



DOCTORS
WITH AFRICA
CUAMM



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A DECENT LIFE FOR ALL





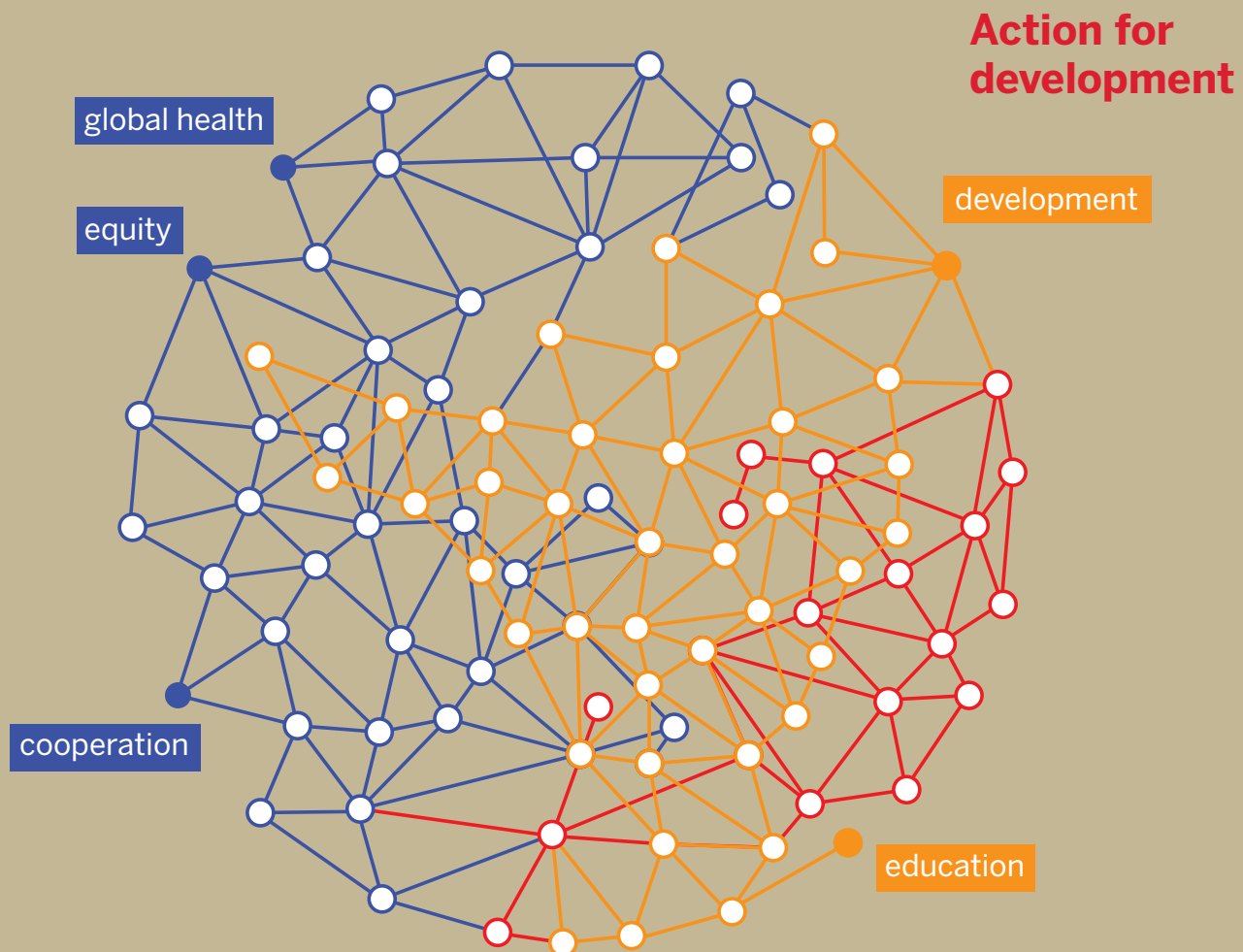
NEWS

“A decent life for all”

On the 1st of February 2014 the international conference “A decent life for all: Equal opportunities for health. Action for development” was held in the Palazzo del Bo, Padua. It was organized by Doctors with Africa CUAMM as one of the activities of the European project *Equal opportunities for health: action for development*. This edition of *Health and Development* is entirely dedicated to the topics discussed during the conference and contains articles written by the speakers.

FIGURE / THE ADVERTISEMENT FOR THE CONFERENCE “A DECENT LIFE FOR ALL: EQUAL OPPORTUNITIES FOR HEALTH. ACTION FOR DEVELOPMENT”

A decent life for all: equal opportunities for health



February 1st 2014

www.mediciconlafrica.org/adecentlifeforall

INDEX

EDITOR

Gavino Maciocco

EDITORIAL STAFF

Andrea Atzori, Egidio Candela, Dante Carraro, Adriano Cattaneo, Donata Dalla Riva, Silvio Donà, Serena Foresi, Fabio Manenti, Luigi Mazzucato, Giovanni Putoto, Angelo Stefanini, Anna Talami

EDITOR-IN-CHIEF

Anna Talami

OWNERSHIP

Medici con l'Africa CUAMM

ADMINISTRATION

Via S. Francesco, 126 - 35121 Padova
t 049 8751279-8751649
f 049 8754738
e-mail cuamm@cuamm.org

EDITORIAL COORDINATION

Chiara Di Benedetto, Davide Pocchiesa

EDITORIAL SECRETARIES

Elisa Bissacco, Francesca Forzan

CREATIVE IDEA AND COVER ILLUSTRATION

Ramon Pezzarini

LAYOUT AND PRINTING

Publistampa, Via Dolomiti, 36 - 38057 Pergine Valsugana (Trento)

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Joanne Fleming, Louise Allan

Cover illustration by Ramon Pezzarini.
"A decent life for all", ending poverty to give the world a sustainable future. But what role does health play in European and international guidelines on sustainable development goals?
Can there be a "decent life for all" without active participation by health providers and without equal opportunities to access healthcare?

DIALOGUE

PAGE 2

TRAINING HEALTH PROVIDERS **FOR GLOBAL CHALLENGES**

Text by / Dante Carraro

PAGE 3

THE STRENGTH OF **IDEAS**

Text by / Gavino Maciocco

FORUM

PAGE 6

EU DEVELOPMENT POLICY ON THE HORIZON FOR 2015

Text by / Franco Conzato

PAGE 7

THE EU RESEARCH PROGRAMME **HORIZON 2020**

Text by / Gianluca Quaglio

PAGE 8

UHC. **WHY IT TAKES A GLOBAL SOCIAL PROTECTION REGIME**

Text by / Gorik Ooms

EXPERIENCES FROM THE FIELD

PAGE 12

BEST PRACTICES: EQUAL OPPORTUNITIES FOR HEALTH

Text by / Chiara Cavagna

PAGE 14

INTERNATIONAL **HEALTH COOPERATION**

Text by / Giovanni Putoto

PAGE 15

TEACHING GLOBAL HEALTH **IN ITALIAN UNIVERSITIES**

Text by / Gavino Maciocco

PAGE 16

SISM AND TEACHING GLOBAL HEALTH

Text by / Samantha Pegoraro

TAKING A CLOSER LOOK

PAGE 17

WHO AND THE RIGHT TO HEALTH: WHICH FUTURE

Text by / Adriano Cattaneo

REPORT

PAGE 18

TEACHING GLOBAL HEALTH **IN EUROPE**

Text by / Carlo Resti



DIALOGUE

TRAINING HEALTH PROVIDERS FOR GLOBAL CHALLENGES

Health today is global, because the globalization processes that have shaped economics, finance and communications over the last three decades have also affected numerous aspects of health. Training health providers to deal with new scenarios is a challenge that is both difficult and fascinating.

