Supporting a Human Rights Agenda: A Three-Pillar Virtue-Based Personal and Social Anthropology of Public Health Policy for Sub-Saharan Africa

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SUPPORTING A HUMAN RIGHTS AGENDA: A THREE-PILLAR VIRTUE-BASED PERSONAL AND SOCIAL ANTHROPOLOGY OF PUBLIC HEALTH POLICY FOR SUB-SAHARAN AFRICA

A Thesis Submitted in Partial Fulfillment of the Requirements for the Degree of License in Sacred Theology

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CHAPTER ONE: INTRODUCTION

I.1. Human Rights-Based Public Health Ethics in Sub-Saharan Africa

> "No doubt (that) an examination of what policy regarding the distribution of health in a particular population is fair or just will have to take into account some aspects of local beliefs and culture. The same inquiry into policy must also attend to the general implications of social science and political philosophy where they frame the problems raised by local policy."[1]

What is stated in this citation is important for public health policy making in general and may explain what happened in Sub-Saharan Africa since the movements of independence swept all around the continent.

Sub-Saharan Africa has one of the worst health care systems in the world. Besides, underdeveloped economies paired with political instability do not offer much hope for improvement. In fact, despite many efforts by local, international organizations and governments to help in this field, the majority of the populations in this region do not have access to basic health care. With this in mind, the aim of this research project is to develop a personal and social anthropology of the human rights language read through the lens of the common good in order to contribute to creating and developing sustainable healthcare systems. While agreeing that many efforts have been made using different frameworks in the sphere of public health ethics in the past two decades and aware of the possibility that other underlying causes may have contributed to the failure of health systems in Sub-Saharan Africa, we will choose to address the human rights language as the main interlocutor for future contribution. This choice is motivated by the influence of

[1] Norman Daniels, Bruce P. Kennedy and Ichiro Kawachi, "Why Justice is Good for Our Health: The Social Determinants of Health Inequalities," *Daedalus*, Vol. 128,

human rights on public health policies that affect the lives of people in general. How did this language emerge?

In 1997, Jonathan Mann introduced the language of human rights into the field of public health in order to replace medical ethics based on the four principles also known as the "Georgetown mantra." Practically, the shift came as a result of public health policy officials' awareness that these principles could not be applicable in areas where socio-economic and political problems abounded. This complex socio-political situation was and is still significantly influential in Sub-Saharan Africa. Nevertheless, even as the use of the language of human rights has had a major impact on public health policies in Sub-Saharan Africa by addressing disease outbreaks like HIV/AIDS, Tuberculosis etc., in some places its promises came along with many contradictions.

In fact, even Mann rightly acknowledged its limitations when he asserted that human rights work will not stop all preventable diseases or premature deaths but will rather contribute to the increase in respect for human dignity thereby reducing or even eliminating societal contribution to disease, disability, and death.[2] Nevertheless, in many Sub-Saharan African Countries, societal contributions to these health problems still abound.

Later, other scholars like Bayer and Fairchild maintained the importance of the language of human rights especially with regard to HIV/AIDS by stressing that no public health policy that violated the rights of individuals could be effective in controlling the

[2]Jonathan M. Mann, "Human Rights and AIDS: the Future of the Pandemic," in *Health and Human Rights: A Reader*, Jonathan M. Mann *et al.* eds (New York: Routledge, 1999), 223.

spread of HIV.[3] Sadly, however, the reality is that Sub-Saharan Africa is still often cited as one of the worst on the planet in terms of individual rights violations. What may be the cause of this violation and its subsequent consequences?

Some answers to the question above come from pioneers of the use of the human rights language approach. As a matter of fact, in their discussion on the use of the language of human rights in public health policy, Jonathan Mann and colleagues also recognized that for health and human rights to interact there was need for a common ground.[4] Furthermore, the authors recognized that a vocabulary and set of human rights norms are becoming increasingly widespread among different geographical settings, but they also acknowledged tremendous controversy about human rights.[5]

Following the same line of ideas, in 2001 a former colleague of Mann, Gostin tried to elaborate on the reason for the controversy by raising some ambiguities of the use of the language of human rights: "Some use human rights language to mean a set of entitlements under international law, others use human rights to mean a set of ethical standards that stress the paramount importance of individual interests and still others use human rights for its aspiration, or rhetorical qualities."[6] Furthermore, on the one hand, Gostin stressed that the use of the language of human rights finds difficulties as, in the context of legitimately powerful government and concrete needs of people, it struggles in

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[3] Ronald Bayer and A. L. Fairchild, "The Genesis of Public Health Ethics," *Bioethics* 18, no. 6 (2004): 478.

[4] Jonathan M. Mann *et al*, *Health and Human Rights: A Reader* (New York: Routledge, 1999), 7.

[5] Ibid., 11.

[6] Lawrence O. Gostin, "Public Health, Ethics, and Human Rights: A Tribute to the Late Jonathan Mann," *The Journal of Law, Medicine & Ethics* 29, no. 2 (2001): 126.

defining human rights and in enforcing them through policy. [7] On the other hand, Hessler criticized the fact that the grounding of the human rights approach in international human rights laws and the lack of the moral philosophical analysis of rights undermine its moral significance.[8]

Following on the critical analysis of the use of the language of human rights and even as they claimed that the rights-based approach is still relevant, Elvira Beracochea and colleagues admitted that, although the legal definition of the right to health has been clearly understood at a greater extent, there still remain problems related to public health policies' effective planning, implementation, and evaluation.[9] With all these conflicting views on the use of the language of human rights in public health ethics and its ineffectiveness paired with the fact that the fulfillment of human rights is often a pre-condition imposed by foreign individual benefactors, charity organizations, or governments who are willing to contribute in building sustainable healthcare systems in Sub-Saharan Africa, there is a need to find out what are the ways of stabilizing and mending its limitations. The conclusions above are the foundations we are going to use in this project to show not only how important the use of the human rights language is but also why and how it is important to strengthen it and support it with some new tools for more efficiency within the context of sub-Saharan Africa, and even hopefully in the

[7] Gostin, "Public Health, Ethics, and Human Rights, 126.

[8] Kristen Hessler, "Exploring the Philosophical Foundations of the Human Rights Approach to International Public Health Ethics," in *International Public Health Policy and Ethics: International Library of Ethics, Law, and the New Medicine*, Michael Boylan ed., (Dordrecht: Springer, 2008), 35.

[9] Elvira Beracochea, Weinstein Corey, and Evans P. Dabney, "Introduction: Why Do Right-Based Approaches to Health Matter," in *Rights-Based Approaches to Public Health*, (New York: Springer Publications, 2011), 6.

developed world and beyond.

I.1.A. The Importance of Human Rights in Global Healthcare

The preamble of the constitution of the World Health Organization states: "The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition."[10] From this statement, the right to health is given a global priority because it implicitly calls for the satisfaction of this right as foundational in the process of upholding any other human right. Health is the foundation of human life. However, human existence is closely linked to the satisfaction of the needs for food, shelter and clothing. All these affect the quality of life and even decide how healthy human beings will be. Therefore, the right to the highest standard of health is very important but human rights related to food, shelter, and clothing as well as other civil rights will be very crucial for the foundation of the locus of the right to health. Where human rights are violated and wars are waged, healthcare policies cannot be or will hardly be implemented. That is why the human rights agenda has often become the basic requirement for the release of donations from foreign government or other organizations.

I.1.B. Human Rights and the Right to Health in Western Democracies

Over the centuries, western democratic nations have evolved from endless wars to champions of human rights. With the stabilization of economies, health care systems have also been harnessed to combat new diseases and provide better health care. However, from the example of the United States, one can see that the claim for human rights championship and huge investments in health care do not necessarily translate into

[10] World Health Organization, "The Constitution of the World Health Organization," (NY: World Health Organization, 1946): 1.

a right to health for all layers of its population. In fact, the mixed private and public health insurance in the U.S. was found inadequate for covering the health needs of its all its people. As a matter of fact, in 2009 alone, before the Affordable Care Act, the US had 40 million people without health insurance. Another 15 million had only poor coverage.[11] This reflects that the U.S. healthcare system is not only inequitable but also is the costliest in the world.[12] The healthcare system in this country is built upon a capitalist framework within which healthcare is being purchased rather than it being a right. This is still affecting millions of Americans despite the promise of the Affordable Care Act to reduce considerably families' expenses on healthcare and to offer free preventive care. This is most obvious with the business orientation of insurance companies.[13] Worse, in order to increase their own benefits, these companies do not even provide insurance to the patients who are most in need of it.[14] The right to health disappears to give place to the market of healthcare where purchasing power alone has the last word.

Paradoxically, economic development paired with the desire to export political systems beyond borders have led many western countries to present the protection of human rights as a precondition for foreign aid even in the field of health care. One may wonder how countries that are not capable of providing all their citizens with the right to health can export it beyond their borders using the same framework that has clearly failed. In this research project, we will contend that the lack of a clear and practical

[11] Theodore H. Tulchinsky and Elena Varavikova, *The New Public Health 2nd ed.* (Amsterdam; Boston: Elsevier / Academic Press, 2009), 383.

[12] Ibid., 478.

[13] Laurence W. White, "The Corporatization of Healthcare," in *Healthcare Reform: Ethics and Politics*, eds. Timothy H. Engström and Wade L. Robison (NY: University of Rochester Press, 2006), 109.

[14] Ibid., 103-104.

framework for public health policy in these countries heavily undermines both their healthcare systems as well as those to which they want to export the right to health—especially Sub-Saharan Africa. Below, we are going to explore how this export of the right has failed.

I.2. The Problematic of the Right to Health in Sub-Saharan Africa

In Sub-Saharan Africa, due to many socio-political and economic problems, the right to health is hardly debated in the national decision-making bodies. Besides, despite many health problems and healthcare systems in need of improvement, health budgets have been on the decline with some countries devoting less than 2% per capita.[15] Because its healthcare systems are built following the framework imposed from outside, these critical local conditions are not given due consideration thereby undermining the efficiency of public health policies.

Working on a possible alternative framework, public health policy authors like Jacquineau Azétsop suggested that civil society and human rights activists include in their agenda the right to health[16] in order to improve our healthcare systems in Chad. Nevertheless, one may argue whether such endeavors are feasible under prevalent human rights violations in the Sub-Sahara. In these settings where even the right to life is under threat, the right to health has nearly no room for debate.

Even Mann's suggestion that the dialogue between health and human rights disciplines is crucial for a better development of the right to health[17] can hardly take

[15] Tulchinsky and Varavikova, *The New Public Health*, 506.

[16] Jacquineau Azétsop and Michael Ochieng, "The Right to Health, Health Systems Development and Public Health Policy Challenges in Chad," *Philosophy, Ethics, and Humanities in Medicine* 10, no. 1 (2015): 5.

[17] Mann *et al., Health and Human Rights*, 18.

place in countries where human rights activists are jailed or forced into exile and any reference to human rights language is considered a threat to national security by dictatorial regimes.[18] What should be addressed before the right to health is discussed?

I.2.A. The Right to Basic Commodities

In most cases, non-political organizations involved in the processes of basic needs are easily trusted as better at addressing the real needs of the people they serve. Charity organizations are usually identified with a "Good Samaritan" spirit. Nevertheless, even these foreign charity organizations can hardly fare better in improving the healthcare systems in Sub-Saharan Africa. As a matter of fact, Azétsop points out that the presence of many NGOs involved in healthcare contributed to bringing healthcare into remote villages, while at the same time increasing the fragmentation of the health care system by recruiting local personnel and diverting funds which were meant for the public sector.[19] According to Azétsop, this parallel system undermines the development of the local health system.[20]

The failure of the current healthcare frameworks in Sub-Saharan Africa could also easily be traced back to the fact that these frameworks are not in tune with the local socio-economic conditions. Any government or organization that sets out to help in the field of healthcare should be well informed about the real situation of Sub-Saharan

[18]Makau Mutua, "Human Rights NGOs in East Africa: Defining the Challenges," in *Human Rights NGOs in East Africa: Political and Normative Tensions*, ed. Makau Mutua (Philadelphia: University of Pennsylvania Press, 2009), 15.

[19] Jacquineau Azétsop and Michael Ochieng, "The Right to Health, Health Systems Development and Public Health Policy Challenges in Chad," *Philosophy, Ethics, and Humanities in Medicine* 10, no. 1 (2015): 8.

[20] Ibid.

Africa. What contributes to the failure may be the fact that 60% of urban population in Sub-Saharan Africa lives in slums.[21] Another reason is that, while in 2010 all the other parts of the world concerned with the Millenium Development Goals had already succeeded in reaching half of the goals, Sub-Saharan Africa still lagged far behind.[22] With 40% of the population still living in extreme poverty,[23] it appears that it is not a mere focus on the language of human rights in a persistently poor socio-economic and hostile setting that will help secure the right to health especially for the marginalized. Unless there is a framework that contributes to the development of local health systems and the improvement of living conditions conducive to the promotion of health and prevention of diseases, the possibility of achieving the right to health is still far from sight. The right to basic commodities should be addressed before all other endeavors.

I.2.B. The Political Rights *vs.* the Right to Health

a. Healthcare Structural Reforms: Democracy For Health?

Another major issue that needs to be addressed in Sub-Saharan Africa is the confusion that takes place when suggested solutions to all the region's problems aim at instituting democratic reforms. In this perspective, even the healthcare structural reforms are seen through the lense of political reforms. However, in the past two decades, political reforms have made most Sub-Saharan healthcare systems even more vulnerable than during dictatorial regimes. Here, we are not praising dictatorships but rather pointing

[21] J. T. Boerma, *Health in 2015: From MDGs, Millennium Development Goals to SDGs, Sustainable Development Goals*, (Geneva: World Health Organization, 2015), 23.

[22] Ibid., 23.

[23] Ibid., 17.

to the failure of the political reform framework as a means to implementing healthcare structural reforms among other reforms.

The same can be observed in the United States where, despite a solid democratic system, the right to health for all is still impossible. Therefore, Sub-Saharan Africa needs a new framework for public health policy that does not gauge the health of people through political lenses. What kind of healthcare systems will be inherited from ineffective frameworks?

a. Policies without Structures: Unsustainability

As already discussed above, public health policies that result from the introduction of the language of human rights or political reforms will not yield structures that can be sustained for the right to health to emerge. This is very obvious in Sub-Saharan Africa where political reforms result in economic collapse and political instability. The unsustainability should be expected when premature political structures are to be the foundations of healthcare structures. Moreover, the policies that will be defined will be most likely aimed at mirroring the political systems which, in different countries of the region, are marked by extensive corruption at all levels. As a consequence, the policies that will be implemented will not be capable of producing much-needed healthcare infrastructures. Finally, not only infrastructures collapse but also there is a well-documented loss of skilled healthcare manpower from poor African countries to the wealthy countries.[24]

[24] Tulchinsky and Varavikova, *The New Public Health*, 507.

I.3. Conclusion

The aim of this research project will be to show that instead of remaining at the level of the language of human rights, there is need for focus on collective duties and responsibilities. We agree that Azétsop's solution for Chad is equally valid for the whole of Sub-Saharan Africa: progressive strengthening of health systems as well as provision of other goods conducive to good health are crucial for achieving the right to health.[25] However, in this work we will contend that the inadequacy of healthcare policies calls for an integrated anthropological profile of public health officials and social institutions that theoretically provides the guiding concepts, which will illuminate practical attitudes and behaviors both from public health policy makers and from the populations at large. The public health officials who will have gradually grown in virtue through the different stages suggested in the anthropological profile will be able to guide and accompany the people they serve and eventually allow them to grow in the virtues necessary for the building of healthy communities and sustainable healthcare infrastructures. This process will also allow the emergence of a deliberation on the necessity of other goods conducive to good health such as food, shelter, and clothing. The public health officials will, therefore, have to engage the communities they serve in a process of dialogue and listening. I do not agree with Roberts and Reich who insist that, when communities are engaged in the realm of public health debates, there will be broad philosophical positions that will bring confusions as to what constitutes virtue.[26] It is exactly in striving to live

[25] Azétsop and Ochieng, "The Right to Health, Health Systems Development and Public Health Policy Challenges in Chad," 3.

