REVIEW

COVID, ADVOCACY AND DEMOCRACY

Speaking out for the voiceless to ensure their access to health services, vaccines and protection: during the Covid-19 pandemic the Italian voluntary sector worked hard to bring these issues to the attention of decision-makers in an effort to heal social rifts, create public/private bridges and launch participatory actions.

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Italians and foreigners living in Italy in very difficult circumstances, without homes, mandatory doc-uments, or cards to access the National Health Service[1]: from the onset of the pandemic, such individuals struggled to gain access to pathways towards health protection and prevention in our country.

Civil society implemented a range of initiatives to identify, provide orientation to and assist such people, and undertook advocacy work on their behalf, advising the appropriate authorities of the obstacles, barriers to access, and organizational oversights that arose throughout the various stages of the pandemic[2].

Proposals made by Italy's voluntary sector vis-à-vis procedures, paths and processes ("the 3 Ps") to help marginalized people were ultimately adopted, although belatedly and only in part, and a request to create "bridge facilities" for the safe reception of migrants was met. However, the inability to obtain a National Health Service card made it impossible for entire groups of Italians and foreigners living in Italy to use the country's regional websites to book an online appointment for a Covid-19 vaccination, even when their age made them eligible for one. In the absence of timely instructions from the federal government with regard to these matters, Italy's regions and autonomous provinces made their own decisions and established their own rules, which led to further delays for this already-overlooked population. Eventually they, too, obtained access to Covid-19 swabs, vaccines, and "green passes" (the official document certifying vaccination, negative testing, or recovery from Covid-19), but only after first facing great challenges.

By now it is clear that many cases, clusters and Covid-19-related deaths could have been prevented, just as vaccination hesitancy (which excessive public uncertainty only exacerbated) and the rise of social tensions among the poorest could have been limited to some extent. What happened, and why were the voluntary sector's appeals disregarded?

It is difficult to answer these questions[3] unless we link them to what occurred during the crisis the pandemic gave rise to: the radical cutting back of interpersonal relationships as part of the public health approach; the drastic reduction in existing pathways to care and new organizational set-ups for risk containment; restricted decision-making processes at the political level, since those usually in charge of them were focused on the continuity of operations; and the disappearance of more or less established participatory pathways. Both nationally and, especially, on the local level, technical/political "entrenchment" often occurred, with the need for speed and efficiency frequently being used to justify restricted lines of command. These top-down decisions proved effective, but also left out a part of the population that while perhaps negligible in terms of its size was still socially important. One possible cause might lie in the fact that participation was not considered an important aspect of public policymaking in the new organizational set-up. It became clear that organizational culture is still weak when it comes to the phenomenon of circular subsidiarity[4], where the public and private social sectors work together not just on aspects of welfare, but also in terms of analysis, collaboration and planning – in other words, governance that is to a certain degree *shared*.

Advocacy efforts failed due to an apparent misalignment of interests; paradoxically, the requests that were made were perceived as "corporate demands" rather than appeals made on behalf of the voiceless. The importance of integrating socially and juridically marginalized individuals into pathways of protection was understood only later, as was the fact that the voluntary sector was a worthy ally, not a "pest" to be held in check. Since that time various constructive alliances and synergies have developed around Italy, but this does not make it any more easy to accept the many hours wasted on fruitless meetings, or the silence that appeals were so often met with.

NOTES

1 Geraci S., *E gli ultimi sono rimasti ultimi*. In *Health and Development*, n. 82, July 2021. Doctors with Africa CUAMM. 17:18.

2 AA.VV.: Tavolo Asilo Nazionale, Tavolo Immigrazione e Salute, Dossier COVID 19. *Procedure, condizioni di sicurezza, criticità nei sistemi di accoglienza in Italia*, N. 1 June 2020, TA-TIS. https://inmigration.caritas.it/sites/default/files/2021-03/Primo%20report%20salute.pdf

AA.VV.: Tavolo Asilo Nazionale, Tavolo Immigrazione e Salute, Dossier COVID 19. *Procedure, condizioni di sicurezza, criticità nei sistemi di accoglienza in Italia*, N. 2 February 2021, TA-TIS. https://inmigration.caritas.it/sites/default/files/2021-03/secondo%20dossier%20covid_rev2402.pdf

AA.VV.: Tavolo Asilo Nazionale, Tavolo Immigrazione e Salute, Dossier COVID 19. *Indagine sulla disponibilità a vaccinarsi contro il covid-19 da parte delle persone ospitate nei centri/strutture di accoglienza in Italia*, N. 3 July 2021, TA-TIS. https://www.epicentro.iss.it/migranti/pdf/Terzo%20Monitoraggio%20Covid%20-%20TIS-TAI%20rev.pdf

3 Geraci S., *Immigrazione, salute e advocacy: successi e fallimenti*. In Atti dell'XVI Congresso Nazionale SIMM: "La SIMM, 30 Anni + le Epidemie: Nuove Diseguaglianze, Nuove Sfide." Roma, 18/20 ottobre 2022. Pendragon, Bologna, 2022; in press.

4 Zamagni S.: *Dell'origine e del fondamento del principio di sussidiarietà circolare*. Edizioni Studium, 2022; in press.