TEXT BY / DON DANTE CARRARO / DIRECTOR OF DOCTORS WITH AFRICA CUAMM

The important three-year project, co-financed by the European Union, *Equal opportunities for health: action for development*, came to a close at the end of February. The academic celebration of the results achieved and of the best practices in Global health took place on the 1st of February in the University of Padua, at the International Conference "A decent life for all: equal opportunities for health. Action for development".

134 courses on Global health, 46 accredited course for health professionals, 1600 professionals trained, 13 training of trainers, 303 lecturers trained, 70 international conferences, 15,000 people receiving the magazine Health and Development. Exciting results made possible by a formidable network involving institutions and health associations in 6 European countries besides Italy: Bulgaria, Latvia, Malta, Poland, Romania and Hungary. Our country has seen the active participation of the Italian Observatory on Global health (OISG), the Italian Network for Global health Teaching (RIISG), the National Federation for the Orders of Doctors and Dentists (FNOMCeO), the Italian Secretariat of Medical Students (SISM) to name but some, all coordinated by Doctors with Africa CUAMM.

Today, more than ever before, health is global! Global, because the globalization processes that have shaped economics, finance and communications over the last three decades have also affected numerous aspects of health. The speed and intensity with which risk factors of communicable and non-communicable diseases (such as obesity) can spread throughout the planet; the consequences linked to exploiting natural resources and the use of energy sources resulting in climate change and food and water shortages; market-oriented health policies and privatization of services, driven by international institutions like the World Bank and the World Trade Organization; pressure on population masses, including health providers, to migrate from one country to another and from one continent to another.

Besides its geographical connotations, the term global also refers to the complexity and scale of problems and issues that play a role in disease pathogenesis and in health protection strategies. Likewise, Global health encompasses the social determinants of health, the causes of the causes (economic, political, environmental, etc.) of diseases, and the intersectoral and multidisciplinary interventions required, as indicated, almost prophetically, in the Alma Ata Declaration of 1978. These topics and disciplines have been incorporated into a specific training programme in Italian and European universities, by adding a defined and shared standard Global health curriculum, with four separate modules. The first addresses inequalities and social determinants of health, hence changing from a biomedical model of medicine that privileges the individual doctor-patient relationship totally concentrated on the etiopathogenesis, diagnosis and treatment of disease to a biopsychosocial model of medicine, in which the physical, mental and social factors of health are considered, also giving importance to the increasing globalization of the community and the surrounding environment. The second module addresses the origin and development of different health systems, helping to understand how health protection (or the lack of it) as a right for all and not as a privilege for the few comes into play in these systems. The third focuses on the multidisciplinary and globalization of health: subjects such as demographics, economics, epidemiology, economic policy and sociology thus become essential. The fourth module addresses the important topic of health in migrant populations. Training, particularly aimed at students and health professionals, has been structured and promoted around these complex issues. We have also dedicated a special website with updated bibliography and sitography organized according to thematic areas and the four-monthly publication Health and Development, a scientific information tool on public health policies and international cooperation issues.

The intention is not to add further technical and scientific notions to the already vast knowledge of the health professional, but rather to bring about a change of culture, approach and mentality, which must take place, as advocated by the Royal College of Physicians¹ and the British Medical Association², by focusing and taking action on the causes of the causes of health in the doctor's day-to-day practice.

This is a formidable and difficult challenge, which makes it all the more fascinating.

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¹ Royal College of Physicians, *How doctors can close the gap*, 2010.

² British Medical Association, *Social Determinants of Health - What Doctors Can Do*, 2011.



DIALOGUE

THE STRENGTH OF IDEAS

The Erice courses, held in Sicily in 2001 and 2008, which involved doctors, researchers, university lecturers and voluntary work representatives, were a breeding ground for ideas and projects on the topic of Global health. The project *Equal opportunities for health: action for development* also has its roots there.

TEXT BY / GAVINO MACIOCCO / DEPARTMENT OF PUBLIC HEALTH, UNIVERSITY OF FLORENCE

From 22-26 March 2001, a residential course entitled - *Flussi migratori e politiche per la salute* (Migration flows and health policies) - organized by SITI (Società Italiana d'Igiene) was held in the Ettore Majorana Centre in Erice, Sicily. The course closed with a Declaration addressed to civil society and the scientific community, drawn up and signed by doctors, researchers, university lecturers and voluntary work representatives, some passages of which are set down below.

"Never as today has Humanity suffered through such vast and increasing inequalities of income and health. And yet it was not so long ago that Humanity seemed to be moving in the direction of greater justice between peoples and implementing the principles solemnly proclaimed in the Universal Declaration of Human Rights (1948). These principles also include the right to health. Just over 20 years ago, the World Health Organization launched the campaign "*Health for all by the year 2000*" and reasserted that 'good health – as a state of complete physical, social and mental well-being, and not merely the absence of disease or infirmity – is a fundamental human right, and that access to the highest level of health is an extremely important social objective' (Alma Ata Conference 1978). The journey towards greater justice among peoples and globalization of rights seems to have been interrupted. Globalization of current times concerns finance and economics. It is no coincidence that the World Bank has taken over from the World Health Organization in indicating – and in certain cases dictating – international health policies, namely those of user fees in health care, privatization of services and of insurance: in a word, health as a commodity, available to those who wish, but above all to those who have the means, to purchase it". (...)

"The scientific community – and in particular those responsible for producing culture, education and research – has the duty to address topics of equity, sustainable development, protection of human dignity and life in a widespread and systematic manner. These topics cannot be allowed to remain the subject of negotiations "behind closed doors" in international summits, or of news reports. There is an increasing need for in-depth studies, for independent evaluations, for widespread transmission of information and knowledge, and therefore schools and universities can no longer distance themselves from this duty".

A few years later, from 14-18 April 2008, during another SITI course held in Erice – *Globalization and Inequalities in Health* – there was the opportunity to bring the discussion up to date and redefine goals. Among others, the final document contains the following passages:

"The scientific community – in particular those responsible for producing culture, education and research – has the duty to address topics of equity, sustainable development, protection of human dignity and life in a widespread and systematic manner, and to speak out about the terrible and growing imbalances that afflict our planet, also and above all in the health sector.

Faculties of Medicine and other university, health and research structures involved in training in the health and social sectors have the duty to be more open to the topics of "global health", to improve the quality of the educational offer, to strengthen the skills of health providers and to stimulate their role as defenders and promoters of the right to health.

Implementation of the right to health requires the action of multiple social and economic sectors. It also requires guaranteed access to essential health services for all, without economic barriers: failure to respect this principle causes millions of deaths every year, above all among the most vulnerable population groups, and plunges millions of families into misery.