[26] Marc J. Roberts and Michael R. Reich, "Ethical Analysis in Public Health," *The Lancet* 359, no. 9311 (2002): 1057.

out solidarity with those who are suffering that an environment that allows gradual awareness of the concrete needs of people will emerge and the very definition of virtues necessary for the flourishing of healthy communities will take flesh. Mark A. Rothstein also echoes this need for communal discernment when he suggests that public health officials be vigilant to new public health threats and be aware of cultural sensitivities and public health attitudes and patterns in order to take appropriate measures.[27]

Thus, the anthropological profile we suggest is woven in the unity of the following virtues found in the Beatitudes[28] as presented by the late Yiu Sing Lúcás Chan in his work on the Commandments and the Beatitudes: humility, solidarity, meekness, fortitude, charity and justice, integrity and truthfulness, peacemaking and finally the virtue of *kenosis* or martyrdom.

We will show how the personal and social anthropology of human rights enfleshed by the character traits informed by the Beatitudes and their attendant virtues will contribute to the building of what Michael Rozier calls 'structures of virtue'[29] by calling for ways of being and doing which further collaboration and solidarity between both policy makers (including benefactors who finance health projects) and the populations they serve. On the one hand, living and acting according to this anthropological profile will allow policy makers to implement well-elaborated policies that are reflective of how virtuous they are as they commit to planning for the health of the population under their

[27] Mark A. Rothstein, "Rethinking the Meaning of Public Health," *The Journal of Law, Medicine & Ethics* 30, no. 2 (2002): 148.

[28] Yiu Sing Lúcás Chan, *The Ten Commandments and the Beatitudes: Biblical Studies and Ethics for Real Life* (Lanham, MD: Rowman & Littlefield Publishers, 2012), 229.

[29] Michael D. Rozier, "Structures of Virtue as a Framework for Public Health Ethics," *Public Health Ethics* 9, no. 1 (2016): 39.

care. On the other hand, the resulting policies and structures should not only provide material infrastructures of healthcare but also make possible the change of attitudes of the populations with regard to self and mutual care. This double effect will, as it were, further the strengthening of usually poorly structured healthcare institutions and ill-informed population masses in Sub-Saharan Africa.

In the following chapter, we will present our suggested personal and social anthropology. We shall start by elaborating on how, historically, Catholic healthcare projects inform the relevance of this anthropological profile. Then we shall discuss each of the three pillars starting with the first built around the first three Beatitudes, then the second founded on the following three Beatitudes and, finally the third pillar from the last two Beatitudes.

On the one hand, we will focus on showing how these three pillars in their interrelationship and unity will help to support the human rights approach to health care through a participative model of promotion of rights to health. On the other hand, we will also show how the three pillars will help in the production of sustained health policies, infrastructures, and responsible moral agents both at the decision-making level and within the population at large.

As a conclusion to this research project, the third chapter shall explore the application of this three-pillar personal and social anthropological profile to healthcare policy for the mentally disabled in Sub-Saharan Africa.

CHAPTER TWO: TOWARD A PERSONAL AND SOCIAL ANTHROPOLOGY OF PUBLIC HEALTH ETHICS IN SUB-SAHARAN AFRICA

II.1. Christian Healthcare in 21st Century Africa

II.1.A. Inspiration from the Concept of the Common Good

In colonial Sub-Saharan Africa, missionaries who established dispensaries in rural areas to care for the local populations were the first to introduce modern healthcare.[30] Together with other activities such as education or agriculture, this was the backbone of missionary work, which was very successful in treating disease outbreak as well in prevention of epidemics. Even as in many parts of the African continent missionary activities were organized in line with colonial administration, local populations were united behind them in their efforts to make life in the communities better. What was the principle, which made these efforts successful? What would be the differences between missionary works in healthcare and the promotion of the right to health as compared to the use of the language of human rights in public health ethics? Behind these efforts was the foundational principle of Catholic social teaching and practice: the principle of the common good.

David Hollenbach defined the common good as the good that results from a community characterized by solidarity among agents who are not only active together but also equal.[31] In the same line, Lisa Cahill, one of the most prominent writers on the concept of the common good, defined it in her account of the distinctive threefold articulation and defense of rights in the Catholic tradition as follows:

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[30] Tamara Vernick and Webb James L., *Global Health in Africa: Historical Perspectives on Disease Control* (Athens, OH: Ohio University Press, 2013), 4.

[31] David Hollenbach, *The Common Good and Christian Ethics* (Cambridge, UK: Cambridge University Press, 2002), 189.

> The development of a framework for the interpretation of social justice (the "common good") in which are presupposed: a) both the dignity and the sociality of human beings; b) both their rights and the duties on which those rights are founded; and c) the interpretation of dignity, sociality, duties and rights across several interlocking and reciprocal spheres of religious, political, cultural and economic well- being.[32]

In 2004, during the "Père Marquette Lecture Series," she defined again the common good as association in solidarity that extends beyond the good of individuals in the aggregate and which revolves around important matters such as social communication and cooperation.[33] Moreover, as she acknowledged the fact that with globalization, the issues of poverty, sexism, and racism have increased the number of people vulnerable to diseases, she also stressed that Catholic bioethics should now go beyond traditional moral principles and embrace an ethics of the common good.[34] She also expressed hopes that at the local and global level, there are already structures and networks that are emerging to make more effective the participation of the poor and those in solidarity with them.[35]

From all these definitions of the common good and the hopes expressed, we can see that the participation of the population in the process of public health policy-making—especially those at the margins—is very crucial.

It is good to note that the common good advocated by Catholic healthcare institutions were supposed to make sure that material needs in healthcare would be provided as well as to build a whole network of agents who would participate in the total wellbeing of each member of the communities. In other words, each member of the

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[32] Lisa Sowle Cahill, "The Catholic Tradition: Religion, Morality, and the Common Good," *Journal of Law and Religion* 5, no. 1 (1987): 93.

[33] Lisa Sowle Cahill, *Bioethics and the Common Good* (Milwaukee, WI: Marquette University Press, 2004), 8.

[34] Cahill, *Bioethics and the Common Good*, 75-76.

[35] Ibid., 77.

community had rights and duties to fulfill in order for rights, and in our case the right to health, to be delivered. Even when it comes to legislation regarding healthcare, such as the implementation of public health policies, there would have to be participation of all the forces of the nation by ensuring that none is left behind due to socio-economic reasons. Cahill states this again as follows in her summary:

> Since the realization of duties and rights in life is of the essence of the common good, and since law regards the ordering of the common good, civil rights are certainly objects of legislation. The protection of those rights in the life, however, is, in the broader Catholic view, for the sake of full participation in that life, and thus inevitably bound up with the protection and promotion of the socio-economic conditions of their effective actualization.[36]

The focus on inclusiveness of all forces of the nation in the elaboration of civil rights and the pledge to protect and promote socio-economic conditions that are conducive to their actualization will provide added value to public health ethics focused mainly on the language of human rights. The development of a personal and social anthropological profile based on the concept of the common good and enfleshed in the character traits informed by the Beatitudes and their attendant virtues will function as a ladder allowing all people to work together toward a higher goal in public health policy. The aim of this anthropological profile inspired by the concept of the common good is to bring social justice in healthcare to its full realization.

II.1.B. The Role of Moral Agents of the Common Good

As already mentioned above, unlike public health ethics that uses only the language of human rights in policy-making, the moral agent of the common good is a receiver of the right to health as well as a giver of it. The right to benefit from the

[36] Lisa Sowle Cahill, "The Catholic Tradition: Religion, Morality, and the Common Good," *Journal of Law and Religion* 5, no. 1 (1987): 94.

structures put in place following the virtues enfleshed within the personal and social anthropological profile of public health ethics will imply an automatic demand on all the moral agents to participate in the stewardship of available structures and in the continuing discernment on how to address emerging threats to population health.

This anthropology will, therefore, further authentic collaboration between policy makers and the population at large and will transform both parties into agents of equal rights and duties. However, most importantly, this collaboration based on rights and duties toward the community will help develop in the moral agents virtues that are necessary to contribute efficiently to the building up of the healthcare system. In order to understand this, let us turn to Michael Rozier who rightly describes the importance of virtues as applied in public health policy:

> Virtues respect that we are more than rational creatures, allowing for relational and creative solutions. When applied to programs on individual behavior, structures of health preserve personal liberty but also recognize society's responsibility to help individuals thrive. When applied to social policy, we acknowledge that structures are both influenced by our values and influence them.[37]

Given the equal share of duties and responsibilities, the common good principle should also provide a fair share in the benefits of healthcare among all agents. For example, in the framework of the common good, the missionaries like the population they serve, would receive equal treatment at these health facilities. In the contemporary context, because all partners for healthcare will be checking on each other for any malpractices, the implications of this collaborative framework are transparency and prevention of both corruption and waste of available resources. As a consequence, the

[37] Michael D. Rozier, "Structures of Virtue as a Framework for Public Health Ethics," *Public Health Ethics* 9, no. 1 (2016): 44.

practice of the virtues commanded by the anthropological profile distinguishes itself from the use of the language and principles based on human rights, in which, for example, employees of NGOs involved in healthcare in Sub-Saharan Africa usually receive far higher wages than their local counterparts and are granted airlifting in case of special medical needs. The salaries and expenses for special needs of employees oftentimes exceed exponentially the total cost of running healthcare facilities of these same NGOs.

The same situation can be observed in many African countries where the principles based on the language of human rights are applied in public health policy. Political leaders fly to European capitals for their healthcare needs because they do not trust the very infrastructures they have built for their own populations. These practices are incompatible with the work ethics of charitable organizations and governments, which are supposed to work selflessly for the betterment of the communities they are responsible for.

This personal and social anthropology of human rights enfleshed by character traits and inspired by the common-good principle will help in restructuring and strengthening already effective healthcare structures in Sub-Saharan Africa. We will show that this personal and social anthropology will work very effectively in this cultural context because Sub-Saharan African culture is deeply embedded in the African Religion's central concept of "abundant life." The result of endeavors by each member of a community with equal rights and duties will contribute to this ideal. However, the influence of the concept of "abundant life" in Sub-Saharan Africa in the field of healthcare has attracted much attention so far. In the concluding chapter, we will show that the concept of abundant life has had a negative impact on healthcare for the mentally

disabled. We hope to prove that the practice of virtues found within the Beatitudes will fill up the gaps in the application of this highly valued concept and contribute to better healthcare for the mentally disabled of Sub-Saharan African communities.

II.1.C. Conclusion: The Kingdom of God and the Ethics of Abundant Life

We have already stated clearly that although the use of the language of human rights in public health policy has been successful at many levels, there is still need for improvement because many layers of the populations still cannot enjoy their right to health. The application of the concept of the common good in the fight for social justice aims to make the world a better place by bringing justice to all and indiscriminately providing relief of suffering in this world. The subject of the application of the common good is the whole of creation and the activities that aim at this project are understood as a call to all to be shepherds of God's creation. The end result of a well-applied concept of the common good is the creation of an environment that resembles the kingdom of God where all human beings are in communion with the creator and enjoy God's presence. In this realm, since all people are equal in the eyes of the creator, due to the authentic sense of interconnectedness and mutual interdependence, the resulting harmony will create abundance of life. The living according to this profile will lead the agents toward the creator as their final end. However, in the realm of living here on earth, this environment will be illustrative of the Kingdom of God on earth, which calls for mutual concern and support. Echoing the necessity for mutual care, in his discussion about the fact that the ultimate end of human beings is not only God but one's own fulfillment, Germain Grisez reminds us that individual fulfillment is inseparable from the flourishing of the other:

> No possible action appeals to us unless it offers some benefit for ourselves. So, our ultimate end must include our own well being or flourishing.

> However, since we are social by nature, we need others, and our own fulfillment requires us not to use them but to cooperate with them—to intend with them a common good that includes their good for their own sake, not just for ours.[38]

In order to reach this realm, the personal and social anthropology of human rights enfleshed by character traits will contribute to creating structures of virtues that will make human beings mutually support each other in the building of health care systems and communities. In this way, it will also make the fabric of the Kingdom of God manifested through good health for all both real and sustainable.

II.2. The Three-Pillar Virtue-Based Personal and Social Anthropology of Public Health Ethics

II.2.A. The Structures of Virtue

The aim of our three-pillar virtue-based anthropology of human rights is to build structures of virtues that will define and refine all the human relationships in the field of public health policy in Sub-Saharan Africa and sustain healthcare systems that stem from them. Since this anthropology is based on the Beatitudes as found in the fifth chapter of the Gospel of Matthew, it uses the hermeneutical structures of virtues as understood from the Judeo-Christian tradition.[39] We will emphasize the way virtues work in a normative way, by guiding character formation and informing actions following the patterns of the imitation of Christ. In this work, we do not intend to provide a personal and social anthropological profile that will create perfectly effective human beings who are like gods, but human beings on the path of holiness who are willing to participate in the

[38] Germain Grisez, "The True Ultimate End of Human Beings," in *Moral Good, the Beatific Vision, and God's Kingdom: Writings*, Germain Grisez, Peter Ryan, and Peter J. Weigel ed. (New York: Peter Lang, 2015), 138.

[39] Chan, *The Ten Commandments and the Beatitudes*, 16.

building of the kingdom of God. In this way, there may be some guarantee of some great outcome in terms of effective healthcare policies to be realized. In fact, as Jason B. Hood once stated: "Our participation in God's work is corrupted, but never completely corroded."[40]

Many theological ethicists have written extensively on the relevance of cooperation and collaboration within virtuous practices and dynamics in social structures especially in promoting social justice. They emphasized the role society plays in general in the formation of moral agents of the common good. In one of the recent publications, which analyses the outcomes of Vatican II in terms of building a virtuous society, Daniel J. Daly puts it clearly in these terms:

> Social structures must be scrutinized ethically because of their profound effects on the lives of persons. Structures have the capacity to systematically promote the human good, the common good, and human happiness, or frustrate the realization of these goods. Furthermore, they have the capacity to form the moral character, and the conscience of the individual agent. Human persons are habitual creatures, and thus, acquire a second nature, or a set of characteristic habits of action.[41]

As we have seen above, it appears clearly from what is stated here that if a framework of public health policy allows, for example, embezzlement of funds or corruption practices, there will be a promotion of bad habits, which will become part of normal practices by all people including policy makers and beneficiaries of these policies. With these practices will emerge vices, which will gradually overshadow any possibility for the promotion of virtues in the field of public health. That is why we now

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[40] Jason B. Hood, *Imitating God in Christ: Recapturing a Biblical Pattern*, (Downers Grove, IL: InterVarsity Press, 2013), 55.

[41] Daniel J. Daly, "Structures of Virtue and Vice," *New Blackfriars* 92, no. 1039 (2011): 353.

turn to the understanding of the key players and objects constitutive of the structures, which will embody this personal and social anthropological profile.

II.2.A.1. The Anthropological Profile of Public Health Officials

In this research project, whenever we mention public health officials we will be implying both officials involved in crafting health policy and healthcare professionals applying those policies in hospitals, clinics, or any other centers directly concerned with provision of treatment protocols, hospitalization, health delivery or promotion of health.

As already mentioned above, public health officials in healthcare systems that are managed using principles inspired by the language of human rights are like technicians who use scientific tools to analyze health care needs in the lens of rights, crafts policies and then, apply them without much dialogue with the people they serve. However, in order to truly advance the cause of the population and, since these public health officials are inspired by the principles of human rights, they should engage the population in authentic dialogue as people with not only rights but also duties toward the healthcare system. In order to promote this perspective, Mann advocated education in human rights for healthcare professionals and this approach was implemented during the past two decades.[42] This education has, however, not produced much result that may affect the broader public health policy. We have also seen that in the context of Sub-Saharan Africa, this education in human rights is impossible given the socio-political tensions around implementing rights as well as the low level of education of the population.

