HHR Health and Human Rights

DREXEL UNIVERSITY Dornsife School of Public Health

FXB Center for Health & Human Rights at Harvard University

PERSPECTIVE

Accountability Reimagined: Decolonizing Global Health Through Virtue and Subsidiarity

THANA C. DE CAMPOS-RUDINSKY AND DANIEL WAINSTOCK

Introduction

Accountability is widely recognized as a defining feature of human rights practice, including in the context of global health.[1] However, prevailing models of accountability remain deeply state-centric, structured around formal mechanisms that require power holders (governments, international organizations, and global health authorities) to justify their actions and remedy failures. While the demands of justification are essential for maintaining the legitimacy and trustworthiness of authorities, they often reinforce top-down structures that produce inflated bureaucracy, perfunctory transparency, and the marginalization of local voices. In many cases, they also reproduce colonial dynamics: concentrating evaluative authority in donors, experts, or international actors while diminishing the agency of local actors in setting priorities, defining success, or identifying harm.

We argue that effective and just human rights accountability requires an alternative, people-centered model, one that is not only structurally distinct but ethically reimagined. The alternative we propose is a relational approach that reconceptualizes accountability as a virtue and operationalizes it through the principle of subsidiarity. As a virtue, accountability is understood not as an external demand grounded in blame and shame but as an internal disposition: a moral and relational capacity marked by truthfulness, responsiveness, and a willingness to be answerable in ways that nurture mutual recognition, trust, and co-responsibility.[2] Operationally, we ground the virtue of accountability in the principle of subsidiarity, which affirms the moral and political authority of local communities while obligating higher-level institutions to provide support without displacing or abandoning them.[3]

This perspective essay focuses on the relationship between one defining feature of human rights—ac-

Thana C. de Campos-Rudinsky, DPhil (Oxon), is an associate professor of ethics, law, and global public policy at the Pontifical Catholic University of Chile, Santiago, Chile.

Daniel Wainstock, LLB, is a researcher in global health law and policy.

Please address correspondence to Daniel Wainstock. Email: danielwainstock@gmail.com.

Competing interests: None declared.

countability—and two concepts that can deepen its ethical and structural grounding: virtue and subsidiarity. While accountability and power have been extensively theorized, a comprehensive review of such scholarship lies beyond the present scope.[4] Our focus, instead, is to explore how virtue and subsidiarity can together reimagine accountability in global health as both a moral disposition and a structural principle. The upshot of our proposed account reinforces and resonates with well-established human rights dimensions—such as community engagement, empowerment, and equity—rendering them more conceptually robust. Although our argument dialogues with the human rights literature on accountability, sharing with it the view that accountability's true purpose is to empower local communities, our contribution lies elsewhere: in offering a virtue-centered and subsidiarity-driven reframing that complements rather than replicates existing analyses.

The limits of state-centric human rights accountability

While state-centric mechanisms of accountability remain the norm, their structure and logic have significant limitations, particularly in global health governance, where coloniality persists in the asymmetries of voice, knowledge, and authority that structure accountability relationships.[5] In these contexts, accountability is often reduced to periodic reporting, compliance checklists, or institutional audits. Real human rights accountability requires far more than this.

As Lynn Freedman emphasizes, genuine accountability entails more than the procedural routines of monitoring or bureaucratic oversight.[6] It demands a deeper, more nuanced understanding, one grounded in dialogue, responsiveness, and moral engagement. When reduced to technical compliance, accountability loses its transformative potential as a relational practice of trust, learning, and shared responsibility. These instruments may satisfy formal requirements of oversight, but they seldom disrupt entrenched power asymmetries or meaningfully engage the communities most affected by health policies and interventions.