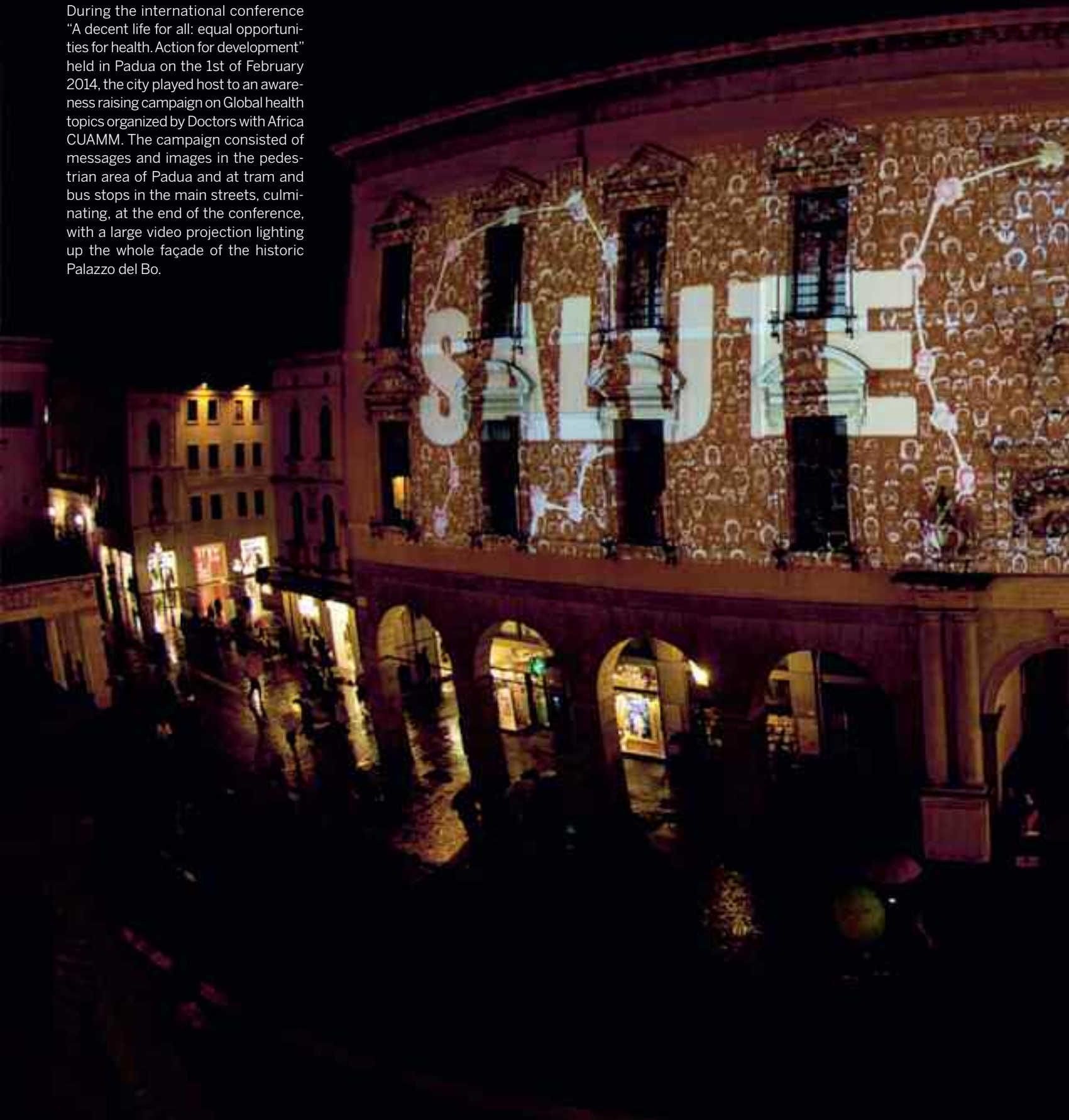
The fight against health inequalities must be considered a fundamental strategy for improving the state of health of the population. In fact, social health inequities indicate the extent of improvements possible, as they show which groups have reached the highest possible health standards and also indicate the ability of other groups to develop their health potential at that specific time".

The Erice courses held in 2001 and 2008 were a breeding ground for ideas and projects on the topic of Global health, giving rise to discussions on how they could be taught in university classrooms. The project *Equal opportunities for health: action for development* also has its roots there.



GLOBAL

During the international conference "A decent life for all: equal opportunities for health. Action for development" held in Padua on the 1st of February 2014, the city played host to an awareness raising campaign on Global health topics organized by Doctors with Africa CUAMM. The campaign consisted of messages and images in the pedestrian area of Padua and at tram and bus stops in the main streets, culminating, at the end of the conference, with a large video projection lighting up the whole façade of the historic Palazzo del Bo.







EU DEVELOPMENT POLICY ON THE HORIZON FOR 2015

An important European Commission communication from 2012 adopted by the European Council is aimed at paving the way for the challenges the EU's development policy will have to tackle in view of the 2015 deadline, while the international community will be called on to establish the new global development goals.

TEXT BY / FRANCO CONZATO / DEPUTY HEAD OF UNIT - EUROPEAID, EUROPEAN COMMISSION

In 2012 the European Council adopted the European Commission's communication "Increasing the impact of EU Development Policy: an Agenda for Change".

The communication falls within the complex and difficult discussion, concluded at the end of 2013, on the 2014-2020 Union budget. The Commission's proposal was to allocate around € 50 billion to development aid, to be used over the next seven years in Sub-Saharan Africa, Asia and Latin America. It should be mentioned that, through the Commission, the European Union is responsible for 20 percent of all European aid and that, together with its 28 Member States, it provides over 50 percent of world aid.

The communication is aimed at paving the way for the challenges the EU's development policy will have to tackle in view of the 2015 deadline. For that date, the international community, represented by the United Nations, will be called on to establish the new global development goals to replace the current millennium goals.

Without prejudice to the European Union's main goal of eliminating poverty in a context of sustainable development, the agenda identifies two specific goals at which cooperation should be aimed:

- supporting human rights, democracy and good government;
- promoting inclusive economic growth sustainable for human development.

Added to this is the fact that these goals must be accompanied by coordinated action by the Union, in order to reduce aid fragmentation and aimed at consolidating joint planning processes between the EU and member States. Moreover, EU aid must be limited to a maximum of three sectors of intervention for each country.

A differentiated approach has been applied to middle income countries (such as Costa Rica, Malaysia, Kazakhstan) or emerging countries (Brazil, China, India) that have sufficient internal resources to combat poverty. This consists of limiting aid funds

for these countries to only regional and thematic programmes (e.g. funding to support global public assets and in particular challenges related to climate change or funds allocated to support the actions of civil society and local authorities), excluding them from the bilateral programmes they enjoyed in the past. This will allow an increase in funding to fragile countries.

Inclusive and sustainable growth, health, education and energy and food safety are the key goals and sectors the European Union aims to support in partner countries. Other priority areas of intervention are reforms in the public finance management, justice and security sectors.

The EU and member States are involved in joint planning actions in around 40 countries. The establishment of the European External Action Service (EEAS) with headquarters in Brussels in 2010 offered a new and important opportunity to make development cooperation between the EU and its member States more effective.

One important aspect addressed by the Commission's communication is the emphasis placed on reporting results. The Commission has published a *Staff Working Document*¹ to illustrate the reporting process for the results of cooperation activities obtained at global level.

Finally, it should be mentioned that during 2013 the Commission issued the following specific communications aimed at strengthening its aid policies in the priority sectors indicated above, which can be consulted on the website:

http://ec.europa.eu/europeaid/index_en.htm.

- A decent Life for All: Ending poverty and giving the world a sustainable future;
- Enhancing Maternal and Child Nutrition in External Assistance: an EU Policy Framework;
- Empowering Local Authorities in partner countries for enhanced governance and more effective development outcomes.

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¹ *Paving the way for an EU Development and Cooperation Results Framework*, Commission Staff Working Document, 2013.



THE EU RESEARCH PROGRAMME HORIZON 2020

With a budget of € 78 billion, *Horizon 2020* is the EU's main instrument for funding research over the seven years 2014-2020 and includes three main pillars: *excellent science*, *industrial leadership* and *societal challenges*.

Any business, university, research centre or NGO can participate.

TEXT BY / GIANLUCA QUAGLIO / EUROPEAN PARLIAMENTARY RESEARCH SERVICES, BRUSSELS

Horizon 2020 represents the EU's main instrument for funding research and has a duration of 7 years (2014-2020). H2020 has a budget of around € 78 billion, which, although significantly higher than the previous programme (FP7), is still less than many, in particular the scientific community, had hoped for. One of the key features of H2020, compared to previous programmes, is that the rules for participants have been simplified, launching calls for proposals with a validity of two years (as opposed to one year), making it easier to better prepare the content of the application, with topics that are less specific and more open, promoting a more bottom-up approach. Briefly, the programme is divided into the following three main pillars:

- excellent science
- industrial leadership
- societal challenges.

THE THREE MAIN PILLARS OF HORIZON 2020

The **excellent science** pillar aims at elevating European scientific research by supporting the best research and innovation ideas, facilitating access to research infrastructures, making the European continent an attractive place for researchers. This will be implemented by funding granted by the European Research Council (ERC), through support for future and emerging technologies (FET), offering researchers training and mobility opportunities (in the European research space) through "Marie Curie" actions, offering more easily accessible world class research infrastructures.

