"Public health is a political problem": Amanda McClelland of Resolve to Save Lives on enlisting government investments, partnerships, and systems thinking"

Lissa Harris
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Lissa Harris: Would you please introduce yourself and talk about your organization, the problem you're addressing, and how you're tackling it?

Amanda McClelland: My name's Amanda McClelland. I am the senior vice president of the Prevent Epidemics team at an international NGO called Resolve to Save Lives. Our team tries to ensure every country has a robust public health system that finds and controls outbreaks before they become large epidemics and pandemics.

We started this work pre-COVID, so we were one of the few teams in the space who used to talk about not *if*, but *when* a pandemic happened. We were almost three years old when the [COVID-19] pandemic began. That took two to three years in terms of working through the pandemic with several countries, and now we're back in the preparedness space, supporting countries to build stronger health systems.

Lissa Harris: Could talk about your audiences? Who do you speak with the most, and how do you engage them? How do you raise their attention and communicate with them?

Amanda McClelland: We take a systems view and actively link internal knowledge with external sources, avoid empty jargon and ensure that "buzzwords" are backed by meaningful actions. We try to talk up and work at the global level where our main counterparts are the big influential organizations. The World Health Organization (WHO) sets the normative guidance, and we work with them in translating the lessons we're learning on the ground, and what it means for global norm-setting.

We work with the World Bank, the dollars behind the implementation. Between the World Bank and WHO, we connect the normative guidance and the money. We work with other global health agencies, the Global Fund [The Global Fund to Fight AIDS, Tuberculosis and Malaria] in particular, and the United States President's Emergency Plan For AIDS Relief (PEPFAR), because this is where the money and the standards are set.

We accompany countries on the ground and engage with ministers of health and heads of national public health institutes about why and how they should invest in preparedness. One of the biggest challenges is that everyone thinks about preparing during peacetime, but there is little peacetime. Trying to advocate for dedicated teams working on preparedness every day is an important part of our role, and then showing their added value in daily outbreaks. We play the translation role of lifting the local examples and learning up into the global work and vice versa.

We're increasingly working with frontline healthcare workers because the interface between the primary healthcare level and communities is where the action happens. If we find outbreaks, it's because a well-informed primary healthcare practitioner has identified early symptoms, worked with that individual and community to protect themselves, and let someone know there's a problem. We work at the interface between communities and primary healthcare, the national governance level, and the global normative setting level.

Lissa Harris: What do you think makes your approach distinct in the space?

Amanda McClelland: We tackle difficult problems that don't have immediate solutions to them. We begin by prototyping possible solutions that we then refine, test, and, if successful, scale up more broadly. We take a problem orientation without knowing the solution and a prototyping approach. No one's getting this right, no country is fully prepared, acknowledging that has allowed us to think about this problem based on positive deviance studies. We looked at who's

doing it right and where and how do we amplify that. We have an advocacy package called [Epidemics That Didn't Happen](#) because no one gets to see when we're successful, nothing happens when we do a good job. What does it look like when it happens well?

A combination of systems thinking and design thinking has helped us take a zoomed-in, zoomed-out approach to understand the overall architecture. COVID-19 is a good example. It affects every aspect of our lives, from the health system to economics, travel, tourism, and the supply chain. We zoom out and understand the environment in which epidemics are occurring, and acknowledge that they're a health risk, but they're social and political crises. Thinking about the risks within that context makes us different. Then we zoom down into granular problems that are solvable. Our approach in terms of zooming in and zooming out, helps us to find implementable and scalable solutions to wicked challenges.

Lissa Harris: Talking about problems with no obvious solution, I can see the parallels between pandemic preparedness and child sexual violence as an epidemiological phenomenon, as a broader phenomenon of a problem in public health.

Amanda McClelland: Yes, it's interesting. I first came across positive deviance in nutrition, and my understanding is it came from an organization called Save the Children which was trying to address childhood malnutrition. It's worth looking at positive deviance, but it's then taking and understanding the root causes of why that worked and being able to contextualize and generalize it. Using positive deviance is a spark of a reason or an idea, but make sure that you are using several different tools and approaches to understand why and how it works in that context, and how transferable it is. In our case, we ask ourselves, is it for every disease and every context?

In public health, we are good at looking at what went wrong after big outbreaks like COVID-19 and Ebola. What we didn't have was the counterbalance and connecting that when we get it right or wrong, it's the same thing. We created a new approach called 7-1-7, probably our biggest success. It took us several years of iteration to get there, but it's now been declared a global goal for outbreaks.

