



At Heart, Global Health Draws on Compassion, Solidarity and Justice

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The mystery of human suffering — and our need to understand and find meaning in it — lies at the heart of religion and is central to the healing professions. Of its many forms, we especially fear the suffering of physical pain, and, in the United States, we spend more than \$250 billion dollars a year to avoid or control it.¹ The burden of mental suffering, too, is immense. For example, the World Health Organization now ranks depression as the leading cause of disability worldwide, affecting more than 300 million people.²

Law professor John A. Powell distinguishes existential suffering — the inevitable suffering inherent in living and dying — from “social” or “surplus” suffering, inflicted by “social arrangements” such as racism, violence and poverty.³ The structural and systemic causes of social suffering are pervasive, eroding human dignity and undermining the human spirit.

We also suffer spiritually when deprived of basic spiritual needs⁴ or exposed to intense physical, mental or social suffering. Moral distress, a form of spiritual suffering, has been described primarily among nurses⁵ and among health care workers who provided care during the 2014-2015 Ebola outbreak in West Africa.⁶ Another form of spiritual suffering, moral injury, has been documented in soldiers who, on returning from warfare, cannot reconcile the acts they witnessed or committed in battle with their core values.⁷

The immensity of human suffering throughout history is unfathomable. For most of our history, our awareness of suffering was limited to those in our own community. But we now live in an age

of globalization, bombarded by 24-hour news and images of suffering from around the world. Suffering that used to be hidden now is revealed. With that awareness comes a desire and a responsibility to respond.

The field of global health represents one such response. Global health emerged during the past three decades, fueled by a recognition that, as humans, our health is deeply interconnected.

The values of secular global health are remarkably similar to the principles of Catholic social teaching. These values include interdependence, solidarity, social justice and health equity (which necessitates a preferential option for the poor).^{8,9,10,11} They also include respect for human persons and compassion.¹² Particularly in recent years, Catholic social teaching has informed global health’s core value of solidarity, as illustrated by the fruitful dialogue between physician Paul Farmer and Fr. Gustavo Gutierrez, OP, founder of the liberation theology movement.¹³

Two examples will illustrate how global health draws on these values in its response to distant,



previously unknown, suffering. Both examples come from the field of neglected tropical diseases. These diseases are manifestations of social suffering caused by systemic influences that create what Theodore Bailey and colleagues described in the *American Journal of Public Health* as intractable “clusters of disadvantage” — vicious cycles of poverty and disease.¹⁴

RIVER BLINDNESS

Onchocerciasis is a parasitic disease that for centuries was a leading cause of blindness in rural West and Central Africa. The parasitic worms are spread by black flies that breed in fast-flowing rivers (hence, its common name, river blindness). Until the 1980s, there was no safe and effective drug to treat onchocerciasis. In addition to their physical suffering from blindness and its accompanying disability and economic devastation, affected persons were socially stigmatized. They experienced mental anguish due to constant, severe itching.

In the 1970s, researcher Bill Campbell, at Merck & Co. laboratories in New Jersey, began studying a compound that had been isolated from bacteria found on a golf course in Japan.¹⁵ The resulting drug, ivermectin, proved to be a potent antiparasitic agent and soon was developed into a blockbuster product for the veterinary market.

Mohammed Aziz, a scientist at Merck, was born in Bangladesh but had worked for the WHO in Sierra Leone, where onchocerciasis is endemic. He recognized the potential of ivermectin for human use and pushed for it to be tested against onchocerciasis. After a global network of scientists demonstrated its remarkable efficacy and safety, Merck pledged in 1987 to donate ivermectin free of charge for as long as needed to control onchocerciasis. Some 1.5 billion treatments have been donated for this purpose, delivered through a vast network of community drug distributors working at the village level. These efforts have eliminated onchocerciasis as a public health problem in many parts of sub-Saharan Africa.¹⁶

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who recognized their shared humanity — and who cared. Collectively, the decisions of these men and women formed what authors David Hunter and Harvey Fineberg describe in the *New England Journal of Medicine* as “a global tapestry

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of influences”¹⁷ that, in solidarity and collaboration with affected persons and their communities, alleviated a significant cause of physical and mental suffering and began to dismantle the systemic effects of social suffering.

