

# : Global Governance Spotlight

2 | 2021

sef:

## Solidarity and Global Health Cooperation During Covid-19 and Beyond

Hanna Kienzler

Barbara Prainsack

Solidarity has been one of the most over-used terms during the Covid-19 pandemic. In many cases, the term solidarity is mentioned but not followed by any substantive action. Such expressions of solidarity, without a genuine commitment to the values and practices underpinning it, can create tangible harm. By papering over the very power differentials and inequities these expressions of solidarity pretend to address, they distract from what different people and countries have in common, and can hinder equitable distribution of resources, access to health care, mutual learning, and capacity strengthening from a

position of equality. A genuinely solidaristic approach requires actors to focus firstly on what they have in common, and secondly to be willing to accept costs to support others if necessary.

In this Spotlight, we explain what we mean by solidarity, argue that we are far from achieving it in our current global pandemic response, and outline ways forward that would allow for a more effective pandemic response based on practices of genuine solidarity.

### Solidarity: What it is and what it is not

During the Covid-19 pandemic, politicians, policy makers, journalists and community organisers have embraced the concept of solidarity to justify different, sometimes opposing goals. The concept has been used to ask nations to share vaccines with people around the globe while, at the same time, it has also been employed by states to justify vaccine nationalism as an expression of solidarity at national levels.

Against this background, we need to define what solidarity is, and what it is not. Drawing on earlier work by one of the authors (BP), we believe solidarity is best defined as a practice whereby people express their support for other people or groups with whom they see themselves as having something in common. This commonality is rarely something abstract. Solidarity is always enacted in situa-



Source: Sarita Kulli, Adriana H.C., produced for the SolPan+ project

tions that determine what commonalities matter. Moreover, what we perceive as having in common is dependent on how our families and societies have taught us. If we grew up in a society that treats people with different skin colour, religion, gender, or political values as ‘other’, then it is harder for us to see commonalities with these people.

Another key aspect of solidarity is a requirement for mutual give and take, even if it is not in the same instance and the same kind. This is particularly important for institutionalised forms of solidarity. An important example at national level is public healthcare. People contribute according to ability (e.g. a percentage of their income), and receive according to need. The system works because people are bound by a shared vulnerability to disease. Even if someone currently contributes more than they take out, they may benefit in the future. In terms of solidarity beyond the national level, examples of institutionalised solidarity are harder to find. We argue below that oft-cited examples of supposed international solidarity are in fact camouflaged national self-interest.

---

## The lack of solidarity in global health cooperation during the Covid-19 pandemic

### The case of vaccination politics

At present, a lot of ‘solidarity’ in the context of global health cooperation does not deserve this title. Even political leaders who regard the pandemic as a common global threat respond by using language of ‘charity’, whereby high-income countries of the Global North share their left-over resources with resource-poor countries in the Global South. For instance, in anticipation of vaccinating their populations as soon as vaccines proved effective, and before they would be available to other nations, countries of the Global North signed agreements with pharmaceutical manufacturers allowing them to pre-order more doses than needed (e.g. the US has more than 1 billion extra doses). Only when this surplus threatens to go to waste, it is ‘generously’ donated to poorer countries that lack secure supplies. Such ‘charitable’ gestures are problematic as they hide underlying causes that have led to the inequitable distribution of vaccines – and they are certainly not an act of solidarity. They also maintain a situation where ‘the poor’ are dependent on the goodwill of ‘the rich’, unable to develop their own systematic and strategic healthcare delivery.

Giving left-over vaccines to poorer countries goes hand in hand with an unquestioned position of privilege, enabling countries in the Global North to negotiate cheaper vaccine deals. This hinders

genuine solidarity where the Global North could advocate and enable subsidised vaccine pricing to guarantee a global pandemic response. Instead, pharmaceutical companies refuse to disclose vaccine prices, and sell their products more cheaply to those countries with leverage to negotiate better deals. Investigation into how much countries and non-profit organisations are paying revealed that while the EU pays US\$3.50 for the AstraZeneca vaccine, Uganda shells out US\$8.50, as Jason Beaubien reports. Such inequality means many nations will struggle to vaccinate their populations in 2021, while high-income countries could vaccinate theirs several times over.

The WHO voiced concern that such a lack of solidarity risks the lives of millions, arguing “none of us will be safe until everyone is safe”. Seeking to ‘implement’ global solidarity, it established Covid-19 Vaccines Global Access (COVAX) which raises money and procures resources to support research, development and manufacturing of different Covid-19 vaccines, and negotiates their pricing. COVAX is founded on principles of equitable access, where every country has the same chance to obtain vaccines. Whereas the vision is that wealthy countries will pool resources and invest in vaccine development to increase global vaccine access, the reality is that bilateral negotiations between powerful countries and producers have knocked COVAX to the back of the vaccine supply line. Consequently, COVAX’s potential for solidaristic action has fallen victim to the national self-interest of individual WHO member states.