[42] Jonathan Mann, "Health and Human Rights: Broadening the Agenda for Health Professionals, " *Health and Human Rights* 2, no. 1 (1996): 3.

Therefore, following the anthropological profile that we will propose, public health officials will have to work together with the populations with a greater sense of solidarity, which has to begin with learning to be patient with those who do not share the same level of knowledge but who are the source of information about the needs to be addressed as well as the subjects of all policies. Moreover, since this educational gap between public health officials and the population is very deep, aside from being patient, engaging in collaboration requires skills and attitudes that are not necessarily acquired through education. Public health officials will, therefore, need to embody virtues that are needed to truly be effective in this process. The three-pillar personal and social anthropological profile will work in this perspective allowing them to constantly adapt to the new challenges and acquire habits, which will eventually become strengthened over time and allow them to grow in virtue.

II.2.A.2. The Anthropological Profile of the Population and Healthcare Infrastructures

Public health institutions aim to improve the life of the public they serve and they should be accountable for the consequences of their policies. Otherwise, the lack of accountability will lead to loss of trust from communities. Ruth J. Prince and Rebecca Marsland express this point as follows:

> If public health were to have a public, it might be one that reflects rationally and critically about survival and the activities its members undertake to keep its members alive. It might also reflect critically on the work of public health authorities.[43]

[43] Ruth J. Prince and Rebecca Marsland, *Making and Unmaking Public Health in Africa: Ethnographic and Historical Perspectives* (Athens, OH: Ohio University Press, 2014), 82.

The population and healthcare infrastructures are discussed together because public health policies are basically aimed at meeting the needs of people through the building of a healthcare system endowed with sustainable health infrastructures. Moreover, the changes in the needs of people will affect the efficacy of healthcare infrastructures. When the needs of the population increase, the infrastructures will have to be revamped. In the same manner, the beginning of the building of these infrastructures will have to consider the short and long term needs of the population. Therefore, the population has to be actively involved in policy-making. Besides, public health officials should use interdisciplinary resources for the study of demographics, statistics, public health issues, and policies in order to figure out in what ways the collaboration with the population can be more efficient. The whole process will be based on the three-pillar anthropological profile which will guide both sides in ways of being and doing that will help manage properly both human and material resources for the sustenance of healthcare systems.

II.2.B. Conclusion: The Unity of the Structures of Virtue

The three-pillar personal and social anthropology of human rights enfleshed in character traits informed by the Beatitudes and their attendant virtues will, therefore, offer a set of virtues that will provide, as it were, a ladder onto which public health policy decision-making and implementation processes will be set to climb for the building of a kingdom of good health for all. This climb will contribute to the building of healthcare systems that would provide therapeutic protocols and also allow people together with policy makers to experience healthcare provisions and benefits as man-made miracles through temporal efforts as well as the beginning of an entry into the realm of the

Kingdom of God. This climb based on the Beatitudes calls, therefore, for action patterns that imitate Christ and make His presence felt by everyone. Similarly, the late Lùcàs Chan rightly claims that the Beatitudes are neither mere moral demands nor eschatological promises but call for active responses within the community as well as a projected attentiveness to the ultimate end which is the Kingdom of God—an already-but-not-yet.[44] This attentiveness, paired with the disposition to climb the ladder of virtue, will support the public health systems built on principles of human rights and make it more effective by bringing together the different partners in a unity of structures of virtues.

II.3. The First Pillar: The Making of Moral Agents of Mutual Dependence

The use of the language of human rights in public health has been very efficient in solving problems related to the tension between collective rights and individual rights. In the discussion on this tension a decade ago, Ronald Bayer recognized that, in determining public health policies, there are always difficult challenges and compromises that need to be faced.[45] The principles coming from the language of human rights give more responsibility to the government to sometimes implement coercive measures especially when it comes to ensuring collective protection. Paternalism takes hold on policymaking and implementation while taking hostage the individual patients by preventing them of any voluntary participation. However, positive community participation and solidarity is very crucial for public health. This participation is even more important when sectarian

[44] Chan, *The Ten Commandments and the Beatitudes*, 158.

[45] Ronald Bayer, "The Continuing Tensions Between Individual Rights and Public Health, Talking Point on public health versus civil liberties," *EMBO Reports* 8, no. 12, (2007): 1102.

interests paralyze policy-making processes.[46] In fact, while criticizing the US constitutional tradition three decades ago, Dan Beauchamp recognized the need to further the communitarian spirit within the highly individualistic American society when he affirmed:

> The main lesson to learn from public health paternalism as it has developed in the constitutional tradition may well be that the second language of community and the virtues of cooperation and beneficence still exist, albeit precariously, alongside a tradition of political individualism. Strengthening the public health includes not only the practical task of improving aggregate welfare, it also involves the task of reacquainting the American public with its republican and communitarian heritage, and encouraging citizens to share in reasonable and practical group schemes to promote a wider welfare, of which their own welfare is only a part.[47]

Similarly, the virtue of mutual interdependence within the community in Sub-Saharan Africa will be crucial in developing attitudes leading to the awareness that collective welfare in community healthcare allocation or, as already mentioned above, "common good" is the beginning of the enjoyment of an individual right to health. Given the already existing communitarian spirit in Sub-Saharan Africa, the need for collective awareness for participation in the protection of the community could be easily promoted. The spirit of mutual interdependence that we advocate in this pillar is, therefore, very crucial. Furthering this spirit allows individuals and communities to work together in the implementation of policies. Besides, it also contributes in maintaining a harmonious society in which the rulers and the ruled understand the community's needs and work together to improve life conditions.

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[46] Bruce Jennings, "Health Policy in a New Key: Setting Democratic Priorities," *Journal of Social Issues* 49, no. 2 (1993): 243.

[47] Beauchamp, "Community: The Neglected Tradition of Public Health," *Hastings Center Report* 15, no. 6 (1985): 35.

This interplay between the rights from both sides is found in the argument of Bruce Jennings that the notion of the common good and the notion of the public are crucial in two ways: they allow field assessment of the health status and prospect of the population in their concrete life and also allow public health officials to own their identity and value due to the capacity of the populations to understand their common good and common danger.[48]

Since the African culture ideally emphasizes the need for mutual dependence in the spirit of increasing life energy, advocating this spirit should be easily understood and applied without much friction. However, we unfortunately know that, because much of this region has been marred by corruption at most levels of governance, the spirit of mutual dependence has been on the decline and has given way to a lack of trust in public officials. Therefore, in order to restore this trust, all levels of the communities should be made aware of the need for solidarity and be called to grow in the virtue of mutual dependence and authentic solidarity. In this first pillar, we will explore how the unity of virtues found in the first three Beatitudes can help in furthering this authentic solidarity within the community of public health policy makers and the populations they serve. We will show that the awareness and the practice of solidarity through concrete virtuous actions are crucial for the success of public health policies.

[48] Bruce Jennings, "Public Health and Civic Republicanism: Toward an Alternative Framework for Public Health Ethics? In *Ethics, Prevention, and Public Health*, Angus Dawson and M. F. Verweij, eds. (Oxford: Clarendon Press, 2007), 77.

II.3.A. Poverty of Spirit in Public Health Ethics

"Blessed are the poor in spirit, for theirs is the kingdom of heaven."[49]

The Gospel of Matthew begins with the first Beatitude about the poor in spirit. The word *poor* as understood from the Greek language word φτωχός means beggar or the one who is very destitute. Therefore, according to Lùcàs Chan, the word *poor* in spirit refers to those who are socially and economically dependent on others.[50] Moreover, he also asserts that the poor in spirit are those who have an inner attitude of humility.[51]

The first character trait in the personal anthropological profile of public health officials is, therefore, the virtue of humility. As one embodies the virtue of humility, one also needs to rid oneself of spiritual pride and learn to find God in all things in order to move beyond the level of mere stewardship to that of lover of all things.[52] According to Daniel Harrington and James Keenan, for Aquinas, humility serves to check for pride.[53] We may also say that to get rid of spiritual pride, one has to practice perfect humility à la Aquinas: to relate with and respect those above us, our equals, and our inferiors all in their respective conditions.[54] This second step will be the foundation for all the positive attitudes required on the part of policy-makers and benefactors in order to truly meet the healthcare needs of all in Sub-Saharan Africa in a sustainable way. As a

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[49] Mt 5: 3.

[50] Chan, *The Ten Commandments and the Beatitudes*, 162.

[51] Ibid., 86.

[52] Ibid., 165.

[53] Daniel J. Harrington and James F. Keenan, *Paul and Virtue Ethics: Building Bridges Between New Testament and Moral Theology* (Lanham, MD: Rowman & Littlefield, 2010), 145.

[54] Aquinas, *Summa Theologica* II-II, Q 161, Art. 6, sec. 4.

matter of fact, Michael Crosby reminds us that, with so many cultural addictions that control us such as racism, sexism, heterosexism, ageism, elitism, clericalism, nationalism and without this virtue of humility that allows people to find God in all things, there is the danger of denying God in some persons just because they do not belong to the group with power.[55] Moreover, he rightly claims that the *modus operandi* of these addictions also creates a network of domination, oppression, and abuses, which not only impede freedom among people but also undermine the equal distribution of the Earth's resources.[56]

Poverty of spirit, which yields humility, is therefore very crucial in the assessment of needs in public health. In the process of public health policy and implementation, the virtue of humility should come from the realization that we are engaged in God's work which, as Jason Hood rightly asserts, should result in attitudes of humility, dependence, and worship.[57] Further, echoing the above descriptions, Neal Krause and David R. Hayward state the importance of humility this way:

> A humble person has less motivation to use dissonance reduction strategies, such as the derogation of others, to maintain an unrealistically high self-appraisal and, as a result, the humble person is more likely to make less biased (i.e., more compassionate) assessments of the situation of others.[58]

Jim Forest, a convert to the Russian Orthodox Church, offers us another definition of poverty of spirit, which I think encapsulates all that is to be expected from officials in public health:

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[55] Michael Crosby, *Spirituality of the Beatitudes: Matthew's Vision for the Church in an Unjust World* (Maryknoll, NY: Orbis Books, 2005), 55.

[56] Ibid.

[57] Jason B. Hood, *Imitating God in Christ: Recapturing a Biblical Pattern* (Downers Grove, IL: InterVarsity Press, 2013), 14.

[58] Neal Krause and David R. Hayward, "Humility, compassion, and gratitude to God: Assessing the relationships among key religious virtues," *Psychology of Religion and Spirituality* 7, no. 3 (2015): 195.

> It is my awareness that I cannot save myself, that I am basically defenseless, that neither money nor power will spare me from suffering and death, and that no matter what I achieve and acquire in this life, it will be far less than I wanted. Poverty in spirit is my awareness that I need God's help and mercy more than I need anything else.[59]

Similarly, Lisa Fullam reminds us that humility is a virtue that allows self-understanding in context, permits finding the gifts and moral excellences of others, and allows the acquisition of other virtues.[60] Fullam's emphasis on the importance of self-understanding in the context is very crucial as it points to the moral agent's own psychological maturity. As a result, poverty of spirit with its virtue of humility will create sustainable ground for the development and effectiveness in the process of building communal discernment for the sake of public health. This spirit could break down the oftentimes-observed attitude of arrogance and paternalism seen among those in powerful positions in public health or even among some benefactors or other charity organizations. As a matter of fact, since Sub-Saharan Africa is among the poorest regions of the world, benefactors who provide support for the building of healthcare systems will, most often, bring with them either a certain arrogance or inauthentic "Good Samaritan" spirit. This attitude can undermine the ability to assess objectively the real needs of the people they want to help. As a matter of fact, two decades ago, when Mann was advocating for the adoption of the use of the language of human rights in public health policy, he stressed

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[59] Jim Forest, *The Ladder of the Beatitudes* (Maryknoll, NY: Orbis Books, 1999), 22.

[60] Lisa A. Fullam, "Humility and Its Epistemological Implications," in *Virtue: Readings in Moral Theology No.16*, Charles E. Curran and Lisa A. Fullam, eds. (Mahwah, NJ: Paulist Press, 2011), 250.

the spirit of professional pride among public health professionals unfortunately still prevalent today. He stated:

> In addition, the relationship between public health officials and the public and political process is complex. Public health professionals are trained and expected by society to perform certain tasks, using well-developed analytic methods and operational approaches. A dramatic reframing of the public health problem from a specific disease or problem to the respect actually granted to rights and dignity of the most vulnerable in society may appear to public health practitioners as a dilution of their "specificity" or a weakening of their position.[61]

Therefore, any beginning of action or policy-making has to be assessed in light of humility. However, it can sometimes be difficult to gauge this virtue. For example, who will be the assessor and what will be the threshold of humility? Let us now try to answer this question.

Since the three-pillar personal and social anthropology of human rights enfleshed in character traits will contribute to the development of structures of virtue that will spread toward the whole population, each member of the community, including the public health officials as well as the benefactors, will assess each other mutually through dialogue and will call each other to conversion which will take place in the exchange of ideas and subtle summons. This process that begins with and leads to the development of the virtue of humility will take place when each member of the community will learn to acknowledge that God is the ultimate source of power, life, and the meaning of their lives.[62]

The virtue of humility, coupled with the virtue of finding God in all things, will therefore allow public health officials and benefactors to aim at accomplishing God's

[61] Jonathan Mann, "Human Rights and the New Public Health," *Health and Human Rights* 1, no. 3 (1995): 232.

[62] Crosby, *Spirituality of the Beatitudes*, 44.

will. In other words, humility will allow them to fully depend on God and as they find God in all things, their actions will also aim at doing God's will. And God's will, or the "heavenly father's will," as Crosby calls it, is very much concerned with doing good and with justice.[63] This justice will aim at creating an atmosphere that brings forth both a fair distribution of rights and duties and also furthers relationships of compassion among human beings. We find here clearly that humility will be crucial, as it will gradually further compassion for those suffering at the margins—a virtue that will be discussed in the next subchapter. This again finds echo in Neal and Hayward's discussions on the relationship between humility, compassion, and gratitude to God, which showed clearly that humility has a lot to do with empathy, which is close to compassion.[64]

Finally, the call for poverty of spirit in this Beatitude is the beginning of all the processes of public health policy and will be crucial in the Sub-Saharan African population whose healthcare systems are in shambles. It will bring the powerful to humility and compassion for them and eventually solidarity.

II.3.B. Self-Identification with the Sufferer in Public Health Ethics

"Blessed are they who mourn, for they will be comforted." [65]

According to Jim Forest, the poverty of spirit found in the first Beatitude is inseparable from mourning in the second Beatitude.[66] This is because, as he continues, if one has no poverty of spirit, he/she will have a tendency to always be on the side of self-protection whereas when one is poor in spirit, he/she will be sensitive to the pain and loss

[63] Crosby, *Spirituality of the Beatitudes*, 48.

[64] Krause and Hayward, "Humility, compassion, and gratitude to God," 195.

[65] Mt 5:4.

[66] Forest, *The Ladder of the Beatitudes*, 38.

of all people indiscriminately.[67] It is true that one who engages in doing God's will, after having lived with humility, will feel some pain for those who need help and will, to a certain extent, learn to console them. This pain will be the beginning of walking in the shoes of others. Therefore, Chan reminds us that mourning points not so much to one's own suffering as to the poverty and suffering of all the members of the human community, calling people not just to console one another but rather to mourn with the sufferers.[68] This mourning should be manifested in the concrete human experience of poverty and suffering encountered by all members of the community similar, as Chan rightly puts, to "a certain disposition that genuine disciples have with one another."[69] The second character trait of the anthropological profile of public health officials is, therefore, the virtue of solidarity.

