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The burden of inequity

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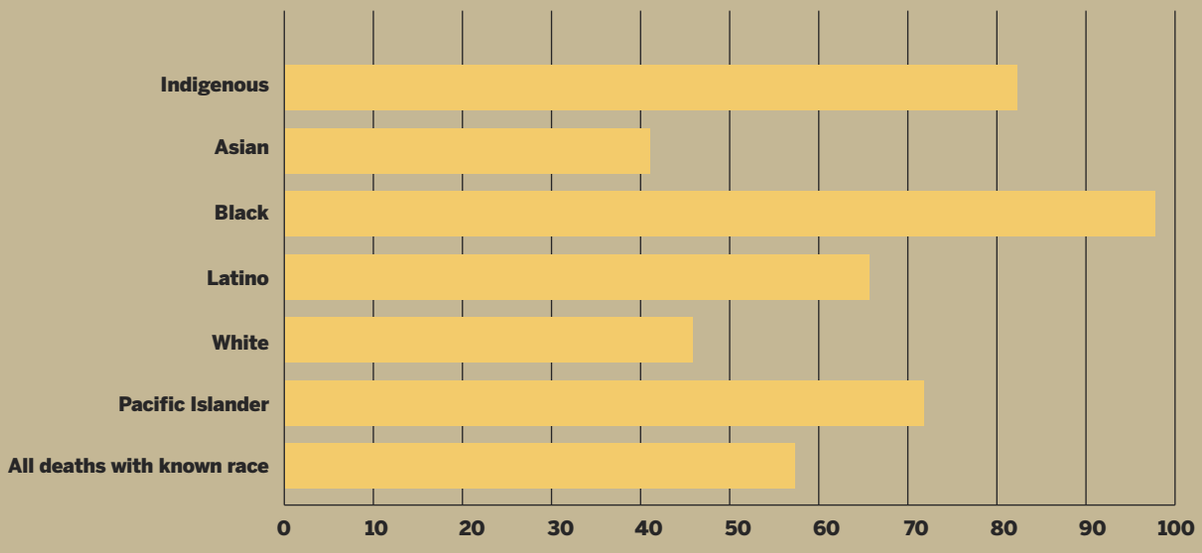
NEWS

Inequity in death

The Covid-19 pandemic has cast a harsh light on the tragic phenomenon of racial disparity as a determinant of health, one that until recently received little attention, or, worse, was simply disregarded. Now, however, the shocking numbers being seen in the United States are opening more and more people's eyes to systemic racism, a still-open wound resulting from centuries of slavery in the country. Black Americans account for approximately 13% of the total population, yet represent 26% of all Covid-19 deaths. In some areas, such as Milwaukee County, in Wisconsin, where around 26% of the total population is Black, Covid-19 mortality for the group has reached a high of 73% of the total. Cumulative U.S. Covid-19 mortality data (per 100,000 residents) by race/ethnicity as of 15 September 2020 showed that Black Americans are dying at more than twice the rate of White Americans (the data is unfortunately incomplete, as death certificates often do not provide racial/ethnic information).

FIGURE 1 / U.S. COVID-19 DEATHS (PER 100,000 RESIDENTS) BY RACE AND ETHNICITY AS OF 15 SEPTEMBER 2020



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Cover

The burden of inequity

The Covid-19 pandemic is not affecting everyone in the same way. Once again, those hit hardest are the most vulnerable, including women, children, the elderly and the poor. Reduced access to health care, fewer treatments, and a lack of educational services are just some of the burdens visited upon these population groups.

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DIALOGUE

AN UNEQUAL PANDEMIC

In 2020, as the Covid-19 pandemic raged on, nearly every development indicator worsened – an unprecedented phenomenon. Indeed, it has been estimated that the first 25 weeks of this global health crisis set development back by 25 years. But what does this actually mean, and who is bearing the greatest burden? Here we take a closer look at the pandemic's health and societal impact.

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

Just as powerful storms churn up what lies below the sea's surface, nine months of devastation by the Covid-19 pandemic have revealed not only the magnitude of cases and deaths, but also a stark picture of problems that have been ignored for too long. We've seen clinical excellence in the wealthier parts of the world crushed almost from the start by the novel virus; the limits of health systems whose links with local territories, people and community medicine have been weakened or severed, at least in our part of the world; Western countries caught unawares by their own vulnerability as death tolls rocket, and struggling to come up with a collective response that addresses both health and political concerns; and economies ravaged by the cyclone-like pandemic. Recent data reported by international agencies show that nearly every development indicator worsened in 2020 – an unprecedented phenomenon. In September the Institute for Health Metrics and Evaluation (IHME) estimated that 25 weeks of the pandemic had set development back by some 25 years, with vaccine coverage dropping to levels not seen since the 1990s. It has been estimated that interruption to therapies and other disruptions could lead to an increase in deaths due to malaria, tuberculosis and HIV by up to 36%, 20% and 10%, respectively, over five years (Lancet, July 2020).

How is it possible for advances in development to be swept away so abruptly? I believe that the dramatic period we are living through has revealed the underlying fragility of our societies. We were under the illusion that we "would stay healthy in a world that is sick", as Pope Francis put it on World Environment Day last June. But now, having failed to grasp the deep interconnections between places, fields of research and human beings, we are witnessing the havoc wrought by a pandemic that has cast its long shadow over multiple facets of society, a kind of domino effect where the dominoes fall hardest on the poorest. The general reduction in access to health care, including treatment for chronic diseases and prevention, has heightened morbidity and mortality risks. Economic fallout and job loss has brought insecurity, which has in turn engendered greater social and health risks among the most vulnerable populations, including child marriage in Mozambique (see p. 12), and worsening political instability, for example, the civil conflicts in Ethiopia (Tigray) and Mozambique (Cabo Delgado, p. 13).

In this issue we have tried to interpret the global impact of the pandemic through this lens, focusing on these secondary – but certainly no less significant – repercussions, which are unfortunately going to be with us for a long time to come. Seven decades of work with African communities have taught us the importance of taking into account all the factors in a given society, tackling complexity by recognizing the social, economic and anthropological aspects that underlie it. This is the challenging vision that continues to guide us, in our knowledge that there are no simple solutions to multifaceted problems.

Although the situation is still very critical, it is also important to note some positive signs: CUAMM's experience in Uganda, for example, where we have seen therapeutic indicators for tuberculosis actually improve during the pandemic. This wasn't by chance, but rather the outcome of a response that adapted rapidly to the imposition of lockdown in the country; to lower the risk of sick individuals no longer accessing health services, we quickly reorganized the health care system to monitor and administer medicines to patients in their homes. In Sierra Leone, despite almost 11% of health workers having been infected with the virus, Princess Christian Maternity Hospital has managed to provide healthcare services almost without disruption since March 2020. We've been active in recent months in Italy, too, to mitigate the pandemic's negative impact, especially on the most vulnerable, making improvements to residential and territorial health facilities and hospitals, as well as providing support to the "new poor": migrant agricultural workers, the homeless and Italian families who have been particularly hard-struck by the crisis (see p. 18).

This issue of our magazine is very much an "on-the-ground" one that aims to give a voice to those working on the front line in some of the most challenging areas in Africa and Italy. But wherever each of us may find ourselves right now, we are all experiencing firsthand what a pandemic feels like. Hopefully, we are close to the time when we will be able to share best practices and processes in order to identify an optimal way of envisioning global health and undertaking its challenges.

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2 Bill and Melinda Gates Foundation, *Report 2020*.

DIALOGUE

BLACK LIVES MATTER

Covid-19 is a global health emergency that calls for a global solution. A veritable storm, it has intensified health inequalities and affected the most disadvantaged and marginalized social groups around the world, including Italy, underscoring the fact that no community is safe unless all communities are protected.

