Realizing *Ubuntu* in Global Health: An African Approach to Global Health Justice

Nancy S. Jecker [ID]*, Department of Bioethics and Humanities, University of Washington, School of Medicine, 1959 NE Pacific Street, Seattle, WA 98195-7120, USA; Department of Philosophy, University of Johannesburg, Auckland Park, Gauteng, South Africa

Caesar A. Atuire Nuffield Department of Medicine, University of Oxford, Oxford, UK; Department of Philosophy and Classics, University of Ghana, Legon, Accra, Ghana

Nora Kenworthy University of Washington, School of Nursing and Health Studies, Bothell, WA, USA

*Corresponding author: Nancy S. Jecker. Tel.: +1 206 616 1865; Email: nsjecker@uw.edu

The COVID-19 pandemic has highlighted the question, 'What do we owe each other as members of a global community during a global health crisis?' In tandem, it has raised underlying concerns about how we should prepare for the next infectious disease outbreak and what we owe to people in other countries during normal times. While the prevailing bioethics literature addresses these questions drawing on values and concepts prominent in the global north, this paper articulates responses prominent in sub-Saharan Africa. The paper first introduces a figurative 'global health village' to orient readers to African traditional thought. Next, it considers ethical requirements for governing a global health village, drawing on the ethic of *ubuntu* to formulate African renderings of solidarity, relational justice and sufficiency. The final section of the paper uses these values to critique current approaches, including COVAX, the vaccines pillar of the Access to COVID-19 Tools (ACT) accelerator, and a proposed international Pandemic Treaty. It proposes a path forward that better realizes *ubuntu* in global health.

Introduction

The coronavirus disease 2019 (COVID-19) pandemic shines a bright light on the question, 'What do we owe each other as members of a global community during a global health crisis?' In tandem, it raises underlying concerns about how we should prepare for the next infectious disease outbreak and what we owe to people in other countries during normal times. Attending to these questions has exposed gaps in bioethical principles and concepts. Yet, even before the COVID-19 pandemic brought such concerns to the fore, scholars of public health, global ethics and feminist bioethics had raised related concerns. Powers and Faden have argued that nation–states ought to abide by a 'Principle of Interstate Responsibility' that constrains each state's pursuit of national benefit, global advantage and the exercise of

power over others (Powers and Faden, 2019). Buchanan has insisted that even in the absence of a political constitution to regulate it, there exists a 'global basic structure', along with a responsibility for cross-border justice (Buchanan, 2004). Pogge has stressed that the global political order harms people and argued for a duty not to expose people to life threatening harms and to shield them from harms for which we would be actively responsible (Pogge, 2002). Young has demanded that theories of justice bring into view structural injustices, understood as social processes that 'put large groups of persons under systematic threat of domination or deprivation of the means to develop and exercise their capacities' and simultaneously 'enable others to dominate or to have a wide range of opportunities for developing and exercising capacities' (Young, 2011: 52). Francis *et al.* trace gaps in current bioethics approaches to the

period of bioethics' birth following the Second World War, when the predominant view was that science had largely conquered infectious diseases, leading to a virtual absence of infectious diseases examples at bioethics inception (Francis *et al.*, 2005).

Scientists predict that threats to health wrought by infectious disease will not only persist but intensify. Experts report that emerging infectious diseases are on the rise, occurring 'with increasing scale, duration and effect, often disrupting travel and trade, and damaging both national and regional economies' (Lee *et al.*, 2021b: 17). Globally, the number of outbreaks has risen steadily since 1980. Over the last decade, this rise was driven primarily by zoonoses, which accounted for about 75 per cent of new human infectious diseases (American Veterinary Medical Association, 2008). Epidemiological modeling shows climate change is also among the key drivers of increased rates of zoonoses, because it leads to environmental degradation and brings humans into closer proximity with wild animals (Bartlow *et al.*, 2019). The ethical quandaries presented by infectious disease outbreaks may well extend to other global crises, like climate change.

If these forecasts are born out, bioethics will need to adapt. The situation of a global pandemic invites thinking anew about the ethics of relations between people who, though geographically distant, are neighbors in terms of their shared vulnerability to infectious pathogens. Where might new ways of thinking about bioethics come from? Baylis *et al.* propose that an ethics framework for pandemic planning should build on the notion of 'relational personhood' and 'relational solidarity' articulated in certain strands of feminist thought (Baylis *et al.*, 2008). MacKay highlights a role for virtues in structuring the practices of institutions at the collective or whole-of-society level (MacKay, 2022). Ten Have recommends considering a communitarian approach to global bioethics (ten Have, 2011). Jecker *et al.* set forth a non-statist framing of global justice that appeals to a principle of subsidiarity to normatively order the many individuals and groups that must coordinate their efforts (Jecker *et al.*, 2022).

