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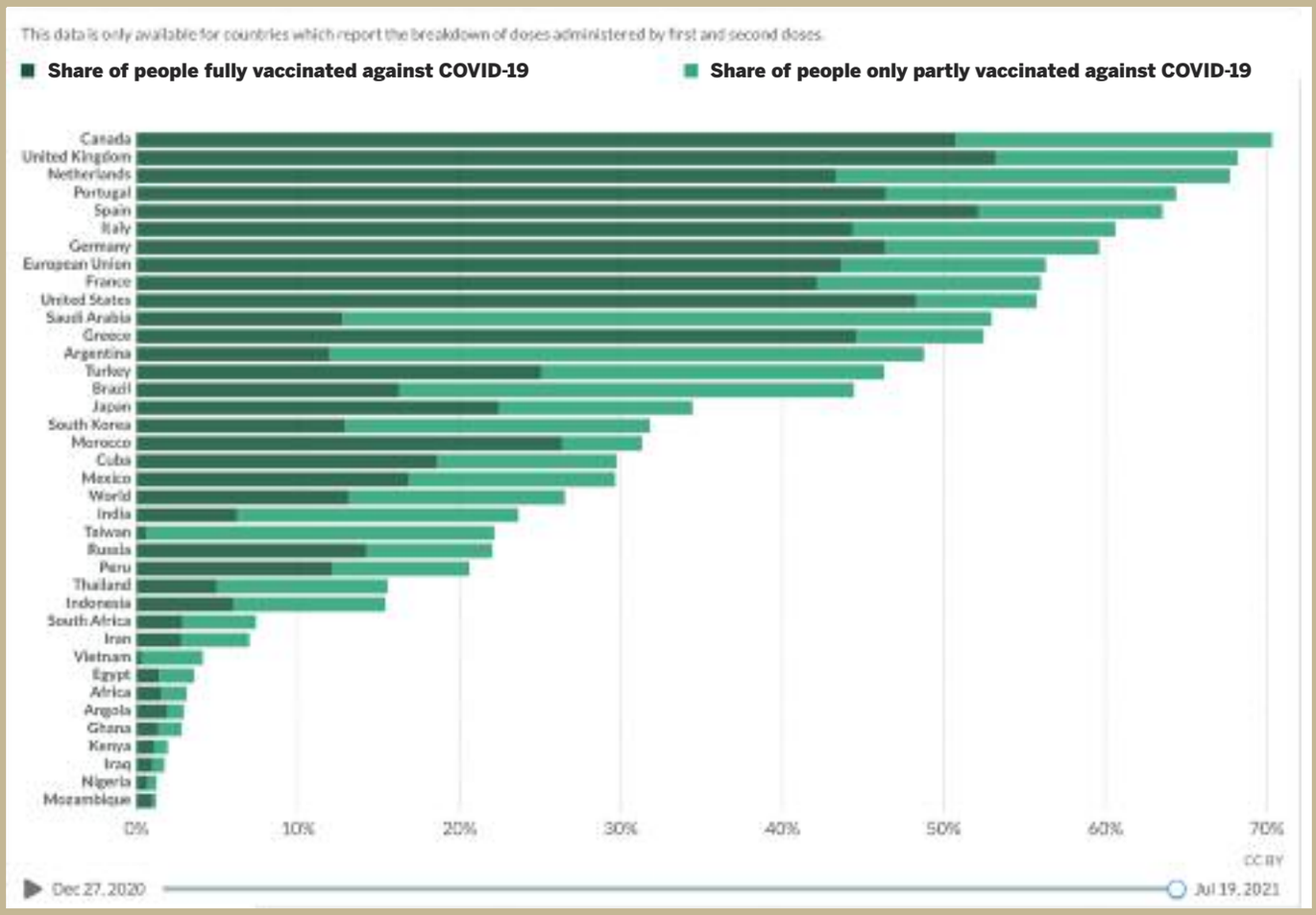
Vaccinations in Africa: an Obstacle Course

NEWS

Share of people vaccinated against COVID-19, Jul 19, 2021



Source: https://ourworldindata.org/covid-vaccinations

EDITOR

Gavino Maciocco

EDITORIAL STAFF

Andrea Atzori, Dante Carraro, Adriano Cattaneo, Silvio Donà, Fabio Manenti, Martha Nyagaya, Ana Pilar Betran Lazaga, Giovanni Putoto, Angelo Stefanini, Anna Talami, Ademe Tsegaye, Calistus Wilunda

EDITOR-IN-CHIEF

Anna Talami

A PUBLICATION OF

Doctors with 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

COVER ILLUSTRATION

Lorenzo Gritti

LAYOUT AND PRINTING

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

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Miriam Hurley

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Cover

Vaccinations in Africa: an Obstacle Course
Getting vaccinations to the most fragile groups is like running an obstacle course where the hurdles are many: the first, basic one is the scarcity of vaccines, of which there are still too few. And then logistical, organizational, and cultural barriers also must be overcome for vaccines to truly become vaccinations.

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GETTING FROM VACCINES TO VACCINATION, EVERYWHERE

Striving for an equitable distribution of vaccines as a form of "intelligent solidarity": this is not just out of a powerful sense of social justice but out of an ever-growing awareness of how much each of our lives — whether we're African, Italian, Asian — are connected to each other, in a collective perspective that reminds us that to save ourselves, we need to take a common path.

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

When over a year ago, Covid came to Europe from China, it seemed that there could be a "reversed world" in which the impact on Africa might be lesser or at least less overwhelming. There were ideas about why this might be the case — its younger population, exposure to other coronaviruses, possible coverage given by TB treatments — and it was hoped that the virus would not overwhelm a continent that is already fragile and scarred by recent natural disasters.

Now, a year and a half later, we are back to the same old situation. Attention is now not only on the spread of Covid-19, but also on vaccinations, which together with masks, social distancing, and tracing, are the tools we have available to control the epidemic. And so, if we look at the map of the world (see page 14-15), Africa is once again at the back of the global line. Few, very few, vaccinations define the too-familiar gap between the global north and the global south, rich countries and poor countries. The epidemic is turning out to be unequal too, because of the unequal consequences it bears in terms of disease, impact on the economic and social fabric, and unequal access to treatment.

Less than 1% of the population is vaccinated in countries such as the Central African Republic and South Sudan, less than 2% in Ethiopia, and just over 3% looking at Africa as a whole[1], compared to about 55% in Europe and the United States; these numbers make up the sort of map we have long been used to, the map of "a two-speed world," in the words of Prof. Mantovani (pg. 8).

The core of the problem is the shortage of vaccines for poor countries, underscoring the short-sightedness of international decision-makers: it should be clear to everyone that as long as there isn't protection for everyone, in every area, faraway and close, in Africa too, there is still the very real possibility that the virus will remain in circulation, generating new variants. Likewise, it is obvious that no virus will remain isolated or stop at the borders between countries.

This is how we should look at vaccine sharing globally, as a form of solidarity not only driven by ethics and a sense of social justice but also driven by practical intelligence. We could call it *intelligent solidarity*: an ever-growing awareness of how much each of our lives — whether we're African, Italian, Asian, etc. — are connected to each other, in a collective perspective that reminds us that to save ourselves, we need to take a common path. Pope Francis said as much this last May, that a "variant of this virus is closed nationalism, which prevents, for example, an internationalism of vaccines"[2]. This reflects an economy that cares about profit for few, forgetting the values of humanity and brotherhood. Forgetting that in a situation like this, sharing is the only way to take care of everyone and each of us.

While there are important initiatives such as those of COVAX to ensure vaccines to at least 20% of the population of low-income countries, at Cuamm we have recently developed and approved a vaccination plan for the eight countries where we work. The approach is the same that we have been taking for over 70 years: supporting African governments and organizations in the management of vaccines so that they can become actual vaccination. It is not enough for the vaccines to get to Africa; a healthcare and logistical effort is also needed, aimed at overcoming the obstacles often encountered in that last mile in Africa: the transport of vaccines to remote villages as well, and making sure they are stored and administered correctly. Our vaccination plan aims to integrate international initiatives and local efforts to make effective the right to vaccination.