The **industrial leadership** pillar aims at making Europe a more attractive place to invest in research. Private investment in research in Europe is considerably lower than, for example, the United States, but also other countries. European companies will be provided with new funding instruments, helping them to play a more active role in research and innovation.

The **societal challenges** pillar addresses policy priorities of the Europe 2020 strategy. This part of H2020 will bring together resources across different fields and disciplines. Funding will be concentrated in the following areas: 1) health, demographic

change and wellbeing; 2) food security, sustainable agriculture, marine research and bioeconomy; 3) secure and efficient energy; 4) green and integrated transport; 5) climate, resource efficiency and raw materials; 6) inclusive and secure societies.

H2020 promotes the participation of a wide variety of players and stakeholders. Any business, university, research centre, NGO or other legal entity established in any of the EU member states, or in an associated or candidate country can participate. Moreover, with minimum rules, participation is open to any country in the world.

The various opportunities offered by the European research programmes include, in particular, the Edctp (*European & Developing Countries Clinical Trials Partnership*) programme, which funds (among other things) clinical trials on HIV/AIDS, malaria and TB, very prevalent in the sub-Saharan area. The mission of Edctp is to accelerate the development of new drugs, vaccines, microbicides and diagnostics against HIV/AIDS, malaria and TB.

THE IMPORTANCE OF RESEARCH IN THE FIELD

The main objective of the activity of Doctors with Africa CUAMM is to strengthen health systems and accelerate improvements in the health of African people. For over sixty years Doctors with Africa CUAMM has been carrying out extraordinary treatment and prevention activities, and working to strengthen sub-Saharan African health systems. In these years, a wide range of medical, surgical and of public health activities in general have been implemented, some of which of a particularly innovative nature. However, this enormous number of activities has not always been adequately documented and shared.

Research carried out in the field, with systematic data collection (clinical, laboratory, epidemiological, etc.), allows us to better quantify and to increase the scientific visibility of the work of hundreds of doctors and nurses operating within Doctors with Africa CUAMM. Therefore, attention to research in the field must become a constant of future programmes, allowing us to better quantify what has been done and, in parallel, to increase our credibility in the eyes of local and international partners.



UHC. WHY IT TAKES A GLOBAL SOCIAL PROTECTION REGIME

Access to decent health care services is a fundamental human right. But even if all countries would make their best efforts, some would not succeed. The estimated 40 billion dollars it takes from high income countries to enable low income countries to provide decent health care is not only a legal obligation, it could also be a wise investment in high income countries' own social policies.

TEXT BY / GORIK OOMS / INSTITUTE OF TROPICAL MEDICINE, IN ANTWERP

Gavino Maciocco is correct when he writes that access to decent health care services is a fundamental human right¹. It is embarrassing to witness the unwillingness of high income countries to commit the 40 billion dollars annually needed by low income countries to provide health care services at a modest cost of 50 dollars per person per year. But it is not only embarrassing; it is also unwise and short sighted. To protect the social policies that exist in most high income countries against the downward pressure from global economic integration, a global social protection regime will be needed.

SOCIAL DETERMINANTS OF HEALTH

As the Commission on Social Determinants of Health argued, health inequalities are related to inequalities in income and power². Some causes of ill health are purely biological, but medical science can now tackle many of them. However, the benefits of medical science are unevenly shared, because the money it takes to buy them is unevenly distributed. Furthermore, many causes of ill health are the result of daily living and working conditions, which are related to social status. If we want to reduce health inequalities to differences that are beyond our collective capacity to address, we have to address inequalities in income and power.

All high income countries and most middle and low income countries rely on market competition for the distribution of income: the more your skills and assets are in demand, the higher your income will be. That may not be unfair in itself, but it means that we should not count on market forces to bring about the more equal distribution of income that is needed to address health inequalities. Furthermore, income inequality is strongly correlated with intergenerational social immobility: the poorer your parents were, the higher the chances that you will be relative poor as well, or vice versa³. That is why all of today's high income countries have adopted – mostly during the course of the 20th century – redistributive policies: after the 'primary' distribution of income by the market, states intervene. The redistribution can take the shape of financial transfers, or the shape of social services (like health care) that are distributed in accordance with needs⁴.

These redistributive policies worked quite well during the 20th century (in the countries that adopted them): inequalities in income

and health narrowed substantially, and social mobility increased. But these policies have a serious limitation: they only work within the borders of countries. This has a double negative consequence. First, national redistributive policies do not address global inequality. For example, when a clothing company based in Italy negotiates a deal with a company based in Mozambique and most of the benefits go to the company based in Italy – because of uneven negotiation power – there is no correction: the taxes paid in Italy on the profits of the cooperation do not support social services in Mozambique. Second, national redistributive policies are undergoing pressure from increasing global economic integration. The company based in Italy could relocate to Mozambique and pay taxes there. At this point, one may argue that this would be good for the Mozambican people: relocation as a form of redistribution. But the problem is that all governments are under pressure to keep tax levels low, in order to attract investment.

RACE TO THE BOTTOM?

This phenomenon is known as the 'race to the bottom': a tax and social policy competition between countries. For each government, it makes sense to lower taxation a little bit: they will lose some government revenue (and ability to pay for health care, for example), but they may lose a lot more if new investments go to other countries. But if all countries do the same, none of them has the advantage; they just follow each other on a slippery slope. Between 1993 and 2007, average corporate tax rates have gone down from 38% to 27%, globally⁴.

Not everyone agrees that there really is a race to the bottom going on. Some argue that this is a temporary phenomenon, and that over time social movements in emerging economies will force governments to increase tax and social policy, until they all reach a similar level⁵.

Whatever argument one accepts, it seems rather unwise to wait for the race to the bottom to further unravel (if one believes in race to the bottom), or to leave it to national processes that may take many decades to arrive at some 'international convergence' (if one believes in international convergence). If the purpose is to arrive at a level of social policy that is substantial enough to keep health and other social inequalities within an acceptable range, why not organise it?

A GLOBAL SOCIAL PROTECTION REGIME

Most of us think of tax and social policy as unavoidably linked to states. After all, it takes a government to make people contribute and to decide how to redistribute. But social policy existed long before the emergence of states as we know them. Social policy started within local communities, trade unions like guilds, or cities. Many present day social policy schemes still carry the marks of that history: we pay taxes that are either collected or allocated by city councils, by regional entities below the level of the state, or by the state. As citizens of the European Union, we also pay taxes that finance – albeit very modestly – redistributive policies within the European Union.

It may be difficult to imagine an international tax and social policy authority, with offices somewhere in Geneva or New York, collecting taxes from all over the world and redistributing the revenue to all parts of the world – and prioritising where it is needed most.

To move towards a global social protection regime, we can learn from so-called 'equalisation' transfers that exist within most federal countries. These are mechanisms to ensure that sub-state jurisdictions can – in spite of their fiscal autonomy and differences in the scale and profitability of their economic activity – provide comparable levels of social policy. The Canadian Constitution Act, for example, imposes equalisation "to ensure that provincial governments have sufficient revenues to provide reasonably comparable levels of public services at reasonably comparable levels of taxation"⁶. Wherever they exist, equalisation transfers create controversy and frustration. But they also are remarkably robust, as their abolition would create even greater problems.

Equalisation transfers not only keep inequality in check, they also mitigate tax and social policy competition between sub-state jurisdictions.

UNIVERSAL HEALTH COVERAGE AS A STARTING POINT

The World Health Organization proposes 'universal health coverage' as a "single overarching health goal" for the next formulation of the Millennium Development Goals⁷. But it acknowledges that "[i]n lower-income countries, where prepayment structures may be underdeveloped or inefficient and where health needs are massive, there are many obstacles to raising sufficient funds through prepayment and pooling", and that "[i]t is essential, therefore, that international donors lend their support"⁸.

