https://doi.org/10.1038/s44360-026-00191-1

# Solidarity is essential in a more transactional global health era

**Caesar Atuire, Dijana Spasenoska, Julian Natukunda, Zaida Orth, Ashish Giri, Athanasius Afful, Simisola Akintola, Donna Andrews, Gabriela Arguedas Ramírez, Agathine Asamoaning, Primus Che Chi, Jantina de Vries, Hannah Healey, Unni Karunakara, Peter Kilroy, Petronell Kruger, Nchangwi Munung, Mary Ndu, Alice Norton, Elysee Nouvet, Ntobeko A. B. Ntusi, Barbara Prainsack, Bridget Pratt, Salome Wawire & Katharine Wright**

Check for updates

As geopolitical interests increasingly shape global health funding and partnerships, there is a growing need to build solidarity in guiding how resources are shared, decisions are made and health equity is advanced.

Efforts to advance equity-driven global health are not merely being contested; they are in decline, and increasingly being supplanted. A transactional model of global health is on the rise, driven by geopolitical competition, conditional partnerships and the retreat from multilateralism[1]. Under this model, cooperation is no longer organized around shared commitments to improving health for all, but explicitly around exchange, leverage and strategic interest[2]. What is at stake in this context is the survival of global health as a meaningful ethical and political endeavour. Against this backdrop, taking a fresh look at the ethical principle of solidarity and what it means for global health is essential. Solidarity is not only a moral aspiration, but also the only viable organizing principle that is capable of drawing and sustaining collective commitment in an actively fragmenting, yet deeply interdependent, world[3,4].

The epiphany of the transactional shift in global health is most visible in the policy orientation of countries, such as the UK, Germany, France, the Netherlands, Belgium and the USA, that are cutting back on global health funding[5]. One example, currently being debated across several African countries, is the 'America First' global health agenda that emphasizes bilateral arrangements that link aid to access to data, biological materials or strategic resources in recipient countries[6]. Such arrangements may yield short-term gains, but erode trust, entrench inequities and weaken collective capacity to address underlying disease challenges and new and emerging health threats[7]. This marks a turn away from cooperative internationalism and multilateralism towards a nationalist and transactional approach to global health engagement.

Challenges to global health equity are particularly prominent in crisis contexts, such as the COVID-19 pandemic and the 2022 and 2023 mpox outbreaks. Commitments to global health cooperation are challenged by unequal access to life-saving tools. However, contemporary global health challenges (such as pandemics and climate change) operate irrespective of borders; their effects are inherently transnational, place the highest burden on those who are contending with historical and structural inequities, and demand cooperation rather than siloed, self-interest-driven approaches. Interdependence is constitutive of any form of co-existence on the planet, including the current global order.