This is the basis of a form of health ethics and respect for people: without protection human, social, and economic exchanges slow down and the gap between the global north and south becomes even more acute. How we understand global health seeks first of all to be fair, "decolonizing," so to speak, an approach to health that risks being for the few and dragging all the others towards health injustice, and economic injustice as a result.

A Vaccine for Us All is the name of the campaign we have launched to raise funds for vaccinations in African countries: the meaning is precisely in the shared value of that "us" because when it comes to public health, it is essential to overcome individualism and to think and especially act as a community.

NOTES

1 Updated data at https://africacdc.org/covid-19-vaccination/

2 Video message of the Pope sent to the participants of "Vax Live: The Concert To Reunite The World," May 2021.

DIALOGUE

WHEN THE VIRUS HITS INERTIA

The pandemic will be remembered for the lack of quick decision-making despite many authorities urging a rapid global vaccination program. This inertia has led to imbalances between global north and south, worldwide and locally, forgetting that the universal nature of the emergency should be met by a universal response.

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

"Vaccines are a global common good. It is a priority to increase their production, ensuring safety, and removing the obstacles that limit vaccination campaigns." These were the words of Prime Minister Mario Draghi on the same day Ursula Von der Leyen, president of the European Commission, said in her speech on the State of the Union 2021, that "the European Union is ready to support the suspension of vaccine patents." These words were in keeping with those spoken less than 24 hours earlier by U.S. President Biden, who officially declared his country's commitment to a temporary suspension of patents, in the name of the universal nature of the emergency.

We read this in the newspaper *La Stampa* last May 6. It seemed as if the world's top political authorities had become aware of the *universality of the emergency*, of the fact that the COVID-19 pandemic will not end until there is a rapid vaccination program on a global scale to protect against severe forms of the disease and preferably aim for herd immunity."[1] To quote an idea expressed in a *Lancet* editorial, agreed upon by all: no one can be saved from this pandemic unless everyone is saved.

Two words are key in Lancet article: "rapid program," especially "rapid." The time variable is fundamental: the more prolonged and massive the circulation of the virus, the greater the probability of variants emerging that make the epidemic more aggressive. Yet, one thing this pandemic will be remembered for is the lack of rapid decisions. This inertia is unjustified and negligent given the gravity of the situation.

This inertia is, first and foremost, on a global level. The statements made on May 6 turned out to be mere words: no step was taken in the direction of suspending patents and transferring technologies and know-how from the global north to the south, and those are the only decisive, lasting solutions to ensure vaccines are truly a "global common good." It quickly became evident that they were empty promises when at the *Global Health Summit* – held in Rome on May 21 and 22 overseen by the European Commission and the Italian Presidency of the G20 – in the final declaration (Rome Charter), though it recognized that the pandemic will not be defeated until the virus is under control in all countries, no mention was made of the suspension of patents, opting instead for Big Pharma's favorite solution: voluntary *licensing agreements* between pharmaceutical industries and governments. The overview of the percentage of the population vaccinated in different areas of the world (see the figure in the News) reflects the first phase of the vaccination campaign which saw the richest countries grab over 85% of the vaccine doses produced. If this situation does not change quickly, the problems will not only concern the poorest countries.

This inertia is at the local level as well. The richest countries have sucked up the vaccines – buying and reserving amounts of doses up to twice the national needs – and they have not been able to avoid the Delta variant epidemic wave due to serious strategic mistakes, as happened in Great Britain, where everything was reopened without having first achieved herd immunity through vaccination, exposing 17 million people (mostly young people) to the risk of contagion, a strategy that Lancet called "dangerous and immoral."[2] But the Delta variant wave affected – albeit less violently – all the other European countries that have carried out an excessively slow vaccination campaign (having vaccinated less than half the population after seven months), adopting methods of access to vaccinations based on online reservations (more difficult for the older population), not actively calling the target population, which requires preparing up-to-date vaccination registries, capable of including the "invisible population," such as irregular immigrants. This was a classic public health intervention but alien to the "logistical-military" culture of Commissioners Arcuri and Figliuolo.

NOTES

1 Wouters O. J. et al. (2021), Challenges in Ensuring Global Access to Covid-19 Vaccines: Production, Affordability, Allocation, and Deployment, in "The Lancet," 397, 10278, pp. 1023-34.

2 Gurdasani D, Drury J, Greenhalgh T, et al. Mass infection is not an option: we must do more to protect our young. Lancet 2021. Published Online July 7, 2021 https://doi.org/10.1016,/ S0140-6736(21)01589-0

OVERCOME BARRIERS

Vaccinations in Africa and all low-income countries are like an obstacle course. The scarcity of vaccines and the difficulty in turning them into actual vaccinations are caused both by international political failings and logistical and organizational shortcomings within each country. In Mozambique, activists have to overcome natural barriers as well as social and cultural obstacles to go the last mile, get to the most remote villages, and in the case of Mutua, to a camp of people displaced by the most recent cyclone. They do it to guarantee for all the right to health and the right to be vaccinated.

NICOLA BERTI

FORUM

AFRICA STUMBLES: THE THIRD WAVE OF COVID-19

Stumbling in the darkness of the third wave and its aftermath, Africa today is showing a drastic increase in cases of Covid-19 infection in many of its countries, showing signs of overburdened hospitals and growing deaths. The vaccination numbers are still too low, due to a shortage of vaccines but also due to logistical, distribution, and diffidence on the part of the population.

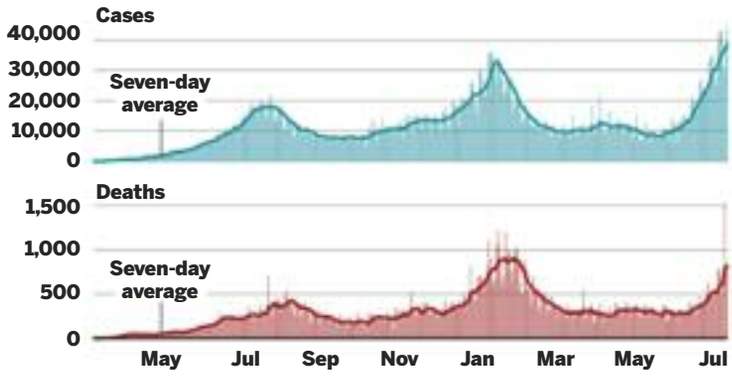
TEXT BY / GIOVANNI PUTOTO / DOCTORS WITH AFRICA CUAMM

Here we are again. The third wave of Covid-19 infections in Africa has started. With the usual note of caution about the reliability of data – very few tests and scant reporting – this is the situation on July 15: over 6 million positive cases reported and 153,549 deaths[1]. Trends: in over 30 African countries there has been an increase in positive cases of almost 30% on a weekly basis starting from June, exceeding the peak from last January (**Figure 1**).

This means 1 million additional cases were recorded in the last month. It is the fastest increase seen so far. According to CDC Africa, deaths related to Covid-19 have increased by 48% in the last week (July 7-15) led by South Africa (39%), the Democratic Republic of the Congo (24%), Uganda, Zambia, Tunisia, and Namibia[2]. The number of excess deaths recorded in South Africa from May 3, 2020, to July 7, 2021, reached 193,204 cases, largely attributable to Covid[3]. In other words, regarding the spread of Covid-19 in African and the effects in terms of morbidity and mortality, the title of the 2005 Lancet editorial "Stumbling around in the dark" unfortunately still applies.