LYMPHATIC FILARIASIS

The second example comes from Haiti, where in the 1990s, anthropologist Jeannine Coreil and her colleague, Gladys Mayard, began to study suffering caused by lymphatic filariasis, a disfiguring parasitic disease spread by mosquitoes. Infection with filarial worms leads to swelling of the leg, known as lymphedema, in an estimated 14 million people worldwide. The painful inflammatory episodes and decreased mobility associated with filarial lymphedema were well known. Less understood was how to alleviate the mental and social suffering caused by stigma. Also unclear was how to address the spiritual suffering of perceived abandonment, which researcher Bobbie Person described in her study of affected women in the Dominican Republic, “Can It Be That God Does Not Remember Me.”¹⁸

Coreil and Mayard began by listening. They learned about the complex web of physical, mental, social and spiritual suffering that women with lymphedema experienced. Guided by the narratives and inspired by the pioneering work¹⁹ of Geresa Dreyer in Brazil and of R.K. Shenoy in India, Coreil and Mayard helped the women to develop support groups. In these groups,



the women with lymphedema shared their stories and insights, meals and laughter. They also began to share a conviction that positive change was possible. Over the years, such self-directed groups have provided their members with emotional encouragement, information on self-care, micro-enterprise opportunities and spiritual sustenance. Similar groups, some called “hope clubs,” now are active in filariasis-endemic countries across the globe. Participation in such groups has been linked to decreased suffering as well as improved physical health, economic status and mental well-being.²⁰

With lymphatic filariasis, as with onchocerciasis, when caring people became aware of the hidden suffering of marginalized people, broad partnerships rooted in solidarity developed and flourished across geographic distance. These partnerships assisted local people in promoting their own health and well-being, and began to dismantle the complex webs of suffering that entangled them.

BEARING WITNESS TO SUFFERING

These two examples are not unique in global health. Despite many such “successes,” however, the burden of human suffering remains immense. Communities remain impoverished, structural causes of social suffering persist and the gap widens between rich and poor. Jesus said, “The poor you will always have with you.” In a sense, even

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our best efforts are never enough.

Humanitarian, health and human rights workers, chaplains, counselors and first responders meet us in our suffering to offer assistance and provide relief. In doing so, they contribute immeasurably to our lives. By walking alongside us, they experience the vulnerabilities, struggles, hopes and dreams that make us fully human,

and through their journey of accompaniment, they find meaning and purpose. We owe them a debt of gratitude. But, to be fully present to suffering, day in and day out, requires a great deal of inner strength. At times, the flame burns low. When faced with overwhelming need and suffering without the resources to alleviate it, they may be tempted to turn away in despair or, conversely, to double down in compulsive work to “save the world.”²¹

We are just beginning to understand the human costs borne by those whom we, as a society, pay to bear witness to suffering. For example, as many as 54 percent of active physicians report one or more symptoms of burnout,²² and an estimated 300-400 practicing physicians die from suicide each year in the United States.²³ Studies of humanitarian workers show that the prevalence of depression and psychological distress increases significantly after deployment to the field, and it remains elevated or even increases when assessed three to six months after returning.²⁴

Thomas Merton, the 20th-century Trappist monk and author, reminds us, “To allow oneself to be carried away by a multitude of conflicting concerns, to surrender to too many demands, to commit oneself to too many projects, to want to help everyone in everything is itself to succumb to violence.”²⁵

Faced with an acute awareness of overwhelming suffering and need in the modern world, how are we to respond? How can we approach suffering to alleviate and prevent it without succumbing ourselves?

THE GOOD SAMARITAN AS TEACHER

In response to a legal scholar’s question, “Who is my neighbor?” Jesus told a story. A man was beaten, robbed, and left by the side of the Jericho road. Two religious leaders, pressed for time, passed by without stopping, hurrying to attend to their official duties. Only a Samaritan was sufficiently moved by the man’s suffering to respond with compassionate action.²⁶ This well-known text offers us insight and guidance for responding to the world’s suffering with compassion — and self-compassion.

First, the Samaritan, as an outsider, probably had experienced social suffering caused by prej-

udice, exclusion and marginalization. His own acquaintance with suffering predisposed him to recognize and empathically respond to the suffering of another. In her reflections on the Rule of St. Benedict, Sr. Joan Chittister, OSB, reminds us that acknowledging our own suffering and limitations, and honestly and compassionately facing our own failings, is often the first step on the road to true humility — and freedom.²⁷ Humility is the basis for right relationship in our personal lives and also for massive undertakings such as global health. We cannot effectively address the sufferings of others from a position of superiority or personal invincibility.

Second, the Samaritan understood at a deep level that his life was interconnected with the life of the man by the side of the road. This sense of connection did not permit him to merely pass by. He already had cultivated a sense of solidarity with those who were “other.”