With Ebola, we missed the first cases for several weeks. By the time we knew it was there, it was already too big, it spread out to three countries, and it was hard to control. The community didn't know about the disease and didn't trust the government infrastructure and the initial response. The combination of finding it late and not being able to engage the community seems to be one of the critical pieces that go wrong consistently. When we find outbreaks, it's because we find

the first case and the community trusts the health system or the government structures and engages early. That came out of positive deviance and our lessons learned work.

7-1-7 combines our systems thinking and helps countries find outbreaks in seven days; notify in one day, and respond in seven days. It uses bottleneck analysis to understand what's going wrong in the system and rapid quality improvement to address it.

Lissa Harris: Some people are much more focused on delivering the solutions that they know can work, and some people are more like, what does the community want? It's interesting to see an organization doing both at once and iterating through that.

Amanda McClelland: We're only seven years old, we have that startup Silicon Valley model, heavily influenced by people who joined the team early and knew about digital iterating, prototyping, and thinking about addressing complex problems with a disruptive model. The disruptive model of Silicon Valley breaks systems, and we are working inside fragile ones that we can't just disrupt and break. System thinking has balanced that out nicely by understanding the system and the environment we're in, and the complexities of that from a people, process, and political perspective.

One of the big learnings for us is that public health is a political problem, not just a health problem. We have multi-dimensional expertise, with a public policy political team, a team that focuses on operations and understanding of money and processes, and a technical team. Internally, we call it the TOP approach, technical, operational, and policy. It's the combination that helps us accelerate implementation, but there's a gap in implementation.

We talk a lot about translation and implementation, taking the big normative guidance, lessons, and potential solutions, translating them into what that looks like on the ground, and supporting governments to implement it. We see organizations think up good solutions but not necessarily implement them, or those who are good at their implementation but just follow the recipe book. Our team tries to do both.

Lissa Harris: Is there an example that shows the impact of the work that you do?

Amanda McClelland: Maybe the best example is the [Epidemic Ready Primary Health Care](#) project, which is close to my values. I worked in West Africa's Ebola, and during that crisis, we saw more than 500 healthcare workers die. Part of the challenge is a lack of knowledge and access to equipment to help them safely manage high-risk cases. When we first started working on COVID-19, we created a project on infection prevention control for frontline healthcare

workers to use the right protective equipment. We should be able to find outbreaks without healthcare workers dying.

We focused on the problem of how frontline healthcare workers are managing outbreaks. One of the challenges we faced during the outbreak of the COVID-19 pandemic was to know exactly what protective equipment to wear based on the disease that's walking in. If you're in a clinic every single day, you're seeing a hundred patients, you have to be able to identify that one high-risk patient and you have to decide in real time what equipment to put on and how to protect yourself. How do you know? We call it clinical suspicion.

We took a systems approach and worked with frontline healthcare workers on their workflow. How do they connect with communities and build a trusting relationship? How do they detect the initial case as it walks through the door? How do they protect themselves and their community? And how do they start treatment and maintain services during an outbreak?

We rolled out the Connect, Detect, Protect, and Treat Program within the Epidemic Ready Primary Healthcare project, in 800 facilities for the last nine months. That's built on three or four years of work and learning through the stages of COVID-19. We just got some results back in the last couple of weeks and the impact is impressive. We see big changes in behavior with nine outbreaks detected in the last few weeks within those first seven days without a healthcare worker getting infected. We're proud of the evolution from a specific problem to a systems-level, scalable implementation.

Lissa Harris: On the other end of that, we learn as much from things that don't work as things that do. Did you try something that didn't work but did teach you a lesson?

Amanda McClelland: Internally, we use an approach called fail fast. Every quarter, our teams get together and pick their biggest failures, and we analyze those and adjust. It means that we are learning from mistakes regularly, but it also means that we're not making huge mistakes because we're analyzing and pivoting along the way.

Digital transformation to public health has been a difficult nut to crack. We're hitting challenges around paying technologist's salaries. They want a lot more money than public health people are paid, and so recruiting big people hasn't worked.

Having senior leaders within public health understand the difference between IT and the guy who fixes your laptop and a technologist who's there to build the infrastructure and architecture

of the digital system has been hard. They get shifted into fixing email and IT problems rather than digital infrastructure problems.

And then there's a graveyard of piloting different digital tools. In some of the countries where we work, multiple apps are half alive, and there is a cleanup process of giving up the apps for something better. There are operational maintenance costs and the fact that those apps are often financed for a specific disease for a short time.

Lissa Harris: I love the idea of failing fast. It's making sure that when something fails, you learn why. It seems like good practice for a larger organization.