Since in our case we are concerned with disease and the possibility of death, solidarity and self-identification with the sufferer in public health should include the characteristics that marked Jesus' attitude in healing those who are afflicted. These can be summed up in the following words that express the healing promise of Jesus as he endured our afflictions:

> It is the reconciliation and warmth, the comfort and consolation, the experience of tenderness and compassion, as well as the understanding and love that come in a loving, caring relationship. If Jesus bore our infirmities and sufferings, it was to bring wholeness and healing. The same is ours.[70]

In other words, self-identification with the sufferer in public health ethics requires that there be among public health officials, benefactors, and the population at

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[67] Forest, *The Ladder of the Beatitudes*, 38.

[68] Chan, *The Ten Commandments and the Beatitudes*, 171.

[69] Ibid.

[70] Crosby, *Spirituality of the Beatitudes,* 64.

large loving and caring relationship. However, these relationships should be sincere and authentic, just as Jesus loved humanity. It is a relationship that should be, as we shall see later, ready to enter the level of self-sacrifice even to the point of martyrdom.

According to Meghan J. Clark, the object of solidarity is our common humanity and its end is our common good.[71] Therefore, in solidarity, any action aimed at creating an environment of healthcare for all especially the most marginalized should be based on the basic awareness that the goal pursued is for both the people served and oneself. In the field of healthcare, we have usually two separate worlds. On the one hand, we have the world of the victims of a disease outbreak or of people in need of preventive measures in order to avoid a possible epidemic. On the other hand, we have the world both of the public health officials, who have the responsibility to act and save lives, and of those who provide means through charitable organizations—benefactors. Due to the fact that human beings in these two worlds are usually paternalistic, the suffering of those in need of help is perceived by public health officials or benefactors as a problem to be solved. We suggest instead seeing this suffering as a human condition to be addressed by being with the sufferers and concretely experiencing their fate before acting. In fact, these two modes of perception create a gap in the interconnections between these two worlds that undermine the crafting and implementation of public health policy. This gap can be filled using the model of Doctors for Global Health (DGH).

> DGH employs liberation medicine so that the poor decide what they need and are empowered to explore different ways of achieving their goals. Once the

[71] Meghan J. Clark, "Anatomy of a Social Virtue," *Political Theology* 15, no. 1 (2014): 30.

> poor are empowered, true development and liberation for health and healing can occur.[72]

The second Beatitude provides us with a possibility of narrowing down the gap between the worlds of the powerful rich and the weak poor. The love of all things which was also advocated in the first Beatitude by Chan, especially the love of human beings who are suffering the lack of basic healthcare, is more manifest and yields better results when those in charge of deciding and implementing healthcare policies can identify themselves with them following the DGH model. It is not simply a matter of defending the right to health through some sort of advocacy or remote projects, which have no clear popular support or engagement that will bring the much needed healthcare. There is clearly a need for closer ties and identification with the sufferers.

Identification with the sufferers found in the call for mourning invites the virtue of authentic solidarity. This solidarity should be understood in the way Clark explains it: first as an attitude, which stresses the feeling and awareness of our interdependence; and, second, as a duty pointing to the moral requirements of interdependence.[73] This identification will also move beyond the virtue of humility which is mostly concerned with the self as it helps develop reliance on God and doing God's will. Identification with the sufferer is, in fact, becoming the sufferer as one journeys with those who suffer, and as Diana Fritz Cates rightly asserts as she defines compassion

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[72] Jennifer Kasper and Clyde Lanford Smith, "Liberation Medicine and Accompaniment in El Salvador: The Experience of Doctors For Global Health," in *Rights-Based Approaches to Public Health* (New York: Springer Publications, 2011), 294.

[73] Clark, "Anatomy of a Social Virtue," 27.

as "suffering with him something of the same desire that he suffers."[74] Now, what are the concrete steps to be taken by those who enter into the suffering of the other and become companions on the journey?

Only when public health officials and benefactor institutions work together with the population, even at the risk of their lives, will they be able to understand their needs and gather their support and participation in the implementation of policies. The need to listen and promote participation is also echoed by the great physician Barry R. Levy in his 1997 presidential address where he stressed how partnership is very crucial.[75] Moroever, according to Clark, without the participation of both sides of the projects, the virtue of solidarity will be non-existent.[76]

Finally, concrete steps to implement and to achieve this goal of self-identification with the sufferer and realization of love and care relationships demand living-in experiences with the sufferers. Public health officials are supposed to distinguish themselves with a kind of hospitality *à la Jesuit,* which James Keenan described as "hospitality not in receiving but in sending," in going to the marginalized and making one's home there.[77] It is, as it were, a call to allow those at the margins to find a home in their own home as human beings who live with dignity. Field visits and living with those who need support for a certain period of time is, therefore, very crucial.

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[74] Diana Fritz Cates, *Choosing to Feel: Virtue, Friendship, and Compassion for Friends* (Notre Dame, IN: University of Notre Dame Press, 1997), 212.

[75] Barry. S. Levy, "Creating the Future of Public Health: Values, Vision, and Leadership," *American Journal of Public Health* 88, no. 2 (1998): 190-191.

[76] Clark, "Anatomy of a Social Virtue," 30.

[77] James F. Keenan, "Jesuit Hospitality," in *Promise Renewed: Jesuit Higher Education for a New Millennium,* James F. Keenan and Martin R. Tripole, eds. (Chicago: Jesuit Way, 1999), 237.

This can be very challenging for the benefactors who, most of the time, come from a world so different from that of the sufferers in Sub-Saharan Africa. However, Chan also reminds us why these benefactors should bear the brunt of these challenges when he defines mourning as follows: "Mourning is then the ready subordination of one's comfort and wellbeing to the suffering of others in order to bring strength and courage to those who suffer."[78] The purpose of this staying-in time will be not, as many experts of public health would do, to gather epidemiologic data. The aim will be rather to share the living conditions of the local populations and experience their needs and pains, and do it just as if one was focused on his/her own needs. In this way, the policies that will be crafted will be reflective of concrete field reality. In his book *Pathologies of Power*, Paul Farmer beautifully depicts this process of understanding the needs of the people to be served by highlighting compassion and solidarity.[79]

The lack of these experiences mars the work of many NGOs, which work in the field of healthcare in Sub-Saharan Africa. They usually come with practical strategies of action and intervention designed abroad and often fail adjust to the actual living conditions of the people by engaging the populations they serve not as passive beneficiaries but as active members engaged as partners for the same goals.

Eventually, implementing policies that come from real-life experiences of the people will help in building trust and promote legitimacy and accountability for public health institutions and benefactors. Nancy Kass echoes the result of this endeavor in her

[78] Chan, *The Ten Commandments and the Beatitudes*, 172.

[79] Paul Farmer, *Pathologies of Power: Health, Human Rights, and the New War on the Poor* (Berkeley, CA: University of California Press, 2003), 27.

proposed framework for ethics analysis in public health for the sake of trust in these terms:

> The most important asset that public health can have is the public's trust that work is being done on its own behalf. In such a context, public health professionals can and must advocate what they believe, on balance, are the ethically best approaches for furthering social justice and the public's health.[80]

A good example of this need for community participation and the importance of the voices of the population comes from Wanjiku Miano who discusses the situation of human rights advocacy in Kenya. He claims that, in order to be more effective in defending and promoting individual and collective rights, human rights organizations should enhance legitimacy and accountability by making sure that what they defend is exactly what the local people have at heart. [81]

Finally, as we have already discussed, this call for self-identification with the sufferer will fit better in the African cultural context which values community. We just need to steer away from the bioethical framework focused exclusively on human rights or principlism. I agree with Azétsop who argues for an alternative to principlism, which still guides most health-care policies in Sub-Saharan Africa and calls for new directions for bioethics in Africa:

> The African sense of solidarity, religiosity, social responsibility and family can help reshape the principles and values that guide bioethical reflection, according to African mindsets, concepts of personhood and social relationships. These values can renew the understanding of medical practice as a service to the community and envision the healing relationship between the patient and the health professional as a collaborative and life-giving

[80] Nancy E. Kass, "An Ethics Framework for Public Health," *American Journal of Public Health* 91, no. 11 (2001): 1782.

[81] J. Wanjiku Miano, "Governance and Democracy in Kenya: Challenges for Human Rights NGOs," in *Human Rights NGOs in East Africa*, (Pennsylvania, PA: University of Pennsylvania Press, 2009), 227.

relationship, shaped by trust, responsibility, respect and mutual concern.[82]

The characteristics mentioned in the passage above sum up what are the most significant tasks that any individual, government, or organization needs to take into account both in discussing healthcare policies but also in implementing them. Trust, responsibility, respect, and mutual concern through loving and caring relationships will be the hallmark of authentic self-identification with the sufferer and will make the human rights approach to healthcare and public health policy more authentic and well-grounded.

We know that patients or people in need of healthcare or prevention sometimes fail to comply with public healthcare protocols. The adoption of this personal and social anthropological profile will allow radical identification with the sufferers and the resulting policies will reflect the real needs and conditions of people creating a sense of trust, responsibility, and respect for the ordinances that will contribute to the improvement of compliance. Moreover, this compliance will be both at the level of faithfully following prescription protocols and also that of material support for the preservation of healthcare infrastructures. When populations are active participants, they not only benefit from health services but also participate in building infrastructures for the sustenance of health systems.[83]The participation of the population at this level will also allow communities acquire capacities to solve local problems related to health. Lawrence Gostin and Lesley Stone also acknowledge this level of participation.[84]

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[82] Jacquineau Azétsop, "New Directions In African Bioethics: Ways of Including Public Health Concerns in the Bioethics Agenda," *Developing World Bioethics* 11, no. 1 (2011): 5-6.

[83] Jennifer Kasper, Dabney P. Evans and Corey Weinstein, "Conclusion: Right-Based Approaches to Public Health," in *Rights-Based Approaches to Public Health* (New York: Springer Publications, 2011), 375.

[84] Lawrence O. Gostin and Lesley Stone, " Health of the People: The Highest

For now, we have argued that the virtue of humility, which leads to ridding oneself of spiritual pride, will help individual moral agents to enter into self-identification with the sufferer through concrete actions. These actions are very crucial because of their imminent effect on the building up of relationships of trust and mutual care necessary to promote the solidarity that is advocated in this first pillar. In the following part of this pillar, we will see that there is an even deeper call for the spirit of service. Why is this spirit so crucial?

II.3.C. The Spirit of Service in Public Health Ethics

"Blessed are the meek, for they will inherit the land."[85]

Chan rightly describes the meaning of meekness in the third Beatitude as an attitude of humility and patience without resentment.[86] The third character trait of the anthropological profile of public health officials is the virtue of meekness.

In order to reach the target of service, there is clearly a need to change the *modus operandi* making sure that public health institutions do not work for their own interests. The spirit of service will, therefore, demand that public health officials make further sacrifices beyond just living with those suffering in order to assess their needs. These are qualities that are very important for someone who has to grow in service, living with those he serves and tolerating theirs ways of perceiving and doing things. The individual will need to learn to listen and accept everything without questioning too much as he/she enters into the broken lives of the sufferers who should remind him of the

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Law?" in *Health, Ethics, an Public Health,* Angus Dawson and M. F. Verweij, eds. (Oxford: Clarendon Press, 2007), 66.

[85] Mt 5: 5.

[86] Chan, *The Ten Commandments and the Beatitudes*, 180.

suffering Christ on the Cross. In this context, the agents should realize that, as they came to serve those who are suffering, service should be more in patiently listening to their groaning and pleas and less in trying to impose one's ideas. In this process, they will understand that in order to carry out their task, they need help from those they serve.

Why is the spirit of service, as opposed to the provision of goods (which sometimes comes with interests for the provider) so important for the development of public health in Sub-Saharan Africa? The need for this spirit is rooted in the realization that various malpractices related to corruption and sectarian interests have undermined healthcare systems. As a matter of fact, reprimanding the failure of powerful institutions whose aim is to improve the quality of life of the poorest, Jennifer Kasper and Clyde Smith remind us that in practice, they do not always aim at the target:

> Historically, therefore, many development initiatives have ensured that the interests of those organizations and governments in power are safeguarded, usually at the expense of true sustainable development initiatives that seek to benefit the poor by significantly raising their quality of life.[87]

As an example to illustrate the relevance of the attitude presented above, generally speaking, the employees of NGO's which operate in Sub-Saharan Africa have much higher salaries than most if not all government workers. Because of this situation, no matter whether they have grown in the love for the people they serve and have gradually acquired the capacity to identify with them with a certain level of pain for their suffering and respect for their dignity, the financial gap may impede the possibility of developing a sense of service but rather may further that of supremacy and paternalism.

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[87] Jennifer Kasper and Clyde Lanford Smith, "Liberation Medicine and Accompaniment in El Salvador: The Experience of Doctors For Global Health," in *Rights-Based Approaches to Public Health* (New York: Springer Publications, 2011), 294.

Instead of a sense of service in partnership, there will develop a paternalistic pattern of service in which those who make and those who implement policies will gradually lose the sense of service thereby severing the tie of partnership that is so crucial for the success of policies.

Therefore, the virtue of meekness will be very helpful in this perspective as it will lead to the awareness of one's insufficiency–despite one's being capable of leading his life perfectly—and to the transformation of the desire to dominate into a desire to serve.[88] This will happen especially when one gets to the awareness of helplessness, waits patiently for God's help, and constantly makes an effort to obey God's will.[89]

Agreeing with Crosby's point, Chan reminds us that with egoism and narcissism widespread in our world today, those in positions of power will always have a tendency to protect possessions, power, and prestige to the detriment of the oppressed thereby creating a vicious circle of vengeance.[90] As we have seen above, the moral agents in public health can transcend these challenges in order to break down this circle. In fact, through a process of self-evaluation and discernment of one's place in the realm of things, the individual moral agent of public health has already understood that he/she needs to surrender his/her comforts to enter into the life of the sufferers.

When agents who determine policies and practical methods to implement them have already put into the project a sense of love for the populations for which policies are intended and have authentically identified themselves with the people by mourning with them with a sense of respect for their dignity and mutual concern, the

[88] Chan, *The Ten Commandments and the Beatitudes*, 180.

[89] Ibid.

[90] Ibid., 179.

spirit of service will be taking root. The virtue of meekness, which has to develop in the person the practice of a life that worships God rather than worshiping the self, will, therefore, strengthen the virtue of solidarity by inviting the moral agents to realize that they are not self-sufficient and capable of executing their tasks until they become agents of God's mission—men and women for and with others. As Chan tells us again, in the practice of meekness, the poor and the powerful will both need psychological and spiritual strength.[91]

The moral agents in public health will equally need this gift which they will earn gradually as they learn to serve others humbly and patiently allowing God to guide them to do God's will. They will not be afraid to be there for others and share whatever they have. It is therefore very crucial that the virtue of meekness be given its due place in the process of policy-making.

II.3.D. Conclusion

The first three Beatitudes provided us a personal and social anthropological profile of moral agents in public health, which will produce authentic solidarity through humility, identification with the sufferer, and the spirit of service. We also have seen that this solidarity will take place only when the moral agents of public health will engage in concrete actions of solidarity. The spirit of poverty calls for a sense of humility and dependence on God. This sense leads to another step which allows the moral agents of public health to see human beings as not only objects at their service but rather as creatures who reflect God's presence. In the spirit of the *Imitatio Christi*, seeing God in the people one serves leads to another level of love and care which is an imitation of

[91] Chan, *The Ten Commandments and the Beatitudes*, 181.

