

BOSTON UNIVERSITY
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BUSPH PUBLIC HEALTH CONVERSATION
THE FUTURE OF PUBLIC HEALTH:
PERSPECTIVES FROM AROUND THE WORLD
12:00 PM ET

(Recording in progress)

>> ADNAN HYDER: Good evening, everyone. Do I have the online attendees on? Let me know when the online audience is ready.

>> ADNAN HYDER: Welcome back, everybody. I am so excited and so honored that you have chosen this evening to be with us. Adnan Hyder, and I have the privilege of serving as Dean of the Boston University School of Public Health. Boston University School of Public Health is part of Boston University, an institution, private institution, in Boston, in the United States, and an important element that people don't know about BU is that it was established in order to get access to black and brown people, because other universities were not giving admission in the 1800s, so a group of people joined together and said that is unacceptable.

So, an institution should be formed that will give entry.

Our School of Public Health was established in 1976, so this is our 50th Anniversary. As part of our 50th Anniversary celebration, I have the privilege of starting a new series of what we call Public Health Conversations.

The basis of the Public Health Conversation is the future of Public Health.

Why about future of Public Health? And that is because we believe that in many, many countries around the world, including ours, Public Health is a little bit under threat.

Non-profit, in some cases, it is actually under attack. That is not an isolated phenomenon for Public Health, but also, science, in some ways is under attack.

The nature of evidence is also in question, so this is a very important and opportune time to think about long-term the future of Public Health.

So, I am so honored that you are all here. I want to welcome our online audience, as well. I know several hundred are

available, and I hope to engage both our in-person and online audience throughout this conversation today.

I am so privileged that we have imminent Public Health personalities to join us in this conversation.

I am going to first invite each one of them up to the stage, then request for an opening comment for about 5 or 6 minutes about the future of Public Health from them.

First, I would like to invite -- I am hearing a little echo. Can somebody handle that, please? Thank you.

I first want to invite Dr. Jarbas Barbosa da Silva Jr., a national of Brazil, was elected Director of the Pan American Health Organization (PAHO) by the Member States on September 28, 2022, and began his five-year term on February 1, 2023. Dr. Jarbas Barbosa da Silva Jr., a national of Brazil, was elected Director of the Pan American Health Organization (PAHO) by the Member States on September 28, 2022, and began his five-year term on February 1, 2023.

I will also comment that each one of my panelists has probably a hundred-page biography, but I do not have time to go through the pages, so I will abbreviate to maximize the conversations.

I want to emphasize, before joining PAHO in 2018, he held several positions in the Brazilian National Health System: Vice Minister for Health Surveillance, Vice Minister for Science and Technology, Deputy Minister, and President of ANVISA, the national health regulatory authority. Dr. Barbosa da Silva Jr. has received several awards and recognitions and is an honorary member of the Brazilian National Academy of Medicine and an International 2 Member of the American National Academy of Medicine. He has published numerous articles on global health, health systems management, disease surveillance, and digital transformation., so looking forward to your conversation, Dr. Barbosa da Silva Jr.

Our next panelist I am so excited to invite is Dr Sania Nishtar, the Chief Executive Officer of Gavi, the Vaccine Alliance. Dr Nishtar, most recently a Senator in her home country of Pakistan, joined Gavi as its CEO on March 18th 2024. A trained medical doctor, Dr Nishtar has built an outstanding career over 30 years as a national and global leader. In Pakistan's national government, she served between 2018 and 2022 as Special Assistant to the Prime Minister on Social Protection and Poverty Alleviation, a role with the status of a Federal Minister. During this time, she founded a social protection programme and chaired the Council on Poverty Alleviation and the Benazir Income Support Program. In 2013, during Pakistan's

Caretaker Government, she served as a Federal Minister with responsibility for re-establishing the country's Ministry of Health among other roles, winning acclaim for transparency and accountability during her time in office.

During her career, Dr Nishtar has fulfilled several leadership positions in civil society and international organizations. She founded the non-profit NGO think tank Heartfile, which campaigns for health reform in Pakistan. She was the inaugural Chair of the UN Secretary-General's Independent Accountability Panel (IAP) for women's and children's health; and, among other roles, served as Co-Chair of the WHO Independent Highlevel Commission on Noncommunicable Diseases, WHO Commission on Ending Childhood Obesity, World Economic Forum Global Future Council on Health and Healthcare and US National Academy of Sciences' global study on health care quality in low- and middle-income countries.

