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Pandemic, Poverty, and Power: Biosocial Ethics of Global Solidarity for Health

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BIO

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> "COVID-19 has robbed us of people we love. It's robbed us of lives and livelihoods; it's shaken the foundations of our world; it threatens to tear at the fabric of international cooperation. But it's also reminded us that for all our differences, we are one human race, and we are stronger together …. Now more than ever, we need a healthier world. Now more than ever, we need a safer world. Now more than ever, we need a fairer world."
>
> Dr. Tedros Ghebreyesus, WHO, Director-General[1]

A very close friend of mine woke me up early in the morning in May 2020 with a sad phone call. He coordinates the initiatives for the defense of the rights of children and promotes policies and programs for children's protection from abuse and neglect for a UN agency in northern Nigeria. He was broken because he had spent the previous night out rescuing more than 200 children between the ages of five and ten years who had been abandoned on the streets of Kaduna, one of the largest cities in northern Nigeria. In his sadness, he said to me, "What kind of society will allow her most vulnerable ones who should be the *first call* on society's resources to suffer this way?"

Many of these children, he said, were malnourished. Some had visible signs of physical and sexual abuse. Most were emotionally distressed and were infected by many diseases, including the dreaded COVID-19. These children are referred to in Nigeria in the local Hausa language as *almajirai*, which is derived from the Arabic word *al-Muhajirun*, or emigrant. Most of these children, having been "given away" to the Islamic teachers (called *malams*) so early in their lives, no longer knew their family roots or their village of origin. These *malams* are usually poor, and the kids pay them for their education by begging along the major streets and highways. The *malams* in return provide them with food and lodging, often in squalid and unhealthy conditions. Following the outbreak of COVID-19 in Kano and Kaduna and the closure of these home-based schools and driven by the fear that these kids could be infected through their contact with people on the streets, most of the *malams* had to shut their doors. The kids ended up homeless.

According to the BBC, the Kaduna state government was picking up these kids from the streets and repatriating them to their states of origin. In 2020, Northern Nigeria witnessed the largest mass movement of minors in living memory in West Africa with as many as 30,000 being moved to different states.[2] The pitiable condition of these kids, which my friend observed, broke his heart. It also broke mine.

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1 Quoted in "Historic Health Assembly Ends with Global Commitment to COVID-19 Response," World Health Organization, 19 May 2020, at: https://www.who.int/news/item/19-05-2020-historic-health-assembly-ends-with-global-commitment-to-covid-19-response.

2 See "Coronavirus in Nigeria: The Child Beggars at the Heart of the Outbreak," *BBC News*, 16 May 2020, see: https://www.bbc.com/news/world-africa-52617551.

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A student uses a hand sanitizer station in the Student Center, January 21, 2021, on the Lincoln Park Campus.

Courtesy DePaul University/Randall Spriggs

What I provide in this essay is a personal ethical reflection on this pandemic. I will begin first by examining the nature of the vulnerabilities that the poor face by exploring the social determinants of health, particularly in Africa, all of which have shaped the emerging stress and strains in the continent's struggling response to the pandemic and the lack of access to vaccines. I will focus on the aspect of power in the concluding part of my essay and how a biosocial ethical approach to health, human, and cosmic well-being could contribute to building resilience and hope. I will also discuss how Catholic universities like DePaul could contribute to developing practices of global solidarity through a pedagogy and praxis of love.

Pandemic, Vulnerabilities, and Africa's Resilience

Early in March 2020, I received a distressing email from my colleague, Andrew Obara, one of the Kenyan agents of the Canadian Samaritans for Africa—a charity I founded in 2003—asking us to help the women in the slums of Kibera, Nairobi, where we support a micro-credit community agency, the Village of Love (Kijiji Cha Upendo or KCU). These women had received training and financial support to set up businesses ranging from agro-based mini marts and grocery shops to skills-based income-generating activities. They had lost all their savings to the shutdown and could no longer provide food for their children. The government offered them no support to cushion the effects of the shutdown. The situation of these Kenyan women is not unique. I have heard the same stories from women's groups in South Sudan, Uganda, Nigeria, and Burkina Faso. Most African countries followed the WHO's advice and shut down their countries as a way of mitigating and suppressing the spread of COVID-19, but the governments failed to address people's hardships and

suffering. COVID has exposed the unacceptable political structures in Africa today, where governments have largely failed to protect, promote, and preserve the common good, from which all should draw as a wellspring.

It will take many decades to determine the lockdown's impact on the lives of so many people in Africa and in the world. As Nicholas Christakis posits, "Like other infectious diseases, coronavirus strikes differentially along socio-economic lines. While the pandemic did not cause the structural inequities in our society, it nevertheless brought them into stark relief."[3] Many African public health officials worry that the focus on fighting this infection has led not only to the abandonment of the people with regard to food security, but also to the neglect of treating other diseases that kill more people than COVID-19—AIDS, Ebola, malaria, Lassa fever, and some non-communicable chronic diseases like coronary vascular conditions, high blood pressure, and diabetes.