TEXT BY / GAVINO MACIOCCO / DEPARTMENT OF THE SCIENCE OF HEALTH, UNIVERSITY OF FLORENCE

"We're in the same storm, but not the same boat": the saying seems to have been invented precisely to describe the global health crisis we are experiencing, and the different fates of the "boats" that are being hit by it. As we witness what is taking place in the United States, where Black Americans are dying at more than twice the rate of White ones, it has quickly became clear how the Covid-19 pandemic is exacerbating social disparities both there and elsewhere. Multiple causes underlie the excessive mortality of Black Americans: many are on the front line of the pandemic due to their increased likelihood of holding "essential" jobs as nurses, caregivers, cleaners at hospitals and assisted living facilities, grocery store clerks, food industry workers, and so on. In addition, Black Americans often live in urban or residential areas where social distancing is more difficult; suffer disproportionately from chronic diseases (in part due to the high prevalence of obesity among the population); and may be vulnerable to more severe forms of Covid-19. Too many have precarious jobs, a lack of health coverage, and far greater difficulties in gaining access to a Covid-19 test. Finally, Black Americans are poorer than other Americans: in 2016 the median wealth of a Black household was $17,100, while that of a White household was $171,000. But in other areas of the world, including Italy, we could replace this population group with other disadvantaged, marginalized and impoverished ones and find a similar picture.
The fact that we are not all "in the same boat" is borne out by the unfolding situation vis-à-vis vaccine availability– something very similar to what happened earlier with HIV drugs. The latter became available to patients in the poorest countries, especially those in sub-Saharan Africa, ten years too late, when millions of preventable deaths had already occurred. We all know the reasons: the cost of the products and the patent barrier. The current pandemic is not even remotely comparable, in terms of the numbers of victims, to the HIV/AIDS epidemic that has plagued Africa; in fact, Covid-19 numbers are considerably lower in Africa than on other continents. But the indirect costs of the crisis – on economies and political stability, and in terms of international isolation – may well be higher[1]. This is why Africa needs vaccines just as much as other countries, both in terms of quantity and timing. In an editorial dated 5 December 2020[2], The Lancet had this to say about the situation: «COVID-19 is a global health emergency that demands a global solution. No community is safe from SARS-CoV-2 unless all communities are protected.» However indisputable this argument may be, though, it has done little to prevent the tendency of the world's wealthiest nations to hoard vaccines; indeed, they have already snatched up to 53% of the available vaccines despite accounting for just 14% of the global population. Canada has purchased more doses than any other country, enough to vaccinate each of its citizens five times[3]; and if it is true, as news reports claim, that Italy has ordered 200 million doses, then our own country has not been outdone. Philanthropic action has been taken with the launch of an initiative known as COVAX, whose aim is to secure 2 billion doses for poor-middle income nations and to distribute them by the end of 2021. 97 higher-income countries have already signed a commitment to ensure 20% population coverage to 91 lower-income ones by that date, but this figure is far below what would be required to achieve herd immunity[2]. Nine months after the onset of the pandemic, there is still no international policy measure to ensure universal access to Covid-19 vaccines or other effective remedies that have been developed. However, India and South Africa are working toward that goal: on 2 October 2020, the two countries sent the World Trade Organization a joint proposal asking that patent and other intellectual property rights related to Covid-19 drugs, vaccines, diagnostics, PPE and other medical technologies be suspended for the duration of the pandemic, and until herd immunity has been achieved[4].
As was the case with HIV drugs, we are once again seeing a global match between the drive for profit and the need to secure the health of the world's peoples.

NOTES

1 Murru M., Covid-19 in Africa/2, https://www.saluteinternazionale.info/2020/11/covid-19-in-africa-2/
2 Editorial, *An African plan to control COVID-19 is urgently needed*, Lancet 2020; 396-1777.
3 https://www.repubblica.it/esteri/2020/12/09/news/coronavirus_vaccino_privilegio_dei_paesi_ricchi_irraggiungibile_per_9_persone_su_10_in_70_paesi_poveri-277602156/?ref=RHTP-BH-I274746038-P2-S6-T1
4 Garattini S, Dentico N, *Vaccini (veramente) per tutti.* https://www.saluteinternazionale.info/2020/11/vaccini-veramente-per-tutti/

PREVENTION OUTSIDE UGANDA'S ABER HOSPITAL

Wash basins at the entrance to the Aber Hospital in Uganda, where CUAMM has adopted various measures to help prevent Covid-19, including the creation of triage areas in which to keep patients suspected of infection separate from others, and other new spaces like the one shown here, where water and soap are made available so that people may wash their hands before accessing health services.

NICOLA BERTI

FORUM

PANDEMIC WITHIN A PANDEMIC

Alongside figures on case counts, overwhelmed intensive care units and an-ever growing death toll, we're now also beginning to see data on the indirect impact of the Covid-19 emergency – a pandemic within a pandemic where women and children are both the first to stop using health care and the hardest-hit by the social and economic repercussions of the crisis.

CHIARA DI BENEDETTO INTERVIEWS FLAVIA BUSTREO, CHAIR OF THE GOVERNANCE AND NOMINATION COMMITTEE AT THE PARTNERSHIP FOR MATERNAL, NEWBORN AND CHILD HEALTH AND CO-CHAIR OF THE LANCET COMMISSION ON GENDER-BASED VIOLENCE AND MALTREATMENT OF YOUNG PEOPLE

For the last nine months, we have been immersed in a global health crisis, constantly bombarded with numbers on the state of the pandemic: case counts, intensive care unit capacity and death tolls. But this data on the "direct" impact of the crisis has left in the shadows other, equally important health and social repercussions, which are so extensive that people speak of "a pandemic within a pandemic". Flavia Bustreo, who served for many years as the Assistant Director-General for Family, Women's and Children's Health at the World Health Organization and is now Chair of the Governance and Nomination Committee at the Partnership for Maternal, Newborn and Child Health (PMNCH), is here to discuss the situation with us.

- **Recent reports show that those worst affected by the pandemic are women and children. This might seem paradoxical, given that Covid-19 has generally been shown to affect men more severely than women. So what do the reports actually mean?**

We're seeing a direct short-term impact on the health of women and children due to their lack of access to reproductive, prenatal and delivery health services. In addition, there's been a drop in the number of vaccinations for under-5 children, heightening the risk for potential outbreaks of more common diseases such as measles, which can be fatal in malnourished children. So in terms of morbidity and mortality, the primary impact of the pandemic on these populations is their reduced access to health care. There are two main reasons for this: health workers are busy taking care of other patients, and women are also reluctant to seek out care due to their fear of being infected.
Secondly, we are seeing a significant impact on the mental health of both women and children, a consequence not only of the pandemic itself but also the lockdowns. In Wuhan, China – the first country to impose a significant lockdown – one child out of three has had post-traumatic stress symptoms. Another critical consequence is the rise in domestic violence, a phenomenon which has yet to receive sufficient attention. Data show that one out of every three women is subjected to such violence at some point in her lifetime, most frequently perpetrated by an intimate partner; and in many countries the phenomenon has intensified during the lockdowns.
Finally, it's important to underscore the social impact of the pandemic on women and children, and the additional workload that this social and health crisis has brought for women. Seven out of ten healthcare workers are women, who after battling on the front lines of the pandemic must then also shoulder the burden of the unpaid labor of caring for children, the elderly and unwell men. Thus they are dealing not only with a heavier workload, but also a weakened capacity for paid employment; in the United States, for example, two-thirds of the 30 million individuals who have lost their jobs as a result of the pandemic are women, for whom it is more difficult to return to paid work and make their contribution to societal progress.
These phenomena are being seen both in higher-income European countries (including northern Europe) and in lower- and middle-income ones in sub-Saharan Africa and Asia, for example in India, where data has shown the pandemic's significant impact vis-à-vis women's unpaid work burden.

- **Are there any strategies or good practices that could be undertaken at the global level so that progress made in terms of women's empowerment, and the focus on women and children, will not suffer major setbacks?**

Yes, there are, in different forms in different countries. One example is Latin America, where economic support strategies using vouchers for women and their families have been developed as a mechanism to tackle poverty in the continent's poorest countries, including Brazil, and among the most vulnerable population groups. This helps women to access health care, and can be especially crucial at a time like this.
But there are also other experimental forms of support including microcredit for women, something that's particularly widespread in Asia. Bangladesh is well-known for its own such programs, which make it possible for women to access credit at very low interest rates and thus avoid losing their access to health services even during crises. There are also additional strategies to help women and children at such times, such as those enabling them to take part in active citizenship networks or to tap into sources of organized human capital through interest groups.
I'd also like to call attention to the importance of female leadership. Seven of the twelve countries that have responded best to the pandemic, in fact, are led by women. Such leadership isn't sufficient to ensure a scientific approach, but it can be of great importance when leveraged during emergencies, as women understand not

only the urgency of these crises, but also their broader repercussions for society and the production of human capital within families.

o So could we say that wide-ranging health policies are beneficial to human development?

Absolutely. Human development is measured in terms of the capability of individuals to reach their objectives without having to face steep barriers. And the ability of more than half of the world's population – women – to do this is central. It's equally important to keep a focus on other aspects of inequality that are being underscored by the pandemic. For example, in many countries around the world, the pandemic has amplified racial disparities, making it disproportionately more difficult, in the United States for example, for many Black Americans to access services and hold on to their jobs. Over the long term, the Covid-19 crisis is going to generate an extensive and protracted economic crisis, particularly in lower-income countries, and this impoverishment of populations will have a direct impact on development. So, it's absolutely critical that we not fail to focus on developing long-term policies to ensure sustained human development even during such crises.

o Experts are warning that crises like the current zoonotic pandemic, but also enviromental and climate-related ones, are going to become ever more frequent. What can we do to prepare for these emergencies?

It has been obvious now for a decade that an acceleration of epidemics and pandemics is underway. Although the last major pandemic was the Spanish Flu in 1918, in 2009 the World Health Organization issued a statement on the swine influenza H1N1 in humans, which affected some 70 countries around the world even though it fortunately did not have as dire an impact in terms of mortality as Covid-19. Since then we've seen SARS, MERS, Ebola and Zika, and are beginning to understand the ways in which this rise in epidemics – and unfortunately pandemics, as well – is associated with climate change. The latter's impact shows up in various ways, for example, by altering the biology and epidemiology of disease vectors, as well as heightening the risk of diarrheal diseases in the aftermath of floods and other severe climate events (e.g. typhoons, tsunamis, and hurricanes), particularly in Asian countries such as Bangladesh. So the links between climate change and epidemics and pandemics are among the areas that require further study, to enable us to develop long-term policies and actions.