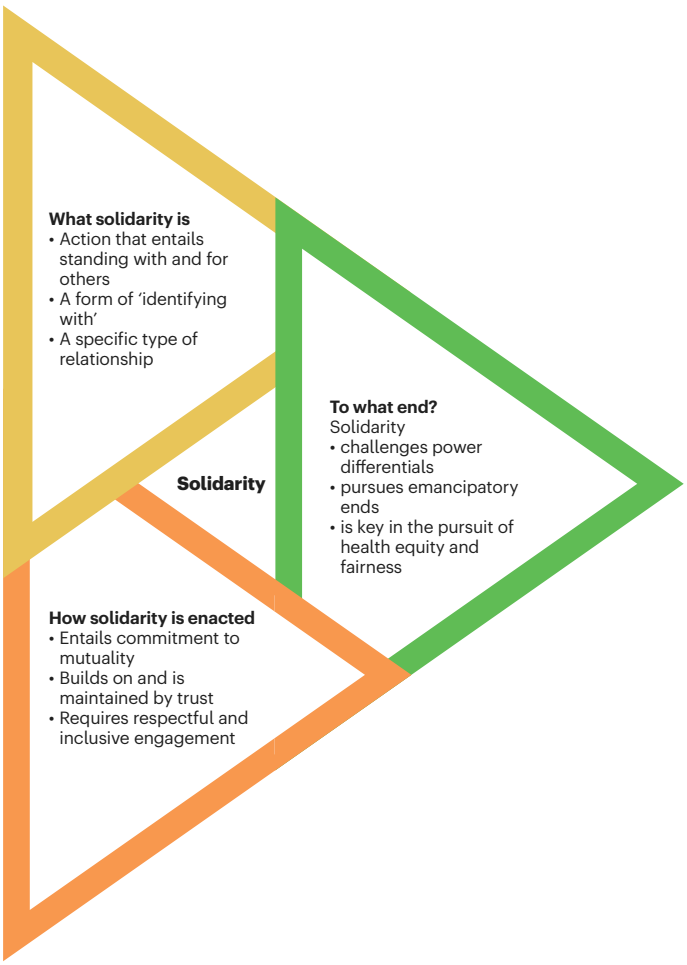



**Fig. 1 | A 3–3–3 framework for solidarity in global health.** The nine articles are intentionally relational. They articulate distinct but inseparable dimensions of solidarity. Each article should be interpreted in the light of the others, as part of an integrated normative framework rather than as an independent or self-sufficient statement.

A global health system that denies this is structurally unstable, ethically problematic and strategically self-defeating. Although global health systems have always been imperfect, they have been a space where calls for equity and justice in health within and across countries could

**Table 1 | Illustrative examples of differentiated solidaristic responsibilities, implementation tools and obstacles across global health actors**

| Actor | Key solidaristic challenge | Solidaristic responsibility | Example implementation tool |
|---|---|---|---|
| **Governments** | Inequitable distribution of resources and capacities across and within countries; persistent health inequities that affect marginalized and vulnerable populations; tensions between national interests and collective global health goals | Promote equitable access and burden sharing in global health and prioritize the needs of marginalized and vulnerable populations in health policy and resource allocation | Equitable financing commitments<br>Pooled procurement mechanisms<br>Equity-focused allocation frameworks<br>Targeted outreach and access programmes for underserved populations with a commitment to non-extractive practices<br>Support for technology transfer and capacity building |
| **Multilateral institutions** | Power asymmetries in global health decision-making; inadequate representation and accountability in governance processes | Ensure inclusive, transparent and accountable global-health governance, while addressing power asymmetries in decision-making processes | Governance reforms that improve representation and accountability<br>Equitable participation mechanisms<br>Transparent monitoring and reporting processes<br>Facilitation of international cooperation |
| **Private actors** | Profit-driven priorities, competitive practices and proprietary control of health-related goods, technologies and knowledge that undermine equitable access, cooperation and benefit sharing | Support equitable access to health-related goods, technologies and knowledge in ways that contribute to shared global health goals | Equitable licensing arrangements<br>Fair pricing policies<br>Data- and technology-sharing practices<br>Voluntary knowledge-transfer initiatives |
| **Civil society organizations** | Marginalization of affected communities and exclusion of local knowledge from decision-making processes; limited public accountability | Promote inclusive participation, represent affected communities, advance epistemic justice and hold other actors accountable | Community engagement mechanisms that demand accountability from powerful actors<br>Independent monitoring and reporting<br>Advocacy for equitable access and benefit-sharing<br>Formal inclusion of community expertise and lived experience in decision-making processes |

be demanded as an underlying normative aspiration[8]. The 'global' in global health is not merely a geographical descriptor of transnationality. It denotes a concern for improving the health of people irrespective of national borders. Recentring global health requires a return to its normative core: that 'global' denotes a shared concern in the health of people everywhere.