Yes, there is a tendency to over-the-top catastrophizing but there is a tend to minimalize as well, and the latter is prevalent in the recent public discussion. What about on the ground? The local and international press and the Cuamm volunteers themselves report a very critical situation in the African cities of the most affected countries regarding hospitals that are overloaded with patients and lacking essential resources such as oxygen for ventilators[4]. Many governments have been forced to reinstate lockdown measures by restricting various social activities, such as religious and school activities as well as economic ones such as markets. Meanwhile, Africa is in recession with serious implications in terms of unemployment, violence, inequality, and food insecurity[5]. In this sense, what is happening in South Africa is emblematic[6].

FIGURE 1 / NUMBER OF DAILY CASES AND DEATHS IN AFRICA



Note: Deaths on 5 July 2021 include historic deaths in Uganda that were reclassified
Source: Johns Hopkins University, July 7, 2021

VARIANT SPREAD AND VACCINE SHORTAGE

What are the underlying causes of this new epidemic spike in Africa? There appear to be three causes: the spread of the Delta variant, low vaccination coverage rate, and public fatigue in applying individual prevention measures (mask, distancing, hand hygiene). The Delta variant has established itself as the dominant one in 21 African countries where genomic sequencing tests are possible. It is more contagious than the other variants (about 60% more) and affects young people more. Over 66% of complicated clinical cases involve people under the age of 45. There is also the Beta variant first recorded in South Africa and in over 30 African countries, and the Alpha variant, first found in England, which then spread to Africa.

As for vaccines, less than 2% of the African population of 1.3 billion has been vaccinated. Just over 70 million doses of the vaccine have been administered so far across the continent.[7] Only about 20 million people have completed the vaccination course. Morocco has a complete vaccination coverage of 27%, South Sudan, 0.2%; South Africa, 13.6% compared to 0.8% in the Central African Republic. So far, the suspension of patents as well as solemn promises from rich countries to donate (sic!) excess batches vaccines have so far remained just words. The result is that in many African countries, vaccination campaigns have been suspended due to lack of vaccines, and 90% of the African countries part of the Covax initiative will not reach the target of 10% of the vaccinated population by September[8]. According to WHO Africa, 43,101 doses of vaccine have expired and been destroyed due to shipping delays,[9] while they are aiming to develop vaccine production centers in Senegal and South Africa within a year to reduce dependence on other countries.

THE SURGE OF CASES IN UGANDA

The emergency situation in Uganda is paradigmatic. In June, there was a surge of over 33,000 cases, 42% of all cases recorded so far. There were over 2,000 recorded deaths, and the few ICUs in Ugandan hospitals were overrun with Covid patients with respiratory failure during a national crisis in the availability of oxygen cylinders. The surge in the epidemic has been driven by the Delta variant, spreading mainly in young people. The vaccination campaign, which has so far delivered just over 1 million doses, mostly Astrazeneca, has been paralyzed by the shortage of vaccines. Those who have been vaccinated (one dose) as of July 5 were 58% of the 24,421 health workers, 56% of the 250,000 security units, 26% of the 550,000 teachers, and 7% of the 3,348 million elderly over 50 years of age[10]. Vaccination campaigns in the field had to face many difficulties: financial, human, and logistical resources (transport, cold chain, etc.), and registration.

It is estimated that for every 1 dollar spent on the vaccine, it takes 5 to get to the actual injection.[11] Overall, just over 1% of the population in Uganda has been vaccinated. New batches of Covax vaccine and a donation from the Norwegian government are expected in August. However, it is not enough to reach the 10% target set for the end of September. Meanwhile, a study of 600 medical students showed low acceptance of the vaccine (37%), low perception of risk, high hesitancy, and strong propensity to form an opinion from social media[12], which is to say that it is also urgent in Uganda to have a well-designed, well-conducted communication campaign to avoid the spread of fake news.

ECONOMIC EFFECTS ON FAMILIES

However, the social and economic effects of the epidemic and the lockdowns in rural areas are the most dramatic. A study conducted by the University of Florence with Cuamm in the Oyam district showed a drastic drop in business for those who had non-agricultural businesses; the monthly savings accumulated by households have been nearly halved, and the total expenses on a monthly basis have fallen by 20% in the last year[13]. Finally, the use of loans and debt to meet the needs of families increased significantly among the interviewees. All this has translated individually into a marked decrease in the use of health services[14].

Urgency is growing, as recently reported in Nature by researcher Andrea Taylor of the Global Health Innovation Center, Duke University in Durham, North Carolina, "Timing is extremely important. Doses shared now will be so much more impactful than doses in six months. We need wealthy countries to send doses immediately." The most realistic forecasts for achieving vaccination globally are 2023, but policies to support fragile countries must start immediately.

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FORUM

VACCINES AS A COMMON GOOD

Vaccine distribution and administration is a "two-speed" situation: the map is always the same with low-income countries on one side and the global north on the other. "Solidarity," "Ethical Obligation," and "Safety for All" should be the guiding concepts to guarantee equity of access to health.

CHIARA DI BENEDETTO INTERVIEW ALBERTO MANTOVANI, *HUMANITAS UNIVERSITY*

What appeared to be a global virus, the same for everyone, at least at first in the pandemic, is now spotlighting the stark differences between areas of the world and within the same countries, with extremely different consequences and burdens, almost always borne by the most vulnerable.
While Europe is discussing the "green passes" for vaccinated people to facilitate a return to pre-Covid life – albeit with limits and precautions – the situation in the rest of the world is very different. In most low-income countries, getting vaccinations is still an obstacle course.

We discussed the importance of vaccinations and their profound significance for global health with Professor Alberto Mantovani, Scientific Director of Humanitas and President of the Humanitas Foundation for Research.

o What is the current situation with vaccination coverage around the world?

The data speaks for itself: over 30% of the population of rich countries vaccinated (46% of us), about 1% in poor countries.
We can see it as a "two-speed" progression: there is one speed for high-income countries like ours that could optimistically reach protection for 80% of the population as early as next autumn and then there is a speed of low-income countries where the scarcity of vaccines – in addition to numerous other organizational, logistical, and social obstacles – prevents reaching coverage even remotely comparable to ours. Added to this is the worrying variants of the virus that are spreading: the Beta variant started in South Africa, there is a Gamma variant, which started in Brazil in the Amazonian jungle, in a place where it was estimated that 60% of the population had already come into contact with the virus; this proves how extremely shortsighted it is to leave incubators where variants can be generated, and vaccination is the way we have to fight the virus.

o Professor Mantovani, you have chaired prestigious international boards and have been part of initiatives such as GAVI — Global Alliance for Vaccine Immunization, which have promoted global vaccinations. What role do they play for global health?

I served on the board of GAVI, the global alliance for vaccines and immunizations, which has helped reduce mortality from lack of access to essential vaccines, lowering mortality from 2.5 million to just over 1 million children per year. In that situation as well, like in the current pandemic, the challenge was "to go the last mile," to reach the furthest village to make vaccination a common good.
Now COVAX – the international program led by the World Health Organization and the Gavi Alliance – has this same purpose: to be able to bring enough vaccines to cover 20% of the low-income population, in order to contribute to more equal access to protection for all, counteracting "vaccine nationalism." We should have learned the lesson and we have to understand how Covid-19 is a full expression of the concept of global health: if Africa isn't covered, this means less protection for the populations of the rest of the world too.

o It has often been said that "we have to turn vaccines into vaccination." What exactly does this mean?

The vaccine is not enough on its own, it has to become vaccination, reach the population, including to the last mile. There are three good reasons to share vaccines and turn them into vaccination:

1) One reason is about solidarity, many of us think is a moral duty, an answer in terms of fairness;

2) one is ethical: there's an accepted guideline by international scientific associations that says if I'm doing clinical trials on a community, that community must benefit from it. We shouldn't forget that all Covid-19 vaccines have been tested in low-income countries. These countries, which have let us learn that vaccines work, must not be left out;

3) and then our safety in terms of protection and global health. We should remember that cynicism does not pay; there's no benefit to letting the virus "run rampant" in these apparently distant countries, because the highest price would be paid by those populations, but because variants would continue to be generated – as in the case of the Brazilian Gamma variant – it also exposes all of us, everywhere, to the risk of contagion.