In the short term, there needs to be a focus on preparing public health systems to handle pandemics like this one. As we saw, Italy itself was insufficiently prepared, and our Ministry of Health's response plans were outdated. Public health system readiness must encompass health workers' capacity to handle outbreaks and equipment and materials for the containment of infectious diseases both in hospitals and peripheral health facilities.

Another vital aspect involves communicating with communities and readying local health systems. One of the things that made a difference in Asian countries was their curbing of the virus's spread through contact tracing, early case identification, and isolation and treatment of infected individuals. And I'd like to underscore one last aspect: investments in research. What we are seeing now vis-à-vis the response to the Covid-19 emergency is very encouraging, and it has already paid off with the development of vaccines in record time.

FORUM

THE ASYMMETRICAL IMPACT OF THE PANDEMIC IN UGANDA

Covid-19 is having asymmetrical impacts on different population groups, thereby magnifying already existing disparities. Here is some information on the initial results of a World Bank analysis: first data in Uganda confirm inequities in access both to essential goods and services and to educational services.

TEXT BY / MARIA NANNINI / ACTION RESEARCH FOR CO-DEVELOPMENT (ARCO), UNIVERSITY OF FLORENCE

In Africa, as in other more or less developed regions around the world, Covid-19 is having an asymmetrical impact on different population groups, intensifying already existing disparities. To design carefully-targeted policies and interventions in response to the crisis, it is essential that data and information vis-à-vis the impact of the pandemic on various aspects of the wellbeing of families be constantly updated. The World Bank has helped finance a coordinated survey initiative in several African countries whose aim is to analyze the socioeconomic consequences of Covid-19 by conducting ongoing, high-frequency phone surveys of a set sample of households.

Here is some information on the initial results of the survey conducted in Uganda, which revealed rising asymmetries among the population.

Firstly, **knowledge of the main symptoms of Covid-19** infection is not uniform, but instead correlated with the education levels of respondents. For example, on average 67% of the latter knew that fever was a possible symptom, but the figure dropped to 48% when respondents with no schooling were questioned. Furthermore, the poorest families, as well as those living in rural areas and those with low education levels, were less aware of important **preventive measures** such as the use

FIGURE 2 / SHARE OF HOUSEHOLDS WITHOUT ENOUGH SOAP TO WASH HANDS

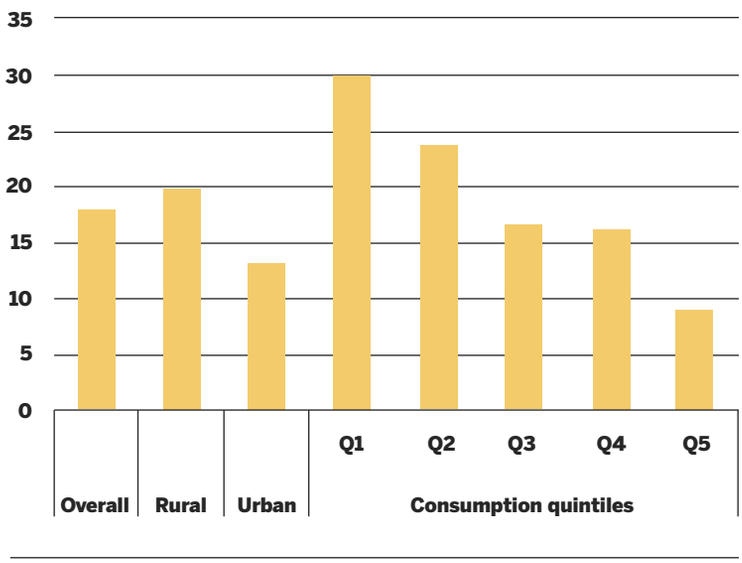
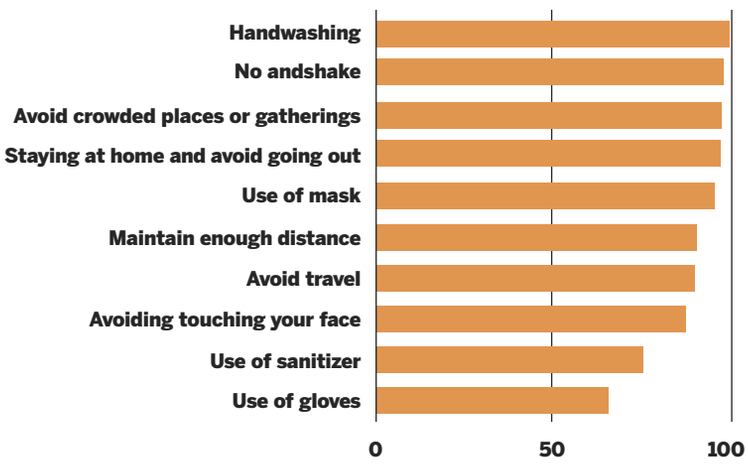
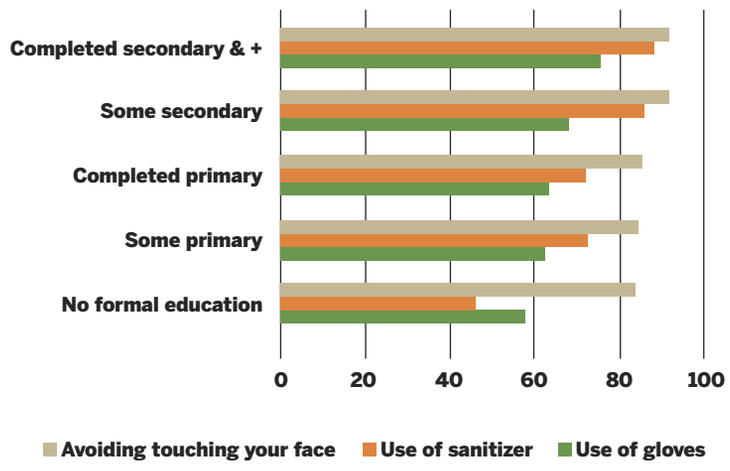


FIGURE 1 / KNOWLEDGE OF SELECTED MEASURES TO REDUCE THE RISK OF CONTRACTING CORONAVIRUS (% OF RESPONDENTS)



a) at the national level



b) by the level of respondent's education

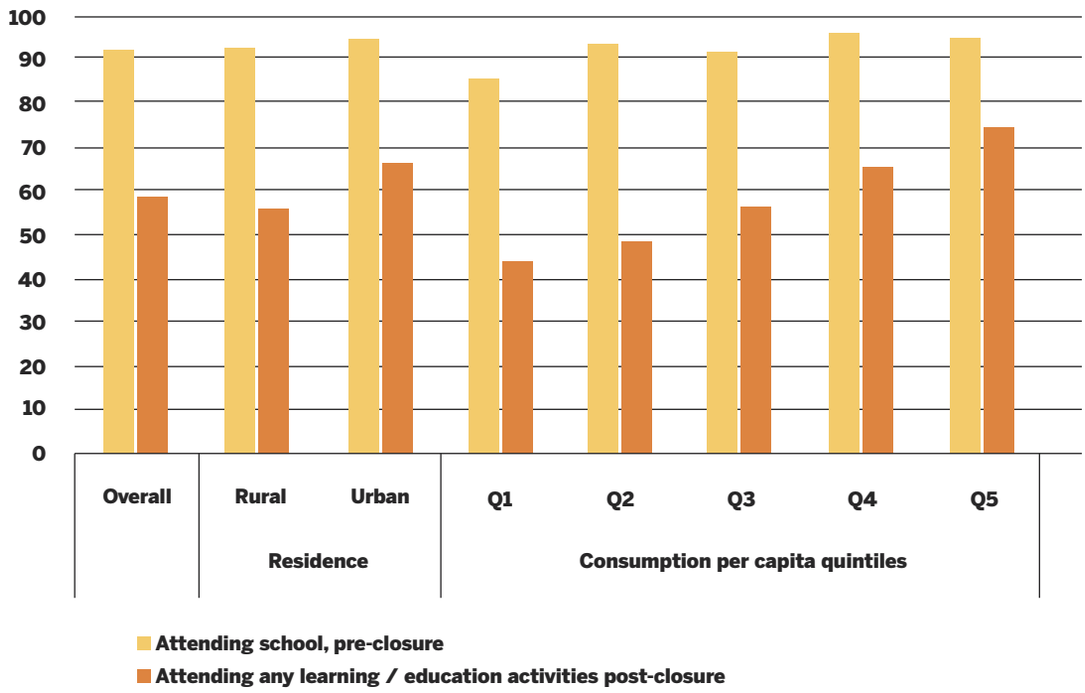
of sanitizers and gloves, and the need to avoid touching one's face.

No significant differences were found among the population in terms of perceptions of and **concern about Covid-19**: in fact, the vast majority of respondents considered Covid-19 to be a serious health threat – with 76% expressing worry about the possibility of infection – while an even higher number (86%) were worried about the impact of the crisis on their household financial situation. Despite this shared awareness, there were major **inequities in terms of access to essential goods and services**: although most of the population had access to water, the poorest families found it much more difficult to purchase soap. In addition, a lack of savings and growing costs were cited as key barriers with regard to the purchase of food items.

