DO GOVERNMENTS HAVE ANY PRIMA FACIE DUTIES TO FUND INFLUENZA VACCINATION (FOR THE ELDERLY IN SA) AND ADULTS 65 YEARS AND ABOVE TO VACCINATE AGAINST INFLUENZA, RESPECTIVELY?

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Date of Submission: 04 March 2023

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I, Ruach Sarangarajan,

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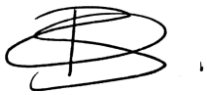

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Date: 04 March 2023

Dedication

I would like to acknowledge and show appreciation for those who have made this lifepath before me possible, those who have enabled and ensured my success and prosperity, and those who have continued to walk beside me consistently.

First and foremost, I give thanks and honour to God for being my provider, for blessing me with amazing career and academic opportunities, and for granting me the wisdom and strength to see this research project to completion. He has blessed my path so that everything I have been able to achieve in my academic career brings honour to Him.

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Abstract

In this dissertation, I draw on the thinking about solidarity, reciprocity, distributive justice, incompleteness and conviviality grounded in African philosophy broadly, including African ethics, African epistemology, African aesthetics, African metaphysics and African logic, to name a few, to argue that institutions, particularly the South African (SA) government, have a *prima facie* responsibility to fund the influenza vaccination for adults 65 years and above. Equally, I draw on the moral norms arising from the same values grounded in African philosophy to argue that adults 65 years old have a *prima facie* duty to vaccinate against influenza. These claims address three core issues relevant to fostering influenza vaccine access: availability, affordability and acceptability. While the former claim ensures that influenza vaccinations are affordable and available to the target population group, the latter underscores the obligation of adults 65 years and above to vaccinate to address acceptability issues. Although the dissertation focuses specifically on the South African government to defend its core thesis, I believe the arguments can reasonably be adapted to address the responsibilities of other African governments and older persons in other regions. Notably, these responsibilities are that the SA government should make influenza vaccines freely available for adults 65 years and above in public and private health facilities, provided financial allocation and their extant relationships allow for this. Additionally, the SA government has a responsibility to improve influenza vaccine procurement and availability in the country, preferably through increasing manufacturing capabilities. Furthermore, the dissertation argues that adults 65 years and above have a *prima facie* responsibility to vaccinate against influenza. Notably, adults 65 years and above have a duty of conviviality to act in ways that limit harm to them and others. This project is intrinsically valuable to promote epistemic justice, thereby contributing towards the decolonization of the global healthcare system. Moreover, this project has social significance in contributing to mitigation efforts against future public health challenges associated with population ageing in resource-limited developing African nations, wherein the impact of population transition will be most felt.

Word count: 226

Keywords: African ethics; conviviality; decolonization; distributive justice; incompleteness; influenza vaccine; reciprocity; solidarity

Acronyms

SA	South Africa
OAG	Old Age Grants
GAVI	Global Alliance for Vaccines and Immunisation
WHO	World Health Organisation
CDC	Centers for Disease Control and Prevention
OECD	The Organization for Economic Cooperation and Development
SAHPRA	South African Health Products Regulatory Authority

Chapter 1: Introduction

1.1 Background

Influenza-related complications/deaths occur more in adults 65 years old and older. Throughout this dissertation, we will use the short-hand *elderly* as synonymous to *adults 65 years and older.* It is also a large contributor to the global disease burden through continual cyclical outbreaks (World Health Organization (WHO), 2020a). Some symptoms of the seasonal infection of the respiratory pathway include fever withbody aches, sore throat, cough, rhinitis, congestion and fatigue (Centers for Disease Control and Prevention (CDC), 2022b). For most, influenza is a mild disease, and recovery spans between two days to two weeks (CDC, 2022b). However, vulnerable populations, particularly older adults are prone to developing complications from influenza including pneumonia, myocarditis, encephalitis, multiple organ failure and even death (CDC, 2022b). About 50%-70% of influenza hospitalizations and 90% of influenza-related deaths are adults 65 years or older (CDC, 2019). As age increases from 65 years old, the risk of hospitalization due to complications and influenza-related mortality significantly increases.

The term vaccine access needs to be unpacked. I conceptualize vaccine access in the same way it has been described by Di McIntyre, Michael Thiede and Stephen Birch (2009) as consisting of three dimensions – affordability, acceptability and availability. This description presents access as encompassing key issues concerning the cost of vaccines (who is responsible for bearing this cost?) and the individual's responsibility to vaccinate. Increasing influenza vaccine access for the elderly will play a critical role in limiting influenza's impact on this population.

Although the effectiveness of different influenza vaccines varies, vaccination remains the best preventative method against the influenza virus. Current vaccines can decrease the risk of infection between 40% and 60% during seasonal outbreaks (CDC, 2022a). Recognizing this, the WHO (2020b) recommended – during the global COVID-19 pandemic – that two population groups be prioritized above other groups for seasonal influenza vaccinations:

healthcare workers and older adults. Other risk groups for vaccination prioritization include young children, pregnant women, and individuals with illnesses such as HIV and tuberculosis (McMorrow et al., 2019). Furthermore, in 2018, the WHO developed the Global Influenza Strategy 2019-2030 with three goals: (i) decrease seasonal influenza burden, (ii) reduce the risk of zoonotic influenza, and (iii) alleviate the impact of influenza pandemics (WHO, 2019).

Consequently, increasing influenza vaccination uptake through easy access to the same by the older adult population will be pivotal in reducing influenza-related complications or deaths and realizing the WHO Global Influenza Strategy 2019-2030. However, global influenza vaccination in adults 65 years and older has either decreased or remained low. For example, in Germany in 2020, only 47% of adults aged 65 years and older were vaccinated against influenza (The Organization for Economic Cooperation and Development (OECD), 2018). Vaccination rates for older adults in Spain rapidly declined from almost 75% in 2009 to below 58% in 2014 (Dios-Guerra et al., 2017). Most low- and middle-income countries have limited data – owing to a lack of surveillance – on influenza vaccination coverage and uptake, especially for the specified risk groups (Duque, McMorrow and Cohen, 2014). A 2016 review found that only five African countries - Côte d'Ivoire, Egypt, Libya, Mauritius, and Tunisia – have influenza vaccination policies (Hirve et al., 2016). South Africa only has influenza vaccination guidelines (South African Health Products Regulatory Authority (SAHPRA), 2020).

There is a need for a more intentional strategy to increase influenza vaccine access and foster its uptake amongst older adults, particularly in developing nations in Africa. Ethics, activism, and vaccine campaigns will play essential roles. This project is primarily normative, exploring how ethics can be engaged to increase influenza vaccine access and foster its uptake in older persons. Importantly, there are various contributing factors for decreasing vaccination coverage against influenza in older adults. One factor is vaccine hesitancy – defined as the "delay in acceptance or refusal of vaccination despite the availability of vaccination services" (MacDonald, 2015). Reasons behind influenza vaccine hesitancy include concerns about vaccine efficacy and safety, fear of side effects (Rikin et al., 2018; Teo et al., 2019), belief that

influenza is not dangerous (Teo et al., 2019) and even misbelief that the vaccine is harmful or causes influenza itself (Rikin et al., 2018), preference for natural immunity and a low sense of collective responsibility (Nicholls et al., 2021). A significant factor equally identified by a national Australian workshop is an equity gap in vaccine coverage and promotion between infants and adults, exacerbated by systemic reasons such as a lack of randomised control trials, ageism and lack of adult vaccination record systems (MacIntyre et al., 2016). An equity gap occurs when children have higher vaccine uptake rates than adults because there are more vaccine promotion initiatives aimed at them than at adults, creating vaccine coverage disparities between these age groups and further exacerbating the effects of ageism (MacIntyre et al., 2016).

Age- and literacy-related factors must also be recognized, such as a decline in physical and mental functioning, living arrangements and social support (Nicholls et al., 2021). Elderly who are single or live alone have a lower chance of vaccinating compared to those who are married or co-habit (Nicholls et al., 2021). However, in developing countries, other contexts and/or community-specific factors should be explored (MacDonald, 2015).

Vaccination education and mandates can usefully address misconceptions, hesitancy, and misbeliefs regarding influenza vaccines. However, deeper engagement with ethics is required to tackle core questions concerning, (i) who is responsible for funding influenza vaccination for the elderly (to ensure its availability and affordability) and why they are responsible, and (ii) the responsibility of the elderly to vaccinate (to foster acceptability). Should institutions and which institutions fund seasonal influenza vaccination for older adults? Equally, do the elderly have a corresponding ethical duty to vaccinate against influenza and why? This project interrogates these vaccine access questions by drawing on key values, particularly solidarity, distributive justice, incompleteness and conviviality, grounded in African moral philosophy and scholarships in the Global South. Although I provide a detailed description of the African moral philosophy in the body of the work, it is worth emphasizing that a philosophy is said to be African to the extent that it draws on thought patterns that are more common on the continent

and have not come to the continent from elsewhere (Metz, 2013). One way of thinking common on the continent is that communal relationship is good in itself and should inform morality (Gyekye, 2011). This differs from Western theories like Kantianism, which require individuals to honour the rational capacity of human beings. Specifically, in African moral philosophy, an action is moral to the extent that it fosters social cohesion (Wiredu, 1992). In subsequent chapters, I will articulate the thinking about solidarity, distributive justice, incompleteness and conviviality that can be grounded in this philosophy.

1.2 Literature Analysis & Critique

Ethical reflections on influenza vaccine access, particularly for older adults 65 years and above, are scanty or almost non-existent. While many studies have explored questions around attitudes, perceptions and other factors influencing older adults' behaviour surrounding vaccines and the influenza vaccine for children, ethical reflections that focus explicitly on fostering influenza vaccine access for older adults of 65 years and above are still absent in these conversations. Equally missing are normative studies that support a focus on promoting seasonal influenza vaccination uptake from unique, underexplored African perspectives. Notably, existing ethical reflections on the seasonal influenza vaccines, more broadly, tend to adopt dominant theories in the Global North like Principlism, Utilitarian and Kantian moral approaches. One such position is the deontological argument that it is the government's responsibility to fund necessary healthcare in correspondence to citizens' right to healthcare (Reay, 1999). Furthermore, the elderly face specific age-related health challenges that other population groups may not experience (Sibanda et al., 2021), such as increased influenza-related health risks. Miguel (Kottow, 2019) posits that older people's physical and health-related vulnerabilities would imply that older adults should be afforded special rights to realize these specific health needs and achieve equality through simplifying accessibility to healthcare services, especially in developing countries.

Some scholars (Ibom and Soni, 2015) deny that governments have this responsibility by drawing on the principle of utility grounded in consequentialism. According to them, it would

benefit the greatest number of people if hospitals were operated as businesses so that governments could allocate those health funds to other sectors. Although this research study justifies that the government, particularly the South African government, has a responsibility for maintaining these special rights of preventative health measures (namely, influenza vaccine) for the elderly, it defends this view by drawing on an under-explored philosophy salient in Africa.

Although I focus on South Africa, this project has implications for other governments. Nonetheless, the focus on South Africa requires justification. The United Nations, Department of Economic and Social Affairs, Population Division (2020) estimates that the global population of those over 65 years will reach 1.5 billion by 2050. This population explosion will mostly occur in developing nations like South Africa. To effectively mitigate future public health challenges associated with population ageing in resource-limited nations like South Africa, the government must prepare adequately for healthy ageing through the development of comprehensive national policy in the promotion of a life-course approach (rather than only focusing on infants) to vaccination (Sibanda et al., 2021).

It is worth stating here that the South African government currently provides influenza vaccines for the elderly at no cost through the National Immunisation Program 2023. However, free influenza vaccinations for the elderly are only available at the country's public health facilities rather than in private facilities (National Department of Health, 2020). According to a report (Statistics South Africa, 2023), almost 68% of adults aged 60 and older accessed public healthcare facilities and over 31% accessed private healthcare facilities in 2021. Furthermore, the National Immunization Program 2023 does not have the force of law and is akin to a guideline for influenza vaccine access for the elderly in South Africa (SAHPRA, 2020). Notably, these guidelines are useful in informing healthcare professionals as to who should be targeted for prioritized influenza vaccination through the outlined at-risk population groups, the signs and symptoms to identify infection, recommended dosages for vaccination, prevention and treatment of different age groups, amongst other useful information. However,

the implication is that there is a lack of willpower to enforce the guidelines. Equally, where some efforts have been made to enforce the same, it is difficult to accurately measure the success of the implementation of and adherence to such guidelines since a system for adult vaccination records (other than that for Covid-19 and a paper register system for minors recording the Expanded Programme on Immunisation) do not currently exist in South Africa causing barriers to efficient influenza vaccination surveillance (Moonsamy and Singh, 2022), especially for specified risk-groups like older adults (Duque, McMorrow and Cohen, 2014).

To address these gaps, I contend in this dissertation that the SA government has a *prima facie* duty to make influenza vaccination available for adults 65 years and above. Although this thesis has implications for two core components of vaccine access (affordability and availability), it may not be sufficient to ensure acceptability. To promote acceptability, the study defends the view that the elderly also have a moral obligation to vaccinate against influenza. To justify these positions, the dissertation draws on previously mentioned values grounded in African philosophy: solidarity, distributive justice, incompleteness and conviviality.

There are many reasons to inform influenza vaccine interventions designed for African countries with these under-utilized African values. One reason is that it is important for epistemic justice for policies and interventions in Africa to be shaped by African values so that the communities wherein they are implemented can fully identify with them. Notice how this dissertation defines epistemic justice. It is the capacity to be recognized as a valid contributor to knowledge production that feeds into various policies, guidelines and measures that have implications for oneself. Policies and interventions that guide people should reflect their values and be cohesive with their beliefs for people to be able to identify with them. Importantly, individuals are more likely to abide by or accept policies that align with their values. Furthermore, this approach can increase the acceptability of these interventions in the communities and contribute to the success of the interventions if they are guided by values already ingrained in the communities.

Another significant reason is that informing vaccine interventions in an African context with values that are dominant on the continent would contribute towards the decolonization of the health system in Africa, ending scientific or health colonialism and demonstrating the exact ways in which normative theories from the Global South are useful and relevant alternatives to the dominant normative theories elsewhere.

Although I will provide detailed descriptions in subsequent chapters, it is worth acknowledging that the values in the African philosophy I draw on also exist in the Global North. Nonetheless, the dissertation focuses primarily on the thinking about these values that are salient on the African continent. For example, it is common to argue in African philosophy that solidarity requires one to conduct oneself in a compassionate and considerate manner, that is, in a way that might benefit others. The intention behind this behaviour in African thought is to care for the well-being of others (Metz, 2019). Equally, the thinking about reciprocity in the Global South entails an obligation of mutual aid and is typified by the common agricultural practice in Southern Africa known as *letsema*. This is the Sesotho practice wherein members of a community undertake to assist each other during each step in farming, including ploughing, sowing, weeding and harvesting (Mohapi, 1956). Directly translated, the Setswana word *letsema* means “a group of people coming together for a common purpose” (Setlhodi, 2019). This practice encapsulates several norms implicit in the significance of reciprocity in communal living. *Letsema* calls for mutual collaboration and cooperation underpinning collective responsibility among community members (Mofuoa, 2015). Furthermore, it predicates compassion in contributing towards an agricultural project that will benefit others in the community.

In African normative literature specifically, although both are considered expressions of social justice, distributive justice is sometimes differentiated from commutative justice. While distributive justice describes the first-order duties of institutions and states to their citizens (to protect their civil liberties, distribute goods equitably and create a conducive environment for communal relationships), commutative justice describes the responsibilities of citizens to one

another and the State. Notably, their responsibility to be solidary to one another and to the State (Ewuoso, Cordeiro-Rodrigues, et al., 2022).

Finally, the use of incompleteness as an established African normative theoretical principle in texts is still relatively new, and the formation of a concrete definition and the parameters of normative application is still in its infancy stages. However, one component of incompleteness in African scholars' literature is that it tends to express the idea of a default mode of being. Specifically, the shared West African Yoruba and Central African ontological belief is the acknowledgement that everything – nature, humans, the supernatural and human achievement exists in a state of incompleteness (Guma, 2020). This state of being is also true of entities that appear to be complete or a finished product. This manner of being incomplete is one of normalcy (Nyamnjoh, 2019b). Contrary to more Western or Eurocentric thinking, the state of incompleteness does not denote a lack or an inadequacy. Instead, incompleteness exists only because of the existence of a multiplicity of possibilities (Nyamnjoh, 2015). Relationality is the natural consequence of incompleteness (Nyamnjoh, 2015). This is true of all entities that experience incompleteness: humans, animals or supernatural beings. Relationalism allows one to reach out, engage and extend the incomplete self into a multitude of possibilities of being and becoming that would not otherwise be possible in isolation (Nyamnjoh, 2019a). Incompleteness enjoins one to conviviality. According to Francis (Nyamnjoh, 2015), “If incompleteness is the normal order of things, natural or otherwise, conviviality invites us to celebrate and preserve incompleteness and mitigate the delusions of grandeur that come with ambitions and claims of completeness.” Thus, conviviality calls us to actively search for ways to extend, transform and complement our incomplete selves within relationships by ensuring that the ways in which we relate are more effective and successful. Conviviality then encourages conversations within relationships, the extension of more compassion to others, the pursuit of collaborative choices that forgoes self-centred decision-making and the alignment towards collective interests (Nyamnjoh, 2015).

1.3 Research Question

The dissertation's overarching question targets two groups who can play critical roles in increasing influenza vaccine access in light of the definition I provided in the previous section: the governments and older adults 65 years and above (the elderly). Precisely, the research study interrogates the question, "Do governments have any *prima facie* duties to fund influenza vaccination (for the elderly in South Africa) and adults 65 years and above to vaccinate against influenza, respectively?"

1.4 Thesis Statement

Drawing on the moral norms that arise from key underexplored values – such as solidarity, reciprocity, social justice, conviviality and incompleteness – dominant in Africa, some of which have been articulated, defended and expounded upon by African philosophers, I contend that the South African government has a *prima facie* duty to fund influenza vaccination of the elderly in South Africa and adults 65 years and above have a moral duty to vaccinate against influenza.

1.5 Research Aim

This project aims to defend the thesis, that is, to justify how the described underexplored values dominant in Africa ground the respective *prima* facie and moral duties that the South African government and the elderly have to increase accessibility of the influenza vaccine for the elderly.

1.6 Rationale

This study is of both social and academic significance. One reason it is socially significant is that vaccination access for older adult populations is important to reduce gaps in preventative health equity between age groups, decrease the burden on the health system and prevent unnecessary waste of health resources that could otherwise be used to treat more urgent health cases. Influenza vaccine access is equally an important public health measure to limit infections to particular population groups. In this case, vaccine access can prevent infection

in the elderly population, where complications of influenza and more significant associated health risks are more prevalent. Increasing vaccine access for the elderly would contribute to mitigation efforts against future public health challenges associated with population ageing in resource-limited developing African nations, wherein the impact of population transition will be felt most. Furthermore, guidelines and policies must be ethically informed so that influenza vaccine policy not only holds willpower in that they provide actionable change, but also has a value-based impact.

Regarding academic importance, normative explorations from a unique African perspective that support a focus on influenza vaccination access are intrinsically valuable and can increase African voices on issues that affect the continent. A failure to echo these voices on health issues relevant to Africa contributes to the colonization of health on the continent. Additionally, such failure is less likely to respond to the call to shape public health policies and interventions for Africans in Africa by drawing on more prominent values and philosophies on the continent (Mbali and Rucell, 2022). The methodological approach of this study should also be of interest to academic scholars unfamiliar with dominant theories in the Global South.