The Sustainable Development Solutions Network proposes that high income countries allocate the equivalent of 0.1% of GDP to universal health coverage in poorer countries⁹. Low income, lower middle income, upper middle income and high income countries are expected to allocate at least the equivalent of 3%, 3.5%, 4% and 5% of their GDP to universal health coverage domestically.

This proposal could be the starting point of a global social protection regime that includes international transfers and minimum national efforts. It would mitigate tax and social policy competition that exists among low and middle income countries¹⁰, thus allowing them to increase government revenue and budgets for universal health coverage faster, and it would speed up international convergence of taxation and social policy, which would protect social policies in high income countries. 10 cents out of every 100 euros is a very small price to pay for all that.

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SOUTH SUDAN EMERGENCY

A few weeks after a cease-fire agreement was signed on the 24th of January by government and rebels, headed by the former Vice President Riek Machar, the health emergency among the populations in South Sudan remains high. The hospitals in Lui (Western Equatoria) and Yirol (Lake States), where Doctors with Africa CUAMM teams operate, continue to treat the injured from areas in which fighting is still taking place. The hospital in Yirol is the only point of reference for the whole region and, as well as offering primary and secondary care, it is trying to deal with the health emergency and help displaced persons, another matter of great urgency.







EXPERIENCES FROM THE FIELD

BEST PRACTICES: EQUAL OPPORTUNITIES FOR HEALTH

The three-year *Equal* project has involved 18 European partners in 7 countries (Italy, Poland, Romania, Latvia, Bulgaria, Hungary and Malta) with the aim of promoting Global health education and awareness. It will end on 28th February 2014; great results have been achieved and there are many prospects for extending the network even further.

TEXT BY / CHIARA CAVAGNA / DOCTORS WITH AFRICA CUAMM

The 28th of February is the closing date of the three-year project *Equal opportunities for health: action for development* (hereinafter abbreviated to *Equal*) involving a network of 18 European partners working together to promote Global health education and awareness.

In Italy, Poland, Romania, Latvia, Bulgaria, Hungary and Malta, medical students, doctors, nurses, trainers and university lecturers have been involved in a successful international exchange of experiences, know-how and best practices in training programmes focusing on the key concepts of Global health.

ACTIVITIES PERFORMED BY THE EUROPEAN NETWORK IN THE PAST THREE YEARS

- There have been numerous **formal and non-formal educational activities**. Each of the partner countries has organized elective university courses, training seminars for doctors and health providers, and retraining courses on teaching contents and methods for university lecturers interested in incorporating new Global health topics into their existing courses.
- **Study and research activities**: national mapping of university courses in Global health; participation in various conventions and conferences on the subject; publication of scientific articles and joint international studies.
- Creation of **awareness raising and communication tools**, aimed not only at increasing the project's visibility, but also at raising awareness and involving a wider and more heterogeneous target. In this regard, the most effective communication tools were:
 - the website www.educationglobalhealth.eu – an area dedicated to the project, in Italian and English, with different materials – shared by all partners –, updated bibliography and sitography organized according to thematic areas, from which presentation formats on key topics of Global health can be downloaded;
 - the scientific review *Health and Development*, also available both in English and Italian, in paper and online format; this is an important common information tool dealing with public health policies, Global health and international health co-operation;

- the production of documentary films, for which an international contest aimed at young European artists was promoted to encourage reflection on Global health topics also among those outside the health sector, and transmit its contents in a young and more immediate language.

RESULTS AND BEST PRACTICES OF THE EQUAL PROJECT

- The project's initial result, from which we were able to produce all those that followed, was the **building of the European network**. Right from the first meetings of partners, a heterogeneous scenario relating to Global health training experiences was immediately outlined. This resulted in important internal work to promote a shared and well-defined concept of Global health, respecting the differences of individual countries, achieved by organizing 10 training meetings – guided by international experts – with all the partners, to discuss the topics of Global health, training, contents, methods and public awareness and to define effective communication tools to reach the populations of partner countries. Through these training and mutual learning sessions, it was possible to create a common ground that facilitated increased

TABLE / ACTIVITIES AND NUMBERS IN THE THREE-YEAR PERIOD 2011-2014 OF THE PROJECT *EQUAL OPPORTUNITIES FOR HEALTH: ACTION FOR DEVELOPMENT*

GLOBAL HEALTH COURSES IN EUROPEAN UNIVERSITIES	134
ACCREDITED COURSES FOR HEALTH PROFESSIONALS	46
PROFESSIONALS TRAINED IN EUROPE	1,600
TRAINING OF TRAINERS	13
LECTURERS TRAINED	303
INTERNATIONAL CONFERENCES OR MEETINGS	70
PEOPLE RECEIVING <i>HEALTH AND DEVELOPMENT</i> IN THE PAPER AND ONLINE FORMATS	15,000

European integration, including the populations of new member states. In this regard, a lesson learned from this process was the efficacy of constant dialogue and debate in order to overcome any cultural barriers and achieve a shared vision, while respecting the specificities of individual countries.

- **Standardization of training courses.** The same activity models (training and awareness) have been replicated in all countries involved in the project, reaching important results. (see **table**).
- **Bottom-up approach: the role of university students.** Other important results were achieved thanks to the tenacity and action of university students. In this bottom-up approach, the students are the driving force, requesting and obtaining elective courses. Moreover, in some cases, such as in the universities of Genoa, Perugia, Rome La Sapienza, Milan Bicocca and Riga in Latvia, these elective courses have actually been included in the curriculum. In Latvia, a further result achieved has been the co-funding of 25% of the project by the Latvian Ministry of Foreign Affairs.
- **Training of Trainers** is another of the best practices that have emerged: this annual training meeting is organized in

each of the partner countries to promote teaching GH among academic staff.

This activity generates a multiplier effect, as it in turn has important effects on academic training and often leads to the organization of elective courses in universities where no lessons on GH were previously available.

Finally, the format used for Training of Trainers makes it easier to reach civil society, as on the last day of these events conferences are open to the public.

During these conferences, efforts are made to raise citizens' awareness on simple concepts, which are never discussed by the national mass media: the right to health, evolution of health systems in Italy and Europe, also in relation to the current economic crisis, ... All this has led to increased interest by civil society in the health of all, both in near and distant countries, throughout the world.

- **Health and Development:** to increase the involvement of partners, it was decided to share this communication tool and allow them to take an active part in the editorial process. This was achieved by including one or two articles by partner associations in each edition, giving them a space to talk about their health system or about the awareness raising activities organized by students of other countries. The magazine has been widely distributed during training courses, conferences, presentations and meetings of various nature. More space has been dedicated to Global health and education contents, and a language style that is easy for all to understand has purposely been chosen. Partners have also taken an active role in the distribution and dissemination of both the paper (five thousand copies) and online formats (ten thousand contacts) of the magazine.

FIGURE 1 / MAP OF THE 7 COUNTRIES INVOLVED IN THE EUROPEAN PROJECT *EQUAL OPPORTUNITIES FOR HEALTH: ACTION FOR DEVELOPMENT*



THE NETWORK'S FUTURE

Although the *Equal* project comes to a close on the 28th of February, the players who contributed to its activities have no intention of ending their collaboration. Instead, all the associations involved in the project, which is still active, have expressed their interest in continuing to work together, to continue to spread the key concepts of Global health. Moreover, in recent months we have worked together to expand the network to include other states, both new members of the European Union and from "old Europe".

At present, we have already defined a new network that includes 15 European countries and together with them we are working to further promote the right to health for all: in Italy, Europe and throughout the world.



EXPERIENCES FROM THE FIELD

INTERNATIONAL HEALTH COOPERATION

In Africa the map of poverty is being redefined and international cooperation is experiencing “constructive destruction”, caused by the entry of new players, such as local agencies or unconventional donors. Doctor with Africa CUAMM’s strategy to strengthen local health systems remains in force, but research in the field and academic partnerships must be further strengthened.