In terms of **access to health services**, approximately 80% of the respondents stated that they had had a need for medicines or treatment during the week prior to the interview, yet 33% of them, on average, had been unable to gain access to health services (36% in rural areas and 26% in urban areas).

The underlying causes of these differences were fewer savings and means of transport among rural households. There were also inequities in the **use of educational services**: following the closure of all Ugandan schools (on 20 March 2020), the percentage of households with at least one child able to study by remote learning varied greatly among different population groups, from 44% among the poorest to 74% among the wealthiest.

FIGURE 3 / SHARE OF HOUSEHOLDS WITH A CHILD (3-18) IN SCHOOL PRIOR TO CLOSURES VS. SHARE OF HOUSEHOLDS WITH ANY CHILD PARTICIPATING IN REMOTE LEARNING ACTIVITIES AFTER CLOSURES



SOURCE

1 *World Bank and Uganda Bureau of Statistics (2020). High-Frequency Phone Survey on Covid-19: Impact Monitoring First Round.* Available at https://blogs.worldbank.org/opendata/uganda-high-frequency-phone-survey-covid-19-results-round-1

EXPERIENCES FROM THE FIELD

PANDEMIC COMPLICATIONS: THE CASE OF WOLISSO

The Covid-19 pandemic is taking a devastating toll even in countries that have managed to mitigate its direct impact, such as Ethiopia. Despite a relatively low death rate, the country has seen dire consequences vis-à-vis hospital admissions for in-patient visits, hospitalization and deliveries; and the drop in payment for services has brought grave financial consequences for health facilities.

TEXT BY / FABIO MANENTI / DOCTORS WITH AFRICA CUAMM

The Saint Luke Hospital in Wolisso, Ethiopia, is located about 100 km from Addis Ababa, the nation's capital. Owned by the Ethiopian Catholic Church, it is a non-profit private facility supported through the partnership of Oromia Regional State, Doctors with Africa CUAMM, other donors and patient contributions. It serves an area with some 1.2 million inhabitants. The first suspected case of Covid-19 was recorded in Ethiopia on 13 March 2020. Although it turned out to be negative, and notwithstanding the containment measures already instituted, fear of a potentially swift and dire pandemic scenario began to spread among the population (health workers included), leading to a plunge in hospital admissions.

Immediate steps were taken to curb the spread of the virus, including setting up:

- systems for triage and entry screening in a tent in front of the hospital, in order to isolate patients suspected of infection before allowing them to enter the premises;
- training and awareness-raising activities for all hospital workers to ensure adequate containment measures and management of suspected or confirmed cases;
- a task force to handle the emergency in line with Health Ministry guidelines, which called for a Covid-19 point person inside the hospital.

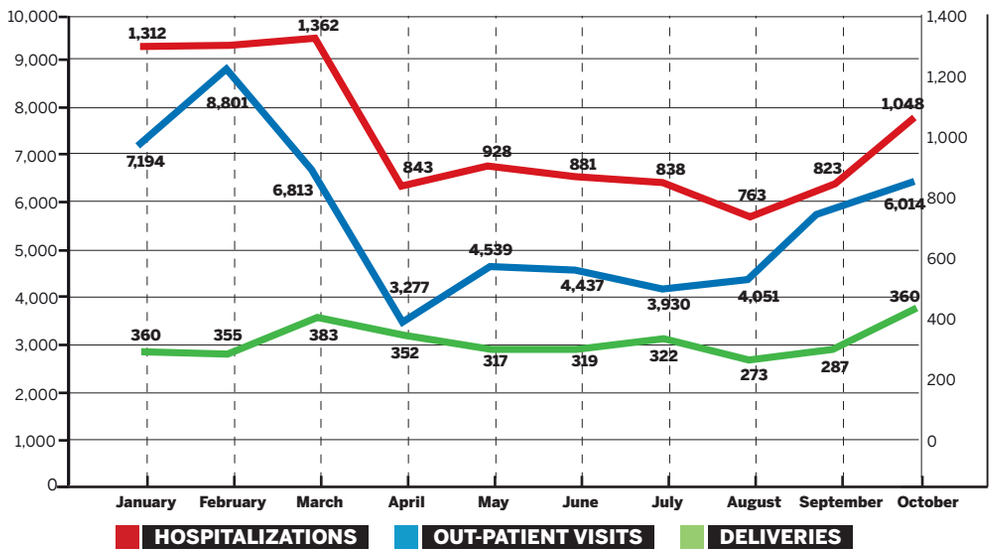
Infected patients – most of whom were asymptomatic – were kept in a special facility outside the hospital, while the most serious cases were treated in special isolation rooms inside.

The first case, in a patient who passed away, was recorded on 3 August 2020. Thereafter there were few other cases up through 1 October, when the numbers began to climb. Overall, 30 positives cases were found after 162 swabs; 18 were asymptomatic, 7 had moderate symptoms and were sent home to isolate, 3 were hospitalized and 2 died. Despite the limited number of severe cases and total of three dead, a disproportionately steep drop was seen in both out-patient visits and hospitalizations: compared to 2019, 2020 end-of-year projections estimated a 24% drop in the former, an 18% drop in the latter, a 9% drop in deliveries, and a 17% drop in pediatric and neonatal admissions. Only in September 2020 was there a partial recovery (**figure 1**).

It is not difficult to understand how people's failure to access visits and treatments had an indirect impact in terms of their health, bringing a risk of increased complications. But it also weighed heavily with regard to the revenue of the hospital, which as a private non-profit facility depends on the payment of certain fees by patients to cover part of its expenses[1]. Overall, in 2020 the hospital will see a 20% drop in the revenue derived from such fees – equivalent to some 150,000 Euros. At the same time, due to an increase in health workers' wages instituted by the Ethiopian government, its expenses will actually rise slightly. A way had to be found to cover these costs in order to maintain the hospital's appeal. The difficult situation has been managed thanks to extraordinary donations.

In conclusion, the indirect effects of the pandemic have been far greater than the direct ones in terms of both people's health and the hospital's financial stability. Further fallout from the macroeconomic situation, including even greater impoverishment, are a cause for concern in terms both of the former and of the capacity of hospitals like Saint Luke and public health care systems overall to cope with expanded health needs.

FIGURE 1 / 2020 TRENDS AT THE HOSPITAL IN WOLISSO



NOTES

1 Delivery, which is always free, is an exception.

EXPERIENCES FROM THE FIELD

HOME-BASED CARE: TACKLING TUBERCULOSIS IN UGANDA

Based on a swift assessment of the heightened risk of patient abandonment of TB treatment during Uganda's lockdown, we implemented an intervention to provide the population with a monitoring service and home-based care, and had an unexpected success in times of Covid-19: a rise in completed treatments and lower drop-out rates.

TEXT BY / SIMONE CADORIN / DOCTORS WITH AFRICA CUAMM

Tuberculosis (TB) is one of the leading communicable diseases today, with some 10,000,000 cases worldwide yearly. Although epidemiological studies show that the numbers are slowly falling, thanks to the efforts of the international community and affected countries, the disease remains widespread, particularly in the Global South, where it usually strikes those who are already the most marginalized and vulnerable.

A quarter of all new TB cases worldwide are in Africa, most of them in lower- and middle-income nations in the sub-Saharan region, whose national health systems – given their deficiencies in terms of preventive, diagnostic, and therapeutic treatment services – do not yet have the capacity to cope with the epidemic.

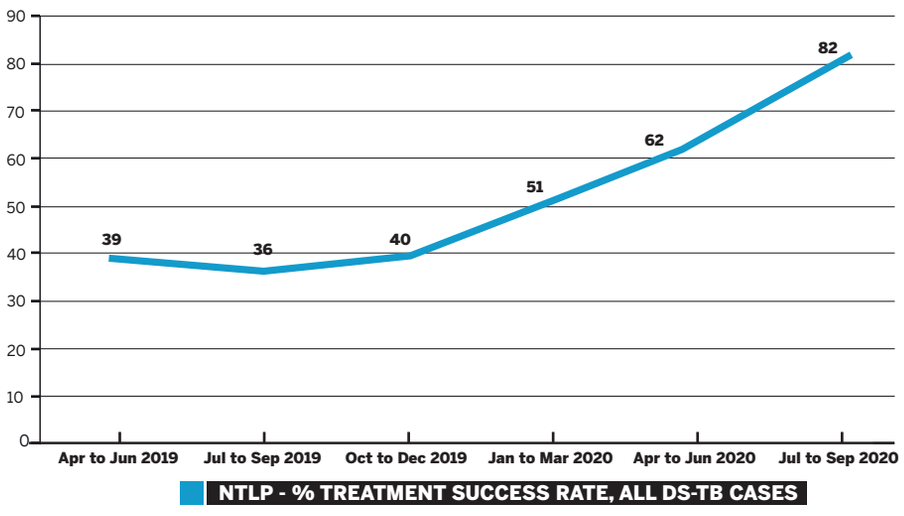
In Karamoja, in northeastern Uganda, where CUAMM began carrying out a program to tackle TB in 2018, some 6,176 new TB patients are expected every year, weighing heavily on an already fragile regional health system that has few resources to ensure the implementation and monitoring of services. The situation has been aggravated by a high rate of non-compliance with treatment, which is mainly due to the local population's semi-nomadic culture and the low disposition of patients for long-term therapies.