Solidarity arises when people recognize their shared vulnerabilities and interdependence and stand together to protect goals that they value or to confront shared threats and injustices[9]. Given that, globally, health is marked by profound and persistent inequalities in which some populations bear disproportionate burdens of disease and limited access to care, solidarity is not optional but a necessary response to the dual reality of shared vulnerability and unequal exposure to harm. Too often, however, solidarity is reduced to sentiment or rhetoric without action. Solidarity entails enactment in ways that distinguish it from other forms of cooperation or simple discretionary acts of goodwill. It is a distinctive moral orientation, because it regularly directs attention to those who are worse off — not as a matter of charity, but as a requirement grounded in the recognition of shared belonging to an interdependent human community[4]. Without a shared definition in mainstream practice or tools to measure the enactment of solidarity, practices of solidarity in global health and the role of solidarity in advancing health equity remain limited. To advance health equity, solidarity must be specified in ways that can guide institutional design and policy action[10,11].

Recent empirical work from the Global Health Solidarity Project, which draws on research and engagement across five continents, has sought to address this gap by articulating solidarity as a set of relational and institutional commitments[12,13]. Focusing on the global-health funding ecosystem, the project has articulated a nine-article framework ('3–3–3') for embedding solidarity in global health (Fig. 1). The framework is a practical starting point to embed solidarity in funding decisions. The articles — which are derived from a pluriversal bottom-up approach — are a synthesis of workshops, in-depth interviews and webinars that involved community leaders, activists, academics, civil-society-organization members, national and multilateral global-health actors, and funders. They characterize what solidarity is, how it is enacted and the ends towards which genuine solidaristic practices in global health aspire: the achievement of health equity, fairness and justice. At its core, solidarity is expressed through action: standing with and for others in ways that carry cost and are oriented towards measurable improvements in health and reductions in inequity. It is embodied and enacted, and not merely proclaimed.

Solidarity is relational and involves identifying with others in ways that recognize similarities without erasing or ignoring differences. This distinguishes solidarity from direct, linear and transactional forms of reciprocity. Direct reciprocity is structured around an expectation of return; solidarity is grounded in mutuality, understood as a commitment to act together towards common goals, whilst explicitly recognizing inequalities and asymmetries between participants, without reducing cooperation to conditional exchange.

Such relationships depend on trust built through repeated interactions in which actors demonstrate humility, reliability and responsiveness (particularly across asymmetries of power). Solidarity also requires practicing respectful and inclusive engagement, anchored in deliberative, participatory processes; recognizing diverse knowledge systems; and ensuring that participation in decision-making is substantive rather than symbolic. Without such inclusion, solidarity risks reproducing the inequities that it seeks to address.

Solidarity is not neutral with respect to power. Most forms of solidarity challenge entrenched asymmetries in global health governance and aim to redistribute decision-making authority and address the structural conditions that perpetuate inequitable access to resources, knowledge and care. In this sense, solidarity is not merely a charity-like response to alleviate health inequities, but seeks to transform and reshape the systems that generate them.

These salient features of action, relationality, mutuality, trust, inclusivity and attention to power clarify what it means to treat

solidarity as an organizing ethical principle. For these features to become part of the essence and modus operandi of global health praxis, solidarity needs to be institutionalized.

One way to support the operationalization of these commitments is through differentiated actionable tools that reflect the distinct responsibilities of actors within solidaristic relationships. Rather than imposing a uniform standard, such tools recognize variation in capacity and role, which allows actors to measure progress to implementation. By tailoring expectations, differentiated tools render solidarity both practicable and assessable. They also enable accountability, which allows evaluation of whether actors contribute to or undermine the common goals of global health. Without such mechanisms, solidarity risks remaining rhetorical. Table 1 is an illustrative (rather than exhaustive) example of how solidaristic responsibilities may be differentiated across actors according to their roles, capacities and functions within global health governance, including responsibilities related to equitable distribution, inclusive participation, accountability, epistemic justice and the mitigation of power asymmetries.

Global health now stands at a crossroads[14]. It can continue along a trajectory of fragmentation and transactionalism towards eventual decline or be reconstituted around solidarity as a binding, institutionalized principle. The frequent and often futile calls for solidarity in global health in times of emergency run the risk of remaining rhetorical until the principle is embedded in governance, financing and accountability structures. The framework for solidarity in global health outlined here is a first step to generating actionable tools and metrics to embed solidarity in global health practice. The question is no longer whether solidarity is needed, but whether it will be institutionalized in an increasingly fragmented global-health order.