I like to summarize these reasons with an acronym: SOS, Solidarity, Obligation to Ethics, Safety for All.

- **What role can NGOs play in acting as intermediaries in this situation?**

I'll start from my experience. For 5 years as part of GAVI, I served alongside large organizations, such as the WHO and the World Bank. I think it takes two pieces: one is that of large organizations to give resources, economic or concrete support, such as vaccine vials, like COVAX does. Then there's the other part, which is getting to the last mile. In the case of Cuamm, you go "with" Africa, "with" the local population. My university, Humanitas University, works in this same way.
Then I would like to add a third key factor: that of training, or "capacity building." Training is essential if we want a continent like Africa, made up of 1.3 billion people, to be able to go forward with development. It is essential if we want it not to depend only on aid coming from other countries. Training the local population, creating resources in the country and for the country is the real engine of development.
There is also something we can do in our own home: remember that what we do wrong here is reflected in the poorer countries. I'll give a historical example that has parallels to the current situation. Years ago, fake news was circulating that the vaccination against the *papilloma virus* caused fatigue in adolescents. It was fake news that was spread mainly in Japan. This made HPV vaccination levels drop and Japan is paying a price in disease and death. But the worst thing is that the use of the vaccine has also fallen in low-income countries of Southeast Asia; we should keep in mind that the greatest price for fake news given at home is paid by low-income countries.

- **It has often been hoped that Africa could play an active role in scientific production and research too. Do you think this is an achievable goal?**

Africa would be able to promote scientific research but work has to be done to make this happen. I chaired the International Union of Immunological Societies (IUIS) from 2016 to 2019 and now I am Past President. Our motto has always been Immunology without Borders. For this not to be just a slogan, to be translated into reality that generates positive change, we make it concrete by training in Africa, Latin America, and low-income Asian countries. Board meetings always take place in countries of the global south, where we also initiate fellowship programs for African students, aware of the role of training in generating growth and development. So I'd like to answer based on what I've done and am doing: I have hope. But let's all get to work doing something.

EXPERIENCES FROM THE FIELD

OBSTACLES TO VACCINATION IN SOUTH SUDAN

South Sudan has chosen to join the global effort to vaccinate its population for Covid-19. But there are many critical issues: it is not enough to just have the doses, they must also be managed logistically and administered correctly to the population. There is a lack of funds for the implementation of a massive campaign, making the role of NGOs such as Cuamm crucial to bridge the existing shortfalls.

TEXT BY / CHIARA SCANAGATTA / DOCTORS WITH AFRICA CUAMM

THE SITUATION IN A FRAGILE COUNTRY

According to the latest epidemiological bulletin of the Ministry of Health[1], since February 2020 in South Sudan, 10,829 cases of Covid-19 have been identified out of 178,868 tests (6%), with a mortality of 1%. These numbers are likely underestimated, given the difficulty of accessing health facilities for a large part of the population, the poor ability of these facilities to identify and report suspected cases, and the diagnostic system, which is limited in space and inconsistent.

Given the inability of the national health system to adequately cope with the epidemic and the direct and indirect costs that this and the containment measures implemented to this point are causing the community, South Sudan has chosen to join the global effort to vaccinate its population for Covid-19 and to ensure that this becomes an opportunity to strengthen their basic prevention and treatment.

This is written in the national Covid-19 vaccination plan published in February 2021[2], considered suitable by international agencies to include South Sudan on the list of countries entitled to receive a first supply of vaccine doses through Covax. Of the 864,000 doses initially planned, 732,000 were actually allocated, enough to vaccinate only 3% of the population, 15% of the groups considered at risk (health personnel, teachers, refugees/displaced persons, chronically ill, and people over 40).

But the actual first delivery was only 39,504 doses reserved for the staff of health facilities, community health workers, and people over 65.

VACCINES ARE NOT VACCINATIONS

The immunization campaign officially began on April 6, 2021, but only at 4 hospitals in the capital city. A month later, just under 5,000 people had received the first dose, of which only 23% were medical staff, and concern began to rise that they would not be able to use all the doses received by the deadline set in mid-July, which would prevent South Sudan from receiving further doses.

South Sudan has received the vaccines but does not have adequate funding to support their nationwide delivery. Lacking funds for the implementation of a massive campaign, the only choice was to integrate the new vaccination into the routine immunization system, but, in the absence of dedicated resources, what could actually be an opportunity to strengthen the system, put both the success of the Covid-19 vaccination at risk as well as the maintenance of an already inherently weak service. Furthermore, not being able to bear the costs of the complex logistical and organizational system necessary to bring the new vaccine to the more peripheral areas, where there is a lack of qualified and trained staff and where there are the greatest obstacles to transport and the cold chain, vaccination sites were limited in terms of number and geographical area.

THE ROLE OF NGOS ON THE GROUND

In May 2021, the South Sudanese Ministry of Health, racing against time, decided to ask NGOs for help to expand Covid-19 vaccination outside of Juba; the vaccines left the capital in early June and will have to be used within just over a month. To this end, it was also decided to extend the target population to all those over the age of 18.

This openness to the intervention of outside partners without indications regarding the geographical priorities, the implementation methods to be preferred, the standards to be respected, the stakeholders to be involved and related responsibilities has created some confusion. There have been episodes of competition between different organizations working in the same area and tension between local authorities and NGOs due to unmet expectations and unclear roles.

An attempt to coordinate and harmonize was made by involving the main funder of the national health system, the Health Pooled Fund, and its network of implementing partners, already in charge of supporting the regular provision of services, given the mandate to introduce Covid-19 vaccination in the hospitals they support.
Here too, the idea of being able to minimize costs by integrating the new service into the existing system has clashed with the re-

ality of hospitals not being organized and equipped for this purpose, and staff and managers are accustomed to the major resources usually allocated to vaccination campaigns and so reluctant to work without a particular compensation.

CULTURAL BARRIERS

Problems on the supply side are compounded by those relating to demand, i.e. the vaccination acceptance and access to it. Some studies[3] have been carried out about the knowledge and awareness of Covid-19 in the local population, and it is clear that the disease is perceived as a problem for others, not a real risk for the South Sudanese community.

This means that indifference to the vaccine, if not outright refusal, fueled by the spread of false information, especially through social networks, has generated a climate of suspicion and fear that has led to concern about acts of sabotage against the vaccine storage and delivery sites, requiring the implementation of emergency security measures, such as armed escorts to transport the doses from the cold chain to hospitals. Centralized and standardized communication and education initiatives have proved to be quite ineffective.

Several NGOs have chosen to adopt awareness-raising strategies adapted to the specific context, with the involvement of leading figures in the community as spokespeople.

CUAMM: GOING THE LAST MILE

Doctors with Africa Cuamm supports five hospitals, all of which have been selected to be vaccine sites. The areas previously set up for the screening of patients and the isolation of suspected cases have been adapted to accommodate the various phases of the vaccination process (registration, injection, observation, and management of any adverse events), in compliance with distancing rules, and the qualified personnel, already involved in the Covid-19 response, have been trained to implement it and adequately equipped with protective material.
Competent staff and an orderly and organized environment (in some cases offering snacks to the patients) are essential to reassure and attract the population. To contribute to this, there is also mobilization in the markets, at the churches, and in all the public gathering points, with the participation of prestigious authorities.

From June 14 to July 4, the three Cuamm-supported hospitals in Lakes State reported 3,940 vaccinations, including 637 health care staff (16%) and 221 (6%) people over 65. There are 75 vials left; to speed up their use, we are considering having hospital vaccination team go to major health centers, reaching part of those who are unable to travel to hospitals or who are intimidated by hospitals; these are likely to include members of the most exposed, vulnerable groups, from peripheral health workers who cannot leave their workplaces unattended, to the chronically ill and elderly, who struggle to make long, inconvenient trips and are more bound to their location.