Dr Nishtar graduated from Khyber Medical College as the best graduate in 1986 and joined the Pakistan Institute of Medical Sciences as a cardiologist in 1994. She worked at Guy's Hospital and studied Medicine, graduating in 1996 from King's College London - which awarded her a PhD in 2002 and an honorary Doctorate in Science, Honoris Causa, in 2019. Dr Nishtar has received many international awards for her work, including the European Association for Population Studies Award, Pakistan's prestigious Sitara-i-Imtiaz (Star of Excellence) and The Rockefeller Foundation's Global Innovation Award..

Thank you for being with us, Dr. Nishtar.

And, finally, I would like to invite Dr. Francisco Sangone, who is the former Minister of Health of Mozambique. He has had an extensive involvement in the international community that has included serving as Executive Committee member and board member of Global Alliance for Vaccines and immunization-GAVI Alliance. He was also a member of Task Force 4 of the UN Millennium Project, analyzing the practicalities of achieving the goals related to maternal and child health, a member of the Board of Trustees and the Executive Committee of the International Vaccine Institute IVI, and served in several Advisory Committees. But for us, we have a special relationship with him as he did his at Boston University.

So, I thought it would be great to hear from our panelists as we reflect on Global Public Health. Over the next 50 years, what are you thinking, and from your vantage point. First, Dr. Barbosa da Silva.

>> JARBAS BARBOSA DA SILVA: Thank you. I am very happy to share this session with very good friends. Thank you for

inviting me.

Let me tell you, you are asking a very tricky question. As I think of a period of 50 years, we talk about what we are doing.

And there is, I could say, that if you read through our homework probably, in the future, 30, 40, 50 -- I don't know -- but Global Public Health Institutions should be completely different than they are now.

Because my dream is to have a world where each country has full national capacity to deliver the health and well-being agenda that the population deserves.

Global Public Health Institutions should be institutions that can bring the countries together in an emergency, because despite all the new technologies and developments that will be probably facing threats in the next five decades, so, I think it will be a total difference as I see, that we could already have overcome the inequality that you have.

That you overcome the heavy access, equipped access to the new technologies that you have now and the new technologies that will be developed in the next 50 years or so.

Global Health -- Public Global Health that you know of through the Governance, coordination, and trying to address some future challenges that you have, so, I think that this is my dream, in fact, in that this is a way that we need to work now.

I know that this is not an easy dream to become a reality, because we still live in a world that to get the access to vaccines, some countries are struggling. And even to have a Primary Health Care System that can deliver elimination of communicable diseases, that can address preventable deaths as it relates to series, and several countries are struggling to do that. Some countries have a National Health System that is really very weak, because they don't have the resources to perform their duties and to perform -- to deliver the public health and well-being end.

The population has, so my dream is this one that, Global Public Health will be much more than it is now, and the countries will be having much more capacity than they have now so they won't rely on philanthropy. They won't rely on benefits or accounts, but they will have the sovereign right to guard the access to their populations to health in those moments.

>> ADNAN HYDER: Fantastic. There is no point in having an easy dream, right? Dreams should be difficult. I love that. It is not an easy dream, but it is really, really important. Thank you for your opening reflection.

Dr. Nishtar, your opening reflection on the coming 50

years.

>> SANIA NISHTAR: Well, thank you so much for having me, Dr. Hyder. Thank you for having me. I think the question of what does the future of Public Health look like, I think we should not divorce this from basic normative framings, such as the national order being rule-based. The respect for science, and the respect for evidence, and the basic tenants of truth.

We are constructing our entire international et fit on things that are so alien to what we have grown up to believe is right. I think we cannot divorce Public Health from truth, from science, from evidence, and from the need for international global order. That is rule-based and values-grounded.

And I think that is absolutely fundamental.

Secondly, and when you talk about your Public Health, and what we have been able to achieve, as a Global Health Community, it is very important that we should preserve the gains of the past. Notwithstanding the weaknesses of what exists today in Geneva, and notwithstanding the mayhem that exists on grounds and countries, we have been able to reduce child mortality. There has been 10 years' increase in life expectancy over the last few decades. That is significant.

We have been able to narrow the equity gaps. The number of people suffering malaria, tuberculosis, and HIV has declined, thanks to the power of public-private partnerships, we have eradicated many diseases from -- well, if not eradicated, significantly reduced their burdens. Infectious disease is a poverty and the progress we have seen there.