The World Poverty Clock estimates that the Sustainable Development Goals (SDG) target of no poverty by 2030 has been upended by COVID-19 and that Africa will be the most adversely affected.[4] According to Baldwin Tong, "COVID-19 has caused a great deal of economic uncertainty throughout the world. Millions of Africans who were on the lower rungs of the middle class have seen their incomes plummet due to rapidly vanishing jobs and a lack of social security. As a result, millions of people from this group are being pushed back into poverty. Recent estimates indicate that the number could be around eight million. Regions that were already economically vulnerable pre-pandemic are now in need of more targeted support from the international community to ensure a sustainable and inclusive recovery in the coming years."[5] Faced with this grim prospect, the UN Economic Commission for Africa called for a $100 billion safety net for the continent, including halting external debt payments.[6] Whether halting the repayment of debts will be enough to address Africa's vulnerabilities in this pandemic and after is an open question. The other question is whether Africa's vulnerabilities in the face of new infections can be met through international aid, especially given the failure of the interventionist aid regime that has characterized Africa's dependency on the West and now China for her development designs and healthcare.[7]

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3 Nicholas Christakis, *Apollo's Arrow: The Profound and Enduring Impact of Coronavirus on the Way We Live*, (New York: Little, Brown Spark, 2020), 189.

4 "World Poverty Clock," World Data Lab, accessed 15 February 2021, at: https://worldpoverty.io/map.

5 Baldwin Tong, "COVID-19 Has Pushed Extreme Poverty Numbers in Africa to over Half a Billion," *Development Matters* (blog), Organisation for Economic Co-operation and Development, 12 October 2020, see: https://oecd-development-matters.org/2020/10/12/covid-19-has-pushed-extreme-poverty-numbers-in-africa-to-over-half-a-billion/.

6 "African Finance Ministers: Urgent Need for $100bn Immediate Emergency Financing for COVID-19," United Nations Economic Commission for Africa, 31 March 2020, at: https://archive.uneca.org/stories/african-finance-ministers-urgent-need-100bn-immediate-emergency-financing-covid-19.

7 I have discussed this question extensively in my book, *The Church and Development in Africa: Aid and Development from the Perspective of Catholic Social Ethics*, 2nd ed. (Eugene, OR: Pickwick Publications, 2014), 132–51.

For the world's vulnerable people—those who are poor, elderly, or who have underlying health conditions—COVID-19 is another layer of agony built on lives already bruised and broken by suffering. For me, the children abandoned on the streets of Kaduna represent the conditions of so many people who are abandoned to die as a result of this pandemic. Many poor people in the African continent and elsewhere in our world are suffering and dying because our society has not equitably allocated resources for the urgent intervention needed to roll back the hand of death.[8] A team of scholars from the Global South has studied the impacts of COVID-19 and the asymmetries of power and privilege that it has brought to the fore with regard to lack of diversity and inclusive social policies in local, national, and global institutions and systems. They have also considered the pandemic with respect to white supremacy, saviorism, coloniality,[9] racism, patriarchy, and the foreign gaze. The team summarizes these points this way: "COVID-19 has put a spotlight on existing inequalities and on processes of coloniality (mind, body, knowledge, and power). It has created conditions for further inequities, with growing populist nationalism and isolationism, widening income disparities, and fractured systems of global cooperation. The pandemic continues to enable those with money and power to expand their influence—making decoloniality, solidarity, and distribution of power, knowledge, and resources (e.g., vaccines) even more urgent. The fact that HICs [high-income countries] have reserved enough COVID-19 vaccine doses to vaccinate their own population multiple times over is a stark indication of power asymmetry in global health."[10]

COVID-19 has also revealed the false sense of security on which the world has been built. We humans have lived as if we were the center of the universe. Our world operates on a dysfunctional value system which glories in all forms of iniquitous hierarchies of power and hardened walls of indifference and isolationist national and cultural practices

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8 See the discussion on how to manage local and global resources to meet the disparities in health outcomes between the rich and the poor in Udo Schuklenk and Darragh Hare, "Issues in Health Ethics" in *Global Bioethics and Human Rights: Contemporary Issues*, ed. Wanda Teays et al. (Lanham, MD: Rowman and Littlefield, 2014) 301–12.

9 *Editor's note*: Coloniality is a concept originated by Aníbal Quijano and later developed by Walter D. Mignolo. As Mignolo writes:

> The key concept of coloniality calls into question the idea that knowledge is disembodied and independent of any specific geohistorical locations. The members involved in the project argue that such belief has been created and implanted by dominant principles of knowledge that originated in Europe since the Renaissance. In order to build a universal conception of knowledge, Western epistemology (from Christian theology to secular philosophy and science) has pretended that knowledge is independent of the geohistorical (Christian Europe) and biographical conditions (Christian white men living in Christian Europe) in which it is produced. As a result, Europe became the locus of epistemic enunciation, and the rest of the world became the object to be described and studied from the European (and, later on, the United States), perspective.
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> The above passage comes from Mignolo's "Modernity and Decoloniality," Oxford Bibliographies, 28 October 2011, see: https://www.healthaffairs.org/do/10.1377/forefront.20200319.757883/full/.

