year 2000*
 - Individually as a basis for formulating national policies, strategies, and plans of action
 - Collectively as a basis for formulating regional and global strategies

According to an Evaluation Report in 1996

- ✦ Between 1979 and 1996: Per capita public spending on health in developing countries decreased while it rose in other countries
- ✦ While planning toward intersectoral collaboration has been common, the health sector in most countries is still seen as a weak partner in development

According to an Evaluation Report in 1996

- ✦ Donor priorities have made it difficult for countries to integrate vertical programs into comprehensive care



National Immunization Days are often run as vertical programs

What Happened

- ✦ Decentralization has occurred on the books in some countries, but lack of personnel, resources, supervision, and transportation have painted a bleak picture

What Happened

- ✦ The bold, unprecedented strategy of direct community participation in PHC has not, for the most part, been achieved
 - Local populations have not become self-governing
 - Health personnel have not become self-governing

What Happened



Health Committees are launched with media coverage, but community representatives may soon drop out

- New structures (health committees) were set up but were not sustained
- It was difficult to sustain community inputs and contributions

Lack of Administrative Support

- ✦ Health workers felt a lack of administrative support for community participation because:
 - Excessive centralized control of resources and decision making
 - No clear policy statement on involvement

Lack of Administrative Support

- Poor educational opportunities for community members (to enhance their ability to become partners)
- Passive community dependence on government
- Particular difficulty in urban areas with such heterogeneity

What Happened

- ✦ Policy makers and politicians had fears
- ✦ Community involvement might lead to community control
- ✦ Empowerment of community seen as a foreign concept



Politicians may feel threatened when community members speak out

Constraints to C-PHC at the Community Level

- ✦ Lack of information
- ✦ Non-representation
- ✦ Factions
- ✦ Frustration with bureaucracy
- ✦ Greater demand for the curative

Constraints to C-PHC at the Community Level

- ✦ Two-tiered system:
Quality if pay
- ✦ Cultural practices
- ✦ Economic hardship
- ✦ Ecological-
environmental
problems: Lack of
water, deforestation,
etc.



*Hunters may
deliberately set fires*

Constraints to C-PHC at the Health Systems Level

- ✦ Lack of interest/awareness of community issues
- ✦ Lack of capacity to address cultural determinants
- ✦ Rigid, uniform program objectives
- ✦ Non-appreciation of community heterogeneity
- ✦ Pressure for demonstrable results
- ✦ Budgetary and time constraints

Inability to Define Problems in a “Comprehensive” Way

Diarrheal Diseases

✦ **Selective/disease approach**

- Personal hygiene
- Measles immunization
- Reduced animal exposure
- Hygienic water management
- Improved case management using:
ORT, diet, algorithms

Inability to Define Problems in a “Comprehensive” Way

Diarrheal Diseases

✦ Integrated approach

- Female education/literacy
- Improved agricultural practices
- Access to better sanitation and water supplies

Community Participation as a Capacity Building Process

- ✦ Community participation in water supply improvements leads to --->
- ✦ Enhanced community problem solving capacity which shifts --->
- ✦ Health locus of control from external to internal so that --->
- ✦ Individuals have confidence to engage in other health-seeking activities, such as getting their children immunized

Empowered Communities Engage in Advocacy for Policy Change

- ✦ Advocacy is part of community action
- ✦ In the “new” public health, the individual is an advocate (vs the individual as audience)
- ✦ Advocacy promotes policy change (vs health services promoting messages)

Advocacy for Change

- ✦ Advocacy aims to change the environment (vs a traditional system that tries to change individuals)
- ✦ Advocacy addresses the power gap (while the traditional system worries about an information gap)

Roll Back Malaria Advocates for Change in Policy

- ✦ Comprehensive national malaria policies needed
- ✦ Tax and tariff policy changes required so that bed nets can be made available at prices people can afford



Source: The CDC

The Challenge for 2000 and Beyond

- ✦ Selective PHC as a real millennium bug, disabling the health system's will to work with communities as partners
- ✦ Working at the grassroots with indigenous organizations and social networks communicating with indigenous knowledge to facilitate local solutions for local problems

The Challenge for 2000 and Beyond

- ✦ Catalyzing local action into advocacy that will result in systems change from the bottom up
- ✦ Having the patience to let HFA take its own time by letting communities bring about change on their own terms