In this paper, we extend our gaze beyond the predominant bioethics literature, drawing insights from philosophies of the Global South. This approach recommends itself not only because philosophies of the Global South yield important insights for our time, but also as a response to the lopsided nature of the field. In a survey of the bioethics literature on global health from 1977 to 2015, Gibson *et al.* found that 88 per cent of articles were written by authors in high-income countries, with

just 5 per cent from those in low- and middle-income countries (LMICs) (Robson *et al.*, 2019). Among the most troubling findings was the virtual lack of voices from the Global South. This very fact not only undercuts efforts to conduct global bioethics in a truly 'global' way (Graness, 2015; Flikschuh, 2020; Jecker and Atuire, 2021a), it suggests the field is missing opportunities to expand its repertoire of knowledge. These concerns are heightened when one considers the spread of Western bioethics to non-Western societies, which has led some scholars in the Global South to call for decolonizing bioethics (Fayemi and Macaulay-Adeyelure, 2016; Bamford, 2019).

This paper will contribute in a substantial way to expanding global bioethics to include insights from the Global South that are non-individualistic. It begins with an exercise designed to shift the analysis from one driven by the global north to one shaped by ways of thinking more prevalent in the Global South. We set the stage by positing the idea of a 'global health village'. A global health village draws inspiration from the Builsa people of Ghana, which furnishes a way to conceptualize the duties and rights that interconnected human beings have toward one another. The paper next considers the governance of a global health village during an infectious disease outbreak. It draws on the African ethic of *ubuntu* (humanness) in particular, specifying values of solidarity, relational justice and sufficiency based on it. The final section uses these concepts and values to critique current practices and proposals related to the COVID-19 pandemic and suggests directions for future inquiry.

Throughout the paper, we tag certain views as 'African' and others as 'Western' as a shorthand way to indicate views frequently espoused by people in these regions. We do not mean to imply that they are held by all people in these regions, or that no one outside these regions holds them. Nor do we aim to suggest that they are 'pure' and untouched by outside influences.

The Global Health Village

Cooling the *Teng*

Imagine that the planet and all her people comprise a single *global village*. This idea takes inspiration from *teng*, a concept native to the Builsa people of the Upper East region of Ghana. *Teng* can be doubly translated, both as 'earth' and 'community', implying not just a geographical location, but an interrelation among a group of people (Angles *et al.*, 2021). Likewise, 'global village' suggests

an interconnected group of people and their location on the earth. 'The *Buli-English Dictionary* defines *teng* as 'earth, ground, piece of land, town, settlement, village or country' (Kroeger, 1992). 'Village' is literally both a physical space, that is, 'a collection of dwelling-houses and other buildings', as well as 'a center of habitation' (Oxford University Press, 2021). Although a village that exists on a global scale includes villagers that differ in many respects, speaking different languages and practicing different ways of life, they comprise a center of habitation because they share a biological affinity and are increasingly interconnected with respect to health through globalization and the rise of systemic health threats, like emerging infectious diseases and climate change. By thinking of themselves as belonging to a global village, people identify as a 'we', highlighting their shared stake in sustaining health.

Among the Builsa, addressing a village-wide crisis requires marshaling the entire village to fix the *teng* and 'cool the land' (Schott, 1987). Where the crisis is perceived as an evil to the village, a rite of *teng nyuka* (drinking the land), is performed where participants disavow any role they had in perpetuating or sustaining an evil and commit to expunging it from the village (Atuire, 2020). During a pandemic, 'cooling the land' might mean protecting everyone from a dangerous pathogen, since the health of one affects the health of others in an interconnected planet. The African proverb, 'the stranger does not sleep in the street', reflects this. Recognizing human interdependence, Mbiti posits, 'I am, because we are; and since we are therefore I am' (Mbiti, 1969: 106). Shutte invokes the African proverb, 'a person is a person through other persons' to explain the interdependence of persons (Shutte, 1993: 46). Kasenene makes the point this way: '"to be" is to belong' (Kasenene, 1994: 141). The self, on this construal, is not 'inside' a person, but 'outside', 'subsisting in relationship to what is other, the natural and social environment' (Shutte, 1993: 47). Underlying these ideas are the seeds of what we need today.