God's love for humanity. Love and care, as it were, take place only when the moral agents allow themselves to enter into the lives of the sufferers through self-identification with them. However, with the huge socio-economic gap between the healthcare providers and the people, moral agents will also need to be humble and patient as they surrender their comfort and self-understanding to this new way of life for and with the sufferers. In this process, the moral agents will grow in a spirit of service, which is so much needed for authentic solidarity through mutual interdependence. This first pillar is the foundation for each of the following two pillars because it provides the beginning of authentic collaboration between public health officials, benefactors and the population at large. This collaboration can be effective only if, as DGH advocates, public health providers work with the populations they serve by sharing risk and responsibility in order to create conditions that demand and facilitate social justice.[92]

As the beginning of the whole process of building sustainable healthcare systems in sub-Saharan Africa, it is also necessary that there be a sense of responsibility to protect and improve the existing infrastructures to provide and comply with suitable treatment protocols as well as disease prevention guidelines. As we shall see in the following pillar, when the moral agents of public health reach the level of mutual interdependence and solidarity, they will need to row into the deep[93] to promote a sense of responsibility.

[92] Kasper and Smith, "Liberation Medicine and Accompaniment in El Salvador," 293.

[93] This is the motto of the Society of Jesus' 36th General Congregation.

II.4. Second Pillar: The Making of Shepherds of the Common Good

In this second pillar, we will discuss how solidarity and the sense of mutual interdependence resulting from the first pillar can be sustained only by the virtues of obedience to God's righteousness, mercy, integrity, and truthfulness found in the following three Beatitudes.

II.4.A. God's Righteousness and Public Health Ethics

"Blessed are those who hunger and thirst for righteousness, for they will be filled."[94]

The virtue of justice is the fourth character trait in the anthropological profile of moral agents in public health. After the moral agents of public health will have developed the virtue of solidarity, they will need to ground it in the divine will in order to be sustained. The first pillar has already helped them to find God in all things and its associated need for the divine guidance. However, in order to root this solidarity in the divine will, the moral agents need to allow God to be the master, to allow what God wills for humanity to be the light that monitors and guides policy-making. Since this Beatitude calls for efforts to advocate for the sake of God's justice, what does God's justice mean and what are the means for advocating for it? In his description of a household or community constituted in God's justice, Crosby states:

> To achieve the constitutive experience of God's justice in us invites us to hunger and thirst for God's presence and life, power and care, to rule our lives, to ground our being. Since our hearts have been made by and for God, they will never be satisfied until we dwell in Gods justice, until we are 'right with God.'[95]

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[94] Mt 5:6.

[95] Crosby, *Spirituality of the Beatitudes*, 107.

Echoing Crosby, Chan reminds us that this Beatitude calls us to pay attention to the need for God's righteousness. We may also say that, in the process of crafting public health policies or implementing them, the moral agents of public health should pay special attention to whether or not God's righteousness is sought or served. I agree with Chan when he rightly states the need to assess whether we are acting for the sake of God's righteousness rather than one's own.[96]

What does this mean or where does it lead? This Beatitude will bring authentic solidarity to fruitfulness due to its clear grounding in divine justice instead of the mere call for finding God in all things found in the first pillar, which may still falter as one's needs grow. Public health policy-making process will require a discernment *à la Ignatius* which should be practiced on a daily basis. Chan claims that discernment will give a sense of direction to one's ongoing hunger and thirst for God's justice.[97] Aside from this discernment, Chan reminds us again that when we seek God's justice, we will be developing the ethical standard of righteousness, which manifests itself in right moral conduct and relationships.[98] From here we can learn two important points: the relationship between, (1) seeking God's justice and (2) the habits that we acquire in the process.

What will be the relationship between practicing the virtue of solidarity and that of justice? According to Clark, even if solidarity is related to justice, the former connects oneself to others in a totally different way from justice because the former is recognition

[96] Chan, *The Ten Commandments and the Beatitudes*, 86.

[97] Ibid., 189.

[98] Ibid., 188.

that the violation of another's human rights is also the violation of my own rights.[99] Therefore, since God's most important concern is to bring justice to the oppressed, one who engages in bringing justice to the oppressed will consequently need to grow steadily in the virtue of solidarity or right relationships with God and human beings. These relationships are no other than the relationship developed in the first pillar: solidarity with and for the sufferers. God's justice for the sufferers in public health is more manifest in sound public health policies that generate sustainable healthcare systems for them. In other words, the justice that is sought here is that which is concerned with the common good in public health, which will contribute to alleviating the suffering of the population. And this common good requires the participation of all members of the community who, in the first place, have to think and act according to God's will and command and have to develop rightful relationship with each other. This Beatitude calls therefore for the formation and transformation of all the moral agents into shepherds of the common good. As they make efforts to promote the right to health in the light of God's righteousness, they will not only produce structures that sustain the common good of health but also, because of the authentic relationship of solidarity among all the people involved, they will be transformed into authentic shepherds of those very structures. This will happen because of the gradual awareness of a common origin and end—in God as the creator, the Alpha and the Omega.

According to Chan, fortitude and the development of rightful relationships with God and other human beings are the two key values called for in this Beatitude.[100] There is therefore the need for moral agents of public health to be brave enough to fight for the

[99] Clark, "Anatomy of a Social Virtue," 37.

[100] Chan, *The Ten Commandments and the Beatitudes,* 189.

right to health even as they face threats to their own life. This is actually in line with the argument of Chan that this Beatitude is connected to the last one,[101] which calls for *kenosis* and which we will discuss in the third pillar. Only this way will they be striving for God's righteousness and developing right relationships with other human beings especially those who are suffering. Just like Jesus the Good Shepherd, who took human flesh and fought for justice for the oppressed and the sufferers until his death, the moral agents of the common good in public health are also called to stand firm in the fight for this justice. Only then will they be called shepherds of the common good.

II.4.B. Charity and Justice in Public Health Ethics

"Blessed are the merciful, for they will receive mercy."[102]

The virtue of mercy is the fifth character trait in the anthropological profile of public health officials. This Beatitude brings the element of mercy to compensate for any fear that one may have while striving to uphold justice because it will, according to Chan, produce divine rewards for the one acting righteously. What does mercy mean in this Beatitude and what is its implication for the making of shepherds of the common good? What will be the demands of this Beatitude on the shepherds of the common good?

Chan tells us that mercy cannot be separated from charity because it is the "active work and immediate effect of charity." Moreover, from Chan's statement that rightful human relationship finds its place in "justice and charity towards others,"[103] we may conclude that mercy is also that disposition which prompts the moral agent to act in order to bring justice to others and that charity is the content of that act.

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[101] Chan, *The Ten Commandments and the Beatitudes,* 189.

[102] Mt 5: 7.

[103] Chan, *The Ten Commandments and the Beatitudes*, 188.

We have already seen that the thirst and hunger for righteousness is crucial to make God's justice take flesh. The building of justice should therefore be the result of putting together all means—financial and human resources—toward relief of the sufferers.

Is providing financial and human resources enough to bring justice? Or could we call people or organizations, which participate in such projects, shepherds of the common good even if they do not have the disposition of mercy? Or could we have manifestations of mercy or "active work and immediate effect of charity" coming from people or organizations which are not shepherds of the common good? These are the questions that we need to answer here.

James Keenan defines mercy as entering the chaos of another and he acknowledges that this act could be especially difficult when practiced in a very different culture and far from home.[104] We have already seen that, in the striving for God's righteousness through the fight for the right to health and advocacy for the allocation of resources necessary for this purpose, the moral agents may have to face many challenges some of which may threaten their own lives. I agree with James E. Gilman in his discussion on benevolence as mercy when he reminds us that mercy is subversive and not submissive and that it should neither accommodate nor collaborate with oppressors but confront them.[105] However, sustained reports such as that from the Nuffield Council on Bioethics confirm that NGOs may have vested commercial interests due to the financial

[104] James F. Keenan, *The Works of Mercy: the Heart of Catholicism* (Lanham, MD: Rowman & Littlefield Publishers, 2008), 150.

[105] James E. Gilman, *Christian Faith, Justice, and a Politics of Mercy: The Benevolent Community* (Lanham, MD: Lexington Books, 2014), 128.

support they receive from commercial businesses.[106] Even in wealthy countries like the U.S, Oxfam reported political influence of big corporations on all public policies, which keeps increasing economic inequality.[107] In Sub-Saharan Africa, the shadow of powerful countries like France with its mining corporations also keeps many countries under the grip of poverty and inequality.[108] Given that many NGOs benefit from donations coming from tax avoidance or money laundering, real shepherds of the common good in this region should not accept to act against the promise they make to the people they intend to serve and should be accountable to the source of support.

However, even when public health officials should already have an inner appreciation of the mission entrusted them, such appreciation and inner determination may still falter. As a matter of fact, the existence of NGOs that work in the field of healthcare, which use excessive resources for their own care and much less for those they serve, may be tempted to do so as a pretense of charity. Charity in this sense will be no different from an empty show of mercy, which has no content. Therefore these NGOs will not deserve to be identified as shepherds of the common good. The reason for this denial of identity as shepherds of the common good is that they cannot sustain their work in face of any attempt on their comfortable lives, let alone in the case of threat of death or

[106] Bob Hepple, *Public Health: Ethical Issues* (London: Nuffield Council on Bioethics, 2007), 44.

[107] Ricardo Fuentes-Nieva and Nicholas Galasso, "Working for the Few: Political Capture and Economic Inequality" (Oxfam International, January 20, 2014), http://www.oxfam.org/sites/www.oxfam.org/files/bp-working-for-few-politicalcapture-economic-inequality-200114-en.pdf.

[108] Ibid.

dismissal from their position. That in itself is a sort of death to oneself and may indeed contribute to real death in the long term.

In the same manner, public health officials who do not manifest in their thoughts and actions the characteristics of "active work and immediate effects of charity" will lose their identification as shepherds of the common good. What then are the concrete attitudes they will have to adopt for the purpose of earning this appellation?

Firstly, as they strive to bring justice in public health for the promotion of the right to health, they will need to always assess their thoughts and actions to make sure that the expected end result of the policies is justice. If the end result is mere actions of distribution of resources to cover up other intentions, the policies should be scrapped. Aside from corporate interests, this may also happen when governments, out of other concerns related to political survival or some group interests, impose some policies or reject some others. It may also be true of NGOs that are clearly aiming at some corporate interests in their "charity projects" and pass through public health officials to gather support. In these cases, public health officials should make sure that what appears as acts of charity truly mirror the virtue of mercy, which is so crucial in any program aiming at saving the lives of the sufferers.

Secondly, as we have already discussed in the first pillar, in order to assess justice, shepherds of the common good have to consider the conditions in which the population lives and raise up those areas of public health that need to be addressed. Simply relying on the means they have at their disposal, and doing as if they are sharing what they have for the sake of charity, is not appropriate. In fact, this has contributed to the mushrooming of NGOs, each of them claiming to offer services in a specific area of

public health without however any collaboration with other organization working in the same field in the territory. They also do not consider the existing healthcare infrastructures and available resources so as to improve on them. As already mentioned earlier, this way of proceeding has produced fragmentation of the healthcare systems. Therefore, the assessment of the existing conditions is very crucial in order to ensure a fair allocation of resources.

In the process of crafting healthcare policies and deciding the proper allocation of resources, if moral agents of public health give due importance to the assessment of the conditions of the populations they want to serve and pay attention to the grounding of their own intentions and thoughts behind the final outcome of the deliberations, charity and justice will be served. In other words, they would have engaged in a sort of active work that has an immediate charitable effect—they would have been merciful and would deserve the title of shepherds of the common good. While already engaged with the populations, as a consequence of this engagement, the populations they serve would also have been made responsible of the need to promote the common good and would gradually become shepherds of it.

II.4.C. Integrity and Truthfulness in Public Health Ethics

"Blessed are the pure in heart, for they will see God."[109]

Finally, we will end this second pillar with a very important characteristic trait of the anthropological profile of shepherds of the common good. The purity of heart proclaimed in the sixth Beatitude presupposes the virtues of integrity and truthfulness, which make the keystone of both the first and the second pillars. These two virtues act

[109] Mt 5:8.

like highway bumps that keep moral agents on the path of God's righteousness, which is more manifest in solidarity with the poor and the marginalized, by upholding the truth even in the face of conflicts of interest.

In his description of the meaning of this Beatitude, Chan writes: "The 'pure in heart' emphasizes the integrity of one's whole being and understands such an attitude as fundamental, all-encompassing virtue."[110] The emphasis in this statement is on the value of the integrity of one's whole being. We have already seen earlier that there are many challenges to the decision-making process in public health. Many challenges come either from the interest groups that collaborate with the decision-making body in public health or from the thoughts and intentions of moral agents. All these forces need to be channeled properly in order to arrive at well-integrated decisions, which embody the virtues enumerated so far. Thus, the moral agent of public health should constantly check on the truthfulness and integrity of his thought and actions in order to ensure that there is no negative inclination that favors the exterior forces or leads them to give in to inner disordinate attachments. Echoing the need for this caution, Chan tells us that purity of heart will manifest itself when the inner self finds parallel expressions in outward actions.[111]

What will be the hallmark features of living out this Beatitude as a shepherd of the common good? In the first pillar, we have already discussed the foundational anthropological profile of moral agents of public health ethics leading to solidarity, manifested in the development of mutual interdependence. In this second pillar, we have shown how charity and justice are crucial in living out this solidarity with the sufferers.

[110] Chan, *The Ten Commandments and the Beatitudes*, 203.

[111] Ibid.

In order to achieve truthfulness and integrity, there appears also a need for some virtues that contribute to truthfulness and integrity: honesty, prudence, and vigilance. These virtues will be crucial in the process of purification of the hearts of moral agents that aim at promoting the common good. We are speaking of a process because, since this profile is virtue-based, it allows space and time and invites moral agents to grow in virtues while focusing on the need to ask what one wants to become and how or what he/she can do to become virtuous as a way to arrive at the desired goals.

First, we will discuss the virtue of honesty, which is connected to the moral agent's inner thoughts and intentions. According to Chan: "Honesty implies that integrity first points to truthfulness."[112] We can also conclude from this statement that when one lives on lies and acts on them, he/she will lose his/her integrity. Moreover, he/she will be losing purity of heart, which is crucial in the process of making shepherds of the common good. Integrity is very much connected to purity of heart because it contributes to connect the interior self to the exterior actions. Honesty, as it were, is the virtue of paramount importance since it is the concrete bridge to this connection. When one does not act according to the truth, there will be a disconnection between his/her actions and the inner self.

As already discussed, the assessment of the needs of the population and the constant checking on ones inner thoughts and intentions is very crucial. This is where the virtue of honesty will play a role. As one makes an effort to understand the needs of the sufferers and makes sure that his own needs do not interfere with the needs of others, honesty about ones' inner motives is crucial. Because we live in a highly competitive and

[112] Chan, *The Ten Commandments and the Beatitudes*, 204.

individualistic world, the mere process of assessing ones' intentions alongside the needs of others will not help until one has not discerned the inner motives whether negative or positive. Only in this way can one aim at honesty, which is the sustained bridge between thoughts and actions.

Second, the virtue of prudence is important and is connected to external acts. The most prominent writer on this virtue, James Keenan, tells us that prudence is first and foremost concerned with justice, which orders all operations and exterior actions.[113] In the process of bringing justice to the sufferers, honesty cannot be sustained unless there is constant use of the virtue of prudence to assess needs and interior motives as new challenges arise. The virtue of prudence will allow for a questioning that never ceases just because policies have been implemented. The questioning should continue until one reaches what Keenan calls, referring to the term used by Stephen Toulmin, the "limiting question" which leads to discover the basic moral orientation or fundamental motivation.[114] The virtue of prudence will contribute both to right action and also to clarify the fundamental motivation. Moreover, it will contribute to the purification of the heart of moral agents in public health.

Finally, the virtue of vigilance, which should accompany the prudent moral agent, is also very crucial. In fact, Chan tells us that this continuous self-evaluation or watchfulness will help the moral agent to achieve integrity at different moments of discernment but also will be able to form the moral character of integrity in the moral

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[113] James F. Keenan, *Moral Wisdom: Lessons and Texts from the Catholic Tradition* (Lanham, MD: Rowman & Littlefield, 2010), 148.