NOTES

1 Press release dated June 27, 2021 from the Ministry of Health; also data updated daily at https://covid19.who.int/region/afro/country/ss
2 South Sudan COVID-19 National Deployment and Vaccination Plan, Ministry of Health of South Sudan, 9th February 2021.
3 *Public authority in a pandemic: South Sudanese NGO and local government responses to Covid-19*, day of studies can be viewed at: https://youtu.be/UdAaf9JI3i4

EXPERIENCES FROM THE FIELD

THE EFFECTIVENESS OF MATERNITY WAITING HOMES

Researchers have long been interested in maternity waiting homes, but few have studied their effectiveness. This study evaluated how their use cut the perinatal mortality rate in half at the Wolisso hospital in Ethiopia. These important results confirm their value and support policies for their implementation.

TEXT BY / CHIARA BERTONCELLO AND TERESA DALLA ZUANNA / UNIVERSITY OF PADUA

MATERNAL WAITING HOMES

Maternal Waiting Homes (MWHs) are residential structures located near health facilities where women with at-risk pregnancies can stay when their due date is approaching so their health can be monitored and they can be transferred quickly to the health facility should complications arise.
The idea to set up such a structure is not new. MWHs have been used in Canada, Northern Europe, and the United States in remote areas without obstetric services since the early 20th century. The first ones in Africa were built in Nigeria in the 1950s, followed by those in Uganda and Cuba where within 20 years they helped bring the hospital birthrate to 99% and caused perinatal mortality to drop. The goal of the MWH is to reduce the distance between pregnant women and health facilities that can manage obstetric emergencies and thereby reduce perinatal and maternal mortality. Currently, they
are mostly used in rural areas of countries with limited resources such as that of Wolisso, Ethiopia, the case studied here.

THE WOLISSO STUDY

MWHs are widespread in countries with limited resources, yet there is little evidence of their effectiveness, and we can only rely on observational studies. A retrospective cohort study in Ethiopia showed that maternal mortality and stillbirths were significantly lower for mothers admitted to the hospital through the MWH. A cross-sectional study in Tanzania shows a significant tie between the use of the MWH and the low socioeconomic status of the women it receives, with better results in terms of neonatal and perinatal mortality.
The study at hand was launched precisely to evaluate if the MWH helps reduce perinatal mortality at the Wolisso hospital in Ethiopia where the Italian NGO Doctors with Africa Cuamm has been operating since 2000.

A case-control study compared the perinatal mortality between women admitted to the MWH located inside the St. Luke Hospital in Wolisso and women admitted directly to the hospital. The "cases" were women with at least one child born dead or deceased before discharge between 1/1/2014 and 31/12/2017. The first two mothers with a positive delivery[1] after each case were selected as control subjects to minimize the differences in the health care received by each case and the related control subjects.

For each woman, exposure to the MWH was assessed, and medical and other records were collected: (1) maternal and pregnancy-related conditions, (2) birth-related conditions, and (3) neonatal characteristics.

The study included 3,525 women: 1,175 cases, and 2,350 control subjects. Fifty-one cases (4.3%) and 143 control subjects (4.4%) had been admitted to the MWH. Of the cases, 843 cases were women whose child was stillborn and 332 were women with children born alive who died within seven days of age.

Regarding maternal characteristics or conditions related to a previous pregnancy, the women in the MWH mostly: came from rural areas (88% vs 68%); belonged to older age groups; were "large multiparous" (20.6% vs 9.8% had had five or more children); had had Cesarean sections in the past (6.2% vs 32.0); had a positive medical history for previous pregnancies with maternal or fetal complications (0.3% vs 3.6%); had had at least one prenatal visit (46.1% vs 23.9%); and had had a twin pregnancy (14.4% vs 5.2%) and a breech presentation (9.3% vs 3.7%).
More women in the MWH had preeclampsia (6.7% vs 3.1%), polyhydramnios (3.6% vs 1.3%), and prenatal bleeding (6.2% vs 3.2%). On the other hand, there were no significant differences when it came to malpresentations, the presence of hypertension, chronic diseases, infectious diseases (including HIV/AIDS), oligohydramnios, and post-term childbirth.

Considering the overall regression, adjusted for all confounding factors, the risk of perinatal mortality for mothers admitted to the MWH was 54% lower than those not admitted (OR=0.46, 95% CI: 0.30-0.70; p<0.000).

EFFICACY AGAINST PERINATAL MORTALITY

In the case of the St. Luke Hospital in Wolisso, the results of the study show the effectiveness of the MWH in cutting perinatal

mortality in half, a result that accords with the results of the two previous studies conducted in Ethiopia or in similar contexts, conducted on smaller populations or without adjusting for the many confounding factors. It also supports the MWH implementation policy in Ethiopia, especially when the MHW is close to a hospital.

These results offer important springboards for further thought. In a 2015 reassessment,
the WHO designated it a priority to produce results showing whether MWHs should be proposed to certain female targets as opposed to others based on factors like vulnerability, distance, and obstetric risk. The results of our study justify criteria already applied to indicate MWH access, though they have yet to be defined at the structural or regional/national health-policy levels. These results could be a good starting point for defining clear, shared criteria for admission to an MWH based on scientific evidence.

They have also confirmed how key prenatal visits are for identifying risk factors early. In fact, having had at least one prenatal visit is itself a protective factor for perinatal mortality. Indications already given by the literature in this regard have been ambiguous. Sometimes the advantage was only clear after a number of visits. Our study also found that prenatal visits are useful for diagnosing risk factors early so women can be directed to use the MWH and accessibility barriers can be mitigated.

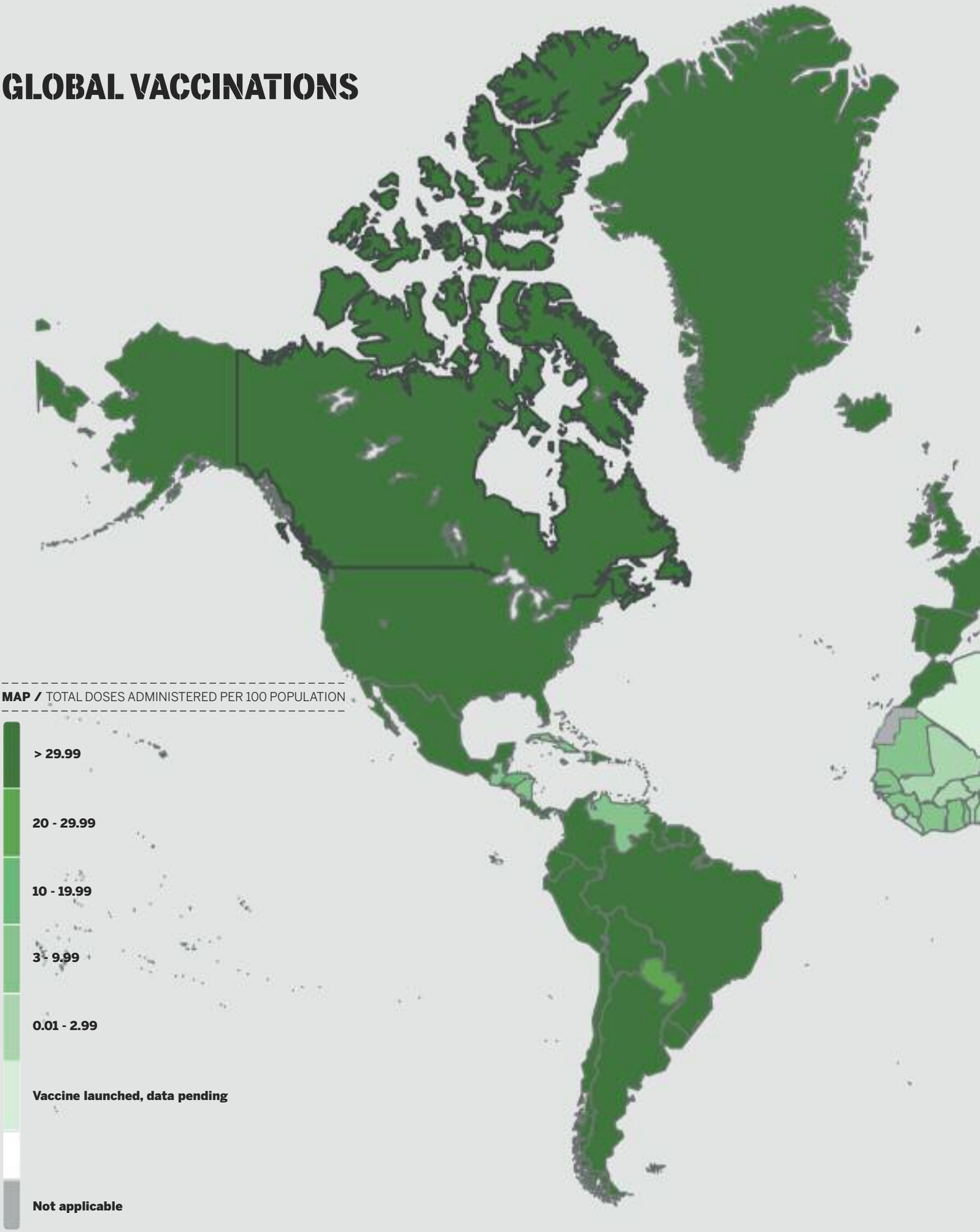
New studies will better describe how MWHs can reduce mortality. To date, the literature shows how MWHs can facilitate the planning and performing of Cesarean sections under risk conditions. Our data also support this evidence. The MWH is an important tool for intervening early with a planned Cesarean section whenever vaginal delivery could pose a risk to the survival of the unborn child. In general, we can confirm that transferring women with at-risk pregnancies to an MWH allows them to be monitored during the final phase of their pregnancy and, through early intervention, be supported in the birth process in the most ideal, safe way for mother and baby.

