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PUBLIC HEALTH CONVERSATION
THE ROLE OF ACADEMIC GLOBAL HEALTH: RECKONING WITH OUR PAST, PRESENT, AND FUTURE
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>> SANDRO GALEA: Good afternoon, good evening, good morning, wherever you are. Thank you for joining us. My name is Sandro Galea. I have the privilege of serving as Dean of the Boston University School of Public Health. On behalf of our school, welcome to today's Bicknell Lecture. Our Bicknell Lecture is one of the highlights of our academic year, endowed by Dr. William Bicknell to provide, and I quote, a periodic but register infusion of iconoclasts and original thinkers who will bring ideas to students and faculty that stretch, upset, stimulate, and leave us with renewed energy and commitment.

We are here today for a conversation that I hope will stimulate us, about the past, present, and future of global health. The events of the past two weeks have brought home for us a reminder of how local the global really is. What can seem like it is happening over there is actually deeply linked to our community, to the people we see each day. It is on all of us to become better at recognizing the global as part of the world we share, at understanding that we are all connected to everything that happens, everywhere.

Reflecting the founding spirit of the lecture, this conversation aims to take a self-critical look at both strengths and shortcomings of global health enterprise. Global health has done much to create a healthier world. It has also shaped a legacy for the field that is, in part, one of colonialism, of acting without the full input of communities with whom we engage. Creating a better future for global health means reckoning with the past. Thank you for joining us today as we engage in the necessary, at times difficult, conversations that make us better as a field.

Before I introduce our moderator, a brief word about the co-sponsor of today's event, the Department of Global Health at SPH. About two years ago, faculty and staff in the department came together to establish a working group to promote fairer partnerships in global health. The group's work is done in alignment with, and in support of ongoing efforts by colleagues across the world to decolonize global health.

One of the specific objectives of the working group is to develop practice recommendations for the Department of Global Health and the school community that can guide self-study to

reflect on the power asymmetries of global health and support practices to promote fairer partnerships in keeping with our think, teach, do, mission.

This work is one example of how SPH is engaged in an ongoing basis with the discussions that we are having today in this webinar. As we work together to be ever better in our pursuit of health.

If you are interested in finding out more about the working group, or joining the group, please reach out via our website or email. We will put both in the chat.

I am pleased to introduce the moderator of today's event, Alice Lakati. Dr. Lakati is the current director of research and community extension at Amref International University, an affiliate of Amref Health Africa. She has led design and implementation of research and evaluations in multiple countries across Africa. She has served in various expert committees including the World Health Organization committee that reviewed safe water guidelines in 2005. At Amref International University, she has served in several capacities, including acting vice chancellor, and founding Dean of the School of Public Health and Graduate School. We are pleased to have Dr. Lakati with us today. She will introduce our panelists and lead today's discussion.

>> ALICE LAKATI: Thank you, Dean Galea, for that introduction. It is my pleasure to be moderating today's discussion. I am pleased to get the opportunity to speak and be part of the larger team in the world in discussing this topic about the role of academics in reckoning with global health.

So, as already said, my name is Alice. I work for Amref International University. And just before I introduce our panelists, I'm just going to spend probably two minutes to tell you something about my institution that I work for, because people from different nationalities, different regions. So, I work for a university called Amref International University. We are a very young and vast team that is focused on primary health care. And as a university, I just put this slide, and I hope that this slide is also going to challenge the conversation that you are going to have today.

So, our university is a Pan-African university that is looking at four strategic areas of focus. Even as we interrogate this topic today about the role of academic institution, as staff of university, we also need to interrogate ourselves on what we are doing in the area of global health. So, we are working on four strategic areas. That is to develop fit-for-purpose leaders for primary health care. We believe that primary health care is where the greatest change happens in our communities, especially here in Africa.

The other objective we are looking at is being able to drive evidence that really advises our local primary health care systems, and that really speaks into what this discussion is about today.

And as a university, as I come to the end of my slides, we are running the first Primary Health Care Congress this year, from 29th November to 1st December. In this Congress, we want to interrogate whether in our settings in Africa, primary health care is really advised by evidence. So, join us in this Congress.

I want us now to come to our topic for today, which is The Role of Academic Global Health: Reckoning with our Past, Present, and Future. So, we are going to really interrogate and

listen to rich conversations from experts from different regions. And I really want to thank the school for putting this panel that has experts from Africa, so we are going to listen to experience from Uganda; we are going to listen to people from Europe; and we are going to also listen from Canada, South America. And I want to believe that after this discussion, we would really be challenged, we would be disturbed, we would be excited to ask ourselves, how is the future going to be like? Is it possible to decolonize global health?

So, to address this topic today, I want to introduce our panelists. And I'm going to pull down my slides so that you can see our panelists. So, our first panelist today is going to be Tammam Aloudat. Dr. Aloudat has served as President of the Board of Medecins Sans Frontieres. That is Doctors Without Borders in the Netherlands. He is a medical doctor who has worked in multiple humanitarian and global health organizations with over 20 years' experience. He has also done international assignments for the Red Cross in Iraq, Haiti, Zimbabwe, Libya, Tunisia, among others. And during his time working with the Doctors Without Borders, he has served in Turkiye, Syria, and Yemen. So, that is going to be our first presenter for today.

We will also have the bluer of listening to -- and we hope that he is going to join us, Blessing Mberu. Blessing Mberu is a Senior Research Scientist and the Head of the Population Dynamics and Urbanization at African Population Health Research Center. And I'm glad to say, this center is actually headquartered in Nairobi. Dr. Mberu works on migration, urbanization, urban livelihood and urban health in sub-Saharan Africa. He holds a PhD and Master of Arts degrees in Sociology from Brown University in USA and a MSC from University of Ibadan in Nigeria. Quite a rich experience.

We will also have the pleasure of listening to Annettee Nakimuli. Professor Nakimuli is the Dean of the School of Medicine at Makerere University in Uganda. She is a prefecture Chair of the Department of Obstetrics and Gynecology at Makerere University and is also a leading maternal and child -- maternal health researcher. She is clinically active as an obstetrician.

We are also going to have the privilege of listening to Dorina Onoya. Dr. Onoya serves as a Principal Researcher of Epidemiology at the Health Economics and Epidemiology Research Office. She joined HERO in August 2014 as a Senior Researcher and has 13 years of experience in HIV/AIDS, researching infectious diseases, epidemiology and HIV/AIDS intervention research. Dr. Onoya holds a BSC degree in Medical Biochemistry from the University of Witwatersrand, an MPH in Epidemiology from the University of Cape Town and a PhD in public health from Maastricht University. We will be honored to listen to her.