10 Seye Abimbola, Sumegha Asthana, Christian Montenegro Cortes, et al., "Addressing Power Asymmetries in Global Health: Imperatives in the Wake of the COVID-19 Pandemic," *PLoS Medicine* 18 no., 4 (22 April 2021): 2, at: https://doi.org/10.1371/journal.pmed.1003604.

and stratagems. By leaving paralysis in its wake, COVID-19 has laid bare our collective vulnerabilities. Indeed, this pandemic offers a mirror into the brokenness and woundedness of our world which was already bleeding before the pandemic

On the other hand, COVID has shown us the resilience of African peoples. At the time of this writing, the African continent has been the least impacted by the pandemic in terms of deaths and infections rate. Within the limited resources at their disposal, African countries have continued to follow national guidelines on mitigation and suppression without the kind of political drama we find in the United States, for instance, where mask wearing has been considered a political statement rather than a public health protection measure. The former president of Liberia, Ellen Johnson Sirleaf published a letter to the world—"Coronavirus: What the World Can Learn from Ebola Fight"—at the onset of this pandemic, where she made an argument on the need to keep hope alive in the face of the pandemic and extolled the resilience of Africa.[11] She proposed that what is needed particularly in Africa is not a spirit of fear, but a resilient spirit to manage the pandemic. Ethnographer Paul Richards reached a similar conclusion in his study of the 2013–2014 Ebola epidemic in West Africa. According to Richards, even though Ebola unleashed a deadly force, it also revealed how a people's science could help fight an epidemic. He proposes that rather than focusing only on the shortcomings of public healthcare in Africa and failure of international solidarity, one should pay greater attention to how Africa's victory over Ebola reveals the resilience of African communities.

Although these communities were originally "scared into mass flight" over the disease, they rallied together and worked with local agents and international responders. Richardson says that these communities ended the Ebola epidemic despite the "doom-laden predication" that millions would die and despite the international isolation mandated through forty nations' flight bans to affected countries.[12] The success of the communities' measures was dependent on the use of communal social networks and communal surveillance. People tapped into the social capital in the complex and rich chain of African communal and social ties, neighborhood groups, and social solidarity. According to former President Sirleaf, countries in West Africa emerged from the Ebola outbreak with resiliency, health protocols, and practices that are helping to slow down or even break the chain of transmission and flatten the curve of COVID. Sirleaf and Richards remind us to always focus on the assets of the people. As James Cochrane points out, "Even in the most deprived situations, if people

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11 Ellen Johnson Sirleaf, "Coronavirus: What the World Can Learn from Ebola Fight," *BBC News*, 30 March 2020, see: https://www.bbc.com/news/world-africa-52061547.

12 Paul Richards, *Ebola: How a People's Science Helped End an Epidemic* (London: Zed Books, 2016), 3.

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Face covering and social distancing signage is posted outside on the Lincoln Park Campus Quad in order to comply with safety and social distancing guidelines during the COVID-19 pandemic. August 3, 2020.

Courtesy DePaul University/Jeff Carrion

are able to survive let alone flourish, it can be assumed that there are assets of one kind or another that, based on hard experience, they have learned to leverage in ways appropriate to their contexts." These assets are embedded within worldviews, religious convictions, local practices, and activities that can be leveraged in designing interventions that will meet people's needs.[13] However, one must pay attention to the social determinants of health that undermine the assets of people and communities and harm their well-being.

Biosocial Ethics and the Social Determinants of Health

The WHO provides two important definitions of health equity and social determinants of health (SDH) that are important in providing the framework through which one can understand the importance of developing a biosocial ethical leadership. The SDH are central to understanding the different outcomes from infection for different people. A biosocial ethical approach to leadership must therefore address these SDH because they help us understand the presence or absence of those conditions necessary for holistic health, and the structural issues in local and global settings that create injustice and lead to preventable deaths and human suffering. The SDH can be better explained through a brief analysis of health inequities both locally and globally.