The onset of the Covid-19 pandemic has made matters even worse, negatively impacting access to health services, including that of TB patients. In fact, the restrictive measures imposed by the Ugandan government – including the suspension of public transport, a curfew, and a travel ban – have seriously jeopardized people's ability to access medicines and monthly clinical visits.

As a solution to these difficulties, CUAMM personnel, together with Uganda's Ministry of Health and district authorities, decided to create a home-based care service to enable the distribution of medicines and clinical review of TB patients in their own homes. This measure helped to ease some of the negative effects of the pandemic, and to improve patient compliance with treatment.

Thanks to the intervention, we were able to continue to treat the patients and recorded no significant negative changes in their treatment completion trends; indeed, the percentage that successfully completed treatment rose sharply, from 39% in April 2019 to 82% in September 2020. Moreover, drop-out rates also fell, from an average of 42% in 2019 to 11% in 2020.

FIGURE 1 / TB TREATMENT SUCCESS RATE IN KARAMOJA IN 2020



EXPERIENCES FROM THE FIELD

REORGANIZING HEALTH SERVICES IN SIERRA LEONE

Our experience organizing health services and preparing communities during Ebola has played a vital role in our handling of the Covid-19 pandemic. Even so, the current crisis has led to a drop in the number of assisted deliveries and a rise in maternal mortality in the facilities we manage here. CUAMM's work continues, based as always on our longstanding principles.

TEXT BY / CLAUDIA CARACCIOLO / DOCTORS WITH AFRICA CUAMM

Since the start of the pandemic, Sierra Leone has recorded a total of 2,406 cases of Covid-19 – a relatively limited number compared to other countries, and also a noteworthy one, given that the local culture complicates social distancing and 47% of the population has only on-and-off access to running water. The factors underlying this apparent "resistance" to SARS-CoV-2 are being looked into, but credit is due at least in part to the government's timely actions: **the National Covid-19 Emergency Response Center (NACOVERC) launched a plan for a prompt response** to the health crisis in February 2020, adopting many of the measures used during the Ebola outbreak that brought the country to its knees in 2014, but left it with critical know-how on epidemic preparedness.

Community Care Centers (CCCs) were readied, Covid-19 Treatment Centers (CTCs) with a total of 820 hospital beds were set up, and an awareness-raising plan was implemented to provide the community with information on preventive measures such as social distancing, handwashing and the correct use of masks. The country also adopted restrictive measures including lockdown and the closures of borders and airports.
CUAMM took part in NACOVERC's technical meetings, helping draft guidelines on the management of Covid-19 in pregnant women and protocols for Community Health Workers (CHWs, who are among the most at-risk parties), while at the operational level we sought to identify new needs:

- the **National Emergency Medical Service (NEMS) ambulance service** made transport available not only to obstetric patients, as before, but now also to Covid-19 patients, who would otherwise be unable to get to the hospital for a safe delivery due to the lockdown;
- **support for hospital clinical activities** was ensured thanks to the ongoing presence of specialists from abroad;
- **stocking and distribution of drugs**, equipment and protective items (e.g. masks) was carried out;
- **540 health workers were given training**, with theoretical and practical courses on Covid-19;
- **tents were set up at hospital entrances** for patient screening, and other areas were reworked to create isolation spaces for patients suspected of infection;
- **CHWs provided communities with accurate and clear information** on the pandemic and taught them how to prevent infection.

Despite this response, as the virus advanced, anxiety continued to grow among the population – understandably, given how Ebola seared the collective memory. This led to a **drop in the use of health services**, with deliveries at the Princess Christian Maternity Hospital (PCMH) plunging by 46.8% in April 2020 compared to the previous year (779 in April 2019 vs. 414 in April 2020).

In the three Regional Hospitals in Sierra Leone where CUAMM maintains a presence (PCMH, BO Hospital and Makeni Hospital) **16 maternal deaths due to indirect causes were recorded between April and June 2020, compared to 4 in the same period in 2019**. At PCMH alone there were eleven such deaths in 2020, while 2019 saw only a single maternal death in the first three months of the pandemic.

Restrictive measures such as social distancing also led to a falling-off in blood donations, which has jeopardized the timely response to obstetric emergencies.
In addition, nearly 11% of the country's health workers have been infected with Covid-19. Quarantine by doctors, nurses and cleaners has made it necessary to close some wards (including Freetown's pediatric hospital, with infants in critical conditions being transferred to unsuitable facilities) and operating rooms, thereby increasing the workloads of other hospitals.

The crisis has not yet come to an end, but CUAMM's work continues, based as always on our longstanding principles: ensuring care and trust in our relationships as we stand side by side with local populations.

EXPERIENCES FROM THE FIELD

UNDER THE RADAR: COVID-19'S SOCIETAL IMPACT

Nine months since the first cases of Covid-19 were reported in Africa, the impact of the crisis in Mozambique can be gauged not only in terms of health but also social phenomena such as child marriage, violence and demand for traditional healers. Rising poverty is producing "under-the-radar" reactions that imperil both health and development.

TEXT BY / EDOARDO OCCA / DOCTORS WITH AFRICA CUAMM

HIDDEN NUMBERS

The Covid-19 pandemic in Mozambique is not only an enormous challenge for the country's already shaky health system; it is also affecting sociocultural dynamics, making manifest often hidden phenomena that impact the health of rural communities. Among these are a worrisome resurgence of the practice of child marriage; a rise in the number of women exchanging occasional sexual acts for money; the regaining of influence and authoritativeness by traditional leaders and healers through the spreading of (erroneous) health-related messages; a significant increase in cases of gender and domestic violence (situations which health facilities rarely pick up on, usually only in extremely serious cases); and a widespread intensification of ethnic and linguistic identity (addressed especially toward non-Africans, who are seen as "importers" of the pandemic). Together they are breathing new life into the same sort of mass psychological mechanisms and beliefs seen years ago vis-à-vis HIV/AIDS, and that tend to appear whenever some far-reaching health problem imperils the already precarious subsistence economy and undermines social cohesion.

Due mainly to the restrictions imposed to curb the virus's spread, commercial and economic flows have slowed down, and sometimes even come to a complete standstill. It is against this backdrop of mounting uncertainty and poverty that the above-mentioned phenomena, which the health system often fails to pick up on, are taking place. It is difficult to expose, track and document them, unearthing evidence in terms of data and cases. But the numerous accounts received by the hundreds of activists who work on the ground for CUAMM are vital for conducting a broad analysis of the situation through a systematic reading of the social response to the worsening life conditions indirectly engendered by the pandemic.

THE FALLOUT ON THE WEAKEST

The situation is leading to girls, even very young ones, being seen as "stores of value" that can help rally dire financial circumstances: our activists have seen cases where instead of actual marriages, parents make formal agreements to "mortgage" off their underaged daughters as future wives in exchange for advance payments of assets by the future husbands.

Even though they are monitored by local health services, especially vulnerable and marginalized groups such as sex workers report worsening life conditions due to the significant rise in the number of destitute women offering occasional sexual services; this, in turn, is heightening both tensions and the risk of sexual and reproductive health problems that the system often misses.

THE ROLE OF ACTIVISTS

Carried out through qualitative interviews and door-to-door follow-up (although the effectiveness of these methods has been negatively impacted by the pandemic), the painstaking work of activists, together with the involvement of formal and informal institutions such as health committees, councils of the elderly and community courts, is a precious tool for keeping abreast of the situation on the ground, informing and providing services to the community and keeping a large at-risk "borderline" population from being excluded from the health system.

WORKING WITH THE COMMUNITY

Analyzing the current situation through a social lens underscores two points:

- maintaining deep roots in urban, peri-urban and rural areas is an indispensable strategy for reaching the most vulnerable, marginalized and destitute populations;
- health indicators, especially vis-à-vis reproductive health, are a vital prism through which to understand local communities and analyze their care-seeking attitudes and behaviors. Doing so enables the design of the most apt support strategies for local systems, ones able to respond to objective priorities through ever-more timely and effective interventions characterized by expertise and sociocultural sensitivity.

EXPERIENCES FROM THE FIELD

MOZAMBIQUE: MOVING BEYOND CRISIS

It's not enough to respond to emergencies; a long-term perspective is necessary in our work, with the design of interventions in partnership with local people and organizations to tackle actual needs while also promoting a sense of community and resilience. In Mozambique CUAMM carries out targeted pandemic-related projects alongside non-crisis-related initiatives to support the most vulnerable.

TEXT BY / GIOVANNA DE MENEGHI / DOCTORS WITH AFRICA CUAMM

A FRAGILE TERRITORY

Although it is one of Mozambique's wealthiest provinces in terms of natural resources, Cabo Delgado suffers from a lack of government investment in services and job opportunities. It became the center of armed clashes in October 2017, with an intensification in the number and brutality of the attacks (kidnappings, houses set on fire and other forms of violence) in the early months of 2020. To date, in a province with 2,320,261 inhabitants (CENSO Moçambique 2015), there have been more than 600 attacks and 2,000 deaths, 1,100 of which were civilian (ACLED, November 2020), generating more than 350,000 internally displaced persons (IDPs), according to United Nations estimates.