1.7 Research Design & Methods

This dissertation is a mostly normative ethics research study (rather than an empirical one) that draws on moral norms arising from values dominant in the Global South. This normative approach is essential and is reckoned by others to be equally valid for research articles because of their philosophical analytic method (Vogelstein and Colbert, 2019) (Molina Wills, 2022). Other scholars like Luis Cordeiro-Rodrigues and Kevin Behrens have also used the philosophical method this dissertation adopts. As a philosophical analytic method, the dissertation builds on relevant articles that have been retrieved from databases like PubMed, PhilPapers, and Google Scholar, using key phrases like "solidarity and African moral philosophy", “incompleteness, conviviality, Africa”, “vaccination, influenza and elderly”, “elderly vaccination and South Africa”, to name a few. For example, for the discussion on solidarity, the dissertation retrieved relevant articles from PhilPapers and Google Scholar by

using key phrases like “solidarity and Afro-communitarianism”, “formulations of solidarity in African moral philosophy”, and “African philosophers and solidarity”. More than researching various conceptions, common features and formulations of solidarity in African scholarship and how the nuances might impact the research question, this dissertation will also juxtapose the African conception with global conceptions of the same, especially those that might have implications for the thesis this dissertation defends. These philosophical approaches are not uncommon and have been used by others to push the boundaries of knowledge in normative ethics papers (Atuire, 2022).

This theoretical approach is vital for several reasons. Although I explained the reasons in the previous section, it is worth repeating key points here. Firstly, it is crucial for epistemic justice for policies and interventions in Africa to be shaped by African values so that the communities wherein they are implemented can fully identify with such guidelines. Policies and interventions that govern people should reflect their values and be cohesive with their beliefs for people to identify with them. Secondly, it would lend to the acceptability of these interventions in the communities and contribute to the success of the interventions if they are guided by values already ingrained in the communities. Finally, informing vaccine interventions in an African context with values that are dominant on the continent would contribute towards the decolonization of the health system in Africa, ending scientific or health colonialism and demonstrating the exact ways normative theories from the Global South are useful and relevant alternatives to the dominant normative theories elsewhere.

The dissertation conceptualizes Afro-communitarianism in the same way it has been described by Cornelius Ewuoso and Susan Hall (2019), as the moral philosophy informed by values that are dominant on the African continent. These values are not only found in the Global South. But the thinking about these values has not come to this continent from elsewhere.

1.8 Research Objectives

1. To draw on the norms arising from the thinking about solidarity, reciprocity and distributive justice grounded in African philosophy to assert that institutions, particularly the South African government, have a *prima facie* duty to fund influenza vaccination for adults 65 years and above in South Africa.
2. To draw on the moral rule of thumb arising from key values of incompleteness and conviviality that can be grounded in the scholarship of the Global South to contend that adults aged 65 years and above have a moral duty to vaccinate against influenza.
3. To defend the dissertation's core thesis against potential objections.

1.9 Argumentative Strategy

To realize objective 1, first, I will provide broad descriptions of solidarity, distributive justice, and reciprocity in the works of African philosophers, epistemologists, and anthropologists. What key features of these values are dominant in these scholarships? In what ways are the views of solidarity, distributive justice, and reciprocity different from ideas about the same in philosophies dominant elsewhere?

Having provided a broad description of solidarity, distributive justice, and reciprocity in this section, I will proceed to outline moral norms that can arise from these values. For example, one moral norm that can arise from the thinking about solidarity in African philosophy is that we ought to act for the group's well-being since we are implicated in one another's lives (Metz, 2010). Subsequently, I draw on these norms to defend the position that institutions, particularly governments, have a *prima facie* duty to make influenza vaccine freely accessible to the elderly 65 years and above.

Against the above, the specific research question the project interrogates in the first chapter is, "Do governments have a *prima facie* duty to fund the influenza vaccination of adults 65 years and above? I draw on the relevant values and answer in the affirmative. Herein, I briefly re-introduce the three interrelated dimensions of access (Thiede, Akweongo and McIntyre,

2007) – availability, affordability, and acceptability – and limit my focus in this section to affordability and availability. Suppose the dimensions of access are interrelated. In that case, an improvement in availability can impact affordability. Availability and affordability may not guarantee acceptability and thus foster an increase in influenza vaccine uptake (Thiede, Akweongo and McIntyre, 2007). Evidentially, according to Ayako Honda and colleagues (2015), if only the availability and affordability of healthcare services, for example, say in South Africa, are improved, patients may not find the quality of the service acceptable, and access to the services would still not be increased. To successfully develop effective influenza vaccine access measures, I focus on questions around acceptability in the second section.

Furthermore, I address potential objections to the position I endorse in this first part of my dissertation. For example, someone may contend that requiring governments to fund influenza vaccination could spiral into forms of authoritarianism. Governments may begin to think that they have the responsibility to dictate their citizens' health habits or choices. The Chinese one-child policy is one example of how the position this project endorses could encourage governments to make arbitrary health, including reproductive decisions, for their citizens. Individuals who exercise their freedom to refuse vaccination may be penalized or sanctioned. Freedom may be curtailed in the world where governments believe that they have the prerogative to make health decisions for their citizens.

Additionally, another critic may deny that the moral norms I draw on can arise from African views about solidarity, distributive justice, and reciprocity or imply that institutions have a *prima facie* duty to provide free influenza vaccines to the citizens. Still, another critic may indicate that the *prima facie* duty I endorse may create unrealistic expectations for a government with an overwhelming elderly population but limited resources. The dissertation addresses these and other potential objections to its position that governments have a *prima facie* duty to fund seasonal influenza vaccination for adults 65 years and older.

To realize objective 2, the project provides broad descriptions of incompleteness and conviviality in the works of prominent African scholars. It describes the key features of these

values. Equally, the project identifies and analyses how the African thinking about incompleteness and conviviality is similar and different from this conception in other scholarships. Having provided these descriptions, the project outlines the moral norms that emerge from these values. For example, one moral norm that can arise from the thinking about conviviality in the scholarship of African anthropologists and philosophers is that one ought to act in collaborative and compassionate ways since everything and everyone else in relation to oneself is just an extension of oneself (Samuel and Fayemi, 2019). In other words, conviviality suggests the interconnectedness of lives, implying that we are accountable for each other's lives and well-being. In African scholarship, individuals are not unimpacted by the actions of others. This interdependency also typifies the pattern of thought evident in African epistemology, wherein relationships and connectedness between humans (Metz, 2017) and even between animals and nature are valued (Ojomo, 2011). The project justifies why conviviality implies that the elderly aged 65 years and above have individual and collective responsibilities to vaccinate against influenza.

The project's analysis in this section is not merely limited to justifying this duty. It also includes defending the same against potential objections. For example, a critic could reason that conviviality places too much burden on individuals since it assumes that these individuals who are expected to endorse and encourage influenza vaccination uptake do, in fact, agree that influenza vaccination ought to be endorsed. They may have a contrary view. Moreover, there are many other ways to exhibit conviviality other than influenza vaccination, like promoting sanitary practices to limit infection. Furthermore, a critic may point out that the call to act in collaborative ways in the pursuit of collective interests violates one's freedom of personal pursuits, personal interests, individuality, creativity, and autonomy. The project addresses these and other potential objections.

1.10 Research Outcomes and Outputs

The project aims to publish insights from the research in highly-rated journals like *Vaccines*. Furthermore, the project aims to engage with policymakers and create awareness of the

responsibilities of entities like the government in ensuring and establishing influenza vaccination programs that target adults 65 years and older. The project will promote this awareness at important public and town hall meetings and health seminars. This population group remains under-targeted in many influenza vaccination programs, particularly in Africa. Equally, the specific ways home-groomed (African) approaches can inform influenza vaccination programs deserve greater visibility in global influenza vaccination programs to realize global health justice. This project will contribute towards this effort by presenting its key findings regarding how Global South scholars use and apply important concepts like solidarity, reciprocity, distributive justice, incompleteness or conviviality. Additionally, the insights from this project will be shared at international conferences like the *World Congress of Bioethics*, *Oxford Global Health and Bioethics International Conference*, and the *International Conference on Clinical Ethics Consultation*.

1.11 Limitations

This project is largely a normative and conceptual research study. Some of the limitations of conceptual analyses in research are that it is complex and time-consuming to investigate a concept. Furthermore, this can be a challenging process that can be overwhelming since the analysis requires large amounts of data and literature to be processed. Since this project focuses on a framework that could be applied in a multitude of African countries, a limitation is that this framework analysis cannot be made highly specific since high specificity would limit the variability and flexibility of the framework's application capacity and interpretations of analyses in differing contexts can be error-prone.

Equally, this study is mostly applicable to countries in the Global South and would not be of great use in application to Euro-centric and Western countries. A limitation of most normative projects is that it is mostly explorative studies relying on existing empirical studies so that no new data is produced.

1.12 Ethical Approval

The project is mostly a normative and evaluative project that draws on norms arising from key concepts in Global South scholarship to think critically about issues regarding influenza vaccine access for older persons 65 years and above. Hence, the study does not involve research with humans/animals. In light of this, the project did not apply for ethical approval.

CHAPTER 2

AVAILABILITY AND AFFORDABILITY OF THE INFLUENZA VACCINE

2.1 Introduction

In this chapter, I draw on the norms arising from the thinking about solidarity, distributive justice and personhood grounded in the African Ubuntu philosophy and African philosophy more broadly to argue that institutions, particularly the South African (SA) government, have *a prima facie* duty to fund seasonal influenza vaccination of the elderly aged 65 years and above in South Africa. This will likely contribute to vaccination uptake by fostering influenza vaccine access by this population group. From the outset of this dissertation, it is essential to note that although my focus in this chapter is on influenza vaccine access by the elderly in South Africa specifically, the arguments I articulate can be contextually adjusted to ground the dissertation's thesis within other African countries. Subsequently, I believe that my argument extends to all governments. To this end, I draw on African norms that arise from values dominant in African regions.

This project has become necessary since ethical reflections on whether governments have a duty to fund seasonal influenza vaccination for the elderly from the *unique, underexplored African perspectives* are mostly missing. As previously stated, existing ethical reflections on the government's responsibility to fund the vaccination of older adults tend to adopt dominant theories from the Global North. One such position is the deontological argument that it is the government's responsibility to fund necessary healthcare in correspondence to citizens' right to healthcare (Reay, 1999). Furthermore, the elderly face specific age-related health challenges that other population groups may not experience (Sibanda et al., 2021). One of these age-specific health needs is prevention from influenza infection since 50%-70% of influenza hospitalizations and roughly 90% of influenza-related deaths are adults aged 65 years and older (Centers for Disease Control and Prevention, 2019). However vaccination

programmes (the most effective preventative public health measure against influenza) have been mostly aimed at infants, and global vaccination coverage in the elderly is low. Miguel Kottow (2019) posits that older people's physical and health-related vulnerabilities would imply that older adults should be afforded special rights to realize these specific health needs and achieve equality through simplifying accessibility to healthcare services, especially in developing countries.

Some scholars like David Ibom and Piyush Soni (2015) deny that governments have this responsibility by drawing on the principle of utility grounded in consequentialism. According to them, it would benefit the greatest number of people if hospitals were operated as businesses enabling governments to allocate those health funds to other sectors. This argument justifies that the government is responsible for maintaining these special rights of health prevention for the elderly by ensuring that they have equitable access to age-specific preventative healthcare such as influenza vaccines.

Furthermore, this project has social significance in light of the United Nations, the Department of Economic and Social Affairs, Population Division's (2020) estimate that the global population of those over 65 years will reach 1.5 billion by 2050. This population explosion will mostly occur in developing nations like South Africa. To effectively mitigate future public health challenges associated with population ageing in resource-limited nations like South Africa, the government must prepare adequately for healthy ageing through the development of comprehensive national policy in the promotion of a life-course approach (rather than only focusing on infants) to vaccination (Sibanda et al., 2021). This dissertation will be important in addressing the ethical considerations of influenza vaccine access for the elderly in South Africa and should contribute to more comprehensive policy formation.

In consideration of the elderly population group's vulnerabilities to influenza as well as the impact of the burden on the healthcare system, the South African government does currently provide influenza vaccines for the elderly at no cost through the National Immunisation Program 2023. This is *only* available at the country’s public health facilities rather than in the

private facilities (National Department of Health, 2020). According to (Statistics South Africa, 2023), almost 68% of adults aged 60 and older accessed public healthcare facilities and over 31% accessed private healthcare facilities in 2021.

There are also limiting factors that undermine access to influenza vaccines, even at public health facilities. These are particularly challenging for the elderly such as prolonged waiting times, costs incurred by transport, and overburdened and understaffed health professionals (Solanki et al., 2019). In fact, in 2019 (the most recently captured available data) only 67.4% of the elderly in South Africa that were surveyed were willing to consult a healthcare professional in a public health facility when ill and more concerning, 27.4% chose to self-medicate instead due to some of the barriers mentioned above to accessing public healthcare facilities (Statistics South Africa, 2021). 31.2% of adults 60 years and older responded that they *usually* access private healthcare as opposed to the 36,2% that accessed public health care when ill (Statistics South Africa, 2023). If influenza vaccines were made freely available to all elderly persons at private healthcare facilities (regardless of whether they can afford private health insurance), these challenges and barriers to accessing healthcare would be significantly alleviated. Currently, at private facilities and pharmacies (such as Clicks, Dischem and Medirite) that are widely accessible by adults 65 years and above, the influenza vaccine comes at a cost, often between R109 and R250 (Thukwana, 2021).

What is more, as stated in the previous chapter, in South Africa, the National Immunization Program 2023 does not have the force of law and is akin to a guideline for influenza vaccine access for the elderly in South Africa (SAHPRA, 2020). The implication is that there is a lack of willpower to enforce the guidelines. Equally, where some efforts have been made to enforce the same, it is difficult to accurately measure the success of the implementation and adherence to such guidelines since a system for adult vaccination records (other than that for Covid-19 and a paper register system for minors recording the Expanded Programme on Immunisation) do not currently exist in South Africa causing barriers to efficient influenza vaccination surveillance (Moonsamy and Singh, 2022), especially for specified risk-groups like

older adults (Duque, McMorrow and Cohen 2014). The most recent report presenting data on vaccine coverage by age group reported a vaccine coverage of 53% for adults 65 years and older (Wolter et al., 2022). While this coverage rate may seem adequate, the accuracy and reliability of this data estimate may be greatly skewed and subject to bias due to the small sample size of 34 older adults. My thesis that the SA government has a *prima facie* duty to make influenza vaccination available for adults 65 years and above also includes the responsibility of implementation. Additionally, I will provide clear guidelines on what concretely needs to happen to realize these duties in SA.

2.2 Afro-communitarianism in African Scholarship

The value of community is salient among Africans in their practices and perceptions (Metz, 2013). This is not to say it is necessarily representative of *all* Africans or that communalist thinking is not common elsewhere in the Global North. Still, this thinking pattern on the *African continent* specifically (although globally shared) has not originated elsewhere. An Afro-communitarian ethic is very generally described as prizing harmonious communal relationships (Cordeiro-Rodrigues and Metz, 2021) and denotes a way in which individuals in a group ought to relate with one another (Metz, 2013). However, there is some contestation in African scholarship regarding whether communalist ideals are of intrinsic normative value with an end in and of itself (Metz, 2007) or whether it is a means to an end, such as the improvement of vitality, flourishing or well-being (Gyekye, 2011). Although the reason behind the pursuit of communalist ideals may differ, the main motivation remains the same – to become more human. The late Desmond Tutu (1999, p. 35), South African Archbishop and Chairman of the Truth and Reconciliation Commission, befittingly remarked,

> We say a person is a person through other people. It is not I think therefore, I am. It says rather: I am human because I belong. I participate I share… Harmony, friendliness, community are great goods. Social harmony is for us the *summum bonum* — the greatest good. Anything that subverts or undermines this sought-after good is to be avoided like the plague.

This excerpt denotes the paramount importance of social relations in Afro-communitarian ethics. It is the utmost moral pursuit in which one becomes more human – an increase in moral value in developing humanness.

Of equal ongoing dispute is the primacy of the community and its interests compared to individual interests and rights – specifically, the debate between which takes precedence if either (Molefe, 2017). Regardless of existing contestations in African scholarship, there remain presupposed normative values common in Afro-communitarianism ethics.

Kwame Gyekye (1992, p. 103), a most prominent Ghanaian philosopher, asserts that "A communitarian socio-ethical philosophy [puts] emphasis on communal values, collective good and shared ends…" Similarly, Cornelius Ewuoso (2023) refers to some principal communal values, including interdependence, fellowship, solidarity, communal relationship and harmony. Segun Gbadegesin (1991, p. 65), a Yoruba Nigerian philosopher contends, "Every member is expected to consider themselves an integral part of the whole and to play an appropriate role towards achieving the good of all."

All of these abovementioned communitarian values can be summed up into two overarching principles to facilitate harmonious relationships from a framework of Ubuntu philosophy formulated by philosopher Thaddeus Metz (2007) – *identifying* with others and exhibiting *solidarity* with one another. Briefly described, identifying with others entails sharing a way of life with them by perceiving oneself as part of a group. Exhibiting solidarity involves acting with goodwill in promoting the well-being of others and acting for the common good (Metz, 2017). Since in the next section, I provide a substantial overview of African conceptions of solidarity,in this section I provide a brief overview of the conception of *identification* only.

Identifying with others is essentially to fully devote oneself – mentally/intellectually, emotionally and actionably – to sharing life in an interdependent manner with others (Cordeiro-Rodrigues and Metz, 2021). Not only is one cognisant of existing in as part of a group, but one also experiences a sense of togetherness in a place of belonging (Metz, 2007). With a deep emotional investment in the group, she/he would feel embarrassed or proud of the actions of

her/his group (Metz, 2019). Furthermore, identification garners a longing to engage in a common way of life with group members which culminates in an inclination to collaborate in communal projects and coordinate one's actions to be in line with common goals (Metz, 2013).

Another way to conceive of Afro-communitarian ideals is to consider the virtues one should exhibit. If the goal is to become more of a moral human, then it follows that there are certain moral characteristics one ought to exhibit. These other-regarding moral virtues include "generosity, kindness, compassion, benevolence, respect and concern for others" (Gyekye, 1992, p. 109). Similarly, when one exhibits humanness (*Ubuntu*), they would be considered to be "generous, hospitable, friendly, caring and compassionate" (Tutu, 1999, p. 35). Most of these above-mentioned virtues are encompassed in *Ubuntu* philosophy as *solidarity* – specifically compassion, caring, sympathy and friendliness (Metz, 2007).

A few African scholars hold the conception of Afro-communitarianism as not merely a type of Virtue Ethic but as upholding altruistic ideals (Masolo, 2010; Metz, 2012; Ewuoso and Hall, 2019). For example, Thaddeus Metz (2013) contends that acting in aid of others, out of sympathy and compassion, is purely motivated by altruistic service. This line of thinking is also typical of the Philosophy of Care, and Afro-communitarianism is often understood as a kind of Care Ethic of which Metz subsequently provides a brief comparative analysis.

Particularly, common in both ethics is the expression of empathy. In care ethics, one is not only called to exhibit empathy but also to try to understand others' unconscious motives. In practising empathy for the other, one naturally becomes sympathetic so that the other's emotional condition would affect his/her emotional state as well (emotions are bound up with one another). Thus, one would strive for an improved condition of the other in the expression of compassion for the other, hoping that he/she has a good life with less suffering. Being emotionally invested, one would desire to aid the other him/herself and not just hope for an improved condition without necessarily implicating oneself by being actively involved in that improvement. Lastly, these kind actions in aid of the other are motivated by successfully helping the other for their sake (altruistic service).