The WHO's Commission on Social Determinants of Health defines health inequity as "the absence of unfair and avoidable or remediable differences in health among population groups defined socially, economically, demographically or geographically." Health inequities

13 James Cochrane, "A Model of Integral Development: Assessing and Working with Religious Health Assets," in *Religion and Development: Ways of Transforming the World*, ed. Gerrie ter Haar (London: Hurst and Company, 2011), 245.

are thus to be understood as health differences "that are socially produced, systematic in their distribution across the population, and unfair. Identifying a health difference as inequitable is not an objective description, but necessarily implies an appeal to ethical norms."[14] Health inequity has been called "an inverse care law" because it shows that the poor who are most in need of healthcare locally, nationally, and globally are the ones who consistently have less access to health services than the rich.[15]

Health inequities are thus worse than diseases because they make birthplaces and social locations the number one condition for whether people live to a glorious old age or whether they die from deadly early childhood diseases. Health inequities are the greatest drivers of unacceptable social reproduction, stubborn cultural habits, and intergenerational socioeconomic gradient differentials in the remotest villages of Africa as well as in the big cities. The WHO's definition is very helpful in explicating this important point:

> The social determinants of health (SDH) are the non-medical factors that influence health outcomes. They are the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life. These forces and systems include economic policies and systems, development agendas, social norms, social policies, and political systems. The SDH have an important influence on health inequities—the unfair and avoidable differences in health status seen within and between countries. In countries at all levels of income, health and illness follow a social gradient: the lower the socioeconomic position, the worse the health.[16]

The following non-exhaustive list provides some factors that come into this wide pool of SDH: income and social protection; education; agriculture and food production, unemployment and job security; working life conditions; food insecurity; housing and sanitation, basic amenities, and the environment; early childhood development; social support and inclusion; structural conflict; and access to affordable quality health services.[17] The SDH force us to consider the "causes of the causes" of disease, meaning that ethicists must go beyond judgment of etiology or epidemiology in a particular environment to the wider causes of the disease, which go beyond a single pathogen, virus, or bacterium. The SDH invite us to a holistic understanding of health and to more system-based ethical analyses of healthcare, health systems, governmental priority settings and policies, and the focus of

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14 World Health Organization, *A Conceptual Framework for Action on the Social Determinants of Health* (Geneva: World Health Organization, 2010), 12.

15 Charles Guest et al., *Oxford Handbook of Public Health Practice* (Oxford: Oxford University Press, 2013), 408.

16 "Social Determinants of Health," World Health Organization, accessed 15 February 2021, see: https://www.who.int/health-topics/social-determinants-of-health#tab=tab_1.

17 The best presentation of SDH is the Dahlgren-Whitehead Rainbow Model.

the pastoral and social engagements of churches. All these must take into account the social construction of diseases across history. Diseases do not just happen; epidemics don't just occur. They are the sum of aggregate factors of diverse nature that must be understood and addressed in providing a comprehensive approach to human and cosmic flourishing. This is what Henry Giroux means with regard to the devastatingly disproportionate impact of COVID to African Americans in the US and Black and Brown people in Canada, the UK, and South Africa compared to whites. He writes, "The pandemic may have been indiscriminate in terms of those it infected, but its effects bore down disproportionately on poor people of color proving Martin Luther King Jr's claim that 'of all the forms of inequity, injustice in healthcare is the most shocking and inhumane.'"[18]

Ethicists must burrow deeper into understanding the resocializing factors beyond epidemiological data and etiology in interpreting the presence of an infectious disease and the responses that individuals and society ought to make. Such factors include culture, funds of knowledge,[19] social status, racism, ethnocentrism, religious beliefs and practices, worldviews, and the failings of the state in public health that all contribute to the preexisting conditions and comorbidities of certain racial, gender, age, and social groups in the face of the current pandemic, for instance. As people say in public health, healthcare is what you do when public health fails. In other words, ethicists should study more the social production of diseases; local, national, and global politics; and the economies of scale with regard to public health and other social provisions in the world. Finally, ethicists must pay particular attention to the conclusion of the WHO report that "inequities in health arise from inequities in societies"[20]; and I will add that inequities in global health arise from inequities in the world today. Therein lies the need to look at the ways these inequities are constructed, sustained, and defended through the abuse and misuse of power by leaders at different levels leading to deaths, chronic sicknesses, and suffering in the world.

The biosocial approach has the capacity of taking these factors seriously because it combines three aspects of public health—the biomedical model, the behavioral model, and the social model. The biosocial approach focuses on all the contributing factors that interact in health improvement, protection, and healthcare in the procurement of abundant life. These factors include nutrition; sanitation; the environment; quality of one's social

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18 Henry Giroux, *Race, Politics, and Pandemic: Education in a Time of Crisis* (London: Bloomsbury Academic, 2021), 181.

19 *Editor's note:* There are different definitions of funds of knowledge, but the most well known was proposed by Luis Moll, Cathy Amanti, Deborah Neff, and Norma González. They defined it as "historically-accumulated and culturally-developed bodies of knowledge and skills essential for household or individual functioning and well-being." Quoted in "The Funds of Knowledge Approach," Funds of Knowledge Alliance, accessed 17 July 2021, see: https://fundsofknowledge.org/the-funds-of-knowledge-approach/.