CUAMM'S TWO-PRONGED RESPONSE

In this volatile situation, with the crisis fast turning into a civil war, CUAMM – which has been active in Cabo Delgado since 2014 – has taken a two-pronged approach. First, we are proceeding with our development work, but adapting activities to the new circumstances so as to reach a larger number of beneficiaries, including IDPs; second, we are intensifying our efforts in order to tackle multiple new emergencies (Covid-19, IDPs, and a cholera epidemic).
The end goal is to ensure the continued functioning of the national health system, preventing it from collapsing under the weight of the frequent acute emergencies in recent years (cholera and Covid-19 epidemics). Thus our efforts are aimed at ensuring basic health services, such as prenatal and post-natal visits for pregnant women and mothers, vaccination coverage for children, and ongoing treatment for chronic patients.
We are basically working on two fronts, bolstering our human and financial resources while making the most of our presence in the area, which is by now consolidated and recognized by district beneficiaries and authorities. For example, at the moment CUAMM is supporting the Montepuez Rural Hospital not only with drugs and equipment, but also a doctor in charge of neonatology, a surgical health technician in the surgical unit, and two maternal and child health nurses who are providing maternal, infant and neonatal training in health centers associated with the hospital.

ACTIVISM IN THE FARTHEST CORNERS

Another key role in the provincial health system is played by 300 community health activists who work to raise awareness among the population, providing information and advice on prevention on Covid-19 as well as HIV/AIDS, malaria, cholera and diarrheal diseases.
Recognized officially by health authorities, traditional leaders and the community, these activists play an essential role in connecting the latter with health facilities, helping to create bridges between patients and care centers and ensuring the continuation of treatment plans, for example for HIV patients.
Indeed, HIV is still a major problem in the country: according to WHO data, Mozambique recorded 120,000 new cases of infection in 2019 (4% of all African cases), and the number of HIV/AIDS-related deaths was expected to rise dramatically in 2020 due to patients' restricted access to health units to begin therapy, an indirect result of the Covid-19 pandemic.
Sub-Saharan African nations are currently experiencing very daunting challenges. In these areas, responding to emergencies is not enough; to avoid jeopardizing the progress made until now we need to do more. That's why CUAMM takes its more systemic, broad-based approach in close partnership with local health systems – the only way, in the words of the United Nations, to "leave no one behind".

ROUTES OF CARGO FLIGHTS

SUPPLIERS
10
coming from
all over the world

TOTAL
PACKAGE
VOLUME
102 CUBIC METRES

TOTAL WEIGHT
OF THE GOODS
13.730 KG

TOTAL VALUE
OF THE GOODS
629.000 USD

TOTAL VALUE
OF THE
FLIGHTS
135.000 USD

CARGO
FLIGHTS
16

HUMANITARIAN
PERSONNEL
36

OPERATIONAL PROCESS

HUMANITARIAN PARTNERSHIPS

Intervening in a timely manner to bring aid during humanitarian emergencies is very challenging, with logistics playing a fundamental role in making things work. That's why Doctors with Africa CUAMM became a partner of the United Nations Humanitarian Response Depot (UNHRD) early on in the Covid-19 pandemic.
UNHRD is one of the services that the World Food Programme (WFP), a UN agency, makes available free of charge to the global humanitarian community. With six logistical bases located in strategic points around the world (Brindisi, Italy; Accra, Ghana; Dubai, United Arab Emirates; Kuala Lumpur, Malaysia; and Panama and Las Palmas, both in Spain), the network offers its partner organizations a broad range of logistical services for emergency preparedness and response – from warehousing to purchasing to shipping – making it possible for various humanitarian agencies and groups to respond swiftly to crises around the world. Thanks to our own partnership with UNHRD and WFP, CUAMM has been able to act quickly during the current crisis, organizing 16 cargo flights to get protective materials to South Sudan, the Central African Republic, Sierra Leone, Uganda, Mozambique and Angola.
Given our well-consolidated knowledge of African health systems and ability to intervene during emergencies when necessary (for example, during the Ebola crisis in Sierra Leone and Cyclone Idai in Mozambique), CUAMM can now also rely on UNHRD's services to respond even more rapidly when humanitarian crises strike.

(Maria Brighenti, Doctors with Africa Cuamm)

EXPERIENCES FROM THE FIELD

CUAMM'S RESPONSE TO COVID-19 IN ITALY

Thanks to our experience in sub-Saharan Africa, CUAMM has been able to intervene not only there but also in Italy in response to the Covid-19 crisis. Underscoring the imperative of acting in unison during a pandemic, our integrated project trains health workers and junior doctors and provides support to hospitals and the most vulnerable segments of the population.

TEXT BY / ANDREA ATZORI / DOCTORS WITH AFRICA CUAMM

A DUAL RESPONSE TO COVID-19: AFRICA AND ITALY

At a time of profound crisis worldwide, Doctors with Africa CUAMM is implementing a dual response – in Africa and in Italy – to the Covid-19 pandemic. In Africa, we have secured more than 20 hospitals in 8 countries, using international humanitarian flights to provide both personal protective equipment (PPE) and equipment for triage and patient care. We have also trained health workers and done awareness-raising among communities on preventive measures. In Italy, we've sought to respond to numerous appeals from health workers who've taken part in missions to Africa over the years, and who have now been on the front line in our own country since the start of the pandemic – appeals related to problems such as the needs for the right quantity and type of PPE[1] to keep operators safe[2], for "dirty" and "clean" paths in facilities, and for triage areas to screen patients prior to entry. These are all issues that CUAMM already dealt with to some degree while tackling Marburg, Ebola, cholera and measles.

AN INTEGRATED PROJECT: INTERVENTIONS, TRAINING AND ASSISTANCE

Given our prior experience as well as our network of operators already on the ground in Italy, in April 2020 CUAMM launched its "4 respirators for 4 hospitals" program to support four intensive care units. Alongside our work in Africa, these initial activities served as a pilot for the development of a broader program subsequently approved by the United States Agency for International Development (USAID). Entitled "IRC19 Italian Response to COVID19", the program will last 14 months (June 2020 to August 2021) and involves 3 broad areas:

- supporting public and private hospitals, including through interventions by less traditional actors (e.g. NGOs);
- rethinking the training of already-active health professionals as well as that of new generations;
- bringing social and health aid to marginalized and vulnerable groups who often lack access to basic services, to tackle the pandemic's socioeconomic impact.

Every problem identified, and every intervention and activity proposed, was conceived and implemented thanks to constant dialogue and coordination with regional authorities, national associations, health facility managers and health worker representatives. Four main activities were defined:

1. **Supporting health workers in their fight against Covid-19 through infrastructure changes and in-service training.**

We modified spaces in 15 residential, territorial and hospital facilities, for example reorganizing entry/exit and "clean"/"dirty" routes, implementing triage sites, and creating staff dressing/undressing areas. These interventions also seek to humanize care, helping to create opportunities for patients to have contact with loved ones to reduce their sense of abandonment and isolation. Because human interaction can help to manage illness and suffering[3], the program will also provide network connections, purchase tablets for video calls, launch telemedicine for remote psychological consultations and create protected areas for visits with family members, for example in nursing homes. In addition to this infrastructure work, CUAMM is also training doctors, nurses and health workers through the development:

- in partnership with the Novara-based Research Center in Emergency and Disaster Medicine (CRIMEDIM), of a training package for health professionals on the management of emergencies in health facilities and the organization of emergency work (e.g. patient paths, procedures for putting on and removing PPE, etc.);
- of a free training package by CUAMM focused on the wellbeing of nurses and social/health workers, whose work conditions have been made more difficult and stressful by Covid-19. The package will consist of videos on nutrition, psychology, physical preparation and breathing.

2. **Training upcoming generations of health workers by integrating university/higher training with new modules on public health and epidemics/pandemics.**

In partnership with the Italian Secretariat for Medical Students (SISM), the FederSpecializzandi Association, the Italian Secretariat for Young Doctors (SIGM) and 39 Italian universities, CUAMM continues to intensify its work in this area, offering both traditional training modules and digital debates to spur discussions on the topic of health in the broadest sense.

3. **Expanding CUAMM's local engagement with a focus on the concept of health as a universal right and the repercussions of Covid-19 both in Italy and worldwide.**

CUAMM is able to foster dialogue at the local level thanks to its 27 volunteer support groups in 11 Italian regions. These groups or-

ganize awareness-raising events and campaigns focused on Covid-19, international cooperation and our global world.

4. **Protecting specific vulnerable groups by ensuring their access to basic health care and preventive measures and providing them with immediate material help.**

With projects focused as always on the poorest and most vulnerable sections of the community, CUAMM has identified two Italian areas heavily affected not only by the health crisis but also great social hardship:

- in the Apulia region, thanks to the work of a mobile team of health professionals and psychologists, we are providing basic health care to seasonal migrant farmworkers in the heavily populated area known as "Ghetto Pista" (see p. 18)[4];
- in the Liguria region, near the city of La Spezia, we are distributing food kits to families in financial distress and providing daytime hospitality services (breakfasts/dinners, showers, toilets and washing machines) to the poor and homeless, whose numbers have grown as an indirect effect of the pandemic (see box at right)[5].