This critique is increasingly echoed in human rights and global health scholarship. For example, Anuj Kapilashrami, Neil Quinn, and Abhijit Das argue that traditional models of political and bureaucratic accountability are inadequate for today's shifting health governance landscape.[7] They highlight the limitations of linear, top-down models and call for an expanded understanding of the accountability "ecosystem," one that includes community-led mechanisms, addresses corporate actors, and accounts for the sociopolitical contexts in which accountability is practiced.[8]

Yet the reality of most international systems of accountability, in being state-centric, remain tied to a narrow logic. They presume that the primary duty bearers are state actors and that legitimacy is preserved through upward-facing review. This is increasingly out of step with a global health landscape shaped not only by states but by powerful private actors: philanthropic foundations (donors), transnational corporations, and global health partnerships, whose influence often escapes formal accountability structures. For more than two decades, the international human rights system has sought to extend accountability to nonstate actors, for example, through the United Nations Working Group on Business and Human Rights and the development of the United Nations Guiding Principles on Business and Human Rights.[9] These mechanisms mark an important evolution in recognizing that corporate and transnational power must also be subject to human rights scrutiny. Yet their reach and enforcement capacity remain severely limited. The result is a fragmented architecture of accountability that continues to privilege state oversight while leaving significant sources of global health power insufficiently answerable to those most affected by their actions.

Moreover, state-centric models tend to reinforce technocratic norms: privileging quantitative metrics, formal procedures, and bureaucratic rationality over moral deliberation, relational trust, and contextual knowledge. Remedy, in this context, is often aimed at restoring functionality, ensuring that the system continues to operate rather than re-

imagining who should be accountable, how power is distributed, or what justice entails.

These mechanisms perpetuate the coloniality of knowledge and epistemic injustices that are inherent to global health governance. Knowledge is too often assumed to flow from evaluators in the Global North to recipients in the Global South. At the same time, the technical and phenomenological expertise of local communities is sidelined, extracted, or reinterpreted through external frames. Accountability, then, often risks becoming an instrument of blame, shame, and compliance rather than a space for shared reasoning, mutual recognition, and co-responsibility. When this occurs, it erodes the community's capacity to act and decide, subtracting and displacing local agency in the service of external interests, a dynamic that philosopher Caesar Atuire identifies as the moral wrong of colonialism.[10] While this critique does not deny that contemporary human rights accountability aspires to correct such an imbalance, our point is that practice too often reproduces the very hierarchies it seeks to overcome.[11]

To move beyond these limitations, an alternative model is needed, one that does not simply discard institutional mechanisms but grounds accountability in community agency, shared responsibility, and a horizontal dynamic of co-deliberation. The next section outlines the conceptual basis for such a model: accountability as a moral virtue.

Accountability as a virtue: From compliance to a reason-giving relationship

In many global health contexts, accountability is equated with oversight: a mechanism to ensure compliance, expose failure, or enforce transparency. But this framing, so common in reviews, donor contracts, and international partnerships, often reduces accountability to a tool of control. It emphasizes reporting over responsiveness, and output over moral engagement. As Lynn Freedman, Carmel Williams, and Paul Hunt have observed, this conflation of monitoring with accountability has long eviscerated the concept itself.[12] However, when accountability is reframed as a virtue (a cultivated disposition to offer justification to those with a legitimate moral claim), its logic shifts from blame, shame, and managerial control to relational trust, shared responsibility, and justice.

As philosopher C. Stephen Evans explains, to live accountably, in this sense, is to welcome appropriate moral expectations and offer meaningful explanation: not out of fear of sanction, but out of respect for those affected by them.[13] Accountability, then, arises from our shared moral standing. Since humans are accountable to other humans just because they are fellow humans, as philosopher Stephen Darwall argues, we have the authority or right to make certain demands on one another.[14] When accountability is viewed as shared authority, it is then not merely an obligation to submit to review, but a two-way moral exchange in mutual recognition.