I have provided a brief overview of Afro-communitarianism, some of the norms and values derived from it and various conceptions of the same. I have also discussed some similarities with other common ethical frameworks of which Afro-communitarianism is sometimes understood to be a sub-categorical philosophy. I will now provide a brief global comparison of Afro-communitarianism with some other philosophies dominant in the Global North to highlight some major differences thereof and to showcase how Afro-communitarianism can be uniquely useful.

One of the most dominant theories often utilized in health ethics is *Kantian Deontology*. Immanuel Kant believed humans are rational agents and have a duty to act in certain ways (Dhai and McQuoid-Mason, 2020,p. 11). He asserted that this rational ability is what grounds personal dignity. These duties were formulated in the structure of moral laws/rules (Kant, 1993, p. 32-36). Contrastingly, in Afro-communitarianism, a person becomes more human the more one successfully and harmoniously relates with others and the more one upholds others' capacity to relate (Shutte, 2001). That is, a person attains more moral value the more one prizes harmonious relationships. Unlike Kantian Deontology, one does not need to be a *rational* human being to be considered a person (of moral value) as long as one is capable of entering into and maintaining relationships. Similar to Afro-communitarianism, Kant (1993, p. 30) contends that people are not merely a means to an end, but are valuable as ends in themselves and should befittingly be treated with dignity and respect that moral value commands.

This is in direct contrast to another dominant ethical theory in the Global North – *Utilitarianism* otherwise known as *Consequentialism*. Herein, the 'ends justify the means' (Dhai & McQuoid-Mason, 2020, p. 13). Consequentialism entails locating the morally wrong or right action by first evaluating the outcome of the actions to determine which one would be favourable. This type of analysis requires unbiased or impartiality in decision-making (Kainz, 1988, p. 78). Unlike Afro-communitarianism, which values interpersonal relationships, Utilitarianism rejects considering the nature of a relationship with an individual when one must make a decision

regarding this individual. Utilitarianism is often useful for public health dilemmas (*Act Utilitarianism*) and policy formation (*Rule Utilitarianism*) but, according to Afro-communitarianism, it fails to account for what makes us truly human – empathy and compassion, or more comprehensively referred to as *solidarity*. Particularly, if one were to make a difficult and *cold/unbiased* decision void of empathy with the primary goal to increase the overall 'good', it could be said that the individuals implicated by this decision (the minority who may have to deal with the unintended negative consequences of the decision) have been treated *inhumanely*. This is not to say that this is always the case, but rather that Utilitarianism as an ethic is lacking in this aspect as it fails to look after minorities and account for their vulnerabilities.

There are two main forms – *Rule* and *Act* Utilitarianism. Act Utilitarianism is essentially what has been described above wherein a specific act/decision is only morally right if it increases goodness, pleasure, happiness or flourishing (Shaw, 1993, p. 54). However, Rule Utilitarianism, similar to deontology, relies on a set of rules or laws to govern actions and these norms or rules should have an impact of maximising utility when universally followed. Similarly, Afro-communitarianism considers the impact of actions on everyone in the community, but this does not necessarily mean that everyone ought to follow the exact same rules. What is of importance in Afro-communitarianism is the common good and requires everyone in the community taking collective responsibility. However, this does not necessarily entail everyone following the same rules or actions to collaborate in a certain communal project that will have some common good for the community. Different individuals in the community might be able to collaborate on the same project but with different contributions according to their unique strengths to achieve the same goal. However, Rule Utilitarianism may not take differences in ability between individuals into account. The same general rules and norms would apply to everyone in the same way and may end up disadvantaging certain people or overlooking specific abilities or ways in which others could contribute more efficiently. One of the most drawn-upon ethical frameworks in healthcare is known as Principlism or the 'Four Principles'

(Dhai and McQuoid-Mason, 2020, p. 17). An ethical analysis is done by considering the principles of beneficence, non-maleficence, autonomy and justice from which certain *prima facie* duties can be drawn (Beauchamp and Childress, 2013). Afro-communitarianism often has a strong underlying value system of justice in restorative aid and reconciliation. Furthermore, it advocates for the common good of the community and in this way seeks to minimise harm. However, it does not necessarily rule harm as morally wrong if it is in response to a greater harm (but only in an attempt to prevent or stop that harm on someone else). Lastly, Afro-communitarianism does not put an emphasis on autonomy and individual freedoms. This is not to say that the individual is not valued, but rather, if an individual's interests are in direct contrast with communal interests, it is regarded as selfish or ego-centric and would be discouraged if acting upon this individual freedom might harm the community or decrease social ability .

Lastly, it is worth noting that *communitarianism* is not unique to the Global South and various Communitarian ethical frameworks exist in the Global North as well (Dhai and McQuoid-Mason, 2020, p. 13-15).

In this section, I have provided a brief overview of conceptions of Afro-communitarianism. This does not exhaust all possible conceptions of Afro-communitarianism from the continent, and some conceptions have been precluded from this discussion (such as feminist ethics). Still, I have briefly mentioned ones relevant to this dissertation's argument. In the next section, I will briefly outline key components of solidarity that are dominant in the philosophy I described in this section.

2.3 Solidarity in Ubuntu Philosophy and Afro-communitarianism

The term, Ubuntu, is a Nguni expression meaning humanness (Metz, 2007). To exhibit Ubuntu is to live a human way of life sincerely or display human excellence; to lack Ubuntu is to be deficient in human excellence (Metz, 2016). Thus, to exhibit Ubuntu, it is necessary to develop humanness wherein moral status, personhood and dignity are found, and to lack Ubuntu is to

no longer be considered a person. This begs the question, ‘How should one develop humanness?’

A foundational maxim of Ubuntu philosophy, “A person is a person through other persons” (Ewuoso and Hall, 2019), roughly infers that one develops humanness through forming positive communal relationships and valuing harmony with others (Metz, 2010a). Augustine Shutte (2001, p. 30) states, "Our deepest [ethical imperative] is to become more fully human by entering more... deeply into community [or harmony] with others and forgoing selfishness." The thinking about solidarity grounded in Ubuntu requires that we conduct ourselves in a compassionate and considerate manner, that is, in a way that might benefit others. The intention behind this behaviour in African thought is to care for the well-being of others (Metz, 2019). But to be able to show true solidarity requires acknowledging our interdependence. If we can do this, we will not feel obligated to just show compassion or try to benefit friends and family with whom we have close relations; we will equally try to benefit all other members of the community to whom we may not have personal ties but are aware that we are nevertheless connected to as a fellow functioning member within our society.

The knowledge that the well-being of others in our community is inextricably linked to our own well-being enables us to consider ourselves as a group and to act for the common good of our community and society. This way of thinking implies that we value other individuals the same as we value ourselves without needing to have direct personal ties to them because their value is found through their ability to contribute to society by their capacity to enter into relationships with others in society. Any act of aid for the greater good benefits both others around us and ourselves simultaneously. As such, there is no specific distinction between oneself and others around oneself because one regards themselves as a part of the greater community.

Contrastingly, other global conceptions of solidarity, such as that defined by Barbara Prainsack and Alena Buyx (2012), which a Nuffield Council on Bioethics report has used, still lean towards a nuanced individualistic perspective with a delineation of the individuals that comprise the basis of groups and they posit that these individuals should also be regarded on

an individual level, not just on a group level. This conception of solidarity does distinguish between oneself and the larger group. This conception subtlety rejects the thinking of others as an extension of oneself and may present a barrier to valuing others in the community as equal to oneself. Barbara Prainsack and Alena Buyx's (2012) conception of solidarity can be useful to ground both individual and collective interests, and so it tends to be more inclusive. However, it does not account for the location of individuals' place in communal relationships. A conception of solidarity wherein the individual and communal interest is not necessarily a dichotomy but could be considered compatible interests or distinguishing between the two is actually irrelevant. This is also alluded to by Innocent Asouzu (2011), an African philosopher who has produced numerous works on the metaphysics and ontology of studying *Ibuanyidanda* (complementary reflection). He interestingly questions whether it is entirely necessary to categorize individualism as quintessentially Western because, in reality, both individual and communal interests inevitably exist simultaneously regardless of cultural association.

Notice that there are other ways in which the thinking about solidarity differs from the conception of the same in the Global North. For example, although this conception of solidarity from the Global North similarly prizes acting compassionately in aid of others, it sometimes evaluates actions in solidarity by their costs incurred. An action for the benefit of others incurring a cost implies that these beneficial deeds may become a burden or come at a disadvantage to oneself, further highlighting the individualistic perception that benefiting others does not necessarily entail concurrently benefiting oneself. Based on the preceding thinking about solidarity, solidary actions are primarily *individual-regarding*. By contrast, the African view of solidarity is other-regarding and often entails the moral duty to act for the well-being of others.

It is important to outline some conceptions of solidarity derived from common maxims and motifs in various African regions to underscore Global South's tautology of the principle of solidarity and how it can be understood in the African context and the norms deriving from it.

One foundational maxim by John Mbiti (1969), a Kenyan Christian philosopher often referred to as the 'father of modern African theology' is, "I am because we are; and since we are therefore I am". This maxim denotes the utmost importance of relationships with others in realizing one's moral duties and values and developing one's humanity or personhood. He also aptly highlights the necessity of interdependence, that one cannot exist as a human without being connected with others, and that others' states of being are intricately bound up with our own. West African traditional Igbo philosophers (of Nigeria) often use a set of allegorical statements to draw on the principle of complementarity or mutual dependence (Asouzu, 2005, p. 142-148). "Ibu anyi danda" translates to 'no task is insurmountable for danda (a species of ants)' (Asouzu, 2007, p. 11). *Danda* can move hauls much heavier than themselves when working in mutual dependence on one another (Asouzu, 2011).

From this allegory, other African philosophers derive values of togetherness and a sense of belonging (Ikechukwu, 2016). In a similar vein, consider the East African Luo proverb, "Alone a youth runs fast, with an elder, slow, but together they go far" which underpins the value of togetherness, that we can accomplish much more together than we could on our own in the communal project. In this proverb, the elders provide wisdom, knowledge and guidance while, amongst other things, the young can offer strength and put this guidance into action. There is a mutually complementary relationship that exists with this sense of togetherness, where all parties contribute towards the communal project in their capacity, but their contributions are of equal value since they collaboratively bolster the common good of those in the community. This depicts a sort of *horizontal solidarity between community members* (Ruch and Anyanwu, 1981).

Equally, to justify how we are implicated in each other's lives, some scholars use the motif of the Siamese Crocodile, with two heads but one stomach. This is a common motif in West Africa and depicts how deeply connected and impacted African lives are (Cordeiro-Rodrigues, 2020).

While the conceptions of solidarity grounded in Afro-communitarianism depicted above represent various nuanced understandings of solidarity from different African regions, it does not exhaust all possible conceptions of African solidarity. I acknowledge that within these conceptions of solidarity of the Global South remains a "missing link" of where the place of the individual can be located within the community (Asouzu, 2011). As such, the African principle of solidarity – like everything else in existence – exists in a state of incompleteness (Nyamnjoh, 2015), wherein the space for many possibilities of enhancing and extending this principle arises, possibly even to a conception of solidarity wherein a complementary relationship of mutual dependence between the individual, their interests and community interests can be found (Asouzu, 2011). Nonetheless, the analysis indicates that the moral imperative arising from solidarity in Afro-communitarianism often requires individuals to prize togetherness, fellowship, docility, and acting for the well-being of others.

2.4 Reciprocity and Afro-communitarianism

Reciprocity refers to the notion that one is morally obligated to help those in their community who need aid in whichever capacity one can, since others are morally required to do the same (Metz, 2007). A common maxim used to express this idea is that *"the right-hand washes the left-hand and the left-hand washes the right-hand."* The moral norm that arises from this is that the relationship of mutual aid is moral, and ought to be promoted since this is who we are.

It is essential to state here that this act of mutual aid is not necessarily done *with the expectation of exchange.* Instead, it is a mindset which Julius Nyerere (1962) expresses aptly, "we took care of the community, and the community took care of us. We neither needed nor wished to exploit our fellow men." Again, the African thinking of interdependence, wherein others around us are merely an extension of oneself, encapsulates this motive to act in reciprocity.

The thinking about reciprocity in the Global South is typified by the common agricultural practice in Southern Africa known as *letsema.* This is the Sesotho practice wherein members of a community undertake to assist each other during each step in farming, including

ploughing, sowing, weeding and harvesting (Mohapi, 1956). Directly translated, the Setswana word *letsema* means “a group of people coming together for a common purpose” (Setlhodi, 2019). This practice encapsulates several norms implicit in the significance of reciprocity in communal living.

Letsema calls for mutual collaboration and cooperation underpinning collective responsibility among community members (Mofuoa, 2015). Furthermore, it predicates compassion in contributing towards an agricultural project that will benefit others in the community. Reciprocity is highlighted by those undertaking this practice in their recognition of the African maxims that “a single finger cannot remove fluff” and “two heads are better than one” (Modipa, 2014). The value of collective efforts towards a communal project that brings about a common good (for those contributing as well as for others in the community) is also aptly exemplified by the Setswana phrase “*kgetsi ya tsie e kgonwa ka go tshwaraganelwa*” which means “it takes a collective effort to overcome a swarm of locusts” (Setlhodi, 2019).

Reciprocity has also been derived from motifs from other regions in Africa. The previous section explains how the motif of the Siamese Crocodile explains the interconnectedness of lives. This Ghanian motif, *Funtumfunafu-Denkyemfunafu,* about the ‘Siamese Crocodiles’ originating from the Akan tribe, is also a typology of reciprocity. The translated motif states, “Siamese crocodiles with a common stomach but struggle for food when eating” (Sium, 2014). This Adinkra symbol (**Error! Reference source not found.**) depicts two individual crocodiles with separate heads and tails, but their torso is conjoined with one shared stomach (Sladojević, 2009). Although the food entering either crocodile’s mouth will come to be in the same stomach, they wrestle and compete to relish the flavour of the food on their own tongues and harm their survival as a

Figures

Figure 1: Adinkra Symbol of Funtumfunafu-Denkyemfunafu - ‘Siamese Crocodiles’

whole in doing so, as they eventually realize (Kyiileyang, Ama Debrah and Williams, 2017).

In realizing that the good that individuals in the community acquire becomes a shared good of the community or a common good, competing for that good is no longer necessary (Müller, Dorvlo and Muijen, 2021). Furthermore, preventing one from acquiring goods out of competition only harms the community. This reflects back to the needlessness of exploiting fellow community members and that aiding others in the community will help oneself in the process.

This thinking about reciprocity is not unique to the Global South and can be found elsewhere in the Global North. For example, Care Ethics also conceptualizes reciprocity as mutual aid. However, the mutual freedom to enter a reciprocal exchange is necessary and requires a mutual agreement to this exchange. A response to reciprocal action by one party (which may be unequal) is then demanded by the other party to the agreement (Andrew, 1998). This is not necessarily true in African thinking,for the reason that we are already in existing potential reciprocal relationships with everyone else with whom we are in the community. In other words, there is no specific agreement between parties to enter into a reciprocal relationship as such. Moreover, acts of goodwill to others in the community are done neither with the expectation of receiving anything in exchange nor to require an immediate reciprocal response of equal measure from others (Nyerere, 1962), as it tends to be the case with Care Ethics.

2.5 Distributive Justice and African Moral Philosophy

Justice alone entails relating to others in a right manner wherein each person is given their due (Ewuoso, Berkman, et al., 2022). Distributive justice in the scholarship on Ubuntu requires one in a state of authority to equitably distribute advantages and disadvantages accordingly, to reach as close to a state of equality among disparity groups as possible (Chroust and Osborn, 1942).

Although distributive justice is not uniquely an African principle, there are unique features of this principle emanating from the literature on African philosophy that are worth highlighting.

First, distributive justice is sometimes differentiated from commutative justice. Both distributive justice and commutative justice are considered as expressions of social justice in the literature on African (moral) philosophy. While distributive justice describes the first-order duties of institutions and states to their citizens (to protect their civil liberties, distribute goods equitably and create a conducive environment for communal relationships), commutative justice describes the responsibilities of citizens to one another and the State. Notably, their responsibility to be solidary to one another and to the State (Ewuoso, Cordeiro-Rodrigues, et al., 2022).

Evidently, commutative justice also involves the distribution of some sort, but this is a second-order duty that explores issues around equity and relations on the horizontal (amongst citizens or equal parties) and vertical (towards the State). For example, this conception of justice can enhance our thinking about citizens' duty to pay taxes or vote in elections. In contrast, distributive justice describes the State's responsibility to its citizens.

Second, although *social justice* and *distributive justice* are conceptually distinct, nonetheless, it is not uncommon to find that the discussion on distributive justice is sometimes framed as *social justice*. Specifically, matters of *social restorative justice* in Africa, such as land redistribution to rectify unjust colonial land distributions, have been reframed and understood as *distributive justice* in some publications (Masitera, 2020). For example, Thaddeus Metz (2011), one of Ubuntu's most prominent African philosophers, does not distinguish between social justice and distributive justice. He contends that Ubuntu philosophy bears many values reminiscent of social justice, such as respect for all, communal participation and societal inclusion. Ubuntu philosophy, he adds, is also representative of distributive justice wherein values of equity, through a culmination of collective responsibility and promoted interdependence and respect for others, through caring about the wellbeing of others in the community (solidarity) as a motive to restore equality are located. In other words, the values found in Ubuntu are positioned as expressing core concerns about social *or* distributive justice.

Furthermore, in the scholarship of African authors who contend that a distinction ought to be made between distributive justice and social justice, it is not uncommon for one to read the following to be the core of distributive justice from that positionality; i) it entails the responsibility of States and established organizations to honour the rights of individuals, including their health rights. ii) to create opportunities for individuals to enjoy a deep communal relationship, which may include funding their health care since illness can undermine their capacity to enjoy communal relationships, and finally, to regulate interactions amongst individuals (Ewuoso, Cordeiro-Rodrigues, et al., 2022).

Although the main aim of this section is evaluative rather than descriptive, it is worth outlining how distributive justice in the African philosophy literature broadly, has been described. Distributive justice requires governments and institutions to showcase humanity to their citizens by ensuring that they have a decent minimum to flourish, viz, they can access the basic conditions necessary for participating in communal relationships or share a way of life with others (Ewuoso, Berkman, et al., 2022).

In the subsequent section, I demonstrate why this description will require governments to fund the vaccination of their elderly population, particularly in private healthcare facilities. Notably, suppose communal relationships (and/or the capacity for the same) are the basis of morality and moral status in the African Ubuntu philosophy. In that case, an essential way of fulfilling the duty of distributive justice is for governments and established institutions to remove conditions that undermine participation in communal relationships, especially when they can. Illness undermines participation in communal relationships. To understand how, notice that one needs to be a subject and object of a relationship to have full moral status in Afro-communitarianism. To be a subject is to be able to commune with others, exhibit caring or other-regarding behaviours towards others. Objects of communal relationships are those with whom one communes. Illness undermines one's capacity to be the *subject* of this relationship since it reduces one to an *object* of others' care, love and compassion.

Notice that I have not claimed in this section that all sick people cannot exhibit caring relations towards others at all. Sicknesses and illnesses have a spectrum, and individuals may still be able to exhibit other-regarding behaviours to others, even in that state. Instead, I focus on the more intense forms of sickness, which are often lethal, like seasonal influenza in the elderly. I contend that these often undermine adults 65 years and above's capacity to enjoy deep communal relationships as *both* a subject and an object of these relationships. As I demonstrate, governments have a responsibility to alleviate conditions that undermine citizens' capacity. In that case, they ought to fund the influenza vaccination of this population group. The preceding is, in fact, a moral response to the rights adults 65 years and above enjoy as a party in communal relationships with the government. In other words, communal relationships encumber what Thaddeus Metz aptly expresses when he remarks that, "if one has been party to a communal relationship with others [such as the government]…. then one can have some strong moral reason to aid these intimates as opposed to strangers, even if the latter are worse off and if one did not promise to aid the former." (Metz, 2018) The basis of a State or government's duty of distributive justice to others is communal relationship. I will provide further justification in the subsequent section.