We also have the privilege of listening from Madhukar Pai. Professor Pai is a Canada Research Chair in Epidemiology and Global Health at McGill University, Montreal. He is also an Associate Director of the McGill International Tuberculosis Centre. He also serves on the WHO Strategic and Technical Advisory Group for TB in the Southeast Asia Region and the WHO Advisory Group on Tuberculosis Diagnostics and Laboratory. He is a member of the Scientific Advisory Committee of FIND, Geneva. He serves as the Chair of the Public-Private Mix Working Group of the Stop TB Partnership and serves on the editorial boards of Lancet as well as BMJ, PLoS, and Global Health.

And finally, we also have the privilege of hearing from Jeanette Vega. Dr. Vega is the Chief Medical and Innovation

Officer at Red de Salud UC-Christus. That is the main private health provider in Chile. She started her career as a medical doctor in Chile specializing in family medicine. She has a master's degree in Public Health from the University of Chile, and a PhD day in Public Health from the University of Illinois, Chicago. Dr. Vega has over 20 years of experience in international health with expertise in social determinants of health, health equity, and health systems.

So, colleagues, we have a very experienced panel that we are going to listen to today. And we hope that after this, we are going to be challenged as we dig into this conversation. So, I take this opportunity and the honor to welcome Dr. Tammam to speak. Over to you, Dr. Tammam.

>> TAMMAM ALOUDAT: Thank you very much. Thank you for the introduction and for the opportunity to speak today. I am very grateful for that. I will give you my first caveats of a recent experience. I have been asked to write a chapter in a book on depoliticizing AIDS recently, by brilliant editors, and the request was to write what they called a practitioner piece. And I found that fascinating because the instructions were don't go too much into theoretical stuff. Give us like examples from reality. And I found that fascinating, because I couldn't really figure out where the practitioner part and the knowledge part, where one ends and one starts. So, forgive me for not being very good at that separation. But I come here from a perspective of practitioner, actually. It annoyed me in the beginning, then I thought, I owned that. This is not a bad place to be.

So, in talking about global health, I first have to also give an acknowledgment, because I realize in our eagerness to progress, we have allowed ourselves to take the good out while we talk about the questionable and problematic. So, we can stop for a moment and talk about the fact that we have measles reduction nearly complete for the first 15 years of the century. Now, it has broken out again multiple times, but there has been significant programmatic changes. The EPI -- the extended program for immunization. There have been political health moves that have saved lives and made a real difference.

But it is out of that eagerness that one has to question a few things. And I have a year ago, about a year ago, published a paper whereby my question was, is, having looked at the last 30 years of global health big promises, is global health failing at doing what it promises, health for all, three by five, vaccines for all, and so on and so on, or is it succeeding as something else? And I felt that assuming that it is an all-benevolent discipline, whether the practice of global health, its governance, or its academic, my view is guided, and the argument is, there are people who benefit. We have a lot of us who gain a living out of having global health expertise, as ambiguous as this is. There are governments and organizations and companies that make their existence dependent on having a discipline that is quite expensive as well as filled with highly practiced and experienced and paid people.

So, what are we criticizing here. If we move from the global health as a discipline towards academia, I would argue that I have a few problems. And one of them starts by the positionality of global health academia. Even when we have managed to move from an entirely western or Global North-based academia that goes into an understanding from that perspective into universities that exist in the Global South, we have still accepted a few premises. Universities everywhere have to qualify

themselves as universities in the western description of a university, regardless to where they are.

We have to start -- our starting point largely comes from an acceptance of a normative basis upon which the global health and its academia exist, that is that this is a policy discipline, that this is about a technical provision of knowledge and action and that this is positioned exclusively within a multilateral system, without which there is knowledge legitimacy policy-making.

I struggle with that, because as COVID has shown us, when that is the normative framework, most of the academia for global health ends up being confined in critiquing or pushing, or so on, policies that are not the only possible position. I'll give an example.

Massive amount of literature in global health has gone towards vaccines, towards vaccine distribution, and towards the policy issues of creating a pandemic treaty. Very little, at least in the mainstream academia, have gone to the fact that a treaty is as good as the framework that allows it. We have plenty of treaties from the International Criminal Court to the refugees treaties to the International Humanitarian Law as we see today in Palestine, that are there, that exist and are violated on a daily basis.

To put all of the effort of global health and academia in discussing policies that are, without arguing about their normative basis, that would never allow them to take place, is in itself a problematic prospect. And without accepting that there are other views of the world that do not acknowledge the multilateral system and the institutions of global health as the sole possible way of providing health equity and justice, we would be missing half the sort.

Then it comes to our methodologies. And here we have a long literature. You know, the 1999 book by Linda Tuhiwai Smith about methodologies is a good example. We are still confined by blinded peer review system that only legitimizes knowledge according to the existing knowledge. It has to be an expert that validates our knowledge or knowledge creation.

We have, Madhukar Pai here, Professor Pai is one of the two editors and Chief of BLS Global Health, and we have talked about this. There are points of knowledge that do not come from the rigid methodologies that are accepted in political science and physical science today and those have to be there or we, again, miss a big part of this story. Academia today doesn't seek the -- seeks information. We go to people and call them informants and then aggregate their knowledge in a mass of faceless, nameless data sets. We do not go and talk to people as producers of knowledge based on ways of seeing the world that is different from ours. That is a missed opportunity. Finally, epistemology in the sense of what people produce and possess knowledge that is valid and useful. And what disciplines as well.

As I mentioned rapidly that global health has become a legal political science discipline in many ways. We are talking about policy-making. We aren't talking about the position of health and health care provision as part of a social, cultural, political economy that governs people's lives. We are assuming that the policy created in Geneva or Washington, D.C., or New York, where, by the way, most of global health organizations exist, is a valid enough way of dealing with it. We're not talking about philosophical concepts that talk about justice and

injustice, positionality; we're not using feminist, critical theory, or other ways of seeing the world that do not conform with, you know, the current stethoscope of politics and economics. So, all that happens within a discipline that inherits economics from a post Keynesian discipline, that inherits (?) from PowerPoints and that inherits the art of the possible, the politics of compromise from our collective, you know, fatigue we try to change.

Is decolonizing a good argument? I think it is. We've argued -- many better people than myself argued for it and argued very well for it. I fear now, after all those years, that if we are talking about eliminating the coloniality of power, the coloniality of being in global health, we'd end up with a void, because we aren't talking about the day after, assuming that there is that happening over a day.

