The Best Health for the Most People for the Least Cost

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ABSTRACT

This article: (1) summarizes the accomplishments of the Center for Global Public Health (CGPH) at the Brown University School of Public Health, with a focus on the Center's work over the first decade following the School of Public Health's accreditation (2013–2023); and (2) provides a vision for the Center's future. Select research studies are highlighted throughout the article as examples of the Center's approaches to public health leadership and global partnerships.

KEYWORDS: Global health; low- and middle-income countries (LMICs); HIV; non-communicable diseases

INTRODUCTION

The Center for Global Public Health (CGPH) was founded in 1988 (then called the International Health Institute, IHI) to serve as a hub for Brown's international health initiatives, with a focus on strengthening faculty and student's global involvement. The goal was (and continues to be) to improve health in low- and middle-income countries (LMICs) through interdisciplinary research and training. The Center fosters research collaborations with institutions in the Global South, and provides supervised research opportunities for students at the undergraduate, master's, and doctoral level. The renaming to the Center for Global Public Health in 2025 signifies a broadened commitment to tackling complex global health issues through partnerships and innovation. The Center now integrates faculty, students, and staff from across the School of Public Health's four departments. Stephen McGarvey, PhD, was director of the Center from to 1999 to 2021, Mark Lurie, PhD, was director from 2021 to 2024, and the author has been the Center's director since 2024. This article showcases the scientific contributions by CGPH members over the past decade, illustrating how the Center works to achieve the best health, for the most people, for the least cost.

THE BEST HEALTH IN CONTEXT

Comprised of 18 faculty, the CGPH has led hundreds of studies testing epidemiological, behavioral, and socioeconomic interventions for and with populations at greatest risk. CGPH directs collaborative research, including identifying influences on adiposity and cardiometabolic phenotypes among Pacific Islanders,[1] determining migration-related risk factors for HIV-1 infection in Sub-Saharan Africa,[2,3] understanding factors shaping the utilization of antenatal care in African women,[4] and quantifying impacts of national health financing programs for low-income households in Latin America.[5] This and other cutting-edge work is possible due to the unique, long-standing partnership between the Center and non-US institutions. CGPH faculty work with more than 17 research partners in 13 countries (e.g., Kenya, South Africa, Mexico, Samoa, Ghana, Ecuador), and has over $10 million in annual funding for global health-related research.

Understanding disease spread in context

CGPH strives to help move beyond solely the biology of diseases like HIV and TB, and show how factors like migration,[6] gender, and social networks influence disease transmission.[7] The research provides comprehensive analyses of why HIV-infection rates remain so high among key populations. Work by previous CGPH Director Mark Lurie, for example, examined the role of migration in the spread of two diseases nearly 100 years apart: tuberculosis following the discovery of gold in 1886 and HIV in the early 1990s.[6] Both cases found poor living and working conditions led to highly efficient transmission "hot-spots" of these diseases in South Africa when male migrant workers returned back to their rural homes. Other research by Dr. Lurie and CGPH faculty describes the syndemic effects of HIV, high fertility, gender inequality, and poor mental health contributing to sustained, high HIV-incidence among young women in Southern Africa, even as other groups' experience declined.[7] It argues that interventions must address these larger issues to be effective; focusing solely on individual choices and behaviors is not enough to achieve health gains at the population level.

Tailored interventions

CGPH improves public health strategies through better-targeted health interventions in LMICs, especially in regions like Sub-Saharan Africa, where social and cultural factors play a critical role in infectious disease dynamics. CGPH studies focus on groups facing the highest health risks and least access to care, including migrants, youth,[8] and sex workers.[9] The Center's research emphasizes health

programs and health interventions that cater to these groups. CGPH faculty apply rigorous methods and evidence-based frameworks to ensure interventions for these groups are population- and context-specific. Such approaches have applied the Assessment, Decision, Administration, Production, Topical Experts–Integration, Training, and Testing (ADAPT-ITT) framework to adapt and integrate entrepreneurship curriculum with a reproductive health-education platform to improve economic opportunity and reproductive health outcomes for indigenous adolescents in Ecuador,[10] and human-centered design processes to develop and tailor mobile mental-health tools to deliver evidence-based depression treatment in primary care in India.[11] Developing tailored and person-centered interventions enables evaluation not only of their effectiveness, but also their longer-term sustainability within the populations they are meant to serve. The work has directly informed public health programs aimed at reducing the impact of infectious and non-infectious disease at the national level, in Sub-Saharan Africa, Latin America and elsewhere.

Strengthening public health through medical expertise

The Center integrates clinical and medical expertise with public health practice; over a quarter of CGPH faculty are certified medical practitioners, with training in emergency medicine, surgery, clinical psychology, clinical psychiatry, and dentistry. Medically-trained faculty in the Center apply a population-level perspective to ensure public health strategies address individual care needs and simultaneously promote the greatest good for the most people. Examples of this work include partnering with the World Health Organization (WHO) to develop, implement, and evaluate technology-mediated education programs for dental workforce training,[12] and testing mobile phone-based surveillance systems in Ethiopia to assess community focal points to monitor cases of unaccompanied and separated children during humanitarian crises.[13] By integrating the two disciplines—public health and clinical care—the Center transforms clinical insights into scalable solutions that have a population-level reach.