We define accountability, therefore, as *a reason-giving relationship* in which both parties have a responsibility to answer and receive correction.[15] It calls for attentiveness to the other's concerns, a commitment to communicate with honesty and discretion, and the discipline to listen carefully and empathically in justifying one's actions in ways that are understandable and responsive to those affected.[16] This relational approach to accountability is not one-way. It emerges through mutual engagement, where both parties participate in building shared understanding and purpose moving forward. It is not a reaction to failure, but a proactive posture of relational trust. The accountable person speaks the truth with integrity, but also listens well. They recognize that being questioned is not an attack, but an invitation to grow. This shift in posture transforms accountability from a performance to a moral practice—from a burden to a form of moral care.

Defined as *a reason-giving relationship*, accountability depends on four interrelated dispositions: truthfulness, responsiveness, receptivity, and openness to correction.[17] These virtues resist both paternalism and passivity. Accountability thus construed avoids both the arrogance of imposed authority, which presumes to know better, and the irresponsibility of disengagement. It em-

powers communities to ask critical questions and to expect reasoned answers, not because they hold formal power but because they are moral participants in decisions that shape their lives. This vision resonates with recent calls for "human rights accountability from below"—an approach that seeks to democratize accountability by grounding it in community agency, moral reciprocity, and collective deliberation.[18] In doing so, accountability becomes not merely a mechanism of oversight but a practice of empowerment that redistributes moral and political authority toward those most affected.

In global health governance, this reframing would have far-reaching implications. Donors, international organizations, and national authorities are typically treated as the "accountors" (those who demand explanation). But from a virtue-based perspective, these actors also bear a responsibility to be accountable to communities: to justify their decisions in terms that are intelligible and assessable by those affected, and to listen with genuine openness to critique or dissent. This is not a procedural demand; it is an ethical and human rights requirement. It recognizes the standing of affected communities as moral equals and affirms their right to receive *truthful, intelligible, and timely justification*.[19]

This reframing orients accountability toward flourishing and interdependence rather than error correction alone. It opens space for solidarity, not surveillance, and for partnerships grounded in mutual care, not top-down compliance. In what follows, we offer a structural complement to this moral framework: the principle of subsidiarity, which gives institutional form to the ethic of shared authority and community agency.

Subsidiarity as a structural principle for decolonizing accountability

If accountability as a virtue offers a people-centered perspective that reframes how we stand in relation to one another (as co-participants in reason-giving relationships), then the principle of subsidiarity offers its structural complement. Subsidiarity holds that decision-making authority should reside at the most local competent level, unless there is a compelling reason for higher-level intervention.[20] It favors bottom-up governance, where local actors are empowered to take initiative, while higher-level institutions support rather than override them.[21] It is not simply a call for decentralization but a normative principle that seeks to align responsibility with contextual knowledge and capacity, and agency with proximity to need.[22] In this sense, subsidiarity offers a compelling alternative to both technocratic centralization and abandonment in the face of need.

By structuring responsibility along lines of proximity and capacity, subsidiarity ensures that accountability relationships remain horizontal, responsive, and contextually appropriate. It anchors the moral commitments of answerability, mutual recognition, and shared authority within the institutional architecture of global health governance, ensuring that these are not merely ethical aspirations but structural norms.[23]

In this context, subsidiarity becomes essential to global health. While solidarity is often invoked to promote shared goals across nations and communities, subsidiarity ensures that solidarity does not slip into colonialism or paternalism. It operationalizes solidarity through structures that protect community agency and foster mutual accountability. Rather than imposing "one-size-fits-all" solutions devised by centralized institutions, subsidiarity requires those institutions to support locally grounded responses, without abandoning their duty to assist when needed.[24]

The principle consists of two mutually reinforcing elements: agency and non-abandonment.[25] Agency refers to the freedom and responsibility of local actors to identify problems, determine priorities, and define appropriate responses based on their knowledge and lived experience. It recognizes that those most directly affected by injustice often have the clearest insight into what will work, and why.[26] Non-abandonment ensures that these actors are not left to fend for themselves, especially in contexts of structural inequity, corruption, or crisis. Instead, it

obliges external actors to assist in ways that are proportionate, respectful, and explicitly invited.