This window dressing harms the emergence of genuine solidarity. As noted, genuine solidarity also requires mutual support (reciprocity), even if it is indirect. Solidaristic institutions and policies can only persist if all actors know that even if they are currently giving, they may receive in the future. This echoes the national healthcare system. COVAX could have become such a model. Ideally, each country would receive doses based purely on risk and population size, with the assessment of risk not limited to the risk of infection, but also taking into account the availability and quality of healthcare. Furthermore, high-income countries would have to be prevented from undermining the distribution scheme through bilateral deals to further their national self-interest.

### The case of knowledge exchange

Another area of solidaristic practice could be global health information sharing and the willingness to learn from the experience and expertise of others. While knowledge exchange has improved since the beginning of the Covid-19 pandemic, the arrogance of the Western World prevented rapid mutual learning at the start, contributing to high infection

rates and possibly thousands of avoidable deaths. For example, as Jürgen Gerhards and Michael Zürn argue, an opportunity was missed to learn from countries such as South Korea, which already had a highly responsive pandemic preparedness infrastructure in place, made effective use of new technology, and immediately implemented public health measures, like masks and quarantine. Many Western countries initially dismissed the widespread practice of wearing face masks, regarding it as a cultural idiosyncrasy that lacks evidence.

More than a year after the Covid-19 outbreak, researchers and politicians in the Global North still dismiss expertise and know-how developed in the Global South over decades of lethal epidemics and pandemic experience, including the effective use of community health teams. The often lower Covid-19 infection and death rates, and the absence of catastrophic health emergencies in many, though not all, countries of the Global South, are attributed to different forms and quality of data collection, younger populations and climate. These are cited as arguments to dismiss the need to look deeply at what these countries might be doing right. Experts from the Global South consider such reporting biased and patronising as their expertise is not acknowledged. It is, we would add, not merely condescending, but also dangerous. Some high-income countries struggle massively themselves to curate high-quality data on and information about social and economic fall-out of the pandemic. This will negatively influence the social determinants of health, with those living in poverty carrying the burden.

Genuine solidarity in global health cooperation means that country representatives from all parts of the world would encounter each other as equals. Rather than assuming richer countries only have something to give, and poorer ones mostly have something to learn or receive, the assumption should be that each country has its strengths and weaknesses, no matter how well equipped it may be in terms of economic resources. Such recognition of, and reflection on, one's own strengths and weaknesses, is the basis for mutual learning and, thus, an improved global health response in the Covid-19 pandemic and beyond.

A key lesson the Global North could learn from some countries in the Global South is the important role community health workers play in infection prevention and control, especially in the face of austerity, which has left health systems and populations in the Global North vulnerable. It has placed too much emphasis on vaccines and high-tech measures, not realising how community-based efforts and acknowledgment of the social determinants of health protect populations from disease outbreaks such as Covid-19. Embracing this would require

investment in social determinants and low-tech approaches that many rich countries, especially those marked by Public Choice economics and austerity, are not willing to make. As the current situation has made amply clear, people living in marginalised circumstances are more strongly affected by all crises – health, climate, economic ones. A challenge which all countries have in common, and need to work towards in solidarity, is the elimination of poverty and discrimination and the reduction of social inequality. This will help them prepare for, and control, disease outbreaks while providing the best available support and treatment to those in need.

---

## Policy recommendations

We offer four key recommendations to representatives of countries and corporations involved in pandemic preparedness and control:

### 1. Encounters from a position of equality.

Genuine solidarity requires the starting point of action to be what countries have in common, not what divides them. This is the pre-requisite for enabling encounters from a position of equality that cuts through prejudices and allows for mutual learning, new ways of problem framing, search for and experimentation with innovative solutions, and reciprocity where everyone gives and takes according to their abilities and needs.

### 2. Reduction of structural inequalities as a goal that unites all countries.

Although vaccines receive a lot of attention at the moment, the most effective way to increase pandemic preparedness and control across the globe is to avoid poverty and discrimination, and to improve public infrastructures and services. Following Sir Michael Marmot's "Build Back Fairer" review, this includes giving children the best start in life, enabling young people to maximise their capabilities and control their lives, creating fair employment and good work for all, ensuring a healthy standard of living for all, creating and developing healthy and sustainable places and communities and strengthening the role and impact of ill health prevention. Each of these areas carries equal importance – they have to be invested in and worked on simultaneously through solidaristic practices on a global scale.

### 3. Supporting countries in circumstances where one does not see immediate self-serving benefits.

Solidarity is neither free nor easy. It will not be achieved through feel-good practices where people merely clap their hands or declare their support online. Instead, solidarity is most difficult, but also most powerful, where countries support each other globally, regardless

of differences. An expression of genuine solidarity in vaccine equity, for example, would require that countries contribute resources proportionate to their economic strength and receive vaccines proportionate to risk, population size and availability and quality of healthcare. This requires the willingness to accept actual costs on the side of the economically privileged.