I wonder whether we can talk, instead of the negative, decolonizing of academic global health, and into the positive of what is an emancipatory global health that takes people's agency and desire and understanding and view of the world and makes it possible through health policies.

Now, can academia do anything about that? As a practitioner, again, if my life consists, whether I am trying to do a technical or a principled action, of looking through thousands of journal articles that are unaggregated, difficult, hard to reconcile, and do not go into a somewhere, then that removes academia from being very effective in our practice, and more so in the practice of people who have even less access to them and less of the same convoluted language that is used in academia.

Is it possible for academia to do it differently? Yes, probably. Building on each other, having a purpose that goes beyond figuring evidence in the most narrow sense that is publishable and into building on each other's towards a more explicitly political and well-defined goal that takes from the agency of people who are trying to serve might be a very good start. I will stop here. I think I took more than my eight minutes. Thank you very much for having me again.

>> ALICE LAKATI: Thank you very, very much, Tammam. That is really, wow! What a very exciting start in the challenging discussion. I hope, colleagues, that you have been challenged to ask yourselves, do the methodologies we use, do we approach our patients as producers of knowledge? I hope that those very, very many points are going to really form part of the conversations that we are going to interrogate further today.

Dr. Blessing has not joined us yet, as well as Dr. Annettee, but we are going to proceed and we are going now to have to listen to Dorina Onoya. So, we move to South Africa to listen to Dorina. Over to you, Dorina.

>> DORINA ONOYA: Thank you so much, Alice, and Dean Galea for the opportunity to participate in this panel. I have a few slides that I will speak to, so if you give me a minute, I will share my slides. So, I hope to be able to contribute thoughts to this conversation and maybe move how we think about decolonizing global health forward. Give me just a second.

>> ALICE LAKATI: We can see your slides.

>> DORINA ONOYA: Great. All right. Okay. You can see my slides?

>> ALICE LAKATI: Perfect.

>> DORINA ONOYA: Thank you so much. All right, so my name is Dorina Onoya and I am from the Health Economics and

Epidemiology Research Office based in South Africa. I was born in the DRC, but South Africa is my second home, so that's really the perspective that I will bring to this conversation.

So, I titled these slides, "What should academic global health look like ten years from now?" Which is a question that we're asked to think about. Really, what we are hoping, at least from our perspective, is what does Agenda 2033, Decolonizing Global Health, what should it be for Africa or for collaborations with Africans?

And so, from an African perspective, I think it's really important -- and our first speaker began to allude to that -- it's really important to think about global health from our history, as difficult as it is. And we know that the past was really characterized by terrible, brutal extraction of resources from Africa, being people, being materials, being minerals. This subjugation and really -- I think we don't say enough -- the destabilizing effect of these practices, and later on, really, economic and development exclusion, really impoverished the continent. There are many factors to why it is the way it is, but these are really big factors that we do need to acknowledge going forward.

Now, the impact of colonialism also led to changes in disease patterns in Africa. It's really underscored by gaps in infrastructure, in education, and further limits the possibility for economic and social upliftment. And these are not issues that have gone away yet.

Now, in South Africa, the South African inequality -- I don't know if you're familiar with this aerial photograph of Cape Town -- these inequalities, in a way, capture the racially entrenched social and development inequalities that past colonial practices engendered across Africa. However, unlike South Africa, oceans -- you know, in South Africa, oceans do not separate the Africans from the wealth that was generated by their economic exclusion. The problem of resource flight is more localized, and it's still today starkly evident.

Other African countries, on the other hand, cannot authoritatively engage, and this is a difficult process even in South Africa. Now, this process of harnessing all available resources, capacities developed, investments, both past and present, to try to address today's disparities, and that's important, because often when we talk about global health and the various initiatives, we start at ground zero, as if the situation was normal. And we forget that we're not starting at ground zero; we're starting at minus something.

And so, when we think about interventions under global health in Africa, these were driven by the interests of colonial powers. Obviously, this is known by everyone. But what we often avoid, almost, is the fact that for the Global North and European settlers in Africa, half interventions followed a more ecological perspective to health information, but for the African populations, this followed a very focused, disease-specific, a pill, an injection, a vaccine, with little consideration to the broader socioeconomic factors that underscore the conditions that were targeted.

Now, the separate development that established inequalities in health care, in housing, in education, these are based on racial lines, to an extent social status, that we're still dealing with today.

Now, research in Africa, despite all of this, is still primarily involves observational population. We study the

Africans. They are test subject. They are subject of epidemiological assessment. While most of the basic science -- and I think this is almost by design, I think -- and development part of research and development are mainly retained in other countries. For me, the question really is, given that we're dealing with diseases and conditions that are largely in Africa and other low and middle-income settings, why is the R&D continue and not located in Africa or in the affected countries?

And the question that I think we need to consider here is who's driving the research agenda? Who decides what we look at? How does it fit within our broader realities? What is the contribution of African researchers in this work and also in changing strategies in a way that really benefits us? And so, for me, part of this talk, not just -- it's not an Africa to the Global North conversation, but also an introspection for Africans and those of us who are working in this space and what it is that we want and what it is that we want to see in ten years.

Is there goodwill in global health research? Definitely. I think we've seen a lot of changes. And really, in the people, in the institutions that are involved, I think do this from an altruistic perspective, and that should be acknowledged, and this is demonstrated by this talk, this conversation that we're having.

However, to positively shape the future, we -- Africans, I think -- have to define what global health collaboration success means for us. What is success? Is it manuscripts? Is it citations? Is it academic capacity development for its own sake? Are we saving lives by vaccinating them with one thing and leaving them in squalor? Are we improving their quality of life?

So far, the transition from what was called tropical medicine to global health really continued with colonial vertical, campaign-style strategies to combat and eliminate specific diseases. Our definition of success and quality of life should follow what we consider as acceptable minimum living conditions for an African life.

And so, thinking about Global Health Agenda 2033, what do we want? Might seem aspirational, but really, if you want to change the dynamics of what global health is, these are the changes that we need to see or we need to be moving towards.

The health issues that primarily affect Africans, it doesn't make sense for the research and development component of it to be done elsewhere, so that solution can be brought to us. We need to work towards strengthening and locating the development effort within the African context. That's important because that will drive the next wave of innovations, the way the innovations are brought about, and how they are implemented. We need to intentionally leverage. There are institutes in Africa where this work can be done. And strengthen local capacity for innovation development to overcome our current challenges.

