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Advancing social justice through health equity

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NEWS

1967. Medical students and politics
(see “What times they were!” on p. 3)

QUADERNI DI INFORMAZIONE

giornale degli studenti della facoltà di medicina di firenze

dove va la facoltà di medicina? * lettera al preside di facoltà * gli studenti di medicina al servizio della città * il servizio civile anche in italia * internato post-lauream: un anno facoltativo * gli internati ospedaleri all'estero * un contributo degli assistenti universitari sul dipartimento * le nostre interviste

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Cover illustration
Advancing social justice through health equity
Being a doctor doesn't mean just "doing" medicine. It also means being committed to helping *everyone* have the opportunity to achieve health, including those living on the fringes of society. Whether they are underserved communities in Africa, people marginalized by poverty in Italy, or those left behind due to their very young or old age, CUAMM is committed to building a better future for all by advancing global health.

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DIALOGUE

BUILDING THE FUTURE

Standing side by side with the marginalized, those living on the fringes of society not only in economic and geographical terms, but also in terms of age: this is where CUAMM wants to be. On 28 October 2022 in Florence, alongside many of our partners, we look forward to telling you more about how we do our work.

TEXT BY / DON DANTE CARRARO / DOCTORS WITH AFRICA CUAMM

This is a special issue of *Health and Development* that was conceived as a support for *"Towards Global Health: Building the Future in the Name of Social Justice"*, a day of discussion and reflection to be held in Florence on 28 October. The event will see the participation of individuals of all ages, professional backgrounds and fields: those with long-time experience in Africa or as coordination professionals within large health institutions, those who advocate for the dignity and well-being of the elderly, and others who seek ways to develop a general medicine able to serve everyone.

Notwithstanding this rich diversity, everyone in attendance will be united by a single focus: prioritizing those living on the fringes of society, marginalized in terms of where they live, their age, or their lack of economic opportunities. Each of us at the event is guided by a quest for social justice and equity, knowing that being healthy requires having access to care and services.

Thus we will learn about the unexpected commonalities between a forward-thinking Tuscan town that decided to invest in services for the elderly, a young doctor eager to bring health to those most in need in far-flung parts of Africa, and a university professor and researcher who, despite coming from different generations, share the same determination to helping bring about a more equitable future. All of this gives me confidence that despite the times we live in and the epochal changes that our world is undergoing, the commitment to help others in tangible ways continues to thrive.

From the beginning, CUAMM has always stood with the populations of the countries where we work, engaging with communities on an ongoing basis in order to best understand and interpret the specific conditions on the ground, and then build there. The only approach to international development that we believe in, in fact, is long-term, with a priority focus on primary health care. Rather than intervening based on preconceived notions – an especially impracticable method in Africa, with its vast inequalities and particularly complex emergencies – our work entails constant learning, experimentation, evaluation and research. The cornerstones of this approach are continual partnership with communities and teams of local health professionals to identify needs, service integration, continuity of care, and intersectoral collaboration.

This approach to care is evident in many of the articles in this issue of our magazine, and will be discussed further, with additional insights, at our Florence event, which CUAMM organized in partnership with the Tuscany Region's Global Health Center and the University of Florence. And just as this issue does, I too would like to underscore the multidimensional nature of care; indeed, "building" global health entails not only undertaking clinical practice and interventions, but also providing access to training and information. From the very beginning, CUAMM has been firmly convinced of the necessity of doing both. Conducting research is also crucial, as it produces further insights that help guide our work, as is envisioning care in health policy terms.

Both essential and complementary, all of these elements have guided CUAMM from the start. And we are fortunate to have shared them in the course of long years of partnership with Gavino Maciocco, professor of Hygiene and Public Health at the University of Florence, editor of this magazine, and formerly also a CUAMM development worker. Today, after a year of particular significance for him, I would like to thank him, in the hope that together we will continue to generate a culture of health for all, and do the work to achieve that vision.

DIALOGUE

WHAT TIMES THEY WERE!

"Finding solutions together is politics. Finding solutions alone is egotism."
(Father Lorenzo Milani)

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

"The Committee appreciated your course of study and thesis. We've given you the top grade of 110, but you gave up your chance for honors with all that political content, like those quotes from Franz Fanon's *The Wretched of the Earth*."
That's how a member of the dissertation committee for medicine and surgery students at the University of Florence reprimanded me as I left the lecture hall one morning in mid-November 1967. My thesis was titled *"Hunger Around the World"*, and Giuseppe Mazzetti, a professor of hygiene who'd acted as my thesis advisor, had himself been supportive of my historical and political analysis, which contended that the mass poverty and starvation afflicting some two-thirds of the global population at the time was largely the result of colonial exploitation, as well as a glaring contradiction of the principle of the equality of peoples – *"All human beings are born free and equal in dignity and rights"*; Article 1, *Universal Declaration of Human Rights*, 1948 – upon which the new order established in the aftermath of the WWII was based.
Back then, college students both studied and *engaged* in politics. We medical students had our own electoral roll including Catholics, communists and some liberals, one that consistently trounced those of our right-wing adversaries. We were a close-knit group of young people who would meet up to discuss not only how our study programs could be improved, but also how both our university and health care policy could be reformed from an equality and social justice perspective. A group that organized shoestring-budget group summer vacations to the most remote parts of Sicily, Sardinia and Calabria, and once even a tour of the former Yugoslavia, as far as Sarajevo; and who rushed to help when Florence was devastated by a flood in 1966, clearing the mud from health facilities in the hardest-hit areas of the city.
Those of us studying at the Faculty of Medicine used university funds to publish a journal called *Quaderni d'informazione - giornale degli studenti della facoltà di medicina di Firenze*. We wrote up the April 1967 issue (see its cover and editorial staff list on this issue's inside front cover) ahead of our planned occupation of the faculty in May; it contained our political platform and a number of demands for the dean of the faculty. Our two-week occupation was primarily symbolic; we only occupied the medical library. Even so, seeing that building located in the center of the Careggi Polyclinic covered with posters and sheets hanging from windows still made quite an impression. On the third day of the occupation, at 7 a.m., we heard a knock on the front door. We were convinced it was the police coming to take down our names and so forth (that actually did happen a few days later); instead, it was Antonio Lunedei, our dean. It surprised us to see that he was by himself, and asked us if we could get him a cup of coffee. After climbing out of our sleeping bags, we made gallons of it using our camp stove, then gathered round for a long talk with the dean. Its outcome would become clear over the next few months.
Aside from our respective post-university professional paths, those years were truly life-changing for many of us. The public debate over conscientious objection to military service exploded in 1965, following Father Milani's response to a statement put out by a group of retired military chaplains that cast contempt on such objectors. His published rejoinder read in part as follows:
I am not going to discuss the notion of a "homeland" here; I don't like that sort of division. But if you claim the right to divide the world up into Italians and foreigners, I will say this: I have no "homeland" in your sense of the term, and I claim the right to divide the world up into the dispossessed and the oppressed versus the privileged and the oppressors. The former are my "homeland", the latter my "foreigners".[1] Father Lorenzo's response cost him two trials for speech in defense of criminal acts. As for myself and my wife Loretta, it inspired us to opt for a lengthy period of civilian service abroad following graduation from university instead of military service – the beginning of our story with CUAMM and all that came thereafter.