Now we are talking about reformed global architecture, and there is the scramble for downsizing, we should not throw the baby out with the bath water, as you know, they say.

So, I think that is fundamentally important.

I also think we are standing at the cusp of the future where AI is so profoundly changing things and changing things so rapidly, we are not even beginning to appreciate the scale or the change, or the horrible for improvement, or the nature of the threats.

Let alone the regulatory side, and the normative side, and the operational side. We are not even beginning to appreciate, and, of course, the Private Sector is exposing the capabilities of these new technologies so selectively for commercial gain that, we in Public Health and development are not even beginning to appreciate the potential benefits, but also the threats.

To give you an example, I was at the Munich Security Conference, and the entire discussion scream on health was about AI enabled by terrorism threats.

People like myself, and people like us who are in this room, cannot even comprehend what that means, let alone talk about institutional arrangements and let alone talk about an effective response.

So, I think in this new future that we have stepped into, the architecture is so fundamentally important. My greatest worry is if we do down a member state route, we will be exactly where we are standing now, so that worries me a lot.

Finally, because you gave us the flexibility of offering opening statements and my mind wanders here and there to check all boxes, we are at a moment of massive ODA crunch. Of course, all of us know about the massive decline in ODA, the disruption on the ground, and swaths of the African continent, and the huge breakdown of surveillance, one which is the outbreak of Ebola we are living with today.

But we have to appreciate there is a silver lining here. Because today many African Heads of State are committing more resources. There is a sovereignty movement which is real, and flesh and blood and organizations have pivoting for the new future.

We are seeing sovereignty where we are aligning with the sovereignty movement and pivoting decision-making structures in that direction.

So, I think a lot is happening, and at this particular time we require very capable stewardship, and we need to have the agility to be able to respond very effectively, and we need to be able to have, you know, the capacity to reap the moment, the benefits and the potential of the moment, as well.

I fear that we are not set up within the Public Health System to do that. So, a couple of reflections.

>> ADNAN HYDER: Thank you very much. Very, very helpful, and I think a reminder that we must retain the strengths and advances we have made going into the future.

And I will definitely come back to your conversation about AI. We cannot have a conversation about the future without conversing about AI. Thank you very much.

Dr. Sangone, your thoughts on the future.

>> FRANCISCO SANGONE: Thank you. If I can just pronounce my name so you get it right. (Pronouncing name) It is not a joke, but there are some colleagues here from Boston, first of all, thank you for inviting me, and it is a pleasure to be here at this very important occasion to mark the 50 years of the BU School of Public Health, and then to see some of the colleagues there.

So, we went through some courses there. Coming back to my

name, Sangone, because when it comes to BU with one lecturer there, his name is Sangone, so there is always confusion between him and myself, including from the professors, so, to me the pronunciation is different, and for who is who, that works very well.

Congratulations to the BU School of Public Health to say that, well, it is not the purpose of this meeting, and you should be proud of what you have accomplished through the BU School of Public Health. There are many colleagues in the national arena who have learned about the School of Public Health in the 1970s and 80s was not global national health. I remember Bill Kannel, one of the pioneers from the School of Public Health, so many things were learned about international health, now Global Health, whatever name we can put there, on advances and BU.

This is a very pertinent team we are addressing here. I would say there are presently threats, but we should embark on a positive note, because of the strength of Public Health. If we look initially at the capacity of the countries, the main theme echoed by Sania, as well, with the Preamble of the sovereignty of the countries, I think those two things are linked together.

And very well the Global Health Architecture we need to fix. Hmm?

We are sometimes a mess at some occasions, here we get things together with the pandemic, which seems to be in tears after the hard lessons of COVID-19, doesn't seem to scare us at all. It is business as usual to model, another thing similar to COVID-19, and then we will go back to our own silos, hmm? Knowing this is for me, I will do the early and you find for yourself the same thing, it is so obvious, but there is no good Governance Measure or Accountability, those who have questions behind the mess we are in these days.

No accountability, mostly.

But I would say positive, not why. Because Public Health is important in informing and in decision-making. Particularly with COVID-19.