PhDs are obviously not everything there is to capacity development or improving our abilities to what we can do for ourselves, but you need PhDs to increase research outputs, research outputs that are targeted and focused on what are the problems on the continent. While there is increasing effort to improve the opportunities and capacities of African researchers to conduct and lead independent research, these need to be geared towards addressing not just the personal, not just the pill or the injection, but also the societal and developmental

issues that drive disease outbreaks. Okay.

And so, a lot of the time when we're thinking health research, we really focus on the disease, but we need to get our heads out of the sand in a way, so to speak. Because while economic determinants of health and social determinants of health are often seen as the responsibilities of the governments of the countries, we need to -- our interventions need to be focused, unless they could have unintended consequences, if these become human rights are not addressed. So, addressing structural determinants require multisectoral partnerships between governments and researchers and universities to drive the changes that we need. And we need to develop innovations that really overcome challenges in eradicating poverty and reducing income inequalities, dealing with how to best deliver quality education on health care, living conditions, food security, because these are still part of the health promotion continuum.

And lastly, it's important to consider parallel advocacy, because what we see are policies and guidelines that are developed elsewhere, and then the advocacy is how to make sure that the African countries adopt them and improve on the implementation process for how they are adopted. But really, for me, I think we need to consider parallel advocacy with us, Africans, working with our principles to deal with governance and accountability, and we can own that. But our global partners need to work with their principles to improve their trade, global economic practices, things that affect health, things that continue to undermine health. And this will lead us to a place where we can sustainably take care of the health challenges in Africa, beyond aid, really. We need to encourage open conversations about strategy development. Because even now, the vast majority of funding for global health and the campaigns and the research is still international. What this means is that, often, Africans struggle to identify their leverage. Exactly what do we contribute? What are the contributions that we bring? And the weight of their contributions in these exchanges.

And as a result, most refrain to engage in conversations about this, about the disparities, and potentially, zero-sum nature of our engagement and collaborations. And those who speak out really most worry about being labeled as difficult, as problematic, worry about further economic exclusion, in a landscape that really is still unbalanced. And so, I think those are important contextual issues to think about, in thinking about global health efforts going forward.

So, ongoing efforts really should focus on continuously assessing and reassessing our programs, our projects, and practices for colonial biases. These are insidiously ingrained and manifest on different levels. They're not, in my opinion, always intentional, but they do filter through. And so, it's important to be intentional about dealing with them.

And our partnerships should be based on mutual respect. And really, we need to check our motivations for participating and focus on doing global health for truly charitable purposes on both sides. It's important to continue to Promote South-south collaborations and it's important to reduce dependencies. We need to holistically address shared health and developmental challenges within the African context. I think that's important. There's lots of shared learning that can help move our programs forward.

And so, ultimately, for me, when we think about academic global health for 2033, or ten years from 2023, it's really about shaping partnerships in a way that is designed to truly improve health for all, and health in its full definition, not just, "I was vaccinated for X." And with that, thank you so much for the opportunity to speak. I look forward to the discussions.

>> ALICE LAKATI: Championing partnerships. Thank you very much, Dorina, for that exciting presentation, and actually giving us a different perspective from a LMIC, or a developing country, that the challenges are actually quite different. But I note that there are actually similarities in the two presenters. And if you look at some of the things Dorina has brought about, and the previous presenter, we can see that the partnerships, the need to decolonize global health really is very clear.

So, we are going to move to the next presenter. That is Professor Pai. Professor Pai, I hope you're ready, and I want to hand over the mic to you. Feel most welcome, take it up. And I note the questions on the chart. I want to request the audience, we shall have the opportunity to interrogate, to also have the panelists respond to these questions. Over to you, Pai.

>> MADHUKAR PAI: Thank you, Alice. And thank you for the opportunity. It's amazing to see more than 300 people here on this Zoom call. I want to begin by acknowledging that even though I was born and raised in India, where I did all my medical training, I lived in a small town in South India for 30 years of my life. I do recognize that I am now in Canada. I am now a full professor in the Global North. And I'm very aware of the power and privilege that it confers me. And I see that one of my roles as being a, quote/unquote, double agent in global health -- somebody who's seen it from the south and now is based in the north -- it's hard not to see the serious power asymmetries that some of our panelists have already spoken about. And I tried to kind of summarize all the data that is on these power asymmetries in one graphic, and that's what you're seeing on the screen.

What I mean by this is, without careful, intentional work -- I mean, this panel is a beautiful example. Whoever designed this panel put in a lot of effort in thinking about how to bring the right set of people and the voices and diversities. That is not how normally things work. Without any serious intent or effort, I argue -- and that's what the data showed -- everything in global health gravitates to the standard default settings; everything in global health automatically defaults to people in the Global North, institutions in the Global North, mostly to White folks, mostly to men like me, and mostly to the very elite, the BU Schools of Public Health, the Harvard Schools of Public Health, the universities, the Gates Foundation and the London Trust and the schools. This is the reality of global health. With no effort, everything automatically swings towards these most powerful and privileged and elite groups.

Now, if you want to decolonize anything, I would argue that it is impossible in this current structure. And we already saw that during the pandemic, of how rich nations in the Global North cornered pretty much all the vaccine supply, hoarded it, like didn't let it go to waste, not shared it, not shared it in a timely manner and actively blocked countries from using it to manufacturer their own vaccines. This is not new. This kind of a pattern has persisted from the days of HIV/AIDS and

antiretroviral treatment all the way to vaccines and everything in the future. And I worry when there is the next pandemic, nothing will change in the way the Global North approaches the pandemic. They will still do exactly what we did in the last three years. So, this is the honest, brutal reality of doing global health, and we all have to ask ourselves, what does it mean in this context to decolonize?

I actually find it hard to even wrap my head around what that would mean, but I do think we all need to start acknowledging that there is a massive shift/reckoning that global health folks, especially people like me in the Global North, have to really think hard about, and that shift in power I've tried to capture in my second and my last slide.

On the left column is how I think global health operates today. And I think Tammam and others have pointed out the exactly same kind of dynamics in the global development. Global development, global health, it's all the same. We think of global health as a charity case, as aid, as donations of vaccines or supplies or donations of our knowledge, if you wish. We will have to go and save people. As development assistance, as saviorism. White saviorism is one way of thinking about it, but I'm not white, I'm brown. I could also approach my life's work sitting here in Canada through the prism of white saviorism and dependency, something that I think Dorina just mentioned as well.