Together, these two elements hold in tension the dual commitments of empowerment and care, resisting both domination and neglect. Practically, this means that higher-level institutions, including international organizations, donors, and multilateral agencies, should not act unilaterally or assume that formal or perfunctory consultation suffices as *meaningful inclusion*.[27] Instead, they must become accountable partners: answerable to communities for the rationale, timing, and terms of their interventions. They must be willing to listen to critique, adjust their actions in response, and support local priorities rather than assume or dictate them.

This form of shared authority reframes accountability not as vertical enforcement but as a reciprocal structure of care and justification.

Subsidiarity therefore refuses the model in which external experts arrive with ready-made solutions, indifferent to the lived realities they encounter. It also resists the extractive logic that often characterizes donor-driven systems, where communities are sites of implementation but not of co-deliberation. In many global health interventions, resources are conditioned by external metrics, predetermined indicators, or donor timelines.[28] These arrangements often reduce accountability to box-ticking exercises and marginalize local voices.[29] A subsidiarity-based framework challenges these hierarchies by prioritizing agency at the ground level and establishing accountability lines that run multi-directionally *across*, rather than merely *above*.

Therefore, subsidiarity makes space for this kind of horizontal correction without defaulting to external control. It offers a way to institutionalize the shared authority on which the virtue of accountability rests. It reinforces the idea that accountability is not only a virtue practiced by individuals but also a structure that shapes how institutions relate to one another. Together, the virtue of accountability and the principle of subsidiarity form the basis of a people-centered, decolonial approach to global health governance.[30]

Applied illustration: Donor pause and shared answerability

In early 2025, the United States Agency for International Development (USAID) ordered an immediate suspension and review of nearly all international humanitarian and global health assistance, leading to the temporary halt of approximately 90% of more than 6,000 active projects worldwide.[31] The abrupt decision, described by several observers as an act of "geopolitical vandalism," disrupted critical programs in pandemic prevention, maternal and child health, vaccination campaigns, food security, and disease surveillance, with ripple effects across more than 80 countries.[32] While humanitarian exemptions were later introduced, the sudden withdrawal revealed the structural dependency built into vertically organized aid systems and the fragility of donor-centered accountability mechanisms, which often position external funders as unilateral decision-makers rather than partners in shared deliberation.

Viewed through the lens of *accountability as a virtue*, the central question is not the attribution of blame but the construction of a broader system of answerability: Which priorities were shaped by donor logic rather than local needs? How were past funds allocated? And now that this external support has vanished, who is involved in rethinking the future? Local communities are not mere victims; they are primary agents with the human right to ask questions, receive answers, and co-determine the path forward. From the perspective of *subsidiarity*, an adequate institutional response cannot be limited to merely resuming financial flows. It requires a reordering of authority so that local providers, community councils, and ministries of health co-deliberate priorities, timelines, and monitoring frameworks.

Three operational implications follow: first, the need for *truthful accounting* of prior commitments and disbursements at the country level, ensuring clarity regarding both decisions and their underlying rationales; second, the establishment of *inclusive, locally led forums* to identify critical gaps, competing priorities, and context-sensitive trade-offs through deliberative engagement; and third,

the adoption of *system-strengthening partnership terms* that condition renewed external support on demonstrable efforts to build sustainable domestic capacity rather than perpetuating fragmented or vertical programs.

