Aidspan
Independent observer of the Global Fund

AN INTERVIEW WITH JESSE BOARDMAN BUMP

Jesse B. Bump is one of Aidspan's newest Board members, a role he combines with that of being Executive Director of the Takemi Program in International Health, Lecturer on Global Health Policy in the Department of Global Health and Population at the Harvard T.H. Chan School of Public Health, and a Member of the Bergen Center for Ethics and Priority Setting at the University of Bergen. He holds an Artium Baccalaureatum (AB) in Astronomy and History from Amherst College, a doctorate (PhD) in the History of Science, Medicine, and Technology from Johns Hopkins University, and a Master of Public Health (MPH) from Harvard University.

Jesse, what gets you out of bed in the morning (other than coffee)?

In high school and throughout college I was always fascinated with science, research, academia and anything that attracted an enquiring mind. I was really interested in the order of the world—both natural and social. I studied physics at first and then switched to astronomy (which is applied physics), because I wanted to understand the formation of the universe and the rules that govern its movement. I also studied history, because I wanted to understand why wealth, power, and opportunity were distributed so unequally. On the astronomy side there were a lot of convincing answers, but on the history side there was only partial explanation, and not much that seemed fair or reasonable. The inequality was wrong to me, so I took these personal interests and began asking how knowledge develops and how can it be used for development and, as a logical progression, for health?

I grew up in rural Vermont and have always been interested in justice and its violations in slavery, colonialism, and other major processes of extraction. From this I became interested more specifically in health, reasoning that in health it is ethically safer to presume that most people want more of it. In many areas of development, people have to decide for themselves what they want, as in whether to have fishing

grounds or a power plant. I wouldn't guess which one people want. But, regarding health, say someone has malaria, you can presume they want treatment, and if people are at at risk of malaria then they want prevention.

So, this led you to global health: tell us about your research

The overarching aim of my research is to analyze the evolution of ideas and institutions that promote better societal performance in health. I've been looking at the unique opportunities to build health systems and advance social protections that come about during and after widespread disruption by infectious disease epidemics, colonial extraction, conflict, industrialization, globalization, and other processes. I use historical and political economy perspectives to investigate how and when societies develop ways to understand and manage the largest threats to lives and livelihoods. The research straddles many disciplines and leverages in-depth historical research with social science theories and methods to produce strategies for the present and future. This connects to my work in ethics on many levels. So many of the problems we see in low- and middle-income countries were caused by colonialism and the core drivers have never been addressed.

And from the global to the national level?

Well, at the national level we look at how governments, citizens, and the private sector organize themselves around health objectives, including environmental protection, epidemic responses, disease surveillance, universal health coverage, and related public health institutions. And, going back to the global level, I've looked at the development of international organizations, analysed their political economy, and tried to advance the struggle to make them more fair, more accountable, and more effective. I've collaborated with leading institutions to address some of the most significant issues in global health, including designing more equitable methods for setting priorities and allocating resources, developing strategies for managing the political economy of health reform, and navigating the politics of building institutions for public health. I've been fortunate enough to work on some really exciting research projects which have generated solutions in many focused areas as well, such as tobacco control, diarrheal diseases, onchocerciasis, congenital syphilis, and nutrition governance.

How did you find yourself on Aidspan's Board?

Three or four years ago some of my collegues in Geneva nominated me for the Board: and, I have to say, I've really enjoyed it. Aidspan provides information, analysis, training and capacity development to help governments and other stakeholders get the most out of the Global Fund. I appreciate Aidspan's analytical orientation and I value its culture. Aidspan is based in Kenya and is led and managed by Africans. The location and the leadership help connect Aidspan to the experiences and perspectives of the countries that the Global Fund supports, which enhance our effectiveness and our legitimacy. Overall, Aidspan provides a critical public service in promoting more transparent, more effective governance for health.

As a result of COVID-19, Aidspan has lost one of its key donors…

Yes, the immediate impact of COVID-19 is not yet clear but, for sure, we will see a variation in donor willingness to support external activities given that even donor countries' economies have been affected by the pandemic. Aidspan has to date been very successful in attracting funding but COVID-19 means donors are squeezed…

The economic environment is now ‘deflationary’ (note from Arlette: higher taxes and lower spending) and of course this influences donors. But I’m confident that if Aidspan continues to perform well we’ll be able to bridge the deficit.

How do we finance aid for development?

Currently the global health sector is funded mainly through two sources: charity-based ones such as donor agencies and large NGOs, and commercially-motivated initiatives linked to products or markets. The private sector often wants to finance global health as an important way of protecting their interests or selling products. A large share of these sources comes through the Global Fund and since both are connected to the same economic pressures they will always be vulnerable to variation. This way of funding is unpredictable and unsustainable. We need a more permanent solution based on firness and redistribution, not optional charity or commercial self-interest.

Taxes are one way, of course ? at least at the national level, to fund one’s own health system as well as support one’s country’s international health development efforts.

Could you reflect on domestic resource mobilization, global health security, or other ideas now prominent?

‘Domestic resource mobilization’ (DRM) is the term for the money donors want countries to contribute to projects. It raises a lot of questions for me. At face value DRM means ordinary national level revenue collection, or more plainly, taxation of some kind. That is at the core of modern states—citizens agree to some taxes and states provide various services, including some in health. There is no obvious role for donors in that relationship until citizens and their governments agree that they want some consultation. But what DRM seems to be in practice is a way for donors to get countries to pay for what donors want. I think that is really problematic. Similarly, global health security is a term that donors have used to emphasize a narrow part of public health related to infectious disease. I know it usually comes with broad language, but it focuses on infectious disease detections and surveillance from a donor perspective rather than on public health from a citizen’s perspective. The bedrock of water, sewerage, sanitation, and the taxation relationships I just mentioned are not prominent even thought that is where all rich countries began their own public health progress. Instead of advancing that basic proposition for sustainable progress in public health, many global health ideas actually pervert the citizen-state relationship by asserting the priorities of outsiders and redirecting national tax revenues toward things citizens have not explicitly engaged with.

Thank you for this, Jesse, as I know that it is an area that Aidspan wants to cover in more depth, especially given the impact of the COVID-19 pandemic on DRM.

And for Aidspan’s future?

COVID-19 has opened a discussion on the new pandemics. Will it (COVID-19) go away? Will there be more? Aidspan’s future is tied to that of the Global Fund; the Global Fund must now consider how it sets its own priorities. It has had three diseases since the beginning, but COVID-19 shows that we need some flexibility. It would require a global discussion, but you could imagine people suggesting the top five diseases as measured by mortality, or maybe including emerging threats. We know that non-communicable disease are the largest causes of death in many countries, and increasing still. And there are other, new threats that may mean a shift in global health. Will this change the Global Fund’s direction? if this happens, Aidspan’s mission would have to change as well, and in the meantime it’s a topic we can advance with our stakeholders.

As things stand and for the foreseeable future, the world will still need health advocacy, capacity building, policy analysis, information and research, and guidance: this will NOT change and, as long as this is the

case, there will always be international efforts to support these needs. Once countries become fully autonomous, they won’t need help anymore and there’ll be no need for the Global Fund.

Aidspan’s future lies in continuing analytical and capacity building functions as before ? but maybe not for the same diseases.

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