In fact, take the case of Africa as referred to by my two colleagues here. Why Africa stooped, because of the strong information that emanated from the Africa CDC. The leader of Africa at that time was John (?), the Heads of State that came after him, he heard from all the Heads of State in Africa. They were all of them going to him, calling him to ask for advice, and when he produced information that was required, they stood behind him.

All these Committees which were created, that enable Africa

to find a local solution in order to access the COVID measures were the result of Public Health. Were denied the public measures and at a certain stage there was desperation, but the information generated by the teams that were in the field to inform the Africa CDC Headquarters what to do, they united a process of capacity-building in the continent, particularly lung capacity, which was extremely difficult.

When COVID-19 hit, there were only seven labs in the whole country which were able to do genomic sequencing. Now 46.

When the COVID-19 Pandemic was declared, there were and now 46. These were all informed by the Public Health investigations and the African CDC.

That is one. If you move out of Africa and the globe globally, we are talking about the recent surge of COVID-19, whatever we did, even those who were denied, they are trying to over skirt science, what did they do? They were informed by the investigations conducted by public health experts.

They would say publicly, I don't believe in it. But what was the result of the information that was generated by Public Health? I mean, being courageous, having to get up and be stronger in terms of the unit that is generating evidence as Public Health, I think, is a major part you should follow.

I am positive in this regard, but as my colleagues said, we need the whole environment that is favorable, that will enable us to do better.

We are in this world, which is a little village, as COVID-19 showed. There is no way we can do without interfacing and collaboration.

I think that is the way to go, to go back to echo what think colleague said. Capacity-building in the country, get good Governance System and inevitability.

>> ADNAN HYDER: Your fantastic example of going from 7 to 46 labs over a PDF.

So, now if we can reflect from your own positionality of where you are. So, Dr. Barbosa da Silva, your opening reflection was extremely important, but how does that fit with your perspectives for the next 25, 30, or 40 years. Do you think the role of PAHO will evolve or is it even needed as an organization? So, talks about that would be great.

>> JARBAS BARBOSA DA SILVA: Thank you.

You know PAHO is 124-years-old, so I think maybe we can survive another 50. I extremely agree. PAHO, the organization, maybe it is important to share with everybody, we are a double innovation that at the same time is dependent on the

organization, and since 1949 signed to also serve as the Regional Office for the Americas.

So, you know the example now, looking for the example, we are proud to share experiences from the CDC, in some critical points like to establish a full mechanism to guarantee better access to vaccines, to supplies, health technology that is important.

Among other organizations.

I think thinking about the strength and regional organizations, in the case of the region is often very crucial.

I was in an area today in a discussion similar to these points.

Let me tell you, I don't believe the best place to have the initial problem in the world is Geneva, so, we really need to re-think the Global Governance where Geneva is focused on the main areas of the very important functional case, technical guidance and Global Governance. But the direct Technical Support to country, Member States, should be provided, I think, from the PAHO Model and regional. I think they are much more efficient to do that.

I do believe, to be talking about my dream, PAHO in 30 to 50 years will be a totally different organization than we are now.

Some people think the Latin American Region, that the many countries only (?) but think about what is real difference between the low-income country and the middle to low-income country as far as the national budget means for health is almost nonexistent.

I had a discussion with my good friends, we need to re-think how to have the needs of different countries that have a very important correctiveness. The inequality. Not only because you have the regency accounts, and one of the most vulnerable countries that hated, but also when we are looking within the countries, Colombia, Peru, Brazil, very important in terms of access.

So, I think that one probably looking for the future of PAHO, if everything -- I am not an apt mystic person. I prefer to think about myself at a realistic optimist, but if we continue working to strengthen the national capacity, I think that PAHO will maybe concentrate in regional coordination, so these will be the regional works that I think that in the near future we will need to have.

>> ADNAN HYDER: Thank you. Thank you for that realistic optimism. I think that is very, very important.

So, Dr. Nishtar, the notion of Alliances and coalitions,

and you lead one of the most important ones, will that be relevant in the next 50 years, focused around the product or vaccines, or do you think that will change?

>> SANIA NISHTAR: I think in the future we have to leverage comparative advantage even more.

I will give you an example. This morning Richard Hatchett and I met. In the context of the Ebola outbreak, we are responsible for the vaccine response.

There a leg of the response within our mandate, and there is a leg of the response which is within their mandate, and we discussed how we are going to collaborate.