2.6 Government's Responsibility to Fund Influenza Vaccination

In the previous section, I provided an overview of – and described the moral norms that can arise from – the principles of solidarity, reciprocity and distributive justice grounded in Afro-communitarianism broadly. Furthermore, I differentiated these conceptions from the thinking about the same in the Global North and compared various other conceptions of the same in the Global South. It is important to note that solidarity, reciprocity and distributive justice do not exhaust all the principles in the African (Ubuntu) philosophy. There are others like identifying with others. Nonetheless, these outlined principles are relevant to this section's evaluative goal. Equally, many other conceptions of solidarity, distributive justice and reciprocity globally are not represented in this chapter, but are no less critical in their applications in ethics broadly.

This section draws on the moral norms articulated in the previous section to justify why governments broadly, but the SA government in particular, have a *prima facie* responsibility to fund seasonal influenza vaccination of the elderly in private and public health care facilities. To enhance the public health importance of this project, I also describe what efforts are required to ensure that such vaccines are *available* and *affordable.* Notice that I do not contend that accessibility issues *only concern* availability and affordability since such issues will also include concerns around *acceptability.* Nonetheless, I focus on availability and affordability in this chapter and defer the discussion on acceptability to the next chapter.

To justify my position, notice that most elderly Africans are unemployed, and few receive a small pension fund or government grant, which is just enough to cover their living expenses. The situation is worse for older people in South Africa. A 2022 study shows that less than 15% of adults aged 60 years and older in South Africa are employed (Kopylova, Greyling and Rossouw, 2022). In South Africa in 2020, BankServAfrica (2020) estimated under 19% of adults over 60 years old receive private pensions (some of which receive less than R6510 per month and, thus, fall under the qualifying threshold for social grants as well) and under 70% receive Old Age Grants (OAG). This is consistent with the abovementioned study that shows 69% of the elderly receive an OAG of only R1780 (Kopylova, Greyling and Rossouw, 2022). BankServAfrica (2020) also found that under 8% of adults over 60 years old were business owners or still employed in 2017. This leaves an estimate of over 6% of adults over 60 years old with no income, pension fund or government grant (including those with no income from partners or spouses) in South Africa (BankServAfrica, 2020). In the current climate in South Africa, where unemployment has increased to about 32%, these individuals are vulnerable financially and physically, given their advanced years. Notably, many of them cannot work or procure income for themselves or easily attain free quality and adequate basic healthcare without aid. Physical and mental declines in this age group present further barriers to accessing healthcare services.

Moreover, 69% of older adults receiving only the OAG would fall far short of a “decent standard of living” according to SASPRI, the Studies in Poverty and Inequalities Institute, and the Labour Research Service (2020). SASPRI contends that R7541 per person per month equates to a “decent standard of living” in South Africa in 2020. For argument’s sake, say that 19% of adults receive private pensions of R6510, and all private pension owners also receive OAGs of R1780. In that case, about 50% of elderly citizens would receive only R1780 per month (not considering the number of elderly individuals who do not own their housing and have to pay rent or individuals who live with other families). This means that over 56% of the elderly (including those with no income) would have a low standard of living and experience barriers to a good quality of life, including accessibility to basic healthcare services.

Indicatively, low economic levels can significantly impact other quality-of-life factors such as household services and health. With 36,4% of the elderly living in households of three or more generations (Kopylova, Greyling and Rossouw, 2022), overcrowding can become a devastating health factor during seasonal influenza outbreaks. A low economic status can also affect accessibility to quality healthcare services through barriers of transport costs and long waiting times at public facilities (Solanki et al., 2019).

Although this chapter focuses on adults 65 years and older, given that i) this is the retirement age in South Africa, and ii) adults 65 years and older tend to be more vulnerable than adults younger than 65 years. Nonetheless, it is worth stating that influenza vaccination for adults 60 years and older falls under basic healthcare and is a core requirement of what could foster the flourishing or well-being of this population group. This is because of the high risk of hospitalizations and mortalities influenza poses for this population group. Preventative healthcare, like vaccines for adults 65 years and older, should also be considered basic healthcare since it is often life-saving medical care. According to the American Medical Association (2016), basic healthcare includes that which protects the most vulnerable population groups and specifically affords those that are historically disadvantaged (in this

case, the elderly have been marginalized in preventative care, with curative and palliative care being the dominant alternative) with special care.

Suppose governments have a duty of distributive justice to their citizens to provide the essential minimum for their flourishing. Equally, suppose preventive healthcare, particularly seasonal influenza vaccination of adults aged 65 years and above, constitutes this population's basic health requirement. In that case, the government has a responsibility to fund this care for this population, since in fact, many individuals in this population group often struggle with a low standard of living. Accordingly, the government ought to make influenza vaccination accessible to adults in this group, even in private healthcare facilities. Notably, the elderly comprise one of the high-risk population groups (with lower immune systems).

For this reason, the requirement of distributive justice implies that governments should afford them a special minimal healthcare service to fulfil their specific health needs. This will be an appropriate moral response by subjects of communal relationships (the government) to the objects (adults aged 65 years and above) of these relationships since it is a crucial way of acting to improve the latter's life quality. Precisely, the moral imperative of distributive justice that can be grounded in communal relationships is that a party in this relationship ought to be willing to go out of their way to assist the object of this relationship to flourish, especially when the subject can. As a party in communal relationships, adults aged 65 years and above are also entitled (that is, they have a right) to be aided or supported by others since *communal relationships encumber.* Notably, "where there is some relationship, there are some obligations" (Ewuoso, Berkman, et al., 2022). With certain rights held by this vulnerable population exist corresponding responsibilities by other parties (usually stronger parties or those in authority) to maintain, protect or create an environment for realizing these rights.

There is another justification – grounded in the thinking about reciprocity – for the claim that governments are responsible for maintaining and protecting these corresponding rights by ensuring influenza vaccines can be accessed by adults aged 65 years and above at no cost, including at private health facilities. Specifically, adults 65 years and above have contributed

to society over the years. Equally, the elderly, including adults 65 years and above, are highly revered in many African communities. Both their age and life experience position them as conveyors of knowledge and moral education essential for youth formation. This is why the death of an older person is often considered a huge loss to the community (Cordeiro-Rodrigues and Ewuoso, 2022). There are other ways adults aged 65 years and above have also contributed to the State, such as through tax contributions. These contributions entitle them to receive the government's support in realizing their basic (medical) needs.

Regarding medical health needs (such as vaccines), it is worth stating that the South African government sometimes subsidizes basic health services for vulnerable populations (often for those who are financially vulnerable like students and pensioners) to ensure any vulnerable person, no matter their background or circumstance would be able to afford and access the service to meet their health need. As previously noted, the government does this through public health facilities. However, this section contends that the government ought to equally make this opportunity available at private health facilities. Concretely, this chapter contends that the government has a responsibility to maintain and preserve the special rights of the elderly to life-saving preventative healthcare by ensuring that influenza vaccination is available *at no cost* for this elderly population at public and private health facilities.

One advantage here is that this position will have a secondary effect of promoting public health. Although there is a lack of data on vaccine effectiveness on the South African elderly population due to a lack of Randomised Control Trials, a study conducted in the United States found that the 2019-2020 influenza vaccine was associated with a 41% decrease in the risk for influenza-related hospitalizations for older adults (Tenforde et al., 2021). Notably, increasing influenza vaccine coverage for the elderly could significantly reduce the number of influenza-related hospitalizations and, greatly reduce the burden on the healthcare system and save on limited resources in resource-constrained African nations.

Furthermore, suppose countries signed on to the WHO Global Influenza Strategy are serious about reaching the strategic goals of reducing the seasonal influenza burden, controlling the

risk of zoonotic influenza and acting in preparation to alleviate the impact of influenza pandemics. In that case, they ought to coordinate their behaviour to be in line with meeting these goals by ensuring seasonal influenza vaccines are affordable and available to the most vulnerable population groups, in this case, adults aged 65 years and older since this group has the highest influenza-related mortality and infection rates. They would need to coordinate their behaviour and collaborate in the communal project of fostering influenza vaccine uptake in adults aged 65 years and older, expressly by making vaccination available to this population group. This is what it means to exhibit solidarity with the citizens and other countries. Notably, this derives from the interconnectedness of lives: the health of SA is deeply interlinked with the health of other countries and global health, in the same way that the health of citizens can have great implications for society. Suppose, as I have demonstrated in a previous paragraph, that the elderly perform essential roles in fostering the moral formation of the youth. In that case, the SA government ought to foster their basic health needs since health is required to perform this task. Also, suppose the elderly citizens are an extension of the government as valued community members. And if it is true, one should value others in the community the way one values himself. Then in that case, it is the government's prerogative to act within their power to preserve the valuable lives of elderly individuals in the community by ensuring that influenza vaccines are available. In doing so, the government would be identifying with elderly citizens by seeing themselves together with the elderly as part of a whole, and by acknowledging the elderly as an integral part of the community as government leaders themselves are. Furthermore, the government would be exhibiting solidarity with the community by fulfilling the duty to ensure influenza vaccines are available and playing their part in fostering the uptake of influenza vaccines for the elderly.

By both exhibiting solidarity with vulnerable citizens (caring for their well-being in a considerate manner and acting to benefit citizens); equally by coordinating behaviour to meet the WHO Global Influenza Strategy goals in identifying with other countries, thereby protecting these vulnerable populations from influenza infections and its complications, the SA government

would be exhibiting solidarity or forming harmonious relationships with adults aged 65 years and older. By establishing and maintaining harmonious relationships in this way, the government would also develop personhood as they would become even more valuable in their ability and willingness to relate harmoniously with citizens.

Furthermore, suppose the global community wants the elderly to be vaccinated against influenza to reduce mortality rates. In that case, influenza vaccination ought to be made available to them. It seems counter-intuitive or irrational to require the elderly to vaccinate against influenza, and yet fail to make vaccination easily accessible. Funding vaccination will be an important way of making it accessible since most individuals are pensioners, retired or unemployed. In this sense, the elderly are also vulnerable because they don't have the full financial ability to address their health needs, including the basic ones.

Finally, the duty that this section defends is only a *prima facie* duty, implying that this duty must be weighed against other obligations that might be more important. Specifically, neither the moral imperatives that arise from the thinking about distributive justice nor solidarity/reciprocity imply that the duty this section defends is an absolute one. Contrary to consequentialist moral theories that require maximizing consequences, the African philosophy requires one to aid others or exhibit solidarity towards them while considering how one's extant obligations might be impacted. Concretely, the SA government's primary function to protect life and property would imply that a government ought to fund influenza vaccination for the elderly unless doing so will significantly undermine this primary responsibility. However, suppose a government could easily fund the health care needs of the elderly but fails to do so. In that case, it disrespects the elderly, the object of communal relationships. However, suppose a government could not easily fund all influenza vaccinations of the elderly. In that case, a government ought to partially fund influenza vaccines for the elderly to the extent that this funding allocation does not present any barriers to meeting other important obligations. Specifically, partial funding would entail lowering the cost of vaccines with the aim of makng them more affordable for the elderly, but only to the extent that the funding allocation to this

endeavour would not impede other more important governmental obligations. That is, if the government cannot make influenza vaccines for the elderly freely available, they ought to try to lower the cost of the vaccine as much as funding availability allows.

2.7 Institutions' Responsibility to Ensure Availability of Influenza Vaccines

In the preceding section, I demonstrated how the principles of solidarity, reciprocity and personhood arising from African philosophy provide grounds for the government's *prima facie* duty to ensure influenza vaccinations for elderly South Africans are free of cost in both public and private sectors to increase ease of accessibility. This section will describe what needs to happen to fulfil this duty.

In the context of influenza vaccine uptake strategies, I must address the dimension of availability in two-fold. First, referring to the availability of the vaccine in terms of supply to meet needs and second, the availability of vaccines to the elderly in locations where the elderly most often access immunization services. In addition, it is equally important to consider the existing surveillance services' capacity to gather data to measure, monitor and evaluate the success and challenges of the proposed vaccine promotion strategy.

Concerning the former, although a reported 14 out of the 31 African countries that agreed to participate in the respective study have influenza vaccines available (Duque, McMorrow and Cohen, 2014), the Global Alliance for Vaccines and Immunisation (GAVI) (2022) white paper report found a gap (between demand and supply) in the African vaccine market. To address this, there is a need for influenza vaccine manufacturing in African countries (Hirve et al., 2016). Eight African countries have vaccine companies operating, with just four of these facilities currently manufacturing vaccines at the time of this report, and only one of which (located in Morocco) has been reported to handle influenza vaccines for importation but is not involved in its manufacturing (Abiodun et al., 2021).

There is a glaring need for the development of influenza vaccine manufacturing capacity in South Africa, which would ultimately relieve the burden of costs of vaccine import significantly

and could lessen the impact of transportation disruptions in the supply chain, thereby increasing availability in the long run. Concerningly, a recent news report published by the BMJ found that drug companies, including Pfizer and Johnson & Johnson, charged the SA government exorbitant prices for COVID-19 vaccines in “ransom” contracts during the pandemic compared to sales in European countries (Dyer, 2023). Furthermore, these pharmaceutical companies' strong-armed unethical and unjust vaccine sale contractual clauses with the SA government, effectively took advantage of unequal powerplay which included terms and conditions that prevented SA from distributing vaccines to other surrounding African countries in desperate need of vaccine supply. This unethical clause in the contractual agreement between pharma-companies and SA inevitably kept said surrounding countries in a perpetuated desperate state of vulnerability to COVID-19 as well as to being taken unfair advantage of by the same pharmaceutical companies in their own vaccine sale contracts. According to the SA health department spokesperson, Foster Mohale, these pharmaceutical companies had the ability to take advantage of these governmental contracts because of vulnerabilities of the country caused by a “limited number of vaccine manufacturers and vaccine hoarding” amongst other reasons (Dyer, 2023). While the focus of the argument in this dissertation is not necessarily primarily on global vaccine inequity, notably, the unethical events surrounding Covid-19 vaccine equity distributions highlight the significant need to increase local manufacturing capacity. The ability to manufacture more life-saving vaccines locally would contribute to solving problems related to limitations on vaccine supply during future pandemics. Furthermore, it would relieve barriers to vaccine distribution capabilities which would have implications not only for SA but also for other desperate African countries in close proximity during pandemics.

Concerning the latter, it is the government’s responsibility to ensure that vaccines are made affordable for those with the most health needs and the least able to afford them where they can access them. To do this, it would be vital to consider where most communities in African countries access immunization and other health services to foster the uptake of influenza

vaccination amongst different population groups broadly or tailor vaccine promotion strategies accordingly. A study has found that both children and adults access pharmacies for immunization services (Yemeke et al., 2021). In South Africa, a reported 7 out of 10 households choose to access public clinics or hospitals if a member needs medical care (Statistics South Africa, 2017). One way to ensure vaccination accessibility in light of this dissertation's thesis is for the government to address the barriers mentioned in the previous section. Furthermore, the public healthcare system in South Africa consists of 422 hospitals and 3841 clinics or health centres, which indicates how much easier access to health clinics/centres is for most communities than hospitals in terms of distance (Statistics South Africa, 2017).

Mobile clinics may also be utilized. Mobile clinics are vehicles that have been refurbished to provide clinical services in remote locations such as rural areas and can provide vaccinations as well (Rural Health Information Hub, 2019). In Kenya, these mobile clinics have a context-specific alternative to a motor vehicle – they use camel mobile clinics to travel to remote desert areas (Oyaro, 2016). SA government must adapt these clinics to the contextual reality of her people.

Keeping medical records of patients at each facility where individuals access vaccination (including records from mobile clinics) will enable an estimate of the required annual supply of influenza vaccines for each facility to cover adults 65 years and older. This can be done by assessing the number of elderly patients that have accessed each facility yearly and eliminating duplicates across facilities to ensure each access point has an adequate supply available for elderly citizens to vaccinate before the influenza season each year. This strategy will eliminate waste and ensure that supply will meet the potential demand in a way that is easily accessible to the target group.

Additionally, this kind of geographical information would be useful in the formation of monitoring and evaluation of implementation strategies. This surveillance system must be set up so that both successes and challenges of strategies can be picked up and measured. It is

also important to note that in some African countries, vaccination record systems for adults (other than for COVID-19) do not currently exist (Moonsamy and Singh, 2022). Databases wherein health records of the annual number of influenza vaccines administered to adults aged 65 years and older at various service providers would be useful to measure the success of influenza uptake strategies that are implemented and in further age-specific influenza research studies as well.

2.8 Counter-Argument: Encourages Governments to Make Arbitrary Health Decisions

This section explores some potential objections to the argument presented in this chapter. Notably, a critic could contend that requiring the South African governments to provide influenza vaccines freely could spiral into forms of authoritarianism. The government may think they have the responsibility to dictate its citizens' health habits or choices. The Chinese one-child policy is one example of how the position we endorse may encourage governments to make arbitrary health, including reproductive decisions for their citizens. Adults 65 years and above who exercise their freedom to refuse vaccination may be penalized or sanctioned. Freedom may be curtailed in the world where governments believe they have the prerogative to make health decisions for their citizens.

In response, notice that the position of this section is not that freedom *ought not* to be curtailed. While freedom of choice in health decisions is often important, the greater duty to foster overall public good or harmony (as we have seen with various forms of restrictive measures during the COVID-19 outbreak) may require governments to limit an individual's right to freedom. Nonetheless, the counter-argument that this perspective could lead to an authoritarian government is a valid concern. However, I do not think this is necessarily warranted. This is for two reasons. First, authoritarianism will necessarily involve coercing individuals to act in certain ways. However, coercion entails acting in unfriendly ways towards another, based on the Afro-communitarian perspective (Sarangarajan and Ewuoso, 2022). This is justified *only if* it is necessary to end similar unfriendliness. Exhibiting unfriendliness towards those who have not been unfriendly will be a failure to share a way of life with them or exhibit other-

regarding behaviours towards them. Coercing individuals in certain ways when they have not been unfriendly will be a failure to exhibit solidarity towards them. This is what is entailed by authoritarianism. Specifically, this response demonstrates that suppose governments act in authoritarian ways towards their citizens. In that case, this would not be a consequence of the philosophy this section draws on since – from this positionality – one ought to be friendly to those who have been friendly and unfriendly to those who have been unfriendly. Yet authoritarianism often entails acts of unfriendliness towards those who have been friendly.

Second, this concern is also unwarranted due to an evident disconnect. Mainly, defending a health intervention that requires the government to take the financial responsibility to increase accessibility by ensuring a vaccine is accessible to a population does not necessarily afford the government the authority to coerce the elderly to access these vaccination services involuntarily. Ensuring the vaccine is available to the elderly does not guarantee that these individuals will access it. Rather this action serves to alleviate an important barrier to accessibility for those who are willing to accept the vaccine. This chapter highlights that the government has this financial responsibility to ensure decent minimal healthcare is accessible since they have been given the authority to provide for such services, for example, with citizen's taxes. However, it is difficult to see how this responsibility implies that governments *ought to* limit all rights to freedom of choice in healthcare by individuals. As previously stated, limiting individuals' health decisions is permissible on the condition that this is necessary to end comparable unfriendliness. However, arbitrary health decisions would not be ethically justifiable because they would neither be considered necessary in ensuring decent minimal healthcare for all nor would these actions garner harmonious relationships between the government and its citizens. In fact, directing arbitrary health decisions for citizens would harm relationships between the government and its citizens and could cause civil social tensions, as observed during the one-child policy in China (Abrahamson, 2016).