[114] Daniel J. Harrington and James F. Keenan, *Jesus and Virtue Ethics: Building Bridges Between New Testament and Moral Theology* (Lanham, MD: Sheed & Ward, 2002), 82.

agent.[115] Moreover, as moral agents in positions of leadership grow in the virtue of integrity, Chan tells us that they will inevitably challenge the injustices in society.[116] Therefore, we can see clearly that integrity and truthfulness are necessary for the promotion of the right to health for the sufferers of social injustices that cause harm to health.

II.4.D. Conclusion

In this second pillar, we have been trying to strengthen and sustain the anthropological profile obtained in the first pillar. The most important contribution of this pillar is the grounding of justice in divine justice. In the secular world, the concept of solidarity is frequently used when calling for union for mutual support especially in situations of tragedies and calamities. However, we also know that the virtue of solidarity in this setting faces many challenges for its sustenance. The importing of divine justice is very crucial in providing hope beyond the chaos of visible reality, which characterizes public health policy. The grounding in divine justice is the beginning of a process of public health policy-making and implementation, which does not shy away from various challenges including threats to one's own comfort and life. This will take place because the relationships between public health officials and the population they serve is also grounded in the same origin and end of human life—God, the Alpha and the Omega.

The grounding in the divine, however, calls also for obedience to God's righteousness, which is more manifest in the disposition of mercy. We have seen that mercy, understood as active work with immediate effect of charity, is inseparable from charity and corrects any act that is not done in this spirit. Finally, we also have seen that

[115] Chan, *The Ten Commandments and the Beatitudes*, 204.

[116] Ibid., 207.

honesty, as a virtue that bridges the inner motivations to external acts, will help in maintaining integrity and truthfulness, which are the hallmarks of authentic shepherds of the common good. The call for the virtues of prudence and vigilance reminds us that the two pillars are sustained only with a clear sight on the final goals of the right to health for all while, at the same time, moral agents have to discern and make decisions as new challenges arise.

Clearly, therefore, the virtue of prudence is most important in relation to all of the virtues enumerated so far. The virtue of prudence that is called for here will help the moral agent look for anything that deviates him/her from the path of humility, authentic solidarity with the sufferers, and striving for God's righteousness. Similarly, the practice of the virtue of prudence in this context will, as Keenan asserts in his writing on the cardinal virtues, help the moral agents be vigilant and in not only growing in the virtues of justice, fidelity and self care in the present but also in anticipation of further embodying them.[117] This striving is also an invitation to imitate Christ, who, for the sake of God's righteousness, accepted to die on the cross. Similarly, moral agents who have grown into shepherds of the common good in public health are also called to be ready to sacrifice everything, even their lives, for the sake of the right for health. This brings us to the analysis of what the seventh and eighth Beatitude contribute in building the third pillar of this personal and social anthropological profile.

II.5. Third Pillar: The Making of Self-Emptying Moral Agents

In the process of policy-making and implementation, even the keystone of integrity and truthfulness can sometimes be challenged by our society due to greed and

[117] James F. Keenan, "Proposing Cardinal Virtues," *Theological Studies* 56 (1995), 728.

individualism that have penetrated almost all levels of our lives. The third pillar founded on the seventh and eighth Beatitude offers the virtues of peacemaking and *kenosis*, which we may call proto-virtues due to their overall importance. We highlight two reasons. First of all, moral agents of public health should be well-trained technicians and negotiators capable of providing knowledge as well as having dialogue skills necessary to create an environment suitable for building sustainable healthcare systems. Secondly, they should also be psycho-spiritually ready to offer their life for this purpose—if necessary. In this third pillar, we will show that the virtues of integrity and truthfulness should be more manifest especially when moral agents engage in conflicts that require compromising by way of peacemaking.

II.5.A. Peacemaking in Public Health Ethics

"Blessed are the peacemakers, for they will be called children of God."[118]

In the process of crafting or applying public health policies for sub-Saharan Africa, the officials in charge will face many challenges to uphold integrity and truthfulness. As a matter of fact, Sub-Saharan Africa is the most fertile field for exploitations engineered by business corporations or for the work of charity organizations. Moreover, most of this region suffers both from economic and political instability, which creates a favorable environment for corruption practices. With so much corruption and greed producing extreme poverty and death, public health officials or organizations that provide financial support for the building up of healthcare systems in this region need to compromise in negotiations for the sake of the poor. We will now explore how the seventh beatitude will help in this process.

[118] Mt 5:9.

This seventh Beatitude enjoins moral agents of public health to face the contingencies that arise in the practice of their profession with perseverance. In order to climb to the level of facing challenges of this magnitude, one needs to look for Jesus as the answer to the challenge. In fact, Jesus Christ proclaimed it: "I am the way and the truth and the life."[119] Therefore, entering into and remaining in prayerful communion with Jesus Christ—the way, the truth, and the life—will strengthen moral agents of public health in their endeavors to uphold the truth with integrity. How is this *Imitation Christi* achieved?

According to Chan, the practice of the virtue of peacemaking is achieved only in the transformation of human relationships and implies the concomitant attainment of the virtue of justice.[120] Besides, peacemaking requires as a precondition positive actions realized in bringing peace—peacemakers and not pacifists per se.[121] This is where the virtue of peacemaking intersects with the purpose of public health policy in Su-Saharan Africa. As we have already elaborated extensively, urgent actions in the field of justice in healthcare policy and implementation are very crucial in this region. As a matter of fact, in countries where only 2% of the annual budget is attributed to healthcare, justice does not only involve a fair allocation of available healthcare resources but also, and most importantly, the fight for an increase in the annual budget for public health. The officials in charge of financial management, socio-economic strategies as well as politicians should be engaged in a process of dialogue. Chan reminds us that, even as the virtue of peacemaking calls for socio-political engagement, we should always make sure

[119] Jn 14:6.

[120] Chan, *The Ten Commandments and the Beatitudes*, 212-213.

[121] Ibid., 210.

that we are negotiating with human beings in the first place; not social or political groups.[122] Therefore, personal and communal interactions are to come first before social change can take place.[123]

In the process of peacemaking, the officials will not only have to advance the cause of those in need of healthcare but also they need to engage in acts of transformation of interpersonal relationships with partners in their dialogue. They have to enjoin their interlocutors to embark on the path of the virtue of justice for the oppressed and to make them friends of the same journey. If they engage in authentic dialogue, the result will be mutual conversion manifested in communion with each other. This level of dialogue is only possible when the two sides allow the spirit of God—the true spirit of mourning with the sufferers—to work in them. The spirit of God will be present when the ability to listen and hear the cry of the sufferers and obey their summons are nurtured.

As a result, even as healthcare systems may not deliver their promises immediately, this process, which demands authentic interpersonal relationships, will lead to, using the words of Chan, reconciliation and forgiveness. In most of Sub-Saharan Africa, conflicts of interests among external and internal forces have most often culminated in open armed conflicts, which have had negative effects on healthcare for the poor. The gradual success of the healthcare agenda by way of dialogue between public health officials and the different layers of the population will be a good example of the possibility of peaceful resolution of both socio-economic and political conflicts. This process will also create a kingdom of moral agents of the common good in the strictest

[122] Chan, *The Ten Commandments and the Beatitudes*, 210.

[123] Ibid., 212.

sense. At the same time, as the policies will benefit more and more those who are suffering, the latter will grow in trust and sense of brotherhood with the latter two groups.

Nonetheless, we also know that in order to attain peace in places where conflicts of all kinds have prevailed for long periods is not easy. Some sacrifices may be needed to truly bring about social change. One of these sacrifices is the readiness to surrender one's life for the sake of justice for the poor and the marginalized.

II.5.B. *Kenosis* in Public Health Ethics

"Blessed are those who are persecuted for the sake of righteousness, for theirs is the kingdom of Heaven."[124]

We have already discussed that, in Sub-Saharan Africa, the fight for social justice often involves high financial interests at stake. Therefore, in the process of making sure that the poor are not exploited, public health officials may have to face threats to their lives. All throughout our discussion, we have presented the *imitation Christi* as the ideal *modus operandi* that has to guide all actions and attitudes of moral agents in the field of public health. At this level where we talk about the possibility of offering one's life for the sake of those who are suffering, Jesus Christ is the model par excellence. His setting for us as model of self-sacrifice calls all the people involved in public health to find in Him a source of inspiration and strength.

In this process, which has a locus in the common good of public health, the public health officials will have an important responsibility as messengers of Christ, to bring healing to the world. We are now going to follow Hood's proposal of the three

[124] Mt 5:10.

vocations that characterize Jesus's disciples to describe actions, attitude and inner dispositions of moral agents, which will define the anthropological profile of public health officials in this process of *kenosis*.

First, the disciples are, according to Hood, authorized agents who share in the authority of Jesus eternally, rule over all things and, for that matter, are restored to the position that God originally intended for the whole of humanity.[125] However, even if the whole of humanity is entitled to the status of discipleship with all the powers that come with it, we have seen that those at the margins cannot fully benefit from this entitlement and lack the power to change the lives of other people. Given that public health officials wield so much power, it may also be important that they reckon that since their power is an authorized one coming from Christ, they are also required to act like Christ. Hood puts it rightly so when he writes: "The disciples imitate Jesus as they work, and they become so identifiable with Jesus and his authority that some of their actions are heaven's actions, and their presence is his presence."[126]

Therefore, this entitlement comes with a price. We know that, after the resurrection, the disciples were left with both the task of preaching the good news as well as the power to heal diseases, to forgive sins, etc. Like Jesus, many of them lost their lives in the course of carrying out these duties. Moral agents in public health should therefore carry out this task not merely as an enjoyment of the fruit of their profession but as a mission from God, which begs for holy obedience and conformity with God's way of proceeding.

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[125] Jason B. Hood, *Imitating God in Christ: Recapturing a Biblical Pattern*, (Downers Grove, IL: InterVarsity Press, 2013), 66.

[126] Ibid., 65.

Second, according to Hood, the disciples are apprentices. Hood claims that discipleship requires giving up some of the highly valued characteristics of the western culture like independence, comfort, originality and efficiency.[127] Hood stresses this point when he defines what this calling involves: "Vocations require an apprenticeship when their task involves something unnatural."[128] He added that the imitation of Jesus's cross bearing and self-denial is the most unnatural thing and it is the core of Christian apprenticeship.[129]

How does this unnatural character trait affect and is effected by public health officials of Sub-Saharan Africa? We may say that in a world that so values individualism and competition, the anthropological profile of *kenosis* summoned by the eighth beatitude will lead those in position of power to experience gradual self-denial by adopting other-centered attitudes—especially when the corrupt world of public health urges them to do otherwise. They should learn to remember that they are apprentices of the imitation of Jesus and that this imitation cannot be brought down to the banal or the normal things of this world—it is a vocation and at its core is the spirit of apprenticeship of the purpose they are called for—to offer themselves as fragrant sacrifices for the physical and spiritual healing of this world.

Third and finally, disciples are ambassadors because they not only follow in the footsteps of Jesus but also are messengers of truth and mercy, judgment and forgiveness.[130] How does this relate to *kenosis*? As already shown above, conflicts of

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[127] Hood, *Imitating God in Christ: Recapturing a Biblical Pattern*, 66.

[128] Ibid., 67.

[129] Ibid.

[130] Ibid.

interests, lies, deceits, dishonesty, etc., are rife in the field of public health policy. The public health officials and benefactors who fight for the sake of the common good will have to uphold the truth even as they face threat to their death. As ambassadors of Jesus most merciful, they will also have to practice mercy for those who, because of attempts at the lives of the marginalized have failed through negligence or intentional mismanagement. However, they will also have to uphold justice by way of the virtue of prudence, judging the wrong done, and forgiving whenever necessary.

As people with authority but whose measure of efficiency is Jesus Christ for whom they are ambassadors, public health officials should not shy away from accepting any consequences of actions for the sake of the poor and the oppressed. As we can see here, peacemaking is closely related to the possibility of *kenosis*.

II.5.C. Conclusion

Chan tells us, since genuine peace is built upon justice, the cultivation of the virtue of peacemaking will produce the virtue of justice as well.[131] It appears that if public health officials would be endowed with only the character trait of peacemaking, the right to health would be served. Should we, therefore, advocate for the virtue of peacemaking as the sole character trait most important in the anthropological profile of public health officials? It is good to note that, even if the virtue of peacemaking is very important, the virtue of humility, which we described in the first part of the first pillar, will still be called for. As a matter of fact, in order for those who have more responsibilities and privileges than others to plead for the poor in peacemaking, they still need to practice the virtue of humility in order to rid themselves of spiritual pride and

[131] Chan, *The Ten Commandments and the Beatitudes*, 213.

learn to find God in all things. Only in this way will they be able to listen and take note of the cries of the marginalized and the sick whose needs for healthcare should be constantly satisfied urgently.

According to Chan, solidarity and the virtuous acts of mourning are also related to peacemaking because they imply mutual assistance for the sake of peacemaking.[132] Similarly, Chan tells us that meekness and fortitude, which call for patience and rejection of violence, equally contribute to peacemaking.[133] As a matter of fact, we have found out that, these virtues are crucial in surrendering one's comfort and associating with the oppressed, patiently dialoguing with them and experiencing first hand their suffering. There is no better way to start the process of peacemaking than this.

In the second pillar, as we discussed the making of the shepherds of the common good, we saw the importance of developing rightful relationships with God and other human beings and how it is crucial for the emergence and sustenance of God's righteousness—justice. Further, we showed how mercy as 'active work with immediate effect of charity' will be instrumental in avoiding malpractices, which would perpetuate the sufferings of the people. As Chan reminds us in its invitation to practice forgiveness, mercy will also be instrumental for peacemaking.[134] In our case, the avoidance of suffering through authentic acts of mercy accompanied with the practices of 'admonishing the sinner, forgiving the offenses, and bearing wrongs patiently' are the most important attitudes not only for peacemaking but also for negotiating the alleviation

[132] Chan, *The Ten Commandments and the Beatitudes*, 213.

[133] Ibid.

[134] Ibid.

of the suffering caused by unsustainable healthcare systems. As virtues conducive to truthfulness and integrity, honesty, prudence and vigilance are also very important virtues for peacemaking and for avoiding to cooperate with those who exploit the poor.

Finally, we have seen that *kenosis* is attained only when the moral agent has acquired the previous character traits from the first pillar all the way to the virtue of peacemaking. All these character traits, which describe the moral agents in public health, are interconnected. In the process of public policy-making or implementation, public health officials should assess their thoughts, actions and policies in light of this anthropological profile starting from the first to the third pillar and not vice-versa.

In the following and final chapter of this research project, we are going to apply the personal and social anthropological profile that we have just developed to healthcare for the mentally disabled in Sub-Saharan Africa.

CHAPTER THREE: APPLICATION OF THE THREE-PILLAR VIRTUE-BASED PERSONAL AND SOCIAL ANTHROPOLOGICAL PROFILE OF MORAL AGENTS IN HEALTHCARE FOR THE MENTALLY DISABLED IN SUB-SAHARAN AFRICA

This chapter discusses the care of persons with mental disabilities and shows that the language of human rights is not enough to secure them the public health programs and policies that are needed. Rather, I argue that human rights language needs to be anthropologically grounded on the three pillars that should robustly animate both the public health officials and society and could lead to responsible and accountable leaders caring for persons with mental disabilities.

III.1. The Problematic of the Ethics of Abundant Life in Healthcare for the Mentally Disabled

A. The Influence of the Concept of Abundant Life in Sub-Saharan Africa

"The chief means for virtue education is the telling of stories."[135] This statement comes from Alasdair McIntyre in his groundbreaking book *After Virtue*. In the same perspective, I argue that, in order to care properly for the local populations, public health officials need to understand the meaning of virtue in Sub-Saharan Africa by listening to the people's stories and myths. Moreover, public health officials and the population they serve need to fit into the social anthropological profile that we suggest so as to be able to work together toward an effective healthcare for the mentally disabled.