Amanda McClelland: It builds a high-trust environment internally, where teams are celebrated or rewarded for highlighting where things aren't working, instead of trying to fix it or couch it along until a project timeline of 12 months. We tell a donor that we're going to do X to Y and we just keep going and in the end, it doesn't work. We're trying to get away from that by pivoting in real-time.

The NGO sector and the way donors finance projects aren't always risk tolerant, no one wants to pay an NGO to come back if it didn't work. Working with partners who are open to trying new approaches, testing, prototyping, and working towards a solution that's the best fit rather than knowing the solution before we start has been key for us.

Lissa Harris: I'm interested in the barrier of digital transformation and the graveyard of apps. What are the other big barriers to your work that you haven't yet overcome?

Amanda McClelland: The big barriers are that we're working on complex wicked systems and we're trying to solve problems that keep moving. As you solve a problem, it elevates other problems in the system. We work inside ministries of health in low-income countries, and the pace of change is often one of the challenges, being able to quickly adapt within a government bureaucracy. With the number of outbreaks, it's hard to get dedicated time. At the moment, there's mpox and Marburg and all the preparedness work has stopped across most of Central and Sub-Saharan Africa because everyone's focused on those risks.

One of the biggest challenges underlying this is around the workforce. How do we maintain and sustain a high-quality workforce in government departments where they can get paid much more for working in the rest of the public health infrastructure, whether that be NGOs, WHO, or other partners? Working within the constraints of the under-resourced public sector that isn't built for retaining and sustaining high-quality staff is a huge barrier to the work that we're doing.

Lissa Harris: There's some parallel here with child sexual violence. Some people have talked about emerging technology and how things like artificial intelligence, child sexual assault material, and different digital phenomena that are cropping up are changing the landscape so fast that it is hard for governments and legislation to keep up.

Amanda McClelland: Everyone's looking for that silver bullet that's going to fix these problems. In our space, it's genomic sequencing. It's wastewater surveillance, this idea that you can take the people out of the problem, and find the diseases by measuring the sewer system or blood samples testing. We see the financing in particular, but the momentum moves to the bright shiny things, the new innovative technologies.

The positive deviance work that we talked about earlier shows us that it's the basics that make or break the ability to detect outbreaks; the well-trained, well-resourced primary healthcare clinic with the right equipment and a phone to call for help, and the trust of a community.

Lissa Harris: Is shifting cultural norms part of your work? And if so, what are the most effective strategies you use to shift cultural views or change behaviors?

Amanda McClelland: The Personal Protective Equipment (PPE) behaviors are an interesting piece, but vaccines are probably the critical ones for us. If we think more longitudinal, it wasn't so long ago, 50 or 60 years ago, that it was common in every community to see polio or measles. The introduction of vaccines was seen as a scientific advancement and saving lives and the adherence or engagement with vaccines was extremely positive. Over time, we've seen several things erode confidence in vaccines, and there are people on a spectrum from vaccine-hesitant who will never engage and take a vaccine, to vaccine compliance where people are very open to it, and everywhere in between. Several things have led to a cultural shift; misinformation driving hesitancy and a change in risk.

Even as a pediatric nurse and someone who's been in this space, I haven't seen that many measles cases, they used to be commonplace, and people used to understand the risk of not vaccinating a lot more. Whereas now, it's something that happens in other communities.

This shift in the culture of not understanding the risk we're protecting against because it's not visual to you, that's where we're starting to see clusters of measles, even in the United States, and we have polio cases even in New York.

Lissa Harris: What role do partnerships and coalitions play in your work? Who are your main partners? And what strategies do you use to cultivate those relationships?

Amanda McClelland: We take a partnership approach in everything we do. We talk about co-creating on three different levels; we partner at the local level where the work happens, and since that's a government's responsibility, we work inside the government to embed, coach, and accompany local government partners for impact. We partner with like-minded organizations doing similar work, where we can share our learnings and elevate and scale the outcomes.

We have coalitions for things that we're trying to change, the Epidemic Ready Primary Healthcare is a good example. There's a big collaboration with several NGOs and partners around highlighting the risk to healthcare workers and how to make sure they're safe. With 25 different partners, we create momentum for advocacy and policy change on specific topics.

And then, as I said, we partner at the global level, where the normative guidance and funding are because that's what makes the biggest shift; with the World Health Organization, the World Bank, and the Global Fund to ensure that we're communicating our lessons from being smaller and more nimble. We elevate the things that we see on the ground and partner with them in how to influence strategy, normative guidance, and grant-making.

