

# Health Diplomacy: lessons for global health from PEPFAR

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## Abstract

Health diplomacy has become an increasingly important strategy for the US in the less developed world. PEPFAR (President's Emergency Plan for AIDS Relief) provides lessons for future global health initiatives. Technical leadership, accountability, and the future of the US global diplomacy work force are discussed.

In a world of increased global health risks, economic disparities between nations and profound challenges to national security, global health programs have become an important part of the diplomacy. President's Emergency Plan for AIDS Relief (PEPFAR) is a US health diplomacy effort, perhaps the largest ever undertaken -- with well documented successes and limitations -- provides lessons for future global health initiatives. <sup>1</sup> Other global investments in HIV/AIDS have failed due to weak or inexperienced bureaucracies. <sup>2</sup> Building on PEPFAR, the Obama administration has proposed to increase the US investment in global health to \$63 billion. <sup>3</sup> A role of health diplomacy has been recommended in the fight against radical Islamists. <sup>4</sup>

While political influence on foreign assistance have often been cited as a cause for failures, divorcing the global health action of national from diplomacy is rarely possible. <sup>5</sup> There are three rationales for health diplomacy which were part of the original conceptualization for PEPFAR which worked to bridge the differences between diplomatic and health efforts. <sup>6</sup> Morbidity and mortality are inequitably distributed across the globe and principles of beneficence and justice mandate humanitarian action. Second we must protect ourselves from diseases arising in other countries, which include prevention, and treatment of illness as well as efforts to build infrastructure abroad necessary to contain outbreaks. Finally, there is the growing recognition that poor health and inadequate health care in populations lead to destabilization which make our world more dangerous, setting back advancement of our national security and other priorities. These perspectives were reaffirmed by the Institute of Medicine in a recent report on global health. <sup>7</sup>

## Box 1

The President's Emergency Program for AIDS Relief, commonly known as PEPFAR, was created by an act of the US Congress in 2003 supporting by US\$15 billion.

### Five year goals

PEPFAR aims to do the following in the fifteen focus countries:

- Support treatment for two million HIV-infected people
- Prevent seven million new HIV infections
- Provide care for 10 million people infected with and/or affected by HIV/AIDS, including orphans and other vulnerable children

This analysis is based on a review of the published literature on the PEPFAR program, including a comprehensive, two volume evaluation of PEPFAR by the Institute of Medicine. <sup>8</sup>

Three sets of lessons for future global health initiatives from the PEPFAR are highlighted here: 1) the critical need for technical leadership, 2) the centrality of accountability at all levels of implementation, and 3) the need for better training of health work-force to meet the challenges of the future. Commentary on PEPFAR to date has focused on the specifics of the program (issues relate to HIV prevention, the bilateral nature of PEPFAR, and the review of medicines by stringent regulatory authorities). Less has been said about the broader implications of the program for health diplomacy. <sup>9</sup> This analysis, while focused on broad strategic lessons for US global health initiatives now and in the

future.

## **NEED FOR TECHNICAL LEADERSHIP AT ALL LEVELS**

Health diplomacy needs technically sound leadership to bringing together the best of the public and private sector. PEPFAR was guided by decades of experience of treatment, prevention, research and care for HIV brought together with expertise in diplomacy and development. This scientific, professional and clinical leadership was enlisted both in the government and among those who were contracted to do the work. Government agencies involved with PEPFAR included panoply of US government agencies (HRSA, CDC, NIH, FDA, SAMHSA, DOS, the USTR, USAID, and DOD). This whole government approach was complimented by the mobilization of experts from US and foreign medical centers, community based organizations and professional schools. Many of these institutions had long experience in Africa and elsewhere in the developing world because of their participation in publicly funded research and development initiatives. Future health diplomacy should continue to reach out to professionals who can solve complex clinical and health systems problems, especially those from communities and countries around the globe who struggle with these challenges on a daily basis. Complex health problems confronting global health need to be addressed with the best scientific, professional, and technical leadership.

Technical leadership strengthened the diplomatic mission of PEPFAR in ways beyond provision of drugs. The global deployment of America's best: AIDS physicians, nurses, pharmacists, laboratory technicians, health information specialists, and other health professionals, largely from our academic centers and voluntary sectors has had, and will continue to have, a positive impact on the image of America abroad. In addition, the technical leadership these professionals have provided helped to grow a more sophisticated health infrastructure in developing countries where little capacity existed previously. Laboratories, teaching facilities, hospitals, clinics, supply chains and more are now in place that are, should the time come, to be used in fighting another pandemic such as influenza.

## **ACCOUNTABILITY**

Economists have analyzed the weakness of past foreign aid and agree on the need for greater accountability to improve development efforts.<sup>10</sup> The successes of PEPFAR can be

linked to the emphasis of the program on accountability at all levels of implementation. PEPFAR responded to a need in the US Congress and the Administration for a high bar of accountability if the effort was to be sustained. That bar required proof that the program worked and not simply a record of how the money was spent.