During an infectious disease outbreak, we all share a microbial world; beyond this, we all share a planet under stress, with adverse effects on the health and lives of people everywhere. Increasingly, we live our lives through overlapping globally interconnected systems shaping what we see and do, how we communicate, the products we purchase, the food we eat and even the beliefs we hold. Despite the laws, borders and restrictions that separate countries, 'virtually all our activities and ideas have cross-border dimensions… These connections are complex, frequently opaque and often beyond our control.

Yet together they are shaping how the world develops' (Goldin and Mariathasan, 2015: 10). The COVID-19 pandemic underscores that global interconnection generates risks that are systemic, reverberating throughout the entire interconnected system. Since global risks are uneven in distribution and impact, it is helpful to think not only in terms of the spread of a biomedical agent (the SARS-CoV-2 virus) that causes disease, but a syndemic: a convergence of political, economic and biosocial forces that interact with one another to produce and exacerbate clinical disease and create pathways for viruses to spread (Jecker and Atuire, 2021a).

For the Builsa, *teng* indicates not just the fact of a shared dwelling, but how interconnected people ought to interrelate. *Teng* 'as a notion among the Builsa, is both ontological and normative. Ontologically, the earth (village) is a constitutive part of the identity of every human being', while ethically, people incur duties to the *teng* because 'Belonging to a *teng* or the *teng* is what makes life possible physically, culturally and ultimately, morally. Humans do not own the earth, they belong to it' (Atuire, 2020: 72). Similarly, members of a global village live interconnected lives and incur duties toward one another at all times, but especially during a village-wide crisis. During the COVID-19 pandemic, 'cooling the land' might take the form of reducing disease spread by ensuring access to soap and water, face coverings and vaccines, or bettering conditions that endanger people, such as poor ventilation or crowded conditions for living and working. Failing to take such steps 'spoils' the *teng* (*tengka kaasika*), exposing the villagers to disease and dividing people as they vie for protection. Both the fact of interdependence and the duty of mutual aid are forcefully conveyed by the African maxim, 'The right arm washes the left arm, and the left arm washes the right arm', suggesting that one needs the other and the two are parts of an interconnected whole (in this case, the human body). During an infectious disease outbreak, the responsibility to give mutual aid is morally mandatory, because each person depends upon every other for their health and life.

The African conception of community, which we pictured using the metaphor of a global health village, differs in important respects from prevalent Western conceptions. Menkiti radicalizes the difference by describing the African orientation as holding that society is fundamental and persons are derivative, while the Western orientation holds that individuals are fundamental, and society is derivative. According to Menkiti's analysis, a community in the Western sense signifies 'nothing more than a mere collection of self-interested

persons, each with his private set of preferences, but all of whom get together...because they realize...in association they can accomplish things which they are not able to accomplish otherwise' (Menkiti, 1984: 180). By contrast, a community in the African sense implies, 'I am because we are', which according to Menkiti, means quite literally I derive my identity from the collective 'we' that represents the community.

Governing the Village

When individuals reside together in a global health village, certain conditions are needed to sustain them. Villagers require governance to coordinate their activities and establish conditions that enable them to be healthy in an ongoing way. To be resilient during crises, a global village requires additional safeguards. Consider, for example, the first reported case of the novel coronavirus in Wuhan, China (Worobey, 2021). What would be necessary to prevent the virus from spreading and becoming a global pandemic that threatens people throughout the village? To begin with, it would require the ability to activate a range of health system capabilities quickly, before an outbreak took hold:

> (1) a global health surveillance system to spot infectious disease outbreaks quickly anywhere in the world and effectively warn people everywhere of the threat (Carroll *et al.*, 2021);
> (2) infectious disease first responders that can rapidly deploy anywhere in the world to avert a potential crisis;
> (3) a global sentinel surveillance network with the ability to test a percentage of the global population at regular intervals after a dangerous infectious agent is identified (Gates and Gates, 2021).

From an African standpoint, the values underpinning these capabilities should reflect a duty to the collective 'we'. Thus, surveillance and reporting should be conducted in ways that build trust, foster goodwill and encourage cooperation. The values we introduce to characterize the global health village have an African pedigree, yet they resonate beyond Africa and ought to be reflected in global health governance broadly understood. Clearly, this has not been the case. For example, the values on display in response to South Africa's surveilling and reporting of the Omicron variant in November 2021 were divisive (WHO, 2021a). Within days, before the world knew if the variant was more transmissible, lethal or resistant to vaccines, Israel, Japan and Morocco had sealed their borders and a long list of countries banned travel from southern African nations.

