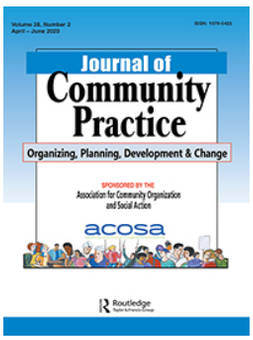

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Community practice, social action, and the politics of pandemics

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FROM THE EDITORS

Community practice, social action, and the politics of pandemics

Joining millions across the globe, we write this editorial for the *Journal of Community Practice* while adhering to stay at home orders. Although frequently invoked during times of public safety concerns (e.g., mass shootings) or natural disasters, current stay at home orders is aimed at slowing the spread, death, and destruction of the COVID-19 pandemic, the disease emanating from the invisible microbial killer SARS-CoV-2. This global pandemic, facilitated by ubiquitous international travel, has quickly but unevenly spread across countries in the Global North during the first four months of 2020 and is intensifying its presence in the Global South. At the time of this writing, there are more than 3.19 million confirmed cases and at least 226,000 deaths across 185 countries worldwide, but these numbers likely underestimate cases due to missteps and disparities in access to COVID-19 testing. Currently, the United States is the global epicenter of the pandemic, reporting approximately one-third of all confirmed cases and more than one in four deaths (Johns Hopkins Coronavirus Resource Center, 2020). Several of us on the editorial team reside in the Detroit metropolitan area, one of the hotspots for the coronavirus in the United States.

While stay at home orders, school and business closures, and other social distancing measures appear to have slowed the spread of the coronavirus in many countries in the Global North, they also have revealed numerous gaps in the social safety nets available to vulnerable families and individuals who have lost their livelihoods, experience housing precarity, have limited ability to meet basic needs, or reside in isolated rural communities with inadequate access to goods, services, and digital connectivity (Council on Social Work Education [CSWE], 2020; Heath, 2020; Wilson, 2020). Flailing global, national and local economies in the midst of the coronavirus pandemic have fueled recent protests against stay at home orders in Global North countries, like the United States, where these gaps are more pronounced and growing numbers of the citizenry feel disenfranchised and disconnected from the professional class and the larger society.

Unfortunately, the various containment or mitigation strategies employed to date to slow the spread of the coronavirus are considered inappropriate for much of the Global South (Mead, 2020). Poorer countries and communities in the Global South that are already burdened with precarious access to health-care services and limited infrastructure and resources to prevent, diagnose, and treat infectious diseases are those deemed most at risk (Kapiriri & Ross, 2020) to the spread of COVID-19. Places exhibiting the greatest inequalities and disparities in income as well as significant concentrations of marginalized, stigmatized, and disempowered populations, regardless of their geographic location, are also disproportionately at risk (CSWE, 2020; Hall, 2007; Kaiser Family Foundation, 2020; Rosoff, 2008; Wilson, 2020).

This current global pandemic should not have caught us off guard. The increase in frequency and geographic spread of disease outbreaks have been evident for some time (Kapiriri & Ross, 2020; Robbins & Freeman, 2018; World Health Organization, 2009). There have been numerous harbingers signaling the likelihood of another far-reaching global pandemic similar to the 1918 or the H1N1 influenza pandemics (see discussions

in Dodds, 2019; Jain et al., 2018; Kapiriri & Ross, 2020). Jain et al. (2018, see Table 1, p. 317) observed that during the first two decades of the 21st century and prior to the current coronavirus pandemic, the world had already witnessed three large pandemics (SARS, H1N1 influenza, and Chikungunya) with considerable geographic transmission of the diseases. Additionally, nine large disease epidemics involving meningitis, cholera, measles, yellow fever, Ebola, and Zika arose since 2000 affecting populations primarily located in the Global South. Combined, these 21st century pandemics and epidemics caused more than 6 million deaths and produced economic losses estimated into the trillions of dollars worldwide (Jain et al., 2018; Lee & McKibbin, 2004; "The Cost of the Swine Flu," 2009).