2.9 Counter-Argument: Moving From Rhetoric to Action

Another critic may express doubts that my contribution will have the impact that it intends. For example, what needs to happen and at what level, to realize the duty to fund the influenza vaccination of the elderly, particularly in South African private healthcare facilities? Suppose there are challenges or difficulties with accessing vaccination in public health facilities. In that case, what concrete changes need to occur to make influenza vaccination more accessible? It seems – to move from rhetoric to action – fine details concerning *how* the government can realize this duty (beyond merely claiming that they ought to fund) need to be outlined carefully and intelligently. But this chapter has not done this to a significant degree.

To some extent, I have partly answered this question in a previous section. Nonetheless, I acknowledge the concern that this position can be construed as idealistic and rhetorical. However, I argue that normative considerations on how to increase vaccine accessibility ethically are important conversations that contribute to the broader discussion of how to actionably increase influenza vaccine uptake by the elderly in South Africa. The overall project of increasing influenza vaccine uptake is an ambitious, albeit not impossible one to undertake. As such, in this chapter, I have endeavoured to provide a conceptual exploration of existing structures and barriers to accessibility by examining the availability and affordability dimensions of influenza vaccine access.

Nonetheless, I acknowledge that the collaboration between the government, and pharmaceutical companies, which I suggested in the previous section, is one concrete way of enhancing influenza vaccine access. Notice that this is insufficient to foster uptake. Vaccines may be freely available and adults 65 years and above may still refuse to vaccinate. I will address this question in the subsequent chapter.

This chapter provides a moral foundation for future conversations on how policy reformation should be grounded in African ethical considerations. However, this chapter's main objective is not to propose how these policy changes should occur outright. My proposal in this chapter may be in a state of incompleteness. Still, it does not render my argument irrelevant or

unnecessary by any means because it is, in fact, the very crucial first step of many in directing and informing future public health policy formation, as many conceptual bioethical arguments are wont to do. Its very existence in incompleteness allows for a space where ethicists, policymakers, stakeholders, and financial advisors can collaborate, transform and advance this contribution.

Notwithstanding, this chapter brings to the forefront a significant equity problem in preventative health measures that the elderly population faces in South Africa and calls for further discourse on where to go from here to address this problem. Specifically, while I argue that the government ought to fund influenza vaccines for the elderly in both private and public healthcare facilities to overcome accessibility barriers in the public domain and to increase the availability of vaccines to the target population, I do not pretend to have all the answers regarding the concrete implementation of this position. The intricacies of exactly how public and private funding ought to intersect or the amount of government interference in the private health sector to realize this objective must be worked out. Nonetheless, I believe that the direct cost of influenza vaccination of the elderly at private health facilities ought to be communicated directly to the government, which should defray this cost from the annual health project. The annual health budget may need to be expanded to accommodate this cost. My argument also somewhat supports a mixed public-private funding landscape in South Africa that aligns with the vision of the National Health Insurance. Further research on financing structures for the availability of the influenza vaccine for the elderly at private facilities ought to be conducted.

2.10 Counter-Argument: Supporting Elderly Health Needs in this Argument is Misguided

Another critic may also point out that there are *far more essential* ways for governments to support the elderly to meet their basic health needs beyond funding vaccination. For example, adults 65 years and above often suffer *more* from old-age-related diseases not limited to neurodegenerative and cardiovascular diseases. The focus on influenza vaccination seems to distract attention away from these health burdens.

This is quite an important and valid concern. While I acknowledge that non-communicable diseases are a significant health burden on the elderly population and deserve attention and funding, I do not think there should be a dichotomy in choosing which health challenge deserves attention. I argue that this critique presents a false dilemma that the government cannot focus efforts on both communicable and non-communicable diseases and that this view, even if it may be true, does not necessitate avoiding discussion over preventative health methods for the elderly.

Even operating under the guise of the conditions of this premise that resources are so limited that focus should be given to either, I argue that this intervention is not a waste of resources and is in fact, using resources more sustainably. This argument is substantiated by numerous studies reporting the cost-effectiveness of targeting vulnerable populations for influenza vaccination, calculated by the number of influenza cases averted, hospitalizations and deaths averted and cost per quality-adjusted life year (Edoka et al., 2021; McMorrow et al., 2019). Encouraging vaccine uptake for the elderly will also be important in reducing anti-biotics and anti-virals prescribed as well as possibly decreasing nosocomial infections without adding to the burden of life-long care costs, which plays a factor in the cost-effectiveness of the vaccine, a significant consideration, especially in resource-constrained countries (Michel and Olivier Lang, 2011).

It is particularly difficult to calculate the estimated cost burden averted through influenza vaccination for specific age-groups and this is made more challenging in South Africa by the lack of adequate surveillance and data collected. Furthermore, the cost-effectiveness of influenza vaccination varies seasonally according to several factors, such as the varying burden of HIV infection in the country, the type of influenza strain circulating that season, and the vaccine type matched to the dominant circulating strains (since vaccine effectiveness of different influenza vaccines varies by age-group) (Smetana et al., 2017). Nonetheless, I think that preventative healthcare for adults 65 years and above will positively impact the overall ability to limit the impact that communicable diseases will have on public health.

2.11 Conclusion

This primarily normative and theoretical argument has drawn on moral norms from the Global South, namely solidarity, reciprocity and personhood grounded in African philosophical thinking to defend the position that SA government has a *prima facie* duty to fund influenza vaccination of adults 65 years and above. I addressed two main considerations in this argument surrounding the accessibility of influenza vaccines for adults 65 years and above in South Africa. Firstly, I claimed that SA governments have a *prima facie* duty to make seasonal influenza vaccines free to the elderly or at the very least, affordable. Secondly, I asserted that institutions (including the government) have a duty to ensure influenza vaccines are available at frequently accessed locations by the elderly. Finally, I responded to some potential counter-arguments on unintended consequences of the government holding power over arbitrary health decisions, that my argument lacks a concrete foundation to move from rhetoric to action and that other more significant health concerns regarding the elderly ought to be advocated for instead of influenza vaccine uptake.

It is important to note that this chapter is part of a series and has only addressed the affordability and availability of influenza vaccines for the elderly. I acknowledge that accessibility is also significantly contingent upon the acceptability of the vaccine. Subsequently, the next chapter in this dissertation will address these ethical considerations of acceptability by focusing on factors such as cultural and traditional values, attitudes, beliefs and social norms held by the elderly population in South Africa. This is an important step in this dissertation because only once I have comprehensively addressed all three dimensions of accessibility can I propose a more concrete framework with which to direct public health policy to drive a more actionable argument.

This project has also brought to the fore the glaring need for stronger surveillance and more research trials in influenza vaccines for the elderly to generate more data with which we can form a more reliable and comprehensive understanding of the accessibility gaps.

CHAPTER 3

ACCEPTABILITY OF THE INFLUENZA VACCINE

3.1 Introduction

The argument in this chapter draws on the norms arising from the thinking about incompleteness and conviviality grounded in African moral philosophy to argue that adults aged 65 years and above have *a prima facie* duty to vaccinate against influenza to foster the uptake of seasonal influenza vaccination in South Africa. Although not the primary thesis, I will also argue that healthcare personnel and community leaders also have *a prima facie* duty to increase the acceptability of influenza vaccines amongst the elderly by encouraging the same.

To foster influenza vaccination uptake broadly, ethical considerations of accessibility ought to encompass all three dimensions, namely affordability, availability and acceptability. The argument in this chapter forms a continuum with the previous chapter that explored a government's responsibility to fund influenza vaccination for the elderly to foster vaccine affordability and availability, particularly in South Africa. The National Immunization Programme exists in South Africa as mere guidelines and not as a national policy (SAHPRA, 2020). This is problematic since it makes it difficult to enforce adherence and creates barriers to effective surveillance.

Vaccine hesitancy – despite vaccine availability – is a major cause of vaccine low acceptance rate (MacDonald, 2015). There are many reasons for vaccine hesitancy among adults. They include misbeliefs, fear of safety and side effects (Rikin et al., 2018; Teo et al., 2019), and the belief that natural immunity is better. Understanding factors contributing to vaccine hesitancy will be crucial to developing behaviourally and ethically informed strategies to increase vaccine uptake by the elderly. Some strategies may include promoting collective responsibility and social support, medical providers' recommendations, and awareness of eligibility as a priority group (Nicholls et al., 2021). While hesitancy is not the only important factor to consider when

addressing vaccine acceptance, it is helpful to identify different reasons for the low vaccine uptake, particularly among adults 65 years and above, to engage more meaningfully with elderly populations in a way that would alleviate such concerns and simultaneously garner trust between patients and the medical community.

There are other factors to consider. For example, a *global willingness* by adults to vaccinate is well documented in published studies. However, this willingness does not often translate to *actually* vaccinating. A study conducted in Israel in 2022 found that 76,8% of elderly participants *were willing* to receive the influenza vaccine (Maor and Caspi, 2022). Similarly, a study in Spain reported 83% of the elderly participants reported *an intention* to vaccinate against influenza during the 2021/2022 vaccination campaign (Prada-García et al., 2022). Equally, a study in China using 2020 data found 92,7% of adults aged 60 years and older *were willing* to receive the vaccine. Still, only 4,8% of the elderly participants were vaccinated against influenza at that time (Chen et al., 2022). Equally, a study in Tunisia found that only 19,4% of the elderly *were vaccinated* despite 64,7% of the participants being willing to vaccinate (Kharroubi et al., 2021). In South Africa, a study found that most participants were unaware of the risk of influenza-associated mortality and the pathology of influenza infection or knew that the influenza vaccine is useful for preventing complications in adults 65 years and above (Wong et al., 2016). Although this study was published in 2016, I have not found any new data.

Whilst education, vaccine campaigns and vaccine activism can help to address the knowledge gap concerning the effectiveness of the influenza vaccine, particularly in South Africa, ethics will play a vital role in translating *willingness* to *actuality.* Notably, behaviours are informed by values. When behaviours align with values, they are rewarded by society and reinforced (Russo et al., 2022). By drawing on key norms arising from existing formulations of incompleteness and conviviality grounded in African moral philosophy, this chapter argues that the failure to vaccinate against influenza represents a disregard for core African values. This has implications for fostering influenza vaccine uptake broadly by encouraging

acceptance and addressing vaccine hesitancy. This project is significant since there are no studies on influenza vaccine acceptance by the *elderly* in *South Africa* that draw on core African values to foster influenza vaccine uptake. My search reveals that most studies on influenza vaccine acceptance in South Africa focus on healthcare workers' attitudes.

This research is significant for other reasons. The project has social significance in providing an analytical ethical review of vaccine acceptability among elderly South Africans so that researchers can better understand complex social factors that affect vaccine uptake in this population group in an African context. Further, this project calls attention to the United Nations, the Department of Economic and Social Affairs and Population Division's (2020) estimate that the global population of those over 65 years will reach 1,5 billion by 2050. This population explosion will mostly occur in developing nations like South Africa. The South African government must adequately prepare by developing a comprehensive national policy to promote a life-course approach (not just a focus on infants) to vaccination (Sibanda et al., 2021). This will be important for effectively mitigating future public health challenges associated with population ageing. The project will contribute these resources for developing such policies.

3.2 Incompleteness in Convivial African Scholarship

This section describes extant components of incompleteness in the published works of African scholars. Since it is nearly impossible to describe *all* these components, this chapter focuses on the relevant ones. It is important to point out that although the chapter focuses primarily on African scholarships, it does not claim that all Africans believe *all* components of incompleteness that it identifies to be true of the same. In this regard, contestations exist regarding what components of incompleteness ought to be accepted or rejected in this literature.

Broadly, the use of incompleteness as an established African normative theoretical principle in published texts is still fairly new. Consequently, the formation of a concrete definition and the parameters of normative application are still in their early stages. However, one

component of incompleteness in the literature of African scholars is that it tends to express the idea of a *default* mode of being. Specifically, the shared West African Yoruba and Central African belief is the acknowledgement that everything – nature, humans, the supernatural and human achievement – exists in a state of incompleteness (Guma, 2020). This is also true of entities that appear to be complete or a finished product. This manner of being incomplete is one of normalcy (Nyamnjoh, 2019b). Contrary to more Western or Eurocentric thinking, the state of incompleteness does not denote a *lack* or an *inadequacy*. Instead, incompleteness exists only because of the existence of a multiplicity of possibilities of what one could become and of ways of reaching out and encountering the world (Nyamnjoh, 2015).

Notice that there are contestations regarding whether contemplating conceptions of this very notion of 'being' can be considered a quintessentially African way of thinking or whether it is indicative of colonial conditioning (at least from an *Akan* or *Bantu* perspective) that exist in the published literature on African metaphysics (Wiredu, 1998). This is evidenced by the fact that 'to be' does not exist in *Akan* or *Bantu* vernacular. Whilst this cannot be assumed of all African languages, particularly in languages widely spoken in Cameroon and Nigeria, it is important to note that certain normative African modalities of thought are still dominant and widely shared by different cultures in the region. The absence of a modality of thought or certain conceptual normative considerations in one culture does not denote a disingenuous African way of thinking just because it might arise from *another* African region or predicate that that way of thinking must necessarily be attributed to colonial conditioning.

A second component of incompleteness is that incompleteness enjoins one to relate or interact. These concepts themselves (relations and interactions) are grounded in common African beliefs about interconnectedness or interdependence, compassion, equality and collaboration (Nyamnjoh, 2015). Precisely, relationality is the natural consequence of incompleteness. This is true of all entities that experience incompleteness: humans, animals, or supernatural beings. Relationality allows one to reach out, engage and extend the incomplete self into a multitude of possibilities of being and becoming that would not otherwise

be possible in isolation (Nyamnjoh, 2019a). In African communitarian epistemology, prizing relationality characterizes a dominant way of thinking. A prominent African philosophy that uses a relationality framework is Ubuntu philosophy, wherein fundamental values of interconnectedness and interdependence are shared (Metz, 2017). Ubuntu philosophy comprises harmonious relationships of both exhibiting solidarity and identifying with others in the community (Metz, 2007). These relationships often comprise ones with shared communal projects wherein one coordinates one's actions accordingly to the end of the common good in choosing to collaborate with others in said communal project (Metz, 2019). Notedly, Ubuntu philosophy has been typified as a cornerstone African philosophy, especially from the perception of the Global North, because of its dominant use and application in written normative literature in the Global South. While it does hold many integral African values and is very useful, relevant and applicable in the African context of normative ethical applications, there is a danger posed by regarding Ubuntu philosophy as the penultimate African ethic. It perpetuates the assumption that because it is dominantly used in normative literature in the Global South, or even if it *is* nonetheless a dominant African perspective, it is a value system held by *all* Africans. The predicament that arises in this way of thinking is that other equally important and useful African ethics that other Africans hold, tend to be underrepresented in normative literature and subsequently overlooked by scholars or even regarded as inconsequential by Global North scholars who have only a singular, narrow lens of understanding of the multiplicity and complexity of what being an African truly means. Consequently, decolonizing African philosophy calls us to equally represent other useful African philosophies in normative application to counter narrow denigratory views of what constitutes African thought, presenting a cognitive injustice. As such, the argument in this chapter demonstrates how incompleteness in African philosophy is equally useful and relevant as other dominant African scholarships in normative application.

A third component is the idea that as inherently relational or reaching for greater possibilities, incompleteness also calls for a recognition of indebtedness to others that enables this

transformation of self in acknowledgement of the necessity of interdependence (Nyamnjoh, 2019a). Particularly, one can only enhance one's incomplete self through engagement with incomplete others (human, animal, nature or object). In acknowledging one's interdependence or need for connection to others to complement one's incompleteness, one accepts that a debt to others has been incurred. Whatever has been contributed to enable one to reach greater possibilities (than one would have on his/her own) creates an indebtedness towards those others. A person ought to acknowledge this debt by repaying the debt at some stage through reciprocal contributions (Nyamnjoh, 2019b). This is not to say it must be equally reciprocal, but rather that one would be willing to complement the incompleteness of others in return, particularly those to whom one is indebted.

Fourth, also as an inherently relational concept, incompleteness enjoins one to conviviality. According to Francis Nyamnjoh (2015), "If incompleteness is the normal order of things, natural or otherwise, conviviality invites us to celebrate and preserve incompleteness and mitigate the delusions of grandeur that come with ambitions and claims of completeness." Conviviality calls us to *actively* search for ways to extend, transform and complement our incomplete selves within relationships by ensuring that the ways in which we relate are more effective and successful. Conviviality then encourages conversations within relationships, the extension of more compassion to others, the pursuit of collaborative choices that forgoes self-centred decision-making and the alignment towards collective interests (Nyamnjoh, 2015). Recognizing that one becomes who they are and is empowered through their relationships with others and being part of a group denotes conviviality. Put in another way, incompleteness necessitates conviviality. If one were already complete, one would have no drive or inherent motivation to transcend one's current state. However, it is because the incomplete state drives ambitions to transform oneself to become more, that one acts in a convivial manner. One can recognize the necessity to enter into relationships and that an existence in isolation is futile. Thus, being in successful relationships effectively is what gives value to one's life.

A consequence of the preceding paragraph is that conviviality becomes a 'currency' with which to maintain incompleteness (or pay its debt) and entails letting go of the idealistic notion of completeness. It ought to be celebrated since it allows for engagement with other incomplete beings or agents, enabling the first step in the process of creating successful relationships and effective sociality. In other words, say one was able to be in a state of completeness (although I acknowledge that this is a futile and impossible endeavour in reality), it would render encounters with others meaningless and would not facilitate potent engagement since completeness does not necessitate any further interactions and is void of any motivation to relate.

Instead, conviviality calls one to act in the capacity of one's own incompleteness, allowing the space to reach out to others and socialize more meaningfully and collaborate to create more potent possibilities together than if one were isolated by their completeness. This ability to relate deeply with others gives cause to celebrate one's incompleteness as well as others' incompleteness.

Summarily, incompleteness challenges the complacency in being content with one's current state of being. This forces one to *actively* and *dynamically* search for ways to transform and enhance oneself through interactions with other incomplete beings to reach greater possibilities of being. This means that repaying a debt through conviviality as a currency would entail collaborating and contributing back to the community and not just accepting unidirectional aid – this facilitates effective engagement and successful sociality.

Fifth, the principle of incompleteness is also closely related to the concept of compositeness and mobility (Wasserman, 2022). Compositeness not only infers being acquiescent to dynamism and mobility but also the capacity to be and become multiple possibilities simultaneously (Nyamnjoh, 2015). These possibilities simultaneously exist because of one certainty – change is inevitable and continuous, creating ever-new and infinite possibilities and realities (Guma, 2020). Specifically, incompleteness is only made possible through the existence of multiple possibilities – we can mitigate the effects of our own incompleteness

because it *is* possible to extend and transform ourselves. Although our own unique forms of incompleteness may present a barrier to ourselves when we are in isolation, it is still intrinsically valuable in its imposition to relate with other incomplete beings (with a different form of incompleteness to our own) as the only possible avenue in which to transcend the limitations faced in isolation. Furthermore, everything in existence does not exist in a sedentary or complacent state, otherwise it would be impossible to reach out and encounter other agents. It is only through dynamism, through movement, that active engagement is exercised, and it is only through these very engagements with others that the multiple possibilities of being can be realized. Thus, incompleteness and the possibilities elicited by incompleteness are contingent upon mobility.