Such measures prompted anger and perhaps, made governments less likely to share information openly in the future (Jecker and Atuire, 2021b). South Africa's President called immediate travel bans in response to Omicron's discovery 'unfair discrimination against our country and our southern African sister countries' (Ramaphosa, 2021) while the WHO called bans premature and an 'attack on global solidarity' (WHO, 2021b). If communal values had driven the response, it might have looked different. Perhaps, we would have heard expressions of gratitude to South Africa for detecting, sequencing and reporting the danger; or seen collaborative efforts to ramp up testing, surveillance and vaccination; or witnessed increased efforts to safeguard unprotected regions by sharing vaccines and helping with last mile efforts to get shots in arms.

In addition to these in-the-moment responses, upstream measures integral to protection are required at multiple levels. At the level of science and policy, upstream efforts might include preventing zoonotic diseases through tighter controls on the animals that harbor them (e.g., tightening regulations on factory farming and animal disease management) and limiting cross-border live animal trade (Peyre *et al.*, 2021). Other examples of upstream protections include: increasing the evidence base essential for pandemic responses through genomic sequencing surveillance sites that collect samples and monitor existing and emerging virus strains (WHO, 2021c); expanding vaccine manufacturing and laboratory testing capacity to ensure that LMICs, which are home to about 85 per cent of the global population, can access diagnostics and vaccines they can afford (Wouters *et al.*, 2021); and regularly practicing pandemic response drills and simulations to model, analyze and improve how the world responds to infectious disease outbreaks (Gates and Gates, 2021). Collective preventive actions also extend to partnering with civil society groups and local communities to distribute masks; support safe housing; improve workplace safety and ventilation; roll-out vaccines; address vaccine hesitancy; and support people who need to temporarily isolate (Jecker and Au, 2021).

Finally, governing a global village requires powers of enforcement and sources of funding. During the COVID-19 pandemic, existing global health systems fell short. They failed to spot, warn, respond and diagnose global health threats and stop them in their tracks. The reason for this relates to the history of the global health structures that were relied upon. Most date to 1945, and the aftermath of World War II, when the United Nations (UN) was formed to facilitate cooperation between

states and offer a forum for international discussion and agreements, such as human rights declarations, conventions and covenants. The various organizations under UN auspices, such as the World Health Organization (WHO), World Trade Organization, International Monetary Fund and UN Children's Fund, have no independent powers of enforcement or sources of funding; they serve at the behest of member states.

This combination of in-the-moment responses, upstream measures and powers of enforcement and funding can be realized to varying degrees—what we call 'degrees of ethicality'—as shown in Table 1. Minimal ethicality exists when the global health village emphasizes *health security.* The village sees its purpose as protecting citizens against imminent health threats by establishing a system for collective defense. Representative are approaches emphasizing pandemic preparedness and efforts to prevent, detect and respond to infectious disease outbreaks. For example, Horton and Das take this approach when they argue that a security lens applied to health in the aftermath of the Ebola outbreak in west Africa called for pandemic preparedness and a recognition that 'each of us has an affiliation to the larger world we inhabit—a global identity that demands global solutions through cooperation between nations' during epidemic emergencies (Horton and Das, 2015).

Moderate ethicality is on display when a global village adds a system of *universal healthcare access.* Illustrative is Erondu *et al.*'s call for embedding global health security into universal health coverage, thereby creating national health systems designed not only to respond to health threats but offer (and continue offering outside emergencies) routine curative services to those in need (Erondu *et al.*, 2018). They envision a proactive partnership whereby LMICs receive not only development aid to build health system capacity, but debt relief and protection from financial hardship. This approach emphasizes establishing a health workforce, resource competency and systems for managing health in an ongoing coordinated way.

Strong ethicality is evident when the global health village supports *human flourishing.* Strong ethicality manages upstream social conditions that help people thrive and that impact people's health later on. Illustrative is the charter that created the WHO, which states its objective as 'the attainment by all peoples of the highest possible level of health' and defines 'health' as '[a] state of complete physical, mental and social well-being and not merely the absence of disease or infirmity' (World Health Assembly, 2006). Also illustrative are Articles of the WHO's Constitution that specify the WHO's scope as encompassing social determinants, such as nutrition; sanitation; recreation; economic or working conditions; mental health, especially aspects affecting the harmony of human relations; injury prevention; and maternal and child health and welfare, especially aspects related to capacities for living harmoniously.