NOTES

1 Father Lorenzo Milani, *L'obbedienza non è più una virtù* ("Obedience isn't a virtue anymore"): https://www.famigliacristiana.it/articolo/l-obbedienza-non-e-piu-una-virtu-il-testo-di-don-lorenzo-milani.aspx

FOSTERING LONG-TERM DEVELOPMENT

Standing with Africa and partnering together on actions to strengthen local health systems: this is how Doctors with Africa CUAMM has always "done" development cooperation. Despite the ever-changing global scenario, our approach of building value for the long term remains unchanged.

Photo: Kampala, Uganda, in 1986, with visiting doctors including Gavino Maciocco, editor of *Health and Development*.

CUAMM ARCHIVE

FORUM

TOWARDS PROACTIVE HEALTH POLICY

A doctor and public health expert, Marco Geddes da Filicaia alternates research activities with his work as health director of the National Cancer Institute in Genoa, vice president of the *Consiglio Superiore di Sanità* (the Italian government's Health Council), and health councillor for the city of Florence, practicing and envisioning medicine in a way that is once again aimed at creating a culture of global health.

INTERVIEW WITH / MARCO GEDDES DA FILICAIA, HEALTH POLICY EXPERT

In 1981 you co-authored the *Handbook of Public Health*, a pioneering book in terms of both its approach and its contents, with Gavino Maciocco and Eva Buiatti. What role did it play for doctors and others at the time?

There had been publications on hygiene and public health as early as the late nineteenth century, but they tended to be technical treatises providing administrative and/or legal information vis-à-vis the settings in which general practitioners, health officers and local hygiene offices were active.

We took a different approach in our handbook: while strongly grounded on technical and scientific bases, it also provided health policy direction. That might explain why it ended up circulating so widely, becoming a point of reference for countless physicians and practitioners in the sphere of public health. It's also worth underscoring that we wrote the handbook just a few years after the passage of the 1978 law that established Italy's national health system (SSN), and were to some extent influenced by it. Our objectives in writing the book, in fact, included outlining a regulatory and organizational framework while reflecting on the political principles underlying it, and, more broadly, although less explicitly, on political ethics itself.

The handbook encompassed a wide range of topics, including health planning, epidemiology, and the innovations and priorities we believed the new SSN should focus on. We also explored in depth two fields then seeing undergoing major changes, mental health and maternity and early childhood, for which local clinics had primary responsibility. So our book covered two relatively new (1978) related laws – Law 180 [known as "Basaglia's Law", this law sanctioned the closure of Italian asylums for the mentally ill] and Law 194 [the law that authorized abortion in Italy] – both in terms of their regulatory references and with guidance on how to organize related services.

Occupational medicine was another innovative area covered in the handbook, at a time when it was becoming increasingly significant, with the 1970 workers' statute that allowed trade unions to bring consultants and inspection services into factories, and local authorities and hygiene offices setting up occupational medicine services inside the same facilities.

So, the same factors seen as critical 40 years ago – the local territory and primary care – are still relevant today. The Covid-19 pandemic underscored this once again, showing the special vulnerability of areas that have weak community health services.

There is huge diversity in this sense from region to region, so responses during the pandemic also varied greatly, including some striking examples like those we saw in the Lombardy and Veneto regions, which I've written about. But overall, the entire country proved weak, and was further weakened, during the pandemic, for a variety of reasons including less care and less funding allocated over the last few decades to community medicine and fewer private facilities, apart from laboratories and specialized medicine, to act in a backup capacity in crisis situations. Hospitals were somehow better prepared to deal with complexities and major risks, although not major crises, as seen by what happened in emergency rooms and intensive care units, in part due to referrals to private and contracted facilities.

There was another key element as well: deficiencies in the primary care skills of general practitioners. Despite the best intentions of single individuals, too many critical and contradictory aspects continue to hold back the progress of community medicine, from the structure of outpatient clinics – private ones that are not accessible by the public – to a lack of connection with the national health system.

Speaking of national health systems, how do you think Italy's is doing?

In general, when it comes to community medicine I'd say that the policies of the past – even the recent past – have not been very successful. Certainly, the pandemic was handled, and interventions were formulated and launched in community medicine as well thanks to the National Recovery and Resilience Plan, but the peculiar organization of communities on the one hand and prospects in terms of resources for facilities like community homes and hospitals on the other haven't yet been defined in regulatory, organizational or funding terms, which leads to uncertainty about how such projects could actually be carried out. Against this backdrop, despite all the difficulties, hos-

pitals have shown better resilience, thanks in part to the professionals who guide and direct their activities.