In light of concerns about the rise of pandemics and epidemics, public health and disaster preparedness experts long have questioned global, national and more localized capacity to prevent, detect and respond to outbreaks of infectious diseases (see discussions in Jain et al., 2018; Kapiriri & Ross, 2020; World Health Organization, 2009). Rosoff (2008) suggests that, more often than not, emergency preparedness plans have been developed assuming that public health crises would be short-term and fairly localized in scope. Limited disease outbreaks would allow governments and public health officials to mobilize resources from elsewhere, if needed. Further, small outbreaks would permit health-care providers to utilize standard protocols for making decisions about care. Yet, major disease pandemics and epidemics rarely unfold as short-term, localized events; rather they manifest as health crises that prevail for months on end with the potential for widespread transmission and overloading existing health-care systems. Therefore, numerous international, national, regional, state, and local entities have recognized the vulnerability of hospitals, long-term care facilities, home health-care services, and congregate detention facilities and their limited capacity to respond to large-scale pandemics and the surges that often accompany them (Kaiser Family Foundation, 2020; Kapiriri & Ross, 2020; Kinney et al., 2009; Klonsky, 2020; Rosoff, 2008; The Marshall Project, 2020; Wilson, 2020; World Health Organization, 2009). These limitations in capacity are only exacerbated in poor and under-resourced countries and communities where existing disparities in access to and delivery of health services to vulnerable and marginalized groups are accentuated during times of crisis (Kapiriri & Ross, 2020; Rosoff, 2008; Wilson, 2020).

Further complicating societal responses to the outbreaks of infectious disease at all geographical scales are what Kapiriri and Ross (2020) identify as the *politics of pandemics* – the political processes and politicking that underlie public health decisions. They emphasize that numerous ethical and political implications are embedded in the decisions that societies make to address pandemics. During this past decade, we have witnessed societies across the globe navigating the tensions between a neoliberal order and rising populism – either of which can undergird the politicking shaping these responses. Moreover, Kapiriri and Ross (2020) stress that the inherent complexity underlying these decision-making processes is often ignored by both medical and political stakeholders. The literature suggests at least eight sets of decisions are affected by the politics of pandemics. These include: (1) negotiating for and securing adequate funding for public health preparedness; (2) coordinating multifaceted response efforts across an array of stakeholders at various levels of government; (3) staffing the essential workforce needed to provide both health-related services and essential goods and services; (4) ensuring the undisrupted operation of critical supply chains; (5) balancing finite resources across public health and economic spheres; (6) funding advanced state-of-the-art research, technology, and analytical capacity to combat infectious disease; (7) providing adequate resources to mitigate disease transmission; and (8) preparing for the

possibility of responding to concomitant public health disasters (see "Covid-19: The Politics of Pandemics," 2020; Jain et al., 2018; Robbins & Freeman, 2018; Smith & Fraser, 2020; World Health Organization, 2009).

As McKibbin (2020) notes in his recent article on the global macroeconomics of the coronavirus,

> World governments did not learn the right lessons from past outbreaks of disease and we are paying for it now as we cope with COVID-19. We have invested too little in public health and disease prevention, particularly in poor countries, given the potential economic (as well as human) costs of pandemics. (para 1)

Over the past 4 months, we have witnessed numerous examples in the United States and elsewhere of the politics of pandemics. These are manifest is the repetition of past governmental mistakes leading to delays or uncoordinated responses; the proliferation of contradictory or inaccurate public health information particularly via social media; the inadequacy of testing capacity, disease tracking, and obsolete public health infrastructures; shortages in the supply of personal protective equipment; and inadequate workplace protections to ensure the health and safety of essential workers (see discussion in Kapiriri & Ross, 2020; Shear et al., 2020; Smith & Fraser, 2020).

One of the greatest challenges that has resurfaced in light of the coronavirus pandemic is the lack of a worldwide universal commitment regarding access to health and public health services as a human right for all. This lack of commitment, in itself, is one illustration of the politics of pandemics. In numerous countries around the globe, including the United States, access to health care is not guaranteed; rather it is a commodity purchased by those who have insurance or the ability to pay while others are excluded. The politics of pandemics also play out in terms of commitments to global health. During the past several decades, global and national budgets have seen significant reductions in public health emergency preparedness funding and commitment to global health initiatives, particularly from nations such as the United States where local health departments have cut 56,360 jobs since the great recession of 2008 ("Covid-19: The Politics of Pandemics," 2020; Hall et al., 2018; McKibbin, 2020; Smith & Fraser, 2020).