Ethical Values Governing the Global Health Village

What level of ethicality should characterize a global health village? An African approach might take inspiration from an African ethic of *ubuntu.* While there is no English equivalent, *ubuntu* is often translated as 'humanness' or 'human dignity' and encompasses both ontological and normative dimensions. The *ontological* dimension is often expressed through pithy sayings, such as 'a person is a person through other persons' and 'I am because we are'. One way of understanding this is to say that human beings are interdependent and need one another, as expressed by the Akan maxim, 'a human being needs help'. According to this ontology, human dependency is not apparent only during illness and infirmity but exists as an 'ineliminable residue' of humanity, reflecting existential facts of human existence, such as embodiment, which renders people susceptible to harm; according to Wiredu, '[h]uman beings...at all times, in one way or another, directly or indirectly, need

Table 1. Degrees of ethicality in a global health village

Degrees of ethicality	Definition	Paradigm	Examples
Minimal	Manage imminent threats to health	National security	Pandemic preparedness
Moderate	Establish systems to ensure universal access to disease prevention and treatment	Universal health coverage	Development aid to build health system capacities
Strong	Attain the highest possible level of physical, mental and social well-being	Human flourishing	WHO Charter

the help of their kind' (Wiredu, 2010: 201). A basic tenet of *ubuntu* ethics is the givenness of communal life.

Ubuntu also encompasses a normative component. The normative component holds that human interdependence enjoins us to live a life with others that is harmonious and to expresses mutual concern and caring. The African saying, 'a human being needs help' does not just convey a fact, but also prescribes conduct and character. Describing the ethical aspect of *ubuntu*, Tutu states,

> A person with ubuntu is open and available to others, affirming of others, does not feel threatened that others are able and good, for he or she has a proper self-assurance that comes from knowing that he or she belongs in a greater whole and is diminished when others are humiliated or diminished, when others are tortured or oppressed (Tutu, 2009: 31).

These dual features of *ubuntu* stress both the fact of human interdependence in our day-to-day lives and the ethic of living together harmoniously.

Solidarity

Building on this analysis, we can formulate *ubuntu* first, as a moral imperative to foreground solidarity. *Foregrounding solidarity involves affirming and sustaining membership in a global village through induction, that is, through deliberate efforts to support each other's health.* On this rendering, as the ability to help increases, so too does the duty of individuals and groups to do so, and with increased need and dependence, individuals' and groups' rights to others' support grows. Ethically, the move from human being to villager is necessary in the sense that it would be ethically incriminating for a society made up of individuals who are health fragile, as all humans are, to fail to make this move, that is, to leave humans beings in a global village to become sickened and die. Beyond this, emphasizing the value of solidarity leads villagers to aspire to other-regarding moral excellences. Tutu, for example, lists generosity, hospitality, friendliness, caring and compassion as the moral excellences that people should aspire to (Tutu, 2009: 30–31). Menkiti characterizes becoming a person in the African sense as a matter of degree and holds that 'the approach to persons in traditional thought is generally speaking a maximal, or more exacting approach' (Menkiti, 2004: 326). Likewise, Metz interprets the African view of persons as holding that 'one should strive to maximize self-realization or human excellence (literally *ubuntu*), where such virtue is capable of continuous development'

(Metz, 1999: 137). Metz adds that 'Perfectionism is a clear implication of ethical systems that deem harmony to be a central value' (Metz, 2017: 152). Interpreted in this manner, a global health community sets a high bar of moral excellence toward others. Solidarity in the African tradition therefore justifies a strong degree of ethicality in a global health village; it sees duties of mutual aid as a requirement of justice, rather than a social ideal.

Relational Justice

Ubuntu also can embed itself in global health structures in ways that promote collective thriving. While a 'structure' is a diffuse concept, it serves well because it invites the possibility that justice is carried out diffusely, that is, by many individuals and groups interrelating to realize health. Beyond the efforts of governments, this includes: non-governmental organizations, civil society groups, philanthropic foundations, for-profit pharmaceutical companies and more. A structure for global health governance as we envision it rallies people throughout the village who are ordinarily not involved in health-related functions: grocery stores and markets; schools and daycares; churches, synagogues and mosques; employers of all sorts; and people in various service industries, like transportation, hotels and restaurants. An ethic of *ubuntu* is enacted when individuals and groups interrelate in ways that are harmonious, rather than discordant; generous, rather than greedy; and symbiotic rather than predatory. *Ubuntu* demands what some call, 'communal relationality' (Metz, 1999: 137), whereby people attempt to keep conflict and skirmishes at bay and stay focused on their shared stake in enabling people to lead healthy lives. These observations suggest that potent forms of global health justice are structural, existing through or by means of structures impacting people's health. Emphasizing the value of structural justice, or what we call *'relational justice'* demands avoiding and dismantling relationships that dominate, oppress or deprive people of their capabilities and promoting relationships that promote harmony, goodwill and neighborliness.

