Bioethical Inquiry
https://doi.org/10.1007/s11673-020-10001-2

SYMPOSIUM: COVID-19

Rethinking the Central Role of Equity in the Global Governance of Pandemic Response

Oghenowede Eyawo · **A. M. Viens**

Received: 7 May 2020 / Accepted: 17 July 2020

Abstract Our initial response to COVID-19 has been plagued by a series of failures—many of which have extended inequity within and across populations, especially in low- and middle-income countries. The global health governance of pandemic preparedness and response needs to move further away from the advocacy of a one-size-fits-all approach that tends to prioritize the interests of high-income countries towards a context-sensitive approach that gives equity a central role in guiding our pandemic preparedness and response strategies.

Keywords COVID-19 · Pandemics · Equity · Global health · Governance

While the global governance of pandemic preparedness and response often touts the importance of equity as a moral value and policy goal, our reaction to the COVID-19 pandemic should lead us to call this into question. On the one hand, we find the failure of omission—the progression of the COVID-19 crisis threatens to disproportionately impact low- and middle-income countries (LMICs) with vulnerable healthcare systems. On the other hand, we find the failure of commission—high-income countries (HICs) battle to buy out ventilators, personal protective equipment, and diagnostic tests on the global market, which freezes out any real possibility of LMICs getting these resources. This lack of collective action is a moral failure that risks losing the gains made in promoting health and health equity globally, and risks calling into question the usefulness of equity-based arguments for responsible governance that were used to justify actions to achieve these gains. We argue that much of pandemic preparedness and response remains focused on the interests, resources, and capacities of HICs and, in the case of COVID-19, requires more than a one-size-fits-all approach. The practicality of any proposed pandemic response measures needs to be strongly reconsidered in light of the flawed expectations surrounding the context, capacity, and governance arrangements in LMICs. We maintain that this requires us to rethink how we can strengthen the role equity plays in guiding the global governance of pandemic preparedness and response, and its wider potential impact for global health governance more generally.

O. Eyawo (✉) · A. M. Viens
School of Global Health, York University, Toronto, Ontario, Canada
e-mail: oeyawo@yorku.ca

A. M. Viens
e-mail: amviens@yorku.ca

Health Equity in an Unequal World

It is widely accepted that equity is central to global health and should be the guiding principle in global efforts to improve the health and lives of all people

Published online: 25 August 2020

around the world (Fee and Gonzalez 2017; Plamondon and Bisung 2019). The current global response to COVID-19—which has been mostly inward looking and nationalistic—calls this premise into question. The global health governance response to the COVID-19 pandemic has been largely modelled from the perspective of HICs without due consideration for how and whether it provides a feasible parallel strategy for LMICs. A predominant reliance on extemporaneous prevention measures, such as stay at home orders, frequent handwashing, long-term social distancing, and business closures cannot be easily or effectively translated into the LMIC context without major political and economic changes.

How can families in most LMICs effectively implement social distancing and self-quarantine when they live together in close quarters and operate within a culture where mingling is the norm? It is a challenge at best and an impossibility in many cases. Most people do not have access to running water at home; they need to go out into the community to fetch water from a public tap or stream—which makes regular handwashing challenging to implement. In some communities, there is no access to safe water at all—a problem that also disproportionately affects certain populations in HICs, as evidenced by some Indigenous and Black communities in North America (Waldron 2018). Many people also need to go to work in an informal setting on a daily basis in order to be able to afford food to eat the next day. They cannot so easily stock up on supplies and stay at home. Many have no personal savings and live from hand to mouth, and there is no steady power supply to keep the fridge running, even if they somehow managed to fill it. Furthermore, the food supply chain relies primarily on daily supplies and deliveries to local markets, since storage facilities are not very functional in these settings due to regular power interruptions. Under a lockdown strategy with insufficient contingency plans including temporary income and an active supply chain, food supplies will run out quickly for families and communities. Hunger will set in, crime may increase, and people may begin to die of starvation even before COVID-19 or another disease gets them. This practical reality must be included at the forefront of our moral theorizing about the global ethical dimensions of COVID-19.

Pandemic Preparedness and Response in LMICs: The Case of Africa

Decades of chronic health underfunding, largely driven by political corruption, has weakened the health system in most LMICs. Before the COVID-19 pandemic, the healthcare systems in these settings were at best already fragile, vulnerable, and ill-equipped to mount a quick and efficient response proportionate to the magnitude of a pandemic such as COVID-19 (Viens and Eyawo 2020). While the experience with responding to Ebola in some African countries may provide some clues on how to respond and mobilize, COVID-19 is different, given its high transmissibility and mode of transmission. Therefore, while the experience will be useful in these countries, it will not be sufficient to help them address this crisis. Reports from early on in the pandemic suggested that the number of COVID-19 cases in Africa could surge to up to ten million in as little as six months (Al Jazeera and News Agencies 2020). However, the reported figures so far appears to be much lower than projected (World Health Organization 2020); although this needs careful observation given the uncertain and evolving nature of the pandemic.