NOTES AND BIBLIOGRAPHIC REFERENCES

1 A "birth with a positive outcome" means a birth in which all the newborns are alive up to 7 days after delivery, or have been discharged alive from the hospital

Dalla Zuanna T. et al., The effectiveness of maternity waiting homes in reducing perinatal mortality: a case–control study in Ethiopia in BMJ Global Health, April 2021, https://gh.bmj.com/content/6/4/e004140

GLOBAL VACCINATIONS



Source: WHIO, World Health Organization, https://covid19.who.int/

EXPERIENCES FROM THE FIELD

WE WON'T SAVE OURSELVES ALONE

One thing that Covid-19 ought to have taught us by now is that no one can save themselves alone, but we're in a kind of "health nationalism" in which the stronger countries are trying to protect themselves first and losing sight of the fact that only by sharing and making vaccines and patents accessible can we achieve shared protection.

CHIARA DI BENEDETTO INTERVIEW SILVIO A. GARATTINI, INSTITUTE OF PHARMACOLOGICAL RESEARCH MARIO NEGRI IRCCS

The map of cases from March 2020 to now has been in constant flux and the pandemic has overwhelmed countries and continents at different times and with different outcomes. Now the access to medicine and especially vaccine has become a point of difference between countries, leaving poorer countries further behind. Or to be more exact, we should say access to vaccination. One difficulty of access to the vaccine is economic when the "big guys" look after their own population in a kind of health nationalism. But something that Covid-19 should have perhaps taught us is that no one can save themselves alone and there being regions still exposed to the Covid-19 storm, even if they are geographically distant, presents a risk for other parts of the globe.

We talked about it with Silvio Garattini, founder of the Pharmalogical Instiute Mario Negri IRCCS who in recent months has repeatedly brought attention to the topic of vaccines as a common good.

- **What is the global "snapshot" of the vaccination situation right now? Are the inequalities as great as they seem?**

Wealthy countries have a good vaccination rate although we have certainly not achieved herd immunity, while low-income countries, especially in Africa and South America, have gotten only scraps at the moment. It is absolutely urgent to vaccinate the whole world. According to the Public Citizens organization, this would be possible at the cost of 23 billion dollars for 8 billion doses available in a year, the amount needed to vaccinate everyone.

- **India and South Africa have asked the *World Trade Organization*, WTO for an exemption from patents and other intellectual property rights in relation to drugs and vaccines for the duration of the pandemic, until immunity is achieved. Is that a possible path?**

Unfortunately, the response was not positive from the wealthy countries to the request from India and South Africa. However, the question is still open, and we hope that Europe will take a more positive attitude. The good news is that last Monday an amendment was approved, proposed by the former Minister of Health Grillo, which in Italy makes a "compulsory license" possible, a temporary suspension of the patent when there are important conditions of public health.

- **Is considering vaccines a common good – like water or the natural environment – Utopian, or can we find a way to make it a reality even in extremely fragile countries such as in sub-Saharan Africa?**

It's not utopian to think of vaccines as a common good, it's a necessity. It's not even an act of charity, like many people think, but a "healthy" selfishness if we think that the virus continuing to run loose in large areas gives rise to variants, which because of globalization, will come back to us. The example of the Delta variant, which originated in India, spreading throughout Europe is an example of the virus's circulation.

- **Do you think that countries in the global south, including Africa, in the near future could somehow contribute to pharmaceutical research and become producers themselves? And could that change the fate of drug distribution?**

I think it is absolutely necessary to set up production facilities in some low-income countries, certainly in Africa. Only by having local producers, can there be rapid distribution.

- **The Covid-19 pandemic has shown us how powerfully we are connected to each other and that one part of the world cannot be considered "safe" if another area is in danger. Are we forgetting that already?**

It has already been said by others before me: "We will not save ourselves alone!" This has to be repeated if we want to return to normal.

- **At Cuamm, we have been working in sub-Saharan Africa for over 70 years. What role do you think we could play as NGOs in the field to promote health justice?**

I know Cuamm's commitment and I believe it is fundamental on many levels. By continuing to spread the idea that the unfairness of inequality does not, of course, have only to do with vaccines; by promoting the need to start to build vaccine and pharmaceutical production facilities in sub-Saharan Africa. This must be done, of course, by continuing the action to build basic health facilities in those countries.

REVIEW

AND THE LAST ARE STILL LAST

There are many people "on the margins" of our society: immigrants and others including homeless people, adults, and foreign minors waiting for their administrative application to be accepted. As the Covid wave hits, it is these people who are left behind: not only economically, but also forgotten by the prevention and vaccination campaigns.

TEXT BY / SALVATORE GERACI / CARITAS ROMA, HEALTH AREA

In this pandemic period we have called them by different names: the invisible, the forgotten[1], the "hard-to-reach," the socially fragile, the last. And they have stayed last.

In Italy, since the dramatic start of the pandemic, there have been hundreds of thousands of people excluded, not so much from healthcare treatment — in the face of the health emergency in the strict sense there is a touch more of equality[2] — but certainly from protection, mitigation and prevention programs, relief funds, and likely from future relaunch policies as well.

But first things first: whom are we talking about?