Understood in this way, the 2025 USAID suspension is more than a moment of disruption; it serves as a revealing case of how the virtue of accountability and the structural principle of subsidiarity can jointly reorient global health governance. Therefore, it can serve as a catalyst for realignment: lines of accountability should begin to run horizontally (among domestic actors) and multidirectionally (with external partners), replacing unilateral control with shared authority and reciprocal answerability. This illustration thus substantiates our normative claim: that *virtue* (the cultivated disposition to speak truthfully, to listen, and to be corrigible) and *structure* (the principle of subsidiarity) should operate together to generate a more contextual, equitable, and resilient ecosystem of global health accountability.[33]

Conclusion

As new global health frameworks such as the Pandemic Treaty take shape, there is a risk that accountability will again be reduced to reporting obligations or centralized enforcement.[34] This paper has argued for a decolonial alternative: one that reframes accountability as a virtue and operationalizes it through the principle of subsidiarity. Together, they offer a people-centered model grounded in shared answerability, moral presence, and structural care. In a fragile world, accountability must move beyond metrics with an approach that resists both abandonment and dependency. Only when global health becomes genuinely accountable to those it claims to serve—by listening across borders, not dictating from above—can it fulfill its promise of justice. This requires more than transparency; it demands a fundamental shift in power, where local communities are not just consulted but recognized as co-authors of the future they inhabit.

References

1. E. A. Friedman, "An Independent Review and Accountability Mechanism for the Sustainable Development Goals: The Possibilities of a Framework Convention on Global Health," *Health and Human Rights* 18/1 (2016), p. 129.
2. See L. P. Freedman, "Human Rights, Constructive Accountability, and Maternal Mortality in the Dominican Republic: A Commentary," *International Journal of Gynecology and Obstetrics* 82 (2003); H. Potts, *Accountability and the Right to the Highest Attainable Standard of Health* (University of Essex Human Rights Centre, 2008); H. Potts, *Participation and the Right to the Highest Attainable Standard of Health* (University of Essex Human Rights Centre, 2008); P. Hunt and T. Gray (eds), *Maternal Mortality, Human Rights and Accountability* (Routledge, 2013).
3. A. Kapilashrami, N. Quinn, and A. Das, *Advancing Health Rights and Tackling Inequalities: Integrating Community Development and Participatory Praxis* (Policy Press, 2025).
4. R. McGee, "Rethinking Accountability: A Power Perspective," in R. McGee and J. Pettit (eds), *Power, Empowerment and Social Change* (Routledge, 2019), p. 58.
5. N. A. Erondu, T. Mofokeng, M. M. Kavanagh, et al., "Towards Anti Racist Policies and Strategies to Reduce Poor Health Outcomes in Racialised Communities: Introducing the O'Neill–Lancet Commission on Racism, Structural Discrimination, and Global Health," *Lancet* 401/10391 (2023); A. E. Yamin, "Promoting Equity in Health: What Role for Courts?," *Health and Human Rights* 16/2 (2014); C. A. Atuire and O. Rutazibwa, "An African Reading of the COVID-19 Pandemic and the Stakes of Decolonization," Yale Law School (July 29,2021), https://law.yale.edu/yls-today/news/african-reading-covid-19-pandemic-and-stakes-decolonization.
6. Freedman (see note 2).
7. Kapilashrami et al. (see note 3); C. S. Evans, *Living Accountably: Accountability as a Virtue* (Oxford University Press, 2023).
8. Kapilashrami et al. (see note 3).
9. Office of the United Nations High Commissioner for Human Rights, "About Business and Human Rights," https://www.ohchr.org/en/business-and-human-rights.
10. Atuire and Rutazibwa (see note 5).
11. M. Sirleaf, "White Health as Global Health," *AJIL Unbound* 117 (2023), p. 88; S. Sekalala, L. Forman, T. Hodgson, et al., "Decolonising Human Rights: How Intellectual Property Laws Result in Unequal Access to the COVID-19 Vaccine," *BMJ Global Health* 6 (2021).
12. Freedman (see note 2). See also C. Williams and P. Hunt, "Neglecting Human Rights: Accountability, Data and Sustainable Development Goal 3," *International Journal of Human Rights* 21/8 (2017).