To illustrate, consider the global roll-out of COVID-19 vaccines. Many wealthy countries accumulated enough vaccines to inoculate their citizens many times over. For example, Canada preordered enough vaccine to inoculate its citizens six times over; the UK and the USA enough to do so four times over; in the European Union and Australia, preorders were enough to protect each citizen twice (Allison, 2021). Meanwhile, most low-income countries were unable to access vaccines to protect

their populations. As of 13 August 2022, 12.45 billion doses of COVID-19 vaccines had been administered, but nearly 80 per cent of them benefitted people living in high-income countries; only 17 per cent of people in low-income countries had completed an initial protocol (2 doses for most vaccines, 1 or 3 for a few manufacturers), compared to 74 per cent in high-income countries (Our World in Data, 2022a). Yet what exactly is amiss? While the narrative on vaccine nationalism and vaccine hoarding pins blame on wealthy nations and holds them accountable, it often overlooks the wider environment in which countries operate and the structures that shape how all nations procure and share vaccines. Governments of wealthy nations and shareholders of for-profit pharmaceutical companies operated in a global environment in which each sought to serve their own interest. Rich governments acquired as many vaccines as they could, even before they were tested and shown effective. Pharmaceutical companies, sought to maximize profits, and could do so with impunity since they legally owned vaccine patents. The structures shaping how nations procure and share vaccines and how drug companies sell them fell short of what we call 'minimum ethicality', since it failed to protect the health and life of people throughout the global village. Relational justice supports a very different model, one requiring a high degree of collective responsibility.

Collective responsibility extends beyond equitably distributing COVID-19 vaccines to encompass efforts to address vaccine hesitancy. 'Hesitancy' can be understood as 'a time of vulnerability and opportunity', when people are undecided and uncertain about vaccination and have not yet made a decision (Larson *et al.*, 2022: 58). In a 15-country survey investigating public knowledge and perceptions about COVID-19 vaccines across Africa, 25 per cent of the respondents who were hesitant to take a vaccine believed that COVID-19 disease was man-made, does not exist, or is exaggerated and does not pose a serious threat (Africa CDC, 2020). Collective responsibility in these instances requires trusted sources to devote time and attention to understanding people's concerns. This, in turn, requires larger scale global efforts to build public health capacity. During the pandemic, international media coverage of Africa has sometimes been reproachful and counterproductive, condemning the use of herbal treatments and healing prayers, belief in conspiracy theories, and refusal to practice physical distancing (Lee *et al.*, 2021a). Collective responsibility-taking, by contrast, requires a multipronged approach, responsive to the complex set of circumstances that give rise to vaccine hesitancy. For

example, historically, concessionary lending practices by wealthy nations contributed significantly to the current underfunding of public health in many low-income African nations, undercutting the substantial public sector investment newly independent African nations were making (Jecker, 2021). Referring to this historical pattern, Lu identifies 'unpaid debts' referring not to pecuniary debts, but moral debts incurred by wealthy nations who benefitted (Lu, 2017: 148). These and other responses give rise to a deeper understanding of the structures that impact people's health. It can nurture deeper commitments to undertake responsibility for the health of people throughout the global village.

Sufficiency

Ubuntu informs a third ethical consideration governing a global health village. It requires ensuring that people's most basic human capacities are supported. These include, for example, the capacity to be well nourished and physically healthy; be emotionally and mentally well; move freely from place to place; and affiliate. From the perspective of *ubuntu*, the most central human capabilities will be those related to capacities to be in communal relationships with others. Metz puts the point this way:

> what is special about human beings is their capacity to be in communal relationship with others. In that case, one should not stunt that capacity for the sake of something worth less than it, nor treat (innocent) others in a discordant way. Respecting another's dignified capacity both to exhibit harmony and to be harmonised with means treating it as the most important value….(Metz, 2016: 180).

During an infectious disease outbreak, people are incapable of exercising their capacity to commune unless they are sufficiently prepared to face down the threat of infectiousness. *Sufficiency* articulates the standard of health protection people are owed to ensure sufficient capacity to commune. *It calls for providing people a threshold level of all or a cluster of central human capabilities integral to health.* When a collective supports its least well-off members, it expresses group solidarity, in this case conveying that they are part of a global health village and do not face health hardship alone.