Despite the work of nongovernmental organizations, such as the World Health Organization, to improve detection, prevention, and response to large disease outbreaks, the politics of pandemics are underscored by the void in strategic global leadership to implement these initiatives, most notably from the United States in recent years. Further, any commitments to recognize health services as a human right need to be scaffolded by policies that enable all citizens to safely access them. As Jain et al. (2018) note, large disease outbreaks often occur "in settings where prolonged civil unrest has destroyed or prevented the capacities for disease surveillance and response" (p. 317). Thus, the politics of pandemics are often intertwined with efforts to support sustainable peace in conflict-ridden areas.

In the United States and elsewhere, we are confronting a world shaped not only by the politics of pandemics but also by the *politics of pandemonium*. Pandemonium is defined as wild and noisy disorder or confusion (Merriam-Webster's online dictionary, n.d.). In the midst of this pandemic, it is clear that communication from some political leaders has added to the disorder and confusion experienced within nations and communities. Most disconcerting in the midst of the current coronavirus pandemic, however, is the heightened risk of political strong men using the distraction of the pandemic *and* political pandemonium to seize power at the expense of the people they govern. A recent article in *The Economist Today* ("A Pandemic of Power Grabs," 2020), suggests the "rulers everywhere have realized that now is the perfect time to do outrageous things, safe in the knowledge that the rest of the world will probably not notice" (para 1). These

concerns are echoed by groups such as Human Rights Watch (2020) who underscore the need for:

> … careful attention to human rights such as non-discrimination and human rights principles such as transparency and respect for human dignity can foster an effective response amidst the turmoil and disruption that inevitably results in times of crisis and limit the harms that can come from the imposition of overly broad measures. (para 3)

As a profession that advances human rights and social justice, we are obligated to stand up and challenge any human rights abuses.

So where is social work, community practice and social action in the midst of all of this? In a joint statement from the Council on Social Work Education, the National Association of Social Workers, and the Association of Social Work Boards (see CSWE, 2020), the social work profession recognizes COVID-19 as "a crisis of social injustice, inequitably affecting vulnerable populations that include among others, individuals who earn low incomes or are incarcerated, homeless, in foster care, older than 65, people of color or undocumented" (para 1). Subsequent website posts and eblasts from these entities to stakeholder groups enumerate the myriad ways in which social workers are considered as integral members of the essential workforce responding to this public health crisis. Additionally, recent works by Wilson (2020) and Walter-McCabe (2020) contend that our social work values and ethics challenge us to illuminate structural inequalities and promote systemic change. The CSWE statement goes on to emphasize the need to "change policies that perpetuate inequities in our health-care system (CSWE, 2020, para 7)" and concludes that "policy makers must ensure that economic recovery is a shared recovery for all Americans (CSWE, 2020, para 9)."

At the global level, the International Federation of Social Workers (IFSW) has underscored the important role that social work has played in advocating in support of keeping social services open and available as well as in adapting treatment modalities to meet existing needs during the pandemic. Moreover, IFSW maintains is strong emphasis on community-based work. IFSW Secretary-General Truell notes that "in countries with "weak state-provided health and social service infrastructures, social workers are focused on community development approaches, providing education and promoting community responsibility (Truell, 2020, para 4)." Truell continues to draw attention to the need for ongoing social work involvement in post-recovery development efforts. He challenges social work to envision longer-term solutions in rebuilding efforts that focus on eradicating the conditions promulgating infectious diseases as well as supporting activities that foster human rights, equality, and sustainability (see para 6–8). A recent update from IFSW (see International Federation of Social Workers [IFSW], 2020) underscores the role that the profession has played, particularly in less-developed countries, in supporting community-level efforts in the fight against COVID-19. Integral to this support is the inclusion of the most vulnerable members within a community in planning and response efforts; organizing communities to ensure access to basic essentials; advocating for continued access to services for all members of the community; supporting community efforts to maintain physical distancing as well as social solidarity; and advocating for improved health and social service delivery systems as vehicles for promoting health and reducing social inequalities. Work by Pyles (2007) and Santiago et al. (2014), similarly underscore the role of community practice in mitigating community crises and community organizing in post-disaster recovery efforts. U.S.-based efforts would be strengthened if we adopted many of the community development/redevelopment strategies used by our colleagues across the globe.