Compositeness embraces the reality that societies do not necessarily neatly fit into any expertly construed dichotomy or binary dialectic in the intricacies of interconnections (Wasserman, 2022). A reductionist perception of the identity of any person or group of people in society into a dichotomy such as feminine versus masculine or vaccinated versus unvaccinated only effectuates disparaging evaluative assumptions of a person while wilfully ignoring other important and valuable components of their identity and further serves to engender exclusion and isolation (Lategan, 2015). Bernard Lategan (2015) provides an in-depth analysis and Francis Nyamnjoh (2015) conceptualizes incompleteness not just as a mode of being but more specifically as identity by drawing on compositeness and dynamism to explain the multiplicity of identity that is also subject to change. Accordingly, the development of identity is constantly fluctuating on a continuum, and there are various contributors that influence this development, such as culture, history, biology and environment to name a few (Lategan, 2015). (Nyamnjoh, 2015) implies it is nevertheless possible to transcend the limitations these conformative influences impose on our persons, collapsing binary perceptions and moving beyond ineffective and neat dichotomies.

In a similar vein, Caesar Atuire (2023), one of the prominent African decolonial philosophers and ethicists instrumental in propagating discussions on global health and research ethics in

global health solidarity as well as a member of the WHO, proposes the Triple Heritage of Africa that depicts the African ethical environment comprising influences of colonialism (in the case of South Africa I would also include Apartheid here), religion, and traditional/indigenous value systems. Atuire asserts, “We need to draw on historical experiences of people in order to address the complexity of health problems we face in the world.” This infers understandings of health issues contextually are shaped by various factors to present as a complex multiplicity of what health pertains to in different regions by different people. Meeting these complex and context-specific needs comprehensively requires a pluriversal approach (not referring to moral relativism but rather in contrast to a universal framework) wherein logical reasoning and disagreements are addressed (Atuire, 2023).

3.3 Global North Comparison of (Mode of) Being and Incompleteness

In the above section, I described components of incompleteness salient in African scholarships on the same. This section will provide a brief comparative analysis with other conceptions of incompleteness and being arising from the Global North. Subsequently, I will delineate the differences and similarities between these globally varying conceptions of philosophical thought to show how useful and applicable the concept of incompleteness in African philosophy is in certain contexts.

Historically, in Western art and philosophy, incompleteness has been held to be an antithesis to perfection, wholeness and virtue. The aesthetic of completeness can be traced as far back as (Aristotle, 1979), instantiated in the following excerpt from *Metaphysics*, Book 5, Section 1021b.20,

> Things, then, which are called *perfect* in themselves are so called in all these senses; either because in respect of excellence, they have no deficiency and cannot be surpassed, and because no part of them can be found outside them; or because, in general, they are unsurpassed in each particular class, and have no part outside. All other things are so called in virtue of these, because they either produce or possess

> something of this kind, or conform to it, or are referred in some way or other to things which are perfect in the primary sense.

This conception of incompleteness directly contradicts the African counterpart since it denotes a sort of deficiency or a *lack of* in its dissatisfactory, unfinished state of being.

Similarly, while the African conception of incompleteness provides a conception of the mode of being (which lends to an understanding of being), Heidegger (2010) went a step further in his *magnum opus*, *Being and Time,* to investigate the existentialist being of beings (Dasein). Nonetheless, the African conception of incompleteness is thus particularly useful for normative applications in ascertaining how one *ought to be,* which Heidegger does not necessarily set out to ascertain with his line of inquiry. Notably, like the African conception of modes (or states) of being, Heidegger describes being in relation to other entities and objects but neglects to describe the nature of relationships with other beings (particularly humans). Instead, Heidegger seeks to understand the meaning of being through its experiences in relationship with other entities and beings, usually through an explanation of the utility of the relationship (equipmental-based). Similarly, African philosophies attribute the formation of humanness and value in humanity to the ability to form effective relationships with not just other entities (activities with objects) but with other beings (human, non-human and even supernatural) (Guma, 2020). However, distinct in African philosophies is the notion that relationships are not established merely for superficial reasons such as to the end of utility-value laden, rather, at the very core of our being, humans are understood to be intrinsically social creatures.

Herewith, in *Being and Time*, the spatial dimension between objects and subjects can be traversed through active engagement and encounters, facilitating stronger relationships between Dasein and entities (Heidegger, 2010). Although space is not identified as what exists between objects of matter but rather how Dasein perceives and experiences that space. Nyamnjoh's conception of incompleteness encapsulates a similar notion of creating effective and successful relationships by actively reaching out and engaging with the agent (entity or being) wherein mobility and dynamism are essential (Wasserman, 2022). Summarily, at the

core of African thinking about the mode of being is the relationality of beings and entities, often depicting a virtuous or good way of living.

3.4 Grounding the Duty to Vaccinate in Incompleteness and Conviviality

As previously stated, this chapter forms a continuum with the previous chapter that explored the *prima facie* duties of institutions, like the South African government, regarding ensuring the affordability and availability of the influenza vaccine. This current chapter focuses on the responsibility of the elderly population themselves to foster influenza vaccine uptake by accepting vaccination. This responsibility is essentially not just responsibility *for o*neself (the elderly) but *of* oneself. Like institutions, adults 65 years and above are mobile and ought to accept the influenza vaccine to undermine the impact that the virus could have on them.

Evidently, context-specific barriers – like the lack of information – to vaccine acceptability and developing vaccine promotion strategies tailored to address these specific challenges would be critical to increasing vaccine uptake. For example, a study focused on the elderly's experiences and perceptions of healthcare in South Africa found that those living in low-income areas, in particular, had low levels of trust in the health system mostly due to unresponsive health services in those areas (Kelly, Mrengqwa and Geffen, 2019). However, effective patient-centred communication was found to garner trust and positively associated with treatment adherence (Kelly, Mrengqwa and Geffen, 2019). It is important to bridge trust through communication by both being open and amenable to listening attentively to the patient and by educating and informing the patient of their eligibility for free influenza vaccination as a high-risk group member. Specifically, it is important to ensure patients are aware that healthcare professionals believe their experiences, feelings and opinions. It is important that the perception of an unwillingness or a hesitancy to vaccinate is not regarded by the healthcare provider as bad or evil, which may affect a bias in treatment – manifesting as a lower quality of treatment because of lower empathy or compassion towards patients who have rejected vaccination (whether consciously or not). To realize this, it is necessary to collapse the dichotomy between pro- and anti-vaccination. This is not to say we should

become complacent in the face of anti-vaccination ploys, but rather to recognize that this regard for vaccines (or even the influenza vaccine in particular) goes far beyond a blatant disregard for public health rhetoric and is far more complex than a mere refusal to vaccinate. This calls for empathy and compassion in effectively relating to the patient by understanding their attitudes shaped by lived experiences, history, culture and other underlying factors.

Another study conducted in South Africa on the knowledge and attitudes about influenza and the vaccine found that although most participants showed a willingness to accept a free vaccine, many demonstrated knowledge gaps about the causes of influenza (this misinformation skewed perceptions of how to prevent it too) and the safety and efficacy of vaccines (Wong et al., 2016). This highlights the need to educate elderly South Africans on influenza and age-related risks of complications and the necessity of vaccinating when they visit health facilities, as well as their eligibility for free or subsidized influenza vaccines as a high-risk population group.

In Kaduna, Nigeria, UNICEF (2022) interviewed community leader, Muhammed Abdulkadir, to demonstrate their strategy to combat misinformation and hesitancy, which has fostered vaccine uptake. The government and other NGOs trained religious leaders in the community to instil in them knowledge about vaccines so that they could “in turn use their various fora to educate the communities to accept the [vaccines]”. According to Muhammed, it is important to educate and mobilise patients and ensure they accept what is beneficial for them. Notably, religious and community leaders already have a long-standing trust established with community members. The community (even the elderly) often draws wisdom and guidance from community leaders. This strategy utilizes these existing strong relationships to supplement vaccine advocacy by healthcare providers. Thus, religious and community leaders work hand-in-hand with healthcare professionals in garnering and strengthening trust with the community.

One might wonder how incompleteness and conviviality provide grounds for the justification of communication and open dialogue between the elderly and healthcare professionals.

Effective relationality constituted by conviviality necessitates *bi-directionality*. The elderly are composite beings with complex attitudes and perceptions towards the influenza vaccine that are comprised of past experiences, history, culture, traditional views and other factors. Empathy and compassion of healthcare professionals allow one to be acquiescent to the complexity of each adult patient in order to adequately and contextually address any concerns or hesitancies regarding accepting the vaccine and facilitate successful relating.

Nonetheless, while I recognize the importance of developing a strategy to address these specific challenges, this project seeks to focus on the ethical obligations of the elderly themselves. Notably, do the elderly or adults 65 years and above have an ethical responsibility to vaccinate under the assumption that – for example – the effectiveness of influenza vaccination has been clearly communicated? Why do they have this responsibility from the incompleteness and conviviality perspective that the argument draws on?

Say, the refusal of the elderly to vaccinate against influenza would greatly increase the risk of influenza-related complications, hospitalizations, and death, and these outcomes would impede the elderly's ability to participate in relationships effectively and successfully. Additionally, say vaccinating against influenza could transform and extend the elderly's health by decreasing their risk of negative health outcomes related to influenza complications. Finally, suppose the principle of conviviality calls the elderly to act in ways that would extend their incomplete selves to relate more effectively. In that case, as mobile agents, the elderly ought to accept the vaccination against influenza to undermine the impact that complications arising from viral infection could have on the capacity to reach out and encounter others.

To understand how, notice that reaching out and going beyond oneself requires a subjective state of wellness that is undermined by illness. Precisely, although influenza vaccines may not be *currently* 100% effective and third parties have a duty to dedicate funds to research on more effective influenza vaccines, they are still likely to reduce the risk of health complications and possibly death arising from infection. Moreover, this will fulfil one's duty of conviviality to limit infection to others and increase the opportunities that others have to enjoy deep

communal relationships. Suppose influenza vaccination can help reduce the burden on the health system (especially in resource-constrained countries like South Africa) and reduce the risk of transmission, especially in old-age homes where there are greater implications. In that case, conviviality enjoins the elderly to vaccinate, since this would be an acceptable means of extending, transforming, and complementing our incomplete selves within relationships by ensuring the ways in which we relate are more effective and successful.

However, the responsibility for the elderly to vaccinate against influenza is *prima facie* contingent upon the healthcare professional realizing their corresponding responsibility as well. Specifically, the responsibility to vaccinate can only be justified if a healthcare professional has made the elderly individual aware of their eligibility for a free or subsidized vaccination and if the individual has discussed the vaccine with a healthcare provider. This discussion might only extend to informing the patient of the benefits of the vaccine, what it is comprised of, and the risks involved in refusing to vaccinate. The dialogue may also include listening to and addressing reasons for hesitancy (such as mistrust in the vaccine or in health services) and concerns about accepting the vaccine. This sort of dialogue would be led by the patient as these reasons might broadly differ between individuals. The patient may have begun the counselling session with a possibly negative or apathetic attitude towards the vaccine, but following the healthcare provider's addressing of underlying factors of vaccine hesitancy, the patient might end that session with a different and *more* composite attitude. For this change in attitude from a narrow lens to a composite view to take place, the patient would need to be willing to consider the alternative attitude and think critically about what rejecting the vaccine might entail, not only for themselves but for those around them. In active engagement with this health professional imparting health knowledge to them, the patient will have incurred some sort of indebtedness (since this knowledge has been able to transform their attitude) and would implore the elderly patient to *actively* accept the influenza vaccine in acknowledgement of this indebtedness and through conviviality.

While I acknowledge that the influenza vaccine does not provide 100% protection to the elderly, and so they are still at some risk of influenza (and its complications), my argument also subscribes to the notion that the vaccine itself also does not exist in a complete state and that this incompleteness provides space to improve upon the vaccine efficiency in ongoing influenza vaccine development. The preceding would imply (for example) that third parties like governments and research institutions, as I briefly referred to in the previous chapter, have a duty of conviviality to invest in research that aims to improve current vaccines. More effective vaccines will further strengthen the claim that the elderly and adults 65 years and above are morally obligated to vaccinate in light of the moral norm arising from incompleteness and conviviality. Recent studies have found the new quadrivalent adjuvanted influenza vaccine is much more immunogenic and has a higher vaccine effectiveness in adults 65 years and older (Calabrò et al., 2022). However, most of these influenza vaccine research trials with elderly participants have been conducted in European countries and I was unable to find any existing empirical data specifically on SA elderly population groups and quadrivalent influenza vaccines due to a lack of trials.

3.5 Does Acceptability Imply Vaccine Mandate?

In this section, I address some potential objections to the argument I presented in this chapter. Particularly, one could contend that forcing the elderly to vaccinate against influenza could have certain unintended consequences. Specifically, it could create an environment that fosters a decrease in the accountability of physicians and scientists. The responsibility to account for the need to increase vaccine effectiveness and to address other health side effects of the vaccine would be shirked.

It is possible that forcing the elderly may lead to complacency in some healthcare providers. However, I do not contend that healthcare professionals ought to *force* the elderly to vaccinate against influenza. That sort of argument would be akin to proposing vaccine mandates. My argument is neither against vaccine mandates nor do I think that vaccine mandates are necessary and appropriate in this instance. This is for many reasons.

First, while the elderly are situationally vulnerable since they are one of the most vulnerable populations to developing influenza complications and influenza-related mortalities, unlike children, they are still fully autonomous. For the sake of this argument, I do not include those with significant cognitive/mental impairment or those in any sort of vegetative, unresponsive or unconscious state. The requirement for autonomy in this matter is contingent upon being fully informed of any information surrounding the vaccine by a healthcare professional to make an informed decision. These vaccine counselling sessions are then not aimed at forcing the elderly patient to comply but rather to encourage them to vaccinate against influenza and to dispel any misconceptions or misinformation surrounding the influenza vaccine.

Second, current influenza vaccines have not reached a high enough vaccine effectiveness for the elderly population compared to that of other age groups to constitute ethically justified mandates. Newer, quadrivalent vaccines are being produced for this purpose, and research trials (which are currently extremely limited) have shown promise of a future greater vaccine effectiveness. However, further studies on other elderly populations in various countries must still be conducted to confirm these findings.

Furthermore, vaccine effectiveness is also variable depending on the strains circulating as well as the matched type of vaccine for that influenza season. Due to these variabilities, it is challenging to determine an accurate estimate of the required vaccine coverage needed for herd immunity. Although it is difficult to assess the indirect protection coverage one might have through herd immunity, vaccination for this age group is still recommended for the direct protection of elderly individuals to prevent serious illness and hospitalizations.

Lastly, especially in developed countries, influenza complications of the elderly present a huge threat to public health since the life expectancy in these countries tends to be higher. It is in the best interest of these countries' healthcare systems to develop more effective vaccines for the elderly populations and ensure minimal side effects to decrease the risks of hospitalizations. It might be a bit counter-intuitive to the real goal of increasing influenza

vaccine uptake by the elderly if healthcare professionals and scientists were to disregard the need for high vaccine effectiveness.

3.6 Is the Project's Approach Misguided?

Another critic may assert that the focus of this argument on increasing influenza vaccine acceptance is misguided. Specifically, a focus on other more effective avenues with which to combat the influenza virus, such as strategies to decrease the influenza viral population itself and creating a healthier environment, should be prioritized.

This is an important point to raise, since communicable diseases such as malaria have been controlled in the past by decreasing the population of the parasite through vector control. Similarly, waterborne diseases like cholera have been combatted through careful water treatment to create a healthier and cleaner environment for the human populations accessing those water sources. What should be noted about these parasite-bourne diseases, water-borne diseases, and communicable diseases is that these examples are easier to control in more contained environments in which. it might be easier to focus targeted efforts toward disease control.

However, the influenza virus is an airborne disease transmitted through aerosol droplets. While a more effective influenza preventive strategy would undermine the means by which individuals become infected, the transmission route of influenza currently makes it very difficult to control its spread. Other preventative measures to control the spread of the disease (other than vaccination) do exist and should be encouraged during influenza season, but not as an alternative to vaccinating. These include adequate hygiene, such as regular washing of hands, social distancing, as well as mask-wearing (to prevent the spread to others, when one is infected). These safety measures that decrease the spread of the virus are not necessarily sufficient to curb the spread of influenza efficiently enough for adequate control during pandemics and should rather be adhered to in addition to receiving the vaccine.

In South Africa, three respiratory illness surveillance teams – Viral Watch influenza-like illness, influenza-like illness, and pneumonia surveillance (National Institute for Communicable Diseases, 2022) – gathered data to determine the burdens of influenza viral strains circulating that particular season so that the appropriate and most effective influenza vaccine can be distributed. They found that this (vaccination) is currently the best-known public health defence strategy for combating and controlling influenza viral spread during annual pandemics. Nonetheless, I acknowledge that more effective means of *eradicating* influenza ought to be researched and developed.

3.7 Are There Valid and Ethical Justifications to Refuse Vaccination?

A critic may also point out that there are valid and ethically justifiable reasons for an unwillingness to accept the vaccine, and patients presenting these lines of reasoning are morally justified in refusing to accept the influenza vaccine. Particularly, a patient may claim that they have received a message from their ancestors through a dream or a vision warning them not to accept the vaccine.

For example, in South Africa, Section 15, sub-Section 1 of the *(Constitution of the Republic of South Africa, 1996)* (hereafter the *Constitution*) remarks that every South African citizen has "the right to the freedom of religious practices". Furthermore, it is a competent adult patient's right to refuse any treatment as enshrined by (Constitution of the Republic of South Africa, 1996), which protects everyone's right to autonomy and bodily integrity (s12, ss2(b), (Constitution of the Republic of South Africa, 1996)) as well as any patient's right to voluntarily observe religious freedom of beliefs and practices at any state institution, including a hospital (s15, ss1; 2, the *(Constitution of the Republic of South Africa, 1996)*. Subsequently, *competent* adults 65 years and older may *lawfully* refuse to vaccinate against influenza.

However, although I have shown a refusal of vaccination may be lawful, there are some cases in which a refusal to vaccinate may be considered unethical and a failure to be convivial. As we witnessed during the COVID-19 global pandemic, resources in healthcare settings were unbearably strained, and even the number of hospital beds was lacking. In the face of another

global pandemic, it is imperative (for the sake of pandemic preparedness) that the highest-risk groups prone to hospitalizations are vaccinated to prevent an unnecessary burden on the healthcare system. Under circumstances such as these, individual freedoms may ethically be curtailed to protect the public health of many.

Such a selfish exercise of individual freedom by refusing to vaccinate against influenza *during a global pandemic*, even for reasons of personal or religious belief, would not be ethically justified particularly if it presented a barrier to pandemic control efforts. This will be a failure to honour the debt of incompleteness. During future pandemics, governments may decide to instate vaccine mandates for certain vaccines and for certain risk groups, effectively forcing these groups to vaccinate regardless of personal beliefs. In these cases, refusing to vaccinate would be regarded as unlawful and ethically unjustifiable.

3.8 Conclusion

This project is mostly a theoretical and normative one that has drawn on key moral norms derived from values grounded in African philosophy, namely, the thinking about conceptions of incompleteness and conviviality. I addressed considerations of the acceptability of the influenza vaccine by adults 65 years and older in two parts. First, I argued that health professionals have a professional responsibility to inform the elderly of their eligibility to vaccinate against influenza as a high-risk group. I also contended that they ought to operate within a framework of open dialogue in these vaccine counselling sessions grounded in components of incompleteness and conviviality principles. Second, I asserted that adults aged 65 years and above have a *prima facie* responsibility grounded in the same to vaccinate against influenza, provided they are fully informed and can give full consent to the vaccine. Lastly, I responded to some potential objections on the implications of influenza vaccine mandates, that this project's approach of focusing on acceptance of the vaccine to combat influenza is misguided, and that there are valid and ethical justifications to still refuse vaccination following the influenza vaccine counselling session. I hope this project will

contribute to opening honest discourse on how public policy in increasing vaccine uptake ought to be directed.