- **What role do doctors play today: purely clinical, or also as people who encourage others to read the reality on the ground in a broad sense, and from a global health perspective?**

It isn't easy to make predictions, but it seems to me that doctors today are moving less toward global health than they were in the 1980s, due to both structural reasons and a certain lack of vision. Undoubtedly, the complexity of medicine has grown, and things are moving in a more technological direction than in the 1970s and '80s, when clinicians had personal relationships with people and an overall clinical vision that are now unconceivable. Moreover, even the young clinicians who approach their work today from a broader global health standpoint demonstrate their commitment in a strictly professional sense, rarely ever translating it into more explicitly "political" initiatives, whether trade union-related or out-and-out political, something that – as used to happen in the past – breaks the mold to some degree, generating new possibilities, dialogue, or public debate without getting to the point of conflict.
It's hard to imagine today's highly-prepared young doctors – who, by the way, know a lot more about international politics than our generation did – taking part in such initiatives. They're likely influenced by the overall political climate, which is so different from that of the past, when our political counterparts tended to be more open to hearing us out. Nowadays, exemplary experiences on the ground usually stay where they are; rarely are they translated into broader action or change at the national level. That's why the need for training in global health is as important as ever.

- **Do you have any suggestions for young physicians today, based on your wealth of experience and scholarship?**

I'd suggest that they reflect and engage with individuals with different kinds of expertise – political, legal, regulatory – to see whether and how their own experience might be translated into organizations and norms that help shape national health care; and to do so in a way that produces proactive health policy that doesn't simply look on, and proactive care that reaches out to people.

FORUM

GLOBAL HEALTH AND SOCIAL JUSTICE

Global health policies have too often proved unworkable, unable to meet the particularities and needs of individual countries. Finding a balance between global and local, adapting broad guidelines to specific realities, actively engaging all actors: these are just some of the possible starting points for putting the health of human beings at the center once again.

TEXT BY / BENEDETTO SARACENO / LISBON INSTITUTE OF GLOBAL MENTAL HEALTH

It's fair to ask whether the pervasive and overworked word "global" is not but a typical example of the post-WWII vision of the public good that has since been transformed into an ideological justification for many facets of neocolonialism. A large body of literature demonstrates, in fact, how global approaches to the development of health policies have systematically failed to meet the needs of local communities (Thomas et al. 2005)[1].

Indeed, the linkage of global health with development remains an example of "political correctness" that has failed to translate into an actual connection between integrated programs for health *and* the reduction of poverty and inequality. And while the issue of rights is now part of the broad global, legal, moral and political debate, their actual *enjoyment* has struggled to be incorporated into global health practices.

GLOBAL AND LOCAL: A NECESSARY CONVERGENCE

The limitations of the global discourse could not be more evident: a universal but tenuous medical epistemology, the pervasive and vested interests of the pharmaceutical industry, a cultural hegemony of professional lobbies, and the cultural universalism of global agencies limited to declarations of principle or normative recommendations, while struggling to face up to the very disparate realities found in the countries where implementation of such measures would be vital. The burden of this limitation becomes clear by surveying WHO's actual impact in countries worldwide and, more generally, the systematic gap between United Nations discourse and the realities on the ground of its member states.

Is there a way to bridge the local and the global so that they "can become reciprocal instruments in the deepening of democracy"? (Appadurai 2002)[2]. The answer to this question is crucial if we want to understand the countless failures of global health programs designed to rescue the failed local policies of low- and middle-income countries. In a nutshell: local failures, global failures.

Stewart, Keusch, and Kleinman note[3] that the proverbial failure of primary health care models in poor countries can be attributed to the verticality of programs focused on single diseases, a traditional biomedical disease control model that ignores the broader cultural setting and social determinants of health, and, finally, enormous inequity in access to health care systems. A vast gap exists between an understanding of the local and the rationale of global programs, and as long as local actors are excluded from the design, production, assembly and dissemination of these programs, this gap will continue to be an obstacle to the effective implementation of the latter. In addition, use of the notion of "local" often seems merely formulaic, with local actors being engaged less as active players than (primarily) as passive recipients.

"DEEP DEMOCRACY": A POSSIBLE KEY TO INTERPRETATION?

Could "deep democracy" be the vital dimension to understanding the settings in which health programs ought to be developed? "Deep democracy is democracy near at hand, the democracy of neighborhood, community, kinship and friendship, expressed in the daily practices of information sharing, house and toilet-building (...)" (Appadurai 2013)[4].

The personal dimension of *morality* – i.e., of individuals working on projects to "build" collective health – and the collective dimension of *rights* – i.e., the set of political, social and legal guarantees expressed by every local or national community – could constitute the vectors of the collective "building" of health and the encounter of global and local tools.

The technological rationale of medicine cannot be a vector in and of itself, only a *technical* complement to the primary vectors, i.e., collective rights and individual morality.

WHEN HEALTH IS SHAPED BY ECONOMICS

As Gianni Tognoni writes, "The growing influence of economic factors (which translate into the IMF's restrictive prescriptions of social, educational and health rights), the taking on by the World Bank of the roles of the WHO in identifying health priorities

in terms of the economic compatibility of disease costs (…) have led to the disappearance of health as a right, replaced by health as a *set of benefits*, that is, commercial goods"[5].

This "growing influence" both has a real impact on the choices made by health systems and permeates health care culture and terminologies. It dilutes the moral and technical power of the vision of public health by turning health into a commodity rather than a public good, and reducing it from an absolute right to a relative one: health policies and the organization of services are increasingly focused on management and cost containment, while living rather than dying, or being well rather than ill, have become dependent on economic logic rather than independent variables.

Some tentative conclusions can be drawn from all this:

1. **Global health isn't global.**
   What is global, instead, is inequality. The major global campaigns promoted by WHO have been major failures (recent examples: alcohol and Covid-19 vaccines). One need only think of the alcohol industry's powerful lobby, which not only sabotaged WHO's Global Strategy to Reduce the Harmful Use of Alcohol (2010), but actually nullified it thanks to aggressive policies that led to major governmental defections from the battle for public health and achieved a rise rather than a drop in the consumption of alcohol.