How engaged and prepared is the profession to respond to this charge of promoting systemic change? Previous work has documented both the ambivalence of social workers to actively engage in the political process and the lack of professional training to do so (De Corte & Roose, 2020; Fisher, 1995; Golightley & Holloway, 2019; Hall, 2007; Lane et al., 2018; Lane & Pritzger, 2018; Reisch & Jani, 2012). Relatively few social work training programs expend significant resources in educating social workers for advanced advocacy work or elected office (Lane et al., 2018; Lane & Pritzger, 2018). Further, macro practitioners, like Reisch, Jani, De Corte, Roose, Santiago, and others, have questioned the extent to which the social work profession, in the United States at least, has surrendered its commitment to social justice and political engagement and replaced it with an emphasis on micro practice and individual therapy. Hall (2007) simply asked if social workers actually cared about addressing the systemic challenges to addressing HIV/AIDS. Moyo (2010) asserts that "social workers are in the business of maintaining the status quo rather than undoing injustices or confronting injustices" (p. 6). He further observed that the profession's devotion to social justice was more about a "commitment to clichés" (p. 6). In more recent work (Moyo, 2018), he suggests that societies with prescribed winners and losers are antithetical to social welfare that is premised on well-being for all. Reisch and Jani (2012) maintained that the depoliticization of the social work profession accentuates the disconnect between the call to action depicted in the NASW Code of Ethics (National Association of Social Workers, 2017) and the rhetoric emanating from the profession's regulatory boards. As De Corte and Roose (2020) emphasize, "a long-standing critique of social work is that it is 'a dog that doesn't bark' meaning that social work doesn't live up to the challenge of changing unjust policies, and as such is merely an affirmative practice of the status quo" (p. 228). *Given the gravity of the coronavirus pandemic in the midst of political chaos, is the profession willing to confront the status quo that contributed to our current circumstances? Is it ready to seek new ways of ensuring structures of opportunity that promote the health and well-being of all?*

So where do we go from here? Given our colliding realities of the politics of pandemic and the politics of pandemonium, perhaps our *From the Archives* articles in this issue provide some guidance and future direction for community practice and social action. These accounts and the accompanying commentaries by Paul Stuart revisit the political and community activities led by two highly influential social work leaders, Lillian Wald and Belle Moskowitz, during a time in U.S. history when the politics of pandemic and the politics of pandemonium also collided. In less than two decades, the world would confront the 1918 Influenza Pandemic, World War II, the collapse of global financial markets with the Wall Street Crash of 1929, and the Great Depression. Wald, a settlement worker and a nationally known nursing and social work leader, was tapped to lead public health responses to the 1918 Influenza Pandemic in New York City. Working through the Nurses Emergency Council, Wald and colleagues mobilized nurses and community volunteers to provide community-based nursing and home care, community education, and after care treatment and disease surveillance stations.

What was particularly striking in this effort was the inclusion and integration of community workers like Wald in public health efforts from the onset and the ability of the Nurses Emergency Council to quickly galvanize health-care workers, ordinary citizens, and financial resources to efficiently and effectively respond to the pandemic. After care treatment and disease surveillance stations, which monitored cases by city districts, as well as the emphasis on community-based nursing, were some of the innovations introduced by Wald and the Nurses Emergency Council. Reading of the work by Wald and colleagues led us to ponder: *To what extent have social workers and*

community practitioners sought to be part of interdisciplinary community-level responses to pandemics like COVID-19? How have we utilized our community organizing skills to galvanize effective and efficient responses to the pandemic? To contest the politics of pandemonium?

Belle Moskowitz, a contemporary of Lillian Wald and also a former settlement worker, is one of the pioneers of political social work in the United States. Her rise to political power corresponds with the emergence of progressive politics and the efforts of social reformers beginning in the early 1910s. Prior to serving as Al Smith's political advisor, Moskowitz served as a dispute mediator between labor unions and employers as well as a consultant, industrial mediator, and advisor. Her political action work coincided with the period between the end of World War II and the Influenza Pandemic and the Great Depression. As Al Smith's campaign manager, she was actively involved in promoting increased political participation through voting. She also was instrumental in facilitating the broad social reforms adopted in New York by Al Smith during his governorship in the 1920s that would later serve as the foundation for the New Deal legislation enacted under President Franklin D. Roosevelt.