20 "Health Inequities and their Causes," World Health Organization, accessed 25 June 2021, at: https://www.who.int/news-room/facts-in-pictures/detail/health-inequities-and-their-causes.

relationships; cultural and spiritual traditions; politics; human rights; the economy; religious beliefs and practices; and traditional and modern knowledge about health, sickness, diseases, and healing. It examines the adequacy of human actions and value preferences. The biosocial model integrates cultural, religious, social, and political factors in advancing the proper interaction of all the integrative elements that must work together in bringing about human well-being. The biosocial approach sees health as relational because diseases and their morbidity and subsequent mortality are not random but involve the relationships among many factors. Therefore, biosocial ethics focus on understanding the many layers involved in *healthcare systems* (personal healthcare like hospitals and services), *health systems* in general (including service delivery, work force, health information, and medical products like drugs, vaccines, and technologies), and *healthworlds* (health finance, leadership, and governance, local-global nexus, knowledge, etc.).[21]

A biosocial ethics for health is an ethical framework and praxis that seeks to understand and address the social determinants of health—how the society behaves and how individuals behave within particular societies with regard to some of the life-altering choices that they are making on a daily basis. It provides both the language and analytical compass to understand health inequity, assessing healthcare systems and health systems as part and parcel of the large indices of human security. At the same time, biosocial ethics offers creative principles for behavior changes—for individuals and religious and civil authorities—to fight the factors that sustain health inequity and accelerate those factors that lead to health promotion and health prevention to foster the necessary conditions for holistic health and abundant life. The biosocial ethics being proposed here address the SDH in a direct way because they proceed from the realization that "diseases themselves make a preferential option for the poor. Every careful survey, across boundaries of time and space, shows us that the poor are sicker than the nonpoor. They're at the increased risk of dying prematurely, whether from increased exposure to pathogens (including pathogenic situations) or from decreased access to services—or, as is most often the case, from both of these 'risk factors' working together."[22]

When we look at the data on human health, particularly the Global Burden of Disease, what we see clearly is that Africa has not made the *epidemiological transition*. That means that, unlike in North America and Europe, more people still die in Africa from communicable diseases like malaria, HIV/AIDS, Ebola, and now COVID than from noncommunicable

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21 See Paul Germond and James Cochrane, "Healthworlds: Conceptualizing Landscape of Multiple Healing Systems," *British Journal of Sociology* 44, no. 2 (April 2010): 320.

22 Michael Griffin and Jennie Block, eds., *In the Company of the Poor: Conversations with Dr. Paul Farmer and Fr. Gustavo Gutiérrez*, (Maryknoll, NY: Orbis Books, 2013), 36.

diseases like coronary heart diseases, high blood pressure, stroke, diabetes, and cancer.[23] Health protection and health promotion have not been prioritized because access to healthcare and an adequate standard of living is not possible given the high index of deprivation in most countries in the continent. Furthermore, there is the absence of adequate frameworks for health protection and health improvement which would include addressing some of the SDH in our continent's fight against diseases. It is not surprising then that the Church's witness in this regard often focuses on the disease control and prevention paradigm and the treatment paradigm (healing ministry, hospitals and clinics, etc.). All these are residues of the continuing impact and the perversive presence of colonial medicine that focused on curing diseases in Africa with its associated racialized fetishization of Africa and the contaminating narratives of Africa as the white man's grave. Biosocial ethical leadership for holistic healthcare, therefore, emphasizes the micro (individual), meso (national), and macro (international/global) factors to understand the African burden of diseases of which COVID is only another layer in the ever-revolving cycle of disability, exposure to disease, and death.

The biosocial theological ethics can also offer a foundation for solidarity on global health and promoting the common good through one health—human health, environment health, and animal health. This kind of solidarity is captured so well by Pope Francis in these words: "This is the time to restore an ethics of fraternity and solidarity, regenerating the bonds of trust and belonging. For what saves us is not an idea but an encounter. Only the face of another is capable of awakening the best of ourselves. In serving the people, we save ourselves. If we are to come out of this crisis better, we have to recover the knowledge that as a people we have a shared destination. The pandemic has reminded us that no one is saved alone. What ties us to each other is what we commonly call solidarity."[24] A biosocial theological ethics of solidarity is grounded on the intrinsic goodness of all lives, and a firm commitment by every human being on earth to make ethical choices to promote, defend, and uphold the rights of every human being to health and well-being and a life lived in dignity as the sole condition for human and cosmic well-being. This ethics proposes what ought to be done by individuals, societies, and nations to promote holistic health through fraternal solidarity to strengthen the bond of our common humanity.

The truth is that no one is safe until all of us are safe, we are all sick when any one of us is sick, and something dies in all of us when anyone dies. As Saint Paul puts it, "If one part suffers, all the parts suffer with it; if one part is honored, all the parts share its

23 Larry Heligman, Nancy Chen, and Ozer Babakol, "Shifts in the Structure of Population and Deaths in Less Developed Regions" in *Epidemiological Transition: Policy and Planning Implications for Developing Countries*, ed. James N. Gribble and Samuel H. Preston (National Academies Press, 1993).