THE LEGACY OF OUR EXPERIENCE IN AFRICA: TECHNICAL AND CULTURAL KNOW-HOW ON MANAGING THE PANDEMIC

The Covid-19 pandemic is one of the greatest health, economic and social shocks of our time. For the first time, developing countries and more economically advanced ones are sharing similar problems, and the experiences of health professionals in the former have become, perhaps never before to such a degree, an added value for their work in Italy. Sharing our experience with the containment of past epidemics in low-resource settings– and on the fight against poverty in general – is something that NGOs like CUAMM have done for decades. We are now applying this technical and cultural know-how to Italy as well, while continuing to implement our programs in Africa and to foster critical dialogue between the global North and South on issues such as the imperatives of sustainable development and universal access to healthcare.

NOTES

1 European Parliament & Council of the European Union (2016). REGULATION (EU) 2016/425 OF THE EUROPEAN PARLIAMENT AND OF THE COUNCIL of 9 March 2016 on Personal Protective Equipment and repealing Council Directive 89/686/EEC. Official Journal of the European Union.

2 Hashikura, M., & Kizu, J. (2009, November). Stockpile of personal protective equipment in hospital settings: Preparedness for influenza pandemics. *American Journal of Infection Control*, 37(9), pp. 703-707. doi:10.1016/j.ajic.2009.05.002

3 Melotti, R. M., & et. al. (2009). Progetto umanizzazione delle cure e dignità della persona in terapia intensiva della Regione Emilia-Romagna. *ANESTESIA FORUM*, p. 2; 75-82.

4 Jedwab, R., Khan, A. M., Damania, R., Russ, J., & Zaveri, E. D. (2020). *Pandemics, Poverty, and Social Cohesion: Lessons from the Past and Possible Solutions for COVID-19*. The George Washington University. Institute for International Economic Policy Working Paper Series.

5 Diwakar, V. (April 2020). *From pandemics to poverty Hotspots of vulnerability in times of crisis*. ODI.org.

AIDING LA SPEZIA'S NEEDIEST

Partnering with institutions and decisionmakers, standing alongside and aiding local communities, conducting awareness-raising activities: CUAMM's three-pronged approach to Covid-19 in La Spezia.

TEXT BY / MARINA TRIVELLI / DOCTORS WITH AFRICA CUAMM

After 12 years as a surgeon with Doctors with Africa CUAMM, I was a bit anxious about life back in Italy. Given the variety of activities in Africa, I was concerned that working in an Italian surgical unit might seem tedious in comparison. That's why I decided to work in an emergency room instead – a stimulating role that offers plenty of variety from both a professional and human viewpoint, and the good fortune of having shiftwork that enables me to spend time with my family and to do volunteer work, both essential for those of us with a missionary vocation.

In La Spezia I had the opportunity to meet other people with the same vocation of working in solidarity with the neediest. A Vincentian association called "Breakfast with a Smile" was established and did its best to make the homeless feel welcome and "at home". While at first it limited itself to simpler services such as providing breakfast and essential goods, later it began to offer services that were otherwise not present: showers and bathroom areas, a laundry service and – importantly – a luggage deposit (you can't bring all your belongings when you go for a job interview).

Other key activities to support our friends include a social secretariat and local chaperoning, also vis-à-vis healthcare needs, with the creation of a mobile clinic in partnership with the Italian Orders of Physicians, Nurses and Pharmacists.

Last but not least, with the onset of the Covid-19 crisis in February 2020 we began to support 96 families, primarily those of seasonal workers whose work contracts had vanished, leaving them with no way to survive.

But doing all of this through self-financing and food collections alone soon became very difficult. So when Doctors with Africa CUAMM decided to focus on marginalized and vulnerable groups in Italy as well, starting with projects already launched by returning volunteers and CUAMM support groups, it felt as if a circle had closed. Thanks to its support, we've been able not only to continue to offer the above-mentioned services (with some 2,400 breakfasts, 700 washing cycles and 640 showers provided every month), but also to provide an evening meal service in La Spezia, with the distribution of approximately 3,000 dinners. We also provide the 96 families (around 300 individuals) with long-life and fresh food products every two months, and have set up more showers and purchased an industry-style washing machine and dryer as well as other appliances for refrigerating food products.

REVIEW

FOGGIA: THE FARTHEST CORNER OF OUR OWN BACKYARD

There is great need for help in the Apulia region's "ghettos", where migrants with precarious jobs live in conditions of terrible poverty. After working in this remote corner of "our own backyard" since 2015, CUAMM has expanded its presence during the Covid-19 crisis to guarantee basic healthcare and necessities.

TEXT BY / LUCIA RAHO / DOCTORS WITH AFRICA CUAMM BARI

When the Covid-19 epidemic struck, we were already there, standing alongside the neediest in our own province of Foggia, to uphold the principle of health as a universal right. Medici con il camper (Doctors with a Caravan) had been launched back in 2015 to help improve dire situations "in our own backyard"; since then it has grown and continues to bring health care to the neediest living in the area's so-called "ghettos"1. Last April, the project became part of the Apulia region's Covid-19 task force, with the SUPREME-FAMI program, whose goal is to help prevent the spread of Covid-19 among migrants living in informal settlements, and to continue to get them the health care they need.

During the spring our beneficiary population did not change much, the usual seasonal increase having failed to come. There was a tangible sense of urgency, recognized in part thanks to the involvement of local and health institutions, which made it possible to begin finding solutions to long-standing, seemingly-irresoluble problems such as garbage collection, clean water, food distribution, the setting-up of housing units and isolation areas for those suspected of infection, public transport, making it easier for local health authorities (ASLs) to issue health cards for "temporarily present foreigners" (STPs). No positive cases of Covid-19 were found among those initially suspected of infection.

After the first few months, people's fear of contagion began to take second place to their need to work, the reason for their migration. Once they began to travel around the region again, reports of suspected cases began to surge, bringing the need for contact tracing, isolation and clinical surveillance. Along with it came resistance to the restrictive measures being imposed, as well as serious logistical problems: how best to trace the contacts of a population that tends to live in remote areas? Or to ensure isolation in overcrowded slums, or enforce isolation rules without breaching the principles of the rule of law? Seventeen suspected Covid-19 cases were reported, and all were found to be positive.

But it was precisely at this time of grave health and economic instability that the forces of solidarity began to mobilize in the area: food items collected by Caritas, donations of PPE, and medicines and health materials provided at a discount. We also received contributions from crucial partners: USAID, which ensured the distribution of food kits at set intervals, and ANLAIDS, with an HIV screening project that was already underway prior to the pandemic and continued after its arrival.

Although the crisis isn't yet over, I'd like to share some reflections. The first has to do with the need to ponder the close interrelationship between epidemics and human frailty that Covid-19 has underscored for us all: the pandemic's primary victims are the elderly and various populations who lack socioeconomic and other certainties. The second concerns Italy's national health system, which should ensure healthcare for all, giving priority to the most vulnerable and marginalized. Finally, the role that politics can play in tackling, as broadly and decisively as possible, the determinants of health: housing, water and sanitation, work and working conditions, education and health services. Health interventions are otherwise only hasty solutions that paper over deep-seated problems without getting at their causes.

NOTES

1 Health services are provided to the inhabitants of two Region-supported migrant centers (Casa Sankara and Arena in San Severo) and two informal settlements in Contrada Cicerone, San Marco in Lamis and Pozzo Terraneo-Cerignola.

REDISCOVERING IVAN ILLICH

The Covid-19 pandemic has set off a perfect storm. Investments and reforms will not be enough to make our societies more sustainable, digital and inclusive; we need to take a critical look at today's socioeconomic model and find a new ethical and human balance. Rediscovering the thought of Ivan Illich is helpful.

TEXT BY / GIOVANNI PUTOTO / DOCTORS WITH AFRICA CUAMM

A CRITIQUE OF CLICHÉS: NO TO THE *PENSÉE UNIQUE*

Ivan Illich was of mixed origins and background. Dalmatian, born in Vienna in 1926 to a Croatian father and a Sephardic Jewish mother, educated in Italy, a heterodox priest pushed aside by the hierarchy, yet deeply religious and tied to the Church; an encyclopedic, polyglot scholar who taught at several universities (including Trento, in Italy, and Cuernavaca in Mexico). And more yet: a historian, an author, a subtle polemicist up until his death in 2002, from a tumor that deformed his face and left him unable to speak. It is impossible to classify his thought, controversial and unique as it was. For Illich, the starting point of all reasoning was a critique of commonplaces, opening oneself up to different, minority, marginal viewpoints. His aim was not to provoke, but to recapture unusual visions of what had become so common that it had lost any signs of being problematic. This led him to expose the great modern illusion that «men are born to consume, and can achieve any goal by acquiring goods and services».