Judged by the standard of *ubuntu*, the standard of sufficiency justifies not only protection against threats (minimal ethicality) but treatment of existing disease and suffering which interferes with threshold capacities to commune (moderate ethicality). Would it support

strong ethicality? To the extent that being a person implies showing generosity, caring, compassion and other relational moral excellences, it would be part of being a person in community with others to support others' flourishing. Metz distinguishes African from Western views of good governance in this regard: from an African perspective, the point of governing is 'to improve people's quality of life and, especially to foster their self-realization as ethical beings...This means not merely meeting the biological needs of citizens and making them well off as individuals, but also promoting the moral good or relational human excellence' (Metz, 2017: 152). By contrast, many theorists from the Western tradition 'maintain that a state should merely enforce people's individual rights to live as they see fit'. A distinctively African conception interprets sufficiency as setting a high bar: governance within a global health village would aim to promote human flourishing (maximal ethicality), not just protect people from biological disease (moderate ethicality). Table 2 summarizes the discussion of this section and the three values governing a global health village.

Pragmatic Next Steps

If we all metaphorically inhabit a global health village, what practical steps can we take to better realize *ubuntu*? While a detailed assessment is outside the scope of our paper, we illustrate strategies that contribute to realizing the approach we have sketched.

COVAX

Early in the pandemic, COVAX (a WHO co-led effort to accelerate and equitably distribute COVID-19 vaccines to LMICs) afforded a mechanism for wealthy governments to accelerate access to vaccines in poorer nations while simultaneously protecting their own citizens. Before effective vaccines were available, COVAX functioned like an insurance plan, pooling money from many nations to advance purchase a portfolio of vaccine candidates still in development. Since wealthy countries paid upfront, they furnished the necessary capital, while LMICs were told they would receive sufficient doses to vaccinate their highest priority populations and 20 per cent of their general population, with the initial goal of delivering 2 billion doses of vaccines to poorer nations by the end of 2021.

Once effective vaccines were available, however, COVAX's shortcomings became apparent. First, COVAX was slow to meet its own target. As of 21 October 2021, just 14 per cent of the 1.8 billion doses promised were delivered (People's Vaccine, 2021). By 23 March 2022, the percent of promised doses delivered had increased overall, yet wide variations were apparent between countries. In Greece, 100 per cent of promised doses were delivered. By contrast, in the European Union, 75 per cent of promised doses were delivered; in the USA, 57 per cent; and in Switzerland, 22 per cent (Our World in Data, 2022b). A second, deeper worry is that COVAX makes sharing lifesaving vaccines a wholly voluntary undertaking, rather than a matter of justice and rights. In this regard, the duty to fulfill vaccine pledges to countries is akin to a duty of charity, which is generally considered less stringent than a duty of justice and unenforceable (Jecker, 2021). In this sense, 'we demand justice, but we beg for charity' (Miller, 2021). Third, the form of charity COVAX relies on, sometimes termed *philanthrocapitalism,* emulates the way business is done in the capitalist world (Bishop and Green, 2010). Through COVAX, rich nations become 'rivals' competing against other nations in 'a vaccine-buying race', while bidding up vaccine prices. This increases profits for pharmaceutical companies but excludes poorer nations, forcing them to rely on loans to finance debt in order to purchase vaccines (Mueller and Robbins, 2021). Philanthrocapitalism is morally dubious not only because it uses a return-on-investment model to incentivize charity, but also because it concentrates power in the hands of a few wealthy philanthropreneurs. For

Table 2. Values governing a global health village

Values	Definition
Solidarity	Transform persons into members of a global health village by engaging with them to affirm and sustain other-regarding moral excellences
Relational Justice	Avoid and dismantle structures that dominate, oppress or deprive people of basic capabilities and promote those that foster goodwill, trust and neighborliness
Sufficiency	Provide a threshold level of all or a cluster of central capabilities, with priority to the capability to commune and flourish in community

example, the two WHO partners in COVAX, CEPI and Gavi, were founded by the Bill and Melinda Gates Foundation, which is also the largest private funder of the WHO. In the 2018–2019 WHO budget, the Gates Foundation contributed 10 per cent of the WHO's total budget, with only the US government contributing more (16 per cent) (Crawford, 2021).