24 Pope Francis, *Let Us Dream: The Path to a Better Future* (New York: Simon & Schuster, 2020), 107.

Click to enlarge

Signs posted in "The Pit" in the Schmitt Academic Center (SAC) emphasize social distancing practices, September 9, 2020, on the Lincoln Park Campus. DePaul University began a new normal as classes commenced for the start of the 2020–2021 academic school year. Students acclimated themselves to the new class structure by participating in Zoom course sessions both on and off campus.

Courtesy DePaul University/Randall Spriggs

joy" (1 Corinthians 12:26). We all share a common human origin and a common human future; we are tied in the same robe of destiny. We must come together as one family at this time to fight this pandemic, and fight against injustice, poverty, violence, and ecological threats to our world so that we can be the heirs to a new world and a new creation where God's planet and all God's people are flourishing. This new world will emerge not simply through good wishes and sympathy for those who suffer, but through a praxis of solidarity and love that invites us to make common cause with the poor in the spirit of Saint Vincent de Paul.

The Power and Politics of Love

Biosocial ethics is built on the capacity of the people or the power of agents who have to act in the right way in order to help generate the right health outcomes—abundant life for humans and the earth. This is where ethical leadership is so important particularly for religious leaders, universities, and teachers who can influence people's behaviors and governmental policies. How does power function? The WHO's document on the SDH proposes that one can look at power from the classical model of "power to," where someone has the capacity to undertake series of actions that could alter the course of a particular event for the individual or for a group. The other aspect of power is "power over," where an individual or a group of people determine or influence the way other people respond or act. The aspect of power over is central to the way our world functions today; it is the kind of power that relates to politics and public health. It is also what is at stake in power struggles

in society, whether in small units like families or in larger entities like universities or the UN. As humans, we are always caught in power dynamics and power tussles even in the household of God. However, power should be about service and procuring the right sets of conditions for a win-win for all members of society. But this is not always the case. How can the exercise of power bring life to everyone, the kind that Jesus exercised when he gave his life away on the cross? Michel Foucault offers good language and insight to make this point.

Power can be understood through Foucault's theory of biopower. According to him, biopower is the power of the modern state to "administer, optimize, and multiply" life, "subjecting it to precise controls and comprehensive regulations."[25] Biopower exerts a positive influence on life because it is a productive power rather than a repressive power. However, like sexual desire, power can operate at two levels. On the first level, it gives life and nourishes relationships when one understands this desire and is at home with it. Sometimes, though, it can operate at a hyper-level (*sur-savoir*) where one "over-understands" this power and employs different techniques in exercising this desire which could be destructive. [26] In the first place, we see the positive exercise of power as "power to" do good for the collective; in the second, we see the negative exercise of power, which is "power over" people that dominates, manipulates, exploits, and destroys the common good for the interests of a few individuals or camps. "Power over" is the kind of unchecked power of the strong over the weak through our systems and institutions, and the selfish exercise of power and abuse of authority that is at the root of the malaise of modern societies, states, and religious organizations.

This classification can be applied as an explanatory account of how power functions in social relations at micro and macro levels. We can give examples of the power of a doctor over her patients or the power of a faith healer over a patient seeking healing. Foucault draws attention to how biopower can be abused, and this power of life can become a deadly form of power (biopolitics), that is, "the power to expose a whole population to death." When this happens, the calculated management of life—collective and individual—becomes a "subjugation of life to the power of death."[27]

Hannah Arendt's definition of power is a good way of capturing the kind of power that Foucault asserts "fosters life;" the kind of power that promotes a cosmic *ubuntu*[28] and

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25 Michel Foucault, *The Will to Knowledge: The History of Sexuality*, vol. 1, 1976, trans. Robert Hurley (New York: Pantheon Books, 1978), 137, quoted in Rachel Adams, "Michel Foucault: Biopolitics and Biopower," Critical Legal Thinking: Law and the Political, 10 May 2017, at: https://criticallegalthinking.com/2017/05/10/michel-foucault-biopolitics-biopower/.

26 Michel Foucault, *Religion and Culture*, ed. Jeremy R. Carrette (New York: Routledge, 1999), 117.

27 Foucault, *The Will to Knowledge*, in Adams.

28 *Editor's note:* According to Fainos Mangena, ubuntu is "the quality or essence of being a person" and also can refer to a person's ethics. See Fainos Mangena, "Hunhu/Ubuntu in the Traditional Thought of Southern Africa" in *Internet Encyclopedia of Philosophy*, ed. Jonathan Chimakonam, accessed 17 July 2021, see: https://iep.utm.edu/hunhu/#H3.

the kind of power that educators can exercise in the face of this pandemic. In Arendt's philosophy, "power is conceptually and *above all politically* distinguished, not by its implication in agency, but above all by its character as *collective* action. Power corresponds to the human ability not just to act, but to act in concert. Power is never the property of an individual; it belongs to a group and remains in existence only so long as the group keeps together."[29] For Arendt, power is not a relation in which people are dominated, exploited, or manipulated, but rather one in which through critical reflection on their world and their experiences, societies can develop collective actions through transformative leaders.