Moskowitz's life and career illustrate how social workers and the social work profession in general can benefit from learning how to use the forces of political action to bring about systemic change. Considering social workers as "prophets, the cranks of one generation moving the next to action" (Moskowitz, 1923, p. 112-120), she advocates for greater political participation by social workers and the larger citizenry in order to demand justice and promote the health and well-being of all. Given the relative newness of women's suffrage and the preponderance of women in social work, her speech encouraged the active participation of women in shaping the political party platforms to include social issues they confronted in their daily work. Yet, her work also underscored the need to seek new and alternative solutions and systems to addressing contemporary social problems. *In what ways are social workers and community practitioners being called to serve as the prophets of our times?*

Social workers and, in particular, community practitioners can be mindful of the lessons of the 1918 Influenza Pandemic and how it overlapped with an era of progressive politics that eventually led to the New Deal. At the same time, we encourage the profession to consider how we might extend our work to incorporate more of a human rights-based approach (see Ife, 2001) to our practice as we confront what might arguably be the greatest global challenge of the past century. Below, we share a few examples of community organizing and practice from Detroit in response to the COVID-19 pandemic and we hope that you will share yours in future issues of the *Journal of Community Practice*.

In anticipation of the spread of COVID-19 to the State of Michigan, the People's Water Board, a coalition of community, environmental, faith-based and labor organizations, including the Michigan Welfare Rights Organization (MWRO), sent a letter to Gov. Gretchen Whitmer in February 2020 asking her to restore water services to the approximately 3000 to 9000 households that experienced shut offs in Detroit. Initially, the Governor's Office indicated there was no evidence that state intervention was warranted. However, on March 10, 2020 – the day Michigan announced its first confirmed COVID-19 cases – she issued an order to restore water service and found the resources to pay for it. For over 15 years, this community coalition had been the prophetic voice warning political leaders of the danger that thousands of households without access to running water during a public health pandemic presented to affected households and the community at large. In response to the governor's order, the MWRO immediately set up a "community command center" to provide affected residents with

the necessary information to restore their water service as well as coordinated the delivery of water to families until their water service was restored.

The pandemic has disrupted already fragile food security systems in Detroit as well. In low-income neighborhoods throughout the city, children receive two meals a day provided at school even during the summer recess. When the COVID-19 pandemic and stay at home orders closed all schools, arrangements were made that enabled families to pick up meals for their children. Numerous families were either afraid to leave their homes or lacked access to transportation to come to school-based sites, so the City of Detroit agreed to host meal distribution services at community recreation centers. Similar disruptions occurred with the cessation of congregate meals for older adults and for homeless individuals at various community centers. Out of necessity, food distribution activities moved from congregate meals to take away lunches for those who are homeless or to some type of door-to-door delivery for food insecure older adults.

Local government and community nonprofit organizations have moved community engagement and information activities normally provided at town halls to online formats with dedicated call-in numbers. These digital formats support calls targeted to council district leaders as well as calls hosted by community development organizations assisting city residents on how to access health, food security, and social services during the pandemic and moving forward in the recovery period. Community practitioners, long used to door-to-door contacts in the community, have struggled with figuring out ways to disseminate information to the greatest number of residents in the midst of stay at home orders. For some organizations and groups, however, this has led to the implementation of information and referral hotlines dedicated to supporting social service workers and the clients they serve. Other hotlines provide community members with direct access to service providers. In a separate act of solidarity echoing Moskowitz, organized labor unions in Detroit have moved to digital organizing via confidential hotlines to support worker's rights as well as protect their occupational health and safety during the COVID-19 pandemic.

The examples described above illustrate potential options for reimagining the relationships between institutions, the community, work, and home. Underpinning several of these community responses was the recognition that access to water and food was a basic human right – a stance sorely needed in communities like Detroit where disparities in health and well-being are great and opportunity structures are few. These examples also illustrate Ife and Fiske's (2006) appreciation that "human rights are experienced in the local context" (p. 302). Having water restored in a household has much greater meaning than a legal decree that goes unenforced. Ife (2001) and Ife and Fiske (2006) contend that a human rights-based perspective provides a valid values framework for community work since it emphasizes the use of a bottoms up approach as well as attempts to redress existing structures of disadvantage. In our current environment where we are surrounded by the politics of pandemics and the politics of pandemonium, Ife (2018) emphasizes the need for "principled activism based on values of social justice and human rights" (p. 121) that counters both the excesses of neoliberalism and provides alternatives to populist notions of dystopia.