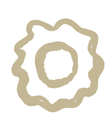
2. **The major global public health victories have not been those won by international institutions and specialized UN agencies, but rather by grassroots movements and low- and middle-income countries such as India, Brazil and South Africa.**
   Think, for example, of the historic and successful battles over patents and antiretroviral drug costs and the associated changes to World Trade Organization regulations on drug patents and possible related waivers.

3. **Social determinants: a question and a challenge.**
   Social determinants cannot be viewed as an "interesting" etiological feature of diseases and disabilities. On the contrary, every type of intervention aimed at "poverty alleviation" and the reduction of risk factors caused by social determinants should be incorporated into the standard protocols for health interventions.

4. **The issue is always the same: whether the right to health is, as a *right*, an independent variable or, as a *commodity*, a dependent one.**
   Rights must regain a central role and place in the design, planning and organization of health systems. It is both urgent and imperative that we stop considering them as "desirable settings" in which health systems deliver care and services, and start treating them as actual *indicators* of health and health policy, planning and delivery.

NOTES

1 Thomas P., Bracken P., Cutler P., Hayward R., May R., Yasmeen S. (2005). Challenging the globalisation of biomedical psychiatry. *Journal of Public Mental Health,* 2005, 4,3, 23-32.
2 Appadurai A., *"Deep Democracy: Urban Governmentality and the Horizon of Politics"* in Public Culture, 2002, 14 (1), pp. 21-47.
3 Stewart K.A., Keusch G.T., Kleinman A., "Values and moral experience in global health: bridging the local and the global", in *Global Public Health*, 2010, 5:2, pp. 115-121.
4 Appadurai A., "Cosmopolitanism from below", https://studylib.net/doc/18706964/cosmopolitanism-from-below
5 Tognoni G., La dominanza del fattore economico contro salute, diritti e beni comuni. In: *Rapporto sui Diritti Globali*, p. 1132-1136, Ediesse, Roma, 2012.



EXPERIENCES FROM THE FIELD

A (WRITTEN) VISION OF THE PRIMARY CARE WE'D LIKE TO SEE

Training and guiding general practitioners so as to ensure effective primary care: this is the aim of a new handbook on general practice and primary health care. A sort of road map, we wrote it to simplify the complexity of general practice, underscore its impact on the health of people and communities, and prepare tomorrow's doctors and health workers.

TEXT BY / CRISTINA VITO AND VIVIANA FORTE / GENERAL PRACTITIONERS

Why is it important to talk about general practice and primary health care at this time?

Primary health care services and general medicine have come under great scrutiny since the pandemic began. There have long been warnings, in fact, both at the national and international level[1], that in the absence of a primary health care model capable of meeting the challenges posed by current developments, two major phenomena are likely to collide and bring health care systems to their knees.

First of all, a rise in the number of people affected by chronic diseases and non-self-sufficiency, due in part to the absence of proactive, preventive, personalized health services. Secondly, an incapacity to respond in a suitable and systematic manner to help such individuals, due primarily to the inability to plan local health services close to where the people who need them actually live. A care model based on the principles of comprehensive primary health care is the only way to guarantee these services and capacities.

Why did you think it was important to write a handbook on general practice and primary care?

We believe that it is impossible to ensure effective primary care without providing suitable training to those who practice it, so we conceived and wrote a handbook to guide the general medicine and primary care practitioners of the future. Above all, we wanted our book to counter flatter, more outdated ideas about the role of general practitioner, to demonstrate how some GPs have different, in fact *broader*, expectations with regard to the profession, including its specific requirements in terms of training, care, social and research.

We talk about the idea that however transdisciplinary and context-dependent, open to study, investigation and change general practice may be, it is still based on specific knowledge with fixed boundaries. Knowledge that is not – as is often still erroneously believed – simply the sum of the basic skills of each medical specialty, but, on the contrary, a multitude of specific skills and characteristics that, in our opinion, need to be made clear in order to then bridge this critical knowledge and training gap.

So we decided to envision the future in a cultural sense, drawing up a sort of road map to a new GP culture, the one we hope to learn and to practice for the good of collective and public health. We hope our handbook will help people to critically explore the determinants of the health-illness continuum, keeping a constant and sharp focus on the individuals they meet in their communities.

How can we structure the training of local physicians for care in the future?

Internationally, the figure of the GP – known as a general practitioner or primary care physician – is a professional who must work at nine specific levels:

TABLE 1 /

1) HEALTH PROMOTION	5) OVERT DISEASE DIAGNOSIS
2) DISEASE PREVENTION	6) DISEASE MANAGEMENT
3) PRE-SYMPTOMATIC DISEASE DETECTION	7) MANAGEMENT OF DISEASE COMPLICATIONS
4) EARLY DIAGNOSIS	8) REHABILITATION
	9) PALLIATIVE CARE AND COUNSELING

The WHO holds[2] that GPs should be able to act within an especially complex theoretical and practical framework, adopting and managing specific skills and a range of approaches in a manner that is both complementary and just as demanding as that of internists.

In keeping with these values and principles, we decided to structure the handbook in three parts, each dedicated to a macro theme, i.e., primary care and general practice; health promotion and prevention in general practice; and general practice clinics.

The section on primary care and general practice lays out a *systemic framework* that outlines the principles underlying the Italian national health service (SSN)'s policies and services with regard to primary care and general practice; the principles underlying the training of practitioners and their research activi-

ties; physicians' practices and their practical management; relationships and communications in consultations; and practical and regulatory aspects related to prescription and certification.

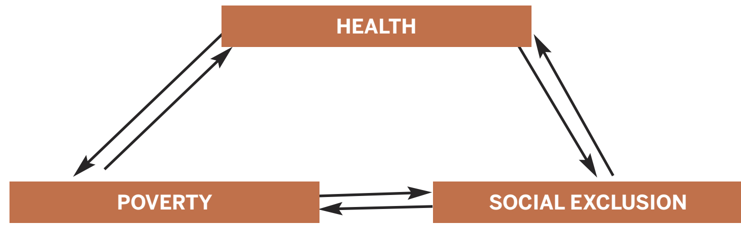
We then move on to an investigation of health promotion and prevention in general practice, offering a *population framework* to analyze the impact of complex systems (i.e., social and environmental settings) on health-illness dynamics, and review the key practices of health promotion and prevention.