This kind of leadership for collective action is in short supply during the pandemic. This is because what we see is that COVID-19 relief, vaccines, and mitigation measures have all become politicized in many parts of the world. Indeed, the greatest threat towards global solidarity is a return to the old ways of doing things in the world. These are characterized by four vices that Pope Francis identifies: indifference, self-centeredness, ideological divisions, and forgetfulness. Examples abound of these, but one egregious case is the tension between the US and China. This played out so badly in November 2020 that both countries refused to participate in the Seventy-third World Health Assembly on the theme of global solidarity in the fight against COVID-19.

Those who are gasping for breath and fighting for their lives in the ICUs all over the world need help, not politics. The sick, who have no access to medical treatment in many parts of the world in the face of this disease and who embrace all kinds of unorthodox solutions to fight the infection, need access to health, not political grandstanding. The vulnerable of our societies, like the *almajiris* of Northern Nigeria, and the seniors who are dying in hospitals and nursing homes in the West, and migrants and refugees who are being exposed to this disease and other health hazards have no other way to resist the powers of entropy that, like a tsunami, are engulfing them. The weapons of the weak are, as James Scott reminds us, often "quiet and anonymous."[30] The sick, especially in this pandemic, become invisible and are instead numbers and statistics of deaths, and trends or curves that must be flattened.

A friend from my home country, Nigeria, sent me a prayer on WhatsApp, saying to me, "May you never be a number in the statistics of deaths from this pandemic." I replied that I am no better than those who have died, and indeed that no one should be a number in the statistics of death. We should save all lives. I believe that a biosocial ethics is needed in order to break this cycle of death by a new movement of all of God's people, journeying

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29 Quoted in World Health Organization, *A Conceptual Framework*, 21.

30 See James C. Scott, *Weapons of the Weak: Everyday Forms of Peasant Resistance* (Yale: Yale University Press, 1985).

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DePaul students Anni Newton and Jack Chandler walk in the quad on the Lincoln Park Campus. January 29, 2021.

Courtesy DePaul University/Randall Spriggs

hand-in-hand in a pilgrimage of life and united in a common concern and action for our collective well-being. How can hope be born from the pains and wounds of the pandemic?

The Poetics of Hope and Love through Prophetic Solidarity

The world today is in desperate need of hope in the face of the dual pandemics of COVID-19 and racism. Just as we are seeking a cure for COVID, so also should everyone begin a serious search for the best way to cure the pandemic of racism and give hope to Blacks, Indigenous peoples, and the many racial and ethnic groups who have historically borne the painful weight of racism and its destructive effects that have all been exposed and worsened during this time.

Can people find this hope in our churches, and what does hope look like for those who are hanging and slowly dying on the cross today before our eyes like George Floyd? The Church exists as a space of belonging where all God's people can find a home. The Church serves as the site of learning where people discover the beauty of diversity through the trinitarian model. In this kind of space, people are inspired to embrace those ethical choices that are driven by gospel values and that help to bring about in history the fruits of God's reign. The hope that the Church can help to give to the world is a reversal of history. The Church is a space for reimagining a better world where people are moved to embrace life-giving choices, which make concrete in people's lives and cultures the saving and transforming grace of the risen Lord. This saving hope is particularly needed in those places where people feel deep wounds and endure injustice and the painful consequences of oppression and

suffering. Hope is a movement which shows people in their lived realities that their history is not contaminated, but that there is a reversal which is real in an experience of redemptive history today. Christian hope is not an idea or an ideal, it is a concrete emergence of a new agency and a new experience of triumph and release from the chokehold of history for those who have been battered by racism and other social evils.

In order for this hope to come upon the earth, there is the need for the Church and all of God's people to move away from *pleasant poetics of hope* to a *prophetic praxis of hope*. The *pleasant poetics of hope* is the all-too-familiar reaction to social problems where Church leaders and ministers use moral suasion and spiritual platitudes to drown the historical injustice and deep human pain borne by those who suffer. These preachments and condemnations are appealing to the ears but end up being only empty rhetoric. They might temporarily raise people's hope for change, but ultimately fail to show how change could actually come about. It is similar to the preaching which many of our ancestors heard in the slave plantations which spoke to them of a God who is pacified by their suffering and who accepts their death as an offering similar to that of God's crucified Son.[31]

The pleasant poetics of hope also sometimes speak of repentance and of why Black people should take responsibility for their lives. However, it fails to speak of conversion of hearts for those who benefit from white privilege and a white-coded church. It does not show how the Catholic Church could begin a process of reform of our institutional culture and hierarchy of power and privilege, which are often coupled with political ideologies and systems of racism and oppression and neoliberal capitalism. Pleasant poetics of hope are false because they fail to address how to change those factors that have wrought the sad circumstances under which Blacks and other people of color have suffered for centuries. The pleasant poetics of hope are an empty religious noise which often ends up emptying the gospel of its force, saving truth, and power.