And then we next met with the World Bank, and we talked about, you know, liquidity arrangements. Well, knows are not relevant so much to Ebola, but in the context of seeing the influence of the pandemic, and it is first very clear that this is our comparative advantage. We need to work together.

And more broadly in emergencies and pandemics, because I have seen it from the country side, sitting in the cabinet, and I have seen it on the international agency, there are a whole host of agencies that get mobilized at the country-level, and others that get mobilized here.

If any one of us thinks that you can pull it off on your own, you cannot. But you need to -- but what is important in the future is that we leave our egos at the door.

What gets in the way is our egos, grandstands and competitive behavior.

Which is why when we were drafting the mandates, we focused on the competitive advantages and hone it. I think in the global architecture of the future, we have to think about how we will draft that new future. When are our strengths and how best do we play? It is very important, to your question, will it be relevant in the future?

It is deeply relevant, because we cannot duplicate, but the system has to create incentives for collaboration. Base right now there is a disincentive to collaborate. Each one is on our parts to do replenishments, which are often competitive.

Not only that, but agency Heads have incentives to collaborate, so I think there is to be some fundamental shifts in the future.

This is not just about Global Health, but about the future of international development, and the future of international development intermediaries, and there you need to structure the incentives to collaborate. Look at it from the country end. My nightmare was to deal with the plethora of national agencies. Each one of them had a different steering Committee, a different

Governance arrangement and mobilized different teams from Geneva who wanted independent time, wanted separate audits, stand-alone indicators, had different Guidelines, different procurement manuals and different reporting timelines.

I think to -- and they have a disincentive to collaborate. Each one are reporting to environment, each one want visibility, and I am not being critical, but your question was so profound. What does collaboration mean in the future? Collaboration means everything in the future, but you have to structure the incentives for that.

>> ADNAN HYDER: Well said. It is so important, leave egos at the door and what are the incentives to collaborate. Critical to us as countries.

And Dr. Sangone, you used the word accountability. How will that work in the future with the notion of the next 50 years, multiple global players, but the country takes responsibility and accountability? Some thoughts from you on that?

>> FRANCISCO SANGONE: Well, think the main question is the change required.

I think what Dr. Barbosa da Silva and Dr. Nishtar said, the institutions have to be prepared to accept the leadership of the country. The initiatives, programs and other lists that Sania brought up here, more independence for each organization, the bottom line, we are there for the country.

If we are there for the country, we have to follow the country plan. Full stop. I think, I would say, we should not violate. We have to be prepared, all the institutions, at the country level to accept the country problem, the country plan. If there are deficiencies, collaborate in improving that plan and we are part of it. And to get one plan, one accountability mechanism, one monitoring system. And stop with the whole diversity, until we reach that stage, we will be going around in circles. We start with programs. And when we are done, we think the changes are profound and we start from square one the development. That is not efficiency.

What is being done in the country is crucial, otherwise we go anywhere. I think it is critical. As we need to look back, Sania said something important at the beginning, that we should look maybe at the passport, the issues that stem from the '90s. Everyone was embracing the swath and at the level acknowledging the importance of the country plan and they are all ready to do it. The two different iterations that ended in 2005. We did a declaration and the ineffectiveness went to two to three iterations. Ghana and (?).

The option this was a second phase of effectiveness, and

then Busa plan, corporation and partnership, and it was redeemed recently in 2023 in the Nusaka (?) agenda. Where it comes to accountability, urgent change, all Governance, and the progress which I said before, how the Global Initiatives work together toward universal -- how the different Global Public Health initiatives work together toward universal health coverage.

The problem, who will hold the institutions accountable to follow this, is the issue. The balance of power is not there. But having said that, the balance budget not there, we need to be stronger at the country level.

The stronger the programs are, the more respected the countries will be.

If the countries will stay this silence, be dependent on what you said from the US or, I don't know from where, this will never move. Saying, this is what I want to do? You want to collaborate, come and join. You are welcome to collaborate. The same spirit has to be transferred from the higher level to the Global level, to talk about the real meaning of solidarity and cooperation. We need to go back to what was developed and why it was created. It was within this context, and it is still valid. The principle of the constitution of the WHO, is stronger today than it was in the 48.

We should not make ourselves confused because there are ideas, whether the WHO will become redundant. No, our expression is that the principles of the constitution of the WHO. No one, no matter how rich the country is, cannot say that I am not in agreement, and the COVID-19 showed us, hmm? Here we are with the crisis worldwide, including Cuba, for instance. We fix what we don't understand.