They are all those outside our local administrative rolls, close to home but without a home of their own.[3] They are those who, though all too visible to some political forces who have built part of their success on alleged invasions of immigrants, are excluded when it comes to rights. They are women, men, and children, Italians and foreigners, who may not be registered but are here. We have tried to calculate how many people there might be in Italy, in the context of "social fragility," who risk being excluded, including from vaccination, if appropriate initiatives and processes are not implemented[4]:

- according to the ISMU – Foundation for Initiatives and Studies on Multi-ethnicity, there are about 500,000 immigrants without a residence permit who, however, in order to access health services, may get an STP code – Temporarily Present Foreigner which would allow them access, at least partially, to the SSN;
- It is very difficult to quantify but likely tens of thousands who are EU citizens without the right papers, who can request the ENI card to access health care (European Non-Registered, but not provided by all regions);
- There are foreigners, just over 200,000[5], who have applied for regularization and who in the vast majority of cases have not yet received any response and are therefore in an "administrative limbo," no longer irregular but not yet recognized[6];
- there are about 76,000 (65% in special reception centers)[7] immigrants received in governmental centers (prefectures) and local facilities (municipalities), whose administrative position is often still pending or who have difficulties in social integration. Though they have the right to register with the national health program, their administrative paths are uncertain and fragmented, particularly in the special reception centers;
- there are many others, including unaccompanied foreign minors, victims of human trafficking in specific facilities, and there are many Roma, Sinti, and Travelers who live in makeshift camps or tens of thousands of people, Italian and foreign, in informal settlements, ghettos, and occupied buildings;
- and there are homeless people[8], both Italians and foreigners, likely over 50,000, who often live in anonymous corners of large cities, such as railway stations, and in the past also the halls or gardens of hospitals, public parks if not closed at night, and unattended shelters. Some homeless people are received in organized facilities or supported by volunteers directly on the street: tens of thousands of people are socially fragile and often vulnerable in terms of health.

THE PANDEMIC IS NOT THE SAME FOR EVERYONE: SOCIAL INEQUALITIES AND THE IMPACT ON HEALTH

The SARS Cov-2 pandemic is showing us, as if through a magnifying glass, how much social determinants affect people's health and cause measurable inequalities in health and healthcare[9].

Civil society has acted to call attention to these obstacles, barriers to access, and organizational shortcomings, suggesting solutions to be implemented to overcome the widespread exclusions and spurring appropriate pro-active interventions by institutions.

The main method for fighting the widening inequalities has been that of networking, and in particular the work of the Asylum and Immigration Committee (TAI), the Immigration and Health Committee (TIS), and the Italian Society of Migration Medicine (SIMM); the latter, by participating in the two former committees, offered the widespread network of its local groups (GrIS) active in 13 regions and the two autonomous provinces of Italy.

Despite this, there has been institutional resistance and delays, including in defining processes and procedures to protect people in reception centers. For months, they were left without any guidance other than being told by local authorities to stop any new receptions, putting thousands of people out on the streets. The association's proposal of the 3Ps (Procedures, Paths, Processes)[10] and the request to activate "bridge facilities" for safe reception only received marginal responses. Access to information, preventive measures, and protective devices, especially Covid tests, has also often not been possible or has been very difficult for socially fragile people.

From the very beginning, these associations involved in immigration issues, realized the fate of exclusion of many Italian people were often compounded by social and administrative marginalization[11]. All recent *advocacy* documents have concerned the entire population of the "last ones" who, in all phases of the pandemic, have unfortunately remained last[12].

VACCINATIONS AND WORKING FOR THE "HARD TO REACH"

The vaccination campaign as well has only recently started to take an interest in "hard to reach" groups, grouping in a single term an entire population which, as we have seen, is very diverse within itself. This compromises the different interventions' specific needs, decisive for reaching everyone: in terms of the information to be given and how to give it, the type of vaccine, the "engagement" method, and the involvement of the communities.

However, in order for the "last to become first" as[13] in the Gospel of Matthew to become an immediate reality, regardless of whether it is out of humanitarian spirit, a feeling of solidarity or the desire for social justice that moves us, we must have the commitment of all. This can happen by putting into effect constitutional prerogatives of mutual collaboration between the different levels of the administration (which are lost in an apparent competition, pursuing easy consensus) and of true horizontal subsidiarity between institutional actors and the third sector, too often ignored. This is the only path to truly achieve protection for the most vulnerable members of society.

VACCINATION FOR SOCIALLY FRAGILE PEOPLE. MAIN STEPS ON THE PATH TO ADVOCACY

February 3, 2021: AIFI acknowledges the request for the full inclusion of socially fragile individuals in the vaccination campaign and indicates documents needed to access the vaccine (TS, TEAM, STP, ENI, temporary CF, any document even expired, self-declaration);
February 4, 2021: letter from the Immigration and Health Committee (TIS) to the Minister of Health Roberto Speranza to officially include socially fragile individuals in the vaccination phases;
February 25, 2021: The monitoring report of the National Asylum Committee and the TIS is presented on "procedures, safety conditions, critical issues in the reception systems in Italy" with the request for inclusion of the socially fragile population in the vaccine plan;
March/May 2021: letters from several GrIS to the Regions to which they belong to make the regional websites usable to reserve vaccines for those without a health card, activate the territorial health authorities, involve the third sector, and foreign communities for mapping, awareness-raising, information, and possible accompaniment;
April 24, 2021: ordinance no. 7 of the Extraordinary Commissioner for the COVID 19 emergency, General Figliuolo, with the instructions to vaccinate "individuals not registered with the National Health Service" (Italian citizens registered in the Registry of Italians Residing Abroad ...; employees of the Institutions of the European Union ...; diplomatic agents and administrative staff of diplomatic missions ...; staff of international bodies and organizations ...)
May 31, 2021: Letter from TIS to the Extraordinary Commissioner Figliuolo on the need to include vaccinations for people without health cards and socially fragile individuals (STP, ENI, temporary CF);
June 18, 2021: Note from the Ministry of Health on the "Completion of the vaccination cycle in individuals under 60 who have received a first dose of Vaxzevria vaccine and clarifications on how to use the Janssen vaccine." It specifies that although this vaccine must be administered to people over 60 years of age, it is expected that, "subject to the opinion of the territorially competent Ethics Committee," it may be "used in the case of specific vaccination campaigns for non-permanent populations... and, more generally, for the 'hard to reach' groups."
July 5, 2021: Note SIMM on circ. min. 18/6/21 and vaccination problems "Vaccines: guaranteeing the same level of protection of health and dignity for all human beings"
https://www.simmweb.it/1034-la-simm-preoccupata,-stesso-livello-di-tutela-della-salute-e-della-dignità-per-tutti-gli-esseri-umani
July 8, 2021: Publication: Vaccination against COVID-19 in residential communities in Italy: priorities and modalities for interim implementation.
https://www.iss.it/documents/20126/0/Rapporto+ISS+COVID-19+16_2021.pdf/b39f0142-41d6-7d4d-94e8-0668cfb95bf9?t=1625751318696

Useful materials for all

AIFA FAQ on vaccination
Materials from the Emilia-Romagna Region with translations in Chinese, Albanian, French, Urdu, Russian, and Arabic
https://www.integrazionemigranti.gov.it/Ricerca-news/Dettaglio-news/id/1817/-Le-Faq-di-Aifa-sui-vaccini-anti-Covid-19
https://sociale.regione.emilia-romagna.it/intercultura-magazine/notizie/covid-19-cosa-ce-da-sapere-in-diverse-lingue#organizzazioni

Informed consent and informational note on individual vaccines
Materials prepared by the INMP in English, French, Romanian, and Arabic
https://www.salute.gov.it/portale/nuovocoronavirus/dettaglioContenutiNuovoCoronavirus.jsp?lingua=italiano&id=5452&area=nuovoCoronavirus&menu=vuoto

NOTES

1 http://www.caritasroma.it/2021/06/i-dimenticati-del-vaccino/
2 Though in Italy, hospitalizations and care are not denied anyone, especially in the early phase of the epidemic, we saw a delay for foreigners in the diagnosis of the infection and greater clinical severity, associated with a higher probability of hospitalization, use of intensive care, and risk of death. See: Fabiani M et al. Epidemiological characteristics of COVID-19 cases in non-Italian nationals notified to the Italian surveillance system. The European Journal of Public Health, Vol. 31, No. 1, 37–44.
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11 National Asylum Committee, Immigration and Health Committee, *Dossier COVID 19. Procedure, condizioni di sicurezza, criticità nei sistemi di accoglienza in Italia*, N. February 2, 2021, TA-TIS
12 https://www.simmweb.it/1032-lettera-al-commissario-figliuolo-per-la-silenziosa-esclusione;
https://www.simmweb.it/1034-la-simm-preoccupata,-stesso-livello-di-tutela-della-salute-e-della-dignità-per-tutti-gli-esseri-umani
13 Gospel of Matthew 20.1-16.