13. Evans (see note 7).

14. S. Darwall, *Morality, Authority, and Law: Essays in Second-Personal Ethics I* (Oxford University Press, 2013); S. Darwall, *The Value of Autonomy and Autonomy of the Will* (University of Chicago Press, 2006), p. 124; S. Darwall, *The Second-Person Standpoint: Morality, Respect, and Accountability* (Harvard University Press, 2009).

15. T. C. de Campos-Rudinsky, "The Principle of Stewardship: Truthful Communication for the Restoration of Trust in Public Health Officials," *Journal of Public Health* (2025).

16. T. C. de Campos-Rudinsky, *The Rule of Love: The Power of Presence for Reforming Health Institutions and Global Health Leadership* (Oxford University Press, 2026), ch. 6.

17. Williams and Hunt (see note 12).

18. P. Hunt, "Health and Human Rights Accountability," *Lancet* 406/10510 (2025); B. Rajagopal, *International Law from Below: Development, Social Movements, and Third World Resistance* (Cambridge University Press, 2003).

19. T. C. de Campos-Rudinsky, "Guiding Principles of Global Health Governance in Times of Pandemics: Solidarity, Subsidiarity, and Stewardship," *American Journal of Bioethics* 20 No. 7 (2020).

20. T. C. de Campos-Rudinsky, *The Global Health Crisis: Ethical Responsibilities* (Cambridge University Press, 2017), ch. 3.

21. S. Gosepath, "The Principle of Subsidiarity," in A. Follesdal and T. Pogge (eds), *Real World Justice: Grounds, Principles, Human Rights, and Social Institutions* (Springer Netherlands, 2005); M. Cahill, "Theorizing Subsidiarity: Towards an Ontology-Sensitive Approach," *International Journal of Constitutional Law* 15 (2017); O. Höffe, "Subsidiarity as a Principle in the Philosophy of Government," *Regional and Federal Studies* 6 (1996); J. Chaplin, "Subsidiarity: The Concept and the Connections,'" *Ethical Perspective* 4 (1997); M. Da Silva, "Subsidiarity, States, and Intermediate Groups: Maintaining Subsidiarity's Distinct Contribution to Moral Philosophy," *Journal of Social Philosophy* 56/3 (2025).

22. T. C. de Campos-Rudinsky, "Global Health Governance and The Principle of Subsidiarity: In Defense of a Robust Decentralization Approach," *International Journal of Constitutional Law* 20 No. 1 (2022).

23. Williams and Hunt (see note 12).

24. T. C. de Campos-Rudinsky, S. L. Bosha, D. Wainstock et al., "Decolonising Global Health: Why the New Pandemic Agreement Should Have Included the Principle of Subsidiarity," *Lancet Global Health* 12/7 (2024).

25. Williams and Hunt (see note 12).

26. De Campos-Rudinsky (2026, see note 16).

27. Ibid.

28. J. Prah Ruger, "Global Health Governance as a Shared Health Governance," *Journal of Epidemiology and Community Health* 66/7 (2012); L. O. Gostin and E. A. Mok, "Innovative Solutions to Closing the Health Gap Between Rich and Poor: A Special Symposium on Global Health Governance," *Journal of Law, Medicine and Ethics* 38/3 (2010).

29. Freedman (see note 2).

30. For an early introduction to participation and the right to health, see H. Potts, *Participation and the Right to the Highest Attainable Standard of Health* (see note 2).

31. S. Seddon, "What Is USAID and Why Is Trump Poised to 'Close It Down'?," *BBC News* (February 7, 2025), https://www.bbc.com/news/articles/clyezjiwnx5ko.

32. C. Kyobutungi, E. Okereke, and S. Abimbola, "After USAID: What Now for Aid and Africa?," *BMJ* 388 (2025).

33. See M. Gibney and S. Skogly, *Universal Human Rights and Extraterritorial Obligations* (University of Pennsylvania Press, 2010).

34. De Campos-Rudinsky et al. (see note 24).