TEXT BY / GIOVANNI PUTOTO / DOCTORS WITH AFRICA CUAMM

THE NEW POVERTY MAP

From “hopeless continent” to “hopeful continent”. This is the title of a report on Africa published by the English weekly newspaper, *The Economist*, highlighting the considerable progress made in the political, economic, social and health sectors. The 2013 Undp report on human development also illustrates structural and sociological changes, the latter characterized by the advent of a well-off middle class. So, although the Africa of today is no longer the same as it was in the nineties, this fact does not eliminate the serious phenomenon of poverty, which remains widespread and dramatic, and of primary health needs, such as safe maternity and infant care, but rather changes its forms and characteristics.

We are seeing a redefinition of the African poverty map. This transformation revolves around a series of selective processes, including the growing importance of fragile States with the largest concentrations of chronic poor, which are lagging far behind in the millennium development goals, and the rapid urbanization of African cities and increasing marginalization of entire social groups in slums, with heavy exposure to problems of violence, alcohol and substance dependence. All this is associated with the epidemiological emergency caused by progressive proliferation of chronic diseases linked to the spread of the risk factors (e.g. smoking, unhealthy food) of new lifestyles and the problems affecting adolescents’ reproductive and sexual health. Other groups “at risk” are those of minorities. A prime example is represented by semi-nomadic populations, such as those living in the region of the Horn of Africa, who are becoming increasingly isolated and detached from the transformations currently taking place. Besides, if on the one hand there has been an increase in the number of medical schools and access to the medical profession, on the other the mentality of favouring the individualized, curative and urban practice of medicine at the expense of essential health services, above all for those living in rural areas, is becoming more widespread.

CONSTRUCTIVE DESTRUCTION OF INTERNATIONAL AID

International aid and international health cooperation fall under this process of redefining poverty. Scholars speak of “constructive destruction”. In recent years new unconventional players, approaches

and policies have continued to multiply. The financial contribution coming from this group to aid development increased from 8% in 2000 to 30.7% in 2009. Major oil and pharmaceutical companies are becoming increasingly involved in the health sector, building alliances and collaborations with all the other cooperating stakeholders, particularly with NGOs.

New unions are developing. For example, *Save The Children* has formed a partnership with GSK, which will not only lead to the funding of health projects targeting children, but also to the transfer of products with costs and formats suitable for the African continent. There is no doubt that many new ethical and moral dilemmas exist and that these novel forms of cooperation have many grey areas. Moreover, new stakeholders are emerging in the African social sphere. In Uganda, for example, the health network set up by the Catholic Church replaces international NGOs, dealing directly with development agencies, receiving substantial funding and creating complex programmes. Finally, with regard to policies, while the debate on the post-MDG agenda appears to be oriented towards sustainable development and inequalities, health is receiving less attention. The only policy issue that seems to be receiving broad consensus is that of universal health coverage. On closer examination, it will be a case of understanding if, and to what extent, public and private stakeholders will succeed in the task of building health systems that are truly able to ensure the poor have access to high quality health services, with fair and sustainable funding mechanisms, without introducing extreme forms of privatization.

THE POSITION OF DOCTORS WITH AFRICA CUAMM

Doctors with Africa CUAMM’s strategy to strengthen local health systems and to carry out training and research in the field remains in force. Health systems must be supported in relation to their operating status or evolution. Interventions must be adapted to local needs and to the level of development and capacity of their health systems. There is a vast difference between operating in South Sudan and working in Uganda and Tanzania. The focus on developing local skills, efficient training and verifying results, such as quality, effective coverage, efficiency and equity of interventions, remains crucial. To meet these requirements and offer greater accountability, research in the field and partnerships with Italian and African universities must be strengthened, giving voice and space to the young.



EXPERIENCES FROM THE FIELD

TEACHING GLOBAL HEALTH IN ITALIAN UNIVERSITIES

The project *Equal opportunities for health: action for development* has represented a strong impetus both for expanding the geographical scope of training activities within the various universities and to reach a common definition of the thematic content of Global health, a vast subject, perhaps too vast, without clear boundaries.

TEXT BY / GAVINO MACIOCCO / DEPARTMENT OF PUBLIC HEALTH, UNIVERSITY OF FLORENCE

“The scientific community – and in particular those responsible for producing culture, education and research – has the duty to address topics of equity, sustainable development, protection of human dignity and life in a widespread and systematic manner. [...] There is an increasing need for in-depth studies, for independent evaluations, for widespread transmission of information and knowledge, and therefore schools and universities can no longer distance themselves from this duty”. This appeal, contained in the Erice Declaration of 2001 (**see page 3**), did not fall on stony ground. Indeed, some of those who signed the Declaration over the following years dedicated themselves to promoting Global health training initiatives within their organizations, setting up elective training activities, mainly in Medical Schools, with contents varying considerably from one course to another: the pioneers of these activities were available in a limited number of venues with a total of 17 courses held up until 2009.

The project *Equal opportunities for health: action for development* has represented a strong impetus both for expanding the geographical scope of training activities within the various universities and to reach a common definition of the thematic content of Global health, a vast subject, perhaps too vast, without clear boundaries. When the project was set up in 2007 the two key objectives were to map academic teaching activities in the various universities that had any reference to Global health and to establish the basic elements of the educational offer, building on Italian experiences in progress and on what was being developed in many international organizations, above all in English speaking countries.

This led to the creation of a “*standard curriculum*”, consisting of five modules covering the following topics: 1) Health, determinants and inequalities in health; 2) The origin and development of health systems. Health as a human right; 3) Health, development and globalization; 4) Immigration and health; 5) International health cooperation.

The organization of four “Training of Trainers” seminars, held in Padua (2008 and 2010), Rome (2012) and Florence (2012), with the aim of preparing new teachers (not only at academic level), was crucial for the dissemination of Global health teaching methods. These initiatives led to the creation of the Italian Network for Global health Teaching (RIISG), a national network formed by academic institutions, scientific societies, non-governmental organizations, associations, groups and individuals engaged in teaching Global health, at university and in civil society. The main objectives of RIISG are: a) to promote Global health teaching at academic level, in health-oriented degree courses and medical residency schools, and at professional level with courses within the framework of continuing education in medicine programmes; b) to promote time and space for exchange and dialogue on Global health with other disciplines and with institutions, groups, associations and networks at European level.

RIISG’s founding principle is coherence with the Global health approach both in terms of working method (based on horizontality and full participation of all members) and in teaching activities (student oriented, open to multidisciplinary, oriented towards integration of theoretical training and practical activity in the field).

“The main focus of GH concerns the health status and the real needs of world population, as well as its socio-economic, political, demographic, juridical and environmental determinants, as well as the relationship between globalisation and health in terms of equity, human rights, sustainability and international diplomacy”¹.

Global health courses are currently held in the following universities: Bari, Bologna, Brescia, Campobasso, Catania, Ferrara, Florence, Genoa, Milan Bicocca and Statale, Novara, Padua, Parma, Pavia, Perugia, Rome La Sapienza, S. Andrea, Tor Vergata and Usc, Sassari, Salerno, Siena, Turin, Trieste, Udine, Varese.

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EXPERIENCES FROM THE FIELD

SISM AND TEACHING GLOBAL HEALTH

The role of the medical student in promoting Global health is split into two distinct and complementary actions: on the one hand the main experience of the student among students, through a peer-to-peer approach; on the other in the academic world, in direct contact with the University as an institution.

TEXT BY / SAMANTHA PEGORARO / SISM - ITALIAN SECRETARIAT OF MEDICAL STUDENTS

“Nobody educates anybody else. Nobody educates himself. People educate each other through their interactions with the world”. This quotation by the Brazilian pedagogist P. Freire was not chosen randomly, but reflects the path followed by medical students over the years in SISM.