International Health Regulations and the Pandemic Treaty

The existing legal framework governing global pandemic response is the International Health Regulations (IHR), adopted by the World Health Assembly in 1996 and revised in 2005. The IHR aims to 'prevent, protect against, control and provide a public health response to the international spread of disease in which to avoid unnecessary interference and international traffic and trade' (WHO, 2005). However, it lacks the power to ensure adequate compliance (Phelan and Katz, 2020), financing (Gostin and Katz, 2016), data sharing (Taylor *et al.*, 2020) and aid for developing nations (Blinken, 2021). As a result, IHR fell short of its stated goal for H1N1 influenza, polio, Ebola virus disease in Africa, Zika virus in the Americas and the COVID-19 pandemic.

Some propose expanding IHR to better prepare for future pandemics. For example, the WHO Director-General, together with the leaders of 25 nations, called for an international Pandemic Treaty to protect future generations against infectious disease (WHO, 2020). A Pandemic Treaty has historic precedent in both the Framework Convention on Tobacco Control and the IHR. Harnessing the power of international law granted in the UN Charter to create a Pandemic Treaty would establish necessary powers of funding and enforcement and create more ability to assist nations prepare for future pandemics.

While an international pandemic treaty could complement IHR and provide a way to fund pandemic preparedness and make pandemic-related cross-border duties enforceable (Jecker, 2022), the analysis of this paper suggests that more is needed. While some critics have charged that a pandemic treaty does not fully realize global health security (Fukuda-Parr *et al.*, 2021), our concern is different. First, a pandemic treaty falls short of what is required to sustain healthy lives. Although it could play a crucial role during a global health emergency, a global village does not exist merely as an instrument for managing threats and crises, which represents the *lowest level of ethicality*. For this reason, a global health village ought not be governed by institutions designed solely for crises; it also requires tools for managing health in an ongoing, daily way.

Global Health Treaty and Sustainable Development Goals

Ultimately, governing a global health village requires not just an international *pandemic* treaty, but a *global health* treaty. A global health treaty finds legal backing in the WHO's founding constitution:

> to eradicate epidemic, endemic and other diseases; to promote...the prevention of accidental injuries; to promote the improvement of nutrition, housing, sanitation, recreation, economic or working conditions and other aspects of environmental hygiene; to promote co-operation among scientific and professional groups which contribute to the advancement of health...(World Health Assembly, 2006: 2).

This conception corresponds to what we called a *high level of ethicality*. One example of a pathway to realize a high degree of ethicality is to incorporate healthy lives within broader goals for sustainable development. The UN Sustainable Development Goals (SDG), adopted in 2015, tries to do this (United Nations General Assembly, n.d.). Among the seventeen SDGs, Goal three explicitly identifies health, calling on all societies to 'Ensure healthy lives and promote well-being of all ages'. Yet SDG goals cannot be realized within the existing global health architecture, which lacks independent powers of enforcement and monitoring. The UN anticipates that the private sector will drive development funding, but this has not occurred (Gostin and Friedman, 2015), suggesting more tools are needed. Realizing SDGs more fully could occur through a combination of efforts, such as a global health treaty, an international tax, and World Bank and IMF lending that supports domestic capacities for universal healthcare, health research, drug manufacturing and other means to ensure healthy lives. Table 3 summarizes the analysis of this section and links it with the examples discussed in previous sections.

Conclusion

The COVID-19 pandemic makes it abundantly clear that existing global health structures have failed us. To address this, we proposed that an African approach is well suited to global health challenges like the COVID-19 pandemic. We envisioned a 'global health village' which draws inspiration from the Builsa notion of *teng*, in which interconnected human beings recognize duties

Table 3. Degrees of ethicality, with definitions, associated paradigms and examples

	Degrees of ethicality	Definitions	Associated paradigms	Examples
Charity	No enforceable duty to help	Encourage donations	Philanthrocapitalism	COVAX
Justice	Weak	Ensure security	National security	Pandemic treaty
	Moderate	Ensure healthy lives	Universal health coverage	World Bank/IMF aid
	Strong	Ensure flourishing in ways related to health	Sustainable development goals	Global health treaty, World Bank/IMF aid

toward one another and toward a collective 'we'. Next, we drew on the African ethic of *ubuntu* to set forth ethical considerations of solidarity, relational justice and sufficiency to guide governance of a global health village. Finally, we gave examples of practical steps that could bring us closer to realizing this approach. Ultimately, realizing *ubuntu* in global health depends not only on global health structures, but on the diffusion of collective ways of thinking among inhabitants of a global health village.

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