The success of global health programs is dependent on setting quantifiable and feasible goals that are tied to appropriate levels of resources. PEPFAR identified at the outset specific quantifiable objectives (for care, treatment, and prevention) with clear time lines set for their achievement. Resources were matched to those goals. PEPFAR was not designed to get at root causes of ill health or to embrace vague, however laudatory, goal. The goals of PEPFAR in law held policy and managerial staff responsible for outcomes. Lack of accountability would have been a set up for a failure that would have abandoned millions of people living with HIV who had started antiretroviral therapy. Congress enforced clear accountability by putting into place specific budget set asides for certain activities in order to insure that implementing bureaucracies would prioritize their efforts according to stated PEPFAR objectives.

Reliance on an evidence base is another critical feature of accountability. While clinical evidence of what treatment worked was available at the beginning of PEPFAR, very little information was available to guide the development of programs in less developed countries. The claim that we know "what works" in development is a bold one and, more often than not, is backed by anecdote rather than evidence. These deficiencies created difficulties for PEPFAR.

A strong evidence base supported recommended that an antiretroviral regimen consisting of three drugs from different classes over other treatment regimes, e.g., two drugs from the same class. There is not, however, parallel evidence base to guide many of the decisions that had to be made in a PEPFAR. There were no studies, for example, that could guide a decision if PEPFAR's provision of antiretrovirals to teachers would have been a better way of sustaining educational systems in Africa than using those resources to train more teachers to replace those would have died. (There are, of course, important ethical considerations operative here as well).

Development of such an evidence base to address these

policy questions is possible, indeed essential. The fact that many global health efforts are not grounded in scientific practice does not mean that they can't be. If we want to see improvement of health status and health systems around the world -- we must continually refine our approaches, policies, and programs through scientific research including large scale studies of implementation. The evidence base for much of development work is weak. <sup>11</sup>

## **HUMAN RESOURCE NEEDS FOR THE FUTURE**

Finally global health diplomacy faces a paucity of appropriately trained people to do the work in the future. A clear challenge encountered during implementation of PEPFAR was availability of people who understood both technical aspects of HIV/AIDS care and who also comprehended the political, social and cultural context of the countries in which the projects operate. Efforts to expand global health efforts must address this limitation. One solution is to expand education of indigenous professionals. Another is to better train the next generation of health diplomats. <sup>12</sup> Deplorable status of maternal and child health in many parts of the global will require a larger and better trained global work force. Although a boom in education for global health in the United States has been documented, <sup>13</sup> the question remains, "How effective is this training for future practitioners of global health diplomacy?" One hundred years ago a similar question was asked about the status of American medicine. The Flexner Report found a work force that was poorly trained, schools accepting candidates with little preparation, graduating doctors who had no practical experience and no contact with science. <sup>14</sup> We find today's work force deployed for global health in much the same circumstance. Few training programs have rigorous requirements for applicants that emphasize a comprehensive foundation in science that would be sufficient to qualify graduates as technical experts in the sense defined above. Nor is there a standard for global public health education that requires international experience. Clearly diplomatic, cultural, and development talent is critical but, without scientifically sound approaches to disease prevention and management more harm than good can result

Ironically the Flexner Report that set medicine on a soaring trajectory also recommended the creation of the current model for public health education. It is time for something of the scope and weight of the Flexner report on global public health that encompasses our training for, and approaches to, health diplomacy.

## **CONCLUSION**

Global health diplomacy is not new. In a 2007 Dr. Margaret Chen, the Director General of WHO noted that "International health diplomacy dates back to at least 1851, when European diplomats and physicians met in Paris to seek collaborative ways to secure their populations and commercial interests against repeated visitations of pestilence." <sup>15</sup> What is new is the scope and scale of challenge on which global health is currently being pursued.

### **Box 2**

Global diplomacy must have technical leadership to play a broker's role in a way that brings the talents and experience of relevant government agencies and, the private sector. We will need to approach our work with greater accountability -- with recognition that we do not have all the answers in hand and will need study and science to guide our way. Finally, we need a new, larger and better trained work force to meet the challenges of the future.

Neither is PEPFAR unique in its accomplishments and lessons. Through a well focused program with excellent technical leadership and strong accountability, Bangladesh was able to dramatically decrease child mortality. <sup>16</sup> The program worked through successive rounds of evaluation -- evidence on which programs were refocused. The program had strong technical leadership at all levels. The Bangladesh experience also met limitations in appropriately trained human resources which have led to the creation of a new school of public health to meet the needs to health and development in that country and the region. These lessons broadly mirror those of PEPFAR. A formula for the success of future global health diplomacy will emerge from thoughtful study of programs that work to save lives and prevent diseases.

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