I am speaking about COVID-19. Cuba help you. We had things from Cuba, Italy and other countries. Today we see this great country with the profound leadership and the leadership in faith as it has been played.

What are we? What are the principles of the constitution of the WHO who funded ANSA.

>> ADNAN HYDER: So, in the next 50 years we need to read the principles and implement the change, clearly a strong reminder of the need, the bilateral flow of information, exchange and support. My audience has been remarkable, so I want to get a few questions from here, as well. If somebody can indicate to me online, as well, so, one of the things really important about asking a question is to be succinct. I have a rule. I only give one minute for you to ask a question.

So, you have to get your thoughts organized and deliver it in 60 seconds. Then I will take two or three and ask the

panelists to reflect on them.

If you can show hands, and I think Jackie has a mic. Make sure you speak into the mic so my online audience also listens. Yes, sir? Can you please identify yourself so the panelists are aware.

I think it will start if you start thinking?

>> Can you hear me? I am Feraz. I lead the partnership Secretary to WHO headquarters.

My question to you, Adnan, and the analysts, who do you see the Public Health gaining traction. Because when we talk about health, may it be the smallest country or the highest country, I don't mean to be combative, but the whole curative part of health, where you practice Public Health at BU, how would you compare yourself, the country your resume comes from, where you see the Public Health in comparative to other fields.

I would like the panelists to reflect on that, because that is where the future of Public Health is also a career.

>> ADNAN HYDER: Very good. Thank you for stimulating us. I see a hand there.

>> I am from WHO, as well. A very simple question. You have all spoken about what your dreams for the future of Public Health is. My question is really what we need to do to get there, and the example that I am thinking of is that Public Health has evolved.

When I was in Public Health, I did my master's in PHC 25-years ago, the biology, the Health Economics, that was stretching it a bit.

Now when we are thinking of Public Health, people are no longer responsible in some ways for their choices. When you think of food, it is no longer the future of nutrition or how they eat, but we are inundated by Social Media that is not controlled by us.

The question is, as we think about the emerging trends and the things that influence Public Health, and the issues that change the dynamic, that make things no longer national but most the things are multinational issues, how do we prepare the next generation of Public Health, and how do we transform, if you will, the existing institutions that you have all spoken about, Public Health, the architecture of Global Health, and the Governance Mechanisms to response to these types of threats.

Because it really isn't about just medical issues, Ebola or COVID, but really broader determinants that impact how we function as a society and how we are able to respond to that.

>> ADNAN HYDER: Thank you. Thank you. Let me check on -- actually, I will take in-person here, and then I will ask

semi panelists to pick and choose, or reflect on all three. Yes, sir?

>> Keith Martin, School of The Consortium of Public Health. We know there is a lack of political attention to it, but what advice can you give to the folks here, the arguments necessary to give to the Ministers of Finance, that have a lot on their plates.

What is the Value Proposition, the relationships and functional activities we need to engage with Ministers of Finance So, when the Ministers of Health are asking them for funds, the Ministers of Health will be their ally as the table. The Value Proposition, the relationships and how will we make that operationalized at the country-level.

>> ADNAN HYDER: One around proposition and Public Health, and the lack of choice and the negotiable Determinants of Health playing very different directions and the notion between the conversation of health and finance.

So, pick and chance, or answer on three, starting with Dr. Barbosa da Silva and I will go down the line.

>> JARBAS BARBOSA DA SILVA: Thank you. A very interesting question. I will try to be brief, but I feel that Public Health, we will be -- a lot of what I would call positive pressure, because we have a paradox. When you think of the tolerance for the preventable deaths related to the diseases are almost 100%. 50 years ago, we still had a problem that we were producing thousands of those, and this was then and now we have much more pressure. We cannot eradicate all the viruses. So, in the future we will have new viruses, but the society will request, what vaccine do you have, but that is not available in 48-hours so I see the Public Health needs to incorporate not only the traditional basic foundations of Public Health, but also Anthropology, Sociology, diplomatic and political skills, because this will be part of what we need for the future.

So, the development of the means of health what, we are trying to present is how can we develop this being more productive. People complain we need more money. We recommend in my region that the country should have 6% of their GDPS Public Health expenditure and the average is around 42%.

But the means of health, I say, is needing more money. The means for finance, they need to be more effective, and both are correct.