Third, the Samaritan saw. He bore witness. He did not turn away. By seeing, the Samaritan opened himself to empathy. We who work in organizations and bureaucracies, even those dedicated to health care or alleviating suffering on a global level, can easily lose touch with the faces of suffering individuals. Even without our noticing, we turn away, our attention absorbed instead in the mechanical aspects of budgets, programs, metrics and processes. All of us — but especially those of us who work at a system level — need to periodically refocus our gaze on the human and relational dimensions of our work and to reconnect with the compassionate impulse that initially inspired us.

CONTEMPLATIVE PRACTICES

Neuroscience recently has confirmed the benefits of compassion training and meditation for those seeking to respond more compassionately to suffering.^{28, 29} The Catholic tradition has a rich history of cultivating these contemplative practices in monastic settings. Among others, Frank Rogers and Andrew Dreitcer, co-directors and founders of the Center for Engaged Compassion in Claremont, California, have adapted ancient Christian contemplative practices and made them available to help us respond compassionately to suffering

in today’s world.^{30, 31}

The ability to regulate emotion in the presence of suffering is a central feature of compassion training. When facing intense or overwhelming suffering, we tend to react with the classic fight, flight or freeze response. To protect ourselves, we often flee, immerse ourselves in frenetic activity to relieve our own distress or become emotionally distant. None of these responses leads to effective, compassionate action.

To stand calmly in the presence of suffering and respond with compassion requires the cultivation of what Roshi Joan Halifax, PhD, founder, abbot and head teacher of the Upaya Institute and Zen Center in Santa Fe, New Mexico, calls a “soft front and a strong back.” We need to let suffering in, but not be overwhelmed by it. We need to be with suffering and, through our presence, trans-

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form it. Few of us know how to do this well.

During their clinical pastoral education, chaplains receive training in navigating these waters. It requires discipline, commitment and courage to critically examine our biases, fears and emotional triggers.

Fourth, the Samaritan acted. He approached the man along the side of the road and did what he could to take care of him. He attended to him skillfully, dressing his wounds with oil and wine. In this sense, he already was prepared. He arranged for the man’s care to continue during his absence.

All of us have specific skills and gifts. It is crucial that we offer them with wisdom, conviction and humility. Some may be called to respond to suffering with the gift of presence, of deep listening and accompaniment. For others, compassionate action is expressed through providing medicine, developing new health programs or fighting systemic injustices.

Fifth, the Samaritan finished his journey. He



did not abandon his own needs. He did not injure, hurt or neglect himself. Theologian Jeanne Stevenson-Moessner reminds us that in genuine caretaking, the caretaker is not submerged.³² With genuine, mature compassion, there is no compassion fatigue. The Samaritan practiced self-compassion.

Sixth, the Samaritan brought the man to an inn, a place of shelter, of healing and restoration. He relied on others. He did not need to be recognized or praised. In a sense, the Samaritan let go of the outcome. Clinging too tightly to our cause, or linking our identity to the success of our projects, ultimately undermines compassion. It is not up to any one of us, individually, to right all wrongs. Both at the community and the global levels, we need each other.

Global health represents a massive collaborative response to human suffering. It operates on a vast scale, yet at its heart depends on the kind of mature compassion exemplified by the Good Samaritan. At its core, global health remains grounded in radical values that are deeply informed by the principles of Catholic social teaching and which situate suffering in a context of solidarity, compassion and the pursuit of justice.

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QUESTIONS FOR DISCUSSION

- David Addiss, MD, explores the incidence of and treatment for two neglected tropical diseases that are endemic in some parts of the world — river blindness (onchocerciasis) and lymphatic filariasis. Both are parasitic diseases accompanied by debilitating symptoms and social stigma, for the sufferers are left disfigured or disabled. Successful treatments are available, but without a global approach to health and education, the physical, mental and social suffering from those diseases would be much greater. What is your ministry involved in that extends its knowledge and treatment of such diseases and increases its spirit of solidarity?
- The story of the Good Samaritan is key to Addiss' suggestions for how to care for people who are suffering. What are the six lessons from the Good Samaritan parable that the author encourages caretakers use to guide their work and their witness to suffering? How might these lessons be used in your organization to reduce compassion fatigue in those associates who regularly care for people who are suffering?
- Addiss connects the values of global health with the principles of Catholic social teaching — human dignity, solidarity, compassion and the pursuit of justice. How does your ministry engage those principles in its care of people suffering in the units of local hospitals as well as in any global initiatives they sponsor? Who ensures that those formative connections are made?

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