Finally, we address the issue of general practice clinics, presenting a *clinical framework* that provides a precise and up-to-the-minute examination of the main issues in disease presentation, the management of consultations and specific therapies, both pharmacological and non-pharmacological, in home care, chronically ill individuals and emergency situations, in patients ranging in age from pediatric to the elderly, including primary palliative care.

How does the handbook address health care for socially frail individuals?

By starting precisely from the "acknowledgement of social complexity", and attempting to expand the concept both inside and beyond GP clinics. We also proposed an interpretation of ways in which economic, social and cultural ties can impact the health conditions of people in need of care.
This is why we sought to address a range of interrelated directions and aims with our book. First of all, we wanted to provide useful tools for identifying people at risk of exclusion and grave social vulnerability, to help GPs intervene *before* the exclusion occurs, and to implement early interventions and avoid reinforcing further exclusionary practices. Next, we wanted to present practices of active participation, construction and maintenance of community social and health networks and the non-profit sector, based on the notion that partnering on joint integrated health interventions is a value that promotes inclusion in and of itself. Finally, we wanted to spur the recording and production at the community level of social epidemiology data to help show how social status analyzed in relation to health data could guide us in developing practices to counter health inequities.

The complexity of the life dynamics of such disadvantaged individuals is challenging for *any* health professional from both a personal and professional standpoint; it is therefore imperative that they be "trained" to sharpen their wits and deepen their sensitivity and tenacity, in order to craft tailor-made and effective social/health interventions in which automatic procedures play no part. They also need to learn how to envision themselves as part of a broader social/health network and be prepared to deal with the challenges of managing the health issues of more socially vulnerable patients, people who often face huge challenges in accessing social and health rights – obstacles which must be correctly framed in order to be overcome. GPs everywhere will need to develop meta-skills regarding *how* to learn what they need to learn and how to "map" the social/health services in their specific communities at multiple, both formal and informal, levels.



NOTES

1 See the World Health Organization's *World Health Report 2008: Primary health care now more than ever*.

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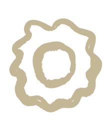


EXPERIENCES FROM THE FIELD

IN SUPPORT OF THE ELDERLY

An innovative project launched more than 40 years ago remains an exemplary model of political, health and social action in support of the elderly, and a viable alternative to Italy's *residenze sanitarie assistenziali* (RSAs)*: the residential cohousing center for self-sufficient seniors in the Tuscan town of Lastra a Signa offers an ideal mix of self-sufficiency, community living and interaction with the outside world to those in their "fragile years".

TEXT BY / ANGELA BAGNI / MAYOR OF LASTRA A SIGNA (TUSCANY)

Established in 1979 near Florence, the residential Social Center (CSR) in the town of Lastra a Signa has been a valuable resource for the local community for over 40 years. A public co-housing facility/group condominium, the center enables self-sufficient seniors to live in a home of their own for as long as possible, thanks to the creation of a network of assistance by its administrators, family members and neighbors of the residents, and the non-profit sector.

It is "a facility that [...] fosters group living and activities, with areas [...], structures, and public green spaces", an organization that makes it possible to provide services in an "equitable, efficient, precise and thus inexpensive way", wrote Gavino Maciocco in 1978. Despite being built in the late 1970s, it is a residential model that is still innovative and that continues to evolve today, a place geared around community living in the typical condominium style of the surrounding urban area.

The CSR is suitable for that delicate time in life in which aging people transition away from their productive age, helping them "stay active as they age" (Gavino Maciocco, 1978) by providing opportunities, should they so wish, to devote their time to group activities that are both socially useful and beneficial on a personal level. The facility is a complex that includes not only mini-apartments, but also a kindergarten, an AUSER office (an association for active old age), a public cafeteria, a library, a public nursery school, and a range of personal services. The area maintains ties with the nearby shopping center, other residential facilities and industrial and commercial activities.

One of the central features of the CSR is its openness to the outside world, based on the principle that "those outside should come in, and those inside should step out". It is a social hub for the community, a venue for social activities open to both residents and outside visitors.

CSR residents live their daily lives in total autonomy and with the same freedom of choice as people who live in their own homes. Each CSR apartment contains a kitchenette and a bathroom, and residents are free to do as they wish throughout the day and night (for example, there is no communal schedule dictated by the need to share a kitchen). New residents furnish their apartments as soon as they have been assigned one, using the previous resident's furnishings whenever feasible.

Over the last forty years the center has shown itself able to keep up with sociodemographic changes both broadly speaking and in relation to the elderly, adapting to changing needs and, above all, offering self-sufficient candidates a viable alternative to living in an RSA. Most importantly, it underscores the possibility, based on a successful real-life example, of developing other inexpensive but more gratifying housing models for seniors.

NOTES

* RSAs are non-hospital residential facilities – a type of nursing home – in Italy for non-self-sufficient elderly individuals who require specific medical care.

EXPERIENCES FROM THE FIELD

PRIMARY HEALTH CARE ON THE GROUND

In the Karamoja region, one of Uganda's poorest, tuberculosis is tackled thanks not only to dedicated anti-TB interventions, but also to primary health care programs. Launched by Doctors with Africa CUAMM in partnership with local authorities, this care model includes medical intervention, health worker training and awareness-raising initiatives, and continues to prove effective.

TEXT BY / FRANCESCA TOGNON AND BEATRICE SGORBISSA / DOCTORS WITH AFRICA CUAMM

In both high- and low-resource countries, health care models based on primary health care (PHC) principles continue to be fundamental in ensuring equity of access to health care, service quality and improved health outcomes.

