Construct a global health practice that is much more customised and driven by the individual needs of countries and specific populations within countries, elevating decision makers and communities in low-income and lower-middle-income countries to priority actors and audience in global health over global elites.

Reboot the global health toolkit, strengthen the focus on in-country presence, and take advantage of the possibilities of remote cooperation, enabling smarter use of virtual and in-person interaction.

Centre the rights and perspectives of communities intended as beneficiaries of global health, evaluate the impact of global health performance of many high-resource income countries, and the struggle for greater gender equality in its practice and leadership has made important gains. Moreover, the poor performance of many high-resource contexts, including in preventing inequities in outcomes of COVID-19, has made prominent the shifting poles of where public health excellence actually occurs and questioned why global health leadership continues to be dominated by and concentrated in a handful of countries. The HIV movement has already shown what is possible in terms of participation and ownership by communities, albeit in unique circumstances. COVID-19 has just re- emphasised lessons that were thought to have been learnt during the west Africa Ebola virus disease outbreak on the importance of community leadership.

Fourth, COVID-19 has again shown the limitations of global and national governance in stewarding multisectoral action to tackle complex problems, notwithstanding prominent national exceptions. The construction of false conflicts between public and economic health in response measures has proved disastrous. The siloed nature of health and development policy making and assistance needs urgent attention; global health practice must no longer ignore the essential truth that health is mostly created and destroyed outside of the health sector.

Finally and most importantly, the dismal performance in terms of equity for COVID-19’s impacts demands a reckoning. Whether in terms of the distribution of commodities such as vaccines, the sadly predictable concentration of mortality in disadvantaged groups within countries, the social and economic impacts of non-pharmaceutical interventions, or access to health care, COVID-19 has shown that, despite decades of rhetoric on the importance of health equity, little has been achieved in terms of mainstreaming its priority within approaches to health. It has never been clearer that attention to the social determinants of health is neither utopian nor abstract but instead fundamental to the effectiveness of public health practice.

None of these deficiencies need be terminal. COVID-19 has made the case more persuasively than ever for an effective global health. It is time to use the political oxygen of the current prominence of global health to construct a more participatory, just, and effective practice out of the cruelty and misery of COVID-19 (panel).

The views in this Correspondence are mine alone and do not necessarily reflect the views, policies, or decisions of any of the institutions I have been associated with. I declare no competing interests.

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Panel: Improving the effectiveness and equity of global health practice in the wake of COVID-19

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Department of Error
Marson A, Burnside G, Appleton R, et al
The SANAD II study of the effectiveness and cost-effectiveness of valproate versus levetiracetam for newly diagnosed generalised and unclassifiable epilepsy: an open-label, non-inferiority, multicentre, phase 4, randomised controlled trial. Lancet 2021; 397: 1375–86—Appendices 3 and 4 of this Article have been corrected as of April 22, 2021.