What our Global South colleagues are articulating, even on this call, is that global health shouldn't be a matter of charity. Nobody's health anywhere in the world should depend on how generous Americans are feeling or Canadians are feeling or whether British people are donating or not. That should not be the conversation at all. It should be a matter of fundamental human rights, equity, justice, reparations for colonial damages, past problems, autonomy, respect, and self-determination.

Now, anyone who has worked with indigenous communities will immediately see that they constantly talk about their right to self-determine their own agenda. It should be no different for the Global South. They have every right to decide how they're going to manage things and how they're going to do things, what they will do or not do, what's a priority for them or not a priority for them. And self-sustenance, exactly what Dorina said. Why should Africa rely on anyone else for their vaccines or their medicines or their tests or anything? Why would they not be manufacturing what they need? So, this pivot from the first column to the second column requires us Global North folks to really rethink how we do approach global health, from what perspective do we approach global health. How do we even engage in global health from a place of great power and privilege?

When I teach global health at McGill, I teach the biggest global health course here. My first class is spent trying to tell my students how ridiculously privileged we are to be sitting at McGill in Canada with the amount of wealth and everything else at our disposal, the power. And so, therefore, everything else after that first lecture, the entire semester, is all about, we are engaging in global health from a place of enormous privilege, and we have to be extra careful in how we engage in global health. We need to be super humble about how we engage in global health. And the last thing we want to do is engage in global health as a white savioristic exercise, which is guaranteed to happen if we don't reframe how academia thinks about global health.

I can think of any number of global health courses in the Global North which would have, the entire course could be taught as, let's go save someone in a poor country, and that is not the way we should be teaching global health in 2023. And so, I will just end by showing you a posting in the chat box, some really important papers, which I hope you will all read and reflect, especially folks based in the Global North. I want you to read this remarkable piece by Muneera Rashid, just published two days ago in the BMJ, on why the Global South should be leading the decolonizing global health agenda and not the Global North. And my piece on allyship -- in other words, I believe that Global South should be leading global health, but I ask myself, what does it leave for me? What do I do, sitting here in Canada? The only path I see for myself is allyship. I need to be a good ally to our colleagues in the Global South, to Black, Indigenous, and people of color, to communities that are at the front lines, to women, because men dominate global health. So, I return a piece about what allyship means, and you're welcome to read it as well.

Lastly, I have two more pieces that I am citing here as well. I ask myself, why is it that those of us in the Global North feel very comfortable in engaging in global health as going 2,000 miles away to a poor country, and we don't think enough about inequities in our own communities. And so, we have returned this piece, which is not new by any means. There are thousands of people have commented on it, on more of a local approach to decenter global health away from this charity, savioristic exercise. We should care about inequities everywhere, whether it's in Boston, whether it's in Baltimore, whether it's in Montreal or up north in the Inuit communities. And we look very disingenuous, and honestly, we lose all credibility if we say, we're going to go solve problems far, far away when we have ignored serious inequities in our own countries. And I think we should give ourselves the license to say, wherever inequities exist, it's fair game for us to get involved. Some of us may choose to go somewhere, some of us will do what we need to do locally.

And there is a piece in the Lancet that was just published on six approaches to counter the white savioristic way of doing global health and we hope you will read and comment about it. In short, I'm worried. And I'm worried that unless the geopolitics change, unless the world is less and less reliant on the Global North's power, this is going to be an uphill battle for all of us. And those of us in the Global North have an obligation to hold our own governments accountable for kind of the stuff that they do.

For example, the AIDS Conference was held in Montreal last summer. Many Africans were denied a visa to come to Canada. So, how do you host an AIDS conference and then deny Africans a leadership opportunity to come here? So, we've written letters to the immigration minister, saying, "What is going on here? How do we be good citizens and allies from our own governments won't back us in some of the things that we want to do? How are we reciprocal in global health when it's all single direction," right?

It's so hard for people to come to the U.S., Canada, UK, EU, and yet, we pretend like we can host global health conferences in Boston or tropical medicine conferences in Seattle without even thinking for a second, what does this mean? Who is supposed to be at the table? How do we pull off a

tropical diseases conference in a country where nobody can even get a visa to attend? This is what worries me most about global health and keeps me awake at night. I believe shift is possible, but we've got to really, really start going beyond these webinars to doing meaningful things -- decentering away from the Global North, supporting conferences in the Global South, holding our governments accountable for visa issues, even moving our programs away from the Global North.

We have so much to do, and PLoS global public health is one example, which I'll stop with. We have made sure, 50% of our goal is Global South. 50% of our goal are women. We have editors in chief, one in the north, one in the south, one male, one female. And every step of the way we have been intentional. This is a point I made -- if you are not intentional, it will magically go towards the default setting that I showed you in the first graphic. The only way to flip this is systematically swinging the other direction, so at least you get somewhere in the midpoint that you want to be. And it's a slog. If you stop doing the hard work of allyship, things will go back to the magnetic North Pole that I just showed you about.

So, allyship is not a destination; it's a daily work that you keep on doing again and again and again and again and again for the next 100 years, and it never ends, and that's basically what Global North folks like me ought to be doing. We need to walk the path of allyship, not declare ourselves to be ally. Our colleagues in the Global South should say, "Hey, this is a good ally," right? That's the trust we need to earn, and we are far away from that destination right now. Thank you.

>> ALICE LAKATI: Fantastic! Thank you very much, Pai, for those comments, those insights. We have to be intentional. And I think one thing I appreciate about this webinar is I did get a visa to come the U.S., and I think this is really a very good opportunity, because totally aware that a lot of us could not attend the conference because we were denied visas. But this webinar has allowed us to connect from different parts of the world.

So, colleagues, we are moving now to the next part of our discussion, where we are going to take questions from the audience. We have quite a rich audience. I see a number of questions in the chat. But before I read the questions from the chat, I have my own questions that I want to ask the panelists. And if I can just start with Tammam.

Listening to your mention, you talked about decolonizing methodologies. And if we look at still the honor is always in the peer-reviewed journals. As a practitioner, what are your thoughts about decolonizing methodologies that are reachable to the people in the Global South so that their work can be seen?

And I just want to bring an example here. My institution is very focused on training primary health care workers. And one of the things we see is the primary health care workers are people like nurses who are at the lowest level. You find that nurses are the ones who stay longer hours with the patients. They actually know so much, but they are always research assistants, whereby the students from Oxford, for example, will come, and the nurses will give all the information, then they get their PhD. So, how do we decolonize these methodologies?