Following the advice above, before we apply this anthropological profile, we need to understand the meaning of the concept of abundant life in Sub-Saharan Africa. Even if we do not agree with the idea of homogenizing traditional beliefs from different

[135] Alasdair C. MacIntyre, *After Virtue: A Study in Moral Theory* (Notre Dame, IN: University of Notre Dame Press, 1981), 114.

countries of the African continent, we will follow Laurenti Magesa's use of the term "African Religion" in its relation to the concept of abundant life. According to Magesa, in African Religion there is a belief that God is the ultimate guardian of the moral order of the universe for the purpose of benefiting humanity.[136] This moral order is made of moral standards that have to be followed by all human beings and are also immune from challenge.[137] Besides, the spirits of the departed ancestors help in maintaining the connection between the Supreme Being and the living by watching over people and enforcing these morals through punishment of those who deliberately violate them.[138] The violation is measured in acts that diminish life force or energy. In sum, in the struggle to fulfill the demand of these moral standards, the individual moral agents do so in collaboration with all the other constituents of the cosmic unity. They act within the community of the living and the dead and this, according to Magesa and Neville Richardson, is the central experience of African Morality.[139] The community in general has, therefore, the duty to uphold culturally learned standards and norms that have to be observed in order to further social cohesion and make the running of the community easier.[140]

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[136] Laurenti Magesa, *African Religion: The Moral Traditions of Abundant Life*, (Maryknoll, NY: Orbis Books, 1997), 46.

[137] John S. Mbiti, *Introduction to African Religion*, (London: Heinemann Educational, 1975), 174.

[138] Ibid.

[139] Neville Richardson, "Can Christian Ethics Find its Way, and Itself, in Africa?," *Journal of Theology for Southern Africa*, 95 (1996): 40.

[140] Sunday Awoniyi, "African Cultural Values: The Past, Present and Future," *Journal of Sustainable Development in Africa* 17, no.1 (2015): 5.

Within the ethics of African Religion, moral agency is the medium through which "abundant life" is realized. Moreover, the aim of actions performed by the moral agents is to increase life energy or, in a more extended way, to preserve life and promote good health and wellbeing of all members of the community. Therefore, it becomes important to understand the rights and duties of each individual and the role that community plays toward the wellbeing of each of its members. In this regard, we analyze how this communitarian spirit is lived, especially with regard to the care of the mentally disabled.

I agree with Sunday Awoniyi, and other African theologians like Magesa, Mbiti, and many others, that African ethics puts more emphasis on communitarian responsibility than on individual rights.[141] Nevertheless, I also maintain that, in this communitarian setting, there are some substantial problems stemming from individual accountability.

If the moral agent has to be generally bound by communitarian demands, are there any clear community guidelines with regard to individual responsibility and accountability for some specific actions? For example, what will be the community-sanctioned measures and actions with regard to families using energy diminishing means in the treatment of the mentally disabled? We will contend that, in cases which do not necessarily produce consequences that can be readily perceived or felt at the communal level, there will be neither communal accountability nor much sense of personal accountability due to the lack of the sense of communal or individual guilt. This is due to the fact that the African ethics of abundant life puts more emphasis on shame than it does on producing guilt in moral agents. There appears, therefore, the need to show the

[141] Sunday Awoniyi, "African Cultural Values: The Past, Present and Future,"9.

difference between shame and guilt. Shame is the representation of a person's superego telling him that unless he acts according to societal expectations he will not receive approval. Shame acts like a tool to control the behavior of children by threatening them to obey to the adults' commands. On the contrary, guilt is a personal awareness of accountability for wrongdoing. Unlike shame that comes from superego, guilt arises from a mature ego that makes the following acknowledgment: I have sinned and I need to change my behavior.

However, in the African communitarian culture shame is supposedly the moral compass and this marks the limits and obstacle to a more responsible and accountable ethics of abundant life. In fact, I agree with the critique of Emmanuel Umeh when he claims that in a shame culture the acts that are considered as not shameful are socially acceptable no matter how detrimental to the entire society they can be in the long run.[142] It is important to note that shaming does not always lead to right attitude. It is just a feeling experienced within a community that makes the moral agent experience a sense of possibility that he might be alienated by the community. Shaming is not a moral compass in a sense that it merely tells you to follow what the community prescribes.

In this concluding chapter, I contend that, instead of allowing shame to be the unreliable moral compass, the sense of guilt that can be produced by a life of virtues found in the beatitudes of the Gospel of Matthew acts as a moral compass that tells the moral agent that he is wrong; in other words it helps him make a suitable judgment in different circumstances. In the course of a faith journey that is committed to the building of the Kingdom of God (which may be equated to a kingdom of "abundant life" in the

[142] Emmanuel C. Umeh, *African Theology of Solidarity and Religion of Self-Deceit: The Nigerian Experience* (Hamburg: Verlag Dr. Kovac, 2013), 150.

African context), this moral compass helps the moral agent to move from general justice with regard to community, to fidelity which calls for the development of sound relationships at the smaller communitarian level and is crucial for an ethics of abundant life. It is the journey toward more responsibility and accountability to the human community starting from sound interpersonal relationships with those who are more vulnerable and to the marginalized that will lead to the making of moral agents of abundant life capable of mutual care and, in our case, to a special care for the mentally disabled. First of all, we are going to explore the influence of the watchdog-character of the community on individual external actions and its implications on the place and life of the mentally disabled in the community of abundant life.

B. The Influence of the Watchdog-Character of the Community of Abundant Life on the Mentally Disabled

As Awoniyi tells us, the individuality of the moral agent is recognized and respected by African ethics insofar as it is not pushed to the extreme.[143] What does "extreme" mean and in the theology of abundant life, what degree of extremity could make a moral agent be found guilty of trespassing the limits of actions that may be regarded as decreasing life-energy? Does the individual moral agent have the freedom to act and the space for growth and maturity? Kwame Gyekye supports the idea of the existence of a certain level of freedom but nuances it by saying that the amphibious character of communality and individuality does create a certain meaningful but yet uneasy tension that is necessary for the moral agent's smooth participation and

[143] Awoniyi, "African Cultural Values: The Past, Present and Future," 8.

integration in the social fabric of the African community.[144] This view was already elaborated by the great African philosopher Léopold Sédar Senghor who rightly asserted that, because of the dialogical and reciprocal character of African community life, the group has to more say on the individual without, however, any intention of destroying him but with the aim of helping him/her to blossom.[145] I would agree more with the above authors and less with J.M. Nyasani whose understanding of the individual in the African community of abundant life is one of quasi-dissolution and loss of self-volition in the reality of others for survival of self.[146]

Bénézet Bujo sums up beautifully this interaction between the moral agent and the community of abundant life when he writes:

> By contributing to the community *qua* community, the individual gives himself freedom. Africans understand freedom not only in the sense as freedom 'from.' It is at the same time freedom 'for,' but most importantly of all, freedom 'with.' Freedom does not only exist for me: it is for everyone, since I myself am free only when everyone is.[147]

However, in this kind of community, many problems arise when one of its members, for example a mentally disabled, performs actions that appear to be disruptive of the harmonious order of the community. I argue that, due to African Religion's belief that mental illness is a punishment from deceased ancestors,[148] this person will be judged

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[144] Kwame Gyekye, *The Unexamined Life: Philosophy and the African Experience* (Accra: Ghana Universities Press, 1988), 5.

[145] Leopold Senghor, "Négritude," *Optima* 16 (1966): 8

[146] Joseph M. Nyasani, *The African Psyche* (Nairobi: University of Nairobi and Theological Printing Press, 1997), 60.

[147] Bénézet Bujo, Foundations of an African Ethic: Beyond the Universal Claims of Western Morality (New York: Herder & Herder, 2001), 129.

[148] Tabona Shoko, "Shona Traditional Religion and Medical Practices: Methodological Approaches to Religious Phenomena," *Africa Development* XXXVI, no. 2 (2011): 283.

on his/her external actions and moods and will be seen as an encumbrance to the community harmony that should be removed from the mainstream. The community does not consider the fact that growth of a moral agent cannot be solely evaluated on the ground of externalized actions. This growth also involves a progressive parallel inner maturity that works in integrating external and internal dispositions. This inner maturity will gradually externalize its content to the community through acts that increase life energy. However, when the mentally disabled act in such an environment, there is a wrong reading of his motives because his external acts do not necessarily translate his inner movements and dispositions. Because their acts or words will be somewhat disruptive of the social order, the mentally disabled persons will be reprimanded by the "normal" as a danger to the cosmic energy. The actions of the mentally disabled will, therefore, affect tremendously their place within the context of abundant life. In a community that strictly evaluates moral actions through the lens of externalized effects, the various individual moral agents in the community will find it difficult to relate with the mentally disabled.

C. The Influence of African Religion in the Diagnosis and Treatment of People with Mental Disability in Sub-Saharan Africa

In this research project, we have argued that the use of the language of human rights in public health ethics has not delivered the right to health to all in Sub-Saharan Africa. As an example of the difficulties encountered in applying the language of human rights, the mentally disabled are not only still in dire need for a healthcare system that can provide their basic care but also, due to complex socio-economic and cultural issues, they are tortured and cast out from society. For example, a report on Uganda describes the issue of inmates with mental health problems not receiving proper treatment or simply

being isolated in solitary punishment cells.[149] Even worse, in South Sudan where there is no mental health facility,[150] some mentally sick have their legs shackled just because they are considered "lunatics".[151]In other words, as the author suggests, the mentally ill patients are imprisoned because their disabilities have been criminalized.[152] Another alarming situation is found in Ghana where mentally disabled people are sheltered in few available psychiatric facilities or prayer camps where they endure tremendous human rights abuses.[153] What may be the reason behind this treatment of the mentally disabled? How can an ethics of abundant life turn to actions that clearly decrease the life energy of some of its constituents?

In his study on mental illness among the Yoruba of Nigeria, Roa Makanjuola reports that in most parts of the African continent, people's attitudes towards mental illness are still strongly influenced by traditional beliefs in supernatural causes of diseases and remedies. [154] As we have already discussed, African Religion believe that the dead continue to communicate with the living and that this can be observed by examining how individual persons or communities benefit or are punished by the departed ancestors. The punishment is due to the fact that interference in the communication with the ancestors

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[149] Katherine W. Todrys and Kwon, *Even Dead Bodies Must Work: Health, Hard Labor, and Abuse in Ugandan Prisons*, (New York: Human Rights Watch, 2011), 3.

[150] Elizabeth Ashamu, *Prison Is Not For Me: Arbitrary Detention in South Sudan*, (New York: Human Rights Watch, 2012), 56.

[151] Ashamu, *Prison Is Not For Me: Arbitrary Detention in South Sudan*, 10.

[152] Ibid., 58.

[153] Medi Ssengooba, *Like A Death Sentence: Abuses Against Persons With Mental Disabilities in Ghana*, (New York: Human Rights Watch, 2012), 11.

[154] Makanjuola Roa, "Yoruba traditional healers in psychiatry: Healers' concepts of the nature and aetiology of mental disorders," *African Journal of Medicine and Medical Sciences* 16, no. 2 (1987): 16.

diminishes the life energy that is so crucial to abundant life. Moreover, it is possible that the community inflicts the punishment when it is clear that one's particular behavior diminishes life energy. That is why, in many African countries, the community punishment of those who are accused of involvement in life-decreasing actions is still practiced in different forms.

According to Bonginkosi Nkosi, in the South African context, disobedience in communication between the living and their ancestors can lead to severe punishment. He writes:

> However, if there is communication breakdown or disobedience, the belief is that ancestors possess the ultimate power to punish those who commit such actions. The disobedient to the ancestor creates a friction or state of punishment in the form of illness, bad luck and other kind of misfortunes. Therefore, it becomes essential for the living to conduct rituals in honor of the dead.[155]

Furthermore, Tabona Shoko also confirms the need for rituals in the case of the Shonas of Ghana:

> When a person is possessed by the spirit of an ancestor he becomes ill and it soon becomes apparent that the illness is 'abnormal'. In this instance, a diviner is consulted and a ceremony is held to accept and honor the spirit. It is generally agreed among the Shona that failure to accept the spirit results in the persistence of the illness or may lead to mental problems.[156]

From the words of Nkosi and Shoko, we can see that the diagnosis of a mental illness is always connected to the realm of the ancestors or, in other words, to the realm beyond the living and need community diagnosis and attempts at treatment. As a matter of fact, referring to the results of the research of Gelfand, Tabona and colleagues

[155] Bonginkosi Maxwell Nkosi, "Understanding and Exploring Illness and Disease in South Africa: A Medical Anthropology Context," *International Journal of Humanities and Social Science* 2, no. 24 (December 2012): 88.

[156] Shoko, Shona Traditional Religion and Medical Practices, 283.

conclude that the n'angas, who are traditional healers receiving the healing powers from mudzimu (spirit of the ancestors), feature in their medico-religious rituals both a 'diagnostician' and 'therapist' identity at the same time.[157] This diagnostic model will put the responsibility for the disease either on the community as a whole or on individuals. For individuals, anyone who is sick will be considered a scourge in the community and will be held responsible for the sickness. Moreover, as we have just seen, he will be tasked to go through certain rituals to mend for his/her offenses to the ancestors or else the punishment will be extended to the whole community. These rituals are meant to calm the angry ancestors and also to heal the community member who is sick due to the punishment. That is why many mentally disabled are cast away from the community confines in order to avoid both spreading negative energy and removing the agent who keeps diminishing the life energy. The ritual may, therefore, be equated to a preventive and treatment protocol.

What is the extent to which this method of prevention, diagnosis and treatment is used in Sub-Saharan Africa? In South Africa, there is widespread use of the traditional healers both in urban and rural settings. Moreover, even people suffering from anxiety and substance abuse are the most likely to seek traditional healers.[158] Besides, as Sorsdahl and colleagues acknowledge, "Traditional healers and religious and spiritual advisors are widely dispersed throughout South Africa, are knowledgeable of the culture norms, and their advice is sought, believed and acted upon by community members."[159]

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[157] Ibid., 279.

[158] Katherine Sorsdahl *et al.*, "Traditional Healers in the Treatment of Common Mental Disorders in South Africa," *The Journal of Nervous and Mental Disease* 197, no. 6 (2009): 440.

[159] Ibid., 441.

As a consequence, Gureje and Alem's report shows that African traditional beliefs have a negative impact on the provision of mental health care services. [160] By emphasizing on seeking help from traditional healers, people can hardly benefit from the development of western medicine in psychiatry. However, another major concern that he they raised is that policy-makers also believe that mental illness is usually incurable. [161]

Added to this scourge, the traditional African community-oriented lifestyle, which could be helpful in the care for the mentally disabled, is being challenged by urbanization throwing many mentally disabled people on African streets.[162] Moreover, not even all the traditional families are willing to take care of their mentally disabled.[163]As we have already mentioned, this situation has contributed to the isolation of those affected by mental diseases and other psychiatric disorders. We will now discuss the contribution of the personal and social anthropological profile developed in this research project in examining care for the mentally disabled.

III.2. Contributions of the Three-Pillar Personal and Social Anthropology in the Care for the Mentally Disabled

III.2.A. Preliminary Remarks

Writing about the essence of African ethics, Etta and Offiong claim that in some African societies like the Efiks, it is forbidden to hurt a stranger and that there is even a saying that praises the Efiks as those who hate indigenous people and love strangers.[164]

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[160] O. Gureje and A. Alem, "Mental health policy development in Africa," *Bulletin of the World Health Organization* 78, no. 4 (2000): 475.

[161] Gureje and Alem, Mental health policy development in Africa, 475.

[162] Ibid., 477.

[163] Ibid.

[164] Etta Emmanuel E. and Asukwo Offiong O., "The Nature of African Ethics," *African Research Review Journals* 1, no. 2 (June 2012): 57.

How should we understand love for a stranger as more important than that for a fellow community member who is affected by mental illness and has to be shackled and isolated from the community?