To date, much of the focus on responding to COVID-19 has been around the use of restrictive measures (i.e., quarantine, social distancing, school and business closures, travel restrictions) as the primary avenue to minimize or prevent community-level transmission. Without an effective antiviral or vaccine, it is claimed, our best chance to save as many lives as possible and prevent healthcare systems from being overwhelmed is to lockdown society—encouraging or requiring everyone to stay home to prevent as much contact as possible, limiting trips outside of the home to essential work or to obtain essential supplies only. This strategy has been coupled with a push to increase the testing capacity and the number of COVID-19 tests being conducted by local public health authorities in affected countries.

While these measures have been the dominant approach in most HICs, we should be sceptical of whether this will be an effective and feasible response for LMICs, especially in Africa. This is because little or no consideration has been placed on the unique challenges and opportunities in these settings—challenges that can impede the successful implementation of any response strategy. For instance, it is noteworthy that alongside the restrictive measures that include school and business closures to facilitate social distancing,

most HICs have created and rolled out a temporary income support benefit to its citizens and residents; something that most LMICs do not have the capacity to do. Canada, for example, which has an existing institutionalized unemployment insurance scheme, has set up a new response benefit to provide $2000 (CAD) per month for up to four months to those who stopped work because of COVID-19 (Government of Canada 2020). African countries cannot provide anywhere near the level of funding that is necessary to expect people to stop working and endure long periods of self-confinement. In comparison, some African countries have offered temporary COVID-19 assistance in form of cash (in Nigeria, 20,000 Naira—approximately $52 USD), food transfers, or unemployment insurance (as in South Africa, the continent's most advanced economy) (Dafuleya 2020; Runciman 2020), amidst concerns that it may not reach the people that desperately need it (Human Rights Watch 2020). This kind of palliative measure for staying at home is key to the successful implementation of such restrictive measures in any setting. The question is: will the economies in most LMICs have the capacity to institute complementary income support measures for tax-paying workers who are part of the formal economy—at a level that is sufficient to support people during the extended lockdown?

An even greater concern has to do with the fact that many individuals in LMICs, particularly in Africa, are either unemployed or are part of an informal economy where they are engaged as day labourers, handymen, petty traders, and local farmers/fishermen. These individuals live from hand to mouth and earn their living on a day-to-day basis as part of this informal economy. Unlike HICs, where the vast majority of residents are fully accounted for in the system and therefore a systematic rollout of support is feasible, most LMICs will not be in a position to support such residents who rely on this informal economy and are unaccounted for in the system (Akwagyiram and Toyana 2020). At the time of writing, Nigeria, South Africa, and Kenya have already imposed a full or partial lockdown response strategy in its major cities. The majority of workers in the informal sector—which accounts for more than 85 per cent of the workforce on the African continent—have been told to stay home (Akwagyiram and Toyana 2020). Most people are faced with the tragic and stark choice of either staying at home and risking starvation or going out to work and risking infecting themselves and their loved ones.

These issues are further compounded by a confluence of other factors resulting from contextual features that render this situation an unmitigated disaster with massive moral implications: an increase in crime and social disobedience; oppressive regimes using the pandemic as an opportunity to further clamp down on dissenters; citizens unable to collect any of the government's meagre pandemic assistance because of a lack of bank or mobile money accounts; already weak health systems at risk of collapse; and food becoming expensive and scarce during lockdowns, especially since there is no government oversight or control against price gouging. Unsurprisingly, poverty is strongly associated with hunger in Africa, with sub-Saharan African countries already having the highest levels of hunger and undernutrition of all the LMICs, which leads to childhood wasting and stunting, higher risk of illness, poor physical and cognitive development, and high mortality rates (Klaus et al. 2016; Otekunrin et al. 2019). The arrival of COVID-19 and the fact that it will exacerbate hunger and poverty provide the potential for this to be a real humanitarian catastrophe that morally requires urgent attention.

First Amongst Equals

According to the Africa Centres for Disease Control and Prevention, it has been difficult for many African countries to scale up their testing programs in response to COVID-19 (Nkengasong 2020). While in some cases this stems from not having the technical capacity, a major reason is that these countries are having trouble securing the chemical reagents needed to process tests. Since Africa does not currently produce their own testing reagents, they need to compete on the world market against HICs for this crucial, yet limited, material. Africa has not been able to get into the market to get much-needed diagnostics due to global protectionism—over seventy countries have imposed restrictions on export of essential diagnostic supplies. Given the established supply chains and purchasing power of HICs, their ability to buy up most of the supplies prevents African countries from taking essential steps to protect themselves from COVID-19. According to John Nkengasong, director of Africa's Centres for Disease Control, "the collapse of global co-operation and a failure of international solidarity has shoved Africa out of the diagnostics market" (Nkengasong 2020).

In these contexts, where it is not lack of capacity or resources that is the source of the harm but the actions of HICs, we find one of many illustrations of where HICs are violating their justice-based duties not to unduly harm others by participating in institutions and taking individual actions that have a causal role in the generation and persistence of ill health and health inequality (Pogge 2005). We have a general moral duty not to cause harm to others; and where we are causally implicated in the commission of that harm, we have a specific moral duty as a matter of justice to alleviate the harm that we have contributed to. These illustrations reinforce the need to revise the structure and function of global health governance systems so as to eliminate the disproportionate and exploitative power relations that have led to the current state of global health and health inequalities.

