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The local bases of global public health: complexities and opportunities

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Historically, the big divide in international and national public health circles has been between the supporters of "vertical" and "horizontal" programmes. Advocates of the vertical approaches have highlighted the usefulness of targeting one disease at a time, through concerted political and social action, with the ultimate goal of eradication. Their opponents, on the other hand, have highlighted the significance of horizontal services, which can be described most easily as the health networks that cater for patients on a day-to-day basis (such as public hospitals, primary health care centres, dispensaries, travelling maternal and childcare services). Both groups have had powerful spokespeople, who have drawn on specific examples to strengthen their arguments; they have, similarly, quoted cases to underline the weaknesses of the other party.

These debates have, by and large, been accusatory – each side has blamed the other for weakening, sometimes beyond repair, working models of their health-care plans. Yet, interestingly, these debates have been – and continue to be – carried on the basis of theoretical ideals and models. Put another way, disjoints between theory and practice have generally not been studied in any detail, which has meant that meaningful reforms have been difficult to implement. The result, according to many observers, is a situation where debates and discussions within organizations like the UN, WHO, United Nations Children's Fund (UNICEF), the World Bank and the International Monetary Fund (IMF) have historically been ideologically predetermined, with relatively very little knowledge about the localities where the health projects are being or will be targeted.

There is, as a result, much space to rethink the theories and the practical intricacies of public health. The acts of identifying disease/s, the calculation of costs inflicted by it/them, the selection of preventive strategies and cures, and, not least, their introduction in different social settings are not value-free processes. To the contrary, all biomedical concepts, products and services are intensely political and social phenomena, where different interest groups, complex market forces and ideologies interact, compete or combine to create a multiplicity of situations. Historians and other social scientists are very well placed to assess these conditions, as they existed in specific regions, countries and localities, over a protracted period of time. Such information can be invaluable to those seeking to develop and apply context-specific public health policies. Historical studies can also help in another way: independent and critical assessments of past global health programmes can provide important pointers for the future, if, of course, one is able to convince those currently involved in managing similar projects. For instance, the doomed malaria eradication campaign, which is generally accepted as a classic "vertical programme", has important warnings to offer the managers of the global polio eradication initiative – overarching policies designed by a handful of officials cannot be forced upon diverse national and local governments and societies.

Should we be looking for new, more lasting solutions? One fruitful strategy might be to convince policy-makers and field workers that it is possible and useful to interlink vertical and horizontal programmes. After all, varying levels of integration are already visible in the field in national contexts where disease control and eradication programmes have been systematically introduced. The strengthening of routine rural health services can contribute to social well-being as well, especially if reliable networks of maternal and child care are made a central element of these delivery systems. Facilities for the immunization of newborns and infants, whose exact form would depend on the disease profiles of the regions that they were serving, would be a significant component, as this has shown to be an effective means of winning the support of mothers and grandmothers (who play an incredibly important role in determining the success of health-care schemes).

The history of global smallpox eradication provides us with another important lesson – the need to develop flexible vertical health programmes, based on partnerships with communities at which they are being targeted. Such exercises in adaptive verticality would help in the early identification of potential social, cultural and political challenges in a diversity of localities, and then allow for the design and implementation of nuanced and effective policy. Apart from anything else, this would allow the target groups to behave like responsible stakeholders and help dispel notions of the forcible, top-down imposition of health-care strategy, which is widely disliked in almost every national context in which WHO officials are active.

If put into practice, the strategy of adaptive verticality can contribute in another very meaningful way in the long term – it will allow the managers of vertical health programmes, which have powerful supporters within national governments and international agencies (and are, therefore, unlikely to be discontinued in any context) to work efficaciously with political constituencies, government health personnel and WHO officials supportive of the worldwide reinvigoration of an organized strategy of primary health care. ■

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