The Primary Health Care was not renewed or strengthened, so they are directing all the -- most of the patients with diabetes, pay attention to the secondary virus.

This is completely unacceptable.

So, what are the best ways to provide resources to this, the needs of Health and Finance.

Let's invest in primary health so they can deal with diabetes, like those protections, and treatment for cancer, et cetera, so we will save a lot of money in the future.

The same thing, not to go over all that, but what helps a lot, is working with the Parliament and means to present the data. So, where we develop together and make a framework to show the impact, like the impact of tobacco use in the country, this will allow the means of health to have a more concrete conversation with the means of scientists.

I also say our team needs to be ready to present concrete solutions. If Heads of State, the President, this is our priority and he says okay, this is my priority, but what are the two or three things I need to prevent tomorrow to address this problem?

There needs to be the best evidence that we have.

>> ADNAN HYDER: Thank you. Dr. Nishtar, any of these?

>> SANIA NISHTAR: People like us that don't have to worry about the next meal on the table, whose children go to good schools, we meet each other and have nice, comfortable lives, often don't know what the reality on the ground is. And I have had this enormous privilege when I was the minister of negotiable protection, to spend four years on the ground with communities, most of my working days.

It completely changed my perspective of what health is, how it is influenced, and how government and societies should look at it.

In my gray matter I look at health in terms of context and choices, on the one side, and private care on the other.

Context and choices, you have vast swaths of communities, in the millions in our countries, living in extreme poverty and squalor, where there is extreme poverty, where there is no running water, where there is no sanitation. 60% of the children are stunted, effectively stunted. Illiteracy is rampant, and we in Public Health know that one of the best Determinants of Health Status Achievement is per capita care.

As opposed to that, the number of hospital beds, nurses, and whatever you and I do, has nothing do with it. The foremost achievement is per capita, so how do you square that equation, when you see such pervasive poverty. Not just in my country, but I see it everywhere, in Africa that I go.

I mean, the best investment in to reduce infant mortality is level of education. The dividends of investing in a child. The importance of clean water, sanitation, and avoidance of

pollution. And the constraints we have on the ground.

And on the NCD side, with respect to -- the inequities of the power and money and the outcome. So, I think a lot of the ill health we see is grounded in context and choices. And lack of choices.

You can call it Public Health; you can call it whatever you like to.

Be honest, is it the reality on the ground that matters more.

Then, understand, on the other hand is point-of-care. I think we need to think fundamentally different about the point-of-care, because the entire mite of Geneva, New York, and northern institutions, is on Primary Health Care, government-led Primary Health Care. And government-led Primary Health Care is a very marginalized part of point of service.

There is a huge burgeoning private healthcare out there that has been our blind spot.

Think about a woman who could be in Africa, who could be in my money, in Pakistan, everywhere. She arrives, she takes her to our bus, she goes to a Primary Health Care facility with two children. She needs a vaccine. She heard about stipends. The children are stunted. She has a mother-in-law who is diabetic, a father-in-law that has hypertension, there is a relative in a wheelchair, the brother suffers from hallucinations, the husband is abusive -- she requires a package of interventions. She needs a suite of care.

She goes to a government healthcare facility where incentivism is rampant and Supply Chain is the name of the gain. Where institutionalized rent-seeking is what the order of the day is, and we are totally blinded to the Private Sector Operations that are only present.

And in that facility, everybody is Interplaying. Immunization, contraceptives, HIV and malaria drugs, all the NGOs of the world are working there. UNICEF is providing RUTF, the food program is providing RUSF -- sorry -- I may be switching the acronyms -- and we are all focused on Primary Health Care Facility where the abuse is deeply engrained. I see it, and the woman who requires all these things goes to the Primary Health Care Center and her needs are not fulfilled and the Private Sector is completely unregulated.

So, I think we need to think very differently about -- and in that very city where this happens, there are 17 UN Agency. There are a plethora of NGOs and a plethora of private foundations. So, we need to think very differently about Public Health Assistance. We need to think completely out-of-the-box

and work with governments to help them overcome the central systemic constraints that are the barriers to effective delivery. I tell you, there is no dearth of money there. is no dearth of money, even in this fiscally contained and (Fading audio quality)

Give a million dollars to a Private Sector entity, and in another year, it will come out at the other end, completely transformed. Having transformed its systems, having invested in the capacity. Having the institution, and we are continuing to put money through a sieve. Things need to change and there are ways to do that.