CHAPTER 4

RECOMMENDATIONS AND CONCLUSION

4.1 Introduction

Influenza vaccine uptake broadly requires ensuring vaccine affordability, availability, and acceptability. These three – affordability, availability and acceptable – are core requirements of vaccine access. In the first chapter, where I addressed the normative question, "Does the SA government have a *prima facie* duty to fund the influenza vaccination of adults 65 years and above at public and private health facilities?", I focused on the affordability and availability of influenza vaccines for elderly South Africans. The previous chapter has now addressed critical concerns regarding the acceptability of the influenza vaccine. The overall thinking informs the recommendations in this section about how to foster vaccine access and contribute useful resources for public policies concerning the same that are informed by perspectives from Africa. In this regard, the overall project has merit in contributing African perspectives to ethical discourses on policies in preventative healthcare for the elderly (specifically focusing on vaccine-preventative healthcare) and providing a concrete African philosophical foundation upon which to ground future discourse on how public health policy on influenza vaccination ought to be directed, for example in South Africa.

4.2 Recommendations

First, the SA government should consider how public-private sector engagement can have the capacity to mitigate barriers to healthcare accessibility, not only in light of influenza vaccine access but also with other health treatments and technologies. However, one might wonder where the SA government could procure the funds to invest in influenza vaccine research or ensure influenza vaccines are free in both the public and private sectors. I reiterate here that this is only a *prima facie* duty, which, all things considered, ought to be done. The government can dedicate a part of the health care budget – in response to the duty of conviviality – for this purpose. The implication here would also be that (for example) the South African government

may have to increase the health care budget. Since health is a basic good for other goods, like relationships, I argue that health ought to receive priority in budgeting. However, suppose a government in a crucially resource-constrained (African) country cannot dedicate funds to influenza vaccine research or make the same completely free. In that case, the cost of vaccination should at least be lowered/subsidized so that it is affordable for the elderly and a long-term research program for increasing vaccine affordability/availability should be implemented. For example, there are currently no known manufacturing facilities in Africa for influenza vaccines. A government ought to initiate a program to address this gap to reduce massive transport costs of importation and mitigate the risk of exploitation of vulnerabilities incurred by a lack of vaccine manufacturing capacity during future pandemics. Specifically, this incomplete state of a lack of manufacturing capacity calls the government to act in convivial ways to transform vaccine accessibility by engaging various stakeholders such as pharmaceutical companies and vaccine researchers to enable manufacturing capacity. Governments have this duty because the elderly have contributed to the wellbeing of the country their whole lives by working as a functional part of society and paying their taxes. In light of reciprocity, the government has a corresponding duty to use some of those taxes to ensure the elderly population's basic heatlh needs are met – to ensure the elderly population's wellbeing when governments have the means to do so.

It is essential to clarify that this recommendation is not necessarily to build new manufacturing facilities solely for developing and producing influenza vaccines. Rather, I argue that existing vaccine manufacturing facilities in their incomplete states allow for the possibility of being extended to manufacture influenza vaccines. Now, I acknowledge that developing the capacity to produce influenza vaccines even in existing facilities may be a lengthy and costly process. This means that stakeholder collaborations in the formation of partnerships to procure funding from NGOs with a focus on global healthcare (such as GAVI, Aspen, and CEPI to name a few) will be necessary to realize this transformation. I do not attempt to propose specifically how this stakeholder involvement or development of manufacturing capacity ought to occur,

because in-depth discussions on health finance and health politics are beyond my current focus. However, this proposition is inferred as an ethically informed recommendation that warrants further investigation and research to determine whether this would be a viable development and to form future strategies for how to realize it. Navigating fair agreements between stakeholders and government with varied power dynamics will be challenging, but it is important that these contractual agreements are discussed prior to another onset of a period of global crisis, such as during a pandemic, to prevent unequal powerplay implicating ethically unjust financial agreements (such as what was witnessed during Covid-19).

Increasing the currently incomplete capacity for vaccine manufacturing in the extension of current facilities will be pivotal to realizing many other *possibilities of being and becoming* – of not only contributing towards preparations to combat future influenza pandemics but also other future global pandemics like COVID-19. This would be a long-term strategy to alleviate the costs of vaccine importation and other transport costs and allow for more funding to be allocated towards making the influenza vaccine more affordable for the elderly.

Second, I recommend that strategies involving the use of mobile clinics in increasing vaccine distribution and availability to more remote, rural areas should be explored. During Covid-19, mobile clinics were utilized to effectively distribute COVID-19 vaccines during a time of public health crisis. It is worth looking into the use of these clinics as a more long-term strategy as well. These mobile clinics could also be utilized for community-based and home-based care visits to increase accessibility to frail elderly citizens who cannot leave their homes to access healthcare facilities to be vaccinated in order to realise distributive justice.

Third, I recommend that a vaccination record system for adults be established. Current data on adult vaccination and surveillance capacity are limited, and developing a structured register system for vaccination would greatly aid capabilities of measuring the success of influenza uptake strategies for adults. Paper-based records, such as those initially used for COVID-19 vaccinations and those issued for infants on the expanded programme on immunization in South Africa, can easily be displaced and damaged. Investing in a robust online health

database system that could hold South Africans' life-course (from birth to old age) vaccination records is required. Data stored only on hard drives and servers are also at risk of being lost through potentially disastrous events such as the fire that occurred in 2022 in Charlotte Maxeke Johannesburg Academic Hospital, one of the largest teaching hospitals in South Africa (Moonsamy and Singh, 2022). Thus, online database storage (such as cloud storage) of these records may be a more reliable and safer long-term alternative. The use of data-capturing technology can also be a means of transforming an unreliable, inadequate and incomplete manner of recording health records on paper. Engaging with technologies in medicine is important in realizing this transformation to a more efficient and effective health system which will facilitate better access to health services.

I also recommend that any adult 65 years and above presenting to a health facility should be informed of their eligibility to receive influenza vaccine. This should be supplemented with counselling, where the patient would be educated on what makes them a high-risk group and informed of the risks involved in refusing to accept the vaccine and the benefits to themselves and those around them. It is important that the patient is also provided with the opportunity to express any concerns or beliefs they may have surrounding influenza and influenza vaccines so that the medical professional can comprehensively address these concerns and garner trust through effective communication. This form of targeted advertising and raising awareness of influenza vaccines allows for open discussion to take place. Bridging trust between healthcare providers and patients through open dialogue will be integral in increasing influenza vaccine uptake and other treatment uptake and adherence. Communication, transparency and trust are all integral values in forming harmonious relationships between healthcare service providers and elderly patients who receive this care. Establishing strong, harmonious doctor-patient relationships play an important role in increasing health intervention (specifically vaccine) acceptability rates.

Current National Institute for Communicable Diseases (2022) guidelines are only directed at healthcare providers, enabling them to provide fully informed care in diagnosis, infection

prevention and control recommendations, treatment, and vaccination of prioritized risk groups. However, it is necessary for the formation of public policy to inform institutions and hold them and the government accountable for making the influenza vaccine fully accessible to vulnerable risk groups (namely adults 65 years and older for the sake of my argument). Subsequently, guidelines must be extended to include strategic plans for how vaccine manufacturing capacity ought to be upscaled in existing South African facilities. Furthermore, this policy should include a discussion of the public-private health sector engagement agreement entailing how the government aims to make influenza vaccines freely available in both sectors, what this may require of private sector personnel and how the government may compensate them within the confines of this agreement. Active engagement with all involved stakeholders is vital to developing successful actionable influenza public policy where collaboration between stakeholders is outlined and encouraged.

Additionally, lacking in current guidelines are holistic patient-centred recommendations on how to approach fostering influenza vaccination uptake. Public policy ought to outline a framework for open dialogue, including guidance on addressing potential patient concerns surrounding the vaccine, specifically directing how the vaccine counselling sessions should proceed. Many healthcare providers are not aware of the importance of allowing the patient to voice worries regarding the vaccine. They may believe that merely informing the patient about the vaccine itself would dispel any misinformation or hesitations towards vaccination. Including this recommendation in policy would ensure that all healthcare providers understand the importance of bridging trust with the patient and that they are aware of how to achieve this.

Lastly, existing guidelines are importantly informed by empirical data but seem to be ethically directed by prinicplist and consequentialist values. Concerningly, they are not explicitly informed by any known African values. It is important that (like our Constitution enshrined in Ubuntu values) other policies that govern African peoples be grounded in African philosophies that Africans can identify with and integrally agree with. Furthermore, grounding policy in

African philosophy would also enable healthcare providers to more easily address vaccine concerns related to cultural beliefs, traditions and values that are often grounded in African religious thought. Specifically, healthcare providers would be enabled to advocate for the uptake of the influenza vaccine by being able to appropriately foster vaccine uptake using values that are important to these patients and directly respond to their concerns related to personal, traditional or religious beliefs.

4.3 Conclusion

This project is mostly a theoretical and normative one that has drawn on key moral norms derived from the Global South, namely, the thinking about conceptions of solidarity, reciprocity, distributive justice, incompleteness and conviviality grounded in African philosophy. In the first chapter, I addressed two main considerations in this argument surrounding the accessibility of influenza vaccines for adults 65 years and above in South Africa. Here, I claimed that African governments have a *prima facie* duty to make seasonal influenza vaccines free to the elderly or, at the very least, affordable. Secondly, I asserted that institutions (including the government) have a duty to ensure influenza vaccines are available with respect to vaccine procurement and distribution at frequently accessed locations by the elderly. Finally, I responded to some potential counter-arguments on unintended consequences of the government holding power over arbitrary health decisions, that my argument lacks a concrete foundation to move from rhetoric to action and that other more important health concerns regarding the elderly ought to be advocated for instead of influenza vaccine uptake.

In the second chapter, I addressed considerations of the acceptability of the influenza vaccine by adults 65 years and older in two parts. First, I contended that health professionals have a professional responsibility to inform the elderly of their eligibility to vaccinate against influenza as a high-risk group. I also contended that they ought to operate within a framework of open dialogue in these vaccine counselling sessions grounded in components of incompleteness and conviviality principles. Second, I asserted that adults aged 65 years and above have a

prima facie responsibility grounded in the same to vaccinate against influenza, provided they are fully informed and can give full consent to the vaccine. Lastly, I responded to some potential objections on the implications of influenza vaccine mandates, that this project's approach of focusing on acceptance of the vaccine to combat influenza is misguided, and that there are valid and ethical justifications to still refuse vaccination following the influenza vaccine counselling session. I hope that this project will contribute to opening ethical discourse on how public policy in increasing vaccine uptake ought to be directed.

In this last chapter, I collated a section of recommendations informed by the overall thinking about how to increase vaccine access, foster vaccine uptake, and contribute useful resources for public policies concerning the same that are informed by perspectives from Africa. Notably, this project has brought to the fore the glaring need for stronger surveillance with a focus on age-specificity and for more research trials in influenza vaccines for the elderly to generate more data with which we can form a more reliable and comprehensive understanding of other related accessibility gaps.

References

Abiodun, T., Andersen, H., Mamo, L. T., and Sisay, O. B. (2021). *Vaccine Manufacturing in Africa: What It Takes and Why It Matters*. Tony Blair Institute for Global Change. https://institute.global/policy/vaccine-manufacturing-africa-what-it-takes-and-why-it-matters

Abrahamson, P. (2016). End of an Era? China's One-Child Policy and its Unintended Consequences. *Asian Social Work and Policy Review*, *10*, 326–338. https://doi.org/10.1111/aswp.12101

American Medical Association. (2016). Defining Basic Health Care. In *Code of Medical Ethics*. American Medical Association. https://code-medical-ethics.ama-assn.org/ethics-opinions/defining-basic-health-care

Andrew, B. S. (1998). Care, Freedom, and Reciprocity in the Ethics of Simone De Beauvoir. *Philosophy Today*, *42*(3), 290–301.

Aristotle. (1979). *Metaphysics* (H. Tredennick, Trans.; Loeb Classsical Library, Vol. 1). Harvard University Press.

Asouzu, I. I. (2005). *The method and principles of complementary reflection in and beyond African philosophy* (Vol. 4). LIT Verlag.

Asouzu, I. I. (2007). *Ibuanyidanda: New Complementary Ontology: Beyond World-Immanentism, Ethnocentric Reduction and Impositions* (Vol. 2). LIT Verlag.

Asouzu, I. I. (2011). Ibuanyidanda (Complementary Reflection), Communalism and Theory Formulation in African Philosophy. *Thought and Practice: A Journal of the Philosophical Association of Kenya*, *3*(2), 9–34. https://www.ajol.info/index.php/tp/article/view/74871

Atuire, C. (2023, September 5). *African Approaches to Global Bioethical Issues* [Black and Brown in Bioethics]. Bioethics and Global Health: In Search of Common Ground, Online. https://www.youtube.com/watch?v=Mlng57O-FMQ&ab_channel=BlackandBrowninBioethics

BankServAfrica. (2020). *The Income of the Aged in South Africa: From Private Pensions to Government Grants* [To Accompany Press Release]. BankServAfrica. https://www.bankservafrica.com/api/public/blogblob/5e61f851714af6004249daaf#:~:text=In%20January%202020%2C%20BankservAfrica%20had,banked%20private%20pensions%20on%20record.

Beauchamp, T., and Childress, J. (2013). *Principles of Biomedical Ethics* (7th ed.). Oxford University Press.

Calabrò, G., Boccalini, S., Panatto, D., Rizzo, C., Di Pietro, M., Abreha, F., Ajelli, M., Amicizia, D., Bechini, A., Giacchetta, I., Lai, P., Merler, S., Primieri, C., Trentini, F., Violi, S., Bonanni, P., and de Waure, C. (2022). The New Quadrivalent Adjuvanted Influenza Vaccine for the Italian Elderly: A Health Technology Assessment. *International Journal of Environmental Research and Public Health*, *19*(4166), 1–14. https://doi.org/10.3390/ijerph19074166

Centers for Disease Control and Prevention. (2019, June 12). *Study Shows Hospitalization Rates and Risk of Death from Seasonal Flu Increase with Age Among People 65 Years and Older*. Centers for Disease Control and Prevention. https://www.cdc.gov/flu/spotlights/2018-2019/hopitalization-rates-older.html

Chen, H., Li, Q., Zhang, M., Gu, Z., Zhou, X., Cao, H., Wu, F., Liang, M., Zheng, L., Xian, J., Chen, Q., and Lin, Q. (2022). Factors Associated with Influenza Vaccination Coverage and Willingness in the Elderly with Chronic Diseases in Shenzhen, China. *Human Vaccines & Immunotherapeutics*, *18*(6), 2133912. https://doi.org/10.1080/21645515.2022.2133912

Chroust, A.-H., and Osborn, D. L. (1942). Aristotle's Conception of Justice. *Notre Dame Law Review*, *17*(2), 129.

Constitution of the Republic of South Africa (1996).

Cordeiro-Rodrigues, L. (2020). Toward a Decolonized Healthcare Ethics: Colonial Legacies and the Siamese Crocodile. *Developing World Bioethics*, *20*(3), 118–119. https://doi.org/10.1111/dewb.12273

Cordeiro-Rodrigues, L., and Ewuoso, C. (2022). A Relational Approach to Rationing in a Time of Pandemic. *The Journal of Value Inquiry*, *56*(3), 409–429. https://doi.org/10.1007/s10790-020-09782-x

Cordeiro-Rodrigues, L., and Metz, T. (2021). Afro-Communitarianism and the Role of Traditional African Healers in the COVID-19 Pandemic. *Public Health Ethics*, *14*(1). https://doi.org/10.1093/phe/phab006

Dhai, A., and McQuoid-Mason, D. (2020). Ethical Concepts,Theories and Principles and Their Application to Healthcare. In *Bioethics, Human Right and Health Law—Principles and Practice* (Second, pp. 3–19). Juta and Company Ltd.

Duque, J., McMorrow, M. L., and Cohen, A. L. (2014). Influenza Vaccines and Influenza Antiviral Drugs in Africa: Are They Available and Do Guidelines For Their Use Exist? *BMC Public Health*, *14*(1), 41. https://doi.org/10.1186/1471-2458-14-41

Dyer, O. (2023, September). Covid-19: Drug companies charged South Africa high prices for vaccines, contracts reveal. *BMJ*, 2112–2113.

Edoka, I., Kohli-Lynch, C., Fraser, H., Hofman, K., Tempia, S., McMorrow, M., Ramkrishna, W., Lambach, P., Hutubessy, R., and Cohen, C. (2021). A Cost-Effectiveness Analysis of South Africa's Seasonal Influenza Vaccination Programme. *Vaccine*, *39*(2), 412–422. https://doi.org/10.1016/j.vaccine.2020.11.028

Ewuoso, C. (2023). Germline Gene Editing Applications and the Afro-communitarian Ubuntu Philosophy. *Filosofia Theoretica: Journal of African Philosophy, Culture and Religions*, *12*(1), 1–14. https://dx.doi.org/10.4314/ft.v12i1.1

Ewuoso, C., Berkman, B., Wonkam, A., and de Vries, J. (2022). Should Institutions Fund the Feedback of Individual Findings in Genomic Research? *Journal of Medical Ethics*, *0*, 1–6. https://doi.org/10.1136/medethics-2021-107992

Ewuoso, C., Cordeiro-Rodrigues, L., Wonkam, A., and de Vries, J. (2022). Addressing Exploitation and Inequities in Open Science: A Relational Perspective. *Developing World Bioethics*, 1–13. https://doi.org/10.1111/dewb.12378

Ewuoso, C., and Hall, S. (2019). Core Aspects of Ubuntu: A Systematic Review. *South African Journal of Bioethics and Law*, *12*(2), 93–103. https://doi.org/10.7196/SAJBL.2019.v12i2.679

Gbadegesin, S. (1991). *African Philosophy: Traditional Yoruba Philosophy and Contemporary African Realities*. Peter Lang.

Global Alliance for Vaccines and Immunisation. (2022). *A New Era of Vaccine Manufacturing in Africa* (White Paper). Gavi, The Vaccine Allianca. https://www.gavi.org/sites/default/files/covid/covax/new-era-vaccine-manufacturing-in-africa-wp.pdf

Guma, P. (2020). Incompleteness of Urban Infrastructures in Transition: Scenarios From the Mobile Age in Nairobi. *Social Studies of Science*, *50*(5), 728–750. https://doi.org/10.1177/0306312720927088

Gyekye, K. (1992a). Person and Community in Akan Thought. In K. Wiredu & K. Gyekye (Eds.), *Person and Community—Ghanaian Philosophical Studies, I* (Vol. 1, pp. 100–122). The Council for Research in Values and Philosophy.

Gyekye, K. (1992b). Traditional Political Ideas, Their Relevance to Development in Contemporary Africa. In K. Wiredu & K. Gyekye (Eds.), *Person and Community—Ghanaian Philosophical Studies, I* (Vol. 1, pp. 240–256). The Council for Research in Values and Philosophy.

Gyekye, K. (2011). African Ethics. In E. N. Zalta (Ed.), *He Stanford Encyclopedia of Philosophy* (Fall 2011). Metaphysics Resarch Lab, Stanford University. https://plato.stanford.edu/archives/fall2011/entries/african-ethics/

Heidegger, M. (2010). *Being and Time: A Revised Edition of the Stambaugh Translation* (J. Stambaugh, Trans.). State University of New York Press.