The *prophetic praxis of hope*, on the other hand, is the commitment by the Church and all her members to become the architects of a new future. It is born from an ecclesial practice that by its very character and manifestations is a reimagination of a new future, a new possible world, and a new possible Church. It inaugurates a change in attitude and behaviors through the conversion of hearts. The prophetic praxis of hope leads to a change in mindsets, changes in our ecclesial priorities and practices, and change in our church's teaching, institutional culture, and hierarchy of power and privilege so that she can truly become a poor and merciful church. It leads to a firm resolve and commitment to turn our anger and outrage into daily acts of reversing history by working for the realization of a just and peaceful world for all of God's people, especially the marginalized.

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31 See John Perry, *Catholics and Slavery: A Compromising History* (Ottawa: Novalis, St. Paul University, 2008), 30-32.

An essential part of this kind of hope is that it is *prophetic and praxis oriented*. It is prophetic because it requires listening to the cries of those who suffer and correctly reading the signs of our present times. By embodying the pathos of the poor and the broken throughout her systems and structures, the Church becomes a credible site for reimagining a different world while amplifying the voices of the poor in a noisy world. As harbingers of a prophetic hope, the ministers of the Church and all Christians must become architects of a different future. This means that the central mission of all religious groups and indeed all people of good will should be informed by the cries and anguish of the long-suffering victims of history. Our liturgies should celebrate the diversity in our traditions and provide a space to lament for those who have been held down by the injustice partly started and legitimatized through our churches.

Hope is also a praxis because it is concerned with constructing a new pathway of reversal through a conscious counterwitnessing that can change the status quo. What this means in actual fact is that the Catholic Church commits herself and her members to a new way of life, a new institutional culture, a new ethics, and a new moral and spiritual journey that will transform the inner life of the church and her mission in history. Racism is the longest-lasting pandemic that humanity has faced in the last 500 years; healing the world of racism is perhaps the greatest challenge facing people of faith and all people of goodwill today.

It is the task of a university like DePaul to be a laboratory for creating a new global vision of justice that is built on the power of love. As Vincent de Paul writes, "Each of us knows that the Law and the prophets are included in the love of God and neighbor … now that concerns not only love of God but love of the neighbor for the love of God … which is so great that human understanding cannot grasp it; enlightenment from on high is needed to raise us up in order to show us the height and depth, the breadth and excellence of this love."[32] A global vision of justice anchored on this Vincentian practice of love must pay greater attention to the cries of those bearing the weight of past and ongoing structures of injustice created by social hierarchies and exclusionary practices. Everywhere and every day we see how the voices of the poor and the marginalized and those carrying the painful wounds of historical injustice in our nations and in the world at large are often suppressed. In many instances, they suffer a double victimhood, because the process of addressing the inequities in the world are designed and moderated by the perpetrators of injustice and those who hold the levers of power. As we face the challenges of the pandemic, power, and

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32 Conference 207, "Charity (Common Rules, Chap. 2, Art. 12)," 30 May 1659 in Pierre Coste, C.M., *Vincent de Paul: Correspondence, Conferences, Documents,* ed. and trans. Jacqueline Kilar, D.C., Marie Poole, D.C., et. al., 14 vols. (New York: New City Press, 1985–2014), 12:213. Available: https://via.library.depaul.edu/coste_en/.

poverty in the world, may we dare to reinvent love as a praxis that will spread a different kind of contagion in the world: one that will help the global community to work together in realizing the goals of sustainable development for everyone, everywhere.

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A student uses a hand sanitizer station in the Student Center. January 21, 2021, on the Lincoln Park Campus.

Courtesy DePaul University/Randall Spriggs

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Face covering and social distancing signage is posted outside on the Lincoln Park Campus Quad in order to comply with safety and social distancing guidelines during the COVID-19 pandemic. August 3, 2020.

Courtesy DePaul University/Jeff Carrion

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Signs posted in "The Pit" in the Schmitt Academic Center (SAC) emphasize social distancing practices, September 9, 2020, on the Lincoln Park Campus. DePaul University began a new normal as classes commenced for the start of the 2020–2021 academic school year. Students acclimated themselves to the new class structure by participating in Zoom course sessions both on and off campus.

Courtesy DePaul University/Randall Spriggs

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DePaul students Anni Newton and Jack Chandler walk in the quad on the Lincoln Park Campus. January 29, 2021.

Courtesy DePaul University/Randall Spriggs