There are some clear policy and practice implications that emanate from our discussion. We offer these with the understanding that the world continues to grapple with the spread of the COVID-19 pandemic and there are many unknowns as we rush to develop a vaccine but also plan for resurgences of the disease until it is developed. We also acknowledge the difficult time ahead as countries around the world transition to the recovery phase and new ways of community life. Yet, we believe that the suggestions

below offer ways in which to minimize if not avoid the missteps we have seen to date in our responses to COVID-19 and other 21st century pandemics.

First, it is time for the United States and countries across the globe to commit to and invest in public health as a fundamental human right. All members of society need access to care that includes health prevention, promotion, and treatment; timely testing and contact tracing for infectious disease mitigation; access to vaccines and immunizations; and access to sanitation systems and safe, potable drinking water. Community practitioners can and should play a role in health education and promotion, community development of resources to provide care, sanitation, and water systems, and serve as integral members of public health teams engaged in emergency preparedness planning.

Second, in countries like the United States, where education and food security systems are inextricably linked, we need to rethink food access points. This could mean relocating food security systems within other community-based institutions to more nimbly address food needs when schools or community centers close. Additionally, we could restore funding and increase eligibility to supplemental nutrition programs such as Supplemental Nutrition Assistance Program (SNAP) and the Supplemental Nutrition Program for Women, Infants, and Children (WIC) so families had more food at home. Community practitioners need to work with public, private, and nonprofit organizations to reimagine alternative ways of improving access to healthy foods across the lifespan.

Third, in situations where schools and non-essential businesses are closed for extended periods of time, it is imperative that we utilize digital technology to expand opportunities for student learning and to facilitate remote work. Community practitioners need to press for solutions and foster community collaborative endeavors that reduce the digital divide between those who have access to technology and internet bandwidth and those who do not.

Fourth, community practitioners need to advocate for the rights and safety of workers who are unable to work remotely. Social protections ranging from paid sick leave, expanded unemployment benefits, and universal basic income guarantees are policy tools that may be leveraged to increase economic security for the next pandemic or disruption. Additionally, communities need to ensure that essential workers are guaranteed appropriate compensation and working conditions that protect their health and well-being, including having adequate supplies of personal protection equipment, reducing densities of exposure via social distancing, heightened sanitary practices in the workplace, and providing universal testing, paid sick leave benefits when workers fall ill because of disease outbreaks on the job.

Finally, community practitioners and the social work profession in general need to be mindful of potential power grabs by political leaders during times of pandemics. Specifically, we need to pay attention to who is included as well as who is being excluded in potential remedies, organize with our communities to address inequities, and advocate for policies that support all. Additionally, we need to pay attention to attempts to pass legislation when politicians believe the citizenry is not watching particularly when proposed measures erode basic human and legal rights. Further, community practitioners and social workers, in general, need to rigorously challenge efforts aimed at suppressing the right to vote, particularly in vulnerable and marginalized communities. Community practitioners should utilize all of their community organizing skills, including digital organizing networks, social media, and access to big data sources, to serve as community watchdogs and advocates for efforts that promote increased participation of all within our political systems.

Although all of our articles in this issue were written prior to the circumstances in which we find ourselves today, they provide insights into daily life, particularly for some

of the most vulnerable members of communities. One of the common themes across the articles is the call to social action to advance human rights. Our first article explores how the call to action is manifest in power dynamics across space in different global and local contexts (Wathen). This theoretical exploration of child welfare reform in Russia raises questions about globalization and neoliberalism that we must address in face of the global pandemic. Next, a case study on the work of NGOs in North Macedonia among the sexual and gender minority (SGM) communities shows that despite success, more work could be done to include SGM Roma populations in movement building (Stojanovski and colleagues). Our third article documents how social movements have used digital organizing to take back power and control of critical conversations related to gender-based violence (Storer & Rodriguez). Our two *From the Field* articles describe practical ways of engaging different stakeholders in social action or social justice. Specifically, the Unity Wall Project provided an opportunity for community members to publicly voice feelings on race relations (Ruggiano and colleagues). Design dialogs were used to engage middle school youth in imagining a future for their neighborhoods (Bruna and colleagues). We hope that you find them to be useful in your teaching, research, and practice.

As we move forward in these uncertain times, may you and yours stay well and safe.

Disclosure statement

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