**Caesar Atuire[1,2] ✉, Dijana Spasenoska[1], Julian Natukunda[1], Zaida Orth[3], Ashish Giri[1], Athanasius Afful[2], Simisola Akintola[4], Donna Andrews[3], Gabriela Arguedas Ramírez[5], Agathine Asamoaning[2], Primus Che Chi[6], Jantina de Vries[3], Hannah Healey[7], Unni Karunakara[8], Peter Kilroy[9], Petronell Kruger[10], Nchangwi Munung[3], Mary Ndu[7], Alice Norton[1], Elysee Nouvet[7], Ntobeko A. B. Ntusi[3,11], Barbara Prainsack[12], Bridget Pratt[13], Salome Wawire[14] & Katharine Wright[15]**

[1]University of Oxford, Oxford, UK. [2]University of Ghana, Accra, Ghana. [3]University of Cape Town, Cape Town, South Africa. [4]University of Ibadan, Ibadan, Nigeria. [5]University of Costa Rica, San Pedro Montes de Oca, Costa Rica. [6]Africa Centres for Disease Control and Prevention (Africa CDC), Addis Ababa, Ethiopia. [7]Western University, London, Ontario, Canada. [8]Global Health Justice Partnership, Yale University, New Haven, CT, USA. [9]Wellcome Trust, London, UK. [10]Center for the AIDS Programme of Research in South Africa (CAPRISA), Durban, South Africa. [11]South African Medical Research Council, Cape Town, South Africa. [12]University of Vienna, Vienna, Austria. [13]Australian Catholic University, Banyo, Queensland, Australia. [14]Science for Africa Foundation, Nairobi, Kenya. [15]Independent researcher, London, UK.
✉e-mail: caesar.atuire@ndm.ox.ac.uk

Published online: 19 August 2026

## References

1. Kickbusch, I. & Liu, A. *Lancet* **399**, 2156–2166 (2022).
2. Evaborhene, N. A. & Oga, J. *Lancet* **405**, 1049 (2025).
3. Prainsack, B. *Democr. Theory* **7**, 124–133 (2020).
4. Wang, Y. *Bioethics* **40**, 211–218 (2026).
5. OECD. *Cuts in Official Development Assistance: OECD Projections for 2025 and the Near Term* https://www.oecd.org/en/publications/cuts-in-official-development-assistance_8c530629-en.html (OECD, 2025).
6. Aremu, S. O. *Int. J. Health Policy Manag.* **15**, 9631 (2026).
7. Morrison, J. S. & Gostin, L. O. *BMJ* **391**, r2088 (2025).
8. Abimbola, S. & Pai, M. *Lancet* **396**, 1627–1628 (2020).
9. Prainsack, B. & Buyx, A. *Bioethics* **26**, 343–350 (2012).
10. Noh, J.-E., Prainsack, B., Weiss, E. & Pratt, B. *Glob. Health* **22**, 29 (2026).
11. Prainsack, B. *States of Solidarity: How to Build a Society* https://doi.org/10.1093/9780198965336.001.0001 (Oxford Univ. Press, 2026).
12. Global Health Solidarity Workshop reports. *Global Health Solidarity Project* https://www.globalhealthsolidarity.org/reports (2026).
13. Nouvet, E. et al. *BMJ Open* https://doi.org/10.1136/bmjopen-2024-095243 (2026).
14. Arguedas-Ramírez, G., Speed, E., Berger, Z. D. & Mannion, R. *PLoS Glob. Public Health* **5**, e0004576 (2025).

## Funding

The authors were supported by Wellcome Trust Discovery Award, grant no. 225230/Z/22/Z: Moving Beyond Solidarity Rhetoric in Global Health: Pluriversality and Actionable Tools.