A CRITIQUE OF INSTITUTIONS: OVERSTEPPING THRESHOLDS

Societies in our epoch have been irrevocably marked by health crises, financial turmoil, mass migration, global warming, growing inequalities and political regression. Institutions have proven unprepared to govern the complexity and global nature of the problems facing humanity. It isn't by chance that we have reached this point, at risk of self-destruction. Back in the 1970s and '80s Illich, in a memorable group of essays, analyses and conferences, undertook a radical critique of modern institutions and the dogma of unlimited production and development. His central argument was based on the key concept of thresholds: when institutions and technologies exceed certain quantitative and qualitative thresholds, they end up backfiring on the very reason for which they came about, and putting the entire social body at risk of destruction – phenomena that generate paradoxical, counterproductive, incapacitating outcomes. Let's look at some examples.

In *Medical Nemesis: The Expropriation of Health* (1975), Illich denounces medical hyperspecialization and identified three forms

of disease generated by medicine itself (iatrogenesis). Clinical iatrogenesis is inherent to every medical act: hospital infection, surgical complications, the side effects of drugs. With social iatrogenesis, patients are subjugated, passive, forbearing, as they rely on the clemency of the medical oligarchy. Finally, with cultural iatrogenesis, medicine, which peddles youth and immortality, inhibits our ability to suffer and leaves us unprepared for death.

In *Deschooling Society* (1971) Illich points a finger at mass education, a superficial exercise that produces only technocrats and an asocial expert élite.

In *Energy and Equity* (1974) he decries as illogical our compulsory, traffic-filled mobility, which generates new addictions, devours time and pollutes the environment.

CONVIVIALITY, ENCOUNTERS, FRIENDSHIP AND HOPE

Illich is neither a proponent of "happy degrowth" nor a traditionalist. The "convivial society" that he proposes is alien from the market, a space in which people are free to mold matter and knowledge with and for others according to their own inclinations, and setting their own limits.

Above all, it is a space for encounters, authentic bonds of friendship with others with whom we seek out mutual credibility, respect and commitment. Thus are born peace and a sense of community, remarks Illich, and they grow stronger thanks to these same dynamics. In this convivial atmosphere, hope is fostered as an unpredictable, unexpected, surprising gift. "The survival of the human species," Illich concludes, "depends on recovering hope as a social force."

Ivan Illich, *Opera omnia*, Neri Pozza Editore, Milano, 2020

DOCTORS WITH AFRICA CUAMM

Founded in 1950, Doctors with Africa CUAMM was the first non-governmental organization focused on healthcare to be recognized by the Italian government. It is now the country's leading organization working to protect and improve the health of vulnerable communities in Sub-Saharan Africa.

CUAMM implements long-term development projects, working to ensure people's access to quality health care even in emergency situations.

HISTORY

In our **70** years of existence
- more than **200** programs have been carried out;
- **2,080** individuals have worked on our projects;
- **43** countries have partnered with our organization;
- **232** hospitals have been assisted;
- **1,139** students have lodged at CUAMM's university college, including 688 Italians and 280 citizens from 34 other countries;
- more than **5,000** years of service have been provided, with each CUAMM worker serving for an average of three years.

SNAPSHOT

Doctors with Africa CUAMM is currently active in Angola, Central African Republic, Ethiopia, Mozambique, Sierra Leone, South Sudan, Tanzania and Uganda with:
- **151 major development projects** and approximately one hundred smaller related initiatives. Through this work we provide support to:
  - 23 hospitals;
  - 127 local districts (with activities focused on public health, maternal and infant health care, the fight against AIDS, tuberculosis, malaria and training);
  - 855 health facilities;
  - 3 nursing schools (in Lui, South Sudan; Matany, Uganda and Wolisso, Ethiopia);
  - 1 university (in Beira, Mozambique);
- **4,777 health workers**, including 434 from Europe and abroad.

IN EUROPE

Doctors with Africa CUAMM has long been active in Europe as well, carrying out projects to raise awareness and educate people on issues of international health cooperation and equity. In particular, CUAMM works with universities, institutions and other NGOs to bring about a society – both in Italy and in Europe – that understands the value of health as both a fundamental human right and an essential component for human development.

PLEASE SUPPORT OUR WORK

Be part of 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 32 C 05018 12101 000011078904 at Banca Popolare Etica, Padua
- **Credit card** call +39-049-8751279
- **Online** www.mediciconlafrica.org

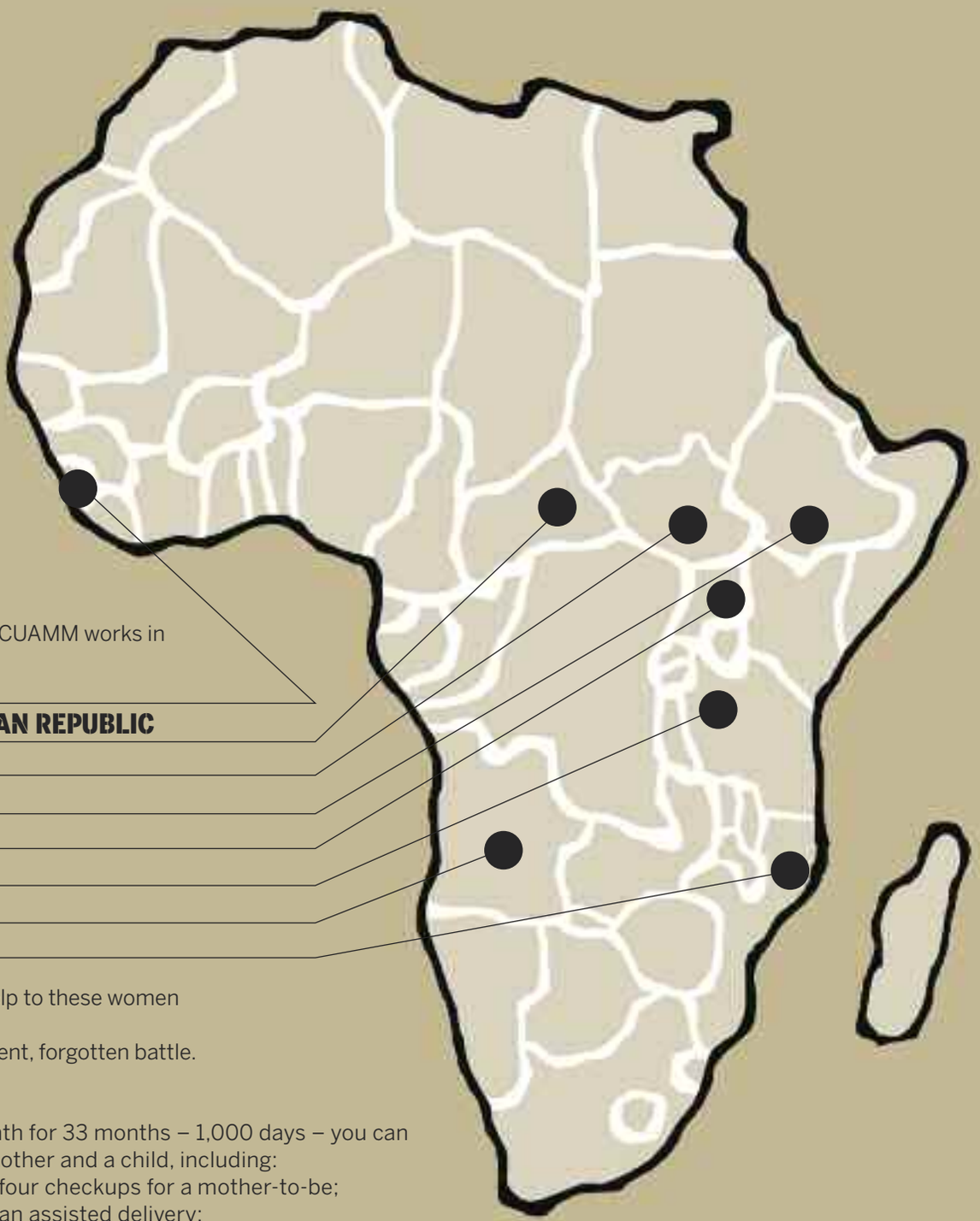
Doctors with Africa CUAMM is a not-for-profit NGO; donations made to our organization are tax-deductible. You may indicate your own in your annual tax return statement, attaching the receipt.

In ***Health and Development*** you will find studies, research and other articles which are unique to the Italian editorial world. Our publication needs the support of every reader and friend of Doctors with Africa CUAMM.

AFRICA IN NEED

EVERY YEAR IN SUB-SAHARAN AFRICA:

- 4.5 million children under the age of 5 die from preventable diseases that could be treated inexpensively;
- 1.2 million infants die in their first month of life due to lack of treatment;
- 265 thousand women die from pregnancy- or childbirth-related complications.



Doctors with Africa CUAMM works in

SIERRA LEONE
CENTRAL AFRICAN REPUBLIC
SOUTH SUDAN
ETHIOPIA
UGANDA
TANZANIA
ANGOLA
MOZAMBIQUE

to bring care and help to these women
and their children.
Help us fight this silent, forgotten battle.

With just € 6 a month for 33 months – 1,000 days – you can ensure care for a mother and a child, including:

- € 50 to provide four checkups for a mother-to-be;
- € 40 to provide an assisted delivery;
- € 30 to support a mother and her baby during the breastfeeding phase;
- € 80 to provide vaccinations and growth checkups during the weaning process.

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"When the Covid-19 epidemic struck, we were already there, standing alongside the neediest to uphold the principle of health as a universal right."