REVIEW

VACCINATION FOR ALL IN ITALY, TOO

A vaccination center in the outskirts of Padua managed by Cuamm with the AULSS 6 and the Diocese, created within a broader Covid-19 response program, where the effort, in Italy and Africa, is to bring prevention and treatment to all on the strength of the contribution of volunteer staff.

TEXT BY / ANDREA ATZORI / DOCTORS WITH AFRICA CUAMM

The Cuamm vaccination center is the first center in the Veneto Region managed by an NGO in partnership with AULSS 6 and the Diocese of Padua. The initiative was launched to support the national vaccination campaign with smaller centers as well, located in densely populated areas on major thoroughfares. The center was created by reconfiguring the spaces of the former middle school of the Rubano seminary, and it follows the operational standards of AULSS6, which supervises its work.
The center's operations are in 4 macro-areas: 1) booking system, 2) vaccine management, 3) vaccination, 4) booster management.

1. **The booking system**, like other vaccination hubs, is managed by AULSS6 and allows all people who have a tax code to book vaccination through a dedicated site. Availability varies according to the days, times, and the number of vaccine lines that Cuamm makes available. Right now, the center is open 7 days a week with 6-hour (Monday-Friday) and 12-hour (Saturday and Sunday) vaccination sessions in the afternoon. The center can open up to 4 vaccination lines with a reservation every 6 minutes, or up to 240 reservations for a 6-hour shift, or 480 for a 12-hour shift.

2. **The vaccine is managed** through the AULSS6 system. On the basis of reservations, a quantity of doses is ordered each day, stored in the center at temperatures from 4-8 degrees Celsius. The stored vaccine is then prepared for vaccination following the preparation or dilution protocols for each different type of vaccine.

3. **Vaccination** is the most operational aspect and is carried out through the set of non-healthcare activities (reception service, management of user flows, etc.), and healthcare activities (vaccination lines).
   - Non-health-care aspects are essential to allow the center to function safely. These include managing the flow of incoming/outgoing patients, verifying reservations, social distancing, and the presence or absence of accompanying persons. These activities are managed by Cuamm volunteers, 7 on average per shift, placed in various locations such as main entrance, triage, pre-vaccine waiting room, and post-vaccine room and exit.
   - The healthcare area mainly consists of two activities: vaccine preparation and vaccination lines. The former takes place in a dedicated, aseptic area and is managed by medical and nursing staff. Here, according to standard procedures, the individual doses are prepared and then brought to the vaccination lines in the timeframes, methods, and quantities needed to support the expected pace of vaccination. The vaccine lines are where vaccination takes place. Each line has 4 phases: medical history to identify risks related to allergies, pre-existing diseases, or other issues; data entry into the regional system (SIAVR); vaccination; second shot booking and/or printing of the vaccination certificate. Each line has a volunteer doctor, an administrative employee for data management and, when available, a nurse for vaccination. One or more nurses or doctors prepare the vaccines.

4. **Management of bookings for second doses.** Depending on the vaccine, each user receives booster options immediately after their first vaccination. The system works so that during the same vaccination session, people are received for the first dose (see point 1) and for the second shot. The combination of the two user flows requires keeping the center open and the minimum number of vaccination lines to provide vaccinations or boosters on schedule.

The vaccination center has been operational since June 12, and through today, it operated non-stop 7 days a week, distributing more than 11.000 vaccines, thanks to the support of 169 volunteers (69 health workers and 100 non-health workers) for a total of 3.500 hours of voluntary service.
The vaccination center is part of Cuamm's broader effort to vaccinate everyone, especially in Africa where today only 1% of the population is vaccinated. This is a major failing that must be addressed to stop the pandemic, in the awareness that either we are all vaccinated and safe or none of us will truly be safe.

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;
- **239** 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;
  - 80 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
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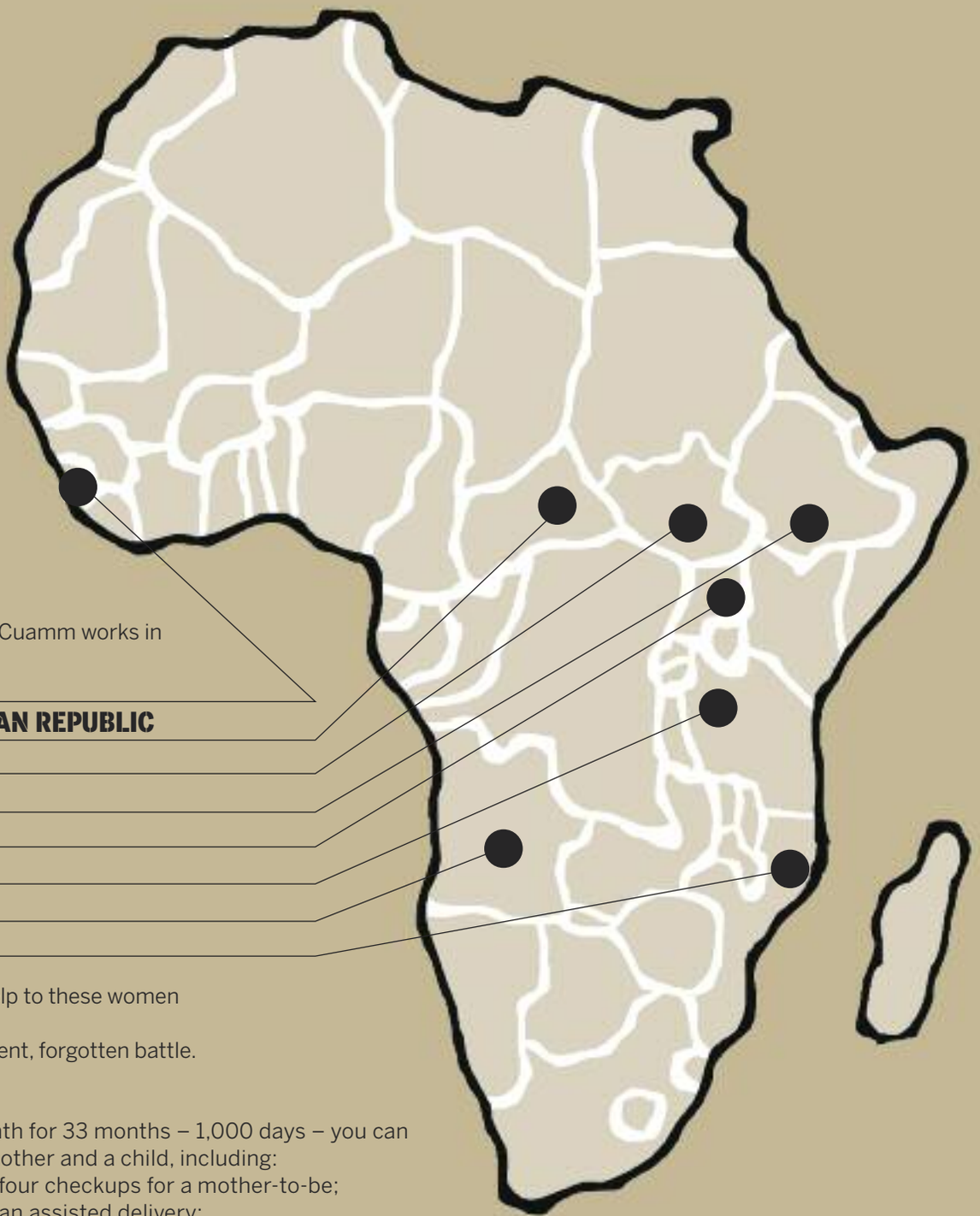
In ***Health and Development*** you will find studies, research and other articles which are unique to the Italian editorial world. Our publication needs the support of every reader and friend of Doctors with Africa Cuamm.

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
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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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"We want to and we must reach every last village, vaccines must become vaccinations, the only way for them to be a common good"