FOR THE MOST PEOPLE

Another key area for CGPH is the use of mixed-methods to evaluate on-the-ground effectiveness of interventions to guide implementation, dissemination and scale-up. The Center has a large focus on implementation science and culturally-tailored interventions, aiming to reduce health disparities while serving sexual and racial/ethnic minorities in partner communities.

Implementation science

Uncovering genetic and epidemiological patterns is just the first step. It is important to move forward to implementation studies.[14] CGHP faculty and students implement culturally-adapted interventions to assess whether nurses and community health workers, for example, can help low-income individuals in high-prevalence countries better manage their diabetes.[15] Such differentiated-care models do not rely on doctors or expensive specialists; instead, they use community-trained workers and culturally-appropriate materials, making it more accessible and practical in resource-limited settings. That means resources can be made available where they are most needed and most effective. Many CGPH faculty are implementation science experts, and use implementation science frameworks and theory to guide each step of their research.

The same rationale underpins task-shifting approaches (i.e., rational redistribution of tasks among workforce teams) for improving access to care for HIV and comorbidities. For instance, as people with HIV are living longer due to wider access to antiretroviral therapy in Sub-Saharan Africa and elsewhere, they are now affected by cardiovascular, metabolic, and other non-communicable diseases. CGPH research shows that coinfection of HIV and hypertension will continue to increase in South Africa and Kenya for the next several years,[16] that integrated care for HIV and cardiovascular disease is effective,[17] and that the budget impact of integrated HIV/cardiovascular disease care is modest.[18]

Cultural context matters

CGPH researchers apply theory-based models, usually developed from Western research, to different LMIC contexts.[19] Although some parts of these models may hold true across regions, cultural factors like family-oriented values and an emphasis on social conformity may shape the impacts of reduced health and how people cope with it. CGPH faculty have expertise in systematically adapting theory-informed interventions so that they have the greatest impact for target populations, including adapting trauma-informed mental health interventions for youth affected by armed conflict in Colombia,[20] or programs focusing on entrepreneurial skills and sexuality education for indigenous youth in Ecuador.[21] This work highlights the importance of adapting social science theories and interventions to fit the specific cultural context of a community.

Need to address stigma and discrimination

Using qualitative approaches, CGPH research offers new models for understanding how stigma and discrimination are experienced and how they impact the psychological and behavioral health diverse populations.[22,23] By identifying key themes like family-prioritization and the use of concealment as a coping strategy, the research provides a solid example for how to create culturally-relevant interventions to improve health outcomes for specific communities.

FOR THE LEAST COST

Another important area of CGPH in the last decade has been the combination of microsimulation modeling[24] with economic evaluation to demonstrate how effective

interventions can also be cost-effective or even cost-saving in the long run. This workstream is guided by the goal of policy relevance. For example, in Mexico, after showing via a randomized controlled trial (RCT) that male sex workers exhibit a high incidence of HIV acquisition (5.2 per 100 person-years),[25] CGPH research showed that incentive-based interventions were not only effective for increasing PrEP adherence among male sex workers at high HIV risk,[9] but were also cost-effective for the national health system[26] in the short-term when compared to Mexico's willingness to pay for HIV-prevention services.

Health systems with limited resources are having to address the growing burden of non-communicable diseases among persons living with HIV in the Global South. To inform feasible approaches, the Center has led intensive modeling exercises to estimate the longer-term cost and budget impact of integrating and scaling up chronic disease management services within HIV-care programs, like those in Kenya, for both cardiovascular diseases[27] and mental health disorders.[28] Findings from this work suggest, scaling layered CVD services could offer 12% cost savings to county healthcare budgets, while reaching WHO Mental Health Action Plan targets would require 3% more of current health budgets.

To achieve long-term health gains in low-resource settings, interventions must be sustainable and, ideally, self-financing. CGPH research in Bangladesh has shown that access to microcredit can increase formal healthcare utilization and reduce catastrophic health expenditures.[29] Similarly, microfinance groups, where members save and lend their own money, can serve as a platform for chronic disease care delivery; our faculty have rigorously tested this approach via a cluster RCT and found group-level microfinance to be effective for improving viral suppression and retention in care among persons with HIV in rural Kenya.[30-32]

THE FUTURE

The past decade of CGPH has helped shape our understanding of how metabolic, infectious, and non-communicable diseases affect diverse populations, and how public health researchers and clinicians can help mitigate these effects on a national[33,34] and global scale.[35] Looking forward, the Center will continue to focus on the health and socioeconomic needs of the most health-disadvantaged populations in the Global South, strengthening its existing partnerships and creating new ones. The Center will expand its interdisciplinary programs for training both faculty and the next generation of early-career scientists. Key focus areas will include: (1) using implementation science to increase access to both oral and injectable long-acting pre-exposure prophylaxis (PrEP) for HIV prevention, (2) quantifying the health and economic impact(s) of integrating NCD services for aging populations living with HIV in settings outside East Africa, and (3) using modeling and quasi-experimental methods to evaluate impacts of changes in national health policies and foreign aid spending. With this agenda, the Center will respond to the latest research priorities,[36-38] increasing its impact through a focus on health equity in the Global South.[39]

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Disclosure

The author asserts no conflicts of interest.

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