**4. Enabling the curation and sharing of high-quality data for pandemic preparedness and control on a global scale.** The lack of high-quality data on infection numbers, mortality, social and personal practices has hindered a successful global pandemic fight. The transparent curation and use of high-quality data, with adequate democratic and civil society control, is a quest that unites all countries. High-quality data generation in preparation for and during a pandemic requires international collaboration, responsible data sharing and shared learning throughout.

In summary, solidarity takes as its starting point what actors have in common, not what sets them apart. This does not, however, mean that differ-

ences are denied or neglected. Solidarity-based approaches sharpen our perception of what unites us, despite all apparent differences, and uses the commonalities between people, states and other actors, as a basis from which a joint commitment to fight inequities emerges. By focusing on the symmetries rather than asymmetries of countries, solidarity can help to contribute to greater epistemic and distributive justice, during the pandemic and beyond.

---

### Authors

**Barbara Prainsack** | is professor and Head of the Department of Political Science at the University Vienna, where she also directs the Centre for the Study of Contemporary Solidarity (CeSCoS), and the interdisciplinary Research Platform “Governance of Digital Practices”.

**Hanna Kienzler** | is associate professor in the Department of Global Health and Social Medicine and co-director of the ESRC Centre for Society and Mental Health at King’s College London.

### Further readings

Ashinyo, M.E., Dubik, S.D., Duti, V., Amegah, K.E., Ashinyo, A., Asare, B.A., Ackon, A.A., Akoriyea, S.K. and Kuma-Aboagye, P. 2021: Infection prevention and control compliance among exposed healthcare workers in COVID-19 treatment centers in Ghana: A descriptive cross-sectional study. *PloS one*, 16(3), p.e0248282.

Béhague, D., Minter, W., and Ortega, F. 2021: Solidarity, infrastructure and critical pedagogy during COVID-19: Lessons from Brazil, 7 April, [http://somatosphere.net/2021/solidarity-infrastructure-and-critical-pedagogy.html/?utm\\_source=feedburner&utm\\_medium=email&utm\\_campaign=Feed%3A+Somatosphere+%28Somatosphere%29](http://somatosphere.net/2021/solidarity-infrastructure-and-critical-pedagogy.html/?utm_source=feedburner&utm_medium=email&utm_campaign=Feed%3A+Somatosphere+%28Somatosphere%29).

Beaubien, J. 2021: Price Check: Nations Pay Wildly Different Prices For Vaccines, [https://www.npr.org/sections/goatsandsoda/2021/02/19/969529969/price-check-nations-pay-wildly-different-prices-for-vaccines?utm\\_](https://www.npr.org/sections/goatsandsoda/2021/02/19/969529969/price-check-nations-pay-wildly-different-prices-for-vaccines?utm_)

[campaign=storyshare&utm\\_source=twitter.com&utm\\_medium=social&t=1616343403268&t=1618782922078](https://www.wzb.eu/campaign=storyshare&utm_source=twitter.com&utm_medium=social&t=1616343403268&t=1618782922078).

Gerhards, J., Zürn, M. 2021: Dangerous ignorance: Why we learn so little about fighting the pandemic from Asian countries. *WZB Orders Beyond Borders*, 22 February, <https://orders-beyondborders.blog.wzb.eu/2021/02/22/dangerous-ignorance-why-we-learn-so-little-about-fighting-the-pandemic-from-asian-countries>.

Marmot, M., Allen, J., Goldblatt, P., Herd, E., and Morrison, J. 2020: Build Back Fairer: The COVID-19 Marmot Review, <https://www.health.org.uk/publications/build-back-fairer-the-covid-19-marmot-review>.

Olla, Akin. 2021: Welcome to the new colonialism: rich countries sitting on surplus vaccines. *The Guardian*. 14 April, <https://www.theguardian.com/commentisfree/2021/apr/14/rich-countries-surplus-covid-vaccines>.

Prainsack, B. and Buyx, A., 2017. *Solidarity in Biomedicine and Beyond* (Vol. 33). Cambridge University Press.

### Imprint

The Development and Peace Foundation (sef) was founded in 1986 on the initiative of Willy Brandt. As a cross-party and non-profit-making organisation, the sef: provides an international high-level forum for shared thinking on urgent peace and development issues.

Global Governance Spotlight is a policy-oriented series whose purpose is to critique international negotiation processes from a global governance perspective.

**Published by**  
Development and Peace Foundation (sef)/  
Stiftung Entwicklung und Frieden (sef):  
Dechenstr. 2 : 53115 Bonn : Germany  
Phone +49 (0)228 959 25-0 : Fax -99  
sef@sef-bonn.org : [www.sef-bonn.org](https://www.sef-bonn.org)

**Editor**  
Dr Michèle Roth

**Design Basic Concept**  
Pitch Black Graphic Design  
Berlin/Rotterdam

**Layout**  
Gerhard Süß-Jung

Contents do not necessarily reflect the views of the publisher.

ISSN 2566-624X  
© sef: 2021