Hirve, S., Lambach, P., Paget, J., Vandemaele, K., Fitzner, J., and Zhang, W. (2016). Seasonal influenza Vaccine Policy, Use and Effectiveness in the Tropics and Subtropics – a Systematic Literature Review. *Influenza and Other Respiratory Viruses*, *10*(4), 254–267. https://doi.org/10.1111/irv.12374

Ibom, D., and Soni, P. (2015). Containing Cost of Care: Healthcare as a Business. *Academic Forum Conference Proceedings*, 16–29. https://www.proquest.com/docview/1709291916?pq-origsite=gscholar&fromopenview=true#

Ikechukwu, K. (2016). Ibanyidanda, Descriptive Statement and the Super Maxim. *Igwebuike - An African Journal of Arts and Humanities*, *2*(5), 83–90. https://doi.org/10.13140/RG.2.2.28179.22564

Kainz, H. P. (1988). Benthamite “Social Utility” as a Strictly Objective Norm. In *Ethics in Context* (p. 178). MacMillan Press.

Kant, I. (1993). *Grounding for the Metaphysics of Morals* (J. W. Ellington, Trans.; Third). Hackett Publishing Co.

Kelly, G., Mrengqwa, L., and Geffen, L. (2019). “They don’t Care About Us”: Older People’s Experiences of Primary Healthcare in Cape Town, South Africa. *BMC Geriatrics*, *19*(1), 98. https://doi.org/10.1186/s12877-019-1116-0

Kharroubi, G., Cherif, I., Bouabid, L., Gharbi, A., Boukthir, A., Ben Alaya, N., Ben Salah, A., and Bettaieb, J. (2021). Influenza Vaccination Knowledge, Attitudes, and Practices among Tunisian Elderly with Chronic Diseases. *BMC Geriatrics*, *21*(700), 1–9. https://doi.org/10.1186/s12877-021-02667-z

Kopylova, N., Greyling, T., and Rossouw, S. (2022). Multidimensional Quality of Life of Older Adults in South Africa. *Applied Research in Quality of Life*, *17*, 3427–3450. https://doi.org/10.1007

Kottow, M. (2019). Intergenerational Healthcare Inequities in Developing Countries. *Developing World Bioethics*, *20*, 122–129. https://doi.org/10.1111/dewb.12244

Kyiileyang, M., Ama Debrah, M., and Williams, R. (2017). An Analysis of Images of Contention and Violence in Dagara and Akan Proverbial Expressions. *Advances in Language and Literary Studies*, *8*(2), 222–236. https://doi.org/10.7575/aiac.alls.v.8n.2p.222

Lategan, B. C. (2015). “Incompleteness” and the Quest for Multiple Identities in South Africa. *Africa Spectrum*, *50*(3), 81–107. https://doi.org/10.1177/000203971505000304

MacDonald, N. E. (2015). Vaccine Hesitancy: Definition, Scope and Determinants. *Vaccine*, *33*(34), 4161–4164. https://doi.org/10.1016/j.vaccine.2015.04.036

Maor, Y., and Caspi, S. (2022). Attitudes Towards Influenza, and COVID-19 Vaccines During the COVID-19 Pandemic Among a Representative Sample of the Jewish Israeli Population. *PLoS ONE*, *17*(2), e0255495. https://doi.org/10.1371/journal.pone.0255495

Masitera, E. (2020). Indigenous African Ethics and Land Distribution. *South African Journal of Philosophy*, *39*(1), 35–46. https://doi.org/10.1080/02580136.2019.1706383

Masolo, D. A. (2010). *Self and Community in a Changing World*. Indiana University Press.

Mbali, M., and Rucell, J. (2022). African voices in global health: Knowledge, creativity, accountability. *Global Public Health*, 1–9. https://doi.org/10.1080/17441692.2022.2139853

McMorrow, M., Tempia, S., Walaza, S., Treurnicht, F., Ramkrishna, W., Azziz-Baumgartner, E., Madhi, S., and Cohen, C. (2019). Prioritization of Risk Groups for Influenza Vaccination in Resource Limited Settings – A Case Study From South Africa. *Vaccine*, *37*, 25–33. https://doi.org/10.1016/j.vaccine.2018.11.048

Metz, T. (2007). Toward an African Moral Theory. *Journal of Political Philosophy*, *15*(3), 321–341. https://doi.org/10.1111/j.1467-9760.2007.00280.x

Metz, T. (2010a). Human Dignity, Capital Punishment, and an African Moral Theory: Toward a New Philosophy of Human Rights. *Journal of Human Rights*, *9*(1), 81–99. https://doi.org/10.1080/14754830903530300

Metz, T. (2010b). Recent Work in African Ethics. *Journal of Moral Education*, *39*(3), 381–391. https://doi.org/10.1080/03057240.2010.497618

Metz, T. (2011). Ubuntu as a Moral Theory and Human Rights in South Africa. *African Human Rights Law Journal*, *11*(2), 532–559. https://hdl.handle.net/10520/EJC51951

Metz, T. (2012). Ethics in Africa and in Aristotle: Some Points of Contrast. *Phronimon*, *13*(2), 99–117. https://hdl.handle.net/10520/EJC128688

Metz, T. (2013). The Western Ethic of Care or an Afro-communitarian Ethic? Specifying the Right Relational Morality. *Journal of Global Ethics*, *9*(1). https://doi.org/10.1080/17449626.2012.756421

Metz, T. (2016). Recent Philosophical Approaches to Social Protection—From Capability to Ubuntu. *Global Social Policy*, *16*(2), 132–150. https://doi.org/10.1177/1468018116633575

Metz, T. (2017). An Overview of African Ethics. In I. Ukpokolo (Ed.), *Themes, Issues and Problems in African Philosophy* (pp. 61–75). Palgrave-Macmillan.

Metz, T. (2018). An African Theory of Good Leadership. *African Journal of Business Ethics*, *12*(2), 36–53. https://doi.org/10.15249/12-2-204

Metz, T. (2019, September 8). The African Ethic of Ubuntu. *1000-Word Philosophy: An Introductory Anthology*. https://1000wordphilosophy.com/2019/09/08/the-african-ethic-of-ubuntu/

Michel, J.-P., and Olivier Lang, P. (2011). Promoting Life Course Vaccination. *Rejuvination Research*, *14*(1), 75–81. https://doi.org/10.1089/rej.2010.1078

Modipa, M. (2014, March 26). Letsema as a Way of Life. *Politicsweb*. https://www.politicsweb.co.za/news-and-analysis/letsema-as-a-way-of-life

Mofuoa, K. (2015). Social Embeddedness of Agriculture for Human Progress in the Nineteenth Century Southern Africa: Evidence and Lessons from Lesotho. *International Journal of Development Research*, *5*(12), 6369–6379.

Mohapi, M. M. (1956). *Temo Ea Boholo-holo Lesotho, (ancient Agriculture in Lesotho)*. Morija Press.

Molefe, M. (2017). Critical Comments on Afro-communitarianism: The Community Versus the Individual. *Filosofia Theoretica: Journal of African Philosophy, Culture and Religions*, *6*(1), 1–22. https://dx.doi.org/10.4314/ft.v6i1.1

Molina Wills, W. (2022). The Original Scientific Article and its Relevant Aspects: Brief Notes. *International Journal of Research*, *9*(9), 1–6.

Moonsamy, W., and Singh, S. (2022). Digital Vaccination Records: Exploring Stakeholder Perceptions in Gauteng, South Africa. *The African Journal of Information and Communication*, *29*, 1–26. https://doi.org/10.23962/ajic.i29.13756

Müller, L., Dorvlo, K., and Muijen, H. (2021). The Adinkra game: An intercultural communicative and philosophical praxis. In M. Metsärinne, R. Korhonen, T. Heino, & M. Esko (Eds.), *Cultures at School and at Home* (pp. 192–224). Rauma Teacher Training School, University of Turku. https://www.researchgate.net/profile/Jaana-Lepistoe/publication/360963115_The_Rauma_teaching_garden_as_a_cultural_heritage_milieu_and_place_to_grow/links/6295bfc155273755ebc4d6dc/The-Rauma-teaching-garden-as-a-cultural-heritage-milieu-and-place-to-grow.pdf#page=192

National Department of Health. (2020). *Primary Healthcare (PHC) Standard Treatment Guidelines and Essential Medicines List for South Africa*. https://knowledgehub.health.gov.za/elibrary/primary-healthcare-phc-standard-treatment-guidelines-and-essential-medicines-list-south

National Institute for Communicable Diseases. (2022). Public Health Surveillance Bulletin. *National Institute for Communicable Diseases*, *20*(2). https://www.nicd.ac.za/publications/communicable-diseases-publications/public-health-surveillance-bulletin/

National Institute for Communicable Diseases, Blumberg, L., Cohen, C., Dawood, H., Shabir, M., Karstaedt, A., McCarthy, K., Moyes, J., Nel, J., Puren, A., Ramkrishna, W., Reubenson, G., Treurnicht, F., Variava, E., von Gottberg, A., Wolter, N., Walaza, S., and Zar, H. (2022). *Influenza NICD Recommendations for the Diagnosis, Prevention, Management and Public Health Response* [Guidelines]. National Institute for Communicable Diseases. https://www.nicd.ac.za/wp-content/uploads/2022/05/Influenza-guidelines_-22-April-2022-final.pdf

Nicholls, L. A. B., Gallant, A. J., Cogan, N., Rasmussen, S., Young, D., and Williams, L. (2021). Older Adults' Vaccine Hesitancy—Psychosocial Factors Associated with Influenza, Pneumococcal, and Shingles Vaccine Uptake. *Vaccine*, *39*(26), 3520–3527. https://doi.org/10.1016/j.vaccine.2021.04.062

Nyamnjoh, F. B. (2015). Incompleteness: Frontier Africa and the Currency of Conviviality. *Journal of Asian and African Studies*, *52*(3), 253–270. https://doi.org/10.1177/0021909615580867

Nyamnjoh, F. B. (2019a). Decolonizing the Academy: A Case for Convivial Scholarship. *Keynote Address (Carl Schlettwein Lecture 2019)*, 1–12.

Nyamnjoh, F. B. (2019b). ICTs As Juju: African Inspiration for Understanding the Compositeness of Being Human Through Digital Technologies. *Journal of African Media Studies*, *11*(3), 279–291. https://doi.org/10.1386/jams_00001_1

Nyerere, J. (1962). *"Ujamaa": The Basis of African Socialism*. Tanganyika Standard Limited. https://ethics.utoronto.ca/wp-content/uploads/2017/11/Nyerere-UjamaaThe-Basis-of-African-Socialism-1962.pdf

Oyaro, K. (2016, November 25). *Taking Health Services to Remote Areas* [E-Magazine]. Africa Renewal. https://www.un.org/africarenewal/magazine/december-2016-march-2017/taking-health-services-remote-areas

Prada-García, C., Fernández-Espinilla, V., Hernán-García, C., Sanz-Muñoz, I., Martínez-Olmos, J., Eiros, J. M., and Castrodeza-Sanz, J. (2022). Attitudes, Perceptions and Practices of Influenza Vaccination in the Adult Population: Results of a Cross-Sectional Survey in Spain. *International Journal of Environmental Research and Public Health*, *19*(11139). https://doi.org/10.3390/ijerph191711139

Prainsack, B., and Buyx, A. (2012). Solidarity in Contemporary Bioethics—Towards a New Approach. *Bioethics*, *26*(7), 343–350. https://doi.org/10.1111/j.1467-8519.2012.01987.x

Reay, T. (1999). Allocating Scarce Resources in a Publicly Funded Health System: Ethical Considerations of a Canadian Managed Care Proposal. *Nursing Ethics*, *6*(3), 240–249. https://doi.org/10.1177/096973309900600306

Rikin, S., Scott, V., Shea, S., LaRussa, P., and Stockwell, M. (2018). Influenza Vaccination Beliefs and Practices in Elderly Primary Care Patients. *Journal of Community Health*, *43*, 201–206. https://doi.org/10.1007/s10900-017-0404-x

Ruch, E. A., and Anyanwu, K. C. (1981). *African Philosophy: An Introduction to the Main Philosophical Trends in Contemporary Africa*. Catholic Book Agency.

Rural Health Information Hub. (2019, April 6). *Mobile Clinics*. https://www.ruralhealthinfo.org/toolkits/transportation/2/models-to-overcome-barriers/mobile-clinics

Russo, C., Danioni, F., Zagrean, I., and Barni, D. (2022). Changing Personal Values through Value-Manipulation Tasks: A Systematic Literature Review Based on Schwartz's Theory of Basic Human Values. *European Journal of Investigation in Health, Psychology and Education*, *12*(7), 692–715. https://doi.org/10.3390/ejihpe12070052

SAHPRA. (2020, March 26). Guidelines on Iinfluenza Vaccination for 2020. *SAHPRA*. https://www.sahpra.org.za/news-and-updates/guidelines-on-influenza-vaccination-for-2020/

Samuel, O. S., and Fayemi, A. K. (2019). Afro-communal virtue ethic as a foundation for environmental sustainability in Africa and beyond. *South African Journal of Philosophy*, *38*(1), 79–95. https://doi.org/10.1080/02580136.2019.1581393

Sarangarajan, R., and Ewuoso, C. (2022). Ubuntu Philosophy and Mandatory Measles Vaccinations for Children. *Religions*, *13*(1184). https://doi.org/10.3390/rel13121184

SASPRI, Studies in Poverty and Inequality Institute, & Labour Research Service. (2020). *A Decent Standard of Living—Quantifying a Decent Standard of Living in Monetary Terms* [Research NFO]. SASPRI. https://www.saspri.org/SASPRI/SASPRI/research/decent-living-

level/index.html#:~:text=The%202018%20study%20found%20that,541%20per%20person%20per%20month.

Setlhodi, I. I. (2019). Ubuntu Leadership: An African Panacea for Improving School Performance. *Africa Education Review*, *16*(2), 126–142. https://doi.org/10.1080/18146627.2018.1464885

Shaw, W. H. (1993). *Social and Personal Ethics*. Wadsworth Publishing Co.

Shutte, A. (2001). *Ubuntu: An Ethic For A New South Africa*. Cluster Publications.

Sibanda, M., Meyer, J. C., Mahlaba, K. J., and Burnett, R. J. (2021). Promoting Healthy Aging in South Africa Through Vaccination of the Elderly. *Frontiers in Public Health*, *9*, 1–9. https://doi.org/10.3389/fpubh.2021.635266

Sium, A. (2014). CHAPTER THREE: Dreaming Beyond the State: Centering Indigenous Governance as a Framework for African Development. *Counterpoints*, *443*, 63–82.

Sladojević, A. (2009). Reviewing the Presence of the Adinkra Symbols in Ghana. *Journal of the Museum of African Art*, *1*, 41–56.

Smetana, J., Chlibek, R., Shaw, J., Splino, M., and Prymula, R. (2017). Influenza Vaccination in the Elderly. *Human Vaccines & Immunotherapeutics*, *14*(3), 540–549. https://doi.org/10.1080/21645515.2017.1343226

Solanki, G., Kelly, G., Cornell, J., Daviaud, E., and Geffen, L. (2019). Population Ageing in South Africa: Trends, Impact, and Challenges for the Health Sector. *South African Health Review*, *1*, 175–182. https://journals.co.za/doi/epdf/10.10520/EJC-1d2b0b4f5a

Statistics South Africa. (2017, October 2). *Public Healthcare: How Much Per Person?* [Government Database]. Statistics South Africa. https://www.statssa.gov.za/?p=10548

Statistics South Africa. (2021). *The Social Profile of Older Persons, 2015-2019* (Thematic 03-19–08; Marginalised Group Series IV, pp. 1–85). Statistics South Africa. https://www.statssa.gov.za/publications/03-19-08/03-19-082021.pdf

Statistics South Africa. (2023). *The Social Profile of Older Persons, 2017-2021* (Thematic 03-19–08; Marginalised Group Series VI, pp. 1–85). Statistics South Africa. https://www.statssa.gov.za/publications/03-19-08/03-19-082021.pdf

Tenforde, M. W., Talbot, H. K., Trabue, C. H., Gaglani, M. J., McNeal, T. M., Monto, A. S., Martin, E. T., Zimmerman, R. K., Silveira, F. P., Middleton, D. B., Olson, S. M., Garten Kondor, R. J., Barnes, J. R., Ferdinands, J. M., and Patel, M. M. (2021). Influenza Vaccine Effectiveness Against Hospitalization in the United States, 2019–2020. *The Journal of Infectious Diseases*, *224*(5), 813–820. https://doi.org/10.1093/infdis/jiaa800

Teo, L. M., Smith, H. E., Lwin, M. O., and Tang, W. E. (2019). Attitudes and Perception of Influenza Vaccines Among Older People in Singapore: A Qualitative Study. *Vaccine*, *37*, 6665–6672. https://doi.org/10.1016/j.vaccine.2019.09.037

Thiede, M., Akweongo, P., and McIntyre, D. (2007). *Exploring the Dimensions of Access* (pp. 103–123). https://doi.org/10.1017/CBO9780511544460.007

Thukwana, N. (2021, March 29). Flu Vaccine Drives from Clicks, Shoprite and Dis-Chem Have Started – How the Prices Compare. *News24*. https://www.news24.com/news24/bi-archive/flu-vaccine-drives-from-clicks-shoprite-and-dis-chem-have-started-how-the-prices-compare-2021-3

Tutu, D. (1999). *No Future Without Forgiveness*. Doubleday.

UNICEF (Director). (2022, September). *How Did Nigeria's Kaduna State Overcome Misinformation to Improve Childhood Immunization Rates?* https://www.linkedin.com/posts/unicef_globalgoals-buildbackimmunity-foreverychild-activity-7109884074621636608-qken?utm_source=share&utm_medium=member_ios

United Nations, Department of Economic and Social Affairs, Population Division. (2020). *World Population Ageing 2019* (Thematic ST/ESA/SER.A/444). United Nations. https://www.un.org/en/development/desa/population/publications/pdf/ageing/WorldPopulationAgeing2019-Report.pdf

Vogelstein, E., and Colbert, A. (2019). A Normative Nursing Ethics: A Literature Review and Tentative Recommendations. *Nursing Ethics*, *27*(1), 7–15.

Wasserman, H. (2022, September 21). *The Incompleteness of Knowledge Production: An Interview with Francis Nyamnjoh* [Online]. https://doi.org/10.1080/23743670.2022.2116587

Wiredu, K. (1992). Moral Foundations of an African Culture. In *Person and Community: Ghanaian Philosophical Studies* (I, pp. 193–206). The Council for Research in Values and Philosophy. https://www.crvp.org/publications/Series-II/1-Contents.pdf

Wiredu, K. (1998). Toward Decolonizing African Philosophy and Religion. *African Studies Quarterly*, *1*(4), 17–46. https://asq.africa.ufl.edu/wiredu_98/

Wolter, N., Buys, A., Moyes, J., du Plessis, M., Mkhencele, T., Moosa, F., Amoako, D., Kekana, D., de Gouveia, L., Cohen, C., and von Gottberg, A. (2022). Inflluenza Surveillance in South Africa: Weeks 1-32, 2022. *National Institute for Communicable Diseases*, *20*(2). https://www.nicd.ac.za/wp-content/uploads/2022/12/INFLUENZA-SURVEILLANCE-IN-SOUTH-AFRICA-WEEKS-1-32-2022.pdf

Wong, K. K., Cohen, A. L., Norris, S. A., Martinson, N. A., Mollendorf, C., Tempia, S., Walaza, S., Madhi, S. A., McMorrow, M. L., Variava, E., Motlhaoleng, K. M., and Cohen, C. (2016). Knowledge, Attitudes, and Practices About Influenza Illness and Vaccination—A Cross-Sectional Survey in Two South African Communities. *Influenza and Other Respiratory Viruses*, *10*(5), 421–428. https://doi.org/10.1111/irv.12388

Yemeke, T., McMillan, S., Weck Marciniak, M., and Ozawa, S. (2021). A Systematic Review of the Role of Pharmacists in Vaccination Services in Low-and Middle-Income Countries. *Research in Social and Administrative Pharmacy*, *17*, 300–306. https://doi.org/10.1016/j.sapharm.2020.03.016