SISM (Italian Secretariat of Medical Students) is a nonprofit association set up by students for students over forty years ago and is involved in promoting the most important social topics of medical interest and in making a decisive contribution, capable of integrating the medical degree course teaching programme. According to RIISG (Italian Network for Global health Teaching), which SISM is a member of Global health is defined as an approach that places particular importance not only on the message being transmitted, but also on the methods with which it is conveyed and, in particular, taught within the University. Non-formal education, intended as the use of methods such as group work, case studies or role play, becomes a fundamental element as it focuses on the student as the active subject of education, attentive participant in the construction of knowledge.

It was this reason that led SISM to approach Global health, recognizing in it a means of action in educational terms, both as regards content and methodology. In this sense, the student's role is split into two distinct actions, which are both complementary and equally fundamental. On the one hand, the main experience of the student among students, through a peer-to-peer approach based on a series of projects created within SISM; on the other, the student's role in the academic world: a horizontal project within RIISG, but also a bottom-up thrust in direct contact with the University as an institution.

LabMond (Laboratorio di Mondialità) is the first concrete example of students' experiences among students. This is a three-day workshop focusing on Global health issues, such as determinants and inequalities, the creation of national health systems,

the link between health and globalization, the environment and migrations through the use of non-frontal teaching. Each year this event brings together over one hundred students from all over Italy and, having reached its eighth edition, has proved to be a multiplier of experiences. After taking part in LabMond, students promoted elective or required courses on Global health in university faculties throughout the territory.

This is shown through a series of mapping operations conducted by SISM in collaboration with the RIISG network within Italian faculties. A total of forty courses were activated during the academic year 2011/2012 (latest updated data).

The workshop on Conflict of Interest is another SISM project inspired by the same methods applied to LabMond, which concentrates on the concept of health and the market or on the role of pharmaceutical companies in the healthcare system. Having a stronger impact on specific topics, although just as important for the student's role in Global health are the *Caught from Inside* project, which uses a multidisciplinary approach in collaboration with ELSA (European Law Student's Association) to focus over the course of one year on the topic of prisoners' rights with particular attention to their health, and the *Wolisso project*, which allows medical students to approach the world of international cooperation by participating in health programmes in Ethiopia and Tanzania.

In parallel, the commitment by students within the Italian Network for Global health Teaching has made it possible to bring the academic and student worlds closer together and, through a horizontal project, to obtain the results described above (required courses and mapping). RIISG is a network including universities, student associations, NGOs and individuals established in 2008 from the first experience of the *Equal¹* project. One more step in the complex process of teaching Global health in Italy.

The Network is where change begins and we are still on a journey.

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TAKING A CLOSER LOOK

WHO AND THE RIGHT TO HEALTH: WHICH FUTURE

The 5th report of the Italian Observatory on Global health focuses on the history, successes and troubles of the World Health Organization (WHO), the United Nations agency established to achieve the highest possible level of health for all the people of the world. Has WHO fulfilled its mandate and is it continuing to do so?

TEXT BY / ADRIANO CATTANEO / ITALIAN OBSERVATORY ON GLOBAL HEALTH - OISG

“The health of all peoples is fundamental to the attainment of peace and security and is dependent upon the fullest co-operation of individuals and States. Informed opinion and active co-operation on the part of the public are of the utmost importance in the improvement of the health of the people”. It was perhaps because of these assertions, contained in the preamble of the Constitution of the World Health Organization (WHO), namely to promote informed opinion and active co-operation by the public, that we at the Italian Observatory On Global health (OISG) decided to dedicate our 5th report to WHO. The same preamble asserts that health is “one of the fundamental rights of every human being”, “without distinction of race, religion, political belief, economic or social condition”, to be guaranteed in connection with other fundamental rights. WHO was established to put that right into effect, with the objective of “the attainment by all peoples of the highest possible level of health”.

Has WHO fulfilled its mandate and is it continuing to do so? Its history, just as that of any other institution or organization, and ultimately of each and every one of us, is filled with light and shadows. Those who have worked and continue to work for health, above all for Global health, probably know the positive aspects of WHO. Even if they don't, they will have undoubtedly come across them in their work, perhaps without realizing it. They will have heard about programmes for essential drugs, for reducing maternal mortality, for managing the most common childhood illnesses. They will have heard about the success of immunization programmes, starting with the one that led to the elimination of smallpox. They will know of the various strategies for reproductive health and for feeding infants and young children, and the protection of breast-feeding offered by the International Code of Marketing of Breast-Milk Substitutes. They will have read about programmes for controlling the major endemic diseases, first and foremost Hiv, malaria and tuberculosis, but also diseases that tend to be forgotten. Even without realizing, they will benefit from measures for reducing exposure to tobacco smoke implemented as a consequence of the Convention for tobacco control. They will at least have heard of the Alma Ata Declaration and of the Commission on Social Determinants of Health.

However, there is no doubt that there have been and continue to be shadows. Over-ambitious programmes for controlling or eradicating diseases abandoned after a few years due to their evident inability to reach their goals. A delayed approach, often without the necessary rigour and efficacy, to non-communicable diseases, including mental health problems, which should have already been a priority for decades, owing to the decrease in relative importance of communicable diseases. With the exclusion of the Alma Ata Declaration (1978), failure to pay due attention to strengthening health systems and above all to primary care. Save for statements of principle, almost total lack of attention to growing inequalities and inequities both of health and of access to health services. Initially, the lack of strict principles and criteria, followed by principles and criteria that are too weak to prevent and address the inevitable conflicts of interest of a world in which the market views health as an opportunity to make profits that are decreasing in other sectors.

There is widespread agreement that there have been more shadows than light in recent years, also due to distortions in the budget made, or perhaps desired, by its major contributors. People are now talking openly about the WHO crisis and the need for reform. This topic is dealt with in the 5th OISG report, in the hope that the debate, already lively at international level, will also take off in Italy, and not only among those who work in the sector. Because health is a common good to be protected and WHO can help to do this better if it receives a push in the right direction from us as citizens.



REPORT

TEACHING GLOBAL HEALTH IN EUROPE

At the International Conference held on 1st February in Padua, the partners of the European Project *Equal opportunities for health: action for development* (Italy, Bulgaria, Latvia, Poland, Romania, Hungary and Malta) discussed what, how and why to teach Global health in Europe.

TEXT BY / CARLO RESTI / DOCTORS WITH AFRICA CUAMM AND ITALIAN NETWORK FOR GLOBAL HEALTH TEACHING

Ever since the late nineties, with the launch of the Millennium Development Goals (three of which closely related to health goals), the role of health in the agenda of global development policies has become increasingly important and has also seen an increase in the financial resources allocated to developing and strengthening health systems and to combating well-known “killer diseases” – AIDS, Tuberculosis and Malaria – through the *Global Fund*. Only the prolonged economic crisis of recent years and the need to make Public Development Aid more effective (from Paris 2005 to Busan 2011) have slowed this trend¹.

In the wake of economic globalization and as the result of increasing interdependency between systems and nations, today even Health, in its broadest sense deriving from the WHO definition of health² as (“a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity”³) cannot but be said to be “global”. During the last two decades the use of the terms “Global health” (GH) has undoubtedly exceeded that of “International Health”, placing emphasis on the health of populations beyond national boundaries and on the influence of other sectors: political, social, cultural and financial. However, today too many issues concerning health tend to be labelled as “global” and the term is very much in vogue⁴.

IN NETWORK FOR GLOBAL HEALTH

In Italy, since 2010 the Italian Network for global Health teaching (RIISG), which is very lean, not in the slightest hierarchical and with a broad student base, has contributed to giving back content and applications to the topic of Global health. Two projects have been funded by the European Union under the organizational leadership of the NGO Doctors with Africa CUAMM (in 2007/2009 and 2011/2014), and which have given wings to numerous university and non-university initiatives by the Network throughout Italy.