>> TAMMAM ALOUDAT: Thank you very much. I think there are a few practical things and a few principal things. One of the practical things is, just like Madhu said, allyship. I'll give an example. I have been asked repeatedly about how do we publish

in places like the Lancet or BMJ, or so on or so on, by people who do not have funding or formal positions in universities. And guess what, the magic is, I can because I have had the privilege of living in the Global North and spending enough time to grow some entitlement, I can pick up the phone and call the editor of, you know, Lancet Global Health and say, "I have colleagues who I think are worthy and are brilliant and you need to waive the cost of their publication ode." And that happens. It doesn't take much, but people don't really know the routes and the methods to do it. Pushing for people who aren't part of institutional global health where they have grants and the ability to pay for the open source.

The other one is in PLoS Global Public Health, we have agreed -- and that's under the leadership of both of our co-editors, Madhu being one of them, is that no one will ever not be able to publish because of cost. That's out of the question. And that was quite significant for most of us section editors, is that we want to do this because it's a systematic effort to overcome the problems with the publishing industry.

There are plenty more. Again, much publication. BMJ Global Health is prominent now in talking about, you know, the traps of the publishing industry, where you know, you put the faceless, nameless, black and brown people in the middle of the pack with a professor in the first publish -- you know, first name and the professor and the last name, both of them work in a globally north university. That needs to be overcome.

Now, all those are doable and are being increasingly done. More and more of us are conscious of that. Just like a few years back, not enough and not yet. We started being conscious of, I don't want to sit on a panel that is all men all the time. We are starting to be conscious of, I don't want to be on an authorship that is all based in Global North institutions.

And just to be clear, there are a couple nuances I want to make. Madhu talked about it a little bit. The problem we might have now, in that moving the discourse of decolonizing to be contained within the discourse of diversity and inclusion is that we end up having people of color, like myself, who are very well assimilated and, you know, capable of playing, you know, performing whiteness in Global North institutions, being used as tokens for diversity and inclusion. I don't think that's enough. I don't represent anyone in the Global South. I've been 20 years in Europe. So, this is -- the two disciplines overlap, but they need to be very well separated.

And decolonizing is not putting only people who are different, morphologically, but different physiologically, and those aren't the academics, even those that come from the Global South. So, the principal part is we need to conscientiously publish in Global South papers. Stop calling them predatory journals, stop condescending to journals in the Global South and start publishing in them. They become high impact when we publish in them. Not they won't become high impact accidentally so we can.

The second thing is, accept that it's not only academics that publish knowledge that is worthy of being known. The nurses you talk about will give us knowledge that no number of PhDs based in the Global North will ever know. And I have once tried, to no avail, but I think I have a theory. If you look at the global health academia, the point that Madhu made in his first slide, the white privileged male -- it's an oligarchy. It is not only an oligarchy of entitlement and of positionality, it's also

one of people who have no experiential position to talk about life and death of people far away. It's shocking how many academics haven't been in a hospital where kids die unnecessarily, and yet, still sit and talk about global policies. I'm not saying you can't know anything without experiencing it, but I'm saying, you can't know everything without experiencing anything. Thank you.

>> ALICE LAKATI: Thank you very much, Tammam, for that quite elaborate response. I like what you said about stop calling the predatory journals, because this is really a very strong factor in terms of publishing and accessing information.

I'm going to direct this question to Dorina. This is a question from the floor, where we have a question asking, how do we use the knowledge of global health in the south without exploiting them? I don't know whether you're able to see the question. I want to read it for you. How do we use the knowledge of those in the Global South in the field of global health without exploiting them? So, basically, Ngozi is asking, how do we leverage -- or you say from an African country, and you talked about partnerships that are a good way of shaping partnerships for improving health. So, when you look at this question from Ngozi, how do we benefit without being exploited, if I can ask that the other way around.

>> DORINA ONOYA: Thank you, Alice and Ngozi for the question. And I think responding to your question about the nurse who works in a project and a student comes and uses the data she collects and gets a PhD, whereas the nurse doesn't. I think the solution is to involve the knowledge generators as much as possible. The issue of capacity development is really in facilitating this involvement, because unless somebody's been in an academic process, often there is uncertainty about how to get involved, how to participate. But that doesn't mean because that person is unsure about how to participate and how to leverage the knowledge that they have generated, that they should be railroaded, right? And that's where the issue of exploitation comes through, right?

It's important to acknowledge the people who are doing the work in generating the data. That's important. And if it's a person who doesn't have the capacity to engage in writing, in publishing, then, really, I think part of what we want to do for decolonizing global health is to have that person say what they're thinking, because it's not for lack of thought that they cannot write for publication; it's because they don't know how to write for publication. So, it's important to honor their contribution and train them and support them.

And they, obviously, that involves a team, right? It's not one person who comes up with a project, it's not one person who collects all the data, but it's really important to find a place for the person, for that nurse, and their learning, so that that's handle appropriately. She might not end up being first author of the paper, necessarily, but it's important to acknowledge what she did.

And I think for me, really, my effort is to make that person see what they contributed, because often, that's our big problem, not that people aren't participating, but often, they don't weigh their contribution enough to insist on being acknowledged.

>> ALICE LAKATI: Thank you. I want to direct this next question to our last speaker. Listening to you, and I really liked the picture you were demonstrating. And I think looking at

that picture, we are normally products of our trainings, basically, what the environment has taught us. And I look at this question from Jessica. She is asking, do we have suggestions on how students can hold academic programs accountable on how they teach global health? What are your thoughts on this? Over to you. Professor Pai?

>> MADHUKAR PAI: I think folks like Tammam will agree that some of the most important work in the past four years or so in decolonizing global health have all come from students, not from established people like me, not from professors, not from deans, not from chairs. It is the youngest people who are challenging status quo, asking very hard questions on what they are being taught, who they're being taught by, and what it all means.

Some of the best papers that we have been lucky to publish in global public health are those commissioned by some of the youngest people. So, I will post some of the links in the chat box. So, I'm 100% convinced that the winds of change that are currently blowing in academic global health are being driven by the youngest people, which is no different from climate justice. I mean, I don't trust any old people to talk about climate justice anymore. I only listen to the youngest people, because they have great moral clarity on what is wrong with this world, and they are unafraid to call out bull shit. So, I think just backing the vision of young people and letting them drive the agenda for change in academic global health I think is an extraordinarily positive development. And in fact, the best paper I've ever read on decolonizing global health was from an MPH student at Hopkins. This was a piece that we commissioned, and please read it. It is extraordinary, and I'm just left breath-taken by how an MPH student can produce that level of insightful work.