This is also the case when it comes to tuberculosis (TB) in the Karamoja region, one of Uganda's poorest, where a fragile and under-resourced health care system means continued high morbidity and mortality from the disease[1]. Poverty, catastrophic expenditures, and excessive distances from diagnostic and treatment centers are the factors most closely associated with the region's low TB treatment success rate, which, at around 48% of notified cases, is Uganda's lowest, and high dropout rate (nearly 45%)[2].
In 2018, in partnership with district health authorities, Doctors with Africa CUAMM launched an innovative program to tackle TB in five districts in southern Karamoja. Inspired by key PHC principles – patient-centeredness, a focus on communities, and leverage of the peripheral health network to improve continuity of care – the program continues to be implemented today and is based primarily on medical care intervention, but also incorporates some health personnel training and mentorship and community awareness-raising activities.

The key pillars of the PHC approach include, first and foremost, strengthening community TB diagnosis and treatment services through intensified case-finding; reducing the number of cases lost to follow-up through the direct and systematic involvement of health center and community workers (village health teams) in the active surveillance of cases by way of scheduled appointments, phone calls and home visits (the bring-back-to-care strategy); launching a "TB day" at health centers with improvement of the quality of laboratory and clinical diagnoses (TB clinic day strategy), and creating a "one-stop shop" to offer integrated services for TB and HIV, COVID-19, malnutrition and diabetes.
In addition, in an effort to ensure local services, we piloted a successful "decentralized" outpatient care model for patients with stable, uncomplicated forms of treatment-resistant TB (MDR-

FIGURE 1 / TREATMENT SUCCESS RATE (PERCENTAGE OF ALL NOTIFIED CASES)

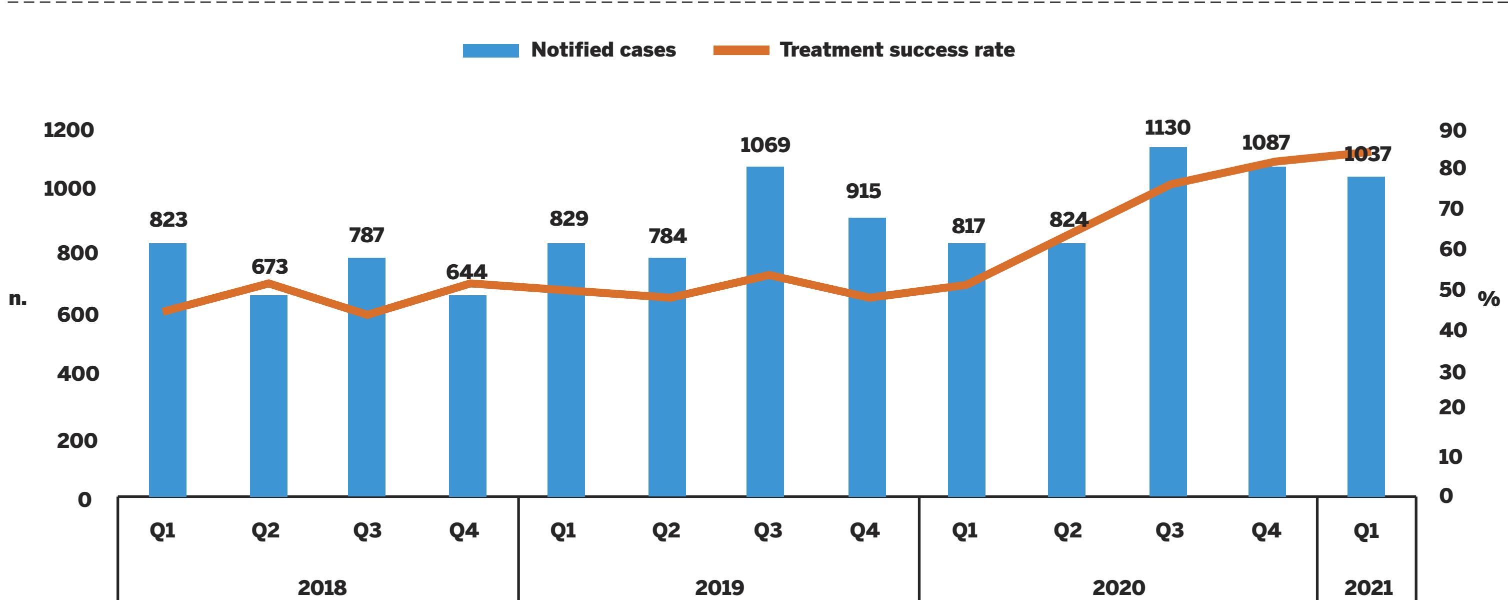
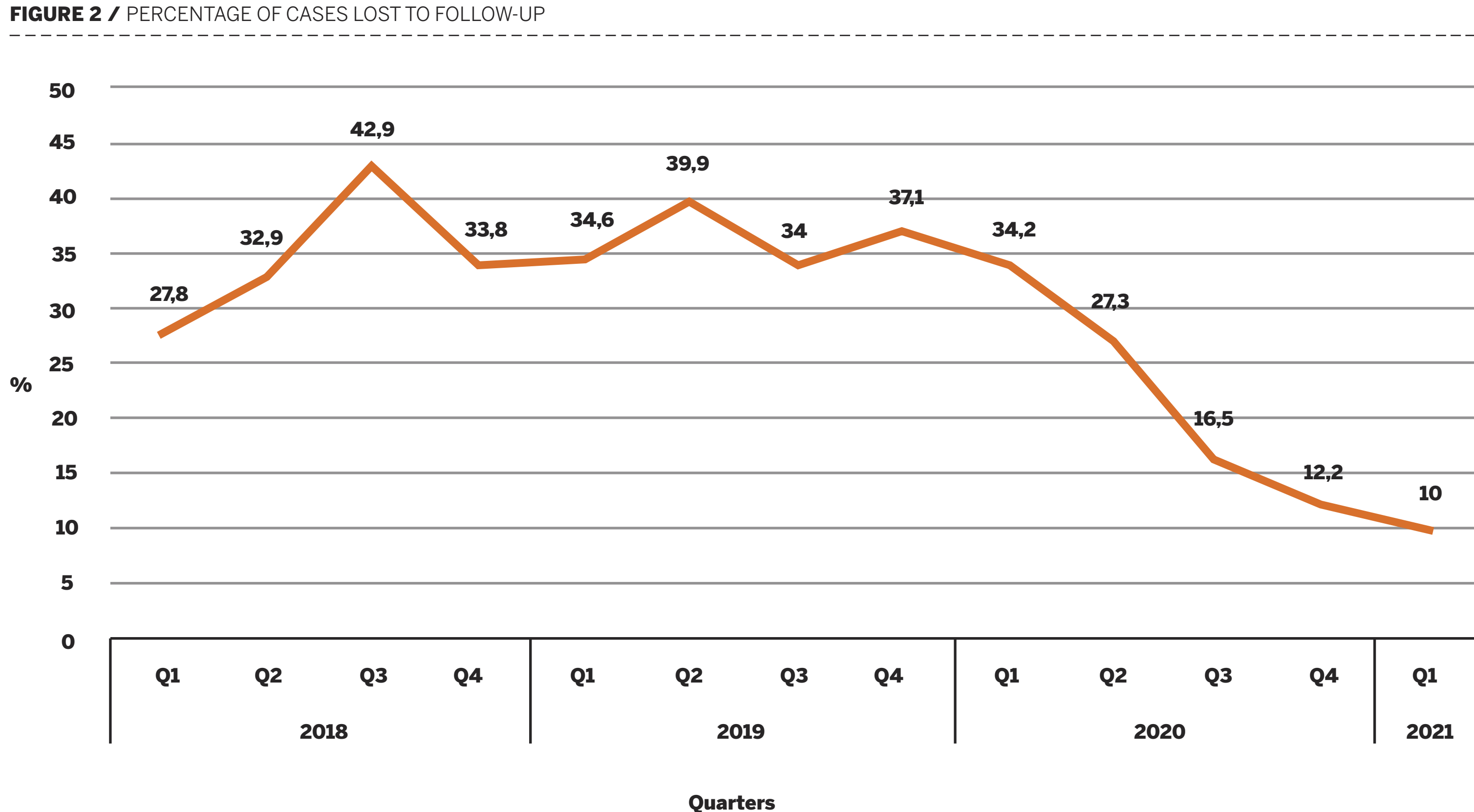