In 2009, a first International Conference in Padua organized by Doctors with Africa CUAMM brought together over a hundred experts divided into four work groups on Teaching GH in universities; Continuing education and retraining of health care staff in GH; Role of international cooperation in advocacy strategies, teaching and implementing GH interventions; Mobilization strategies for human and financial resources in GH. This led to a commitment (“*our common commitment*”)⁵ and an action plan that is

bearing its fruits not only in Italy and other “strong” European countries, but also in partner countries, almost all located in Eastern Europe, producing an effective exchange of experiences, know-how and best practices in Global health education. The commitment of students, teachers, health professionals and non-governmental organizations aimed at promoting GH as a field of research, training and practice in Italy and abroad has grown within the participatory process supported by the European project. Since then a series of initiatives and activities have been promoted, aimed at better defining the field of GH. Initially, it was not easy to adopt a common language, dealing with the specificities of each country and with the crisis of the health professional training model, largely based on a biomedical rather than a biopsychosocial approach. However, RIISG immediately launched a cultural reflection with a definition of GH that introduces a new paradigm and not a new discipline, based on awareness of the social determinants of health, on the principles of Health for All proclaimed in the Alma Ata Declaration of 1978 and applied to all fields, from health promotion and prevention to access to diagnostic and treatment services⁶. In addition to risk factors for health, the influence that determinants of a socio-economic, political, demographic, legal and environmental nature in the environment in which a person is born, grows up, lives and gets sick have on these factors are also important. In the relationship between globalization and health, equity (*Health for All*), participation and human rights (*Health by All*), sustainability, diplomacy and cooperation (*Health in All Policy*) from a transnational perspective are important.

This vision, developed and shared from the beginning, has resulted in concrete collaboration in the project, based on comparison and on improving various aspects: the training of healthcare professionals and operators from other sectors starting from an adapted and reviewed core curriculum⁷; GH study and research; communication with a wider public of cross-sectoral users and players. This common prerequisite has proved useful for the project's partners, to prepare and subsequently share training and awareness raising activities for professionals, teachers, trainers and students capable of addressing the enormous challenges of globalization (safety, migration, climate, inequalities, major endemic diseases and combating poverty) and of acting as “health advocates”. A change also promoted in the 2010 declaration of the British Royal College of Physicians, which contains recommendations for doctors on how to tackle the “causes of the

causes” of health and diseases to bridge the gap between rich and poor, both between countries and within these countries.

A SHARED CONCEPT OF GLOBAL HEALTH

Together with its European partners, a network of new member States (Poland, Bulgaria, Latvia, Hungary, Romania and Malta), Doctors with Africa CUAMM and its Italian partners have pursued the objective of promoting a shared and well-defined concept of Global health that also respects cultural and socio-historical differences. The network has promoted several meetings with experts in education and public awareness and a ToT (training of trainers) international training seminar for project members focusing on interactive teaching methods for adults and experiential learning. A website has been created dedicated to Global health education, with updated bibliography and sitography organized according to thematic areas (www.educationglobalhealth.eu). Some presentation formats on GH key issues, such as health inequalities and social determinants of disease, have been shared. Partners have been involved in writing articles for the four-monthly publication *Health and Development*, a common information tool in digital and paper format that reaches around 15,000 people. Within the activities of the project *Equal*⁸, Doctors with Africa CUAMM has also promoted an international contest for young photographers and film makers to encourage reflection on GH topics also among those from outside the healthcare sector, create international exchange and increase communication between sectors.

THE BEST PRACTICES OF EUROPEAN PARTNERS

In at least two countries – Latvia and Hungary – particular attention is being paid to project activities in the field of international

law and bioethics. Poznan University in Poland is carrying out significant and advanced experimental educational activities in the Public Health School on the use of simulated field activities in refugee assistance and role play. In Pleven University in Bulgaria, in Malta and in Italy, with the SISM (Italian Secretariat of Medical Students), there is appreciation for and increasing development of activities in the Faculties of Medical and Nursing Sciences involving groups of students interested in elective courses in Global health and in activism focusing on protection of the right to health. In Transylvania University in Romania there is appreciation for the need to address these topics increasing the involvement of political and social players, and also of civil society, through coverage of the various courses and events organized by the local and national media respectively.

Italy seems to be ahead with the mapping of courses involved in elective teaching activities and with the number of LLL seminars organized, although these are held prevalently in medical schools.

In general, all partner States place great importance on relations with the public and visibility of the project and appreciate and support participation in network events (the Latvian Ministry of Foreign Affairs is a tangible example).

The partners share a general commitment to improving contacts with all national stakeholders and, more generally, public awareness, to prompt citizens to take an interest and become involved in defending the right to health of all.

At the International Conference “A decent life for all” organized by Doctors with Africa CUAMM in Padua on the 1st of February 2014, each partner spoke enthusiastically about Global health in their country and answered questions on what is taught, how and why it is taught.

For the future, as well as expanding and strengthening training, there is creative thinking about producing new material aimed at increasing public awareness and strengthening and extending the Network, which has become an important part and added value of the *Equal* project.

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DOCTORS WITH AFRICA CUAMM

Established in 1950, Doctors with Africa CUAMM was the first NGO in the healthcare field to receive recognition in Italy (pursuant to the Cooperation law of 1972) and is the largest Italian organization for the promotion and safeguard of the health of the African populations.

It implements long-term development projects, intervening with the same approach in emergency situations, with a view to ensuring quality services that are accessible to all.

HISTORY

In its **60** years' history:

- **1,408** people have departed to work on projects: 396 of these departed on more than one occasion. The total number of departures was therefore 2,250;
- **4,590** years of service have been carried out, with a mean of 3 years per expatriate person;
- **1,500** students have been accommodated at the college;
- **481** doctors have departed from the Veneto region in almost 63 years;
- **216** hospitals have been served;
- **40** countries have benefited from intervention;
- **150** key programmes have been carried out in cooperation with the Italian Foreign Ministry and various international agencies.

IN AFRICA

Today we are in Angola, Ethiopia, Mozambique, Sierra Leone, Southern Sudan, Tanzania, Uganda with:

- **157 providers:** 96 doctors, 16 paramedics, 45 administrative and logistics staff
- **33 key** cooperation projects and about a hundred minor support interventions, through which the organization assists:
 - 15 hospitals
 - 23 districts (for public healthcare activities, mother-child care, training and in the fight against AIDS, tuberculosis and malaria)
 - 3 motor rehabilitation centres
 - 5 nursing schools
 - 3 universities (in Uganda, Mozambique and Ethiopia).

IN EUROPE

Doctors with Africa CUAMM has for years been actively implementing projects and building networks at European level, with the aim of building public awareness on the subject of equality of access to treatment and healthcare systems. Specifically, from 2011 to 2014 the organization has been coordinator of the European project, "Equal opportunities for health: action for development", on which it has been working with 18 other partner organizations from 7 European countries. Universities, student associations, non governmental associations in Italy, Poland, Latvia, Bulgaria, Romania, Malta and Hungary are working together to give room and voice to training in Global health and to promote greater awareness about the relationships between health and development, both individually and collectively.

NOTICE TO READERS

Support and take part in our commitment to Africa, in one of the following ways:

- **Post office current account** no. 17101353 under the name of Doctors with Africa CUAMM
- **Bank transfer** IBAN IT 91 H 05018 12101 000000107890 at the Banca Popolare Etica Padua
- **Credit card** call 0039.049.8751279
- **Online** www.mediciconlafrica.org

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HEALTH AND DEVELOPMENT offers studies, research work and documentation which are unique to the Italian editorial world. Our publication needs the support of all readers and friends of Doctors with Africa CUAMM.



NEEDY AFRICA

EVERY YEAR IN SUB-SAHARAN AFRICA:

- 4.5 million children die before reaching five years of age, for preventable diseases that can be treated at low cost;
- 1.2 million newborn children die in the first month of life through lack of treatment;
- 265 thousand women die from pregnancy- and delivery-related problems.





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