So, by all means, I think follow the lead of young people. But in the end, if the older generations, the professors, so to speak, are unwilling to change their current way of thinking about global health, then we're going to have an increasing separation between the professoriat and the student body. And I think sooner or later, those of us who are in leadership roles have to think hard about how we genuinely change the curriculum in global health, especially as it is taught in the Global North, and decentering our curriculum away from the Global North will take a lot of effort and time, but it's possible.

So, some of us, about 20 of us professors in the Global North, wrote a piece in BMJ Global Health about how we have used the pandemic and the inequities during the pandemic to change the way we teach. For example, many of my guest lecturers in my global health course are from the Global South. They are Indigenous people. They are black professors. I have used Zoom very creatively, thanks to the pandemic teaching me how to do it, to flip my classroom so that they can really learn from people with lived experience, exactly what Tammam just said. The importance of lived experience. So, I no longer teach HIV. A person living with HIV in South Africa is teaching it in our course. That's how I'm slowly but steadily flipping my global health teaching and genuinely walking the path of allyship.

Is it possible? Feasible? 100%. I have done it for the last three years. And having done it, I'm not going back to how I was teaching global health before the pandemic. I will never be teaching the global health purely with Global North literature, only me giving lectures on every single topic. That's not going to happen ever in my course. But it took the pandemic for me to

break my course and put the course back together again.

>> ALICE LAKATI: Thank you. Tammam, do you want to add anything to that before I ask the next question?

>> TAMMAM ALOUDAT: I mean, this is so obvious. Obviously, we still want to see people face-to-face. We still want to be in classrooms. We still want to stand and talk to people and have an interaction. But we can't have that as the singular means of learning and teaching. And that takes us -- you know, this is a step, and it's a very important step. But we also have to accept that even people from the Global South, even people with lived experience, who have the, let's call it what it is, the privilege to be hosted and talk, are still, you know, the privileged few in the Global South.

And we have -- I just want to extend Madhu's argument. We are using the technology that we were forced to use now for a good reason -- a Zoom call. But we maybe are willing at one point to start collecting and collating knowledge and experience to learn from each other in a way that goes beyond lecturer-students, that goes beyond, you know, teacher-student. We have -- and this is not new. Our colleagues in Latin America will know very well the work of (?) who talks about the oppressed, about the teacher-student relationship being an equal one. We have the ability to collate and collect and listen to and understand messages from around the world, if we accept that academic teaching doesn't need to constitute a knowledgeable professor and an ignorant student and accept that the experience is distributed in many ways, whereby everybody's going to learn from everybody once we democratize and dehierarchize the system a bit more. Thank you.

>> ALICE LAKATI: Thank you very much. And I'll actually just agree with you. One of the things we are doing where I work is to try to flip down the approaches to training, because if we look at the university training from many of African countries, they are top down, whereby the lecturer knows everything and the student knows nothing, and you just go and find the knowledge. So, I totally like your point there.

I want to direct this next question to Dorina. In view of what you spoke about, why R&D much more not in Africa because it's normally the place where a lot of things in the science lab. So, what are your thoughts about where do we really want to focus on the global health studies? And this is a question from Veronica, who is part of the audience. Where do we really want to focus global health studies, in your perspective? Over to you, Dorina.

>> DORINA ONOYA: Thank you, Alice. And thank you, Veronica, for your question. I think in Africa, the capacity to conduct research with a basic or epidemiological or clinical trials has improved a lot, and there are clear centers of excellence. And so, I think it's important to use them, because the research will be done by people who understand the context, who understand the impact of the diseases, who understand what those solutions mean for the populations. And using those centers of excellence actually promotes them. It increases their capacity. It increases their ability to do more. And that's why, for me, I think, obviously, global health is global, right? It's not all just Africa. But for problems that focus on us, we need to develop the capacity to develop the solutions for ourselves.

And a lot of the funding for the work and where that funding goes is intentional, I think, right? And if it is intentional, then it makes sense that it should be moved to

institutions that already have capacity to do that. So, I think that's possible. And I think that I'm not the only voice who's raising that issue increasingly.

And the reason why a lot of the capacity hasn't progressed as fast as it could is because, you know, it is funding problems. It is because people are not being used. It's because we're losing talent, you know, people who want to work in this sort of research and find that there are no promising jobs or career options. Why? Because there is no funding in that space. And so, if the intention really is to find solutions, if the intention really is to balance the scales, then you know, moving those research that really affect us -- they're our problems, you know -- to our context I think is important.

>> ALICE LAKATI: Thank you very much. Madhu, do want to argue about where do you think we should focus our global health studies?

>> MADHUKAR PAI: No, I'm fine. We can defer to other panelists.

>> ALICE LAKATI: So, we are going to look at, there is another question from Malawi. And this looks like -- I just want to take this back to you, Dorina, because you spoke about there is something that African countries suffered, and therefore, we are not speaking from ground zero. If I can speak from your presentation where you talked about, if we are looking at global health, we are not all starting at ground zero, maybe starting at negative somewhere. And there is an interesting question here. Has there been any research on global health or social impacts of the loss and damage resulting from colonial resource exploitation? And how do we rewrite the narrative? Any thoughts on that?

>> DORINA ONOYA: So, I think that has been the difficult question. And I would say there's lots of research that has documented the damage and has documented the impact of the past on Africa. What I haven't seen is that damage being quantified. And the challenge, really, for African countries is, okay, so it's quantified, but what is our leverage to demand sort of reparations? We get apologies, that's for sure, but our ability to authoritatively demand reparation is limited. And so, that's the truth that we have to live with. And it's almost a truth that we have to get past.

But given where we are, and given that that's really the reality we're living with, we can frame our questions a little bit differently. I think if you understand that -- let me give you an example. So, I worked in HIV prevention for many years, and we're implementing a risk reduction intervention for young women who had just tested HIV-negative, living in some of the townships that I showed in the picture there. And so, we went to this community, and we have sessions teaching -- and focus really was around negotiations of condom use and how to, you know, how to negotiate for safety within these relationships that the girls were. And in the room, we were -- right next to it was an open store, right? And the girl said, you've come here to teach us about condom use, and you've come here to teach us about HIV prevention, but look at where I live.