Taking Health Equity Seriously

COVID-19 provides an opportunity to reset the structure, function, and aims of global health governance. As far and wide as possible, we should take this opportunity to reinvigorate and re-establish an approach to global health governance with a true central focus on equity. There are a few ways within the global governance of COVID-19 response and global health governance more generally to bring equity back as a central component:

- Strengthen collective action and global cooperation to assure the conditions in which people can be healthy (e.g., universal health coverage, wage subsidies so people can stay home)
- Reduce the dominant focus on individual responsibility for health (washing hands, staying home from work, etc.) and focus on how structural factors act as social determinants of health
- Enhance coordination of response activities so that the actions of HICs do not prevent the ability of LMICs to promote health and reduce health inequities (e.g., at least prevent hoarding by HICs once SARS-CoV-2 vaccines start rolling out and at best coordinate global distribution to ensure affordable access for everyone)
- Develop structures and mechanisms that allow for the prioritization of local response and control in the global response to pandemics and other global health threats
- HICs should not be completely self-protectionist in orientation when responding to pandemics (e.g., while the United States sought to defund/leave the World Health Organization, Canada increased its foreign aid budget)

We believe that the current approach to pandemic preparedness and response—one that is overly driven by the interests, resources, and capacities of HICs—undermines the central role of equity in global health and limits our collective ability to effectively address important global health challenges—which as COVID-19 has reminded us, does not respect borders or social status. We argue that our approach to global health governance must equally consider the context and capacity in HICs and LMICs alike. Strengthening the role of equity in guiding the global governance of pandemic response is a sine qua non if we truly want to successfully confront current and future global health challenges.

References

Akwagyiram, A., and M. Toyana. 2020. Lockdowns: Saving lives, but ruining livelihoods in Africa. *Reuters World News*, April 7. https://www.reuters.com/article/us-health-coronavirus-africa-workers/lockdowns-saving-lives-but-ruining-livelihoods-in-africa-idUSKBN21P1AG. Accessed May 5, 2020.

Al Jazeera. 2020. Africa coronavirus cases could hit 10 million in six months: WHO. April 17. https://www.aljazeera.com/news/2020/04/africa-coronavirus-cases-hit-10-million-months-200417055006127.html. Accessed May 6, 2020.

Dafuleya, G. 2020. Explainer: Why COVID-19 provides a lesson for Africa to fund social assistance. *The Conversation,* May 3. https://theconversation.com/explainer-why-covid-19-provides-a-lesson-for-africa-to-fund-social-assistance-137175. Accessed May 6, 2020.

Fee, E., and A.R. Gonzalez. 2017. The history of health equity: Concept and vision. *Diversity and Equality in Health and Care* 14 (3):148–152.

Government of Canada. 2020. Canada's COVID-19 economic response plan: Support for individuals. https://www.canada.ca/en/department-finance/economic-response-plan.html. Accessed May 6, 2020.

Human Rights Watch. 2020. Nigeria: Protect most vulnerable in COVID-19 response. *Human Rights Watch*, April 14. https://www.hrw.org/news/2020/04/14/nigeria-protect-most-vulnerable-covid-19-response. Accessed May 6, 2020.

Klaus, V.G., B. Jill, N. David, et al. 2016. *2016 Global Hunger Index: Africa edition*. Bonn, Washington, D.C., Dublin, and Midrand: Welthungerhilfe, International Food Policy

Research Institute, Concern Worldwide, and NEPAD Agency.

Nkengasong, J. 2020. Let Africa into the market for COVID-19 diagnostics. *Nature* 580(565). https://doi.org/10.1038/d41586-020-01265-0.

Otekunrin, O.A., O.A. Otekunrin, S. Momoh, and I.A. Ayindea. 2019. How far has Africa gone in achieving the zero hunger target? Evidence from Nigeria. *Global Food Security* 22: 1–12.

Plamondon, K.M., and E. Bisung. 2019. The CCGHR principles for global health research: Centering equity in research, knowledge translation, and practice. *Social Science & Medicine* 239: 112530.

Pogge, T. 2005. World poverty and human rights. *Ethics & International Affairs* 19(1):1–7.

Runciman, C. 2020. Gaps in South Africa's relief scheme leave some workers with no income. *The Conversation*, April 22. https://theconversation.com/gaps-in-south-africas-relief-scheme-leave-some-workers-with-no-income-136403. Accessed May 6, 2020.

Viens, A.M., and O. Eyawo. 2020. COVID-19: The rude awakening for the political elite in low- and middle-income countries. *BMJ Global Health* 5(5): e002807.

Waldron, I.R.G. 2018. *There's something in the water: Environmental racism in Indigenous and Black communities*. Manitoba: Fernwood Publishing.

World Health Organization. 2020. Coronavirus disease (COVID-2019) situation report – 106. May 5. https://www.who.int/emergencies/diseases/novel-coronavirus-2019/situation-reports/. Accessed May 6, 2020.