In Catholic Africa still guided by African Religion, even as some practices may seem to betray the content of Catholic faith, there lies an understanding that Jesus offers a path not only to heaven but also to abundance of life here on earth. In fact, as Ilo tells us, there is a certain convergence between this historical process of abundance of life and the message that Christ's life, death and resurrection offer liberation and salvation for all those who suffer in this world marred by structural sins.[165] Further, according to Magesa, morality and ethics in African Religion both refer to thoughts, words, attitudes, and actual behaviors that promote life.[166] Since this life happens in a universe that is created by God, who is the supreme guardian, and given that humanity is the primary beneficiary, the latter is morally bound, therefore, to sustain this work. [167] I would like to add that the community should pay special attention to the fact that isolating any member of the community is a violation of the very principle of abundant life. As a matter of fact, Magesa reminds us that because of interconnectedness between humans and nature, any wrongdoing on the part of an individual or group may cause harm to the entire community.[168] In fact, any refusal to share with others is seen as a destructive act since it does not contribute to building community.[169] Therefore, just as the fifth commandment

[165] Stan C. Ilo, *The Face of Africa: Looking Beyond the Shadows* (Bloomington, IN: AuthorHouse, 2006), 351 .

[166] Magesa, *African Religion*, 161.

[167] Ibid., 46.

[168] Ibid.

[169] Ibid., 65.

enjoins each Christian to always care and protect life of all human beings,[170] African Religion should enjoin all members of the community to become responsible moral agents who not only protect life in general but also takes care of the sick and especially the mentally disabled. Moreover, just as the moral agent's responsibility as a Christian implies a relationship with God, cosmic unity that calls for the moral responsibility in African traditional Religion implies the same through the framework of the cosmic unity. In this perspective, the moral agent of the ethics of abundant life has to be fully accountable not only to the community but also, and more importantly, to God.

How can African communities reach this goal with so many problems in the local healthcare systems and cultural practices that make the lives of the mentally disabled unbearable? In the following paragraphs, we will show how the three-pillar personal and social anthropological profile of public health officials and the population they serve may help both in contributing to the building up of healthcare facilities for mentally disabled and in helping to promote communities of abundant life capable of taking care of them. In the following sections, whenever we talk about moral agents we mean public health officials, healthcare professionals, benefactors and charity organizations as well as the population at large.

III. 2.B. The First Pillar: Towards Authentic Solidarity with the Mentally Disabled

This first pillar provides a virtue-based personal and social anthropological profile that fosters a sense of solidarity that transcends socio-cultural constraints by forming public health officials as well as all non-governmental organization and individual benefactors in the exercise of authentic solidarity. In this pillar, living out the first

[170] Chan, *The Ten Commandments and the Beatitudes,* 83.

Beatitude requires the practice of the virtue of humility. As already discussed, Chan rightly asserted that as moral agents practice humility, they also reach a second step which is to rid oneself of spiritual pride and learn to find God in all things in order to move beyond the level of mere stewardship to that of lover of all things. This is where the first beatitude intersects with the ethics of abundant life in the African context. As a matter of fact, we have seen that African Religion perceives the universe as a composite of divine, spirit, human, animate and inanimate elements that are directly related to and in constant interactions with the Divine Force—the latter being the ultimate life-giving power.[171] Therefore, the moral agent in African Religion is called to find his place in this united but yet hierarchized universe to discern and find the face of the life-giver in the face of other human beings—especially the poor and the marginalized mentally disabled. Instead of fighting one's way out for the sake of abundant life, the virtue of humility will train moral agents to rely and trust God by way of tolerance and hospitality toward the other. Following the same idea, Magesa tells us that African Religion basic's vision of morality is the avoidance of questioning the actions of the Divine and the nurturance of trust in God, who is considered as "The Wings of the People."[172] Through the practice of humility in solidarity, the moral agents will be able to start engaging critically the community of abundant life and contribute to weaving together the social fabric making it more conducive to the care of and friendship with those who are mentally disabled and who have to utterly depend on compassion and love to survive. With growth in the virtue of humility and striving to find God in the mentally disabled, all the moral agents in the ethics of abundant life will work together to increase life energy.

[171] Magesa, *African Religion,* 39.

[172] Ibid., 45.

To find God in the mentally disabled requires self-identification with them as sharers in the image of God. This is the second character trait informed by the second beatitude and calls not just to console one another but also to mourn with the sufferers.[173] Similarly, Mbiti claims that, in the ethics of abundant life, when the moral agents suffer they do so with the corporate group and when they rejoice, they do so with their kinsmen, neighbors and relatives living and dead.[174] Following the same logic, Chan calls this sociability self-identification with the other accompanied by the subordination of one's comfort and wellbeing to the suffering of the other.[175] This self-identification with the other is rooted in the common origin as *Imago Dei* and common eschatological *telos*. Similarly, African Religion presupposes that human beings are united in a mystical way with the visible and the invisible world. The latter includes God, the ancestors and the spirits[176] and any affliction that befalls a human being within this unity is considered a result of someone's acts of destabilization of the harmonious unity among the elements of the cosmic unity. Therefore, the public health officials and the people they serve have the obligation to implement all possible measure in order to ensure that harmony is reestablished.[177] In the virtue of solidarity, the process of mourning and self-identification with the sufferers invites the moral agents in the ethics of abundant life not only to realize their moral obligation to share with the other but also to become aware of the need to mourn with them. This mourning is also a sign that the other moral agents in the

[173] Chan, *The Ten Commandments and the Beatitudes*, 171.

[174] Mbiti, *African Religions & Philosophy*, 108.

[175] Chan, *The Ten Commandments and the Beatitudes*, 172.

[176] Magesa, *African Religion*, 39.

[177] Ibid., 73.

community and the public health officials feel affected by the affliction, which is disturbing the unity of the visible and invisible world.

Finally, the virtue of meekness found in the third beatitude will contribute to making public health officials and the population they serve acknowledge that they are insufficient on their own and will transform their desire to dominate into a desire to serve.[178] The tendency to control the mentally disabled by casting them out of the comfort of the community will be challenged by this virtue. Even when other moral agents enjoy good health and material abundance, they are called by the virtue of meekness to maintain a certain sense of solidarity and interdependence by caring for the harmony between the visible and the invisible world. This can only take place when the mentally disabled are welcomed in a way that makes them feel part of these two worlds that are physically separate but mystically united.

The mystical connection facilitates also the divine connection, which will help the moral agents to realize that whatever they do is to be accountable to God as the highest in the realm of the invisible forces that check on human beings for compliance to the normative moral order. This sense of accountability to the invisible power of the divine will lead the moral agents to experience the sense of helplessness and reliance on God rather than on mere judgments made according to externalized effects and under the control the principles of communal living. The practice of the virtue of meekness will allow moral agents to strive for forgiveness and compassion for the mentally disabled opening the door to tolerance and care. In this way, the sense of responsibility of the moral agent in African Religion will increase leading them to an enhanced sense of guilt

[178] Chan, *The Ten Commandments and the Beatitudes*, 180.

after committing any life-destructive actions. In the field of public health, such actions may be: officials not committing to allocating enough resources for the care of the mentally disabled and families that mistreat the mentally disabled. In return, solidarity will enhance the sense of being, not only in relation to the small community but also the larger one, thereby increasing life for the whole cosmic unity.

To sum up this section, humility, mourning with the mentally disabled, and radical mutual interdependence found in the first three beatitudes will work toward the making of fully integrated moral agents in the cosmic unity of the ethics of abundant life. In this first pillar, the mentally disabled will enjoy a welcoming community and possibly forthcoming healthcare infrastructures that cater to them. Following James Keenan's proposed cardinal virtues of prudence, justice, fidelity and self-care,[179] we can make the following conclusions: these virtues, paired with prudence, will help sustain the moral agent on the path of fidelity to one's community members and justice to the cosmic unity through an authentic self-care that brings abundance of life for self and community. All these virtues are compatible with the commands of the cosmic unity to never do anything that diminishes abundant life both at the individual level as well as the cosmic level.

III. 2. C. Second Pillar: Shepherds of the Common Good Caring for the Mentally Disabled

The second pillar that is based on the fourth, fifth and sixth beatitudes offers a possibility of furthering authentic shepherding of the common good and eventually the eradication of corruption. The virtues of obedience to God's righteousness, mercy, integrity, and truthfulness found in the three beatitudes constitute the anthropological

[179] Keenan, "Proposing Cardinal Virtues."

profile of shepherds of the common good. They will be very instrumental in sustaining the virtues acquired in the first pillar.

The fourth beatitude emphasizes the striving for God's righteousness, which calls for grounding the virtues that lead to solidarity acquired in the first pillar in divine justice and allow God to be the master of everything. The grounding of solidarity in the divine justice can be generally understood in African Religion in terms of cosmic foundation of the ethics of abundant life in which the creator is the master and the ancestors help the Creator to manage the cosmos. Moreover, this pillar begs for a process of discernment that should lead to the choices that bring divine justice among members of the community of abundant life. We have also seen that God's righteousness calls for fortitude and development of rightful relationships with God and other human beings. In order to achieve God's righteousness, there has to be developed a web of interpersonal relationships within the community of other moral agents both living and living-dead who, not only are always available to help when needed, but also help reconnecting with the realm beyond.

In such a corrupt context as Sub-Saharan Africa where models of virtue are very rare, this reconnection with the other realm of the cosmos which can be done through the following of rituals or real life practices that embody virtues that further divine justice will contribute to the formation of shepherd of the common good.

Even as the living may not be inspirational due to their own moral failures as it is seen in this context, in reconnecting with the saints who have lived as models on earth, African Christians will find help. The saints can be equated to the ancestors who are dead long ago but who may have lived as models. Echoing this point, Mbiti tells us that the

living-dead are very crucial in the making of a righteous moral agent of African religions because they speak both the language of people as well as the language of the spirit and of God.[180] Without this virtue of striving for God's righteousness that helps reconnect with other vital forces which, as we have already seen, are crucial in watching over the protection of moral standards, the moral agent developed in the first pillar will easily crumble. Steadfastness in the commitment to discern how to increase life and maintain harmony within the cosmos is a sign of a righteous moral agent who strives for the sake of the common good in the ethics of abundant life.

The fifth Beatitude brings in the virtue of mercy, which protects, compensate, and rewards for acting righteously. Because divine justice is to be enjoyed by those one serves, the merciful moral agents accompany those they serve by making sure that the goal of justice is achieved in participation rather than in mere paternalistic partnership. Moreover, since we have seen that mercy is "active work and immediate effect of charity," the only condition for mercy to produce its promise is that the practice of mercy be done in accord with the right intention. The intentions behind life-denying actions with regard to the mentally disabled will be challenged by this virtue of mercy. In the ethics of abundant life, the moral agent will be enjoined to adopt radical change of views with regard to the treatment of the mentally disabled. In fact, Chan tells us again that the virtue of charity, which is inseparable from the virtue of justice will lead to concrete actions as well as conversion of one's heart. In the ethics of abundant life, moral agents who hunger for righteousness will be led to this change of heart. This change will transform

[180] Mbiti, *African Religions and Philosophy*, 83.

even further the moral agents into human beings who do not act out of fear but are filled with the mercy of God, whose hearts resemble more and more God's heart.

As a consequence, this change of heart promised by the fifth beatitude is not a mere becoming but rather leads the moral agent to the higher level promised by the sixth beatitude according to which the pure of heart will see God.[181] However, this change of heart should be sustained by the virtues of integrity and truthfulness, which constitute the anthropological profile of moral agents who are of pure heart. As Chan already acknowledged, the virtues of integrity and truthfulness that come with the purification of one's heart bring the moral agent to reexamine, or again, according to Chan, challenge the practices of doing business today.[182] Once the moral agent has been able to challenge the practice of the community with regard to the fate of the mentally disabled by upholding the truth, social change will gradually take place. As promised by the ethics of abundant life, moral agents will also have entered into what we may call the dance of the life force itself together with those at the margins—the mentally disabled—and will, therefore, make effort to contribute to their welfare.

III. 2.D. Third Pillar: *Kenosis* for the Sake of the Mentally Disabled

The dance of life engaged through the practice of the virtues of integrity and truthfulness will not always be smooth especially with the already volatile situation of healthcare for the mentally disabled in Africa. The seventh beatitude offers another character trait that is crucial for the moral agents in the field of public health in Sub-Saharan Africa: the virtue of peacemaking. Instead of trying to secure one's own interest through lies and deceits, as has been shown in many instances throughout the African

[181] Mt 5:8.

[182] Chan, *The Ten Commandments and the Beatitudes*, 206.

continent, the moral agent is called to remember that any actions or attitudes that deviate from the guiding principles of the source of abundant life—truth—will be detrimental to one's own life and, consequently, the communal life. The practice of the virtues of integrity and truthfulness is very crucial in the process of bringing justice to the mentally disabled and is more manifest when one engages in peacemaking when conflicts of interests arise by entering into and remaining in prayerful communion with Jesus Christ—the way, the truth, and the life. This practice, as it were, will become the bridge between the mentally disabled and the other members of the community.

This leads us to the eighth and last beatitude, which calls for the final character trait of moral agents in the ethics of abundant life: readiness for self-sacrifice and death for the sake of the mentally disabled. In the theology of abundant life, the moral agent should find a source of inspiration and strength from the example given by Jesus who, for the sake of giving us life in its fullness, chose to empty Himself. African moral agents should not act like the one apparently suggested by Ogunleye among the Yoruba people who, because one has made an oath of covenant with the divinities out of the fear of death, will choose not to betray the oath by forcing oneself to behave morally.[183] The moral agent of abundant life should not act out of fear but with a resolve to increase life and for the sake of social change even with the cost of his own life. The covenant or oath can only be an external manifestation of a true moral agent. However, in practice, the latter has to grow in the various virtues to be sustained in his/her endeavors. In the Sub-Saharan context, the moral agent who is able to enter into complete

[183]Ogunleye, A. Richard, "Covenant-Keeping among the Yoruba People: A Critique of Socio-Political Transformation in Nigeria," *International Journal of Humanities and Social Science* 3, no. 9 (May 2013): 82.

communion with others, especially with the mentally disabled, through acts of solidarity and concern for the common good should also be able to do so through engaging the institutions that contribute to the wellbeing of all other human beings—to the increase of life energy leading to abundant life.

III.3. Final Remarks

As a conclusion to this project, it is better to be reminded of these words from Emmanuel Umeh: "One who acts in order to win favor or approval from the group or community rather than from God is religiously betraying his or her religious commitment."[184]The African continent cannot only marvel at its lofty communitarian ideal but should also allow for the making of committed moral agents formed in the spirit of virtues from the Beatitudes and who owe allegiance to community, while at the same time, are guided by the desire to do God's will before everything else even in the face of death. Working for the increase of the vital force should be done without clinging too much to one's own life or for the sake of some communitarian harmony. It should be done rather with a clear determination to create space for all life energy to emerge. When the mentally disabled are not welcome in the community, life energy is diminished. On the contrary, when the mentally disabled are freed from the shackles and isolation life energy will increase.

In this context, what is true of the community is also true of policy makers. Collaboration in solidarity with the communities through live-in experiences with the families that have mentally disabled individuals will require sacrifices of their comfort but is crucial in understanding the needs and discussing possible solutions. Public health

[184] Emmanuel C. Umeh, *African Theology of Solidarity and Religion of Self-Deceit: The Nigerian Experience* (Hamburg: Verlag Dr. Kovac, 2013), 152.

officials have to transcend the corrupt practices by making sure that their thoughts and actions follow the anthropological profile we suggest. The life of virtues that follows this profile will function as a ladder that allows all moral agents to work together in solidarity with those most vulnerable so as to increase life energy in the ethics of abundant life. People suffering from mental disorders will be protected and will not be isolated or shackled anymore. The communities will advocate for their care enjoining public health officials to join the dance of abundant life.

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