FIGURE 2 / PERCENTAGE OF CASES LOST TO FOLLOW-UP



TB) that entails training and mentorship work with the health workers who care for them, and organized mobile clinics to travel to communities in isolated areas and transport sputum samples for testing.
We also facilitated the identification and surveillance of high-risk venues and "hotspots" such as prisons and schools, and promoted community outreach activities such as door-to-door and group events, including community dialogues, dedicated days, talk show and radio ads.
In terms of the strengthening of the local health system, a significant investment was made in training, monitoring and data quality using the web-based ministerial platform (DHIS2) as well as in operational research (analysis of determinants and case-control program assessment) in support of district-level and national programming.

Even despite widespread general insecurity, the semi-nomadic nature of the population, and the disruption of services due to the Covid-19 pandemic, a trend analysis of a number of TB-related indicators in the districts where the intervention was implemented demonstrates the positive impact of this care model in a vulnerable area like Karamoja. Indeed, by early 2021 notified cases and treatment success rates had risen to 85% (see **Figure 1**), while the number of patients lost to follow-up dropped to 10% (see **Figure 2**)[3].

These figures underscore the importance of taking a PHC approach to health service provision, with community participation, service integration and equity of access becoming the foundations of healthcare that is affordable and equitable for all[4].

NOTES

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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.

TEXT BY / SALVATORE GERACI / ITALIAN SOCIETY OF MIGRATION MEDICINE AND CARITAS ROME

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

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TRAINING FOR GLOBAL HEALTH

Training as an investment in the creation of human capital and value: CUAMM has long offered opportunities to medical students and residents to take part in field training programs so that they can experience development cooperation directly and develop a global health approach that usually becomes a valuable professional asset. This was underscored by a recent survey conducted by the University of Padua of all the medical students and residents (a total of 257 and 157, respectively) who have participated in these programs over time. The findings, which were published in an international journal, showed that even many years after their experience, respondents felt it had left them both professionally and personally resilient, with a global approach that led them to consider not just their patients' illnesses but also the settings in which they live, and a strong sense of personal responsibility and initiative.

See Quaglio et al., *Medical Electives in Sub-Saharan Africa: A 15-Year Student/NGO-Driven Initiative*, in the Journal of Community Health.

NICOLA BERTI

REVIEW

WAR IN UKRAINE: YET ANOTHER CRISIS FOR AFRICA

The impact of the war in Ukraine is bearing down on Africa, adding to the financial, health, food and debt crises already afflicting the continent. The true scope of new crisis cannot yet be assessed, but there is no doubt that it is making the situations of many African countries even more complex than they already were.

TEXT BY / MAURIZIO MURRU / PUBLIC HEALTH SPECIALIST

The war in Ukraine and the sanctions imposed on Russia are impacting the entire world. In Africa, their consequences are joining those of other crises and mutually exacerbating one another, from the ripple impact of the 2008 global financial crisis to that of the Covid-19 pandemic, from the repercussions of severe food crises to those of the widespread debt crises that make it so difficult for many governments to take action.

CHILDREN OF A LESSER GOD

Following the Russian invasion of Ukraine on 24 February 2022, the refugee crisis was the first of many to manifest itself. In addition to millions of internally displaced people, some 6.7 million Ukrainians have sought immediate refuge in neighboring countries, many with the intention of moving on later to other countries[1]. The numerous Africans who were part of this flight faced discrimination both before and after crossing borders; at least 10,000 African students who left Ukraine have been unable to continue their studies in other European countries due to bureaucratic obstacles[2].

THE ENERGY CRISIS

After Russia invaded Ukraine the cost of oil soared to $120 per barrel, later dropping back down to the current $93[3]. It is still high due to both war-related anxiety and the reluctance of the OPEC countries to increase oil production, which is still about two million barrels below the pre-pandemic level[4]. While African oil-producing countries could benefit from the high cost, every other country will be harmed. In recent years Russia has supplied about 40% of the gas consumed in the European Union[5]; the need of the latter to diversify supply sources could benefit some of the African countries rich in this resource, including Algeria, Egypt, Nigeria, Mozambique, Congo-Brazzaville and Angola.

