



Independent observer
of the Global Fund

Global health architecture: Fit for purpose?

In a few days we will mark the third anniversary of the many countries imposing lockdown as part of their strategies to control the spread of COVID-19. The dates, length, severity and numbers of the lockdowns varied from country to country, as did the actual rules. However, this was a global experience and we all felt the impact of this pandemic.

This time, three years ago, I was in the UK on Sabbatical. I had completed my last term of teaching in Canada at the end of 2019. I had set up a programmes of visits to various universities in the UK and Europe. I had made plans to travel back to South Africa and develop a research agenda. My plans were completely stymied, and, indeed, I have still not made the visits I wanted to.

However, and importantly, my disruptions were inconvenient but not catastrophic. I did not have children who needed home educating, my salary continued to be paid, the shops did not run out of food, services were available. Indeed, I found a purpose in the midst of the turmoil and uncertainty. For many years I have been publishing a monthly blog www.alan-whiteside.com which contains my musings on life and events. It became a weekly COVID-19 communique, where I tried to make sense of what was going on and share the information. The readership rose rapidly. But it was time bound, as more was understood, and the complexity of disease and response grew, a simple oversight was no longer possible.

Most people, including the readers of the Global Fund Observer, will have had a different experience. In many cases it will have been very difficult time. We are now entering a period of reflection and asking ourselves, nationally and globally, how we did. The answer is not great, and assessments will be produced and published in the years ahead. It is to be hoped that we will take notice of them, but I am not optimistic.

One area where we did well was in tracking the pandemic. There were several informative and accessible

websites. The one I made the most use of was the [Johns Hopkins University Coronavirus Resource Center COVID-19 Dashboard](#), produced and updated by the Center for Systems Science and Engineering. This allowed people to track the pandemic globally and nationally in some detail.

It is interesting to review the weekly data. Globally there were just over four million cases recorded at the end of 2020, the peak was 23 million at the end of January 2021, and the most recent data show just under a million in early March 2023. Regarding deaths the weekly data are somewhat different. The first peak was 51,000 in mid-April 2020; the second and largest to date was 101,000 towards the end of January 2021; the most recent data suggest there were about 76,000 cases in January 2023. This also shows the peak in vaccinations was at the end of June 2021 when 300 million people were immunised. Numbers plummeted and went as low as eight million per week in February 2023.

Death data alone were not enough. Excess mortality refers to the number of deaths from all causes during a crisis. These are deaths over and above those occurring in normal conditions. Excess death data set out how the number of deaths during COVID-19 compares to the expected deaths, had the pandemic not occurred. It should include all deaths, to capture those indirectly caused by the pandemic. An example: people unable to access treatment; and this includes those who could not obtain their antiretroviral medicines (ARVs). Two easily accessible sources are [Our World in Data](#) and the [Institute for Health Metrics and Evaluation](#) based in Seattle. The latter estimated that by May 2021 COVID-19 had caused about 6.9 million deaths, more than double the official data.

COVID-19 was the biggest shock to global health, the economy and society for hundreds of years, perhaps since the [plague that ravaged Europe](#) between 1347 and 1351 and killed between one-eighth and two-thirds of the population. The population in England in 1400 was half what it had been in 1300, there was significant depopulation and many villages disappeared.

As we approach the COVID anniversaries it is appropriate to ask where we are, and for readers of the GFO what this has and will mean for the HIV pandemic. The response to HIV took a back seat when COVID appeared on the scene. At best health resources, especially human resources, were diverted from HIV to the COVID response. We tried to document this in the second issue of the [African Journal of AIDS Research](#) in 2022. This was a special issue on AIDS in the Time of COVID, and it is open access.

More pertinent, and interesting, are questions around the longer term. There are lessons from and for the HIV pandemic. AIDS was first recognised as a new disease in 1981 and the pathogen identified in 1983. It spread across the globe and in 2021 it was estimated 38.4 million people globally were living with HIV, 1.5 million were newly infected and 650,000 people had died but 28.7 million were accessing antiretroviral therapy. Cumulatively 84.2 million people have become infected with HIV and 40.1 million people have died from AIDS-related illnesses.

AIDS gave a spur to global health as can be seen by the organisations set up and the resources mobilised. [UNAIDS](#) was established in 1996 to ‘led and inspire global, regional, national and local leadership, innovation and partnership to ultimately consign HIV to history’. In 2002 the [Global Fund to Fight AIDS, TB and Malaria](#) was established. Since then, it has “invested more than US\$55.4 billion, saving 50 million lives and reducing the combined death rate from the three diseases by more than half”. In 2003 [The U.S. President’s Emergency Plan for AIDS Relief \(PEPFAR\)](#) was established and is the largest national commitment to address a single disease in history.

However, in recent years the resources available for HIV in low- and middle- income countries have declined and [UNAIDS estimates](#) that, of the \$29.3 billion needed by 2025, there is a shortfall of around \$8 billion. The crucial point is that, although there have been successes, AIDS has not gone away. Indeed, while AIDS may compete for resources with other health issues, they in their turn are competing with other global challenges such as climate change, the cost of living and conflict, especially the illegal invasion of

Ukraine and its consequences.

The challenge, as we reach this anniversary, is to ask if the global health architecture is fit for purpose. I fear the answer is a resounding no! The primary problem, in my view, is the lack of openness and honesty. Those working in the area of HIV need to recognise, and more importantly, accept that the landscape has changed. There are new priorities. Even though I have been involved in the response to AIDS since 1986, I did my first work on the pandemic in that year, I know the absolute and relative importance of the disease and its consequences has changed.

Aidspan, an international non-governmental organization, was established in 2003. Its core mission was as an independent observer of the Global Fund to fight AIDS, Tuberculosis and Malaria. We are aware that the environment has and is changing, and we will change with it. Indeed, our new Strategy has been expanded to cover all global health initiatives, not just the Global Fund. Perhaps the observation of Louis Pasteur on his deathbed: “I was wrong. The germ is nothing. The Terrain is everything” should guide us and the global health community in the decades ahead.

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