And for me, it's these questions that have sort of -- these are questions that revolt me, because yes, the interventions we are bringing is important and in isolation there is evidence behind them, but the people we're bringing it to, that is the least of their problems, right? And so, we cannot pretend that that is the thing that they need the most. Maybe what they need

is safety. Maybe what they need is a home. Maybe what they need is somebody close up the store, you know. For me, that's where I'm coming from.

So, while for me the technology-based solutions are important, they are almost always challenged by the context in which they are being brought in.

>> ALICE LAKATI: The technology, that is actually the challenge we face in educating people about use of bed nets in the malaria zones, because you're telling, use a bed net, but I don't have a bed. But I want to look at this discussion, which is looking at the role of academics in global health and thinking about the past, the present, and the future. And I just wanted to bring this question to Tammam. This is a question from Sheelagh. And I hope I pronounced the name correctly. And this is because you spoke about -- no, I'm directing the question to Pai, because that was the last speaker -- about the areas about giving aid and whether this aid is a favor. There is a questionnaire that is asking, how can we, with the best intentions, support infrastructural changes that is needed, beyond financial aid to advance global health? Over to you, Pai, Professor.

>> MADHUKAR PAI: So, here is a spectacular example we've just lived through, right? 100 countries around the world said, in a crisis, give us the vaccine technology, give us a limited trips IV vapor and we will make our own vaccines and we will save our people. And what did the Global North countries do? Block it, delay it indefinitely, delay it to a point when it became completely useless. That's exactly what we did, right?

So, we had the opportunity of a lifetime to be great allies, right? I mean, right when the first vaccine, especially vaccines produced by public money -- Moderna was essentially funded by American taxpayers, right, almost entirely funded by American taxpayers. That vaccine recipe should have been just handed over to any country that wanted it, along with the technology, and we could have changed the trajectory of this epidemic very quickly.

Instead, we forced the African RMNA hub to reverse engineer the vaccine in the midst of a global crisis. If this doesn't tell you what's messed up, I don't know what else will, right? This is how we are thinking. Even in a catastrophic global crisis, we cannot think beyond what we are so used to thinking and doing and do business differently.

I mean, Nobel Laureate Joseph Stiglitz wrote a piece in our journal. He basically says, this was a deal that we could have put down billions and saved trillions of economic losses and lost lives, right? And we completely botched it up. We actually have now, I don't know how many trillions the world has lost during the pandemic. We have at least lost 25 million lives, if not more. So much could have been done differently. So, I am convinced that the solution for these sorts of things does not lie in the Global North. We've got to decenter this. Regional manufacturing of everything, moving this away from a donation-based model is the future. Why did COVAX fail? Because COVAX was based on the charity model.

Global South was really not involved in the design of the COVAX initiative, nor was it based on self-determination and self-sustenance. It was all about, oh, when we have enough, we will donate something to you, and that model is a disaster. It can never work. And in fact, the current pandemic according to negotiations, all nations are deleting out accountability

clauses, mandate resharing clauses, the equity clauses. If you take away equity and accountability, the Pandemic Treaty is not even worth the paper it's printed on. What does it even mean? Now we are seeing voluntary sharing. Do you really think Pfizer is going to voluntarily share anything? What does it even mean? We've got to learn from this disaster and do things differently, and it's not happening. It is currently not happening in the Pandemic Treaty, and that worries the heck out of me. How do we even rethink? Even after a three-year, catastrophic situation, we are holding onto the same power and privilege structures that we have seen for centuries. And how does it depress the reality. And I'm sorry, I don't want to depress the heck out of all of you, but that's reality.

>> ALICE LAKATI: Thank you very much, Pai. I see your hand is up, Tammam, and I know that we are running short of time, so let me allow you one minute.

>> TAMMAM ALOUDAT: I just want to answer Margaret's question. She is asking -- she works in rural USA, and same problems as far as population transportation, as many countries in the Global South. She asks, would that transfer of knowledge, using knowledge from the Global South, be another form of colonization or a gaining of significant contribution and creative solutions? And I just want to say, we need to learn from each other. In essence, if we see the oppressed, the unhealthy as separate people, then we are losing a very good thread.

A woman who doesn't give -- a black woman who doesn't get given pain management during birth in the U.S. is in part, in significant part, similar to a health worker who doesn't get a vaccine in Africa, similar to people who are excluded and marginalized.

There is a thread that goes across all people who lose their health enhance the potentiality of their lives. We live under the legacies of hyper nationalism and colonialism, and if we don't learn from each other and share -- and this was done beautifully by the Indigenous people declarations -- if that is not a form of decolonization or appropriation, that is a form of solidarity, in my opinion, Margaret. And I think we should do everything to transfer that knowledge, not between governments, but between peoples, between communities and individuals who have the same interests and the same risks to their lives. Thank you very much for letting me answer that, Alice.

>> ALICE LAKATI: Thank you very much, panelists, for really tackling this conversation about global health from different parts of the world. There are a lot of things that have come up from this discussion. I want to believe that the audience have been challenged, they've learned a lot. Listening to different speakers, there are key points that have come about, that if we have to decolonize global health, we have to be intentional, because we are all interconnected. So, I think that word, that we really have to be intentional. We have to learn from each other. We have to be -- we have to realize that the world is -- it's not possible for one part of the world to be safe if the other one is suffering, because the world is really, we are all interconnected.

And as academic institutions, we have a responsibility to shape the future. I like what was said, that our students are, actually we can learn a lot from our students. And academic institutions have a lot to learn from their students.

I want to thank all the panelists for this discussion and I

want to thank the School of Public Health for giving me the privilege and the honor to moderate this session. I want to hand over to the Dean. Thank you very much. Thank you, everyone, for such an engaging conversation. There were too many questions in the audience, and I want to believe that the panelists are able to type in their answers, please do, because this session is recorded, and I want to leave it to be shared. Over to you, Dean, and have a good day and a good evening for those of us here, it is actually a goodnight. Thank you.

>> SANDRO GALEA: I have little to add, other than to say thank you to all of you and our interpreters who have been with us throughout this whole session. And thank you to the audience. I'm really always -- I learn from the chat and the questions and love to see the community who is engaged in these conversations. These are difficult issues that, the reason we have the conversations about them is that I think if we think there's a simple answer, we're not thinking hard enough, and I think this panel helped us think harder. And I know I have a lot to think about, listening to you all. So, I'm grateful to everybody. I'm grateful to the panelists and to the audience for being with us today and for everything you do. Everybody have a good afternoon, evening, and a good day. Take good care.

(Session concluded at 2:32 p.m. ET)