THE FOOD CRISIS

The food crisis is a complex issue often featured in articles containing biased and seemingly contradictory data[6,7]. The price of food on international markets is set in dollars, a currency that recently strengthened considerably; for many countries, this meant an increase in the cost of imports, including those of food. The cost of transportation has also increased significantly; for example, the cost of sea transport alone increased by 60%[8] between February and May 2022 (UNCTAD). It has also been claimed that the much-feared "world food crisis" is nonexistent since our planet produces enough food for everyone on it[9], and is being aired for purely speculative or propaganda reasons.

As Amartya Sen explained some 40 years ago, many famines occur at times when there is an abundance of food[10]; however, the fact that there is enough food for all does not mean that it is *available* to all. This has always been the case. Many African countries are now faced with ever worsening food crises, and the blockade of Ukraine's ports has only exacerbated situations that are already dire due to climate change, drought and conflict, especially in the Horn of Africa. Overall, African countries import around 40% of their grain needs from Russia and Ukraine[11], but are now being impacted differently given the different ways each depends on its imports: Eritrea and Somalia are close to fully dependent on them; Madagascar and Egypt depend on them for over 70% of their needs; Namibia, Tanzania, Congo, Rwanda, Djibouti and others for more than 50%, and so on[12]. Furthermore, half of the grain stuck in Ukrainian ports was intended for World Food Program operations in Africa.[13]

REBUILD AFRICAN AGRICULTURE?

Given that Africa contains 60% of our planet's remaining arable land, the African Development Bank has allocated $1.5 billion to find a solution, through investment and funding, to the food crisis plaguing the continent, with an increase in agricultural production and improved distribution[14]. The war in Ukraine has given a boost to such initiatives, ideas and objectives, including one that advocates for increased production of traditional grains such as fonio, sorghum, teff and millet, which are nutritionally rich and well-suited to the climate of many African countries[15]. But these are ideas for the future; in the immediate term, millions of people – estimates range from 20 to 50 million – are at risk of hunger in the Horn of Africa alone, an area now entering its fifth consecutive year of severe drought[16]. The crisis in Ukraine has indirectly aggravated the situation, with many donor countries now allocating funds there rather than crises in poorer countries in Africa and elsewhere[17, 18, 19]. It is worth recalling that rising food prices were the spark that ignited the Arab Spring in 2011.

WAR AND DIPLOMACY

The war in Ukraine has only hastened the "scramble for Africa" that was already underway to secure both access to its vast nat-

ural resources and diplomatic backing from its 54 nations. In late July, Russian Foreign Minister Sergey Lavrov began a tour that took him to Egypt, Ethiopia, Uganda and the Republic of Congo, during which he reiterated that one of the objectives of Russia's "special military operation" is to counter the West's global hegemonic plan. He also claimed that the blockade of Ukrainian and Russian grain exports was due not to the war, but rather to the sanctions imposed on Russia[20]. Almost at the same time, French President Macron visited Cameroon, Benin and Guinea Bissau[21] and, in a long-distance diplomatic battle, called Russia the "last colonial empire"[22], while President Biden announced that a long-awaited summit with African leaders would take place in Washington DC in December 2022. Lavrov then announced in Cairo that the second Russia-Africa summit would take place next year, while U.S. Secretary of State Antony Blinken flew to Johannesburg, South Africa, to start his second African tour, including visits to the Democratic Republic of Congo and Rwanda. In the following weeks a U.S. congressional delegation visited both Mozambique[23] and Macron[24]. China and Japan are also going to great lengths in this regard, with conferences, debt forgiveness and various other promises[25, 26, 27].

NEW COLD WAR DIVISIONS IN AFRICA?

The war in Ukraine is once again dividing the continent into two blocs, one aligned with Western positions and the other with Russia and China. Regardless of the positions of individual governments, people in many countries – even those aligned with the West – seem more inclined to fault the United States and Europe for hypocrisy and double standards than to share their positions[28].

The very different treatment of Ukrainians and Africans fleeing Ukraine, the diversion of funds from development aid to aid to Ukraine, both military and otherwise, and the West's focus on this war versus its indifference to the many conflicts in Africa, are all well-founded reasons for skepticism by many in African countries. In addition, the memory of the Soviet Union's support for many African wars of liberation from colonialism is still very much alive; not surprisingly, Lavrov recently stated Russia's intention to help Africa "complete the process of decolonization".

In conclusion, the consequences of the war in Ukraine are making themselves felt worldwide, Africa included. It will take time to assess their magnitude both in a positive sense, for the oil- and gas-producing countries, and in a negative one: high inflation, the energy and food crises, cuts in international aid, and years of education lost by thousands of African students. What we can say already with 100% certainty is that this war, like nearly all wars, will create more problems, direct and indirect alike, in both Africa and the rest of the world, than it can ever solve.

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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 over **70** years of existence

- more than **200** programs have been carried out;
- **2,100** individuals have worked on our projects;
- **43** countries have partnered with our organization;
- **239** hospitals have been assisted;
- **1,160** students have lodged at CUAMM's university college, including 874 Italians and 286 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, the Central African Republic, Ethiopia, Mozambique, Sierra Leone, South Sudan, Tanzania and Uganda with:

- **162 major development projects** and approximately 100 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);
  - 955 health facilities;
  - 3 nursing schools (in Lui, South Sudan, Matany, Uganda, and Wolisso, Ethiopia);
  - 1 university (in Beira, Mozambique);
- **4,581 health workers**, including 493 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

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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;
- 265,000 women die from pregnancy- or childbirth-related complications.

Doctors with Africa CUAMM works in

SIERRA LEONE
THE 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.

“Reflect and engage with individuals who have different kinds of expertise – political, legal, regulatory – to see whether and how your own experience might be translated into organizations and norms that help shape national health care, and do so in a way that produces proactive health policy and care that reaches out to people.”