Lissa Harris: What are the broad insights, the teachable lessons others can take from your work? What advice would you give to other people working on similarly intractable problems?

Amanda McClelland: The zooming-in and zooming-out is the big takeaway, understanding the system you're working in, the connected problems, and in what environment the problem is occurring. And then zoom in on specific bottlenecks, test out approaches, and create feedback loops, to know what the next problem is. Understanding that there is no silver bullet to wicked problems. It's a combination of approaches, tools, and partnerships creating a robust and responsive system that can manage the risk, rather than a solution that solves it all.

Epidemics happen in a context of social, economic, and political vulnerability. One of the key lessons for us is bringing multidisciplinary teams together for these problems, and thinking about the broader system in which the problems occur is something we continue to remind ourselves of.

Lissa Harris: How do you engage with the tech industry that, as you said, likes to break things where you can't afford to break things? And what strategies are effective to work together?

Amanda McClelland: We tackled the change management issue within digital transformation because one of the biggest barriers is governance between the data systems. We started with, what do we want the digital system to do? Rather than changing the opaque and unmanageable

plans, we're taking them in bite-sized pieces and thinking about what we want the digital system to do, and then working backward on the governance and technology issues for that problem.

It means mapping out the decisions that we need at different parts of the epidemic, understanding what data we need to make those decisions, where the data comes from within the digital infrastructure, and then fixing it. It hasn't helped us solve the challenges of getting a chief technology officer on public salary into an institution, but we can provide support from the outside and fix those problems.

Lissa Harris: How do you get the governments and larger institutions that you work with, to own the problem that you are working on? And feel like it belongs to them and act on it?

Amanda McClelland: The first one is making sure that it's their problem and that we're there as a partner to help solve it. We don't work anywhere we're not invited. We work with countries constantly impacted by epidemics, we talk about solving everyday problems on malaria, cholera, and measles to build capacity to prevent viruses such as COVID-19, Ebola, and Marburg. Just arriving and saying you need to get ready for the next pandemic hasn't helped when you're dealing with multiple outbreaks every day.

COVID-19 helped, although it's fading from the general population's minds and the political discourse. The public health people still feel burnout from it. We still have momentum, it's going to wane fairly quickly. How do we get politicians and financing institutions to care about this?

Showing the economic impact, not just on the health system is still an area where we can have leverage. But there are several large challenges across the world, conflict being top of mind, and hurricanes this week. It's a challenge to keep focus on these issues in the context of so many.

Lissa Harris: Do you think there's a role here for accountability measures or efforts, as well as partnerships and trying to lean into fixing the issues that the institutions care about?

Amanda McClelland: We build in that accountability by supporting the pandemic treaty and new global governance on how countries should collaborate. Underneath that, from that regulatory perspective, reinforcing the international health regulations. As those pieces of regulation get negotiated, they get weakened by governments who worry about accountability.

[7-1-7 is our attempt to create simple and understandable targets that civil society can use to hold governments to account](). We're missing a civil society constituency, in the same way that HIV or other big health challenges have. How do you mobilize a civil society group of

organizations that care about all diseases, not just one disease? We're working on it with several grassroots organizations on two levels; setting clear targets, with accountability metrics, and from a budget perspective, where governments have committed to funding post-COVID work, making sure there's accountability the money gets spent.

Lissa Harris: These issues are interrelated. Somebody I spoke to told me there was a pilot project with good evidence for cash payments being made to families as a factor in dramatically reducing economic motivated transactional sex that young people were having. Or in places of severe drought, the rates of sexual violence go up. It seems relevant to pandemic conditions because you're seeing more risks erupt out of conflict.

Amanda McClelland: There's a bunch of well-documented changes in domestic violence and teenage pregnancies during Ebola in West Africa. When the lockdown protocols were in place, people were locked inside their houses with people who no longer left to go to work and didn't have the same economic access. We saw a huge spike in teenage pregnancies and the long-lasting effect that had as girls didn't return to school once schools opened.

And we saw increases in domestic violence. The impact of public health interventions on interpersonal violence and child sexual exploitation is there, but we don't deal with it enough as we're making those decisions. What does it look like in terms of stopping one problem from causing another? It would be an interesting opportunity to think about that more longitudinally.

Lissa Harris: Thank you for talking to me, this has been a great conversation.

Lissa Harris is a freelance reporter, science writer (MIT '08), and former local news entrepreneur based in upstate New York. She is currently working as a consultant on capacity-building and local solutions-oriented community projects in the rural Catskills.

**This conversation has been edited and condensed.