>> ADNAN HYDER: Thank you. Dr. Sangone, reflections on these questions and if I can request 2 minutes.

>> FRANCISCO SANGONE: It is a very important question and I will try my best. Very important and new. Hmm?

This NCD issue, which is new if you take the context of Africa and other countries in the global cell.

Before, if I had a cold, in the old days in the '70s, at the Health Center, you would enter the Health Center and just see children languishes with diarrhea, and you see deaths in the waiting area before you even have time to attend to them.

You get huge numbers of pneumonia, and you go over those things, those are the things we were absorbing.

You go to the Health Center today and that is no longer the picture. So, we are so absorbed by those things that others are dying for other causes, all of which we did not take notice at all.

Because the pressure was such on those deaths among children that you do not have time to look at other things that. Is one reality.

And the other thing, again, back to the international environment, if you have assistance on those days for any health program, you concentrate on this.

I want money to assist my program; you will not get money those days. So, what is killing people is diarrhea, is where you are going to get the money.

So, just the introspective that is important, go back to see why we somehow left the NCDs for two programs. No programs, I agree, but also the pressure, that you do not have time for them. And currently, what is the situation vis-a-vis Ministers of Finance, hmm?

Many countries that are embarking in new programs, including NCDs, they don't have sufficient money to fund health programs. They depend on external money, where they can get about 80%, today, of budget for health from external sources.

And those funds come with strings and conditions.

The areas we are discussing, the Gov instance issues and different -- Governance issues and different programs. Between 2000 and 2005, the countries, considerable amounts of resources for health, but they need the money.

It would be the most funded department in the government, but the single health system is still going down. Because no matter how much money you have, you cannot use, or perform the specific programs. That was the issue.

That is what we needed to change, and I will go back to what we discussed earlier, which is the coordination and sectors of the country's plan, and all the initiatives, whoever is funding, where the money is meant.

And there is another element in the environment, international institutions imposing countries at the country-level. There are these limits. How much of your percentage of GDP are allocated to health. The famous declaration, I remember when we signed up for that this 2020 in Abuja, was a major splash, but very few countries are able to give it 15% of their budget to health.

And, even if you get money, you do invest in preparing your system, you cannot use it. Hmm? Because of the conditions of the International Monetary Fund.

You sitting on the bill, you train people, doctors included, nurses, midwives and there in the suites. If they are not absorbed by the Private Sector, I don't know what you do.

These things have to be changed. If you get a situation where people are suffering, you have the means to use it. I mean, the institution should open up and allow the country to provide that kind of assistance.

And the last important question we said is new, which comes from the WHO about the programs, vis-a-vis promotion and the IGP of people, looking in the silos.

There is one exercise which was done in 2020, since 2018, actually, to 2023. Which is to look into the synergies between health security, coverage and health promotion. Those things go together. Hmm?

And then what came out of that exercise was that we want the synergies, but what happened there is the synergy. And, the conclusion of the exercise, what do we need?

We need to get accountability and the proper mechanism of Governance in order to put these things together. Because, this is about all those things, including health promotion.

>> ADNAN HYDER: Thank you. Thank you. Wow! What a conversation this has been. Unfortunately, our time is up. I

will say that the idea here was to generate a conversation that we knew is going to be difficult, is going to be complex, and is not easy to conduct.

That is why we are having it, because we don't want to shy away from complexity, but rather unpack it, delve into it and figure out how to deal with it. We need to dream big, because Dr. Barbosa da Silva is telling us it is incredibly important to also dream, right?

Dr. Nishtar said we must leave our egos at the door. This means our own territorial behavior needs to change. We need to incentivize and collaborate to do better in the next 50 years.

And Dr. Sangone is reminding us about the notion of accountability, and that is for countries, departments, institutions, and also individuals. That is becoming extremely important.

I am grateful to each of you for sharing this hour with us in the middle of an extremely busy World Health Assembly Week.

I want to acknowledge two of our Board Members here at the BU School of Public Health, who both support the School of Public Health. And we have, as well, a colleague in the audience from the School of Public Health, formerly from the WHO.

Thank you for joining us, all of you here in-person and online. On behalf of the Boston University School of Public Health, thank you for joining us, and we look forward to continuing this dialogue in the future. Thank you.

(Session was concluded at 1:06 PM ET)

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